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Perceptions of hope and expectancy in parents and guardians beginning family therapy with their child

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PERCEPTIONS OF HOPE AND EXPECTANCY IN PARENTS AND GUARDIANS
BEGINNING FAMILY THERAPY WITH THEIR CHILD

by

Andrew Beer

A thesis submitted in partial fulfillment
of the requirements for the Doctor of Philosophy
degree in Psychological and Quantitative Foundations in the
Graduate College of
The University of Iowa

December 2018

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Abstract

The Common Factors Model was introduced in 1992 by Michael Lambert suggesting that four factors that exist in all forms of psychotherapy are what account for positive therapeutic outcomes. The four common factors posited by Lambert include: Extratherapeutic Factors, The Therapeutic Relationship, Hope and Expectancy and Specific Factors. Marriage and family therapy is one form of psychotherapy that has taken an interest in The Common Factors Model and dedicated various amounts of research to understand connections between the two philosophies. Despite the efforts to understand common factors that exist in marriage and family therapy, very little research has been done studying the relationship between the common factor Hope and Expectancy, and marriage and family therapy. The current study aimed to fill that gap, by exploring the relationship between marriage and family therapy, and the common factor hope and expectancy through the lens of Snyder's Hope Theory. In this study, a mixed methods sequential embedded design was implemented to examine the relationship that exists between marriage and family therapy and the common factor Hope and Expectancy. The results indicated that levels of hope and expectancy were high in parents/guardians who were going to start participating family therapy with their child. The high levels of hope and expectancy were likely due to the activation of an interaction between extratherapeutic factors and hope and expectancy. Some of the extratherapeutic factors involved in the interaction were specific to marriage and family therapy, while others can be found in all forms of psychotherapy.

Public Abstract

The Common Factors Model was introduced in 1992 by Michael Lambert suggesting that four factors that exist in all forms of psychotherapy are what account for positive therapeutic outcomes. The four common factors posited by Lambert include: Extratherapeutic Factors, The Therapeutic Relationship, Hope and Expectancy and Specific Factors. Marriage and family therapy is one form of psychotherapy that has taken an interest in The Common Factors Model and dedicated various amounts of research to understand connections between the two philosophies. Despite the efforts to understand common factors that exist in marriage and family therapy, very little research has been done studying the relationship between the common factor Hope and Expectancy, and marriage and family therapy. The current study aimed to fill that gap, by exploring the relationship between marriage and family therapy, and the common factor hope and expectancy through the lens of Snyder's Hope Theory. In this study, a mixed methods sequential embedded design was implemented to examine the relationship that exists between marriage and family therapy and the common factor Hope and Expectancy. The results indicated that levels of hope and expectancy were high in parents/guardians who were going to start participating family therapy with their child. The high levels of hope and expectancy were likely due to the activation of an interaction between extratherapeutic factors and hope and expectancy. Some of the extratherapeutic factors involved in the interaction were specific to marriage and family therapy, while others can be found in all forms of psychotherapy.

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Chapter 1: Introduction

A movement toward family therapy began in the 1940s as the traditional individually-focused mental health field began facing difficulties with their most common disorders, schizophrenia and delinquency (Bertalanffy, 1968). Traditional individual models such as psychoanalysis and play therapy were not as applicable to schizophrenia and delinquency due to the impact the disorders had on the family of the clients (Bateson, 1972). Harry Stack Sullivan's interpersonal theory of schizophrenia furthered ideas that individual modalities were inappropriate for treating schizophrenia by highlighting the interdependence between people with schizophrenia and their families (Sullivan, 1955). Research conducted by Lockwood, Page, and Conroy-Hiller (2004) later solidified these ideas, which concluded that relapse and readmission rates of people with schizophrenia did not improved by individual therapy alone.

In response to the needs of individuals with schizophrenia and delinquency, researchers and clinicians began working together to approach disorders and symptoms from a different perspective (Bertalanffy, 1968). Early family therapy began with the focus being on the family as causing the patient's problems, specifically the mother. The concept of the "schizophrenogenic mother," where mothers intentionally caused mental health problems in their children to stay relevant in their lives, drove early theories about family therapy (Bateson, 1972). However, family therapy soon moved away from the family causing mental health problems to viewing the client's problems as part of the relational process among the family members (Kuhn, 1962). In the 1970s, the incorporation of play components to traditionally talk-based family therapy made it beneficial to families where the child or children were the primary symptom bearers (Gil, 1994).

Common Factors

The early 1990s saw an influx of literature aiming to empirically validate all forms of psychotherapy in an effort to remain competitive with the medical field (Task Force on Promotion and Dissemination of Psychological Procedures (TFPDPP), 1995). The medical field had long been producing studies that demonstrated the effectiveness of pharmaceutical treatments with mental health problems and the psychotherapy world was facing intense pressure to produce similar results. The randomized clinical trial took center stage during this time, helping psychotherapy effectively compare different therapeutic modalities to those receiving no treatment, called a control group (TFPDPP).

Marriage and family therapy faced even more trials than most psychotherapy modalities of the time as they not only have to produce results to remain competitive with the medical field, but also to gain respect in the field of psychotherapy itself (Sprenkle, Davis & Lebow, 2009). Due to the family therapy movement not occurring until the mid-1970s, many skeptics from more established areas of psychotherapy doubted the systemic nature of marriage and family therapy and believed it was not successful at creating positive outcomes (Gurman & Fraenkel, 2002). Despite facing skepticism, marriage and family therapy was able to produce outcome research that demonstrated its effectiveness in treating clients (Hazelrigg, Cooper, & Borduin, 1987; Pincus & Wynne, 1995; Shadish et al., 1993; Sprenkle, 2012).

Overall, the evidence-based practice movement of the 1990s was successful at demonstrating that psychotherapy produces positive outcomes (Wampold et al. 1997). However, the overwhelming majority of the research produced during this time compared different areas of psychotherapy to a control group, which concluded that the psychotherapy is more effective than

not receiving a treatment. Research comparing different forms of psychotherapy to one another was unable to demonstrate any differences (Wampold et al). Stated in another way, all forms of psychotherapy are effective, but no specific theory is superior to another. These findings produced an entirely new form of skepticism in the field of psychotherapy. Building from their skepticism, the emphasis on a theory first introduced by Rosenzweig in the 1930s began to build steam. This was the theory of common factors (Rosenzweig, 1936).

In 1992 Michael Lambert re-introduced the theory of common factors with his meta-analysis comparing numerous outcome studies over the years. The conclusions of the meta-analysis provided his argument for a common factors approach, which stated that when different theories of psychotherapy are compared, no theory has been found superior in producing outcomes (Lambert, 1992). Citing research from his predecessors, Lambert proposed that since no specific factors have been linked to positive outcomes, that psychotherapy success can be accounted for by four common factors that exist within all forms of therapy (Frank, 1961; Lambert; Rosenzweig, 1936). According to Lambert, common factors that account for successful outcomes are: extratherapeutic factors, the therapeutic relationship, hope and expectancy, and specific factors.

As more and more research failed to establish any form of psychotherapy as superior to the others, research supporting a common factors perspective became readily available. In fact, common factors have been shown to be correlated with positive outcomes across a variety of studies (Hubble et al., 1999). However, a great debate now exists within the field of psychotherapy with many scholars maintaining that specific factors are what are truly necessary for change, while others attribute the existence of common factors as most relevant explanation for positive outcomes.

Lack of Process

The psychotherapy debate between specific and common factors appears to have uncovered an even larger question, what are the underlying processes that lead to change? Randomized clinical trials are useful at determining the effectiveness of a treatment in comparison to a control group, but do not explore the processes that lead to the effectiveness of the treatment (Wampold et al., 1997). With the intense focus on empirically validating treatments since the 1990s, there is a lack of process research within the field of psychotherapy. Marriage and family therapy is one branch of psychotherapy that has acknowledged the lack of process research and has called for research to begin exploring this area (Sprenkle, Davis & Lebow, 2009).

This researcher proposes that a great starting point for process research is to explore the relationship that exists between marriage and family therapy and specific common factors. Of the four common factors that exist in Lambert's model, the researcher hypothesizes that given the involvement of multiple members of a system in marriage and family therapy, that there will be a unique relationship with hope and expectancy that contributes to positive outcomes.

Current research available connecting marriage and family therapy with hope and expectancy is nearly nonexistent, but literature expanding the concept of hope and expectancy in general provides a solid basis to build from (Snyder et al., 1991; Sprenkle, Blow & Dickey, 1999; Sprenkle, Davis & Lebow, 2009). Hope Theory introduced by Snyder and colleagues expands hope into two subcategories: agency thinking, which focuses on the determination a person has toward accomplishing a goal, and pathways thinking, which focuses on having the skills and pathways available to accomplish a goal (Snyder et al, 1991). Agency and pathways

thinking under Hope Theory will be the focus of this study. Given the involvement of multiple members of a system involved in family therapy, this researcher posits that the potential for pathways thinking to increase appears likely over the course of treatment, which leads to overall increases in hope and expectancy. By uncovering the relationship that exists between family therapy and hope and expectancy as proposed by Hope Theory, a portion of the processes that lead to positive outcomes will emerge.

Study Purpose

The purpose of this study is to begin to address the lack of research that exists exploring the processes of change in marriage and family therapy. It is beyond the scope of this study to fully address the process of change in marriage and family therapy, but instead it will provide a small starting point for future research to build from. Of particular interest, this study will examine the influence that hope and expectancy have in family therapy. Specifically, this study will measure hope scores in parents/guardians starting family therapy with their child, with an emphasis on observing agency thinking and pathways thinking. The perceived relationship between family therapy and hope and expectancy will subsequently be explored to help explain the process that leads to any hope and expectancy changes during the course of family therapy.

The two research questions guiding this mixed-methods dissertation are:

- (1) What are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child?
- (2) How do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy?

Definition of Key Terms

The following definitions will be used for the concepts below within the context of this study:

Agency Thinking: A sense of successful determination in accomplishing goals in the past, present and future (Snyder et al., 1991).

Common Factors: A set of factors that exist within all forms of successful psychotherapy that account for outcomes, including: extratherapeutic factors, the therapeutic relationship, hope and expectancy and specific factors (Lambert, 1992).

Extratherapeutic Factors: Outside factors that exist in the client, or their lives independent of therapy that influence outcomes (Lambert, 1992).

Family Therapy: All therapy modalities in which there is a client (Identified Patient), one or more family members and a therapist all actively involved in at least 70% of sessions (Bateson, 1972).

Hope and Expectancy: A unidimensional construct that involves the perception that goals can be accomplished (Erickson, Post, & Paige, 1975).

Pathways Thinking: A sense of being able to create successful plans to accomplish goals, as well as possessing the tools and skills necessary to put those plans into action (Snyder et al., 1991).

Specific Factors: Individualized characteristics that comprise different schools of thought in psychotherapy (Lambert, 1992).

Therapeutic Relationship: The working alliance that exists between therapist and client that precipitates and underlies desired therapeutic growth (Rogers, 1957).

Chapter 2: Literature Review

In the 1990s the American Psychological Association (APA), which governs much of the mental health field proclaimed, “if clinical psychology is to survive in this heyday of biological psychiatry, the APA must act to emphasize the strength of what we have to offer, a variety of psychotherapies of proven efficacy” (Task Force on Promotion and Dissemination of Psychological Procedures (TFPDPP), 1995). The goal of this proclamation was to increase the research available on mental health theories to further legitimize the practice of treating individuals with mental health symptoms. To help in this process, specific criteria were developed to identify empirically validated treatments (TFPDPP). The influx of research aiming to validate treatments effectively became known as, the evidence-based practice movement.

In order to become empirically validated, a treatment must show successful outcomes in two randomized clinical trials, which is considered the gold standard in outcome research (TFPDPP, 1995). To increase rigor as an evidenced-based treatment, the randomized clinical trials must be conducted by different researchers. Once a treatment has completed these requirements, it can be stamped with the label of “empirically validated.”

Wampold et al. stated that the problem with requirements set forth by the APA is that “these criteria refer exclusively to studies that assess outcome rather than process, theory or psychological mechanisms of change” (1997, p. 203). As a result of the standards introduced by the APA, the overwhelming majority of research in the field over the last 30 years has demonstrated that psychotherapy is effective. Consequently, with the intense focus on efficacy, there is a lack of research on why psychotherapy is effective. As we continue to move forward with research in the field of psychotherapy it is becoming apparent that more focus needs to be

on the specific mechanisms and processes that create successful change in order to further the field and remain competitive with pharmacological and other medical treatments (Wampold et al.).

Marriage and family therapy is one branch of psychotherapy that has acknowledged the need for more research on the underlying factors that make it effective (Sprenkle, Davis & Lebow, 2009). As Sprenkle, Davis and Lebow describe, understanding what contributes to therapeutic change is incredibly important to marriage and family therapists because “the answer surely guides what we do in the consulting room, determines how we view or explain what we do, and should be the focus of what we investigate” (p.2). Despite the recognition that process research is lacking, marriage and family therapy remains similar to general psychotherapy in that it possesses a plethora of research aimed at validating its practices, while the processes that lead to the positive outcomes remain unstudied. Thus, there is a clear need for more process oriented studies to be completed in order for marriage and family therapy to continue developing. Before further addressing the research needs of marriage and family therapy specific to process, this paper will first introduce family therapy as a whole, as well as the literature supporting its efficacy.

Marriage and Family Therapy

Beginning in the 1940s many mental health workers began moving away from the long-established individual therapy due to its lack of involvement of the systems surrounding the client (Broderick & Schrader, 1991). Due to so much being lost when you break down systems into individual parts (individual therapy), it appeared logical to treat the whole family system instead of each part of the system alone (Minuchin, 1985). In response to these revelations,

marriage and family therapy was proposed a treatment option for individuals and families with mental health problems. The theoretical underpinnings of marriage and family therapy that focus on the system surrounding the client and repairing the relationships within that system help it provide a unique alternative to the traditional individually-focused treatments of the time (Bateson, 1972). In order to gain a more thorough understanding of marriage and family therapy, the foundational theoretical aspects of marriage and family therapy will now be presented.

General Systems Theory

General Systems Theory (GST) first emerged in the 1940s when theoreticians from such diverse backgrounds as mathematics, anthropology, and engineering started to piece together models of the structure and function of both mechanical and biological units (Bateson, 1972). Soon after, commonalities between mechanical and biological units were found, including that each share attributes of a system, specifically an organized collection of parts that come together to form a complex whole. As time went on, one of the leading theoreticians, Gregory Bateson, found that GST represented how families functioned as units (Bateson).

GST states that the most important parts of a living system are not visible, but instead are the interactions and relationships that exist between each part of the system (Bateson, 1972). Unlike machines, when family systems are broken down into their individual parts, pieces are lost, such as the interactions and relationships that exist between each piece. From a therapeutic perspective, because so much is lost when you break down systems into individuals, it would make more sense to treat the whole family system, as opposed to each individual in the system alone (Minuchin, 1985).

Family Systems Theory

Cybernetics represents the study of feedback mechanisms in self-regulating systems (Bateson, 1972). In the context of families, cybernetics is the tendency of a family to maintain stability by using information about its own performance as feedback. Feedback loops are at the essence of cybernetics, which is the process of using information within a system in order to maintain homeostasis (Bateson). The information used to maintain homeostasis not only comes from the external environment, but also within the relationships between each of the systems parts. Thus, each individual part of the systems has a direct role in how the other parts of the system behave.

Feedback loops can be positive or negative in nature (Bateson, 1972). Negative feedback loops are self-correcting and indicate how far away from homeostasis the system is currently operating. Subtle adjustments within the system return the system to its desired state. Applied to families, explicit rules are traditionally used to help control the range of behaviors within the members of the system. The different sequences of family interaction around a problem dictate the system's reaction to it.

Positive feedback loops contain information that confirm and reinforce the current direction of the system (Bateson, 1972). If left unchanged, a positive feedback loops can lead to overwhelming amounts of feedback, which can cause the system to spiral out of control. Positive feedback loops often occur when negative feedback loops become ineffective. However, if positive feedback loops do not get out of hand, they can help a system adjust to changed circumstances. In these cases, most actions that are taken in an attempt to repair a situation generally make it worse.

All systems need both positive and negative feedback loops and both can exist as positive and negative forces within those systems (Bateson, 1972). It is the management of the feedback loops that ultimately results in how they affect the system. Feedback loops also can be viewed as the communication within a family, which is a fundamental source of problems in a family (Bateson). If the family has poor communication, it does not have accurate feedback. Without accurate feedback, a system cannot function properly or correct itself when it is in dysfunction.

As GST came forth, Austrian biologist Ludwig von Bertalanffy turned his work toward intertwining concepts from systems thinking and biology into a universal theory of living systems (Bertalanffy, 1968). Bertalanffy combined the concepts of cybernetics and GST into one larger theory known as Family Systems Theory (FST), which would later be adopted by family therapists. Today, FST presupposes all theories that exist under the umbrella of marriage and family therapy.

Effectiveness of Marriage and Family Therapy

In a similar fashion to many other areas of psychotherapy in the 1990s, marriage and family therapy swiftly turned the attention of its research toward validating its treatments in response to proclamation made by the APA (Sprenkle, 2003). As a result, numerous individual studies have come forth demonstrating the effectiveness of different aspects of marriage in family when treating different presenting problems. While the number of studies aiming to validate marriage and family therapy grew, quality meta-analyses and empirical reviews came forth summarizing the hard work completed by researchers in the field, which further solidified its place in the psychotherapy ranks.

Hazelrigg, Cooper, & Borduin presented the first known meta-analysis associated with family therapy in 1987. The goal of the review was to “provide statistical tests of the overall conclusions reached about the effects of family therapy and express these conclusions in a form that is easily compared with results obtained in other fields” (Hazelrigg, Cooper, & Borduin, p. 429). At the time, research had been conducted by others with similar goals, but all had failed due to poor research methodology. By refining the qualifications of the studies included in their review, as well as using improved statistical methods, the authors were certain they would avoid similar pitfalls others faced. 20 studies located in 24 journal articles were selected for inclusion in their study. When analyzing the effectiveness of family therapy in comparison to no treatment, the mean effect size was .45 (Hazelrigg, Cooper, & Borduin). These results were determined to be innovative for the time because they indicated that family therapy was effective on a larger scale.

The most widely acknowledged meta-analysis studying the effectiveness of marriage and family therapy was conducted by Shadish et al. in 1993. This review built off the methodology introduced by Hazelrigg, Cooper, & Borduin (1987) and emphasized modifications to procedural problems identified. The authors reported that procedural improvements included: the exclusion of quasi-experimental studies, the inclusion of numerous additional unpublished dissertations, and the implementation of more refined statistical analyses. Theoretically these unique qualities would provide more accurate results. In total, 163 studies measuring the effectiveness of marriage and family therapy were reviewed, revealing an effect size of .51 (Shadish et al.). Additional analyses were conducted which separated research studying marital therapy from research studying family therapy. After separation, the effect size of marital therapy was found to be .60, while family therapy had an effect size of .47. Conclusions across the board indicate that

clients that participate in marriage and family therapy are significantly better off than those that receive no therapy (Shadish et al.).

In a follow-up to the meta-analysis conducted by Shadish et al. (1993), Pinsof and Wynne (1995) produced a comprehensive literature review that highlighted the effectiveness of marriage and family therapy with specific problems and diagnoses. The review largely included studies in the Shadish et al. article, but was important because it provided a deeper look into the specific literature available on marriage and family therapy with different topics. The article included sections on implementing family therapy with a wide range of issues, including: schizophrenia, affective disorders, child and adolescent conduct disorders, substance abuse, physical illness, marital problems and comorbid disorders (Pinsof & Wynne). Marriage and family therapy was found to be successful in treating all of the areas reviewed, further supporting its effectiveness and utility in the field of psychotherapy.

A sequel to the literature review conducted by Pinsof and Wynne (1995) was released by Sprenkle in 2012. In the review, he analyzed 12 studies between the years 2001 to 2011 where family therapy was applied to numerous presenting issues. In total, there were ten different content areas, including: conduct disorders, substance abuse, childhood and adolescent disorders, family psycho-education for major mental illness, alcoholism, couple distress, relationship education, affective disorders, interpersonal violence, and chronic illness.

Randomized clinic trials (RCTs) were the primary design of the studies examined, which the author acknowledged makes the review ideal (Sprenkle, 2012). Of the studies covered, it was determined that family therapy was more effective than treatment as usual in reducing the symptoms of interest. Due to its focus on methodological rigor, it provides some of the strongest

evidence to date that family therapy is an effective treatment modality in the treatment of a variety of problems.

As demonstrated by this literature review, marriage and family therapy is an effective treatment and can be applied to a variety of presenting concerns (Hazelrigg, Cooper, & Borduin, 1987; Pinsof and Wynne, 1995; Shadish et al., 1993; Sprenkle, 2012). Despite this strength, marriage and family therapy lacks research that explains the process facilitating the positive change with clients. Significant research analyzing the literature of the psychotherapy domain has identified similar problems with the field as a whole (Lambert, 1992; Lambert & Bergin, 1994; Wampold et al.). To date, the most significant attempt to explain the process of change in psychotherapy emerged with a theory suggesting that all forms of therapy are successful due to the existence of commonalities present in all psychotherapies. This theory has become known as the common factors model (Lambert, 1992). The next section of this paper will be dedicated to introducing the common factors model and reviewing the substantial literature associated with it so that it may be connected to marriage and family therapy later in this review.

Common Factors

The existence of common therapeutic factors (common factors) has long been discussed within the mental health field. In a seminal article published in 1936, Rosenzweig questioned “whether the factors that actually are operating in several different therapies may not have much more in common than have the factors alleged to be operating (p. 412).” Rosenzweig argued that instead of individualized factors present in different therapeutic modalities creating positive outcomes in psychotherapy, that a set of common factors that exists in all therapy is what accounts for change. In his article, Rosenzweig introduced the first concept of common factors

that exist in all forms of successful therapy, including: the therapeutic relationship, the presence of hope in the client, and the individualized nature of different therapeutic modalities.

Similar common factors ideas emerged again in 1961 when Dr. Jerome Frank published his book entitled Persuasion and healing. A comparative study of psychotherapy (Frank, 1961). Dr. Frank's book focused on a number of topics surrounding psychotherapy, with the most relevant being the existence of common themes that are present within all positive therapy outcomes.

The most widely recognized research on common factors came in 1992 when Lambert introduced his comprehensive meta-analytic findings on outcome research for the field of psychotherapy within a chapter of the edited book Handbook for psychotherapy integration (Lambert, 1992). The review included over 40 years of outcome studies and concluded that there appears to be four primary factors that influence positive therapy outcome. Each proposed common factor was given a percentage of relevance to the outcome of psychotherapy. Lambert suggested that extratherapeutic factors accounted for 40% of positive psychotherapy outcome, the therapeutic relationship for 30%, hope and expectancy for 15%, and specific therapeutic factors for 15% (Norcross & Goldfried).

In an attempt to refine research in support of common factors, Wampold and colleagues (1997) conducted an additional meta-analysis on outcome studies completed between 1970 and 1995. The goal of the meta-analysis was to provide a rebuttal to the argument that meta-analyses comparing psychotherapies to date could be inaccurate because they often included studies of treatments not intending to improve mental health (Wampold et al. 1997). To address this concern, the meta-analysis only included outcome studies that directly compared two or more

treatments aimed at addressing mental health. The results further supported a common factors approach when they found that the effect sizes from the studies reviewed were extremely similar, which indicated that all the treatments reviewed were roughly equivalent.

Hubble et al. (1999) aimed to expand on Lambert's (1992) model with a meta-analysis that "accounted for all extant outcome research," including research conducted since the time of Lambert's analysis. In a similar manner as Lambert, Hubble and colleagues concluded that common factors do indeed exist within all forms of successful therapy. However, a unique distinction found within their work is the description of common factors as interdependent, fluid, and dynamic, with the role and degree of influence of any one factor as dependent on the context (Hubble et al., 1999).

The literature available on common factors (Hubble et al., 1999; Lambert, 1992; Wampold et al. 1997) solidifies its relationship with positive outcomes in psychotherapy. However, the focus of this particular study is to explore why family therapy is successful. In order to shed light on that topic, a deeper understanding of each individual common factor must be had. To begin that process, a review of the relevant literature on each individual common factor is provided.

Extratherapeutic Factors

In 1976 Michael Lambert conducted a review of literature that focused on neurotic disorders in adults. Of particular note with this review were multiple studies claiming that individuals with mental illness experienced spontaneous remission outside of formal treatment. After analyzing the results of 14 studies, Lambert found a median spontaneous remission rate of 43% in participants (Lambert, 1976). Due to no formal treatment occurring, it was concluded

that the existence of outside factors facilitated the remission. These outside factors later became known as extratherapeutic factors (Hubble et al., 1999).

Lambert's research, as well as supporting literature by other individuals in the field makes it difficult to argue against the role of extratherapeutic factors in positive outcomes (Cuijpers et al., 2011; Hubble, et al., 1999; Lambert, 1976;). However, identifying consistent predictors of outcome within the realm of extratherapeutic factors has been a more difficult task. Petry et al. accurately described the process as "stalking the elusive client variable" when outlining research aimed at determining specific and consistent extratherapeutic factors (p. 88). To date, literature available has broken extratherapeutic factors down into two categories: internal factors (client factors) and external factors (Leibert & Dunne-Bryant, 2015).

Internal or client factors represent extratherapeutic factors that exist within the client (Leibert & Dunne-Bryant, 2015). In their extensive 1984 review of literature on extratherapeutic factors affecting positive psychotherapy outcome, Lambert and Asay (1984) identified numerous specific client factors. At the conclusion of the review it was revealed that client motivation, client focus, client personality and severity of client symptoms play a major role in client outcomes (Lambert & Asay). This appears to be consistent with other notable research on the topic (Leiber & Dunne-Bryan, 2015; Garfield, 1994; Strupp, Fox, & Lessler, 1969). Other client factors that have been correlated with positive psychotherapy outcomes include client strengths and client health (Garfield; Leiber & Dunne-Bryan).

External factors represent extratherapeutic factors that exist in or around the client's life (Leibert & Dunne-Bryant, 2015). In 2008, Roehrlle and Strouse conducted an exhaustive review of the literature on the most well-known external factor, social support. The results of their meta-

analysis revealed that social support was correlated with small increases in successful outcomes in psychotherapy (Roehrle & Strouse). The researchers concluded that although social support was only shown to have small positive influences on psychotherapy outcomes independently, it is likely that the interaction of multiple extratherapeutic factors, including social support, contributes to psychotherapy success. Other external factors that have less significant research support include a client's lifetime events, client resources and client obstacles to success (Leiber & Dunne-Bryan, 2015).

Qualitative research has also contributed to the available research on extratherapeutic factors. In 1992 David Rennie had participants bring him tapes of therapy sessions they received and reviewed the taped sessions with participants while simultaneously conducting an interview (Rennie, 1992). The focus of the interview was on the participants' perceptions of meaningful events in the session. Qualitative analysis revealed that the client personality, client strengths and client focus were major factors in their perceptions of therapy outcomes, which remains consistent with quantitative research on extratherapeutic factors that was previously outlined (Rennie).

Presence in Marriage and Family Therapy. Marriage and family therapy openly acknowledges the impact that client characteristics have on outcomes and goes as far as to say "the research literature makes it clear that the client is actually the single, most potent contributor to outcome in psychotherapy" (Sprenkle & Blow, 2004, p. 25). However, the literature that they are referring to is based on individual treatments. Most of the research on clients in marriage and family therapy consists of mostly demographic variables, like sex and ethnicity, and virtually no literature exists on client characteristics of traditional outcome studies, such as client motivation or client resources (Sprenkle, Davis & Lebow, 2009). While recognizing the shortcomings of

marriage in family therapy literature in this regard, scholars in the field are hopeful that more studies on the topic will emerge in the coming years.

Summary. The literature on extratherapeutic factors has been reviewed to demonstrate their existence within psychotherapy, as well as their significance as a common factor. As previously noted, Lambert identifies extratherapeutic factors as contributing 40% to outcome results in psychotherapy (Lambert, 1992). The literature points to the interaction of multiple extratherapeutic factors as to why it contributes to the largest percentage influence on outcomes of all the common factors (Roehrlé & Strouse, 2008). To continue gaining a deeper understanding of each individual common factor, the review will continue with an overview of the literature on another common factor, the therapeutic relationship.

The Therapeutic Relationship

The importance of the therapeutic relationship within psychotherapy can be traced back to the early writings of Freud on transference (Freud, 1912/1966). In these writings, Freud struggled with what kept clients in therapy despite the psyche's unconscious fear and rejection of exploring repressed material. His answer to this question was the reality-based collaboration that exists between a client and the therapist, a conjoint effort to overcome a client's discomfort or pain (Freud). He labeled this process positive transference.

Zetzel (1956) furthered Freud's work with positive transference in psychoanalysis and began the discussion that separated transference and the therapeutic relationship into distinct concepts. She posited that non-neurotic components of the therapist-client relationship allow the client to take a step back and utilize insight provided by the therapist to better distinguish between remnants of past relationships and the real association between themselves and the

therapist. She went on to label these non-neurotic components the “therapeutic alliance” and argued that in successful psychoanalysis the client fluctuates between periods of time where they are consumed by either transference or the therapeutic alliance (Zetzel). The therapeutic alliance itself was thought to stem from the patient’s attachment to and identification with the analyst.

Further distinction between transference and the therapeutic relationship came with the work of Greenson in 1965. In his work, Greenson recommended that psychoanalysts consciously distinguish between the patient’s explicit reactions to treatment scenarios, or alliance, and the internal misconceptions of the therapist, or transference (Greenson). Greenson coined the term “working alliance” to describe the alliance between the therapist and patient, but often interchanged it with the term therapeutic alliance. He believed one of the most important components underlying the working alliance was the ability of the therapist and patient to form a personal bond.

Some of the first work on the therapeutic relationship outside of psychoanalysis came with the inception of client-centered psychotherapy (Rogers, 1957). The essence of client-centered therapy synthesizes psychotherapy, personality and interpersonal relationships as the agent of change. In his writing, Carl Rogers introduced the six basic tenets of client-centered therapy, which all directly or indirectly point to the therapeutic relationship as the primary agent of change within his theory, and likely to “any situation in which constructive personality change occurs” (Rogers). Concepts such as genuineness, empathy, perception and unconditional positive regard toward the client are presented as the ingredients for change with the therapeutic relationship and client-centered therapy (Rogers). This is the first instance where characteristics that form a healthy therapeutic relationship are addressed.

Even further deviation from the therapeutic relationship introduced by psychoanalysis came from the work of Bordin (1979). Using Greenson's (1965) ideas as a starting point, Bordin described the therapeutic alliance as collaborative entity comprised of three components: agreement on therapeutic goals, consensus on the tasks to achieve the therapeutic goals, and a bond between the client and the therapist. Here we see the continued development of the concept of the therapeutic relationship by shifting the focus from the traditional psychoanalytic emphasis on the therapist's contribution to the therapeutic relationship toward one focused on collaboration and consensus between both client and therapist.

Bordin (1979) went on to state that different types of therapy would place a different emphasis on the relationship that exists between the client and therapist, but would not undermine the overall importance. This appears to be consistent with most ideas associated with a common factors model, which at that point, had not yet been fully introduced.

As Rogers (1957) asserted, there are a few individual characteristics that constitute a healthy therapeutic relationship when referring to positive psychotherapy outcomes, such as the therapist displaying genuineness and empathy toward the client. However, as Bordin (1979) postulated, many of the ingredients that comprise an ideal therapeutic alliance are unique to the different psychotherapy theories that exist. Although it is likely possible to identify a common set of factors for a healthy therapeutic relationship that exist across all theories, doing so is beyond the scope of this review. Instead, the focus will now turn to the research that demonstrates that the therapeutic relationship is correlated with outcomes in psychotherapy.

The work of Martin et al. in 2000 represented one of the first attempts to legitimize the correlation between the therapeutic relationship and psychotherapy outcomes. In their meta-

analysis 79 studies were reviewed, 58 coming from published studies and 21 from unpublished doctoral dissertations or master's theses. Within these studies, six empirically validated measures were implemented to determine the quality of the relationship. At the conclusion of their review, an effect size of .22 was found, indicating that a small relationship exists between the therapeutic relationship and psychotherapy outcomes (Martin et al., 2000). The researchers also reported that due to the nature of the results that they did not believe that any mediators, moderators or interactions with other variables were necessary to analyze or report on.

In 2002 Horvath and Bedi further investigated the relationship between the therapeutic relationship and outcomes by reviewing the results of 90 outcome studies from 1976 to 2000. The goal of the review was to build upon the work by Martin et al. (2000) by adding more recent studies that were not included in their review and by using slightly different statistical measures that included the measurement of mediators and moderators. Across all studies included in the meta-analysis, the median effect size between therapeutic relationship and outcome was determined to be .25 (Horvath & Bedi). Mediators and moderators of the alliance included client experiences, client skills, and client strengths brought to therapy, as well as a variety of other in-therapy contributions such as the phase of therapy, the raters' perspective and therapist characteristics. It is important to note that many of mediators and moderators of the alliance identified by Horvath and Bedi are commonly known as extratherapeutic factors, which align with the findings of Hubble et al. (1999) which stated that it interaction of all the common factors that create successful outcomes, not each factor individually.

Qualitative research also exists examining the therapeutic relationship and outcomes. Bachelor (1988) conducted a content analysis focusing on clients' perceptions of empathy from their therapist and outcomes. Using interviews from twenty-seven clients in therapy, four styles

of empathy were identified as contributing to outcomes, including cognitive, affective, sharing and nurturing empathy (Bachelor). These conclusions further support the importance of the therapeutic relationship with outcomes, but more importantly demonstrate the utility of qualitative research on this topic. This ties in well to the mixed methods approach that will be used in this study.

Presence in Marriage and Family Therapy. As important as the therapeutic relationship has been shown to be across general psychotherapy (Horvath & Bedi, 2002; Martin et al., 2000), it appears to be much more significant to marriage and family therapy due to the presence of “multiple participants and accompanying struggles to build simultaneous alliances and to keep the level of alliance in balance across clients” (Sprenkle, Davis & Lebow, 2009). Marriage and family therapy has also acknowledged that the presence of a healthy therapeutic relationship interacts positively with other common factors by increasing hope and expectancy, as well as easing the application of specific factors used in the theory of choice. When comparing the literature available on the therapeutic relationship in marriage and family therapy to the research on the other common factors in marriage and family therapy, the importance of the therapist-client relationship is apparent.

Special attention is given to the therapeutic relationship in marriage and family therapy because of the high prevalence of a split alliance, in which some members of the family or couple are motivated to engage in therapy, while the rest are not (Sprenkle, Davis & Lebow, 2009). Even the most skilled therapist struggle with split alliances because it becomes necessary to “respect the ongoing process of the treatment and alliance with the allied parties and yet must reach out to and involve the less engaged clients as well (p.103).” Additionally, marriage and family therapists must tend to each individual relationship they have with each member of the

family system, while simultaneously monitoring the relationships each member of the family system has with each other, as well as the relationship the therapist has with family system as a whole (Knobloch-Fedders et al., 2004). These unique challenges within marriage and family therapy have given way to various studies on the impact of the therapeutic relationship on outcomes.

Some of the most significant research on the therapeutic alliance in marriage and family therapy has been conducted using strategic therapy (Sprenkle, Davis & Lebow, 2009). Research conducted by Green and Herget (1991) using strategic therapy centered on consultation with a team concluded that the therapeutic alliance and degree of therapist warmth had a significant impact on the client outcomes. These results are even more profound considering that the specific framework utilized places no importance on the therapeutic relationship, and in some cases, even works to minimize its importance.

A study by Stolk and Perlesz (1990) further exemplified the importance of the therapeutic alliance in marriage in family therapy when it uncovered that first year students in a strategic therapy program often became less effective in their second year in terms of outcomes. It was concluded that outcomes with these students dropped in their second year because of a decreased focus on the relationships they had with their clients (Stolk & Perlesz). Studies have even gone as far as concluding that 45% of the outcome variance in family therapy is attributed to the therapist relationship skills (Barton & Alexander, 1977).

The amount of time it takes to establish a therapeutic relationship has even been shown to affect outcomes in marriage and family therapy (Sprenkle, Davis & Lebow, 2009). In several studies with large, diverse samples of clients, Leon and colleagues found that if the alliance early

in treatment is poor, the chances for positive outcomes drastically decrease (Leon, Kopta, Howard, & Lutz, 1999). Others have specified that if a healthy therapeutic relationship is not formed by the fifth session, then the chances of spontaneous discharge greatly increase (Sprenkle, Davis & Lebow). Thus, it is clear that the role of a healthy therapeutic relationship in marriage in family therapy is similar to, if not more important than, the therapist-client relationships found in other branches of psychotherapy.

Summary. Since its first recognition within the writings of Freud (1912/1966), the bond that exists between therapist and client has received many different labels: positive transference, therapeutic alliance, working alliance and therapeutic relationship. Nonetheless, the effect that the therapeutic relationship has on psychotherapy outcomes has ultimately remained the same. Lambert (1992) estimated that the therapeutic relationship accounted for 30% of psychotherapy outcome, which appears consistent with other available research indicating small effect sizes (Horvath & Bedi, 2002; Martin et al., 2000). To further understand each individual common factor will now continue with a more in-depth look at the next common factor, specific therapeutic factors.

Specific Therapeutic Factors

The mental health field was established with one goal in mind, to help clients overcome their presenting symptoms. However, no agreed upon methodology on how to accomplish that task has ever come forth (Sprenkle, Davis, & Lebow, 2009). As a result, countless theories have emerged claiming to help clients solve their problems of interest. These different schools of thought on how to treat clients represent the specific therapeutic factors found in the common

factors model (Lambert, 1992). They are the individual ingredients that make each theory unique.

In an effort to justify that specific theories are worthy of practice, individual studies have been conducted demonstrating positive outcomes when applying the theory of focus (Wampold et al., 1997). The attention of some research has even been on comparing specific theories to other theories in an attempt to distinguish best practices (Sprenkle, Davis, & Lebow, 2009). Over time, substantial meta-analyses have emerged summarizing the work of these researchers (Lambert, 1992; Lambert & Bergin, 1994; Wampold et al.). Hubble et al. (1999) presented a review of all noteworthy meta-analyses available through the 1990s that studied the effectiveness of psychotherapy, and/or compared different types of psychotherapy to one another. Types of therapy examined included: cognitive-behavioral therapy, family therapy, narrative therapy, and many more. Some research highlighted even studied different forms of psychotherapy in the treatment of specific disorders, such as anxiety or depression. The effect sizes found across all meta-analyses indicated that psychotherapy in general is “effective and efficient” (Hubble et al., p.28). However, no single form of treatment was determined to be more effective than the others.

To date, numerous forms of therapy have been empirically validated, but none have been found to be superior to any other in terms of outcomes (Wampold et al., 1997). Nonetheless, Lambert still holds specific therapeutic factors in high regard within the common factors model (Lambert, 1992). As Spenkle, Davis and Lebow (2009) describe, the strength of specific models is their organization, which leads to coherence. Due to specific theories, “the people who practice these therapies have a clear roadmap of the dysfunction they are addressing, the place where they want clients to go, and how to get there” (Spenkle, Davis & Lebow).

Presence in Marriage and Family Therapy. Specific therapeutic factors research in marriage and family therapy is another area that remains underdeveloped (Sprenkle, Blow, & Dickey, 1999). One possible explanation for this dearth in research is that marriage and family therapy was developed a significant amount of time after many individually-focused treatments. Researchers have had to focus on legitimizing the field as a whole in order to catch up, leaving the comparison of specific factors for a later time. The meta-analytic study covered earlier by Shadish et al. (1993) represents the lone research that explores the effects of specific factors within marriage and family therapy.

The comprehensive meta-analytic review addressed many different areas in the field, but the most significant findings in respect to specific factors came when they compared different theories of marriage and family therapy to one another (Shadish et al., 1993). In total, 23 marriage and family therapy theories were examined, including foundational theories such as structural family therapy, strategic family therapy, and cognitive-behavioral family therapy. The results concluded that no significant differences existed between theories, which indicate that although the overwhelming majority of marriage and family therapy theories have positive client outcomes, no theory is superior to another. These conclusions remain consistent with individually-focused literature, which heavily points to a common factors perspective (Lambert, 1992; Lambert & Bergin, 1994; Wampold et al., 1997).

Summary. Ironically, much of the literature emphasizing the potential strength of specific therapeutic factors is the same literature that gave way to continued growth in the realm of common factors (Lambert, 1992; Lambert & Bergin, 1994; Sprenkle, Davis & Lebow, 2009; Wampold et al., 1997). Despite the ever-growing research available on common factors, most literature in the area continues to support the power of specific therapeutic factors the theory. Of

particular importance to this study, Lambert concluded that specific therapeutic factors contribute to 15% of the variance in psychotherapy treatment outcomes. To conclude the process of better understanding common factors, literature on the last common factor, hope and expectancy will now be introduced.

Hope and Expectancy

Currently most research on hope suggests that it is a unidimensional construct that involves the perception that goals can be accomplished (Erickson, Post, & Paige, 1975; Frankl, 1963). According to these writers, levels of hope for goal achievement can be used to help explain diverse behaviors, including those tied to physical and mental health. For example, maladaptive thinking and psychopathology have been correlated to low expectancies for goal achievement (Erickson et al., 1975). Similarly, it has been concluded that greater levels of hope are associated with higher expectancies for goal achievement.

In 1991, research by Snyder et al. aimed to expand the notion that hope is connected to goal achievement by broadening the research on how goals are pursued. In their work, they proposed that there are two major, interrelated concepts of hope. First, they outlined that “hope is fueled by the perception of successful agency related to goals (p. 570).” Agency can be defined as a sense of successful determination in accomplishing goals in the past, present and future. Second, they outlined that “hope is influenced by the perceived availability of successful pathways related to goals (p. 570).” Pathways can be defined as a sense of being able to create successful plans to accomplish goals, as well as possessing the tools and skills necessary to put those plans into action.

Snyder et al. (1991) goes on to explain that the two components of hope are “reciprocal, additive and positively correlated, although they are not synonymous (p.571).” The two components, agency and pathways thinking, are meant to emphasize the cognitive analyses that take within an individual when working toward goals. Recognition of important external factors that influence goal achievement is taken into account with hope theory. It is the individual’s subjective perception of reality that influences their belief of whether they can accomplish their goals.

Utility of Hope Theory. Research backing hope theory was first introduced by Snyder et al. in their original 1991 article. The researchers implemented the newly developed Hope Scale to determine whether relationships exist between levels of hope and positive health processes in college students seeking mental health treatment. After a 10-week treatment period, positive correlations between levels of hope and positive mental health processes were found, including goal setting, goal appraisals and goal achievement.

Other research available on hope theory supports its application to mental health coping strategies and test taking performance (Onwuegbuzie & Snyder, 2000). In their 2000 study, Onwuegbuzie and Snyder compared initial levels of hope to coping strategies used to study for exams, as well as actual performance on the exams in 87 graduate students enrolled in traditional statistics and research methods courses. The results yielded that student’s levels of hope were positively correlated with healthy coping strategies used to study for exams and with performance on the exams.

Additional research supporting hope theory came in its application within a 2006 study by Peterson, Gerhardt and Rode that examined the relationship between hope, goal orientation,

verbal persuasion and task performance. The study recruited 212 undergraduate students and established learning goals with them in regard to an anagram task to be completed at a later date. The Hope Scale was administered at this time to measure levels of hope in the participants in relation to the goals they had established.

During the completion of the anagram task, the mediating variable of verbal persuasion was added to determine any effects on task performance. The findings indicated that levels of hope were positively correlated with the learning goals established at the onset of the research, while the mediating variables were found to have no significant impact (Peterson, Gerhardt & Rode, 2006).

Qualitative exploration of the role of hope in therapy is present in the literature as well. Larsen and Stege (2012) used a case study method to explore client experiences of hope in the early stages of counseling. Their results indicated that clients gained the most hope from the establishment of the therapeutic relationship, from supportive identity development and from changes in perspective on key topics. Increased levels of client hope were also tied to successful outcomes (Larsen and Stege). The conclusion that positive interactions exist between hope and the therapeutic relationship on outcomes remains consistent with other common factors research (Hubble et al., 1999).

A comprehensive literature review conducted by Snyder in 2002 fully solidified hope theory's utility and went on to review studies that applied hope theory to even wider domains including academics, athletics, physical health, psychological adjustment and psychotherapy. The most common theme seen in all research using hope theory: participants with high levels of hope fare better than participants with low levels of hope (Snyder).

Hope Theory and The Common Factors Model. Snyder posits that high-hope individuals are more decisive about the pathways for their goals, are able to create alternative pathways when the primary pathway does not work out and continually refine their goal to make it more precise (Snyder, 2012). Additionally, high-hope individuals are able to focus and channel their motivation toward accomplishing a goal in order to best utilize or refine the pathways taken to achieve a goal. Within hope theory, it is necessary to have characteristics of both pathways and agency thinking to succeed, which high-hope individuals have been shown to possess.

As previously noted, common factors research has indicated psychotherapy that possesses each of the common factors creates positive outcomes. This appears to connect well to hope theory's conclusion that high-hope individuals fare better than low-hope individuals. However, even though each common factor has been shown to carry a specific weight in the process of change in psychotherapy, far less research has focused on the unique relationships that specific psychotherapies have with common factors (Sprenkle, Davis & Lebow, 2009). Exploration of this area has the potential to uncover processes that lead to positive outcomes in different psychotherapies.

Presence in Marriage and Family Therapy. The relationship between hope and expectancy and outcomes in marriage and family therapy can at best be described as underdeveloped. Although hope and expectancy has started to take a larger role in marriage and family therapy theory, there is not currently much research that directly addresses how hope and expectancy effect change in the therapeutic process (Sprenkle, Blow & Dickey, 1999; Sprenkle, Davis & Lebow, 2009; Ward, Linville, & Rosen, 2007).

The most significant example of literature that addresses hope and expectancy within the realm of marriage and family therapy exists with the work of Ward and colleagues (2007). In their study, the perceptions of the therapeutic process were examined in 41 participants involved in therapy at a marriage and family therapy clinic in the Washington D.C. metropolitan area. Using a mixed methods design that analyzed data strands independently, all common factors were found to have significant influence on the outcomes for both the quantitative and qualitative data. Most importantly, the quantitative data found that hope and expectancy had the most significant influence on outcomes, which deviates from previous research (Ward, Linville, & Rosen, 2007).

Summary. The review of common factors literature has resulted in a greater understanding of each individual factor, but has also uncovered the major gaps in literature that exist in regard to common factors in marriage and family therapy (Sprenkle, Davis & Lebow, 2009). With the exception of the therapeutic alliance, hardly any research exists exploring how common factors affect outcomes in marriage and family therapy. The greatest dearth appears to be the relationship between hope and expectancy in marriage and family therapy, in which the least amount of significant literature exists.

This research aims to simultaneously address the need for process oriented literature in the field of marriage and family therapy and the need for literature connecting hope and expectancy with marriage and family therapy. Based on the work of Hubble et al. (1999) that states the interaction of all the common factors account for therapeutic change, and the role and degree of influence that each common factor plays depends on context. This researcher posits that a unique relationship exists between marriage and family therapy and the common factor hope and expectancy. Further, this relationship has the possibility to explain a portion of the

process that leads to positive outcomes in marriage and family therapy. The next section is dedicated to highlighting the apparent commonalities between FST and Hope Theory.

Connecting Hope Theory and Family Systems Theory

According to Snyder et al. (1991), increases in hope are correlated with increases in psychotherapy outcomes. This author proposes that marriage and family therapy, via FST, potentially increases hope through a variety of unique theoretical characteristics. Hope Theory suggests that hope is comprised of two subcategories: agency thinking and pathways thinking (Snyder et al.) Both subcategories are relevant for marriage and family therapy.

Roehrle and Strouse (2008) explained that the extratherapeutic factor social support has a small contribution to psychotherapy outcomes independently, but plays a much larger role when interacting with other factors. The most basic tenant of FST as it relates to marriage and family therapy is that the family must be present (Bateson, 1972). Due to the presence of the family in family therapy, the potential to stimulate the interaction between social support and hope appears likely.

The stimulation of the interaction between hope and the extratherapeutic factor social support could occur through an increase in pathways thinking. The very nature of FST to focus on the whole family system provides increased pathways to accomplish goals by identifying problematic patterns and interactions in the family and collaboratively working to modify those patterns and interactions into healthy ones (Bertalanffy, 1968). In addition, because the whole system is involved in the process, there is no one left to get in the way of using the newly formed pathways. Family therapy teaches the family the skills it needs to correct itself and provides an environment to safely do so. This can be framed as the ultimate pathway to success.

Many forms of family therapy are strength focused and actively search for solutions with the family (Sprenkle, Davis & Lebow, 2009). The active focus on creating solutions also connects to pathways thinking. The family is literally creating pathways for success with their therapist. An additional aspect of solution-focused therapy is uncovering solutions that already exist (Sprenkle, Davis & Lebow). The ability to identify past success is directly tied to the other subcategory in Hope Theory, agency thinking. Finally, the ability to reframe negative contexts into positive ones may also increase agency thinking by changing the perception how the family views their current situation and ability to accomplish goals. This is another component of marriage and family therapy.

Conclusions

Overall, there appears to be numerous connections between FST and Hope Theory, which leads to the potential that successful outcomes in marriage and family therapy are at least partially the result of increased hope in their clients. As previously identified, very little literature exists on the processes of marriage and family therapy that make it successful, as well as its connections with the common factor hope and expectancy. The purpose of this research is to simultaneously fill small portions of both gaps in literature by (a.) Identifying the levels of hope and expectancy increases in parents/guardians at the onset of family therapy when they participate in treatment with their child? (b.) Explaining the unique relationship that family therapy has with hope and expectancy that allows for successful outcomes from a common factors perspective.

Chapter 3: Methods

This study implemented a mixed methods sequential embedded design to test the study's two research questions (a) what are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child, (b) how do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy?

Study Design

The mixed methods sequential embedded design consisted of four major steps (Bryman; 2012; Creswell & Clark, 2011). The two data strands in this design were collected sequentially and interactively. The qualitative data strands were given priority in this design and mixing occurred during data collection. The data strands were merged using a connected mixed methods data analysis (Creswell & Clark). The researcher began by collecting the quantitative data. Second, the researcher analyzed the quantitative data using traditional quantitative data analysis procedures. The mixing occurred after the results of the quantitative data analysis were completed, which gave way to specific questions used in qualitative data collection. Third, the researcher collected the qualitative data. Finally, the researcher analyzed the qualitative data using traditional data analysis procedures (Bryman).

The rationale for this design is based on the advantages present within traditional embedded designs. Obtaining and analyzing both quantitative and qualitative data in interaction with one another allowed for the full benefit of both individual modalities to be utilized, while simultaneously building off one another. Specifically, gathering quantitative data on hope and expectancy in parents/guardians beginning family therapy with their child allowed the researcher

to explore which subscales of hope and expectancy connect with family therapy in a concrete manner and develop sufficient questions to explore them in further detail qualitatively.

Obtaining qualitative data served the dual purpose of validating the quantitative data, as well as further exploring the specific relationship that hope and expectancy had with family therapy through the perceptions of the parents/guardians. Additionally, allowing the quantitative data analysis to partially guide the qualitative data collection created richer qualitative data to be obtained. Thus, the interaction of both types of data sets allowed for the weaknesses of each individual modality to be minimized, while providing more complex conclusions to answer the research questions. In essence, this mixed methods sequential embedded design allowed for the individual weaknesses of quantitative and qualitative data to be minimized, while taking advantage of the strengths of both modalities to form more complex conclusions to the research questions in an extremely efficient manner.

Sample

In order to carry out the study's purpose, it was determined that 10 participants would need to be recruited (Bryman, 2012; Creswell & Clark, 2011). Due to a single point of data collection, the potential for attrition was greatly reduced. As a result, the actual number of participants recruited was 12. After a single participant dropout, the actual number of participants was 11, two of which were a couple that completed the study at the same time. Demographic information for the participants can be found in Table 1. The participants were obtained from Tanager Place Behavioral Health Clinic in Cedar Rapids, Iowa. All participants were given the pseudonym "Participant," followed by the number in which their interview was conducted to protect anonymity. For example, the individual from interview one was given the

pseudonym “Participant 1.” In addition, any other names referenced by the participants in their interviews were given randomly generated aliases to protect their confidentiality.

Table 1

Demographic Information of the Study’s Participants

Interview Number	Alias	Sex	Role	Insurance Type
Interview 1	Participant 1	Female	Parent	Medicaid
Interview 2	Participant 2	Female	Parent	Unknown
Interview 3	Participant 3	Female	Parent	Medicaid
Interview 4	Participant 4	Female	Parent	Medicaid
Interview 5	Participant 5	Female	Parent	Medicaid
Interview 6	Participant 6	Female	Guardian	Private and Medicaid
Interview 7	Participant 7	Female	Parent	Medicaid
Interview 8	Participant 8	Female	Parent	Private and Medicaid
Interview 9	Participant 9	Female	Parent	Medicaid
Interview 10	Participant 10A	Female	Parent/Step-Parent	Medicaid
Interview 10	Participant 10B	Male	Parent/Step-Parent	Medicaid

Inclusion/Exclusion Criteria. The sample was parents and guardians who were starting family therapy with their child at Tanager Place Behavioral Health Clinic. The inclusion criteria for this study were: parents/guardians of youths between the ages of three and seventeen years of age, receiving family therapy as their primary treatment modality, and lastly they and their family spoke English. Parents that did not meet these requirements were excluded from the study.

Further, the presence of a major depressive disorder has been shown to negative influence levels of hope and expectancy (Vilhauer et al., 2013). In order to avoid unwanted extraneous influence as a result of extraneous mental health problems that directly relate to hope, parents/guardians that presented with a major depressive disorder were excluded from the study. The presence of a major depressive disorder was screened for during the initial phone call to determine if prospective participants wanted to participate in the study.

Measures

The measures that were used in this study were paper copies of the Hope Scale (Appendix A). Scoring of the measures occurred via paper and pencil summations. Additional open-ended questions were presented in a semi-structured interview. All measures were offered in English.

Hope Scale. The Hope Scale (Snyder et al., 1991) is a 12-item measure of the respondent's level of hope. The scale is divided into two subscales that represent Snyder's cognitive model of hope: (1) agency, which is the belief that a goal can be accomplished and (2) pathways, which is the belief that the skills and pathways to accomplish a goal are present or attainable. Of the 12 items, 4 are for the agency subscale, 4 are for the pathways subscale, and 4 are fillers. Each item on the scale is answered using an 8-point Likert scale that ranges from (1) "Definitely False" to (8)

“Definitely True.” The scale is scored through a simple summation process, which yields individual subscale scores, as well as the overall hope score. A positive relationship exists between hope scale scores and levels of hope in respondents. Research conducted by Snyder et al. indicated that average scores for college and non-college samples of adults is approximately 24.

The Hope Scale has been tested across key dimensions necessary for a sufficient measure, including temporal reliability, internal consistency, convergent validity and discriminant validity. Research demonstrating appropriate internal consistency and temporal reliability (Snyder et al, 1991) revealed that the Cronbach’s alpha to be .84 for the total scale, while the agency and pathways subscales were .76 and .80 respectively. Over a 10-week interval, the test-retest reliability of the Hope Scale was .82, $p < .001$.

Convergent validity of the Hope Scale was tested in a study comparing hope to a number of related attributes (Gibb, 1990). Hope scores were shown to be positively correlated with the following convergent measures: optimism, goal attainment, personal control, self-esteem. A negative correlation was also found with hopelessness and depression. According to Snyder et al. (1991), these results verify the convergent validity of the Hope Scale. Convergent validity for the Hope Scale (state hope) was further supported by the finding that its scores correlated positively with scores on the trait Hope Scale ($r = .78$ and $.79$; Edward, Rand, Lopez & Snyder, 2007).

Discriminant validity for the Hope Scale was evaluated through its comparison to the concept self-consciousness, which was assessed using the Self-Consciousness Scale (Gibb, 1990). The correlations between the Hope Scale and the subscales of the Self-Consciousness

Scale were non-significant ($r_s = .06$ and $-.03$), suggesting that the two scales share very little variance.

Semi-Structured Interview. The researcher conducted semi-structured interviews with the participants. The researcher utilized an interview guide (Appendix B), as well as spontaneously created questions designed to elaborate and follow-up on answers given.

Procedures

Approval for this study was obtained from the Human Subjects Office at The University of Iowa, as well as a research board at Tanager Place in Cedar Rapids, Iowa. Participants were recruited through a wait-list kept at Tanager Place Behavioral Health Clinic. Potential therapy clients were placed on the waitlist after being assessed by a therapist at the Tanager Place Behavioral Health Clinic (at which time demographic and language capabilities were obtained from the traditional Tanager Place intake packet). If the therapist deemed that the client needed therapy services, they were referred for therapy and placed on the waiting list until a therapist that could meet their needs became available. Based on the order they were placed on the waiting list, parents/guardians of potential clients were contacted by the Tanager Place Behavioral Health Clinic supervisor in charge of the waitlist (by phone) and offered available time slots with a therapist. If the parents/guardians of the client were able to find a suitable time with a therapist, the supervisor then introduced the study to them to determine if they were interested in participating.

If the parents/guardians of the client were interested in participating in the study, an appointment to meet with the researcher for more details was made right before their first appointment with their assigned therapist. Further, individuals that expressed interested were

asked whether they currently held a diagnosis of major depressive disorder. No participants reported such a disorder, but if they had, they would have been excluded from the study due to the exclusion criteria. Those individuals that did not express interest in the study had treatment continue as usual.

For clients interested, the researcher met with the client's parents/guardians 45 minutes before their initial appointment with their therapist to introduce all relevant details of the study, to have consent forms signed, and to conduct the interviews. In the event of a two-parent/guardian household, the parent/guardian who was the referring party for therapy was the participant in the study. There was one instance where both members insisted on participating. These meetings occurred in a private meeting room located at the Tanager Place Behavioral Health Clinic.

After the parents/guardians signed the consent forms they were asked to complete the Hope Scale. The researcher explained how to fill out the measure and then the parents/guardians were given 10 minutes to complete it (included the information needed for inclusion/exclusion criteria and demographic variables). The researcher scored the Hope Scale, presented the scores to the participants, and then conducted a semi-structured interview. The researcher allotted 30 minutes for the semi-structured interview to be completed. The completion of the measure and the semi-structured interview marked the end of the study for the participants.

Data Analysis

In this study, data analysis occurred in two parts. The first part of the data analysis consisted of organizing the data obtained from the Hope Scale using basic descriptive statistics. The results of quantitative analysis were used to determine the hope and expectancy scores of

parents/guardians beginning therapy with their child, which partially addressed research question one: what are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child. Mixing of the data strands occurred during data collection as the results of the quantitative analysis were used to inform a portion of the questions asked in the qualitative data collection.

The second part of the data analysis consisted of a grounded theory approach when analyzing the qualitative data obtained from the semi-structured interview. A four-step process was used within a grounded theory framework, which included (1) open coding to create concepts, (2) axial coding to turn multiple concepts into categories, (3) selective coding of categories to create a core category, (4), saturation of the remaining categories into the core category to create a substantive theory regarding the research questions (Braun & Clarke, 2006). The results from the grounded theory approach aided in addressing question two, how do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy?

In order to combat researcher bias that is inherent in qualitative research, this researcher participated in a series of reflective journals (Ortlipp, 2008). The reflective journals (Appendix C) were completed throughout each major stage of the study, including the data analysis and interpretation of the results. The reflective journals examined personal assumptions and goals about the study, as well as made explicit any individual belief systems and subjectivities that could be relevant to the outcome of the study. The completion of this process allowed the researcher to explicitly confront any biases that may exist and remove their influence from the study.

Self of the Researcher

As a member of the field of marriage and family therapy, literature informing its practice has been a guiding force for me throughout my career. During a prospectus defense, it was recommended to me by a professor that evidence connecting marriage and family therapy to the common factors model was scarce and exploring that area could lead to beneficial conclusions for the field (Lambert, 1992). As I scoured common factors research as it relates to marriage and family therapy I uncovered the work of Snyder et al. (1991), which immediately stemmed a curiosity on the relationship between hope and expectancy as defined by Snyder, and marriage and family therapy. In particular, my curiosity grew around the idea that the Hope Theory subscale Pathways Thinking could have a unique relationship with marriage and family therapy.

I spent many hours looking for existing research on Snyder's Hope Theory within marriage and family therapy literature. Very little was found. From that point on, I aimed to design a study to explore the relationship between Hope and Expectancy from the lens of Snyder's Hope Theory in an effort to make some form of impact in the marriage and family therapy community. As I continued to design this study, it became apparent that many of the ideas that would be explored in this study were unique. My passion for the study only grew from that realization. Due to my employment at Tanager Place, I was able to recruit enough participants in the Tanager Place Behavioral Health Clinic to conduct my study. I will never be able to thank them enough for their role in helping me complete this research.

Chapter 4: Results

Following the procedures outlined in Chapter 3, a mixture of a qualitative and quantitative data remained to address each of the study's two research questions.

Research Question 1: What are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child?

The descriptive statistics calculated prior to the interviews were as follows. The mean score for agency thinking was 25.1 (SD=2.43), with scores ranging from 20 to 29 out of a potential of 32. The mean score for pathways thinking was 26.1 (SD= 3.00), with scores ranging from 19 to 30 out of a potential 32. The mean for total hope scores was 51.2 out of a potential score of 64. The quantitative strand of data was not used to directly address the first research question, but instead was mixed with the qualitative strand of data during data collection to help enhance answers provided by interviewees and questions asked by the researcher.

Research Question 2: How do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy?

Each of the 10 audio recorded qualitative interviews was transcribed through the confidential online transcription service, REV.com. The 10 qualitative interviews yielded 131 single-spaced pages of transcripts relating to perceptions of hope and expectancy in parents and guardians beginning family therapy with their child. Saturation of the content was achieved at the conclusion of the tenth interview. The researcher reviewed each transcript and changed identifying information to maintain participant confidentiality. Reflective journals were kept throughout the coding process in order to minimize researcher bias, as well as bolster the quality

of the data analysis. In order to address both research questions posed in this study, a grounded theory coding process utilized to generate a formal theory. The coding process used in this study will now be discussed in detail.

Open Coding

Through the use of *constant comparison*, continuous comparisons were made between and across levels of data analysis (Urquhart, 2013). Transcripts were studied multiple times leading to the creation of the first open codes achieved through line-by-line coding (Saldaña, 2016). Open codes, with their matching quote and qualitative question were placed in a coding spreadsheet in Microsoft Excel and separated into tabs for each transcript (see Table 2).

Table 2

Sample of Open Code Organization Within the Coding Spreadsheet

Qualitative Question:	Quote:	Open Code:
How do you think that family therapy will influence your determination or motivation to accomplish goals?	I think it'll increase it, or it has increased it;	Motivation has increased since enrollment in family therapy
	just kind of the positive thinking that's been happening as far as the process has been so far. It's increased positive thinking,	Noticeably more positive thinking
	potential for good outcomes, I think, and deciding to go ahead and give that a try.	Positive outcomes appear more attainable

Open coding continued, while simultaneously reviewing previous open codes and previous transcripts, until all transcripts were coded. The conclusion of open coding yielded 951 open codes (\bar{x} =95.1 per transcript). All open codes were reviewed in preparation for the next coding step in the data analysis, axial coding.

Axial Coding

The goal and purpose of axial coding was to “strategically reassemble data that were “split” or “fractured” during the open coding process in order to determine which codes in the research were the dominant ones and which ones were the less important ones (Saldaña, 2016, p.244).” At the onset of this portion of this coding regimen, axial coding tabs for each transcript were created within the coding spreadsheet to house the axial codes. Axial codes were created by comparing and subsequently separating similar open codes, along with their original quotes, into groups under a column titled “axial codes” (see Table 3).

Table 3

Sample of Axial Code Organization Within the Coding Spreadsheet

Axial Code:	<i>Family Therapy will Address Family Relationships</i>	<i>Family Therapy will Improve Deficit Skills</i>	<i>Family Therapy will be a Positive Experience</i>
Open Code:	Re-build relationship between mother and son.	Family therapy will help both mom and daughter with emotional regulation skills	Son is excited for family therapy
Open Code:	Re-building family relationships	Mom does not feel like she has many skills	Family therapy will be positive

Table 3—continued

Open Code:	Wants to focus more on the relationship with her kids	Family therapy will enhance skills mom already has	Excited for family therapy
Open Code:	Having specific time to build relationships	Family therapy will help mom improve her parenting	Happy family therapy is starting
Open Code:		Family therapy will help mom to follow through on discipline in family therapy	Family therapy will be beneficial

Reflective journaling took place throughout this stage of coding as well. All ungrouped open codes remained in a column labeled “ungrouped open codes.” Each grouping of open codes was reviewed when all groupings were complete and appropriate axial code headings were provided. This process occurred individually across all 10 transcripts. In total, 211 ($\bar{x}=21.1$) axial codes emerged from the open codes across the 10 interviews.

Selective Coding

According to Saldaña (2016), selective coding functions like an umbrella that covers and accounts for all other codes and categories (open codes and axial codes) formulated thus far in grounded theory analysis. Integration begins with finding the primary theme of the research in order to create a central or core category by which a formal theory can be tied to. Selective coding within this study began by creating a “selective coding” tab in the data analysis spreadsheet. Copies of all 211 axial codes were moved into this tab for comparison. Each axial code was also labeled with which interview it originated in order to ease the tracking process.

Through rigorous and repeated review, the axial codes were grouped by similar theme in a column labeled “selective codes” (see Table 4).

Table 4

Sample of Selective Code Organization within the Coding Spreadsheet

Selective Code:	Enrollment in Family Therapy has Increased Hope (agency, pathways, or overall)	Family Therapy will be a Positive Experience	Family Therapy will Improve Skills in the Family
Axial Code:	Enrollment in Family Therapy has Increased Overall Levels of Hope (Interview 3)	Family Therapy Will Be Beneficial (Interview 3)	Family Therapy will Teach Skills and Provide Insight (Interview 2)
Axial Code:	Family Therapy Increased Parent's Motivation (Interview 3)	Parent has Hope that Family Therapy will Create Positive Change (Interview 4)	Family Therapy will Teach and Improve Skills to the Family (Interview 4)
Axial Code:	Enrollment in Family Therapy has Increased Hope (Interview 7)	Family Therapy will be a Positive Experience (Interview 5)	Family Therapy Teaches Families New Skills (Interview 5)
Axial Code:	Enrollment in Family Therapy has Increased Agency (Interview 7)	Family Therapy will Help Family Accomplish Their Goals (Interview 9)	Family Therapy will Teach Parent New Skills (Interview 7)

Table 4—continued

Axial Code:	Enrollment in Family Therapy has Increased Pathways (Interview 7)	Family Therapy will be Useful (Interview 10)	Family Therapy will Address General Skills Deficits in Family (Interview 9)
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Reflective journals continued to be kept throughout this process. When the axial codes could no longer be grouped, the remaining axial codes were left in a column labeled “ungrouped axial codes” and the grouped axial codes were reviewed once again, and provided appropriate selective code titles. At the conclusion of this stage of coding, 19 selective codes emerged.

Urquhart (2013) states that “at present, it remains an issue that many users of grounded theory do not leverage the method to its full extent to produce substantive theories, let alone formal theories (p. 129).” In order to avoid such shortcomings, Urquhart proposes that researchers engage in a process known as *scaling up the theory*. Scaling up a theory generally refers to connecting any generating theory to existing literature in order to bolster its integrity. However, it appears that generating a formal theory has ties to completing the coding process to the highest degree as well.

Aiming to complete the coding process to the highest degree in order to scale up any generated theories, and due to a higher number of selective codes than anticipated, the constant comparison process continued after the selective coding phase. Within a separate tab in the coding spreadsheet labeled “core concepts,” selective codes were reviewed and compared in hopes of synthesizing them to create fewer, more concrete concepts. After the comparison, six core concepts remained (see Table 5).

Table 5

Sample of Core Concept Organization Within the Coding Spreadsheet

Core Concept:	Extratherapeutic Factors Influence Hope	Enrollment in Family Therapy has Increased Hope	New and Improved Skills Provide Pathways to Accomplish Goals
Selective Code:	Extratherapeutic Factors can Raise or Lower Hope	Enrollment in Family Therapy has Increased Hope (agency, pathways, or overall)	Family Therapy will Improve Skills in the Family
Selective Code:	Family is Enrolled in Multiple Services	Family Therapy will be a Positive Experience	Family Therapy will Improve Family Communication Skills
Selective Code:	Family has Poor Experiences with Past Services		
Selective Code:	Being Actively Religious Increases Hope (agency, pathways, or overall)		

Grounded Theory

In the final stages of grounded theory, Urquhart (2013) outlines four components necessary to build a competent formal theory: means of representation, constructs, statements of

relationship and scope. A theory that has a proper means of representation often contains a narrative framework. However, it can also be in the form of propositions and/or an initial model. Additionally, the constructs of a quality theory must involve building the theory around one or two core constructs or categories (Urquhart). Integrating more than two core constructs is possible, but must be done with discretion.

Quality theories must include statements of relationship, which refers to relationships among constructs, as well as with existing literature (Urquhart,2013). Finally, formal theories must contain a degree of generalizability, also known as scope. With these concepts in mind, the following formal theory emerged from the data in this study: Enrollment in family therapy activates an interaction between hope and expectancy and extratherapeutic factors, which likely increases levels of hope and expectancy in parents and guardians participating in family therapy with their child. Some extratherapeutic factors involved in these interactions are unique to family therapy, while others potentially exist within all forms of therapy.

Core Concepts

At the conclusion of the coding process, six core concepts emerged relating to the perceptions of hope in parent and guardians participating in family therapy with their child (see Table 6). In order to gain a full understanding of the results, especially in regard to the formal theory proposed by the researcher, each core concept and their accompanying selective codes will now be explored.

Table 6

Core Concepts that Emerged in Data Analysis

Extratherapeutic Factors Influence Hope
Family Support Increased Pathways
Enrollment in Family Therapy Increased Hope
New and Improved Skills Provide Pathways to Accomplish Goals
Improved Family Relationships Increase Pathways to Accomplish Goals
Therapist Presentation Influences Hope

Extratherapeutic Factors Influence Hope. Of the six core concepts that emerged at the conclusion of the coding process, “Extratherapeutic Factors Influence Hope” was the most prevalent, with four selective codes comprising the concept (see Figure 1). In total, each of the 10 interviews contributed axial codes to this core concept. Each selective code making up this core concept will now be discussed in detail.

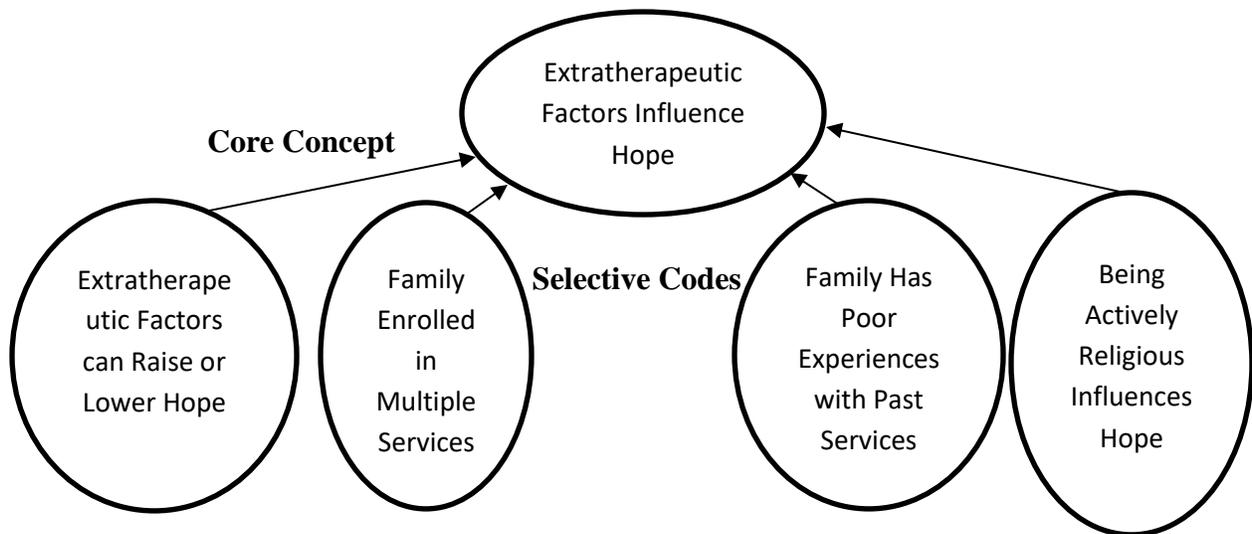


Figure 1. Selective code make-up of “Extratherapeutic Factors Influence Hope.”

Being actively religious increases hope. Of the 10 interviews conducted, only two included information regarding religion in relation to hope. However, the references to religion in those interviews were frequent, and included great conviction. Eight axial codes specific to religion and hope emerged from the two interviews to eventually form this selective code. When asked to explain what hope meant to them, the Participant 8 spoke about it in terms of their faith providing motivation: “Again, it's more spiritual with being a Christian and knowing that if I'm doing everything right, then I'm gonna get good stuff in return, in going forward, and even though what seems to be horrible, God can change everything.” For Participant 8, knowing that God rewards hard work provides extra motivation to achieve her goals. In this context, it refers to helping her child achieve her goals for him in family therapy. In addition, Participant 8 made it apparent that God themselves can change any situation for the positive, as long as a person is working hard and being moral. This belief system powers Participant 8 to continually have hope for her son and her goals for him.

Participant 8 also views religion as potentially providing solutions or pathways to problems that exist in her family's life. The researcher paraphrased the following answer Participant 8 gave back to her for reflection, “it's almost the belief that a higher power is going to be there for you when you need them the most?” Participant 8 responded by stating: “Yeah, definitely. And then, it's not your time, it's His time, so very religious.” No matter what situation that Participant 8 and her family face, the potential for God to intervene and help always exists. To a degree, some success that they cannot achieve on their own, God can provide. However, it is largely out of their control. This potentially provides unlimited pathways for success for Participant 8 and her son to achieve their goals. The researcher prompted Participant 10A and Participant 10B to answer a similar statement provided to Participant 8, “describe what they

knew about hope.” In a similar manner as Participant 8, Participant 10B framed their answer in terms of the unseen potential for success and positivity by the hand of God:

I see hope, I guess my definition of hope is about the same definition as faith. It's an expectation out of something unseen, but tangible. So there's that positiveness out there. We may not see it, but it's always that entity, almost, that there is expectation of something good.

The relationship between hope and faith for Participant 10B is very strong. For them, the term is almost synonymous. The interviewee uses the word “tangible” to describe the potential attainment of all goals, especially those they seek to accomplish in family therapy with their child. The entanglement of hope and faith provides this interviewee with a constant source of belief that they can work hard and find pathways for success for themselves and their family. Participant 10A built off of their partner’s statement to say: “Hope. Basically, hope is just no matter what, things will get better eventually. I mean, no matter what you're going through or whatnot, there's always hope for things to turn around, to look forward to ...”

A common theme has emerged among partners describing hope in terms of God’s ability to make things better. The use of the phrases “things will get better” and “no matter what” infers that eventually a solution to a problem or goal will emerge. However, the basic tone comes across as motivational with the use of “there’s always hope for things to turn around, to look forward to.” Participant 10B followed-up his partner’s talk about hope and faith by discussing it in terms of motivation:

A lot of hope because we have Christ, we know that ultimately regardless of what all happens here, we're going to a better place, we're doing a better thing. So all we can do is

what we can do here. Do the best we can, I mean, trying to better it for the next generation.

The existence in an afterlife and a God that will take them there provides hope for Participant 10A and Participant 10B. The hope discussed here is closely tied to the idea that they should “do the best that they can,” which again references working hard and motivation to make their mortal life as positive as possible, through working hard and accomplishing their goals for their family. At the other end of the spectrum, Participant 10B concludes by stating that there is no hope without faith:

If you don't have that hope of a savior, what is there? I mean, you have no hope of a better life after death, you don't have hope of he's working for you, not against you. You don't have the hope of Jeremiah 29:11 I have plans for you, I have goals for you, I have things better for you. Abundant life, abundant everything. You don't have those things. What do you have? Basically, you know, emptiness. Well, a lot of them look at, "Well, what can I do now? What all can I jam in now, because after death there's nothing?" Well, I'm looking at, if I'm helping and serving and doing for people, I'm gonna have better rewards in heaven. So I have that hope and that desire that if I keep uplifting and encouraging and doing, it's going to get me, you know.”

Simply put, Participant 10A and Participant 10B view a large portion of all hope in their life in terms of faith. The absence of faith takes away from motivation to work hard and discover solutions to problems. The existence of faith will provide a certain level of hope for them to always fall back on and build from. It is the foundation for their lives and fuels their values and desires.

Axial codes generated from interviews eight and 10 have revealed profound connections between faith and hope. As the quotes from these participants have highlighted, the presence of faith naturally increases the motivation to achieve goals, as well as the belief that pathways and solutions to those goals will emerge. Within Hope Theory, motivation to pursue goals and having the pathways to achieve them is the essence of hope. As such, being actively religious has been deemed a way to naturally increase hope. This not only exists within the individual who has faith, but in regard to those around the individual as well, including their family. These ideas have been condensed and summarized to create the selective code: “Being actively Religious Increases Hope.” Due to the inability of religion to be presented within traditional family therapy, it is being viewed as an extratherapeutic factor within Lambert’s Common Factors Model (Lambert, 1992). An exception to this idea would be the introduction of faith in religious-based family therapy, but that is beyond the scope of this study. All ideas relating to extratherapeutic factors will be expanded on in the discussion.

Family is enrolled in multiple services. References to the utilization of services in addition to family therapy represents the most widely cited topic in this core concept, with axial codes coming from seven of the 10 interviews. Unique to other axial codes in this core concept, participant answers all stemmed from a single interview question: Describe other efforts or services that you have made to accomplish the goals you have for your child. Data gathered from this question was synthesized to form the selective code “Family is Enrolled in Multiple Services.

Although Participant 1 does not currently have custody of their child, she provided numerous examples of services her daughter is currently enrolled in, or was recently enrolled in. “She’s in Integrated Health Homes, we did Behavioral Health Intervention Services, we did

regular therapy, we did, quote-unquote, family therapy.” These are a wide range of services that take place in a variety of settings. In addition, Participant 1 shared plans for enrolling her child in even more services when she regains custody.

When she returns home, she can go to that *inpatient* thing where it's a after school program and talk about making yourself feel better. Just give her something to do that's not games, I guess. So, if she could do that *locally*, great. We've tried to put her in different programs to keep herself busy, before and after school programs, she goes to daycare now to be more social. Tried a whole bunch of different things.

Participant 5 was also able to cite other services that her family was enrolled in additional to the impending family therapy. This participant had enough familiarity with the services to provide their specific names.

I do have a Pediatric Integrated Health worker. We've kind of ... that's where we're at now. He does go to the special behavior school, Connections. It's a branch off of Harrison, but it's meant for kids like Billy. So there's only like four or five kids in his class, and they're separated from the normal school. They have like, their own wing. And there's nurses on staff. So if Billy acts out, they know how to restrain him, they're trained in that. They have a safe room so that if he's gonna harm himself or others, they can put him in the safe room, which helps a lot too, just for him to calm down.”

Inclusion of the phrase “which helps a lot” gives the quote a positive connotation, which is very different than Participant 1. After as simple follow up question by the researcher,

Participant 5 was quick to provide even more details about other services her family is involved in and how they interact with one another.

His Behavioral Health Intervention Services worker goes to school once a week and meets with him at the school setting and kind of talks to the teachers and kinda gets their opinion things and how they feel Billy is improving or things he needs to work on. Then he also comes into the home once a week, too. I do have a form, like a signed form, so if they need to contact his therapist, they can do that too. So, they're allowed to do that. They did work with Psychiatric Medical Institutions for Children when he was in the Psychiatric Medical Institutions for Children program for a while because they would transport them to and from school. So they did work with that program, too.

With the exception of a previous experience with family therapy referenced by Participant 1, all additional services reported by Participant 1 and Participant 5 had an individual focus, specifically with the child. This theme continued with the services shared by Participant 7.

When his father and I started the divorce process, I did enroll him in individual therapy, which his dad and I have both played a pretty big role in, but we haven't done, you know, full out family therapy with him as this--up until this point. Aside from that, I'd say, trying to access some community resources like boy scouts and activities; some mental health assistance, he has an anxiety disorder and issues with literacy at school. So, just kind of trying to make that full approach for him.

Emphasizing a “full approach” for her son when it comes to services demonstrates the importance to address all the domains in the child’s life. This idea was not specifically addressed

in any other interviews. Not all parents and guardians interviewed had their family enrolled in as many additional services. Participant 3 only contributed that “we are part of Pediatric Integrated Health here too,” indicating that they only have one additional service other than the family therapy that they are going to start. In a similar manner, Participant 8 briefly discussed the other service their family was involved in:

We do the other Families and Schools Together where it's like once a month, and then you do fun stuff. I did all that, and we go to Longfellow with the other ones, and Cody comes along with us. We're supposed to do it at his school.

Participant 8 was the second participant to reference a family-focused additional service, while also providing the most depth for that service by including both its frequency and location. Other family oriented services came forth in statements made by Participant 9, who contributed information on a wide variety of services their family currently utilizes in addition to family therapy.

With counseling and my five year old he does counseling, too. He does play therapy at school and also has speech problems so he also does speech therapy. We've got Horizons, their family support and then there's credit counseling, we do that. Horizons. Yeah we're with Behavioral Health Intervention Services. But we just haven't been able to make kinda much with our Behavioral Health Intervention Services worker in the last couple of weeks, over the holidays and everything.

It is apparent that services are very important to this family, as the parent was able to cite the utilization of counseling for their youngest child, despite them not being the focus of the interview. A unique contribution came from Participant 10A when she introduces that her and

her partner “have couples therapy.” This is the only existence in the interviews where the parental dyad has services for the purpose of helping the whole family. They presented the need for services themselves in order to obtain “all the skills we can to help with kids.” Participant 10A was also able to cite a number of other services the family is involved in:

Well, everybody's in individual therapy. Looking at having some of the children tested to see levels and things, because there's been some concern about understanding issues. We do books and things at home during dinner time. We have been working on five love languages so that the children learn and know appropriate, healthy ways of things.

Participants who acknowledged the use of services in addition to their impending family therapy were able to provide a wide variety of modalities through which their families received help. Due to the nature of the services and their existence during the enrollment of family therapy, this selective code was given the label “Family is Enrolled in Multiple Services.” Each individual service possesses a different process and potential effects on the interviewee and their family. However, these specifics are beyond the scope of this study. Instead, the major takeaway should be that families that participate in family therapy have the potential to be enrolled other services, which could alter the effectiveness of therapy, either positively or negatively. As such, in this study, the utilization of services in addition to family therapy will be viewed as an extratherapeutic factor from the lens of Lambert’s Common Factors Model (Lambert, 1992). Ideas relating to extratherapeutic factors, including receiving multiple services, as well as how they interact with hope will be expanded on in the discussion.

Family has poor experiences with past services. One of the earliest emerging themes within the data was negative experiences with past services. Axial codes contributing to this selective code

were found within six of the 10 interviews. Numerous references to unsatisfactory experiences with previous services received were provided by Participant 1. When asked to “describe what you know about family therapy” at the onset of the interview, Participant 1 promptly stated:

My ideas are more or less it should be focusing on what's going on, what's wrong, what needs to be fixed as opposed to, before she was in Four Oaks and I was like, "This isn't okay. You're just sitting there playing games with my daughter. You're not doing anything." I understand that sometimes there's play therapy, but no. She's almost nine. She's not a kid-kid anymore. She's understanding. You need to talk to her, tell her what she's doing isn't okay, yelling at people, not listening to your mom and throwing her stuff and stuff like that. It's not okay. Then making up stories about your dad, but then when you want your dad in the conversation, it's, "But I want daddy to" ... I don't like those games.

An immediate reference to a family therapy experience that was underwhelming articulates the displeasure that Participant 1 had with the mental health field. Not only did she fail to see the past therapy experience as helpful for her child, she did not agree with approaches taken by the provider at all. She outlined another negative experience later in the interview.

Sarah wasn't going to be able to start overnights because they had just started visits with Dad and Sarah then all of a sudden more problems started. That's when she went to *inpatient* and they were like, "Maybe it's because she started at visits with Dad." I'm like, "No." We all talked about it. That's not why. She was having these issues before she started visits with Dad. I was like, "You're not going to put that on him. Then they went behind our backs and sent an email saying that it was because of visits with Dad. The

Department of Human Services worker heard it and didn't piggyback off of it like, "No, that's not why," and didn't fix it. So, then they asked for overnights with the babies, but not Sarah, and I'm like, "Why? You're going to cause more behaviors. You need to fix that." I had a long conversation with everybody only to find out that the Family Safety Risk and Permanency worker went behind our back and sent that email. Why would you say something to my face and then go behind my back and say something different to someone who made a big change in what was going on in my family? So, I don't like that at all.

Multiple services workers were involved in this situation where Participant 1 did not feel heard and appropriate services were not provided. The trust that Participant 1 had for her service providers was lowered when they "went behind" her back. A similar theme regarding trust with service workers emerged with Participant 2. When talking about past services that the family has received she provided the following about individual play therapy:

What I was uncomfortable then was the play therapy because I wasn't personally involved in that, and I understand that, but he was younger and I knew something was off, but he's younger and he can't talk to me and he can't communicate, and he can't tell me what's happening. If I ask questions and I say, "What did you guys talk about? What did you do? How do you feel about this person?" And I'm getting no response. It scared me to death, and so I stopped it.

Participant 5 had similar sentiments toward individually-focused services. The lack of family involvement in the therapy process was concerning for this parent, as she felt it inhibited the overall ability for the family to reach its goals.

Everything else we've kind of tried has just been other people dealing with Billy, but not me. So I'm not learning anything, I'm not understanding Billy at all. I don't understand his emotions. I don't understand anything about him because they're not including me in it, where the family therapy is including me.

Other significant data came forth when Participant 4 was asked to discuss past services her family has engaged. Specifically, she talked about how ineffective services have been so far. "It's been completely negative, so there's that ... it's like a, here we go again." One aspect that specifically stuck out for Participant 4 that contributed to her negative experiences was how similar each ineffective service was. When referencing the upcoming family therapy, she stated "but this time around, it seems like it's a completely different approach, so there is more of that hope there." She provided another example with other services where she felt it actually made her child's symptoms worse.

From that point on, for the next, probably, good six weeks it's, "You can't punish me, the voices in my head, da da da." We asked the guy, he said, "Yeah, I asked him if he heard voices and he told me no." So the next time I told him, I wanted to let him know, that if he does hear voices, it's okay. Then the next time I told him, "You know, if you hear voices telling you to do these bad things, you can't get in trouble for it, so you need to be honest with us." Here's Carl, a very impressionable child, "You want me to tell you ... okay, I have an excuse for my actions now."

In her eyes, the worker planted the idea that if the child claims that voices told him to harm others, that he could not be held responsible for his actions. This made the child's symptoms worse while the worker was involved with the family, and dissipated when they

stopped services with him. The characterization of services as damaging was seen with Participant 10A as well. When talking about past therapy services, she described them as “damaging me more than it helped.” The lack of noticeable change was another point of focus when discussing previous experiences with services. This was most prominently heard with Participant 9.

We just didn't see anything changing and he was kind of getting upset towards the end.

So I guess the beginning part, the first few years he was involved with it but then they all say, "Why do we keep doing it when we don't see anything?"

Family engagement in services became harder and harder for Participant 9 and her children when no changes could be seen. She was sure to highlight that it was even the source of conflict with her children, as they became frustrated with having to attend services that they deemed worthless. They eventually came to the conclusion that it was no longer worth attending and discontinued their therapy.

Although no questioning about the specific experiences with past services was provided in the qualitative interview, the majority of interviewees shared their previous attempts to help their families. The examples shared were largely different and included various members of each interviewee's families. Despite the differences in answers that given they did have one commonality, they were not satisfactory. Due to the large number of axial codes involving negative experiences seeking help, the selective code grouping those axial codes was given the title “family has poor experiences with past services.” Since therapists cannot control the past experiences of their clients, this selective code will henceforth be characterized as an extratherapeutic factor within Lambert's Common Factors Model (Lambert, 1992). Specifics on

how extratherapeutic factors and negative experiences with past services are significant, especially in regard to hope, will be covered later in this study.

Extratherapeutic factors can raise or lower hope. One of the most closely related selective codes to the research questions highlighting this study, two of the 10 interviews reference extratherapeutic factors in directly influencing hope. Despite the fact that a low number of interviews actually contributed to this selective code, the ties to changes in levels of hope could not be ignored. Participant 5 was the first to discuss how an extratherapeutic factor changed her views for success when she brought up her continuing education in human services and criminal justice.

I'm also doing human services and criminal justice. So I think that will also, by going to school too, I think that's gonna help me and Billy. And me being able to learn different skills and stuff with Billy too. So I think that's gonna be a big thing, too. So I think once I get to graduate and I learned more, then I think that'll be better for me and Billy' relationship.

Early the interview, Participant 5 mentioned that one of her primary goals for family therapy is to improve her relationship with her son. Due to the presence of mental health problems over the course of his life, mom has struggled to bond with her son. In her eyes, gaining information and skills on how to work with people with mental health and criminal histories will help her to build a better relationship with her son. In other words, it increases her hope that she can have a better life with him. Unfortunately, hope appears to have lowered for Participant 6 due to extratherapeutic factors.

You know, 'cause after I'm gone, there's no one. His mom said he would never be welcome back in her home again, so where's he gonna go, what's he gonna do if he can't ... Is he gonna be on a bridge, underneath ... He doesn't have the street smarts. He wouldn't survive out there.

Hope in this case refers to long-term success for Participant 6 and her grandson. Although Participant 6 is currently helping her grandson to become the best person that he can be, she fears his ability to be successful long-term due to her age and eventual mortality. Participant 6 is the only family and social support that her grandson has and with his current life skills his likelihood for success without her is minimal. Levels of hope in Participant 6 are lowered due to the minimal support this family receives from those around them.

Despite the few references to outside factors influencing hope, examples have been provided highlighting the ability of extratherapeutic factors to both increase and decrease overall levels of hope. These ideas should be considered significant due to the fact that research questions presented in this study inquire about the levels of hope in participants, as well as the relationship hope has with family therapy. Although this selective code does not directly answer either of these areas, it can add to the context around them. The manner in which this selective code provides this context to the research questions will be addressed in later sections. In order to continue gaining an understanding of the results, other core concepts and their selective codes will now be explored.

Family Support Increased Pathways. At first glance, the core concept “Family Support Increased Pathways” relates to the core concept just reviewed, “Extratherapeutic Factors Influence Hope.” While the two core concepts are quite comparable, “Family Support Increased

Pathways” received its own core concept due to its specificity and relatability to the research questions. These ideas will be expanded on in the discussion. Before that can occur, the two selective codes that comprise this core concept will first be discussed (see Figure 2.)

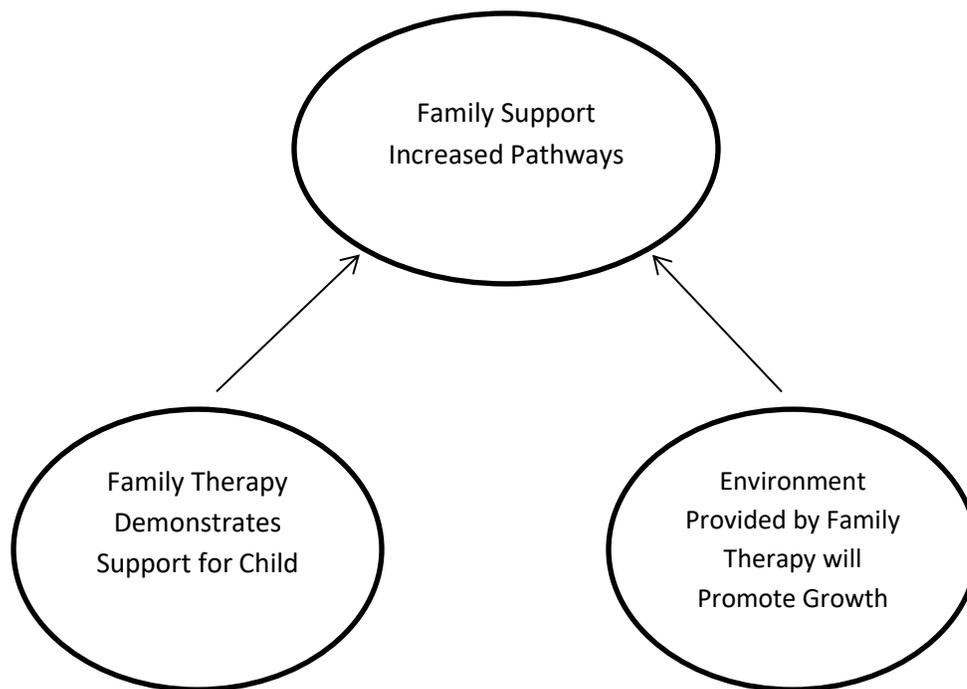


Figure 2. Selective codes that make up the core concept “Family Support Increased Pathways.”

Family therapy demonstrates support for child. Out of the 10 qualitative interviews conducted in this study, three contributed to this selective code. The emphasis of this code is that family therapy is naturally supportive of the identified patient, in this case the child. The manner in which this support is demonstrated is through the presence of the whole family in the therapeutic process. When describing the benefits of family therapy over other services offered, Participant 4 stated “it’s not isolating Carl away from the family. It’s involving the family, and showing Carl that it is a family effort, versus just, Carl.” Past individual services have “isolated” the child, potentially creating self-pathologizing tendencies within him. Family therapy will go against the

tendencies of individually-focused services to frame it as a “family effort” for the child. This has the potential to provide a new pathway to accomplish the goals laid out for him. When asked to describe her role in family therapy, Participant 7 framed that in terms of support and assistance.

I guess I don't know really how to describe my role in therapy with Josh. Obviously, as the parent, I'm there to assist Josh through the process, but also to take the feedback, I suppose, that the therapist is providing me with as a mother. Being able to take the suggestions from an outside perspective and apply them to the relationship that Josh and I have.

The guidance, support and assistance that the parent will provide their child in these family sessions will be imperative to improving their relationship. Another way to state this is that family therapy provides a unique pathway to accomplish the goal of improving parent-child relationships. A slightly different perspective was given by Participant 8 when asked how her presence in family therapy would influence outcomes.

I think in the long, he's gonna really understand that I care and I love him, and that seems to be a challenge for him to see that. So, he's gonna see, okay, Mom's doing this every week, everything's getting better, and he's gonna be more positive.

This parent views her presence in family therapy as an opportunity for her to show her child that she loves him. Being able to demonstrate her love for her son is one way she hopes to improve her overall relationship with him. This is something she has not been able to accomplish with past individual services. The same idea was reiterated at the end of the interview when was asked if she could think of any other benefits to the upcoming family therapy: “Him knowing that the reason why we're here is because I love him, that I care about him.”

Ideas connecting family therapy with the ability to provide family support for the identified patient has been shown to exist in multiple interviews conducted in this study. In particular, being able to provide family support is being viewed as a pathway to potentially help families accomplish their goals. Social support in general has been studied by other researchers in the past and has been deemed an extratherapeutic factor within Lambert's Common Factors Model (Lambert, 1992). The same categorization will occur in this study as well. The manner in which this extratherapeutic factor relates to family therapy and hope will occur in later sections.

Environment provided by family therapy will promote growth. During the qualitative interviews, three participants offered information about the perceived benefits of the environment in family therapy. For some, the unique environmental elements that family therapy provides will be a major contributor to the growth of the child, as well as the family. The presence of other family members to keep therapy on track was one area that stuck out for Participant 4.

I think because it gives Carl less of an opportunity to isolate from the family even more. It doesn't allow Carl to make stories. We've never had any instances of Carl making stories up about family, but we've had Carl make up these wild, elaborate, crazy stories about other people. After Behavioral Health Intervention Services came in, the imaginary man is out of his head. Whereas now, even when they're in there, I just kind of sit back until something comes up. It's like, 'Wait, no, let me just bring this to your attention.' That way, Carl 's held more accountable, versus just a free for all."

For a child with a history of lying and making up stories while participating in services, the ability for the guardian to be present and hold him accountable will be instrumental in the success of the family. In addition, having multiple voices in the same room conveying the same message to the child has the potential to increase his motivation to work toward those goals.

So I'm hoping that by him being actively involved in what the therapist is telling the family, 'Okay, we need to try this and work on these behaviors,' it won't just be us as the parents saying, 'We need to work on this.' It'll be an outsider saying it, as well.

The support offered by the "outsider," family therapist, has the potential to be more influential than anything Participant 4 could say to the child. She viewed this as a major strength of being in family therapy. Participant 7 added a different perspective that articulated her goals for family. Being able to spend quality time together in a healthy environment specifically working to improve their relationship will be invaluable. She described one thing that she feels will be most helpful about family therapy as "having that very specific, consistent, just 'him and I' time set aside each week." Participant 7 not only found the time together in session to be a valuable asset, but "having that, more structured manner that helps us to get through some of the issues, I think will be very helpful." The structure of the family therapy environment allows for relational problem solving to occur in the moment. This cannot be found in any individually-focused services. Similar sentiments were brought forth by Participant 10A:

The way I look at it is a lot of times in a home, there's too much emotion. And so you can't always process through the issues, the problems, the whatever, because it's all about the emotions. Whereas, when you're in family therapy, it's about the problem. It's about

how to solve the problem, resolve the problem, go forward. And so it gives you a different arena, almost, to go through the things so that the emotion isn't the main focus.

Having a therapist present during emotional family conflict allows for the emotions to be set aside when interacting with one another, or articulated in a more health manner. This leads to effective problem solving. Participant 10B added that having a therapist act as a nonbiased mediator during sessions will promote success as well.

And it would be good to have a third party point of view coming in and discussing it with them than just us, because they feel like, probably one parent takes one side and the other parent's taking the other side. And they just need their own little, somebody to talk to.

The environment of family therapy appears conducive to help this family be successful because it allows for someone to maintain neutrality in situations where it's difficult for the parents to do so.

Each participant introduced slightly different views on how family therapy may help them accomplish the goals they have for their child. Despite the differences that exist between each answer, the common theme that the "Environment Provided by Family Therapy will Promote Growth" has emerged. Sticking with the structure of many of the other selective codes covered thus far, environmental factors associated with family therapy will be deemed specific factors within Lambert's Common Factors Model. The manner in which this selective code contributes to the theory generated will be discussed in later sections. Exploration of other core concepts and their selective codes will now occur in order to continue gaining a clearer view of the results.

Enrollment in Family Therapy has Increased Hope. The focus of this study was to explore any relationship that exists between family therapy and hope. To complete this task, the qualitative interviews consisted of numerous questions designed to elicit participant’s thoughts surrounding their upcoming participation in family therapy with their child, as well as the overall concept of hope. With this in mind, it came as no surprise that a core concept emerged indicating a relationship between the enrollment in family therapy and participant’s levels of hope. Even more significant, this core concept directly addresses the research question: What are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child? This core concept consists of two selective codes and contribution from nine of the 10 interviews (see Figure 3).

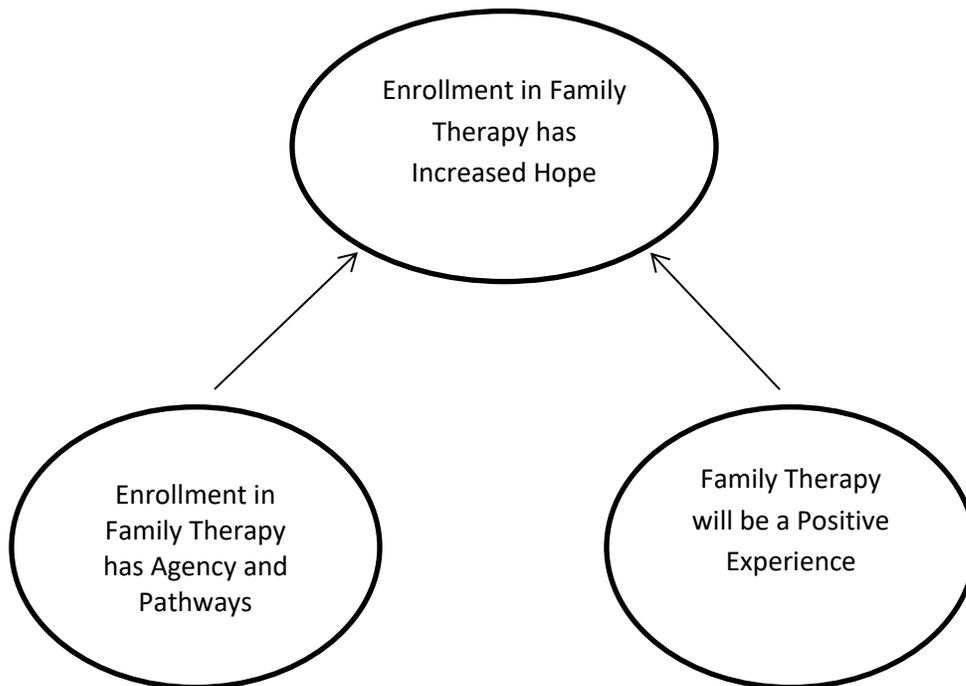


Figure 3. Selective code make-up of “Enrollment in Family Therapy has Increased Hope.”

Enrollment in family therapy has increased agency and pathways. Due to its high level of relatability to the research questions of this study, “Enrollment in Family Therapy has Increased Agency and Pathways” is one of the most significant selective codes that was found. Four interviews contributed to the composition of this code, with some making multiple significant references to the enrollment of family therapy increasing either agency thinking, pathways thinking, or both.

When asked whether enrollment in family therapy has changed their belief that the goals for their child will be accomplished, Participant 4 contributed answers inferring an increase in pathways thinking, as well as overall levels of hope. “I was feeling pretty hopeless before,” implying that she had higher levels of overall hopeful at the time of the interview than she did before her family was enrolled in family therapy. She also revealed higher levels of pathway thinking with, “it definitely gives me hope that there's always a way out, and in my head, I don't feel like that. It always feels like a dead end.” In this case, the “way out” refers to the skills and pathways to accomplish the goals for her child, which will be provided in family therapy.

Knowledge of what will occur in family therapy increased overall levels of hope for Participant 7. She reported that, “the type of therapy that was indicated and the explanation of it has increased my hope for like, positive outcomes.” When asked about how enrollment in family therapy has influenced her motivation to accomplish the goals she has for her child, she stated:

I think it'll increase it, or it has increased it; just kind of the positive thinking that's been happening as far as the process has been so far. It's increased positive thinking, and potential for good outcomes, I think, and deciding to go ahead and give that a try.

Participant 7 noticed positive changes in motivation in multiple parts of her life since enrolling her child in family therapy. Most notably, she cited increases in positive thinking, especially in regard to potential therapy outcomes. In other words, her agency thinking had increased since enrolling in family therapy. When discussing hope scores since her family was informed they were placed on the waitlist for family therapy, Participant 8 described them as having “probably gone up a lot.” In addition, she stated she felt “more confident” that her goals for her child would be accomplished in family therapy than before they were enrolled.

Increased levels of hope in parents and guardians enrolled to participate in family therapy with their child were found across the majority of the qualitative interviews conducted in this study. Participant statements were found supporting increases in agency thinking, pathways thinking and overall levels of hope. This indicates that based on their understanding of family therapy, parents and guardians believe that participating in that service increases their chances of achieving the goals they have for their child. Elaboration of that very idea, as well as what it means for the field of family therapy will take place later in this chapter.

Family therapy will be a positive experience. Many of the questions asked in the qualitative interview required participants to look ahead at their future participation in family therapy, and based on what they know about the service and their family to predict how the process will go. For example, the researcher asked each participant, “what are your expectations for treatment outcome?” Many participants took these opportunities to include statements about how positive of an experience they expected family therapy will be. In total, nine of the 10 interviews included one or more references to how successful they believed family therapy was going to be for their family. Participant 2 viewed family therapy through the lens that anything the family can take away from the experience should be seen as a success.

I definitely think it's gonna be useful. I don't see anything about it being un-useful. Even if we took away one thing and he took away two things, that's useful. Just to take anything ... I think without treatment, he's gonna feel like something's wrong with him and he's not like all the other kids and he doesn't have friends like them. He's always gonna feel like something's wrong with him but he doesn't know what it is, and he's all alone, you know? So without treatment, I just feel like ... There is no hope without treatment for him.

This statement concludes on a very serious note, “there is no hope without treatment for him.” Without family therapy, the future success of this child would greatly decrease. The parent later builds on these ideas by talking about how the family’s agency thinking will be affected in therapy.

I think it's gonna help a lot. I do. I think it's gonna ... I think just seeing some things change is gonna motivate all of us and it's just gonna help to, I think, inspire us to be better and to ... For him, too. If our confidence in him goes up, his confidence in himself is gonna go up. So I just think it's really gonna help us.

The ability to motivate individuals in this family is based on seeing improvement in others. When one member sees another member working hard to achieve a goal, it “inspires” them to do the same. The parent appears to have hope that the child who is the identified patient will begin to show improvement in family therapy, which will lead to higher motivation to aid in this process by the other family members participating in the service. Other interviewees had positive things to say about their upcoming family therapy as well. When asked to describe how she felt about the potential for achieving the goals she had for her child, Participant 3 responded,

“pretty optimistic, I guess.” When the researcher inquired whether this level of optimism was higher or lower than before they enrolled in family therapy, she replied with an emphatic “more!”

While discussing the participant’s scores on the Hope Scale, Participant 4 was able to quantify her current levels of hope for her child from her perspective. “I have 90% hope, and 10% is just setting my mind to what he could become, and it's just, you've got that nagging doubt.” It is very difficult for this guardian to let go of her fear that her child will fail in life, but since enrolling in family therapy her levels of hope enough to greatly outweigh those fears. Later, she elaborated on whether family therapy would be more or less beneficial than other services the family has tried.

I don't know. I honestly don't see where it could be any less beneficial than every other bullshit type thing we've tried with him, I'm not even gonna lie. I don't see where there could be any backlash from it at all.

The frustration from years of failed services is apparent with Participant 4, but she remains optimistic that family therapy will be a positive experience. The comments added by Participant 6 are very similar to Participant 4: “I don't see any downside to it. I really don't, 'cause anything, any kind of help that we can get, I think is gonna be beneficial. I don't see it going downward.” Repeatedly engaging in services that were not helpful for her child has made this guardian skeptical of all attempts to help. However, despite this apparent skepticism, she was able to view upcoming family therapy as having no “downside.”

Although Participant 5 and her family have never utilized family services, she anticipated the upcoming family therapy being extremely useful: “Yeah, I feel like it'll be really good for us. Because we've never done this, this is like ... we've kind of exhausted everything else, but we've never tried this.” She continued her emphasis on never utilizing family therapy later in the interview. All services to date have been individually-focused, which clearly were not helping the family accomplish their goals.

I don't think it really will. I think this will help out more than anything. I think Billy has been, he's been doing individual since he was like 5. It's when we noticed behavior issues and I called right away and had him evaluated. He's now almost 10, he's nine and a half. And I feel like it's ... that's part of the problem, that it's not ... we weren't doing family therapy, we weren't doing anything with the family, it was just all Billy. And I feel like we should've been doing family therapy so that we all had an understanding and we can all communicate and like, understand.

The excitement surrounding the first-time use of a family-oriented service resulted in the belief that family therapy will be a positive experience. More quality information came during the interview with Participant 7. For her, the structure and focus of family therapy is why it will be a positive experience.

I think it'll be extremely useful. I feel like a lot of Josh's behaviors do stem from some issues--unresolved issues that he has that he definitely attributes to myself. I think that he's definitely extremely willing to work on it and more positive interactions he and I have, the better he does.

Having a treatment modality that aligns with your evaluation of the source of the problem naturally allows you to view that service in a positive light. This appears the case with enrolling in family therapy to treat relationally-based problems. Participant 8 was very decisive with her thoughts about the impending family therapy. When asked what her expectations for treatment were, she provided, “positive. I think that it's gonna be positive.” Participant 10A concluded the information gathered for the selective code “Family Therapy will be a Positive Experience” with a single statement of her own. When asked to describe what she believed would not be useful about family therapy, she replied with, “I don't think it's not going to be useful, I think it'll be useful. “ This use of a double negative articulates the thought that family therapy will help this family achieve their goals.

The contributions to this selective code by the nine interviews generally consists of statements about expectations for positive outcomes in family therapy, as well as positive experiences in general. Having positive expectations for an experience is virtually synonymous with being hopeful that an experience will be positive, which is why this selective code feeds into the core concept “Enrollment in Family Therapy has Increased Hope.” The implications for this selective code, as well as the core concept it feeds into are significant within this study. These ideas will be expanded on and connected with other revelations in a subsequent section of this chapter. For the purpose of continuing to gain a clear understanding of the results, the next core concept found will now be reviewed.

New and Improved Skills Provide Pathways to Accomplish Goals. Families that seek out services typically have various goals that they would like to accomplish while utilizing that service. Along with those goals, they typically have preconceived notions on how they can accomplish those goals. One solution to family problems that emerged in this study involves the

skills that members of that family possess. In particular, improving existing skills and adding new skills was frequently mentioned throughout the interview process. Out of the ten interviews conducted, seven of them contributed to this core concept. A total of two selective codes comprise this concept (see Figure 4). Each of these selective codes will now be covered in depth.

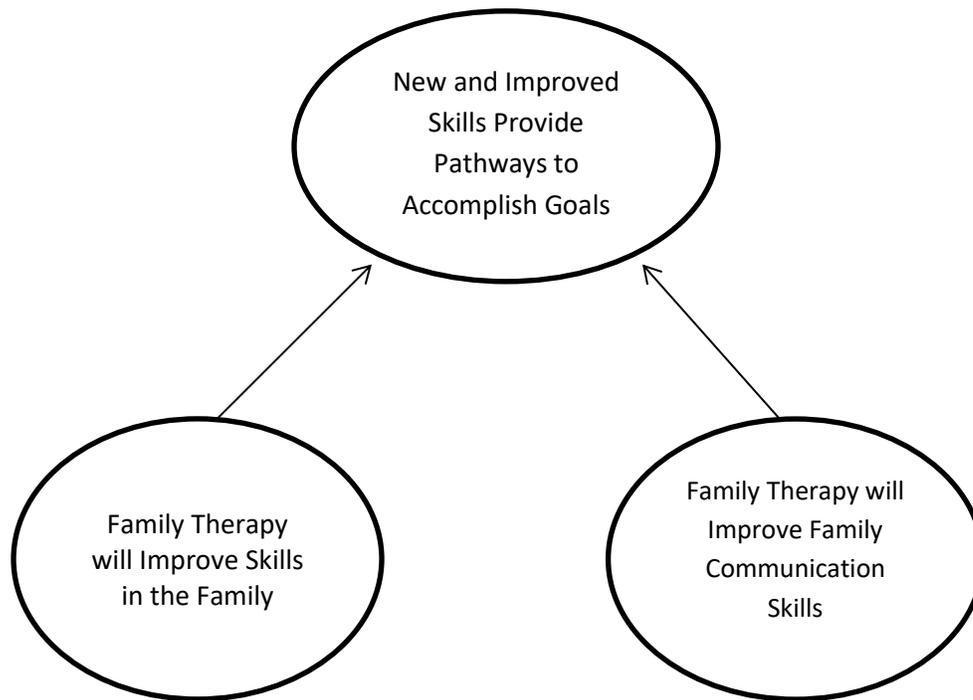


Figure 4. Selective codes that make up the core concept “New and Improved Skills Provide Pathways to Accomplish Goals.”

Family therapy will improve skills in the family. References to the therapeutic approach parents and guardians anticipated their future therapists taking with their family can be found across the majority of the interviews conducted in this study. More often than not, participants told the researcher about skill improvements that would help their family accomplish their goals. The language used to describe the improvements in family skills not only framed it as something that could happen, but as something that would happen. Of those who participated in the study, seven interviews contributed information on different skills that they believed would increase while

participating in family therapy. The first reference to improving skills came from Participant 2 when she was discussing things she would like to take away from family therapy herself.

Definitely open to any skills that I can learn to help to motivate him and keep him on a good, successful road for life. But I don't think I have anything to bring to it, I just think whatever I could take away would be good.

She was not able to identify specific skills that she could “take away,” but she was confident that skills would be taught during the family therapy process. Earlier in the interview she articulated a desire to learn skills that would aid in helping her child: “Well, I feel like it's gonna ... I'm hoping that it's gonna accomplish all of those fears that I have that we don't have the skills to help him.” Participant 5 expressed a similar desire to obtain skills to help her child.

I think it's teaching me ... it'll teach me to learn different techniques, different things, and to change things like even at home. Or to be able to help the school kind of learn different things with him in school too. Because, I mean, we're all just kind of quick to judge bad behavior, "Stop it."

In addition to learning skills to apply with her child at home, Participant 5 wanted to learn skills that she could pass along other domains in the child's life. Other than the struggles her child has at home, school appears to present the largest challenge in their lives.

And if we had ways or different techniques to apply to Billy and kind of work on his level, then I can bring that to the school too. And then the teachers and the staff there can try to use that instead of just automatically calling me and being like, "He's being bad you need to come pick him up."

The importance of gaining any sort of help to achieve the goals Participant 5 has for her child is evident in her interview. The improvement of her skills, especially those that she can pass along to others, is the vehicle she hopes to use to accomplish those goals. In her interview, Participant 3 was also able to provide multiple skill areas that she wanted addressed during family therapy.

Mostly for me probably, you know, 'cause I don't know what I'm doing as far as being a parent or discipline. I'm not very consistent. I feel like I don't know how to deal with my emotions. I don't know how to deal with situations either. I used alcohol and drugs for a really long time, and more recently, just got sober. I feel like I don't know how to deal, and I don't know how to handle things.

For her, the key to helping her child improve their life begins with increasing her parenting and emotional regulation skills. When asked to describe how family therapy will address her tools and skills, she replied with, “I think it would enhance anything that's already there.” In a subsequent interview with Participant 4, the researcher inquired about the interviewee’s thoughts on her results after taking the Hope Scale. In particular, the interviewee discussed why she thought her pathways scores were so high: “Because a lot of tools and skills are being given to us.” From her perspective, participating in future family therapy that would teach the family tools and skills resulted in higher pathways scores in the present. For Participant 7, obtaining skills for both herself and her child is what will lead to success. The ability to see each other’s point of view is one specific skill that sticks out for this participant.

I think that it will build upon the tools and some of the perspective issues for both Josh and I, and maybe some of the disconnects in where I don't see his perspective and he

doesn't see mine. I feel like, therapeutically we can kind of gain some tools and resources to help to see each others' perspectives.

One of the major goals that Participant 7 has for her family is to decrease the amount of conflict that occurs on a daily basis. For her, the source of this conflict originates in different perceptions that are held within the family. By improving perception-based skills within the family, it will help her accomplish that goal. On a slightly different note, Participant 9 anticipated a focus on general coping skills during their impending family therapy.

Well, just being able to like ... the skills that he also needs, like when he doesn't want to do something instead of smiling and being, I guess disrespectful, he can have another outlet or something. Other ways to handle things instead of us going into a big argument like I did with his older brother.

For this family, the ability to improve their skill base will not only allow them to function better as individuals, but within the context of their family and society as well. The data that came forth in this interview further articulates the idea that many parents associate achievement of goals with skills gained in family therapy. For example, Participant 9 identified one of the core problems as “going into a big argument” when the child becomes dysregulated. Gaining “the skills that he also needs” while in family therapy is how the parent plans to accomplish that goals.

The theme that necessary life skills will be enhanced during the course of family therapy is prevalent across the interviews conducted in this study. Most of the participants framed the improvement of skills while in family therapy as one of the primary modalities they see their goals for their child being achieved. This indicates that the participants hold very specific

perceptions about their impending family therapy. The significance of these perceptions as they contribute to the overall findings, including the grounded theory generated will be covered later in this chapter.

Family therapy will improve communication skills. At first glance, there are undeniable similarities between this code and the previous code reviewed, “Family Therapy will Improve Skills in the Family.” However, due to the presence of multiple specific references to communication-based goals and communication skill increases found in the interviews, the researcher felt that it deserved its own selective code. Overall, three of the 10 interviewees contributed data to this selective code.

During interview two, the parent described the need for family members to improve their communication with the identified patient. Past struggles to interact with the child have resulted in behavioral concerns that the family would like to eliminate. Participant 2 articulated the need for improved communication skills in the family by saying, “I think, maybe, teaching the whole family skills where we could interact better and we could just get along with him better and help him.” Despite only being able to pinpoint one specific area that better communication skills would help, it is still a desirable outcome for the parent. The parent elaborated on the need for skill improvement by highlighting its ability to change the whole environment the family lives in.

I definitely think just teaching us, too, how we can better respond with our emotions and communicating because, I mean, we're a family of four and we're all chaotic and loud, and I think if we could learn how to maybe talk the right way to him or speak in a

different way with him, it would make his home life more comfortable and better for him where he could feel like he can go out and accomplish goals.

Participant 2 would like home to be an environment where her child can be comfortable and thrive. At the moment there is lots of conflict, which appears to hold the child back from being able to accomplish the goals his parents have for him. The language used to describe what this parent would like to focus on in family therapy makes it apparent that she felt confident that necessary changes will occur. During the interview with Participant 8 it was very clear that improving the parent-child relationship was the main goal of family therapy. However, one idea that continually emerged was that improving communication skills was one way that they could improve their relationship. The parent made numerous vague references to time where miscommunication was the source of conflict, but was able to identify a specific time where clearing up miscommunication lead to harmony.

I had issues in the past, where it was just a miscommunication completely, and then he was able to see like, oh, it wasn't meant in a negative way ... and then I was able to see okay, well I should have worded that a little bit different so he didn't have the opportunity to take it in a negative way.

Being able to reference times where healthy communication led to healthy interactions makes focusing on this topic in therapy very appealing to Participant 8. When asked to describe why she believed family therapy would be useful in helping family communication, she stated, "because we're in a room and we have to communicate." In this case, the structured family therapy environment will naturally provide improvements in communication skills for Participant 8 and her son.

For Participant 9 and her family, better communication starts with the mother and father. Since Participant 9 and her ex-husband separated, they have struggled to communicate with one another about everything. This has trickled down to create communication problems with their children: “I don't really have the communication with their dad. Like we do communicate but it's not good. There's no real good communication. And then also, just being able to communicate with my boys.”

The ability to model appropriate communication skills among parents is how Participant 9 plans to begin improving her communication with her children. When asked to describe what she thinks will be useful about family therapy, Participant 9 reported, “just being able to talk with him because at home he doesn't ever want to talk with me.” This is another reference to how beneficial having a structured family therapy can be when trying to accomplish family-oriented goals.

One of the most cited goals for interviewees were improved communication within their family. With this in mind, it is no surprise how often increased communication skills were referenced in the interviews. The frequency and specificity of these references are what allowed it to emerge as its own selective code. The role that this selective code and its core concept play within the overall results is significant. Details outlining their significance will occur in later sections. The next core concept and its selective codes will now be explored in order to continue gaining an understanding of the results.

Improved Family Relationships Increase Pathways to Accomplish Goals. The primary function of family therapy for many of the participants in this study will be to improve relationships among family members. However, the majority of parents and guardians have

numerous other goals for their child as well. The data that has emerged suggests that through the accomplishment of healthier family relationships, the ability to achieve other goals becomes more likely. Specifically, improved family relationships increase pathways available to accomplish other family goals. In total, seven interviews contributed data to this core concept, which integrates two selective codes (see Figure 5). Each selective code will now be reviewed in order to gain a better understanding of them.

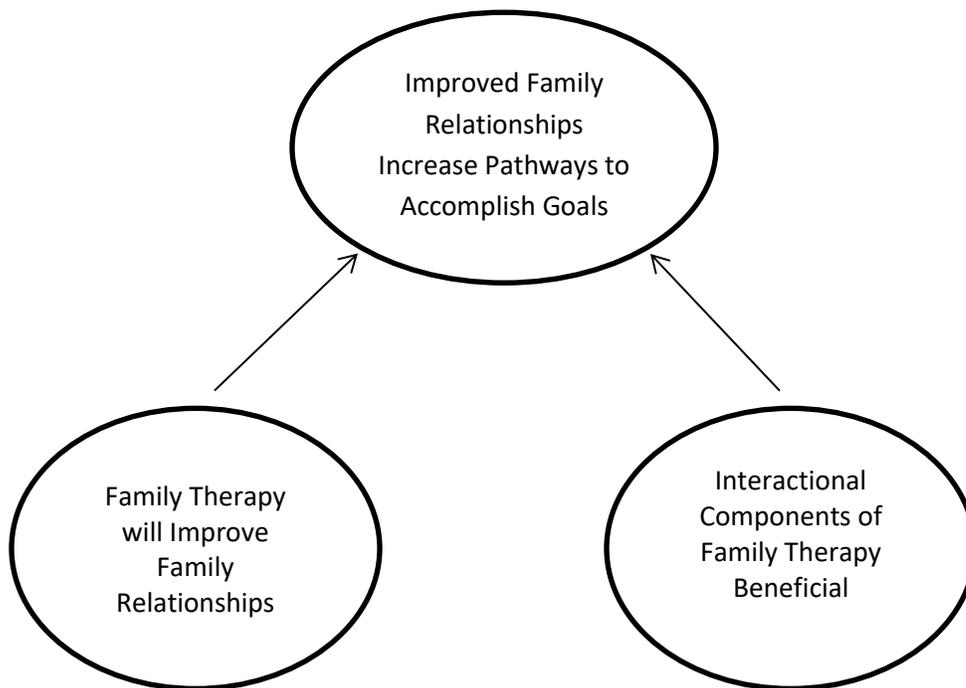


Figure 5. Selective code make-up of “Improved Family Relationships Increase Pathways to Accomplish Goals.”

Family therapy will improve family relationships. The assumption that family therapy would address and improve family relationships was present across the majority of interviews conducted. Although no specific questions about family relationships were asked, six interviews

contributed data to this selective code. The first reference to improvement in family relationships was with Participant 2.

Well, I think if we're all behind him and we all support him, then we're all gonna be more successful. And obviously, he's gonna be more successful because he's gonna feel like we're on his team and we're on his side. So, I think that family therapy is just gonna bring us together and it's gonna help him.

Demonstrating support for the child by participating in family therapy is how Participant 2 anticipates family relationships improving. The parent concludes that when therapy brings the family together that they will all “be more successful.” Another way of saying this is that improved family relationships provide increased pathways to achieve other goals. When discussing her anticipation for family therapy to start, Participant 5 talked about the bond that she has with her child.

But I'm excited, I've kinda been asking for family therapy, and kind of pushing it, because I just ... I really want that bond with Billy. I feel sometimes that he feels left out, or that I don't love him as much. And I, I mean, he has said that to me before. And I do tell him, "I do love you." It's just hard because we don't have that bond.

The biggest thing that she associates with family therapy is the ability to improve her “bond” with her son. She also went on to discuss the potential for both of her children to have a better relationship if they would have had family therapy earlier in life: “I think his brother and him would've had a lot closer bond because they don't, they kind of veer apart from each other and they don't have that brother relationship like most siblings do have.” The essence of family therapy for Participant 5 will be improving all relationship within her family.

When asked to describe what she thought would be useful about family therapy, Participant 7 responded with, “re-building the bond.” Having a structured time each week for her and her son to focus on their relationship was imperative for this parent. A similar desire to improve the bond between mother and son was stated in interview 8. When asked to elaborate on what she meant, Participant 8 provided:

To me, it's just our relationship, how he views me as his Mom. I see him, as far as like he's kind of seeked out other women, and kind of wanting that cuddled kind of thing, where I find it a little bit odd because I'm like, well, I'm here.

There were multiple components of a parent-child relationship that were missing for Participant 8 at the time of her interview. Being able to change how the child views his mother is one area she would like to change in family therapy to improve her bond with her child. She addressed her certainty that their relationship would improve in an earlier portion of the interview after being asked to describe what she knew about family therapy. Without hesitation she answered, “that it's gonna help build a successful relationship with my child and fix problems and miscommunication.” She has a lot of confidence that family relationships will improve during family therapy, which will allow for communication struggles to improve as well.

The necessity to improve conflict-ridden relationships was extremely high in interview 10, as they were in the process of blending two large families into one. References to fighting among family members were prevalent within this interview, which further articulated the need for relationship work in therapy. When asked to describe what he felt would be useful about family therapy, Participant 10B stated, “everybody will probably, hopefully grow closer together

in a sense.” Later, he provided his expectations for how family relationships would be improve while in family therapy: “Balance. Less fighting. More working together.” The ability to produce harmony in this family will promote the collaboration and balance needed to achieve the other goals. In other words, it will provide additional pathways to success.

The decision to enroll in family therapy brings forth a number of benefits that other services do not provide. Of particular note for this selective code is the inclusion of some, or all family members into the therapeutic process. As such, the ability to incorporate family relationships naturally into treatment is conducive to improving those relationships. This is evident by the number of references to improved family relationships in the interviews. The selective code “Family Therapy will Improve Family Relationships” emerged from those numerous references to family relationships and plays a major role in the grounded theory that emerged in this study. The role this selective code play in that grounded theory will be discussed later in the discussion.

Interactional components of family therapy are beneficial. The most basic concept related to family therapy is that the family itself is present in the therapeutic process. Taking that one step further, it is quite apparent that those individuals participating in therapy will be interacting with one another. Multiple participants in this study deemed this as one of the strengths of family therapy. Two participants provided data to this selective code, which will now be explored more in-depth.

Throughout the interview process Participant 3 was adamant that being present in family therapy was going to promote success for her family. The first answer that she provided in her interview, “what is family therapy to you,” supports this idea: “Family therapy to me is figuring

out how to work on things together, make things better, work through things, learning how to do those or work through any problems we may be having.” The emphasis on working together as a family to solve problems indicates that Participant 3 has high hopes for their impending family therapy. She further supported this idea later in the interview when she was asked why she thought family therapy would be beneficial. She simply stated, “Because it's me and Mary interacting.” The interactional process between mother and child is what Participant 3 feels will lead to the accomplishment of goals for the family.

The same question about why family therapy will be beneficial was asked in interview seven. Her response was, “Because, in my opinion, my theory, it stems from an interaction.” For her, one of the largest benefits of family therapy is that it rooted in interacting with one another. These interactions result in solutions to their problems. It is also important to highlight that both participants who contributed data to this selective code had a primary goal of improving their family relationships. Based on the belief that family therapy will be beneficial, it can be said that the interactional processes of family therapy are contributing to the improvement of family therapy. This in turn, provides more pathways for the family to accomplish other goals.

Although only two interviews contributed to this selective code, the similarities between the data and its ties to the basic components of family therapy made it noteworthy. The ability to relate the interactional processes of family therapy with the selective code “Family Therapy will Improve Family Relationships” allows these two selective codes to be easily synthesized to form the core concept “Improved Family Relationships Increase Pathways to Accomplish Goals.” How this selective code and its core concept relate to the grounded theory that was formed in this study will occur in later portions of this chapter. The family core concept generated will now be reviewed to complete the exploration of the results.

Therapist Presentation Influences Hope. The final core concept differs from the others in that it consists of only selective code (see Figure 5). Despite having the makeup of only one selective code, it emerged as a core concept because of its ties to Lambert’s Common Factors Model, which is one of the foundations of this study (Lambert, 1992). In particular, this core concept appears to relate closely to the common factor the therapeutic relationship. An exploration of the selective code that makes up this core concept will now take place.

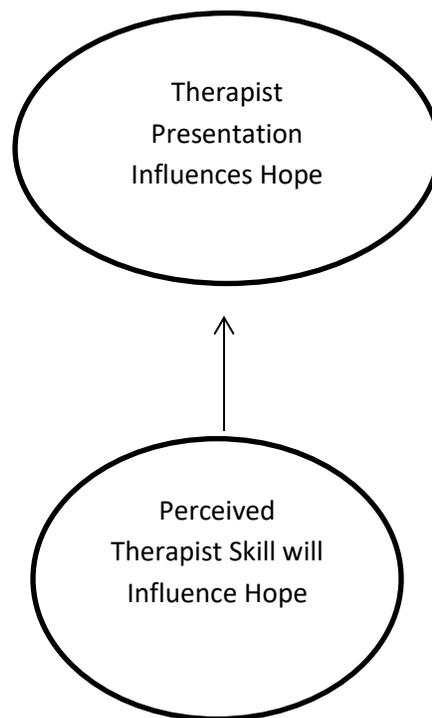


Figure 6. Selective code make-up of the core concept “Therapist Presentation Influences Hope.”

Perceived therapist skill will influence hope. The final selective code covered in the results emerged from data across three interviews. The composition of this code was formed from references to the skill level of the interviewee’s future family therapist. Additionally, statements made heavily inferred that the therapist’s skill would have a major influence on the outcomes of family therapy. In other words, perceived therapist skill has an influence on the levels of hope for the participants to achieve the goals they have for their child.

During interview seven a question was included asking the participant to describe anything about the upcoming family therapy that they did not think would be useful. Participant 7 responded by saying, “I think that it would only be not useful if the therapy approach was poor or poorly executed.” The ability to execute family therapy can also be described as a therapist’s skill level. In this case, if the therapist did not have the skills to apply family therapy well, it would drastically lower the probability of successful outcomes. Since this idea comes from the participant, the perception of lower skills would ultimately lower their hope that their goals could be accomplished.

The potential for Participant 8 and her son to be successful in family therapy is highly dependent on his willingness to open up in that setting. Factors that would determine whether her son opens up in session included her presence in session, as well as “the counselor too that we get.” When asked to elaborate on that, Participant 8 went on to say, “well, we're gonna get a new person, and depending on how they interact or whatever, Cody might not be comfortable or I might not be comfortable.” For her, the ability of the therapist to join with both her and her child will highly determine whether he opens up in session. If he is not willing to open up, then the likelihood for successful outcomes would go down. Levels of hope in this case, would be ultimately tied to the ability of the therapist to join with the family.

The importance of having a skilled therapist was quite evident for Participant 10A, which was easily seen in her multiple references to the necessity of having the right “fit” when it comes to their future service provider. Toward the end of her interview, Participant 10A was asked to explain how she thought family therapy was going to affect her determination toward accomplishing goals she had for her child. She reported, “it depends on the therapist, like I said.

If it's a good, solid, someone that's going to ... I think it could be very beneficial, very positive.”

It was only a short while later that she provided a very similar statement:

Like I said, it depends on the therapist. It depends on ... because in every field, there's positive and goods and some of them are more able to overshadow domineering children, whereas some aren't. And you know, I hope and pray that you find the good fit.

Based on the statement provided, the entire outlook of therapy would be determined by the skill level of the therapist. A unique perspective brought forth by this participant was that it was not only the skill level of the therapist that would affect outcomes, but possessing the correct skills necessary to match well with the family. This appears to go a step beyond the other participant's statements and heavily points to her perception of skill level being important to this parent.

The significance of this selective code lies in its relationship with levels of hope in parents and guardians that participated in this study. The perception that the family therapist the participants are assigned has the tools to help them achieve their goals provides an important piece toward answering the research question: How do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy? An important point to clarify is why this selective code and core concept have different labels despite stemming from the same data points. The selective code was renamed during the final constant comparison process because it allows the core concept to more easily fit into the theoretical underpinnings of this study, which was not realized until that phase of the data analysis. The manner in which this selective code and core concept fit into the grounded theory that emerged, as well as the other literature will be explained in subsequent sections.

Formal Theory

Thus far, this chapter has heavily focused on the introduction of the core concepts of this study, as well as the selective codes that comprise them. The purpose of this process was to gain a full understanding of the data that emerged from the qualitative interviews. Now that the data have been reviewed, the attention of this chapter will now turn to the formal theory that came forth at the conclusion of the data analysis. In particular, a thorough review of the formal theory will take place, as well as its connections to the core concepts and research questions guiding this study.

Theory Generation Process. In many grounded theory research studies, the most significant contribution comes from the generation of a formal theory (Urquhart, 2013). In this study, the theory generation process began during the collection of quantitative data. No actual conclusions were made during the collection of quantitative data, but the process did inform some of the questions the researcher asked, as well as some of the answers the participants provided. For example, the qualitative interview question “describe what the results of the Hope Scale mean to you” relates directly to the quantitative data provided by the participant.

The theory generation process was also seen during the qualitative interviews. Although no official conclusions were made while the interviews were being conducted, the type and frequency of certain answers led the researcher to ask specific follow-up questions to the participants. For example, when the researcher asked the question “how do you think that your presence in therapy is going to help you accomplish the goals that you have for your child,” Participant 7 responded with an answer implying previous knowledge of working in the mental health field. Based on that answer, the researcher followed-up with a statement acknowledging

the information provided and then the off-script question, “how do you think that is going to influence how you guys to in therapy?” Follow-up questions such as this provided ample amounts of data that were utilized heavily in the latter portions of this study.

Theory generation continued during data analysis. The constant comparison process brought forth a number of theory-based questions by the researcher, which were all noted in the researcher’s memos. An example of this process includes the questions “what is the relationship between hope scores and willingness to participate in family therapy? Did they seek family therapy, were they recommended it, or is it mandatory,” which all emerged during the axial coding process with interview 9. This continued through each section of the data analysis, becoming more complex and concrete with every step. The final step of the data analysis in which the core concepts emerged revealed the most information that contributed to the formal theory. The constant comparison process among the core concepts is what allowed the relationships among the concepts to come forth, finalizing the formal theory. At the conclusion of the data analysis, the following formal theory emerged: Enrollment in family therapy activates an interaction between hope and expectancy and extratherapeutic factors, which likely increases levels of hope and expectancy in parents and guardians participating in family therapy with their child. Some extratherapeutic factors involved in these interactions are unique to family therapy, while others potentially exist within all forms of therapy. This theory is composed of three major ideas: a) Enrollment in family therapy likely increases hope and expectancy in parents and guardians that will participate in family therapy with their child, b) Enrollment in family therapy likely increases hope and expectancy in parents and guardians through the activation of an interaction between hope and expectancy and extratherapeutic factors unique to family therapy, and c) Enrollment in family therapy likely increases hope and expectancy through the activation

of an interaction between hope and expectancy and extratherapeutic factors that potentially exist in all forms of therapy. Each major idea associated with this theory will now be explored in-depth.

Enrollment in Family Therapy Likely Activates Hope and Expectancy in Parents and Guardians. The quantitatively-focused Hope Scale was created by Snyder et al. (1991) to measure current levels of hope in those who complete it. This study applied the Hope Scale for a similar purpose, to measure the levels of hope in the participant. At first glance, this process alone fulfills the requirements of the first research question guiding this study: What are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child? However, when analyzed further, completing the measure only partially fulfills this research question, as the purpose of this study was to explore the relationship that exists between family therapy and hope. With this in mind, it is necessary to go beyond the purely quantitative scores provided by the Hope Scale and explore the influence that enrollment in family therapy has on levels of hope in the participant. This cannot be done by collecting quantitative hope scores at a single point in time. The qualitative interview was designed to complete the exploratory process that the quantitative portion of the study could not do alone.

Many of the core concepts that emerged in the data analysis point to likely increases in hope and expectancy in the participants since enrollment in family therapy. Some go as far as to specifically indicate that this has occurred. The most significant example of this is the core concept “Enrollment in Family Therapy Activates Hope.” The data that composes this core concept specifies that overall levels of hope, from Snyder et al.’s model (1991), have been activated in parents and guardians since their enrollment in family therapy. Further, the selective

codes that comprise this core concept specify that both agency thinking and pathways thinking are likely positively influenced by enrollment in family therapy. When discussing the overall levels of hope in this study, it directly relates to the accomplishment of goals participants have for their child. This core concept and the ideas surrounding it are the foundation for this portion of the formal theory that emerged in this study.

Other core concepts further support this portion of the theory in more indirect ways. The core concept “New and Improved Skills Provide Pathways to Accomplish Goals” brings forth the idea that learning new skills and improving existing skills during the course of therapy will increase the available pathways to accomplish goals. The types of skills learned and improved upon in therapy are not specified, just that they provide increased pathways for success. The indirect contribution of this core concept to the formal theory comes from the implication that there will not only be a focus on skills in the impending family therapy, but that there is no doubt that new skills will be learned and old skills will be improved. Based on the belief that skills will inevitably be focused on in therapy provides an increase in pathways thinking upon enrollment in family therapy.

A very similar thought process occurs with the core concept “Improved Family Relationships Increase Pathways to Accomplish Goals.” This core concept outlines the idea that being able to improve family relationships in family therapy will increase the pathways available to accomplish goals. The greatest similarity between this core concept and the core concept “New and Improved Skills Provide Pathways to Accomplish Goals” is the belief that the ideas in the concept will inevitably occur during the course of family therapy. Due to the inevitability of improved family relationships during the course of family therapy, from the perspective of the participants, it is logical to conclude that pathways thinking increased in participants upon the

enrollment in family therapy. An increase in pathways thinking due to the belief that specific situations will take place during the course of family therapy provides support in favor of the portion of the formal theory indicating that increased in hope and expectancy occur upon enrollment in family therapy.

The final core concept that supports this portion of the formal theory is “Family Support Increased Pathways.” The most basic tenant of family therapy is that the family is present in session with the identified patient. For the participants of this study, they framed their presence in session as providing support for their child. From the participant’s perspective, the support they will provide will increase pathways for success with their child. In a similar fashion as the previous core concepts discussed, the inevitability of the family support taking place during family therapy indicates an increase in pathways thinking when enrolling in family therapy. This provides the final piece of evidence in the creation of the piece of the formal theory, that enrollment in family therapy likely increases hope and expectancy in parents and guardians. This section will now move its focus to exploring the second portion of the formal theory, that the activation of interactions between hope and expectancy and extratherapeutic factors specific to family therapy likely increase hope and expectancy in parents and guardians that are enrolled in family therapy with their child.

Activation of Interactions with Family Therapy Specific Extratherapeutic Factors Likely

Increases Hope. The first portion of the formal theory established that levels of hope and expectancy likely increase in parents and guardians that will participate in therapy with their child upon enrollment in that service. The remainder of the formal theory outlines part of what led to the likely increases in hope and expectancy levels upon enrollment in family therapy. Due to this being a single study with a number of limitations, it is important to emphasize that this

theory can only account for part of what increased levels of hope in participants. In particular, this section will discuss how the activation of interactions between hope and extratherapeutic factors specific to family therapy led to the likelihood of increased hope.

The most prominent core concept that supports this portion of the formal theory is “Family Support Increased Pathways.” A common theme that emerged in this study was that the basic nature of family therapy to include the family in the therapeutic process was a major benefit of this form of therapy. Data analysis indicated that participants not only saw this as a benefit, but as positively influencing the pathways thinking in parents and guardians when thinking about the goals they have for their child. Simply put, the activation of the interaction between hope and expectancy and family support likely resulted in increased levels of hope in participants. It is important to note that the concept family support, also known as the extratherapeutic factor social support, could be identified as a specific factor of family therapy. Although an argument for social support as a specific factor could be made, it is beyond the scope of this study to do so. In fact, no literature to date has made an official argument for such a change. Instead, adherence to previous literature on the topic will continue to inform the remainder of the study through the identification of social support as an extrath factor (Roehrle & Strouse, 2008).

Taking a closer look at the core concept “Family Support Increased Pathways” reveals an additional family therapy specific extratherapeutic factor that positively influences hope. One of the selective codes that make up this core concept is “Environment Provided by Family Therapy will Promote Growth.” The “environment” provided by family therapy includes the presence of the family itself. The contribution of this idea to the formal theory comes from its connection to the extratherapeutic factor, utilization of items learned in therapy outside of session. Based on

the environment provided by family therapy, which includes members of the family, the result is an increased likelihood of practice and utilization of items learned in therapy outside of session because everyone is present when they are taught. Since multiple or all members of the family are present when items are taught in session, it creates an increase emphasis on the importance of these items, as well as a natural environment at home for them all to apply them. From the participants' perspective, increased practice and utilization of items learned in therapy increases the chances for achievement of goals. The interaction between the extratherapeutic factor utilization of items learned in therapy outside of session and hope and expectancy was associated with a likely increase in hope levels among participants upon enrollment in family therapy. This core concept has brought forth multiple ideas that contributed to the portion of the formal theory that outlines family therapy specific extratherapeutic factors that likely interact with hope and expectancy in a positive manner. The remainder of this chapter is dedicated to discussion of extratherapeutic factors that potentially exist in all forms of therapy that likely interacted with hope and expectancy to influence levels of hope.

Activation of Interactions with General Therapy Extratherapeutic Factors Likely Increases Hope. The final portion of the formal theory that emerged in this study outlines the activation of the interactional process between hope and expectancy and extratherapeutic factors that potentially exist in all forms of therapy. The activation of the interaction between hope and expectancy and extratherapeutic factors that exist in all forms of therapy influences the levels of hope in those that are enrolled to participate in family therapy. This can occur both positively and negatively.

The core concept "Perceived Therapist Skill will Influence Hope" brings forth the first support for this portion of the formal theory. Based on the perceptions of the therapist by the

participant, a judgment is made on the potential outcomes for their family. There are a myriad of factors that could influence a client's perception of their therapist as a competent practitioner, most notably past experiences with services. Without even meeting their therapist, the participant forms a cognition surrounding their therapist's competence, or potential competence. This thought process directly relates to levels of hope in the client before treatment begins and is independent of treatment type or modality. The activation of the interaction between this extratherapeutic factor and hope and expectancy can affect levels of hope both positively and negatively.

The other core concept supporting this portion of the formal theory is "Extratherapeutic Factors Influence Hope." Although the core concept itself does not provide specific ties to the theory generated, three of the selective codes that comprise the concept shed light on the topic. The selective code "Family is Enrolled in Multiple Services" brings forth the idea that enrollment and engagement in other services has an effect on levels of hope in the client. Participants in this study were able to list numerous services that they were involved in. Each service has its own influence on the client and their potential for success in family therapy. The perceptions and experiences with those services by the participants influence their outlook for achievement in goals in family therapy in any number of ways. This has the potential activate an interaction with hope and expectancy to influence overall levels of hope.

A similar thought process is seen with the selective code "Family has Poor Experiences with Past Services." Multiple participants in this study noted negative experiences with services they have utilized in the past. Based on the participant's experiences and results within those past services, the levels of hope for their impending family therapy are likely influenced. In general, having a poor experience with a past service has the potential to lower your hope for success

with the next service. The activation of the interaction between hope and this extratherapeutic factor has a definite potential to impact overall levels of hope.

The final core concept that informs this portion of the formal theory is “Being Actively Religious Increases Hope.” This selective code posits that the innate tendencies of religious individuals to believe in a higher power increases levels of hope. Specifically, participants who active engage in religion have faith that a higher power will guide them to achieve their goals over the course of family therapy. This does not specify that the higher power will necessarily be the agent of change, merely that they could have a positive influence on potential outcomes if needed. As with the other selective codes covered in this section, the activation of the interaction between religiosity and hope and expectancy potentially influences overall levels of hope.

The core concepts presented in support of this portion of the formal theory indicate that extratherapeutic factors interact with hope and expectancy in clients to potentially influence overall levels of hope. These extratherapeutic factors are independent of any specific form of therapy. Additionally, it is important to note that the extratherapeutic factors discussed in this section are not all encompassing when it comes to levels of hope in clients. There are likely many other factors involved when considering levels of hope in those participating in therapy. These ideas simply represent a small piece of a much larger puzzle when viewing levels of client’s hope in relation to outcomes. This concludes the review of the findings of this study and the exploration of the grounded theory that emerged from those findings. The remaining chapter of this paper will be utilized to complete the following: a) Summarizing the findings of this study, b) Connect the grounded theory to existing literature, c) Examine how the grounded theory answers the research questions of this study, d) Determine the implications of this study

for the field of marriage and family therapy, e) Cover the limitations of this research, f) Propose direction for future research, and g) Conclude the study with final thoughts.

Chapter 5: Discussion

Summary of Results

Lambert's Common Factors Model outlines four constructs that exist within all forms of successful psychotherapy (Lambert, 1992). It posits that extratherapeutic factors, the therapeutic relationships, hope and expectancy, and specific factors all account for desired change exhibited by clients. Of particular interest to this study is the construct hope and expectancy, which is viewed as a unidimensional construct that involves the perception that goals can be accomplished (Erickson, Post, & Paige, 1975). The work of Snyder et al. (1991) revolutionized the research on hope and expectancy when they introduced the idea that hope and expectancy could be broken down into two different types of thinking, agency thinking and pathways thinking.

Family therapy is one specific form of psychotherapy that has existed since around the 1940s (Bertalanffy, 1968). Family therapy is unique to other forms of psychotherapy in that it aims to treat all members of a family system, as opposed to each individual, in order to alleviate the symptoms of focus (Minuchin, 1985). Despite its unique approach to treating symptoms, family therapy shares common ground with all other forms of psychotherapy in that it possesses research indicating its success in treating clients, while also lacking research that outlines the process that makes family therapy successful (Sprenkle, Davis & Lebow, 2009). The purpose of this study was to explore a small piece of the process that makes family therapy successful by analyzing its relationship with the common factor hope and expectancy, as viewed through the lens of Snyder et al. (1991).

A mixed methods sequential embedded design was used to test the study's two research questions (a) what are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child, (b) how do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy? A total of 11 participants completed this study in which 11 Hope Scales were completed and 131 single-spaced pages of transcripts emerged. Data analysis consisted of descriptive data analysis of the Hope Scale, as well as open coding, axial coding, selective coding and the saturation of the remaining categories into the core categories. From the Hope Scale, we learned that participants have high levels of agency thinking, pathways thinking and overall levels of hope. From the qualitative portion, a total of six core concepts emerged from the data analysis. These core concepts were analyzed further, creating the following grounded theory: Enrollment in family therapy activates an interaction between hope and expectancy and extratherapeutic factors, which likely increases levels of hope and expectancy in parents and guardian s participating in family therapy with their child. Some extratherapeutic factors involved in these interactions are unique to family therapy, while others potentially exist within all forms of therapy.

The formal theory outlines three major conclusions that emerged from the data. The first conclusion was that levels of hope and expectancy are likely activated in parents and guardians that will participate in family therapy with their child upon enrollment in family therapy. The hope and expectancy is in reference to the potential accomplishment of goals that they have for their child. The second conclusion indicated that the levels of hope and expectancy in parents and guardians likely increase because of the activation of an interaction between hope and expectancy and extratherapeutic factors that only exist in family therapy. The extratherapeutic

factors unique to family therapy that were deemed to potentially interact with hope and expectancy to create the increases in levels of hope were family support and utilization of items learned in therapy outside of session.

The third conclusion that exists within the formal theory is that levels of hope and expectancy in parents and guardians likely increase because of the activation of an interaction between hope and expectancy and extratherapeutic factors that potentially exist in all forms of therapy. The extratherapeutic factors of note for this portion of the formal theory were perceptions of therapist skill, experiences with past services, enrollment in multiple services, and being actively religious. The significance of the formal theory that emerged in this study is that it fulfills the study's purpose to examine the process that contributes to the success of family therapy. In order to scale of this theory, the next section will focus on tying the conclusions of this study to existing literature in the field.

Empirical Support

Urquhart (2013) suggests that the "job is not done until we have integrated our emerging theory with existing ones in the field (p. 130)." In essence, the ability to connect the findings of a study to research already present enhances the credibility of those conclusions. This section aims to do just that, by highlighting connections between the results of this study with other research that exists.

The first connections seen between the results of this study and other research come from a 2007 study by Yovel and Safren. The purpose of their study was to take a deeper look at the impact of practicing skills learned in cognitive-behavioral therapy outside of session. What they found was that clients that actively practice what they learned outside of therapy were more

likely to have successful outcomes (Yovel & Safren). The significance of the findings by Yovel and Safren relate to idea brought forth in this study that the environment provided by family therapy will increase potential positive outcomes, as supported by the selective code, “Environment Provided by Family Therapy will Promote Growth.”

Diving deeper, the environment provided by family therapy will make it easier to practice items learned from the therapist outside of session because the whole family is present to learn those items. The support offered by the research from Yovel and Safren (2007) lies in the conclusions they came to that practicing items learned in therapy outside of session increases therapy outcomes. Thus, it is the activation of the interaction with the extratherapeutic factor utilization of items learned in therapy outside of session, as offered through family therapy, with hope and expectancy that likely results in the increase pathways thinking. Simply put, being able to practice items learned in therapy outside of session more easily provides more pathways for success for a family. As a result, the likely increase in pathways thinking then leads to higher overall levels of hope (Snyder, 2012).

Other existing research supporting the conclusions of this study came from the work of Roehrle and Strouse (2008). In review, some of the core ideas surrounding social support that were introduced early in this study actually came from this work. In their meta-analysis they posited that the interaction between the extratherapeutic factor social support and other common factors had positive influences on client outcomes. They do not go as far as specifying hope and expectancy as having an interaction with social support, they simply state the interaction between other common factors and social support in general helps create positive outcomes. The results of this study align with, and build upon that research by Roehrle and Strouse by suggesting that some increases in hope and expectancy likely come from the social support provided in family

therapy. In particular, it is the activation of the interaction between social support offered in family therapy and hope and expectancy that likely raises pathways thinking in clients, which in turn raises overall levels of hope. The result of higher levels of hope and expectancy in any situation is a higher likelihood of accomplishing their goals (Snyder, 2012).

The importance of perceived social support in clients was also highlighted in the work of Leibert, Smith and Agaskar (2011). The focus of their research was on how social support and the therapeutic relationship contributed to client outcomes in psychotherapy, both independently and interactively. The most significant result as it pertains to the current study was the indication that perceived social support contributes to positive client outcomes. Going further, the connections to this study come from the methodology, mainly the use of the Subjective Social Support measure. As the name implies the Subjective Social Support tool measures subjective levels of social support from the point of the view of the client. The impact of perceived social support on client outcomes is where the connection between the two studies is most important. In the current study, higher levels of perceived social support offered by family therapy likely increased the belief that positive outcomes would occur. In the Leibert, Smith and Agaskar study, higher levels of perceived social support was connected to actual outcomes. The two conclusions are very similar and strengthen each other as a result.

The impact of the social support provided in family therapy is further articulated in the research conducted by prominent marriage and family therapy figures Blow and Sprenkle (2001). Using a modified Delphi process, a panel of psychotherapy experts were asked questions about common factors specific to marriage and family therapy. The results labeled an expanded treatment system as one common factor specific to family therapy. The extratherapeutic factor social support was highlighted as one component of an expanded treatment system existing in

family therapy. Further, social support was emphasized as particularly important in creating positive change in clients. These ideas are consistent with the findings of this study, which indicate that the activation of the interaction between the extratherapeutic factor social support with hope and expectancy likely results in an increase in overall hope when considering therapeutic outcomes.

The work of Blow and Sprenkle (2001) further aligns with other aspects of this study. The same panel of experts identified the client's perception of their therapist as being "linked" to levels of hope and expectancy. Specifically, the panel reported that "the client's view of the therapist as an expert who is competent" is an important factor in creating higher levels of hope (p. 397). Perception of therapist competency is nearly identical to the core concept "Perception of Therapist Skill" that emerged in this study. The commonalities between these ideas provides support in favor of the final portion of the grounded theory, enrollment in family therapy likely increases hope and expectancy in parents and guardians through the activation of interactions with extratherapeutic factors found in all forms of therapy.

Exploration of the relationship between hope and expectancy and religion was seen in the work of Cockrell (2003). In his quantitatively-focused study, he explored numerous characteristics of religion and how they relate to levels of hope and expectancy from the perspective of Snyder et al. (1991), which is the same perspective used in this research. He concluded that overall levels of hope and expectancy in participants that identify as religious in some form have significantly higher levels of hope and expectancy than non-religious individuals. Indications of higher hope and expectancy in actively religious individuals supports similar findings that emerged in this study. In particular, it provides evidence toward the last portion of the formal theory which states enrollment in family therapy likely increases hope and

expectancy in parents and guardians through the activation of interactions with extratherapeutic factors found in all forms of therapy.

A thorough literature review revealed that no present research has significant connections to this study in relation to the extratherapeutic factors experiences with past services and enrollment in multiple services, especially in regard to their relationship with the common factor hope and expectancy. As such, the results of this study should be seen as a unique contribution about such ideas and potential jumping off point for future research. Other ideas for future research based on the results of this study will be discussed in a subsequent section.

The purpose of this section was to demonstrate the connections to and support of existing literature for the results of this study. Connections to research were found for the majority of the findings of this study, with the most significant support seen in regard to the impact of social support offered by marriage and family therapy. With the empirical evidence supporting the results of this study outlined, the attention of this chapter will now turn to how the result specifically relate to the research questions that outlined this research.

Research Questions

The two research questions guiding this study were: (a) what are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child, and (b) how do parents/guardians perceive the relationship between hope and expectancy and their involvement in family therapy? The most concrete manner in which these questions were addressed in this study comes from the grounded theory: Enrollment in family therapy activates an interaction between hope and expectancy and extratherapeutic factors, which likely increases levels of hope and expectancy in parents and guardian s

participating in family therapy with their child. Some extratherapeutic factors involved in these interactions are unique to family therapy, while others potentially exist within all forms of therapy.

At first glance, research question “(a),” which explores the levels of hope and expectancy in parents/guardians at the onset of family therapy, appears quantitative in nature. In fact, the utilization of the Hope Scale in this study would have allowed for a quantitative answer to emerge. However, the purpose of this study was to explore the parent’s and guardian’s perceptions of hope and expectancy in order to gain more information about the process surrounding family therapy. As such, the qualitative interviews were used to inform this question, with the scores from the Hope Scale being used to elicit deeper answers from the participants.

The first portion of the grounded theory specifies that “enrollment in family therapy likely increases hope and expectancy in parents and guardians.” This statement in itself answers research question “(a).” What are the overall levels of hope and expectancy in parents/guardians at the onset of family therapy when they participate in treatment with their child? They are likely increased levels of hope and expectancy when compared to before their enrollment in family therapy. How much did the levels increase? That answer is not necessary within the scope of this study. The answer to this research question goes a step beyond just answering question itself, it also informs some of the process surrounding family therapy that will be explored in the remainder of the formal theory. Those enrolled in family therapy reported high levels of hope and expectancy. Based on Snyder’s (2012) research, hope scores are positively correlated with positive outcomes. The natural question turns to “why.” Why are levels of hope and expectancy

so high in parents and guardians enrolled in family therapy? Research question (b) dives into that question more thoroughly.

How do parents and guardians perceive the relationship between hope and expectancy and their involvement in family therapy? The remaining portions of the formal theory address that question. Levels of hope and expectancy in parents and guardians likely increased upon enrollment in family therapy through the activation of an interaction between hope and expectancy and extratherapeutic factors. Some of the extratherapeutic factors were unique to family therapy, while others potentially exist in all forms of psychotherapy. Based on the perceptions of parents and guardians regarding the relationship between hope and expectancy and family therapy, it was the activation of an interaction with extratherapeutic factors that account for increases in hope and expectancy. Social support and utilization of items learned in therapy outside of session were the extratherapeutic factors specific to family therapy, while perceptions of therapist skill, experiences with past services, enrollment in multiple services, and being actively religious were those that potential exist in all forms of therapy. Through the exploration of these research questions, some context was provided that previously did not exist for the process surrounding family therapy. Exploration of the implications of these findings for the field of family therapy, as well as psychotherapy as a whole will complete the discussion of the results.

Study Implications

The findings of this study have a variety of implications for the mental health field. Some of these findings have implications for psychotherapy in general, while others are specific to marriage and family therapy. Psychotherapy in general lacks process specific research due to the

limitations of randomized clinical trials, which are typically used to determine the effectiveness of mental health treatments (Wampold et al., 1997). One of the goals of this study was to focus on the process that surrounds marriage and family therapy, specifically in regard to what leads to successful outcomes. However, an unforeseen byproduct of designing a methodology around the process of marriage and family therapy was the emergence of process-oriented data relating to the field of psychotherapy as a whole. Thus, the first major implication of this study is the contribution of data that informs a portion of the process that leads to successful outcomes in potentially all forms of psychotherapy.

The final portion of the formal theory that emerged in this study posits that the activation of the interaction of some extratherapeutic factors found in all forms of psychotherapy with hope and expectancy likely results in changes in levels of hope. Since levels of hope and expectancy are positively correlated with success in psychotherapy, the significance of these findings relates to outcomes (Snyder, 2012). The extratherapeutic factor of being actively religious was found to strictly increase hope, while perceptions of therapist skill, experiences with past services and enrollment in multiple services have the potential to either increase or decrease levels of hope. These ideas are consistent with Lambert's (1992) research implicating extratherapeutic factors in psychotherapy outcomes, but they go a step further and specifically identify some extratherapeutic factors that are involved in psychotherapy and how they are related to hope and expectancy and outcomes. The specificity provided by these findings further informs researchers and clinicians about the potential impact of extratherapeutic factors on hope and expectancy and therapeutic outcomes. Since the main goal of psychotherapy is to provide positive outcomes, being informed on different components that influence those outcomes is quite valuable.

The combination of supporting literature provided early in this research and the results of this study lead to the next implication for general psychotherapy. Although the focus of the research was on determining the relationship between the common factor hope and expectancy and marriage and family therapy, an intense focus on the research surrounding hope and expectancy itself inadvertently provided a renewed emphasis on its importance in treatment. Lambert (1992) stated that 15% of therapeutic outcomes are related to the common factor hope and expectancy, but often it gets little to no consideration when working with clients. The relationships that hope and expectancy has with extratherapeutic factors and outcomes in general indicates that this common factor deserves more consideration than it currently receives. For clinicians, a renewed focus on the importance of hope and expectancy points to the need for a larger emphasis on hope and expectancy in graduate programs training future therapists, as well as continued training on how licensed therapists can focus on hope and expectancy with current clients.

The remaining implications of this study are specific to the field of marriage and family therapy. In a world where marriage and family therapy aims to receive more recognition and support for its efforts in helping clients there remains a lack of empirical support in why and how marriage and family therapy is effective (Sprenkle, Davis & Lebow, 2009). The results of this study, in part, shrink that gap in the literature. A portion of the formal theory that emerged in this study indicates that hope and expectancy is likely activated upon enrollment in family therapy due to the activation of an interaction with marriage and family therapy specific extratherapeutic factors. The extratherapeutic factors of emphasis here are social support and utilization of items learned in therapy that will help their relationship outside of session, both of which are products of the unique environment provided by family therapy. The ability to specify how the

environment provided by family therapy increases hope and expectancy, and as a result of this study, was not something that could easily be done before the results of this study. This should be seen as the biggest takeaway and implication of this study.

The final implication of this study is the evidence provided in support of the use of systemic thinking in psychotherapy. One of the basic tenants of marriage and family therapy that separates it from other forms of psychotherapy is the incorporation of Family Systems Theory (FST) into treatment. Although the purpose of this study was not to specifically to study FST, many of the conclusions were systemic in nature. The first evidence provided in support of systems thinking comes from the conclusions surrounding social support. The desire to have the entire family present in session stems from the idea that lasting change occurs when the system itself is the focus of treatment (Bertalanffy, 1968). The results of this study indicate that the activation of the interaction between social support, as provided by having the entire family present in session, and hope and expectancy likely results in an increase in hope in parents and guardians participating in family therapy with their child. Based on the work of Snyder (2012), levels of hope and expectancy are positively correlated with outcomes, making the likelihood of increases in hope and expectancy initiated by social supported desirable.

The other major conclusion in support of FST comes from the general idea that extratherapeutic factors potentially influence levels of hope and expectancy. Data from this study point to a wide variety of extratherapeutic factors potentially influencing hope and expectancy, ranging from being actively religious to past experiences with services. The emphasis on extratherapeutic factors having an impact on psychotherapy is systemic in nature because it points to the interaction of outside systems with the system of focus, which is the family of the identified patient. These interactions between systems directly affect the behaviors, or symptoms

seen. Thus, many of the conclusions of this study are systemic in nature. These are the major contributions of this study, through which future research should aim to build from. The next section will be dedicated to highlighting the limitations of this study.

Limitations

Consideration of study limitations are important to address in order to demonstrate the critical thinking involved in the research process. In this study, there were multiple limitations worthy of consideration for the reader. The first limitation of this study comes from a limitation inherent in all grounded theory studies. According to Strauss and Corbin (1994), a theory is considered to be “an interpretation made from a given perspective as adopted by the researcher (p.279).” As such, the likelihood of researcher bias in some form certainly exists. The potential for researcher bias in this study was compounded because the majority of the procedures utilized in this study took place at Tanager Place Behavioral Health Clinic. The primary researcher of this study was a practicing therapist at the Tanager Place Behavioral Health Clinic throughout the course of the study. In addition, the researcher’s initial hypothesis that drove this study suggested a possible relationship between marriage and family therapy and the Hope Theory subscale of pathways thinking from the model of Snyder et al. (1991). Based on the specificity of the underlying hypothesis and its potential to aid the field of marriage and family therapy, the potential for researcher bias was increased in this manner as well. The researcher attempted to minimize any biases present due to working at the facility where the study took place by implementing reflective journals throughout the process. However, for the sake of transparency the primary researcher of the study working at the facility where the study took place should still be noted as a limitation of the study.

In general, the utilization of qualitative methodology makes it difficult to replicate any study because of the unpredictability of client experiences that inform the data. Due to this, the ability to verify the findings of this study using exactly the same methods would be difficult. In a similar manner, the qualitative nature of the findings also limits their generalizability because they involve the convergence of individual perceptions of hope and expectancy.

Other limitations exist due to the sample that was analyzed in this study being one of convenience and limited size. In particular, the sample included predominantly middle-aged females that have a low socio-economic status. As a result, the generalizability of the findings is further limited. Further, due to confidentiality limitations, as well as the need to reduce the potential for attrition, many demographic variables were intentionally not collected. The lack of demographic information available also limits generalizability, as well as the depth of some of the results.

The use of Hope Scale as the primary measure of the study provides very specific lens through which the study is framed. The potential exists for disagreement with the philosophy that underlies the Hope Scale, specifically the inclusion of two subscales within the overall concept of hope. As such, the inclusion of the Hope Scale as the primary measure in this study could be viewed as a limitation. In addition, the potential existed for extraneous forces to have an influence on hope and expectancy in participants. The researcher attempted to control for extraneous variables by bolstering the inclusion/exclusion criteria, however in order to feasibly recruit enough participants that too was limited. Overall, the limitations of this study should not minimize its significance. Instead they should help frame the findings in a realistic light to help the critical thinking process of others that will help others build upon them in the future.

Future Research

The researcher proposes two major directions that future research could go in response to the findings of this study. The first direction would be to study how the results of this study could be directly applied to practice. The findings in this research sheds light on some of the process underlying both marriage and family therapy and general psychotherapy, but does not provide any suggestions on how to utilize these findings in clinical practice itself. The exploration of specific services used in addition to family therapy and how they individually relate to the common factor hope and expectancy would be useful for the field. Specifically, more in-depth knowledge of supplementary services available would provide better informed recommendations by marriage and family therapists of such services. More informed pairing of marriage and family therapy and outside services has the potential to improve levels of hope and expectancy and clients, as well as outcomes. Additional research could explore the utility of transparency with clients in terms of hope and expectancy. Given that hope and expectancy is positively correlated with outcomes, exploring how psychoeducation on hope and expectancy and being intentional about its incorporation in marriage and family therapy sessions could be beneficial in helping clients achieve their goals.

The second direction for future research based on these findings would be continued exploration of the therapeutic process of marriage and family therapy. The results of this study provide a very small piece to the much bigger puzzle that is process in marriage and family therapy. Further exploration of marriage and family therapy process could occur by creating similar research that has addressed the limitations of this study, or to build supplementary literature from the conclusions that emerged from the results. Future research could build on the results of this study by utilizing more purposive sampling methods, while maintaining similar

procedures. The convenience sampling method used in this study resulted in primarily low-income participants. Purposively sampling middle-class or upper-class participants and then integrating those results with the results of this study would provide more concrete findings that could be used in a more generalized sense.

Supplementary research could occur through the exploration of the relationship between the common factors hope and expectancy and the therapeutic relationship within the context of marriage and family therapy. Some of the data in this study indirectly indicates ties between hope and expectancy and the therapeutic relationship, which could be expanded on by using a more in-depth approach. Further understanding of how common factors relate to one another within the context of marriage and family therapy would undoubtedly inform practitioners about their usefulness within therapy process.

Final Thoughts

In the most basic sense, this study articulates the complexity that exists within marriage and family therapy and psychotherapy in general. A myriad of literature exists discussing the effectiveness of marriage and family therapy, the different ways that marriage and family therapy can be implemented and many of the intricacies that exist in helping others. Despite that, the undeniable fact exists that many years of research will need to continue to in order to gain a better understanding of everything that marriage and family therapy is, as well as everything that it could be. This researcher feels honored to have been able to partake in the marriage and family therapy research process itself and to contribute information that helps inform the field. Through similar efforts of countless other researchers, the field of marriage and family therapy will continue to blossom into one of the leading fields in helping people manage their mental health.

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Appendix A: The Hope Scale

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1 = Definitely False 2. = Mostly False 3. = Somewhat False 4. = Slightly False
5. = Slightly True 6. = Somewhat True 7. = Mostly True 8. = Definitely True

- ___ 1. I can think of many ways to get out of a jam.
- ___ 2. I energetically pursue my goals.
- ___ 3. I feel tired most of the time.
- ___ 4. There are lots of ways around any problem.
- ___ 5. I am easily downed in an argument.
- ___ 6. I can think of many ways to get the things in life that are important to me.
- ___ 7. I worry about my health.
- ___ 8. Even when others get discouraged, I know I can find a way to solve the problem.
- ___ 9. My past experiences have prepared me well for my future.
- ___ 10. I've been pretty successful in life.
- ___ 11. I usually find myself worrying about something.
- ___ 12. I meet the goals that I set for myself.

Note. When administering the scale, it is called The Future Scale. The agency subscale score is derived by summing items 2, 9, 10, and 12; the pathway subscale score is derived by adding items 1, 4, 6, and 8. The total Hope Scale score is derived by summing the four agency and the four pathway items.

Appendix B: Interview Guide

- How do you think family therapy will influence the tools and skills you need to accomplish the goals you have for your child? (pathways thinking)
- How do think family therapy will influence your *determination* to accomplish the goals you have for your child? (agency thinking)
- How has enrollment in family therapy *influenced your belief* that the goals you have for your child will be accomplished? (agency and pathways thinking)
- What do you think will be useful about family therapy with your child (if anything)? (agency and pathways thinking)
- Describe why you believe the treatment will be useful/not useful. (agency and pathways thinking)
- Describe what you think your role will be in therapy with your child.
- How do you think your presence in therapy will help accomplish your goals for your child?
- How do you think your presence in therapy will make it more difficult for your child to accomplish the goals you have for them?
- Describe why you think family therapy has the potential to be more beneficial in helping your child than any other solution attempted.
- Describe what the results of the Hope Scale mean to you. (question will be asked at after the Hope Score has been introduced to the participant)
- Describe other efforts or services that you have made to accomplish the goals you have for your child.

Appendix C: Researcher Memos

4/13/2018

-Not all answers and codes appear to be directly related to the questions being asked. How do I go about getting quality data from those types of answers?

-Even though I am having to redo a lot of the coding that I am doing, the process appears to be going faster each time. I would assume that it has to do with the number of times I have read the transcripts and the subsequent familiarity with the data.

-Based on the extensive reading through interview 1, as well as references off the top of my head from other interviews, it appears as though family therapy for many of these families is being used as a “last straw.” Thus, their motivation may be lower than they are presenting due to burnout (having extended exposure to family problems).

4/14/2018

-As I progress through the first interview I am beginning to notice many codes repeated. I wonder if they will become larger themes as I progress through the other interviews?

-There are a few major themes beginning to emerge from this interview: mom believes that the child’s behaviors are individual oriented, legal and mental health services do not understand the family, mom is burned out and efforts to help her family are not being noticed or validated.

5/7/2018

-As I complete the coding chart it appears to make more sense to change the verbiage of the codes to be more specific, making it easier to tie back to the question.

5/11/2018

-Will it be easier to compare the codes from the perspective of each question, or to compare each interview to the others?

-In interview 5 mom references an increase in levels of hope due to her being able to take online classes (extratherapeutic factor). Could this infer a relationship between levels of hope and extratherapeutic factors? Also, pursuing college in the human service and criminal justice could potentially increase tools and skills available.

-Mom's answers in interview 5 makes me question the influence of past services on current services (both quality of services and type of services). This is consistent with mom's unhappiness with "family therapy" in interview 1 and lack of hope that it will be successful this time around.

-Sometimes I feel like my codes are more specific to the question that is being asked, while other times I feel as though my codes are providing the context that should be provided by the question. Which is correct?

5/12/2018 (Interview 5)

-I should label memos based on the interview that I am coding so that I can begin to flesh out themes that I notice.

-Pages 8-10 are really focusing on when and how mom should interact with her son about specific topics.

-On page 10 mom makes reference to a relationship between an agency increase due to a pathways increase.

-Mom infers that increases in tools and skills leads to a larger feeling that a pathway exists to reach a goal, which increases overall motivation.

-On page 11 mom describes how the son is excited for family therapy. What relationships could exist between other family member's excitement and hope for family therapy and the interviewee's excitement and hope for family therapy?

5/13/2018 (Interview 6)

-Gaining perspective about mental health problems and gaining more information about those problems appears to be a recurring theme between interviews 5 and 6. It has already made an appearance on page 1 in interview 6.

-Many of the open codes comes across as desires for therapy. Is that a result of the questions I ask?

5/14/2018 (Interview 6)

-Grandmother in this interview appears to be talking more about grandson's problems than family therapy in the middle portions of the interview.

-There is a lot of content in the latter stages of the interview that do not provide useful codes in relation to the question.

-Not as much useful content in this interview when compared to others. Especially the second half of the interview.

5/15/2018 (Interview 7)

-Interviewee has very succinct and educated answers. She appears to know more about the mental health field than other interviewees.

-One theme appears across all interviews so far is wanting the children to understand the struggles of the caregiver in addition to caregiver learning more about the child

5/16/2018 (Interview 8)

-Another example of wanting to gain and provide perspective

-The idea that a parent/guardian in session may inhibit progress because the child may fear consequences for sharing in session. This has been brought up in another interview.

-Extratherapeutic factor of faith brought up as a potential correlation with hope. God provides the path? (pathways)

-“God reward hard work” (page 7), potential tie to motivation.

-Explicitly states that agency and pathways went up since enrolling in family therapy (p.8).

Probably good to go back to other interviews to see if others explicitly state this.

-When I ask about expected treatment outcome I wonder if the interviewee says that outcomes will be positive because I work at the agency where it will take place (unexpected influence). It hasn't been a universal answer, but it seems like it would be possible.

5/17/2018 (Interview 9)

-Second reference (p.2) to not being happy with family-based services received in the past (interview 1).

5/18/2018 (Interview 9)

-On page 7 mom specifies hopes as the goals that she has for her family in family therapy

-To date, I had asked the parents/guardians to view each question from the perspective of one child, especially in regard to the hope scale. This is the first instance where mom clearly has goals for multiple children. How could this effect the data scores and answers given?

-On page 8 mom references hope scores as being dependent on which child you are referring to. This makes sense because hope is directly tied to goals and mom has different goals for each child. I wonder if there is any overlap or correlation between hope for each kids?

-Mom was specifically asked to fill out Hope Scale with the whole family in mind, not specifically in regard to one child.

-On page 10 mom makes reference to the obvious inexperience of their past family therapist, especially how quiet they were. The improvement and experience level infers better therapy and better hope for outcomes.

-On page 10 and 11 mom brings up language and cultural factors that exist in family therapy. In what ways could they be tied to hope? Increased hope for family therapy outcomes due to having a therapist that is fluent in Spanish. Is that considered an extratherapeutic factor or a specific factor?

-I am having to change general codes of “son” to the specific names of the sons because mom switches back and forth with referencing them.

-Mom wants her kids to not make the same mistakes in life that she did.

(Interview 10)

-This is the only interview with two interviewees

5/20/2018 (Interview 10)

-Page 3 provides another reference to the therapist being a neutral third party as an advantage of family therapy.

-Another reference to improved family relationships on page 4 of interview 10.

-Another reference to wanting a non-biased individual to help resolve problems on page 4.

5/22/2018 (Interview 10)

-A second reference (another interview) to hope tied to a greater power and faith on page 11.

-“Faith is a pathway to heaven (goal)” (page 12)s

5/23/2018

-The narratives (individual answers) of both parents are longer than any other interview, which is making it difficult to code.

-There are times where I am questioning the accuracy of the transcription with this interview.

5/28/2018 (Interview 2)

-The first two pages have themes that family therapy will be more beneficial than individual therapy because it will allow skills to be applied more effectively at home.

-Page 5 references different perceptions being gain for the oldest son. This has been a theme across multiple interviews.

-On page 5 mom references son not opening up in family therapy because the rest of the family is present. This is consistent with other interviews.

-Page 7 references a tie between hope and ability to accomplish goals. This is unique theme based on a unique follow-up questions asked, but it comes across as something very interesting.

-Mom appears to have answered the hope scale from the perception of her son. This is unique when compared to the other interviews.

-Reoccurring theme of family therapy providing a feeling of support for her son.

-It is not explicitly stated, but this interview is conducted with a family with the private insurance, blue cross blue shield.

-Page 11 reference a nonbiased therapy party therapist to help with problems. This has been reference in other interviews.

-Mom answers the treatment outcome expectations question in a manner that describes what she wants from treatment, not necessarily what she expects to happen. That is consistent with many other interviews.

Interview 3

-Mom is using many one-word and shorter answers in this interview. It makes me questions how much content I will get from it.

5/29/2018

-Page 4 references family support and showing that they care as a benefit of family therapy. This is consistent with other interviews.

-Page 7 mom makes a statement about how starting PCIT has improved her motivation. It is a very important statement.

Interview 4

-Page 1 references having an unbiased third part as a benefit of family therapy. This is consistent with other interviews.

5/30/2018

-Page 2 references having a non-biased party to provide advice and new techniques. This is consistent with most other interviews.

-Mom references being unhappy with previous family services on page 4, which has been brought up in other interviews.

-Mom references that not being in session is not helpful for progress on page 6. Unique statement, but important.

5/31/2018

-On page 10 there was another reference to having a non-biased outsider as a benefit of family therapy

-Page 10 has another reference to family therapy showing support for the son

-Page 11 references family therapy as not being less beneficial than any other services. This is consistent with most other interviews.

-Page 12 references the family therapist being able to see the behaviors in action as a benefit. This is unique when compared to other interviews, but a significant code nonetheless.

-Page 12 states that family therapy will increase the son's motivations to achieve his goals.

-Another reference to the benefit of a non-biased therapist on page 12. This time it directly relates to an increase in motivation.

-Page 12 contains a code that states all family members will increase the skills and tools they have in family therapy.

-Page 12 has multiple important codes in interview 4.

-Page 13 has reference to gaining a different perspective of her son, which is consistent with multiple other interviews

-I struggle with what type of verbiage to use when referencing the interviewee. Mom? Parent? Or just stating their desires without referencing the person?

Axial Coding

6/9/2018 (Interview 1)

-As I am beginning the axial coding process, the organization of the open codes is making me want to revisit and redo some of the open coding I have already done.

6/10/2018 (Interview 1)

-I would like to come up with a more concrete way of analyzing the axial codes for inclusion. As I am organizing them I am informally guessing which ones are useful or not, but that does not seem like an organized way of completing the process in the long run.

6/11/2018 (Interview 1)

-Viewing the codes in a more organized form makes me want to reorganize some of them underneath other questions.

6/12/2018 (Interview 1)

-I feel as though I gained very little insight toward the codes simply by organizing them. The process was very tedious.

6/23/2018 (Interview 1)

-I am finding it difficult to find an exact step-by-step process of how to do axial coding.

7/3/2018 (Interview 1,2,3,10)

-It appears as though some of the open codes may need to be revised to make the language more succinct.

7/29/2018

-During the axial coding process for the second interview, it has become apparent that the family has generally had higher agency scores and lacked pathways scores. However, with the idea that family therapy will improve pathways through skill building in family therapy, agency scores appear to have gone up have gone up even more.

-The family in interview 2 appears to believe that any skill or insight gained through family therapy will help them accomplish their goals for the child.

-Major themes of interview 2 that family therapy will provide: support, skill building, insight.

8/13/2018

-Axial coding is becoming more fluid to conduct and complete.

-Common axial themes between interviews are beginning to emerge.

8/14/2018 (Interview 6)

-The interview appears to show low agency for both the guardian and the child. Is there a relationship between hope scores between generations of a family (ex: low guardian agency often means low child agency)?

-In this interview it appears that family therapy may have raised the hope scores for the guardian, but they are not high enough to believe that goals will be accomplished. This is an important reminder that these can be mutually exclusive.

-Low agency scores could be tied to being burnt out.

-Things to consider: The amount of resources a family has in regard to hope (extratherapeutic factor), the number of people available to participate in family therapy (extratherapeutic factor), type of problems (magnitude) and length of time dealing with them.

-Interview 6 differs from the other interviews in that it infers more about the research questions than directly answers questions (like in the other interviews).

8/15/2018 (Interview 10)

-I have skipped to interview 10 after completing interview 6 axial coding in order to complete the largest of the interviews, making the work easier it is completed.

-Hope talked about in reference to religion (extratherapeutic factor)

8/17/2018 (Interview 10)

-Religion appears to be another extratherapeutic factor that influences both agency and pathways in this family.

Interview 9

-Type of insurance infers SES, which could relate to the extratherapeutic factors available to the family (resources, history of overcoming barriers)

8/18/2018 (Interview 9)

-Mom makes an interesting statement that her hope levels are related to the effort (agency) that the children demonstrate. Systemic in nature.

-What is the relationship between hope scores and willingness to participate in family therapy?
Did they seek family therapy, were they recommended it, or is it mandatory?

8/20/2018 (Interview 8)

-Parent ties hope to the extratherapeutic factor religion, as has other parents in interviews.

9/1/2018

-Many of the selective codes that I have found to begin the process were patterns that I noticed during the axial coding phase.

9/2/2018

-All of these interviews involve families that have tried other services before engaging in family therapy. What effects could that have on their hope?

9/3/2018

-The more selective codes that are being grouped makes the entire selective coding process easier.

-Providing labels for the actual selective codes makes the selective coding process easier as well.

-Adding color to axial codes that could potentially become selective codes is beneficial for later grouping.

Notes for Writing

-P.278 of Saldana reminds us that theory is tentative in nature, thus we should use language consistent with that tentative nature, such as “something **may occur**” or “thing **tend to.**”

-P.279-280: Glaser via Saldana: “Category relationships are needed to develop assertions, propositions, hypotheses, and theories.” Different types of categorical relationships are available on this page.

-The goal of the theory generated should be that it is a single sentence in length. P. 277 of Saldana suggests that a theory should explain a how and/or why something happens by stating its cause and outcomes; and it provides insights and guidance for improving social life. It predicts and controls action through an if-then/when-then/since-that’s why logic; it accounts for variation in the empirical observations. If a theory cannot be formed, you can utilize a key assertion instead, which is basically a summative and data-supported statement.

-All key assertions and theories should be italicized or bolded in the final report. The same holds true for any significant codes, themes and concepts (p. 282 Saldana).

-Utilize headings and subheadings in your final writing often. Use code, category, theme and concepts labels themselves as headings and subheadings frequently in the writing (Saldana, p. 283).

-P. 283 Saldana, include a matrix display consisting of a major code or theme in one column, followed by an example code or theme (quote) in the second column, then a short interpretive summary of how the major code or theme relates to the overall analytic scheme, or contributes to the study’s conclusions.

-After a description of the participants and the particular data collected for a study, descriptions of coding and analysis procedures generally include: references to literature that guided the analytic work; qualitative data organization and management strategies for the project; the

particular doing and data analysis methods employed and their general outcomes; and the type of CAQDAS programs and functions used (Saldana, p. 284).

-The sampling methods used are a good defense to answer many questions asked about the theory created (Urquhart, p.135.)

-How the emergent theory relates to existing literature needs to be carefully explicated (Urquhart, p.137). It is much easier to demonstrate that it is making a scholarly contribution if the role of the new theory can be demonstrated in the context of existing theory.

-How much context should be presented in the study (Urquhart, p. 152)?

9/7/2018

-Learning new skills as a family is the ultimate pathway to success.