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Chapter I: Introduction

Self-of-the-therapist (SOTT) ideology and practices are woven throughout the foundational fabric that defines the field of Marriage and Family Therapy (MFT). SOTT ideals are promulgated by the American Association for Marriage and Family Therapy (AAMFT) code of ethics defining standards of the profession (AAMFT, 2001). SOTT practices aid in shaping the standards by which the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) certifies their professional training programs (Horne, 1999). SOTT ideology and practices are also an integral part of the MFT theoretical ground founded on systemic principles (Aponte, 1982; Bowen, 1972; Kerr, 1981; Satir & Baldwin, 1983; Schnarch, 1991; Schwartz, 1995; Whitaker & Keith, 1981). Though the insistence of its necessity endures within the field of MFT (Horne, 1999), the literature regarding SOTT lacks documentation of how it is facilitated within those institutions that are responsible for educating MFT professionals.

The use of SOTT practices in the clinical setting are believed to be directly correlated with how those practices are being taught and utilized within training. In as much as the profession is called to legitimize the use of SOTT as a therapeutic practice (Gurman, 1987; Horne, 1999) the profession must have some sense of the working models used to train the professionals relying on SOTT practices. Authors have argued that

"…the integrity of a profession is associated directly with the effectiveness of its clinical education and supervision in the training and socialization of new members" (Everett & Koerpel, 1986, p. 62). This study will attempt to gain some insight into the current trends in the field as defined by those who train future therapists, educators, and researchers.

Historical Context

The field of Marriage and Family Therapy rose from the principles of General Systems Theory (von Bertalanfy, 1950), the study of individual parts that act as a whole unit or system. Satir and Baldwin (1983) offer this definition, "every part is related to the other parts in a way that a change in one brings about a change in all the others. Indeed, everyone and everything impacts and is impacted by every other person, event and thing" (p. 191). Historically the client-family was seen as a separate system, maintaining harmful patterns of organized communication (Mills, 1995; Real, 1990). As an outside observer, it was the therapists' job to intervene and correct the destructive patterns. Despite what would seem to be obvious connections between a therapist's need toward attention to oneself in the therapeutic system, the early marriage and family therapists primarily experienced him or herself as being outside and apart from the client system.

In the mid-1980s a conceptual backlash was experienced in the wake

of postmodernism. Objectivity was questioned as theorist began to reconsider the construction of reality as idiosyncratic rather than a universally "true" experience (Maturana & Varela, 1980; von Foerster, 1981). This movement had a profound effect on the field of family therapy as it gave rise to reconsideration of the therapeutic role. The marriage and family therapist was seen "as positioned within rather than as acting upon a system. Such a therapist facilitates change through participation in, and active engagement with, each system member's perceptions and experiences" (Real, 1990, p. 225). This repositioning of the therapeutic role has enhanced the need for therapist's self-examination and openness to reflexivity as both conscious and unconscious experiences of all participants are understood to interact relationally within the therapeutic setting. Theoretically it seemed apparent that "the practitioner must be conscious of what he brings into the relationship and learn to manage himself and his personal dynamics for the welfare of the clients" (Aponte & Winter, 1987, p. 93).

Construct Definition

Theoretically SOTT ideology can be traced back to Freud (1921/1958) and his expectation that those in training would participate in their own analysis in order to avoid the projection of personal defenses or anxieties onto their patients. In the MFT literature SOTT is defined simply as "the willingness of a therapist or supervisor to participate in a process that

requires introspective work on issues in his or her own life, that has an impact [sic] the process of therapy in both positive and negative ways" (Timm & Blow, 1999, p. 333). SOTT practices have been supported and heralded throughout time by many of the MFT leaders as the cornerstone of exceptional therapy (Aponte, 1982; Bowen, 1972; Kerr, 1981; Satir & Baldwin, 1983; Schnarch, 1991; Schwartz, 1995; Whitaker & Keith, 1981). Timm and Blow (1999) state that it "is a critical component of therapist training and development and that it makes the difference between mediocre and excellent therapists" (p. 333).

Rationale

There is an expectation of marriage and family therapists to participate in some form of consciousness raising work when therapist's issues impede their professional abilities. Principle 3.3 of the AAMFT Code of Ethics (AAMFT, 2001) stipulates that "Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgement." This is one of the mandates that must be met in regards to "professional competence and integrity" (AAMFT, 2001, Principle 3). Seeking professional assistance with personal issues or conflicts is stipulated by COAMFTE accredited marriage and family therapy programs as well, as faculty and students must "possess personal and professional integrity, including but not limited to compliance with the

AAMFT code of ethics" (COAMFTE, 1997, p. 10). Although not specifically stated, accredited programs have an ethical responsibility in attending to both the professional and personal development of the therapist in training when it intersects with the client's welfare. How COAMFTE accredited doctoral programs accomplish this is not documented in the literature.

The adherence to this aspect of professional integrity becomes increasingly important when one considers the profound effects the therapist-client relationship has been shown to play on the outcome of therapy. In their exhaustive research of therapeutic factors on outcome, Miller, Duncan, and Hubble (1997) found the therapeutic relationship to account for 30% of the successful treatment of clients, second only to the factors that exist outside of the therapeutic setting at 40%. And in the field of Marriage and Family Therapy specifically, therapeutic relationship has been touted as "the most important variable that dictates change in families" (Timm & Blow, 1999, p. 337). As we consider the personal factors that bring practitioners and educators to the field (Glickauf-Hughes & Mehlman, 1995; Miller, 1981; Titleman, 1987), in addition to the interactive relational dynamics at work in the therapeutic or supervisory setting (Todd & Storm, 1997), it seems we cannot deny the therapist's impact of his or her personhood on the therapeutic process. "Therapy is a personal relationship operating within

the parameters of a professional structure" (Aponte & Winter, 1987, p.93).

Purpose

There is currently little information detailing how best to implement SOTT issues in educational settings where concerns for dual relationships and transgressing therapeutic boundaries are abundant (Deacon, 1996; Guldner, 1978). The purpose of this study is to examine the practices and procedures of SOTT issues utilized in MFT doctoral programs accredited by COAMFTE. Perceptions of the professors associated with the implementation of SOTT training will also be included in an attempt to contextualize the training that is currently being received. The data derived from this study may prove useful to the future of the COAMFTE accreditation process.

In addition, despite the number of SOTT publications in the MFT literature, to date, there is no empirical evidence showing that SOTT practices either enhance or impede clinical effectiveness (Horne, 1999). Both Horne (1999) and Gurman (1987) have challenged the field to ground these theoretical assumptions regarding the importance of self-of-the-therapist work in empirically validated research. This challenge has been left unanswered. As the field seeks to integrate theory with effective therapeutic practices, we must first detail the process and aspects of those practices in our training programs (Tucker & Liddle,

1978). This study is a preliminary step toward exploring the phenomenon empirically as a forerunner to prediction or explanation (Heppner, Kivlighan Jr., & Wampold, 1999; Sprenkle & Moon, 1996). This research may provide insight as to how self-of-the-therapist issues are being defined and utilized by those who are responsible for training and shaping our future therapists, researchers, and educators.

Research Questions

Descriptive Statistics

This study will address the following descriptive statistical research questions:

1. How do COAMFTE accredited and candidacy status doctoral program's structure and implement SOTT training and is there agreement within programs?
2. How do COAMFTE accredited and candidacy status doctoral program's address the common concerns associated with SOTT training and is there agreement within programs?

Inferential Statistics

This study will address the following inferential statistical research questions:

1. Is there a significant association between any of the personal belief variables presented in the survey and a respondent's attitude toward

required therapy for Ph.D. trainees?

2. Is there a significant association between a respondent's age, years of teaching experience, years of clinical experience, or the number of years s/he has participated in therapy as a client and their attitude toward required therapy for trainees?

Chapter II: Review of the Literature

The MFT literature regarding the practice of SOTT in training programs is primarily theoretical with a large number of personal narratives. Some articles suggest the need for integrating skill-based and personal growth models rather than focusing on only one particular form of training (Aponte & Winter, 1987; McDaniel & Landau-Stanton, 1991; Watson, 1993). Others discuss the potential hazards and pit falls of implementing SOTT practices (Aponte, 1994; Haber, 1990; Timm & Blow, 1999; Watson, 1993). Virtually all studies and theory-based publications continue to support the need to include some form of the therapist's personal development within training programs. To date, there is only one published article detailing the utilization of a growth-oriented model in an educational setting (McDaniel & Landau-Stanton, 1991), however this publication referred to a COAMFTE approved internship site and not a doctoral program. The literature is neither current nor complete. This study is being implemented to fill that gap, potentially offering the field information that may be helpful in the accreditation of programs in the future.

The Theoretical Structure of Training

Historically, marriage and family therapy training has been broken down into two schools of thought: the first is a technical or skill-based

training model, while the second is grounded in experiential or transgenerational practices (Aponte & Winter, 1987; McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). The skill-based training model originated with the work of Jay Haley (1976). As in therapy, the focus of training was in the present and stressed the technical or external skills needed to participate appropriately within one's given context. Both structural and behavioral models are included in this category. Virginia Satir (Satir & Baldwin, 1983) pioneered the effort toward an experiential therapy that focused on the therapist's personal experience in joining with the family system (Aponte & Winter, 1987; Deacon, 1996). Similarly, Murray Bowen's (1972) transgenerational model reflected his belief in the need for personal growth not just for the client but for the therapist as well. Training was based on increasing the trainee's level of differentiation so that personal issues and blind spots were not recreated between therapist and client within the therapeutic setting. The extent to which a therapist's personal experiences are integrated into the training process continues to be controversial (Deacon, 1996; Horne, 1999).

In the 1980s a third camp emerged marked by a desire to accommodate training and supervision to the trainee's developmental level. The developmental structure offered the teaching of skills and techniques to new trainees, integrating more complex views of change and SOTT training only after the basic therapeutic skills had been

mastered (McCollum, 1990; McDaniel & Landau-Stanton, 1991; Todd & Storm, 1997). Although widely utilized (Kaslow, 1986), controversy does exist as to whether or not SOTT training is an advanced skill. McDaniel and Landau-Stanton (1991) have shown that it is possible to integrate SOTT education into training at any level. They suggest that it is more important to pay attention to the particular needs of the trainee rather than dismiss the opportunity for developing the therapist's self at early stages of training.

Training Models

Satir and Bowen are two of the most widely taught systemic models based on the therapist's use of self. While Satir's model is somewhat idiosyncratic, Bowen's model is primarily theoretical. Both are difficult to master due to what Aponte (1987) defines as being internally based. They lack many of the concrete technical skills that allow for specific interventions within the therapeutic process.

In 1987 Aponte utilized both skill-based and growth oriented models to create what he called the Person-Practice model. The Person-Practice model is atheoretical, focusing "primarily on the *bridge* between the therapist's personal life and his actual conduct of treatment" (Aponte & Winter, 1987, p. 99). The goal of the therapist's personal development is second to the use of one's self to increase the effectiveness of his or her clinical work. Aponte believed that therapists' "self" as a clinical tool was

effected by their life circumstances. Resolution of personal issues brought about a certain self-awareness that allowed the therapist to be increasingly open to new avenues of change, adding to therapeutic effectiveness. Aponte's training model involved one to two years of group work to discuss personal and clinical issues, as well as videotapes, training presentation, the role play of clinical issues, and family interviews to bridge the gap between personal dynamics and client treatment.

Training Techniques

A considerable amount of effort has been put toward publishing an array of techniques and skills designed to promote the development of the therapist's self. Ultimately the exercises and practices are designed to free the therapist of their own rigid patterns that interfere in the therapeutic process. It is theorized that as therapists increase their own personal awareness their internal experience can be utilized to act and intervene within session rather than react to the family dynamics. "Since the therapist's experience/interaction within the therapeutic system frequently parallels the family dilemmas, the therapist's personal reactions are key to use to enter and understand the analogic, relational and symbolic process within the client and therapeutic system" (Haber, 1990, p. 376-377).

The most common format for SOTT training is within supervision groups (Aponte & Winter, 1987; Haber, 1990; Merta, Wolfgang, & McNeil, 1993; Timm & Blow, 1999; Tucker & Liddle, 1978). Supervision of client cases allows the trainee's supervisor and peers to observe the trainee in action, giving appropriate time to notice where the therapist's personal life may intersect with the client family's life. MFT educators and/or supervisors have also suggested that supervision groups that include trainees with various levels of experience may enhance a sense of safety for the newest trainees as older group members model self disclosure and personal awareness (Haber, 1990; Timm & Blow, 1999; Tucker & Liddle, 1978). Supervision may happen live, or a family session may be video- or audio- taped (Aponte & Winter, 1987).

Trainee awareness may be developed and enhanced through experiential exercises (Deacon, 1996). Group members may be asked to help a trainee role play a clinical impasse as a way to externalize internal dilemmas (Aponte & Winter, 1987; Haber, 1990; Mintz, 1983; Shalit, 1990; Timm & Blow, 1999). Metaphor, stories, sculptures and myths have been used to dramatize clinical difficulties and future interventions (Haber, 1990; Timm & Blow, 1999). Some authors speak of eliciting images from the trainee that represent the integration of the parts of the trainee's self that are polarized within session as a way to move through a therapeutic impasse (Haber, 1990; Timm & Blow, 1999).

The genogram is a frequently used SOTT training technique (Braverman, 1997; Guerin & Fogarty, 1972; McDaniel & Landau-Stanton, 1991; Protinsky & Keller, 1984; Timm & Blow, 1999), often modified for a trainee's particular needs. Genograms allow the trainee to map out family history, noting patterns and influences that have been handed down through several generations. Often trainee genograms are used side by side with client genograms to emphasize patterns that occur between both client and therapist (Protinsky & Keller, 1984), also known as double genograms (Braverman, 1997) or ecograms (Fontes, Piercy, Thomas, & Sprenkle, 1998). Cultural genograms are also utilized in an effort to bring awareness to the trainee's beliefs and values regarding cultures other than their own (Fontes et al., 1998). Timelines are a similar technique utilized to help trainees experience themselves from a larger perspective (Timm & Blow, 1999).

A more unique training tool calls for the exploration of the therapist's self through specific writing assignments. Carlson and Erikson (1999) ask their trainees to first develop a theory of change based on questions linking their theoretical orientation to their personal values and beliefs. They have found that it evokes accountability regarding who they are and why they choose to implement treatment the way they do. Next the trainees are asked to explore the values of their chosen theory in relationship to the cultural and historical context of the theoretician, eliciting thoughts on how this effects the fit between self, their practice,

and their clients. The final assignment involves exploring the values inherent in the stance they have taken as a therapist, asking trainees to reflect on the kind of influence that may exert on their clients. The authors believe that such training exercises offer therapists an opportunity to redefine and expand their sense of self, in turn allowing the client the same opportunity.

It is uncertain as to how many training programs require personal therapy of their trainees, another technique utilized in the development of therapist self awareness. Those who do require therapy of their trainees are quite passionate about its necessity in the training of family therapists (Aponte & Winter, 1987; Guldner, 1978). Requirements run from individual therapy to involving spouses and families outside of the program (Guldner, 1978), to sessions in-house with supervisors (Aponte & Winter, 1987). In addition to movement through personal issues, personal therapy is believed to help the therapist understand the experiences of the client; to know the difficulty of uncovering unconscious material and how difficult it can be to accept confrontations and interpretations of one's own personal behavior (Liddle, 1982; Stringer-Seibold, 1998).

In a 1986 survey, Saba and Liddle collected the responses from both the American Association of Marriage and Family Therapists (AAMFT) and American Family Therapy Association (AFTA) approved supervisors and trainees regarding the professional needs of trainees. It was found

that 45% of AAMFT and 43% of AFTA members believed that personal therapy was important for therapist trainees. In 1998, therapy as an effective teaching component was supported by Stringer-Siebold's study which revealed that although trainees felt fear at times that they were "flawed," therapy during training provided an excellent experiential lesson in preparation for their professional training. Although personal therapy for trainees is not unanimously supported in the literature, to date the studies questioning its efficacy within the training process have shown positive results for the trainees.

Diversity and Self-of-the-Therapist Training

From a postmodern vantage point, SOTT training is essential in the development of a therapist's values and belief system. As the therapist role has changed from an observer of the family dynamics to a participant in the family system, concerns have risen regarding the values, beliefs and biases toward an increasingly diverse clinical population (Mills, 1995). Training therapists sensitive to marginalized populations has become a crucial issue in the field (Watson, 1993). "In order to have an open exchange, therapists must be open to new information: it is important that they do not feel trapped into defending a particular viewpoint" (Parry & Jones, 1986, p. 189). Issues of gender (Deacon, 1996; Hare-Mustin, 1986; Kramer, 1985; Timm & Blow, 1999; Watson, 1993), sexuality (Kramer, 1985), age (Hare-Mustin, 1986),

ethnicity (Boyd-Franklin, 1989; David & Erickson, 1990; McGoldrick, Pearce, & Giordano, 1982), culture (Boyd-Franklin, 1989; Fontes & Thomas, 1996; McGoldrick et al., 1982; Watson, 1993), religious and spiritual values and beliefs (Haug, 1998; McGoldrick et al., 1982) are all now grist for the SOTT mill. Exploring SOTT in conjunction with the preceding issues is crucial not only to therapist's effectiveness with clients, but supervisor's effectiveness with therapists (Watson, 1993).

Concerns Associated with Self-of-the-Therapist Training

A number of concerns dominate the field of MFT regarding the integration of SOTT training into graduate programming. The most prominent are those concerning the confidentiality of the students, the boundary that lies between supervision and therapy inherent within SOTT issues, and the potential concerns regarding dual relationships. The AAMFT ethical guidelines stress the importance of respecting the power intrinsic within the hierarchical relationships that exist in educational settings (AAMFT, 2001). COAMFTE only stipulates that all accredited programs are bound by the AAMFT ethical regulations, there are no guidelines offered as to how one might safely implement SOTT training (COAMFTE, 1997).

Principle IV of the AAMFT code of ethics entitled "Responsibility to Students and Supervisees" states, "Marriage and family therapists do not exploit the trust and dependency of students and supervisees" (AAMFT,

2001). When utilizing SOTT training in an effort to increase a trainee's therapeutic effectiveness, supervisors become privy to the personal issues of the trainee. The hierarchical power structure that exists between a supervisor or professor and their trainee leaves the student vulnerable when intimate details of the trainee's life are revealed. Principle 4.7 of the code of ethics mandates that,

> Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law (AAMFT, 2001).

The majority of the literature reviewed discussed the issue of confidentiality within SOTT training. However in this particular review only one article regarding the training of therapist in SOTT issues discussed the need for a written contract between trainee and supervisor (Aponte, 1994). Three articles stressed the importance of confidentiality and the need for continued discussion of student safety and self - disclosure throughout the training process (Haber, 1990; McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). The authors did emphasize the importance of obtaining permission from students to

participate in SOTT work, however they did not speak to requiring written authorization. Graduate programs may potentially address this issue in student handbooks and assume that by entering the program the student has automatically given consent. As COAMFTE guidelines mandate the compliance with the AAMFT code of ethics, this would not be in keeping with the regulations for accredited programs.

Once students and supervisees agree to participate in SOTT training, the supervisor is placed in the precarious position of walking the line between appropriate supervision and playing therapist to the supervisee. Section 4.2 of the AAMFT code of ethics (2001) stipulates that "Marriage and family therapists do not provide therapy to current students or supervisees." This is considered one of the many types of dual relationships that potentially lie within the educational setting.

The literature is saturated with the discussion of the boundary that exists between supervision and therapy, however little information is given as to how to walk this line in an appropriate manner. A search through the literature regarding SOTT training and supervision found only one author that pulled apart and delineated specific guidelines (Aponte, 1994). As he offers conditions that might signify inappropriate behavior, Aponte (1994) points out that it is not the dual relationship per se that is problematic, but the exploitation of a student or supervisee within the relationship that is unethical. Aponte (1994) lists the

following three conditions as a way to delineate between *dual qualities* and *dual relationships*:

1. *Abuse of power*: Does the trainee understand the implications of the dual qualities of the relationship and have the freedom to enter into or refuse any aspect of the relationship?
2. *Intent to exploit*: Is their intention to take advantage of a trainee? Is there personal gain that motivates the trainer to enter into the dual qualities of the relationship?
3. *Harm done the trainee*: Has the trainee been hurt by the dual qualities of the relationship? How much and in what ways? (p. 5-6).

The question as to where one draws the line is complex and not easily solved. Even if an appropriate solution were implemented as a standard within the field, disregarding the context of individual relationships has potential to destroy some of the richest mentoring that exists within the educational setting. Most scholars agree that the bottom line in SOTT training is personal work in the name of improving therapeutic effectiveness (Aponte, 1994; Deacon, 1996; Haber, 1990; Protinsky & Keller, 1984; Watson, 1993).

> Personal work is meant to be therapeutic, not therapy, which is essentially an effort to resolve personal issues. Trainers commit to trainees' personal issues primarily to improve their performance as therapists….the ultimate goal is not achieved until trainees learn to

use the original struggle and the journey to resolution as resources for their work with clients (Aponte, 1994, p. 5).

The potential for dual relationships not only exists within the context of supervision and training, but in the realm of advisor and advisee, as a part of the grading system between professor and student, the formation of research committees, and at the doctoral level, the transition from student to colleague. Lines are diffuse and the risk for exploitation is great as professors and supervisors learn more about the intimate details of their trainees' lives.

Guidelines for dual relationships are sparse as most delineations are difficult to make. Scholars have put forth the following suggestions in an effort to decrease the risk of potentially exploitative relationships. Again, the creation of contracts is thought to be vital (Aponte, 1994; Haber, 1990; McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). Some authors propose that supervisors should take on a more collaborative stance in the SOTT training process moving away from the hierarchical, expert position of the past (McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999; Watson, 1993). In extending a collaborative stance some authors believe that it is appropriate for supervisors to disclose their own beliefs and experiences as a way to create safety and model openness for their supervisees (Bennett & Zilbach, 1989; Deacon, 1996; Watson, 1993). One author suggests it is better that professors not facilitate

SOTT groups (Merta et al., 1993), while another believes co-trainers should be utilized as a way to balance the power (Aponte, 1994).

Several scholars have proposed that supervisees should be given the opportunity to define their experience, choose the exercises they participate in and the extent to which they disclose personal history (McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999; Watson, 1993). There are also those authors who suggest that grades for SOTT assignments and experiences are inappropriate and should be judged on either a pass/fail basis or graded for completion only (McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). Ultimately, the majority of scholars reiterate that personal disclosures and SOTT issues are training tools utilized for the purpose of increasing the effectiveness of therapeutic outcome (Aponte, 1994; Deacon, 1996; Haber, 1990; Protinsky & Keller, 1984; Watson, 1993).

MFT Training and Supervision Themes

In 1972 Liddle and Halpin published a critique that reviewed and categorized over 100 MFT training and supervision articles. Six themes emerged in their research. These included: (1) the goals of training and supervision and skills of the supervisor; (2) the supervisory techniques; (3) supervisor/supervisee relationship; (4) personal therapy for the trainee; (5) politics of family therapy training; and (6) the evaluation of training. Although the supervision and training models differed in their

theoretical orientation, almost all contained aspects of the themes mentioned above.

The themes generated by Liddle and Halpin's (1972) work may offer an atheoretical structure from which to begin evaluating the current trends in SOTT training in COAMFTE accredited doctoral programs. The SOTT training and supervision literature reviewed for this study reveal similar themes: the discussion of goals and techniques of training, supervisor/supervisee relationship, in addition to whether or not personal therapy is advisable for MFT trainees. "The politics of family therapy training" theme must be updated. In 1972 when Liddle and Haplin's article was published, MFT was still fighting to be recognized as a legitimate field. The fight for recognition was the "politics" of the day. In today's context and for the format of this study, it may be more appropriate to address the concerns of SOTT training under the political theme. Due to the lack of information on how COAMFTE programs administer, implement, and integrate SOTT supervision and training, this study may be considered a preliminary investigation into the future examination of the topic.

It is important to note that Liddle and Halpin (1972) concluded that the field's publication and research efforts in the area of training and supervision have not kept pace with the energy given to clinical methodologies and theory. Everett and Koerpel echoed this conclusion in 1986 with the only other review of MFT supervision and training

literature to date. In an effort to update and integrate our training and supervision practices it is necessary to detail "the process and components of our training programs" (Tucker & Liddle, 1978, p. 26).

Conclusion

According to Deacon (1996) "...most graduate programs focus on the professional training of the therapist and leave students to develop their personhood as a therapist on their own" (p. 171). In this review of the literature there was no evidence found to support this statement, neither was there evidence to discredit it. Although the importance of SOTT training is emphasized in the literature, there is an absence of information describing the structure and implementation of SOTT training in COAMFTE accredited doctoral program. In fact, the field has no sense of how COAMFTE accredited programs carry out the ethical mandates regarding the maintenance of professional integrity, or the structure utilized to assure the safety of the students.

The most recent publications on the subject of SOTT training in marriage and family therapy suggest that our supervision and training practices are still polarized; they are either primarily skill-based or primarily experiential (Deacon, 1996; McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). The literature whole-heartedly supports the idea "that self-of-the-therapist work is a critical component of therapist training and development and that it makes the difference between

mediocre and excellent therapists" (Aponte & Winter, 1987, p. 96). One of the key elements to a therapist's success with clients is effective clinical training and supervision (Aponte & Winter, 1987). It is my hope that this study may offer the field insight into the process and content of current supervision and training trends.

Chapter III: Methodology

Sample

The focus of this study targeted all doctoral programs in North America either accredited or under candidacy status for accreditation by COAMFTE (See Appendix A). A list of programs was provided by the AAMFT website (www.aamft.org) posted November 19, 2001. At that time there were 18 doctoral programs identified, three of which were under candidacy status, and one accredited Doctor of Psychology program. In the most recent update (October 18, 2002) the AAMFT website posted a new Ph.D. program under candidacy status. As it was posted after the collection of survey data, this program was not included in the study.

Doctoral programs were chosen based on the literature regarding self-of-the-therapist training. Few graduate programs are thought to utilize SOTT techniques in their training programs (Deacon, 1996). When SOTT training is utilized within graduate programs, it is assumed the training is sequentially based rather than integrated (McCollum, 1990; McDaniel & Landau-Stanton, 1991). This supports the focus of early therapist development on the acquisition of skills and a working knowledge of theory. More advanced therapists are then encouraged to develop a sense of self and the use of that self within the therapeutic encounter. It was assumed by this researcher, through collegial discussions and a review of the literature that for the most part, doctoral programs were

more likely to have integrated self-of-the-therapist training as a part of the curriculum.

The original study was created to target both faculty and students in an effort to compare experiences and beliefs of SOTT training. Student response was poor and the study was redefined in accordance with faculty responses. All participating faculty members were working full-time in an AAMFT supported doctoral program.

Procedure

Each of the 18 COAMFTE accredited doctoral programs was contacted by phone to assure the name of the director and the number of full-time faculty teaching in the program. Cover letters, faculty surveys, and postage-paid return envelopes were mailed to each program director. The cover letter detailed the purpose of the study, the major areas of SOTT training to be investigated, and how the resulting data was to be used (see Appendix B). The program director was asked to disperse surveys and self-addressed stamped envelopes to all faculty members, maintaining their confidentiality.

Participants were assured that individual and institutional responses would remain confidential. The materials were kept in a locked filing box accessible only to this researcher. The survey packages were coded for the purpose of contacting programs that did not return the surveys. The coding lists were destroyed immediately after the survey deadline was

reached. Program directors were contacted by phone after a three-week period to remind their faculty to return surveys.

Instrumentation

The survey has been developed primarily from the literature reviewed in preparation for this research (see Appendix C). The structure of the survey was based on Liddle and Halpin's (1978) review of supervision and training publications in the field of MFT. Over 100 publications were reviewed and synthesized. Categories were created based on the most frequent content areas to appear in the literature, then labeled and described. All categories were included in the survey. The survey's sections reflect the categories described in Liddle and Halpin's review. The content of each section was drawn from the literature regarding SOTT training in the field of MFT.

Section B of the survey entitled “Program structure” was an addition to the Liddle and Halpin’s (1972) list of categories. The data collected in this section were utilized to help bring some understanding to the way in which accredited programs physically structure their training. Section G of the survey was changed to reflect the current political context within SOTT training. Originally Liddle and Halpin (1972) had identified a common concern amongst scholars regarding the perceived legitimacy of MFT as a profession. Today MFT appreciates wide acceptance as a professional field. A review of both the past and current literature in

SOTT training revealed major concerns in the areas of confidentiality, dual relationships, and the boundary between supervision and therapy. These areas were all addressed under section G of the survey, fulfilling Liddle and Halpin's (1972) category of political concerns.

As mentioned earlier, the original study had targeted both faculty and students of COAMFTE accredited and candidacy status doctoral programs. Student and faculty were sent similar surveys, differing only in regard to participant's role as student/supervisee or professor/ supervisor. Survey content was consistent between each group. Students were eventually excluded from the survey due to poor response rate and the research questions were reformulated.

Data Analysis

Descriptive statistics were utilized for the first two research questions and calculated based on the format of the survey question. Frequencies were used for categorical questions and means and standard deviations were run for continuous variable questions. A chi-square calculation was utilized to assess significance between personal belief variables and attitudes toward requiring therapy for doctoral trainees, while independent t-tests were employed to test for significance with continuous variables and their association with attitudes toward therapy requirements.

Chapter IV: Results and Discussion

A total of 77 surveys were mailed. Thirty-three surveys were returned. Of the 33 returned surveys, one was unusable due to incomplete data rendering a response rate of 42% (N=32). The 32 usable surveys represented 14 (78%) of the 18 AAMFT accredited doctoral programs. The number of returned surveys within the 14 programs ranged from 100% for six of the schools, 60% for two of the schools, 50% for two of the schools, 40% for one of the schools, and 20% to 38% for the remaining four schools. Exact numbers could not be disclosed as it had the potential of compromising the schools' confidentiality.

It is important to note the sample numbers change throughout this chapter. Items related to personal therapy for trainees and student evaluation are based on a sample of 32 (N=32). Items related to program structure, training goals, training techniques, and supervisor/supervisee relationship are based on a sample of 27 (N=27). The later items were related specifically to SOTT training. The five respondents who did not feel SOTT was part of their program were asked not to complete this portion of the survey.

Sample Demographics

The following demographic information is based on a sample of 32 faculty members representing 14 of the 18 AAMFT accredited and candidacy status doctoral programs. The mean age of faculty replying to

the survey was 48 years old; both median and mode were 50 with ages ranging from 29-67. Thirty-eight percent (38%) of the 32 respondents were female, 62% were male. Race broke down in the following manner: 6% African American, 3% Asian American, 88% Caucasian American, and 3% Middle Eastern. Ten percent (10%) of the respondents reported being single, 10% reported being coupled, 68% reported being married, and 12% were divorced. It is important to note that "remarried" was not offered as an option within the survey, potentially skewing the results.

Respondents reported receiving their Ph.D. degrees in the following fields: 47% in MFT, 28% in Psychology or Counseling Psychology, 3% in the area of Social Work, and 22% in Child/Family/Human Development or Sciences. Fifty percent (50%) of the faculty surveyed reported receiving their doctoral degrees during the 1990s. Ten percent (10%) of the faculty reported receiving their degrees during the late 1960s, 13% of respondents received degrees during the 1970s, 20% received degrees during the 1980s, and 7% received degrees between 2000 and 2002. Graduation dates ranged from 1967 to 2002. The mean number of years teaching was 12 with a range from one to 37 years. The mean number of years in clinical practice was 19 with a range from zero to 35.

Respondents were asked to remark on their theoretical orientation, reporting the three theoretical models that best described their work as a clinician. All 32 respondents answered although some chose fewer than three models. The most frequently reported clinical model was Bowen/

Transgenerational therapy (44%). Structural therapy was utilized by 38% of the respondents and Narrative Family Therapy was used by 28% of the respondents. See Table 1 for a full list of therapeutic modalities.

As the demographics are reviewed it is important to remember that the response rate was 42%, or 32 out of 77 faculty members. One cannot say definitively that those who responded are representative of MFT doctoral faculty as a whole, but one can keep in mind the picture that emerges of the average faculty member as the remaining responses are explored and discussed. The average respondent within this survey may be characterized as follows: male (62%), 48 years old, Caucasian American (88%), married (68%), received a Ph.D. in MFT during the 1990s (50%), has been teaching for 12 years and participating in some form of clinical practice for close to 19 years. Bowenian (44%), Structural (38%), and Narrative Family Therapy (28%) are the clinical models most often used by this group.

Table 1. Respondent's Theoretical Orientation

THEORETICAL MODEL	FREQUENCY	%
Structural	12	37.5
Strategic	7	21.9
Bowen/Transgenerational	14	43.8
Experiential	7	21.9
Cognitive/Behavioral	6	18.8
Psychoanalytic Family Therapy	2	6.3
Feminist Family Therapy	6	18.8
Solution Focused	6	18.8
Narrative Family Therapy	9	28.1
Internal Family Systems	0	0
Emotionally Focused	7	21.9
Other	12	37.5

Descriptive Statistics

Program Structure, Implementation, and Within Program Disagreement

In 1996, Deacon reported that few graduate programs were thought to utilize SOTT techniques in their training programs. Of the 14 programs represented in the survey 12 reported the incorporation of SOTT training. In this section, the survey sample is reduced from 32 (N=32) to 27 (N=27) due to five respondents stating that their program did not incorporate SOTT training.

Those respondents who believed their programs qualified as having an SOTT training component were asked to report on their program's theoretical orientation, choosing the three that best described their program. Thirty-three percent (33%) of respondents reported that their program was "not defined by any one model." Twenty-six percent (26%) of the respondents reported that the theoretical orientation was chosen by the trainee, while 26% of the respondents reported that Structural Family Therapy was their program's primary orientation (see Table 2).

The responses marked in this section would appear to reflect the developmental training structure discussed in the literature as the third theoretical wave (McCollum, 1990; McDaniel & Landau-Stanton, 1991; Todd & Storm, 1997). If a program's theoretical orientation is not specifically defined or instead defined by the participating trainee, one may assume a more advanced level of theoretical understanding and

Table 2. Program's Theoretical Orientation

THOERETICAL MODEL	FREQUENCY	%
Structural	7	25.9
Strategic	2	7.4
Bowen/Transgenerational	6	22.2
Experiential	2	7.4
Cognitive/Behavioral	2	7.4
Psychoanalytic Family Therapy	0	0
Feminist Family Therapy	1	3.7
Solution Focused	1	3.7
Narrative Family Therapy	4	14.8
Internal Family Systems	0	0
Emotionally Focused	6	22.2
Determined by trainee	7	25.9
Not defined by any one model	9	33.3
Other	0	0

N=27

professional development. Supporting this assumption is the fact that two of the most commonly marked models represent both skill-based (Structural) and growth oriented (Bowen/Transgenerational) theories of training. This practice of utilizing both skill-based and growth oriented models was utilized by Aponte (1987) to create the Person-Practice model that bridged a clinician's personal experiences and their participation in the treatment room.

Of the 12 schools represented, however, 11 disagreed internally as to the program's theoretical orientation. Internal agreement was not an issue for the 12th program due to the number of its programs respondents (n=1). Although two of the most popular answers reflected no specific orientation, the most frequently noted models, Structural (26%) and Bowen/Transgenerational (22%), were also two of the most noted models for respondent's individual orientations. Due to the lack of internal program agreement it would be safe to say that the majority of programs are loosely defined theoretically, and though individuals may support and practice a more integrated theory of training, it is not necessarily the official theoretical model held by any one program.

To some degree this would seem to hold true for SOTT training structures across all programs represented in the survey. While 78% of the respondents reported that SOTT training was integrated throughout supervision and course work (see Table 3), 33% of programs disagreed internally as to when that training took place. While 74% of the

Table 3. Format In Which SOTT Training Is Offered

FORMAT CHOICES	FREQUENCY	%
In SOTT training groups	0	0
In individual supervision	2	7.4
In group supervision	0	0
In individual & group supervision	4	14.8
In separate course work	0	0
Integrated throughout supervision & course work	21	77.8
Other	0	0
Total	27	100

N=27

respondents stated that the average number of weekly hours devoted to SOTT training was zero to five (see Table 4), 25% of the programs disagreed internally as to the actual number of weekly training hours. Eighty-nine percent (89%) of the respondents described SOTT training as integrated over the length of the program rather than clustered toward the beginning, middle, or end (see Table 5). Here too, 25% of the programs in the study showed within program disagreement.

Sixty-three (63%) of the respondents stated that their students were allowed to choose the type of SOTT activities they participated in, 58% of the programs disagreed internally. Regarding evaluation of assignments, 30% of the respondents reported that SOTT assignments received letter grades, 14% stated that SOTT assignments received a pass/fail based on completion, while 55% marked the "other" category. Forty-two percent (42%) of programs showed within program disagreement on this issue. Eighty-two percent (82%) of the respondents reported having an on-site clinic, for the first time maintaining 100% agreement within programs.

Again we see that although disagreement within programs is prevalent the structural items chosen most frequently by respondents are primarily supported by the literature, all supporting an avenue for decreasing the risk of potentially exploitative relationships. For instance, the literature supports integration within and across the length of

Table 4. The Number of Hours Devoted To SOTT Training Per Week

HOURS	FREQUENCY	%
0-5	20	74.1
6-10	3	11.1
11-15	1	4.2
16-20	0	0
More than 20 hours	0	0
I'm not sure	3	11.1
Total	27	100

N=27

Table 5. Program Placement of SOTT Training

PLACEMENT CHOICES	FREQUENCY	%
Beginning of program	2	7.4
Middle of program	1	3.7
End of program	0	0
Integrated throughout program	24	88.9
Totals	27	100

N=27

programming (Aponte & Winter, 1987; McCollum, 1990; McDaniel & Landau-Stanton, 1991; Todd & Storm, 1997). Here respondents report 78% and 89% respectively. It has also been suggested that trainees be allowed to choose the SOTT activities they participate in and the extent to which they disclose personal information (McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999; Watson, 1993). Sixty-three percent (63%) of respondents reported this as part of their training structure. Grading procedures do not seem to fair as well. Where the literature supports pass/fail marks based on completion of activities rather than utilizing letter grades (McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999), our respondents report only 14% operate this way.

Survey respondents were also asked to answer questions regarding both their program goals as well as trainee's individual goals for SOTT training. The literature supports the process of goal setting as it outlines what is expected of trainees in the SOTT process and helps to secure student safety and consent (Haber, 1990; McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). Fifty-two percent (52%) of respondents stated that general SOTT goals were discussed with the students. Thirty-seven percent (37%) of the respondents stated that students were required to set individual goals within their SOTT training. Forty-two percent (42%) of the programs within the survey disagreed internally on both issues pertaining to goal setting. Although the literature is sparse in this area

of goal setting, the majority of programs do not reflect the suggested programming structure.

Respondents were also questioned as to whether or not their programs required trainees to participate in therapy as a client (see Table 6). Although discussed in the literature as a training technique (Aponte & Winter, 1987; Guldner, 1978; Liddle, 1982; Stringer-Seibold, 1998), there was no statistical information as to how commonly it was utilized. In this survey, 47% of the respondents reported that therapy was suggested for trainees. General therapy was suggested by 28% of respondents, 19% suggested MFT specifically. This finding would be in keeping with Saba and Liddle's (1986) survey reporting that 45% of AAMFT members believed that personal therapy was important for therapist trainees. Only one respondent stated that therapy was required, the respondent's colleagues did not agree. In fact 58% of the programs within the survey showed internal disagreement as to therapy requirements within their own programs.

Finally, it is important to note that while almost half of the respondents believe that therapy is an integral part of a therapist's training, only 34% believed it should be required. It is unclear why many believe in the therapeutic process but do not support its necessity for trainees. Realistically, even within mandated therapy there is no certainty that a trainee would address and resolve any issues that would impede clinical performance. In addition, mandated therapy is

Table 6. Program's Therapy Requirement For Trainees

ITEM CHOICES	FREQUENCY	%
No requirement	16	50
Therapy is suggested	9	28.1
MFT is suggested	6	18.8
Therapy is required	1	3.1
MFT is required	0	0
Total	32	100

N=32

believed to be ineffective. It is possible that respondents felt requiring a student to participate in therapy lacked the guarantee of specific desired outcomes.

The training techniques utilized for SOTT training were standard and familiar. Respondents were asked to check all techniques they used from a list generated by the literature. Ninety-six percent (96%) of the respondents indicated the use of individual supervision as a means of SOTT training, making it the most utilized format by those responding to the survey. This finding is a slight departure from the literature which states supervision groups are the most common format for SOTT training (Aponte & Winter, 1987; Haber, 1990; Merta et al., 1993; Timm & Blow, 1999; Tucker & Liddle, 1978). Both group and live supervision were reported as utilized by 82% of the survey respondents. A complete list of techniques may be found in Table 7.

The discrepancy between the survey results and what is reported in the literature may be due to the issue of safety and maintaining the supervisee's confidentiality, an issue sighted as somewhat problematic within the group setting (Haber, 1990; Timm & Blow, 1999; Tucker & Liddle, 1978). Another possibility for the discrepancy may be a reflection of the lack of defined program structure as within program disagreement percentages have been suggesting. SOTT training within groups are more likely to be organized at the program level. Survey responses may indicate that SOTT training is really left to individual faculty members

Table 7. SOTT Training Techniques Utilized

TRAINING TECHNIQUES	FREQUENCY	%
SOTT training groups	2	7.4
Individual supervision	26	96.3
Group supervision	22	81.5
Live supervision	22	81.5
Client presentations	12	44.4
Lectures	11	40.7
Discussion	20	74.1
Role play or Sculptures	14	51.9
Metaphor, stories, myth	12	44.4
Imagery	4	14.8
Genograms	24	88.9
Cultural genograms	16	59.3
Timelines	3	11.1
Writing assignments	15	55.6
Personal therapy	11	40.7
Other	2	7.4

N=27

rather than a training process implemented program wide.

As it is reported in the literature, diversity is increasingly a topic of importance in the context of therapy (Mills, 1995; Parry & Jones, 1986; Watson, 1993). Survey respondents were asked whether or not they believed diversity had received enough attention within their programs and to list any techniques utilized specifically for issues of diversity within the SOTT training. Seventy-three percent (73%) of the faculty members believed diversity had received enough attention within their programs. Those who disagreed were all Caucasian women, spread out across several programs. One respondent made a note that s/he believed diversity often received enough attention, but "rarely thoughtful attention." The majority (26%) of those who suggested techniques for SOTT training in diversity found the cultural/gender genogram as the most helpful. See Table 8 for a complete list of diversity techniques.

Common structural elements were also explored in relation to the evaluation of a student's professional competence. Ninety-one percent (91%) of respondents stated that student's within their programs may be removed if they are believed to be professionally incompetent. Ninety-one percent (91%) of the respondents also reported that the entire faculty participated in the student evaluation process. The remaining 9% reflected faculty members who were unsure of their program's protocol. There was 100% agreement within programs. High agreement rates regarding the student evaluation process speak favorably of

Table 8. SOTT Diversity Training Techniques

TRAINING TECHNIQUES	FREQUENCY	%
Cultural/gender genogram	7	25.7
Discussion	2	7.4
Supervision	2	7.4
Faculty's commitment to diversity	2	7.4
Exploring personal issues related to cases	2	7.4
Role play	1	3.7
No response	11	40.7
Total	27	100

N=27

communication within individual programs however, as the student evaluation process is explored more deeply disagreement is prevalent.

With 100% of respondents reporting that they believed gatekeeping (the evaluation and possible dismissal of a student for professional incompetence) was the responsibility of program faculty, the extent of disagreement regarding evaluation protocol within programs was surprising. Fifty-three (53%) of the respondents stated that student information learned through SOTT training was used as a part of the evaluation process. Close to half (43%) of the programs disagreed that this personal information was utilized to evaluate student competence. Sixty-nine percent (69%) of respondents reported that they had written protocol for the student evaluation process (see Table 9), while 36% of the programs internally disagreed as to whether or not the written protocol existed. Eighty-one percent (81%) of respondents stated that students were informed of the evaluation process (see Table 10), 57% of the programs disagreed internally. Sixteen percent (16%) of the respondents reported that students must sign evaluation protocol contracts (see Table 11), 21% of the programs disagreed internally.

The reasons for such high rates of disagreement with regards to the evaluation of student competence are puzzling. Unfortunately the opportunity for ethical violations are likely to increase when faculty are not in agreement as to how the process is administered. As professionals the ethical responsibility to do no harm is extended to both client and

Table 9. Program Protocol For Evaluation of Student Competence

ITEM CHOICES	FREQUENCY	%
No protocol	2	6.3
Written protocol	22	68.8
Assumed protocol	6	18.8
I'm not sure	2	6.3
Total	32	100

N=32

Table 10. Ways In Which Students Are Informed of Evaluation Process

ITEM CHOICES	FREQUENCY	%
No, students are not directly informed	3	9.4
Yes, during orientation	4	12.5
Yes, in student handbook	5	15.6
Yes, in individual advising	2	6.3
Yes, during orientation and in student handbook	4	12.5
Yes, during orientation, individual advising and in student handbook	10	31.3
Yes, informed other ways	1	3.1
I'm not sure	3	9.4
Total	32	100

N=32

Table 11. Students Are Required to Sign Protocol Contracts

ITEM CHOICES	FREQUENCY	%
No	24	75
Yes	5	15.6
I'm not sure	3	9.4
Total	32	100

N=32

student (AAMFT, 2001). It is unclear how COAMFTE accredited and candidacy status programs are maintaining their ethical responsibility to the student when there is so little agreement as to how the evaluation of professional competency is carried out.

Fifty-nine percent (59%) of the respondents agreed that COAMFTE should require programs to have written protocol regarding student evaluation. Nineteen percent (19%) of respondents disagree to the standard protocol and 22% were undecided. Within program disagreement rates ranged from 21% to 57% regarding the common structures for evaluation. Is the client's welfare at risk when training programs are unable to agree upon program policies regarding student competency? This survey's findings would support further investigation into the structures and administration of the structures regarding the evaluation of trainees for the benefit of future professionals and clients alike.

The survey findings indicate that reported SOTT training structures within COAMFTE accredited and candidacy status doctoral programs are, for the most part, supported by the literature. However, within program disagreement rates are somewhat disturbing. It is possible that the training itself is implemented by specific faculty members on a yearly basis, making it unnecessary for all faculty members to be privy to the specifics of SOTT training. This is not the case however, with the student evaluation process, as 91% of the respondents reported that all

faculty are responsible for the evaluation of a student's competence. The remaining 9% were unsure who was responsible. It seems that within program disagreement rates would support evaluation practices that are more likely to be individually assumed rather than discussed program wide. As the literature speaks to implementing specific structures that support COAMFTE guidelines and AAMFT code of ethics, the discrepancies within programs may indicate a lapse of agreement with association mandates.

Common Ethical Concerns and Within Group Disagreement

Common concerns regarding SOTT training generally include confidentiality and the boundary between therapy and supervision. Closely related to these issues is whether or not a program requires its trainees to participate in therapy. The information below offers a small glimpse into how accredited doctoral programs deal with these concerns. Note, in this section the sample size changes from 27 to 26 (N=26). One respondent did not fill out the "common concerns" section.

COAMFTE does not directly stipulate mandates regarding SOTT training, however, AAMFT accredited and candidacy status doctoral programs are bound by the association's code of ethics. The code leaves programs ethically responsible for the "personal and professional integrity" of student trainees. Ninety-six percent (96%) of the respondents stated that their program complied with the AAMFT code of

ethics with no disagreement within program responses. One respondent kept this item from reaching 100% because s/he was unsure of the code. Several hand-written comments within the surveys stated they believed there was nothing in the code that discussed SOTT training. These comments would lead one to assume that the codes are not thoroughly read and/or understood by educators, leaving the students (and therefore the clients) vulnerable.

As mandates are not specified by COAMFTE other than referring to the association code, programs utilizing SOTT must look to the code for guidance. Four areas of compliance are mandated. First, professors/ supervisors must recognize the inherent "power over" position in the educational setting and practice appropriately. Second, MFTs are obligated to seek professional help when personal conflicts effect their clinical integrity. Third, professors/supervisors are not to provide therapy to students/ supervisees. And finally, professors/supervisors can only disclose a student's/supervisee's confidentiality with *written consent*, or where the law mandates disclosure (AAMFT, 2001). These code principles seem to permeate virtually every issue within SOTT training.

Above all, the literature stresses the importance of confidentiality and the need for continuous discussion regarding self disclosure and safety (Aponte, 1994)(McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999). Informed consent helps equal the playing field. Eighty-nine percent

(89%) of the survey respondents stated that confidentiality was discussed prior to SOTT training. Only 15% of the respondents stated that boundaries related to SOTT training and supervision were discussed. Disagreement rates regarding the discussion of confidentiality as well as boundaries occurred within 8% of the programs.

Fifty-four percent (54%) of the respondents stated that students were given reading material concerning confidentiality (see Table 12), and 69% stated that students were given reading materials related to boundary issues (see Table 13). Percentages of programs that reflected internal disagreement for the disbursement of confidentiality and boundary issues occurred at a rate of 91% and 58% respectively. Only 39% of respondents were able to state that they knew the students read the material on confidentiality (see Table 14), and half (50%) were able to state the same regarding the boundary materials (see Table 15). It is interesting that confidentiality appears to be seen as a greater ethical liability than the relational boundary between student and professor, even though power structures and relationship roles are specifically outlined in the code of ethics (AAMFT, 2001).

As the literature has suggested student consent promotes safety (Aponte, 1994; Haber, 1990; McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999) and may be enhanced by the use of a contract (Aponte, 1994; Aponte & Winter, 1987). Fifteen percent (15%) of the respondents reported that confidentiality contracts were dispersed and signed by

Table 12. Students Are Given Reading Material Re: Confidentiality

ITEM CHOICES	FREQUENCY	%
No	11	42.3
Yes	14	53.8
I don't know	1	3.8
Total	26	100

N=26

Table 13. Students Are Given Reading Material Re: Boundaries

ITEM CHOICES	FREQUENCY	%
No	6	23.1
Yes	18	69.2
I don't know	2	7.7
Total	26	100

N=26

Table 14. I Know Students Read the Material Re: Confidentiality

ITEM CHOICES	FREQUENCY	%
No	2	7.7
Yes	10	38.5
I don't know	2	27.7
Not applicable	12	46.2
Total	26	100

N=26

Table 15. I Know Students Read the Materials Re: Boundaries

ITEM CHOICES	FREQUENCY	%
No	1	3.8
Yes	13	50
I don't know	7	26.9
Not applicable	5	19.2
Total	26	100

N=26

students (see Table 16). None of the programs represented within this 15% agreed that confidentiality contracts were a part of the program process. Thirty-one percent (31%) of respondents stated students were given contracts to sign regarding grievance procedures that related to the supervision/therapy boundary. Eighty-six percent (86%) of the programs reporting grievance contracts were signed disagreed internally.

There is nothing in the literature correlating the use of contracts with a decreased rate of ethical incidents due to confidentiality or boundary violation. As so few programs appear to utilize contracts this would seem to make sense. In addition, survey reports of violations against students were non-existent. Eighty-five percent (85%) of respondents reported that they had not violated a student's confidentiality as it related to SOTT training, with the remaining respondents reporting that they were unsure. These percentages, however, are self-reported and those who may have felt violated are not represented, therefore findings may be skewed. In fact, several side comments were written in the margins of respondents asking, "how would I know?" It would seem an important area to investigate, as modeling ethical practices are an integral part of the training and development of ethical therapists.

This study offers data regarding ethical issues within the supervision relationship in the form of faculty self-report. Respondents in general report satisfactory supervision relationships without incident of ethical violation. Survey items regarding the ethical nature of the supervisor/

Table 16. Students Sign a Confidentiality Contract

ITEM CHOICES	FREQUENCY	%
No	21	80.8
Yes	4	15.4
I don't know	1	3.8
Total	26	100

N=26

supervisee relationship were rated on a five-point scale ("1" being equal to "almost never," and "5" being equal to "almost always"). Respondents were asked how often they assumed the role of therapist during supervision. Sixty-seven percent (67%) of survey respondents stated they "almost never" took on a therapist role (see Table 17). In contrast, respondents were asked to rate how often their supervisees assumed the role of client. On the same five point scale, 37% of respondents reported their supervisees "almost never" took on the role of client, and 37% reported supervisees "seldom (2)" did (see Table 18).

Further exploration into the supervisor/supervisee relationship seems to support that trust between parties flourish despite the lack of contracts. Ninety-seven percent (97%) of survey respondents reported that their supervisees had disclosed receiving therapy, while 22 of the 25 (69%) therapists who had reported receiving therapy had disclosed therapy experiences to their supervisees. Respondents reported that throughout their years of experience only three (12%) respondents had had students express they had felt taken advantage of by their SOTT supervisor (see Table 19). Two (8%) respondents reported feeling as though they had been taken advantage of by a supervisee in relation to personal disclosures regarding SOTT experiences (see Table 20). Overall, when respondents were asked to rate their supervisory relationships on a five-point scale, 74% reported their relationships as a 5 or "almost always satisfactory." The other 26% of respondents rated their

Table 17. How Often Do You Assume the Role of Therapist in Supervision?

ITEM CHOICES	FREQUENCY	%
Almost never	18	66.7
Seldom	5	18.5
Sometimes	3	11.1
Often	0	0
Almost always	1	3.7
Total	27	100

N=27

Table 18. How Often Do Your Supervisees Assume the Role of Client in Supervision?

ITEM CHOICES	FREQUENCY	%
Almost never	10	37
Seldom	10	37
Sometimes	6	22.2
Often	0	0
Almost always	1	3.7
Total	27	100

N=27

Table 19. Student(s) Felt As Though I Took Advantage of Them Re: SOTT Training

	FREQUENCY	%
No	12	46.2
Yes	3	11.5
I don't know	11	42.3
Total	26	100

N=26

Table 20. I Have Been Taken Advantage of By a Student Re: SOTT Training

ITEM CHOICES	FREQUENCY	%
No	22	84.6
Yes	2	7.7
I don't know	2	7.7
Total	26	100

N=26

relationships as a 4 or "often satisfactory." Although the vast majority of respondents report not utilizing contracts, supervisor/supervisee relationships would appear to be thriving with nominal incidents of ethical violation.

Apart from contracts, other "safety measures" that have been noted in the literature may help to account for the balance of power within the supervisor/supervisee relationship reported by respondents. It has been noted that supervisor disclosure may help create a sense of safety as well as model desired behavior (Bennett & Zilbach, 1989; Deacon, 1996; Watson, 1993). This survey found that 88% of those reporting having been a therapy client disclosed this information to their supervisees. Flexibility regarding the execution and evaluation of SOTT assignments are also noted in the literature as ways to help flatten the hierarchical nature of the relationship (McDaniel & Landau-Stanton, 1991; Timm & Blow, 1999; Watson, 1993). As stated earlier, 63% of respondents reported that students were allowed to choose the SOTT activities they participated in, while 70% stated that assignments were evaluated in ways other than letter grades.

While reflecting on the data gathered regarding the SOTT relationship between supervisor and supervisee, it is important to remember that it is the party holding the hierarchical power that is the one reporting the information. Although supervisors feel content with their relationships, we cannot conclude that the supervisees are as comfortable as well.

Those students who may have felt violated may be reluctant to discuss this with their supervisor. In addition, we cannot assume that supervisees, as reported by the supervisors, are disclosing information because they feel safe.

Inferential Statistics

The issue of mandated therapy for MFT trainees has a history of controversy that has yet to be resolved (Deacon, 1996; Horne, 1999; Watson, 1993). Requirements for therapy seem appropriate as the theoretical foundation of MFT defines the therapist as part of the system they treat, however, there is no conclusive evidence supporting the claim that a therapist's own emotional health is a prerequisite to effective therapy outcome (Horne, 1999). As stated earlier, COAMFTE does not require therapy for trainees, but does support the AAMFT (2001) code of ethics that stipulates the necessity of seeking professional help when personal issues impede professional effectiveness. An attempt was made at trying to better understand those educators that supported mandated therapy for doctoral trainees.

A series of chi-squares were run to establish whether or not a significant relationship existed between a respondent's belief as to whether or not therapy should be required for doctoral trainees and all other belief based items reported in the survey. The independent sample size was reduced to 31 (n=31) due to one respondent that reported s/he

was unsure whether or not therapy should be mandatory. Twenty chi-squares were run in total. As sample sizes were small, significance can really only point toward potential trends in the data that offers directions for future research. For a complete list of tested variables see Appendix D.

The first significantly associated variable was not surprising, those that believed therapy should be required for doctoral trainees also believed therapy should be required for master trainees (χ^2=9.8, *df*=1, *p*=.000 where phi=.7, *p*=.000). The results showed significance in the expected direction. The sample size for this test was equal to 28 (N=28) due to the elimination of those who were undecided. Three respondents were undecided as to whether or not therapy should be required for master trainees; one respondent was undecided as to whether or not therapy should be required for doctoral degrees. One cell (25%) had an expected count less than five, all cells placed above the minimum expected cell count.

Although not statistically significant, it is interesting to note that the same chi-square revealed that 6% (standardized residual = -1.7) believed that therapy should be required for doctoral trainees, but not master trainees. Another 6% (standardized residual = -1.7) believed therapy should be required for master trainees, but not doctoral trainees. One may be able to associate this finding with the debate over professional identity development and whether or not SOTT is considered an

advanced skill (Kaslow, 1986; McCollum, 1990; McDaniel & Landau-Stanton, 1991; Todd & Storm, 1997). This would be an important question to answer in considering the use of SOTT training within educational and clinical programs, however, sample numbers would need to be increased to test for a significant association before further investigation took place.

In the second chi-square, the belief as to whether or not therapy should be required for doctoral trainees was run against what type of therapy respondents believed should be required. The sample size was 30 (N=30), one cell (25%) showed an expected cell count less than five, and all cells placed above the minimum expected cell count. Both "any type of therapy" and "MFT only" were offered as options to the item question. "Any type of therapy" was found to be significantly associated with those who believed therapy should be required for doctoral trainees (χ^2=18.5, *df*=1, *p*=.000 where phi=.86, *p*=.000).

It is unexpected to find that "any type of therapy" is significantly associated with mandatory treatment while "MFT" is not. One may surmise that any type of treatment is better than no treatment at all, and some trainees may not have access to friends or family members that are willing to participate. However, the experience of vulnerability and intimacy is very different in an individual setting with an unbiased stranger versus a setting with people who are meaningful in one's life. If

the reason for supporting mandated treatment is to give the trainee access to the experience of the client, as the literature suggests (Liddle, 1982; Stringer-Seibold, 1998), the type of therapy the field supports mandating may need to be reevaluated.

It is also important to understand that this process of what and how the field supports SOTT training seems to be at the very heart of the SOTT debate. Most MFTs would agree that what sets the discipline apart from others is the theoretical framework from which one operates. How is it that MFT as a discipline can stand so firmly grounded in theoretical beliefs, yet not support the participation of those beliefs professionally? The experience of talking to an unbiased stranger about those one is in relationship with is very different than the experience of speaking directly to significant others. A trainee may be able to participate in individual therapy and successfully resolve issues related to friends and/or family members without ever communicating with them. Suddenly the theories that are so passionately supported have disappeared in the practice of one's profession. While circumstances limit the interpretations of the test's significance, results of this test do support the overall trend in the disconnect between theory and practice.

In the third chi-square, required therapy was run against a variable that categorized respondent's answers to naming the most helpful characteristics for supervisors to possess. The sample size was 27 (N=27), two cells (50%) showed an expected cell count less than five

although all cells placed above the minimum expected cell count. Self-awareness with the use of SOTT models was found to be the most helpful characteristic. Open attitude and interpersonal skills tied for second place. Authenticity came in third and modeling came in last. Although self-awareness was voted as being the most helpful characteristic, authenticity was the characteristic found to be significantly associated with the attitude that therapy should be a requirement for doctoral trainees (χ^2=3.1, *df*=1, *p*=.017 where phi=.46, *p*=.017). While Pearson's Chi-square was significant at the .05 level, Yates Continuity Correction was not.

Overall this is not an item number that lends itself to statistical inquiry. Respondents offered their own words related to what they believed were helpful characteristics without defining those words. This researcher was forced to categorize respondent answers according to how the researcher defined the words. Authenticity and self-awareness could easily be categorized together rendering a very different result.

Finally, four independent t-tests were employed to assess for significant associations between respondent's attitudes toward required therapy and the following: respondent's age, the number of years teaching, the number of years in clinical practice, and the number of years as a client in therapy (N=27). One variable, the number of years a respondent had participated in therapy, was found to be significant, however outliers existed that accounted for this result. The original t-

test included nine respondents who had both participated in therapy and believed therapy should be required for trainees. Two outliers made the test significant with 18 and 21 years of therapy (M=6.4 years, SD=7.7 years, t=1.8 and *p*=.001). When the t-test was run a second time with the two outliers excluded, the significant association disappeared. There was no significant relationship found between respondent's attitudes toward required therapy and the remaining 3 variables. For a list of all t-test results see Appendix E.

The lack of significance within the t-tests is an interesting finding. One might expect that years of experience in any of these categories would render a strong belief toward either required therapy for trainees or no requirement at all, however, this is not the case with the variables tested. Further testing may find that if the average number of years as a client in therapy were increased, a consistently significant relationship would result, however we do not know whether the outliers found in this variable are typical of professors in COAMFTE supported doctoral programs. It may be that the sample was too small and that further research would find statistically significant associations with a larger numbers. It is also possible that the common variable(s) associated with the test variable is not found in this survey.

Chapter V: Conclusions

General Summary

This study was conducted to serve two purposes. First, there is a void in the literature regarding SOTT training practices within COAMFTE accredited programs. As the use of SOTT practices are commonly heralded as the cornerstone of effective therapy (Aponte, 1982; Bowen, 1972; Kerr, 1981; Satir & Baldwin, 1983; Schnarch, 1991; Schwartz, 1995; Timm & Blow, 1999; Whitaker & Keith, 1981), it would seem that the field should have some understanding of how SOTT practices are being integrated within COAMFTE training programs. This study was developed as an exploration in documenting training practices in the field's doctoral settings. Second, the field of MFT is often criticized for its lack of empirically backed therapeutic claims (Horne, 1999). As the field sets itself apart from other disciplines because of its philosophical foundation in systems theory, it is worrisome that the use of SOTT practices has not been empirically tested for therapeutic effectiveness in the field. This study was also implemented as way of targeting potentially significant relationships that may be utilized for continued research in the use of SOTT practices.

All full-time faculty in COAMFTE accredited and candidacy status doctoral programs were asked to complete a survey regarding the use of SOTT training practices within their programs. Data were gathered to

assess for training structures, implementation processes and the handling of common ethical concerns. The data were also evaluated as to whether or not agreement existed between respondents within the same programs. In addition, personal belief items and years of experience in several categories were tested for significant association with attitudes toward whether or not therapy should be required for doctoral trainees.

As the data were presented and the most common responses were noted, the SOTT training structures that were revealed within the COAMFTE supported doctoral programs seemed almost intuitive. As the respondents reported these structures as program based, it was unclear as to why the high rates of program disagreement existed. One speculation is that SOTT training is an individually implemented process rather than a structure defined and discussed program wide. It is also possible that specific professors implement SOTT training. This limited implementation would make training details irrelevant for other faculty members. Although within program disagreement may not prove problematic for training structures in general, it can be of great concern when considering both student evaluation and common ethical concerns related to SOTT.

This is an interesting finding when one considers the foundational fabric on which MFT was built. Marriage and family therapists work towards creating communication within systems, and in the Post Modern

era, consider themselves to be a part of the system in which they work. As a field we stress the importance of process over content, isomorphism, and modeling appropriate communication both verbally and non-verbally. Marriage and family therapists discuss and often contract around issues of confidentiality and boundaries with their clients and nurture an atmosphere of safety in an attempt to create positive outcomes. It would seem that the philosophical tenants that ground and guide the clinical work of marriage and family therapists do not translate into the training of therapists. The results of the survey seem to support this lapse in continuity.

The statistical trends in the data support this theoretical translation of the findings as well. Tests were run in an attempt to better understand those who believed that therapy should be mandated for doctoral trainees, a contentious debate in a field grounded in systems theory. Although the significant association between required therapy for doctoral trainees and masters trainees was of little surprise, the relationship between mandated therapy and any kind of therapy (versus MFT) was unexpected. Add to this the lack of association between respondent's age, and the number of years participating as a client, teaching or clinical practice, and the theory of the absence of philosophical follow through seems that much more plausible. The findings would appear to reveal some kind of disconnect between theory and practice.

The potential disconnect between theory and practice is an important issue to explore. The trend toward within program disagreement would suggest that most programs lack follow through in the administration of important evaluation and ethical issues. This offers opportunity for the abuse of power whether intended or not. One hopes at this level that all professors/supervisors are responsible and accountable for their actions, however, no one is infallible. It is important to keep in mind that the institutions that employ these individuals usually operate on a tenure system set up to protect the professor. Ultimately the student is left vulnerable.

This survey's findings would appear to support a theoretical landscape of parallel process. As the field has held tight to the content of its beliefs, the process has been ignored. In the educational setting it would appear that the majority of individual respondents utilize the structures established in the SOTT literature, however, there also appears to be a breakdown in the administration of these structures at the program level. As the utilization of concepts such as process, isomorphism and appropriate modeling are ignored students are put at risk and supported in the perpetuation of these patterns in their chosen careers. This phenomenon is experienced in the field at large as it supports theoretical claims in the efficacy of SOTT practices in the clinical setting, yet disregards the process of producing any real evidence

of its validity. From a systems perspective, it is impossible to claim that the client is protected from these overarching patterns.

Horne (1999) asks two questions. "First, does the absence of self of the therapist process/outcome studies in [sic] field of marriage and family therapy reflect the field's level of differentiation as a system?" (Horne, 1999, p. 400), and "Second, does the absence of self of the therapist outcome studies reflect the collective psychological health of the field?" (Horne, 1999, p. 400-401). These are interesting questions in relation to the survey results and the purposed theoretical disconnect cited above in the COAMFTE supported doctoral programs.

This study is not capable of answering the above questions, however it does support the need to continued asking. Whether or not the apparent schism between theory and practice regarding SOTT issues is a reflection of the field's level of differentiation or psychological health, it does pose an ethical dilemma for the field as a whole. Not only are students and clients made vulnerable by the absence of follow through, but as Horne (1999) suggests, the field has no empirically grounded claim in its theoretical distinctiveness.

> "While differentiation cannot be taught, it *can* be systematically fostered and assessed through the content and style of professional training programs *if educators are willing to undertake the enormity of the project*. Such an undertaking would probably require changes in structure, content, duration, admission and graduation

> criteria, and faculty composition. It would raise numerous thorny issues along the way, but not any more than those raised when clinical supervisors and faculty currently permit a student to graduate despite grave doubts about his or her ability to function as a therapist" (Schnarch, 1991, p. 546).

It would appear to be in the best interest of COAMFTE and the field at large to continue a path of inquiry that explores some of the potential disconnects proposed by this study. At the very least, it would seem appropriate for COAMFTE to hold programs accountable for gatekeeping practices; faculty and students alike should be advised of program standards, expectations, and consequences, with contracts to document follow through. The precise content of the practices may be developed based on the needs of the individual programs guided by the field's ethical codes. It would be the ethical responsibility, however, of COAMFTE to hold programs accountable for continued and correct implementation of the process. Ultimately the question is this, "Do we dare offer ourselves the same opportunity for personal growth that we proclaim we offer couples and families?" (Horne, 1999, p. 401)

Limitations

The most obvious limitation of course is sample size. As an exploratory study the research was able to identify areas that needed further investigation, however, due to the number of respondents and the

variability within responses, descriptive information and statistical testing could only point toward potential trends in the field. In addition the vehicle for gathering data was a self-report instrument. This instrument measures the respondent's perceptions of the construct. As the research revealed, SOTT training structures and implementation were defined very differently between faculty teaching within the same programs. It also must be noted that in many ways the construct in this particular arena was two-tailed, yet reported unilaterally. Student perceptions may have helped to clarify the meaning given to the data.

The instrumentation, although theoretically sound, was a first attempt at quantitative research for this researcher. Questions were formulated from a qualitative stance rather than a quantitative one. There is much that can be lost in the translation of nominal data. This precautionary note does not mean that the data collected and quantified were not valuable, however, it does challenge the reader to continue questioning the subject at hand.

One must also consider the possibility of selection bias. The impetus behind responding or not responding is not known. Response differences between those that returned the survey and those that did not must also be considered. As less than half of the surveys were returned, unknown variable(s) could potentially change the research landscape, both in what is reported and how it is interpreted.

The nature of the topic studied must also be approached cautiously. Although this researcher guaranteed confidentiality, the community of those eligible to participate in the study was very small and this researcher's reputation was unknown. Although the survey was anonymous, participants could easily be identified. Discussion of the ethical issues addressed in this survey could potentially create both individual and program hazards. Therefore the possibility of socially desirable answers must be considered.

Suggestions for Future Research

As this study represented the first attempt at exploring SOTT practices within COAMFTE supported doctoral programs, the opportunities for continued research in this area are limitless. There are several initial follow-up studies that would help to expand and refine what has been accomplished within this research. The first possibility might be an attempt to replicate the study, securing a larger sample to increase research validity. Expanding the survey to accredited and candidacy status master programs as well as education specialty degrees and post-doctoral sites may also accomplish this. This may help expand our understanding of SOTT training as it pertains to levels of education and ideas of therapist development. It would also be helpful to elicit student perceptions as a way to more clearly illuminate SOTT practices

within these programs. In addition, ethical concerns regarding confidentiality and boundary issues may be investigated more fully.

Any number of studies may be done on individual items addressed within the current survey, as for example, the attitudes toward required therapy for doctoral trainees were singled out in this study. Longitudinal studies may be implemented to examine continued use of SOTT models within private practice and teaching after students have graduated. All may provide not only a richer description of the use of SOTT training in COAMFTE supported educational sites, but may also offer the field answers as to the efficacy of SOTT practices in relation to therapeutic outcomes.

And finally, avenues of inquiry that explore the ethical issues cultivated by the disconnect between theory and practice need to be investigated more thoroughly. It would be helpful to explore associations between gatekeeping practices and rates of reported confidentiality and boundary violations. Researching the use of contracts related to a student's perceived sense of safety and their participation in SOTT training could also prove helpful.

Self of the Researcher

As a self-defined qualitative researcher and an advocate of SOTT practices, I find it difficult to end this work without a personal note to my readers. As a trainee, I have experienced the impact that therapy can

have in both one's personal and professional life. Participating in therapy as a client has both nurtured my awareness from a client's perspective as well as my growth towards maturity and integrity. As a student, both professors and administrators alike have violated my confidentiality. I have also blossomed under the mentorship of teachers and supervisors willing to risk the strict delineations of educational boundaries.

I know there are no simple answers in the struggle towards integrity. Still, I believe there are ways to enter into hierarchical relationships that keep all parties safe and offer the kind of flexibility that allows for growth. It requires, however, the willingness to tolerate and contain our own anxiety as structures fall and are recreated. This is a challenge we ask of our clients on a daily basis, yet we struggle as a profession to do it ourselves. We will never find the edges if we don't ask the questions. This research was a first attempt in beginning to ask the questions.

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Appendices

Appendix A

List of COAMFTE accredited doctoral programs

Alliant International University **	Purdue University
Brigham Young University	St. Mary's University
Florida State University	Syracuse University
Iowa State University	Texas Tech University
Kansas State University	Virginia Tech University
MCP Hahnemann *	University of Akron *
Michigan State University	University of Connecticut
Nova Southeastern University *	University of Georgia
Ohio State University	University of Minnesota

*Denotes programs that have candidacy status with COAMFTE

**Denotes Psy.D. program versus Ph.D. program

University of Louisiana at Monroe's MFT Doctoral Program is now under candidacy status, although is not included in this study.

Source: List of COAMFTE accredited and candidacy status programs, (2001)

Appendix B

Cover letter

Date

Dear <<name>>:

The purpose of the enclosed survey is to examine the practices and future directions of Self-of-the-therapist training in COAMFTE accredited and candidacy status doctoral programs. All of the 18 MFT doctoral programs contained in the COAMFTE List of Accredited and Candidacy Status Programs are being asked to participate. Your response is critical to the success of this project.

Your program's input will help provide the profession with the details needed to create an overview of the various aspects utilized in self-of-the-therapist training. The areas to be investigated include the following:

1. Program structure
2. Goals of training and supervision
3. Skills of the supervisor
4. Supervisory techniques
5. Supervisor/supervisee relationship
6. Personal therapy for trainees
7. Concerns regarding self-of-the-therapist training
8. Evaluation of training

The time invested by those in your program is invaluable to understanding how accredited doctoral programs are preparing future clinicians, researchers and educators in self-of-the-therapist issues. The resulting data will offer the COAMFTE accreditation board a comprehensive picture on the structure and practices of training regarding this controversial topic.

Please be assured that the information received from your program will be compiled to form an overview of all of the COAMFTE doctoral program's training practices. Individual responses will remain confidential. Survey packets are coded for the purpose of follow-up mailings and the creation of a list of participants who would like a copy of the project's results. Your survey will be placed in a locked filing box accessible only to the primary researcher. The coding protocol will be destroyed immediately following the return of the surveys.

Included in your packet you will find several self-addressed, postage-paid envelopes labeled with either "Student" or "Faculty" in the upper left-hand corner. Please distribute the "faculty" surveys with an envelope to any of the full-time program faculty (excluding adjunct or visiting professors). Each faculty member will be able to mail their surveys in a separate envelope to assure their confidentiality. The student surveys

are designed for *second year students only*. Please distribute the "student" surveys with postage-paid envelopes to all second year students. Participants are free to choose to not answer any of the questions on the survey, or not to return the survey without penalty. The survey should take approximately 25 minutes to complete.

We greatly appreciate your voluntary participation in this research project. Although your participation will not be compensated, your responses will provide essential information regarding the future structuring of self-of-the-therapist training practices in COAMFTE accredited programs. If you or any of the members of your program have questions regarding this research, please do not hesitate to call us at one of the numbers below. Completion and the return of this survey will signify your consent to voluntarily participating in this project. We would appreciate hearing from you by (this date).

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and the Department of Human Development.

Sincerely,

Jennifer S. Sparks	Howard Protinsky, Ph.D.	David M. Moore
Researcher	Committee Chair	IRB Chair
(215) 504-4162	(504) 231-6782	(540) 231-4991

Appendix C

SOTT Training Survey

SOTT Training Survey

This survey encompasses **SELF-OF-THE-THERAPIST (SOTT) training as defined by the practice of a therapist or supervisor actively working on personal issues that impact therapeutic effectiveness in both positive and negative ways.**

Section A - General Information

This section is intended to gain a better perspective of the professional characteristics of those being surveyed.

1. Your age _____

2. Your sex ___Female ___Male

3. Your race
   ___African American ___Asian American ___Caucasian ___Latino ___Middle Eastern
   ___Native American ___Pacific Islander ___Asian ___Multiracial
   ___Other_____

4. Your relationship status
   ___Single ___Coupled ___Married ___Widowed ___Divorced

5. What year did you acquire the following:
   _____Master's Degree: In which field_____
   _____Doctoral Degree: In which field_____

6. Please list the number of years you have participated in the following:
   ___Teaching at a college, university, or training center in MFT or related field
   ___Pre-master's level clinical work
   ___Master's level clinical work
   ___Post-Master's level clinical work
   ___Doctoral level clinical work
   ___Post-Doctoral level clinical work

7. Please choose the 3 theoretical orientations that best describe your work as a clinician (1 being the most commonly practiced).
   ___Structural Family Therapy
   ___Strategic Family Therapy
   ___Bowenian / Transgenerational Family Therapy
   ___Experiential Family Therapy
   ___Cognitive-Behavioral Family Therapy
   ___Psychoanalytic Family Therapy
   ___Feminist Family Therapy
   ___Solution Focused Family Therapy
   ___Narrative Family Therapy
   ___Internal Family Systems (IFS)
   ___Emotionally Focused Family Therapy (EFT)
   ___Other: Please specify_____

8. Please check any category where you have received SOTT training.
   ___Undergraduate course work ___Conference
   ___Master's course work ___Workshop
   ___Doctoral course work ___Readings
   ___Clinical Supervision ___No formal training
   ___Other: Please specify_____
   ___I have received no formal training

SECTION B - Personal therapy for trainees

This section focuses on the expectations of your program regarding trainees and therapy, as well as any personal experiences in therapy you may have had.

1. What is your program's requirement regarding trainees receiving therapy?
   ___No requirement
   ___Therapy is suggested
   ___Therapy is required
   ___MFT is suggested
   ___MFT is required

2. Do you believe receiving therapy should be a requirement for doctoral trainees?
   ___Yes: ___Any type of therapy is acceptable ___MFT only
   ___No
   ___I'm not sure

3. Do you believe receiving therapy should be a requirement for master trainees?
   ___Yes
   ___No
   ___I'm not sure

4. Have you ever received therapy?
   ___Yes
   ___No

If you answered "No" to # 4 please proceed to # 8 of this Section.

5. What type of therapy have you received? (Please check all that apply)

   ___Individual
   Approximate number of years _____
   Was it helpful? (Please circle one number)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

   ___Group
   Approximate number of years _____
   Was it helpful? (Please circle one number)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

   ___Family
   Approximate number of years _____
   Was it helpful? (Please circle one number)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

   ___Couple or Marital
   Approximate number of years _____
   Was it helpful? (Please circle one number)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

   ___Other: Please specify_____
   Approximate number of years _____
   Was it helpful? (Please circle one number)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

6. How helpful has therapy been in improving your supervisory skills? (Please circle one number)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

7. Have you ever disclosed to a student that you have received therapy?
   ___Yes
   ___No

8. Has a student ever disclosed to you that s/he has received therapy?
   ___Yes
   ___No

SECTION C - Evaluation

This section focuses on the protocol for evaluating students and their professional capacities as a therapist.

1. Do you believe COAMFTE should require written protocol regarding the evaluation of student's professional competency as a part of the accreditation process?
   ___Yes
   ___No
   ___I'm not sure

2. Do you feel gatekeeping (the evaluation and possible dismissal of a student for professional incompetence) is the responsibility of the faculty?
   ___Yes
   ___No
   ___I'm not sure

3. Does your program have protocol in place for evaluating the professional competency of students?
   ___Yes, written protocol
   ___Yes, assumed protocol
   ___No, a protocol does not exist
   ___I'm not sure

4. Are students informed of the evaluation protocol?
   ___Yes, during orientation
   ___Yes, through student handbooks
   ___Yes, during individual advising
   ___No, students are not directly informed
   ___ Other: Please clarify_____
   ___I'm not sure

5. Are students required to sign contracts stating that they understand and agree to this protocol?
   ___Yes
   ___No
   ___I'm not sure

6. Which faculty are involved in evaluating student's professional competency?
   ___Entire faculty
   ___Program director
   ___The student's advisor
   ___I'm not sure
   ___Other: Please specify_____

7. Is SOTT training utilized in your program as part of evaluating a student's professional competency?
   ___Yes
   ___No
   ___I'm not sure

8. Can a student be removed from your program if they are felt to be professionally incompetent?
   ___Yes
   ___No
   ___I'm not sure

9. Has a student ever been required to leave due to their professional incompetence?
   ___Yes
   ___No
   ___I'm not sure

SECTION D – Program structure

This section is concerned with the manner in which SOTT training is currently structured within your program. ***If SOTT training <u>is not</u> a part of your doctoral program please proceed to the end of the survey and follow the instructions in bold type.***

1. Please choose the 3 theoretical orientations that best describe your <u>doctoral program</u> (1 being the most commonly taught or practiced).
   ___Structural Family Therapy
   ___Strategic Family Therapy
   ___Bowenian / Transgenerational Family Therapy
   ___Experiential Family Therapy
   ___Cognitive-Behavioral Family Therapy
   ___Psychoanalytic Family Therapy
   ___Feminist Family Therapy
   ___Solution Focused Family Therapy
   ___Narrative Family Therapy
   ___Internal Family Systems (IFS)
   ___Emotionally Focused Family Therapy (EFT)
   ___The program will utilize the orientation(s) requested by the trainee
   ___Our program is not defined by any particular model
   ___Other:_____

2. In which format(s) is SOTT addressed in your program?
   ___In SOTT training groups
   ___In individual supervision
   ___In group supervision
   ___In a separate course
   ___Integrated throughout courses and supervision
   ___Other:_____

3. What is the total number of weekly clock hours devoted to SOTT issues in your program?
   ___0-5 hours
   ___6-10 hours
   ___11-15 hours
   ___16-20 hours
   ___More than 20 hours

4. At what point does SOTT training/supervision take place within your program?
   ___Beginning of program
   ___Middle of program
   ___End of program
   ___Integrated throughout program

5. Are students allowed to choose how and to what extent they participate in SOTT activities?
   ___Yes
   ___No

6. Please check one of the following: SOTT assignments…
   ___Receive a letter grade
   ___Receive a pass/fail based on completion
   ___Other: Please specify_____

7. Does your program have an on-sight training clinic?
   ___Yes
   ___No

SECTION E – Goals of training

This section pertains to the goals of SOTT training within your doctoral program.

1. Does your program discuss general goals with the students regarding SOTT training?
   ___Yes: Please describe briefly_____
   _____
   _____
   ___No
   ___I'm not sure

2. Are students required to set individual goals in regards to SOTT training?
   ___Yes
   ___No

SECTION F – Training technique

This section focuses on the instructional methodologies and tools used in the teaching SOTT curriculum.

1. Please check any of the following techniques utilized in your SOTT training process?
   ___SOTT training groups
   ___Individual supervision
   ___Group supervision
   ___Live supervision
   ___Client presentations
   ___Lectures
   ___Seminars
   ___Discussions
   ___Role play or Sculptures
   ___Metaphor, stories, or myths
   ___Imagery
   ___Genograms
   ___Cultural genograms
   ___Timelines
   ___Writing Assignments
   ___Personal therapy
   ___Other:_____

2. Please list what you believe are the 3 most helpful SOTT techniques beginning with the most helpful:
   1_____
   2_____
   3_____

3. Please list what you believe are the 3 least helpful SOTT techniques beginning with the least helpful:
   1_____
   2_____
   3_____

4. Do you feel the issue of diversity has received enough attention in your SOTT training?
   ___Yes
   ___No

5. Have there been any diversity SOTT training techniques that you have found particularly helpful?
   ___Yes: Please specify_____
   _____
   ___No

SECTION G - Supervisor/Supervisee relationship

This section focuses on the characteristics of both the supervisor and supervisee that may add or detract from the supervisory relationship within SOTT training.

1. Please list the 2 most helpful characteristics (1 being the most helpful) that a supervisor can possess in regards to SOTT training.
   1_____
   2_____

2. Please list the 2 most destructive characteristics (1 being the most destructive) that a supervisor can possess in regards to SOTT training.
   1_____
   2_____

3. Please list the 2 most helpful characteristics (1 being the most helpful) that a student or supervissee can possess in regards to SOTT training.
   1_____
   2_____

4. Please list the 2 most destructive characteristics (1 being the most destructive) that a student or supervisee can possess in regards to SOTT training.
   1_____
   2_____

5. How often do you assume the role of therapist with your supervisees? (Please circle one)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

6. How often do you feel that this behavior is appropriate? (Please circle one)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

7. How often does a supervisee assume the role of client with you? (Please circle one)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

8. How often do you feel that this behavior is appropriate? (Please circle one)

almost never	*seldom*	*sometimes*	*often*	*almost always*
1	*2*	*3*	*4*	*5*

9. Overall, I would rate my relationship with my supervisees as (please circle one)…

almost never satisfactory	*seldom satisfactory*	*sometimes satisfactory*	*often satisfactory*	*almost always satisfactory*
1	*2*	*3*	*4*	*5*

SECTION H - Common ethical concerns

This section focuses on the common concerns associated with SOTT training and supervision: confidentiality, and the boundary between supervision and therapy.

1. Do you believe your program complies with the AAMFT code of ethics regarding SOTT training?
   ___Yes
   ___No
   ___Unsure of the code

2. Is confidentiality clearly discussed between faculty and students prior to any SOTT training?
   ___Yes
   ___No

3. Are your students given any reading materials regarding confidentiality as it pertains to SOTT training?
   ___Yes: Do you know that the students read the material? ___Yes ___No
   ___No

4. Did students sign any type of contract regarding confidentiality relating to their SOTT training/supervision?
   ___Yes
   ___No

5. In the light of any concerns, those responsible for training students have the ethical obligation to discuss student's confidential disclosures with other colleagues who share responsibility of the student's training. Have you ever violated this ethical code by compromising the confidentiality of any student in regards to information learned from SOTT training?
   ___Yes
   ___No
   ___I'm not sure

6. Are the boundaries between training/supervision and therapy clearly discussed between faculty and students prior to any SOTT training and/or supervision?
   ___Yes
   ___No

7. Are students given any materials regarding SOTT training that discuss dual relationships or the boundary between training/ supervision and therapy to read?
   ___Yes: Do you know that the students read the material? ___Yes ___No
   ___No

8. Did students sign any type of contract that outlined the student's and professor's roles, responsibilities, expectations and/or grievance procedures regarding the relationship between students and SOTT professor/supervisors?
   ___Yes
   ___No

9. Have <u>you ever compromised</u> or taken advantage of one or more of your students as a result of SOTT training/supervision?
   ___Yes
   ___No
   ___I'm not sure

10. Has one or more of your students ever felt compromised or taken advantage of by you as a result of SOTT training/supervision?
    ___Yes
    ___No
    ___I'm not sure

11. Has one or more of your students ever taken advantage of you as a result of SOTT training/supervision?
    ___Yes
    ___No
    ___I'm not sure

FINAL INSTRUCTIONS

IF THERE IS ANYTHING YOU WOULD LIKE TO ADD REGARDING YOUR EXPERIENCE WITH SOTT TRAINING/SUPERVISION, PLEASE USE THE SPACE BELOW. BE SURE TO FILL OUT THE NAME & ADDRESS SECTION TO ENTER THE CASH DRAWING. YOU MAY ALSO REQUEST A COPY OF THE RESEARCH RESULTS BY CHECKING THE LABLED BOX.

PARTICIPATION IN COMPLETING THIS SURVEY IS GREATLY APPRECIATED. PLEASE PLACE THIS IN THE SELF-ADDRESSED STAMPED ENVELOPE PROVIDED AND MAIL AT YOUR EARLIEST CONVENIENCE. THANK YOU

WIN CASH

_____
Name (as you would like it to appear on the money order)

_____
Address

_____
City State Zip Code

□ Please send me a copy of the research results

Appendix D

Non-significant Chi-Square Variables

Chi-Square tests were run on the following variables against attitudes toward requiring therapy for doctoral trainees. None of the items listed below were found to be significant at the .05 level.

- Sex
- Race
- Relationship Status
- Field in which Ph.D. was received
- Theoretical Orientation
- Format in which SOTT training was received by respondent
- Whether or not respondent has been a client in therapy
- Whether or not therapy helped advance respondent's supervisory skills
- What type of therapy should be required for doctoral trainees
- Should treatment be required for master trainees
- The most helpful characteristics for a supervisor to possess: an open attitude, self-awareness, interpersonal skills, authenticity and modeling.
- The most destructive characteristics for s supervisor to possess: a closed attitude, a need for power, a lack of self-awareness, a lack of interpersonal skills, and a lack of authenticity.
- A student has taken advantage of a respondent in relation to information learned through SOTT training.
- A respondent has taken advantage of a student in relation to information learned through SOTT training.
- A student *felt* as though s/he had been taken advantage of by a respondent in relation to information learned through SOTT training.
- Gatekeeping is the responsibility of the faculty.
- COAMFTE should require written protocol outlining student competency.

Appendix E

Non-significant t-test Variables

Independent t-tests were run on the following variables against attitudes toward requiring therapy for doctoral trainees. None of the items listed below were found to be significant at the .05 level.

- Age
- The number of years of teaching experience
- The number of years of clinical experience
- The number of years participating in therapy as a client (with outliers removed).