2018

Exploring the Experiences of Clinicians Dually-trained in Behavior Analysis and Family Therapy Working with Families Facing Autism

Janessa Dominguez
Nova Southeastern University, janessa.dominguez@shaping-change.com

Follow this and additional works at: https://nsuworks.nova.edu/shss_dft_etd

 Part of the Marriage and Family Therapy and Counseling Commons, and the Social and Behavioral Sciences Commons

Share Feedback About This Item

Exploring the Experiences of Clinicians Dually-trained in Behavior Analysis and Family

Therapy Working with Families Facing Autism

by

Janessa Dominguez

A Dissertation Presented to the

College of Arts, Humanities, and Social Sciences

In Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

Nova Southeastern University
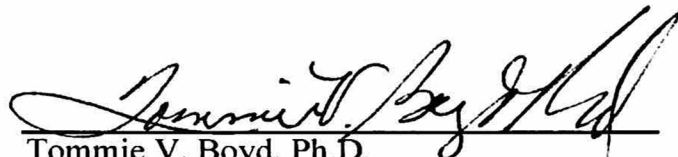
2018

Nova Southeastern University
College of Arts, Humanities, and Social Sciences

This dissertation was submitted by Janessa Dominguez under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, and Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Family Therapy at Nova Southeastern University.
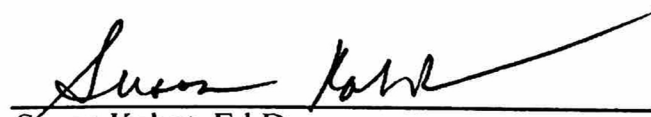
Approved:
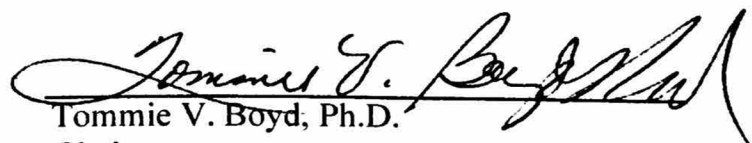
11/20/18
Date of Defense

Tommie V. Boyd, Ph.D.
Chair

Anne Rambo, Ph.D.

Susan Kabot, Ed.D.

12/12/18
Date of Final Approval

Tommie V. Boyd, Ph.D.
Chair

Acknowledgements

I would like to thank my chair, Dr. Tommie V. Boyd, for her support, guidance, and patience throughout my dissertation process. She has been such a pillar of strength for me—in her expertise and encouragement throughout my dissertation process. I'd like to thank my committee members, Dr. Anne Rambo and Dr. Susan Kabot. Their feedback and insight were greatly appreciated. I would also like to extend thanks to my professors, and a special thank you to my staff, who have been incredibly supportive in my fulfillment of the requirements for this program and this research study.

I am so thankful to have the support of my entire family. I have no words to describe the gratitude I feel to have such an amazing family. My parents, Jacqueline and Jorge Dominguez, who have really engrained in me the importance of education and have been so encouraging throughout this process and continuously checked in on me to make sure I was still working to fulfill my dream of completing this doctoral program. My brother, Jordy, who is my rock; I always try to set a good example for you. Thank you for everything. My grandfather, Abo, who I'm sure is smiling down from heaven, thank you for always believing in me.

TABLE OF CONTENTS

List of Tables

Abstract

The main aim of this dissertation is to identify the importance of utilizing both a behavior analytic lens and systemic thinking lens when working with families with children diagnosed with Autism Spectrum Disorder (ASD). Currently, the prevalence of ASD is on the rise, which means more families are in need of services. Services are typically available for the individual with ASD or the family; however, it is the researcher's belief that services delivered utilizing a both/and lens are more impactful. Through the use of transcendental phenomenology, trained behavior analysts and marriage and family therapists were interviewed to gain insight into their experiences working with families with children diagnosed with ASD. Specifically, this dissertation focused on clinicians who implement both lens. The findings of the study revealed three central themes and two subordinate themes: Participants noted boundaries that influence a dual perspective, Participants found it useful to use a dual perspective, Participants noted this is a different approach not shared by others, Participants found it useful to apply ABA and systemic thinking in a specific order, and Participants found a larger systems perspective useful. The experiences of participants were captured through these themes. Their experiences suggest that the utilization of a dual perspective, while challenging, is more beneficial to families with children diagnosed with ASD. This demonstrates a large need for dual perspectives' training in both ABA and systemic thinking fields.

CHAPTER I: INTRODUCTION

In the last decade, from the early 2000s until present day, the diagnosis of Autism Spectrum Disorder (ASD) has been on an upward climb. According to the National Health Statistics Report (Zablotsky, Black, Maenner, Schieve, & Blumberg, 2015), one in 45 children, ages 3 to 17 years, have been diagnosed with ASD. This report is based on a parent survey; therefore, it does not replace the 1 in 59 statistic provided by the Centers for Disease Control and Prevention (2018). For the purpose of this study, the researcher will refer to diagnoses of ASD, Asperger's syndrome, Attention Deficit Hyperactivity Disorder (ADHD) as ASD and related disabilities. Over the years, the researcher has found there are more and more individuals being diagnosed with these disorders, especially ASD (Matson & Kozlowski, 2011).

Gergen (2009) discusses transformative dialogues, where different traditions can create realities and meaning. Language can not only create, but it can also dissolve. Thus, if language created labels, then language can dissolve them. If in therapy, we as therapists can use the combination of linguistic shading and transformative dialogues to shift the way people use labels and then those people carry that new language out into society, we can eventually dissolve the language of labeling. The researcher says labels and not diagnoses because as mentioned before, she can see the benefit of diagnoses. It is when the labels become a stigma, the problem is created.

Additionally, the researcher has noticed a disappointingly low number of services available for the family of the individual with special needs. Siblings are often overlooked, and parents are frequently stressed, overwhelmed, and unsure of "what's

next." The gap between the diagnosis, the services for the individuals, and the whole system involved needs to be bridged.

Applied Behavior Analysis

In the field of applied behavior analysis (ABA), change is seen as a difference—it could be a huge difference or the subtlest of differences. Either way, we are taught to reinforce this change and teach those in the "identified client" system to also reinforce this change, as this signifies an individuals' success and progress toward their goals. This is the process of shaping (Cooper, Heron, & Heward, 2007).

The researcher embraces change in the same manner, setting goals with clients and working toward those goals through change. A difference can be made by the system or by the "identified client" to achieve change. Bateson (1972) talks about "a difference which makes a difference" (p. 459). To the researcher, this is the difference that is made by the family to help the "identified client" or the difference made by the "identified client," which then has an effect on the overall progress towards reaching his or her goal.

By looking at the family as part of the system, there is a distinction that is drawn here between ABA and systemic thinking, which suggests that they are distinct and not included in one another. Applied behavior analysis is considered to be a lineal epistemology, but if you look at who is involved in the process, the goals of the interventions, and how behavior analysts view change, you will see that on the surface it seems very lineal. In reality, it is quite systemic and circular.

Systemic Thinking in Marriage and Family Therapy

Patterns from human interactions with the environment and other organisms and from our self-beliefs are used to construct our worlds—our realities (Keeney, 1983). How

does our reality differ from the reality of others? Bateson (1972) describes difference as change. Then, in reality, a difference is a change in perspective and a change in how each individual selects the patterns and information provided. A change, as Bateson (1972) explains it, is not the same across fields of study. In hard sciences, effects are brought about by concrete events (ABA); whereas, in soft sciences (family therapy), effects "are brought about by differences" (Bateson, 1972, p. 458).

Systems thinking beautifully complements the foundation and process of ABA: finding the problem, finding who is involved in the problem, and implementing interventions. Systems thinking also moves away from the constant underlining of problems, issues, and deficits, and highlights the exceptions; not only the exceptions in the individuals' behaviors or skills, but also the exceptions for the family. In the researcher's experience, these families want someone to hear their story, but the professionals they encounter are not always able to, or willing to, give them the time to talk.

Self of the Researcher

Working with the special needs population (e.g., Autism Spectrum Disorder [ASD], Asperger's Syndrome, Attention Deficit Hyperactivity Disorder [ADHD], and other related disabilities) and their families for the past 7 years has opened the researcher's eyes to the gaps that exist in providing services. The researcher thinks it is important to help these families see the pros and cons of the diagnoses and how to use that language to receive the necessary services. There is such an increase in the diagnosis of these disorders, it would be important to show these individuals and families that "constructing worlds together, as opposed to separately" (Gergen, 2009, p. 118), through

transformative dialogues, could create a new social and cultural construct and new meaning for the diagnosis.

The researcher's time in the Mental Health Counseling master's program was career changing. As she was becoming more aware of the distinctions that labels create, she was noticing it in her work. The researcher became credentialed as a Board Certified Behavior Analyst (BCBA), and began to work more closely with the whole family, not just the individual receiving services. Some of the families she worked with had just learned about the diagnosis, and they were struggling to look past it. Others had lived with it for years and were still struggling to accept it.

The researcher's Marriage and Family Therapy (MFT) doctorate education bridged the gap that she was experiencing in her work: the gap between the diagnosis, the services for the individuals, and the whole system involved. The researcher had become a systems thinker, looking at the parts and the sum of the parts. Since this time, it has been her goal to provide a different type of service. By different, she means different than what had been traditionally offered to the population of individuals with special needs.

The researcher's goal has been to combine ABA with MFT, regardless of the former being considered linear and the latter being circular. Working with these families for so many years has shown the researcher that they are the experts. They spend the most time with the individual, even if the individual is in multiple therapies, such as applied behavior analysis, occupational therapy, or speech therapy, which are common models of treatment for this population. What better way to construct a treatment plan than to receive help and guidance from those who know the individual best?

Additionally, the researcher has noticed a disappointingly low number of services available for the family of the individual with special needs that incorporate the entire system. Siblings are often overlooked, and parents are frequently stressed, overwhelmed, and unsure of *what's next*. The researcher would like to be able to provide services to everyone, using the knowledge she has gained from her entire academic career.

Having worked in various settings, the researcher can see an advantage and benefit to practicing in multiple settings. A clinic setting is effective for individuals who need a more structured setting or have a hectic home, and for parents who want or need to get away for a short time, to talk to someone. A home, school, or community setting provides a natural environment, where chores, tasks, or activities occur. Home settings may also work well for parents who have a lot on their plate and cannot fit *going to therapy* into their schedule.

Several years ago, in conversation, the researcher was told, "If you know one individual with autism, you know *one* individual with autism" (Dr. Susan Kabot, personal communication, August, 2009). This has stayed with the researcher and surfaces each time she meets with a new client. Keeping this in mind and having a strong conviction that it is true, not only of individuals with special needs but of all cases or similar situations, the researcher believes her approach needs to be flexible and vary based on each individual case.

Being in private practice as a behavior analyst for over 3 years now, the researcher has been applying and implementing MFT techniques and strategies. She has found that she is able to join much more with families by matching and using their language. It has also been very noticeable that working in collaboration with the family,

the school, and all other service providers, yields a better treatment plan and flow of services. Consistency is extremely important with this population and using a systemic approach allows for an increase in consistency and effectiveness.

Not having a child herself, the researcher cannot imagine what it is like to have one who may or may not be diagnosed. However, working with this population, she has seen how the language of diagnosis has helped diagnosed individuals to receive services, funding, and special accommodations, where necessary. It is imperative to consider how the use of the language of diagnosis can open the doors to a more successful, accommodating future. Timimi (2004) takes the position of labels not being useful, specifically the ADHD label. The researcher disagrees with Timimi (2004), finding that labels can be beneficial to individuals. There are always multiple sides to a story and, in this case, the other side offers services in school, in the community, and out of school.

Working with individuals with ASD and seeing how it affects the family system as a whole, has made the researcher appreciate this philosophy of treating the entire system. Merging the fields of ABA and MFT, targeting individuals with ASD and behavioral challenges, while also working with their entire system, would be a more effective therapy.

The researcher has found her approach to practicing ABA very similar to systemic ideology. She is identifying the problem, asking what has been done, and discussing the context in which the behavior is not exhibited. The researcher facilitates change by developing socially significant goals for the client and highlighting the importance of shaping. Shaping is the reinforcement of small changes that lead to the larger goal.

From her work as a behavior analyst, the researcher has noticed that what is missing is family and system involvement in reaching the goals. The system is present when we are looking to make changes, but then there is a huge reliance on therapists to make those changes happen. By working with the entire system, the researcher can facilitate the change in the system and not just in one individual. Individuals need repetition and consistency, as per the assumptions of ABA. If the entire system can be involved in the change and help the individual have more consistency, the progress would be enormous.

As a systemic thinker, the researcher can see there is a missing piece in the model of ABA. It addresses the issues of the identified client and of those who interact with the client whose challenges are directly related to those of the client; however, the problems of those around the identified client, regardless of their relation to the identified client, are as yet unaddressed. The goal of this study is to explore the experiences of individuals trained as both behavior analysts and marriage and family therapists when working with families with children diagnosed with ASD.

Statement of the Problem

Considering how these different fields and these different epistemologies play a role in what the researcher knows, how they are distinct and not included in one another, and how they are in a homeostatic balance, allows for questions to be asked in a certain order. Thus, the question arose—why is it that these two epistemologies cannot be included in one another?

In *Completing Distinctions*, Flemons (1991) introduces a limbercated form. A limbercated form is a matrix used to "explore how . . . systemic thinkers characterize the

whole/part relations composing the patterned world of mind" (p. 23). In a limbercated form, a distinction is made between two things that are also connected. In other words, "each side exists by virtue of the difference that separates it from, and connects it to, its complement" (p. 22). Flemons uses the example "COMPLETION / (CONNECTION/separation)" (p. 23) to demonstrate the distinction and connection between two complementary things and how it can be looked at as a whole, by giving it a name.

If we were to create a limbercated form to show this "whole/part relation" (Flemons, 1991, p. 23), it would look like this: EPISTEMOLOGY / (LINEAL/nonlineal). In this matrix, we started with nonlineal, which has a distinction from lineal, on the left, but both are somehow related. When you look at the whole, you see an epistemology—a way of knowing that is composed of lineal and nonlineal thinking. In order to have an effective therapy session or therapy practice, the researcher believes you need the content in order to get to the process and to understand and make sense of the process.

If we take this a step further to consider the relation and distinction between ABA and systemic thinking in MFT, as this is what the researcher hopes to accomplish in practice, we can develop a limbercated form that looks like this: SYSTEMIC BEHAVIORAL THERAPY / (SYSTEMIC THINKING IN MARRIAGE AND FAMILY THERAPY/applied behavior analysis). In this matrix, systemic thinking in MFT includes ABA, and the whole is labeled Systemic Behavioral Therapy.

The ideas of observing behavior, creating measurable goals, defining the problem, changing behavior, and reinforcement from ABA are infused with the systemic perspectives, circular thinking, and relational aspects from systemic thinking in MFT.

Both fields want to help their clients help themselves.

       The use of language applies to therapists as much as it applies to the client. The way therapists word their questions may reveal their epistemology. Their use of nouns, Keeney (1983) says, may reveal epistemology. Nouns are also multifunctional. While nouns may be used to diagnose, drawing that distinction between the rest of society and the identified patient involves a huge epistemological knife (Keeney, 1983). The client may then view him or herself as that label, that diagnosis. On the other hand, it could be that language that results in a change.

       By coming together as a whole, they are complementing each other. When the researcher thinks of complements, homeostasis comes to mind, as well as yin and yang. Keeney (1983) describes that differences between two things "should not be taken as an either/or duality" (p. 62). When you look at yin and yang, while they are two distinct elements, they come together to create a balance, a type of homeostasis. Similarly, ABA and MFT come together to complement each other and create a homeostatic balance of lineal and nonlineal ways of conducting therapy. Therefore, instead of looking at ABA and MFT as two distinct epistemologies, where one is not included in the other, we should look at them as having a distinction and also being connected to create balance.

       If we were to look at how we create balance in the therapy room, we can see that there is homeostasis throughout the session. By this, the researcher means that the client and the therapist complement each other in the ways they interact and the roles they play, and the therapist maintains homeostasis in the questions he or she asks. The client is an expert on his or her own life, which means the therapist is the nonexpert in the client's life. This creates a balance where the therapist can then use his or her non-expert role to

inquire about the client's life and issues faced, which brought him or her to therapy. Bringing this back to lineal and non-lineal complementarity, the researcher believes it is in this instance of therapy where the therapist is gathering content information to inform later process questions and information.

Purpose of the Study

The researcher thinks each client is different and each therapist should treat each client differently, even if he or she has a diagnosis one has worked with before. Therapists need to consider how the use of labeling nouns will affect the client as well as the client's whole system. Therapists also need to be aware of the positives of labels. For example, someone with a disability may be able to receive more services if they have that noun added to his or her file.

The researcher agrees with the assumption "that people are resilient and resourceful" (Nichols, 2011, p. 249). Having the belief that our clients are resilient and resourceful helps us, as therapists, to believe in our clients and believe that change is possible. This assumption changes the therapists' attitudes. The researcher strongly believes that people express how they feel through their verbal and nonverbal language; thus, if a therapist does not believe their clients are resilient or resourceful, it will show in the way they speak to the client and behave towards the client. Who wants a therapist that does not believe a client can change?

It is important for therapists to treat each client as unique. No two individuals are the same, no two systems are the same, and, therefore, therapists need to treat each client as an individual. If not, they are imposing their assumptions on others. The aim of this

study is to explore the experiences of clinicians dually-trained as both behavior analysts

and family therapists when working with families facing autism.

CHAPTER II: LITERATURE REVIEW

Autism Spectrum Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; 4th ed., American Psychiatric Association [APA], 2000) identified ASD as part of the pervasive developmental disorders (PDD) group. Impairments in social interactions and communication, as well as repetitive behaviors are features of ASD (APA, 2000). In 2013, the Diagnostic and Statistical Manual of Mental Disorders (APA) removed ASD from the PDD group in the 5th edition. Autism is now categorized in its own group as Autism Spectrum Disorder and has 3 levels—1, 2, and 3; which represent mild, moderate, and severe needs for support, respectively.

According to the DSM-5 (APA, 2013), the new definition of ASD is more accurate, and a more medically and scientifically useful approach. Diagnostic criteria continue to remain the same: deficits in social communication and interaction and restrictive, repetitive behaviors (APA, 2013). Previous research illustrates that ASD encompasses a wide range of phenotypes in the way behavior is expressed in ASD (Hastings, Kovshoff, Espinosa, Brown, & Remington, 2005).

Earlier research indicates that parents raising a child with a disability experience more stress than parents who are raising a typically developing child (Ireys & Silver, 1996), and that stressors affecting one member of the family affect other members of the family (Riley & Waring, 1976; Rogers & Hogan, 2003). Additionally, changes in job, pay, and sleep patterns are significantly affected by raising a child with a disability (Rogers & Hogan, 2003). Depending on the severity of the child, individuals diagnosed

with ASD, and their families, face very different challenges in locating rehabilitative resources due to the services available (Rogers & Hogan, 2003).

Research has focused on the effects of behavior problems of children with ASD on the family (Baker, Seltzer, & Greenberg, 2011), the lack of support for families with children with ASD (Boyd, 2002), the stress and coping of families with children with ASD (Meadan, Hale, & Ebata, 2010; Pottie & Ingram, 2008), and what life is like for a family with a child with ASD (Rogers & Hogan, 2003). The studies by Baker et al. (2011), Meadan et al. (2010), Pottie and Ingram (2008), and Rogers and Hogan (2003) emphasize the stress the families must learn to cope with, the difficulties of having a child with ASD, and the hardships of finding support and services. Professionals lack effective solutions to help these families. Cognitive-Behavioral Family Therapy (CBFT) interventions have been shown to be effective when treating families and couples in therapy (Dattilio & Epstein, 2005). By utilizing CBFT to treat families with children with ASD, the families learn strategies to help them cope with challenging behaviors to reduce family stress (Dattilio & Epstein, 2005).

Baker et al. (2011) veered away from what previous research was focusing on in the area of stress on families with children with disabilities, more specifically, ASD. Previous research typically focused on child effects, where researchers would look at how raising a child with a disability affected the family (Crnic, Friedrich, & Greenberg, 1983; Scorgie, Wilgosh, & McDonald, 1998). Instead, Baker et al. (2011) focused on how the families' level of adaptability to having a child with ASD affected the mother— the aim was to examine depression in the mother over time.

Family adaptability is the family's ability to change in situations of stress. Adaptability includes coming up with solutions to problems and alternate solutions and a family's ability to compromise and shift roles and responsibilities (Minuchin, 1974; Olson, Sprenkle, & Russell, 1979). In the study by Floyd, Harter, and Costigan (as cited in Baker et al., 2011), a link between child behavior problems and the family's ability to be flexible and reorganize around what is happening was found. However, this study was not longitudinal, and did not examine the long-term outcomes of maternal depressive symptoms (Baker et al., 2011).

Baker et al. (2011) examined 406 adolescents and adults with ASD living in Massachusetts and Wisconsin across a 3-year period. The mothers of the individuals were involved by participating in interviews and questionnaires. Olson, Portner, and Bell (as cited in Baker et al., 2011) used the revised version of the Family Adaptability and Cohesion Evaluation Scales-2nd edition (FACES II) to measure family adaptability. The items on this scale measured aspects such as how well the family compromised, how well they came up with new and alternate solutions to problems, and the flexibility of shifting roles and responsibilities (Baker et al., 2011). To measure behavior problems, the researchers used The General Maladaptive Index of the Scales of Independent Behavior Revised—SIB-R (Bruininks, Woodcock, Weatherman, & Hill, 1996). In this scale, the mothers were asked if the behavior had occurred within the last 6 months and the frequency, if it had occurred. The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was used to measure the depressive symptoms of the mothers. The participants were asked to rate how often specific statements applied to them within the last week.

The findings of the study suggest that family adaptability may influence the depressive symptoms of mothers, as well as the behavior problems in the adolescent or adult with ASD. It was also evident that children with ASD respond to their family environment, and that individuals with ASD may be receptive to the changes made by the family system. This study demonstrates how a larger family system may influence the behaviors of individuals with ASD and the depressive symptoms of the caretaker by being flexible, compromising, and developing new solutions (Baker et al., 2011). However, this study is limited in that it only took the mothers' symptoms into consideration and not the family system as a whole. Additionally, while this study suggests the benefits of flexibility and compromise in developing new solutions, it does not provide the families with the tools and resources necessary to do so.

Meadan, Hale, and Ebata (2010) looked at the impact of behavior repertoires of children with ASD on their families. The article examined stressors and supports for families of individuals with ASD. The researchers focused on stress in the marital, parental, and sibling subsystems; coping strategies; and the sources of support.

Parents of individuals with ASD reported having more stress than parents of individuals without disabilities or with other disabilities (Abbeduto et al., 2004; Baker-Ericzen, Brookman-Frazee, & Stahmer, 2005; Weiss, 2002). Research on levels of stress and well-being of family members and the source of the stress link the individual with ASD and the family members in a linear way (Hastings et al., 2005). The family relationship was looked at as a cause and effect relationship, where the individual with ASD was the source of the stress. However, taking a family systems perspective shows

that the family has an impact on the individual with ASD, and that family members may impact each other (Hastings et al., 2005; Meadan, Hale, & Ebata, 2010).

Pottie and Ingram (2008) conducted a study to examine the effects of stress on the well-being of parents with children with ASD. The aim was to explore the adaptability of parents raising a child with ASD and to identify their coping responses. Abbeduto et al. (2004) found that parents who can cope successfully using problem-focused strategies had less psychological distress. In congruence with the literature, the researchers hypothesized that the use of withdrawal, escape, or blaming coping mechanisms would result in lower levels of positive mood and higher levels of negative mood. Conversely, the use of problem-focused or emotional regulation coping skills would result in higher levels of positive mood and lower levels of negative mood (Pottie & Ingram, 2008).

The researchers recruited 93 participants for their 12-week study (Pottie & Ingram, 2008). The participants recorded their own data by completing the daily data sheets provided by the researchers. Daily stress and coping skills were then assessed by using a modified version of the Daily Coping Inventory (DCI) (Stone & Neale, 1984). The participants were asked to rate whether they used any of the 11 coping responses provided. The coping responses were used to identify which, if any, the parents were using, and if they were successful in helping them cope with stress and increase positive mood (Pottie & Ingram, 2008).

Pottie and Ingram (2008) found that parents who used coping strategies such as social support, compromise, and problem-focus had higher levels of positive mood, while parents that used helplessness, blame, and withdrawal had higher levels of negative mood. This study demonstrated clearly defined, evidence-based coping strategies that

parents with children with ASD may engage in. It took into consideration other stress factors in daily life, to rule them out to avoid skewing the data. Unfortunately, the duration of the study was only 12 weeks, which was not long enough to see the long-term effects of the use of these coping strategies. The study failed to note if the use of one single strategy is effective or if a combination is more effective. It also only focused on parents and left out other subsystems, such as siblings, grandparents, and/or other extended family that make up the larger family system that are involved with the individual with ASD.

The previous literature presented focuses on psychological distress and well-being, neglecting the physical and financial strains placed on a family with a child with ASD. Rogers and Hogan (2003) emphasized the effects of having a child with impairment or a disability on career, finances, and sleep. They also noted the importance of receiving rehabilitation services for individuals with disabilities, and how parents must be resourceful to obtain these services (Rogers & Hogan, 2003).

Rogers and Hogan (2003) began by assessing the type and severity of the child's disability and how it would affect job changes, finances, and sleep. The researchers then determined which services have the greatest effect on families. Lastly, they measured the effects of the services on the three variables of interest. The results of the study found that the more severe the disability or limitations of the child, the greater the effect on job change, financial problems, and sleep disruption. They also found that rehabilitation services, educational services, and visits to professionals negatively affect the family due to time commitment and finances. Likewise, they did not find that the family adapts to the child's disability as the child ages (Rogers & Hogan, 2003).

Furthermore, this study by Rogers and Hogan (2003) captures an aspect of negative effects on families that is rarely explored. Rogers and Hogan (2003) demonstrated the numerous types of rehabilitation services available and that even though they are available, parents and family members must use their resources to find them and to pay for them. On the other hand, the study does not provide a way for families to come into contact with resources nor did it focus primarily on children with ASD. Depending on the severity of the child, individuals diagnosed with ASD and their families face different challenges, in finding appropriate rehabilitative sources, due to the myriad of services available.

Applied Behavior Analysis

Applied behavior analysis (ABA) is the scientific study of behavior, which encompasses a multitude of interventions for behavior reduction and skill acquisition, and promotes the generalization and maintenance of positive behavior change (Cooper et al., 2007). Interventions in ABA focus on socially significant behaviors (Cooper et al., 2007). One of the interventions used in ABA is discrete trial training (DTT) or discrete trial teaching. DTT is a systematic method of instruction; whereby, learning opportunities are maximized based on the principles of ABA (Ghezzi, 2007).

Applied behavior analytic therapy has been shown to be effective in the treatment of children with ASD (Cohen, Amerine-Dickens, & Smith, 2006; Howard, Sparkman, Cohen, Green, & Stanislaw, 2005). Several studies indicate that children with autism display a wide range of problem behaviors, such as task refusal, noncompliance, tantrums, aggression, and self-injury (Tiger, Fisher, & Bouxsein, 2009; Waters, Lerman, & Hovanetz, 2009).

Functional analyses (FA) and functional behavior assessments (FBA) are conducted to identify the function(s) of the problem behavior (Lang, Sigafoos, Lancioni, Didden, & Rispoli, 2010). A FA of behavior focuses on the determinants maintaining a behavior. A FA is a multi-element design, across conditions, which allows researchers to explore various functions of a behavior and conclude which function is maintaining the behavior. Research on the FA infers that this methodology is useful in identifying the function of a wide-range of behaviors, as well as a powerful tool in the process of reducing maladaptive behaviors (Iwata, Dorsey, Slifer, Bauman, & Richman, 1994; Mace, 1994; McCord, Thomson, & Iwata, 2001; Neef & Iwata, 1994; Piazza et al., 2003). However, these analyses take time and are sometimes intricate, as they are conducted in multiple settings where the problem behavior(s) occurs. Furthermore, these analyses can be difficult for the family, as they can be costly, timely, and increase behaviors.

Functional behavior assessments (FBA) were created as a condensed version of the FA originally developed by Iwata et al. (1994). FBAs are commonly used in behavior analytic therapy to identify the problem behaviors and their functions, as well as to generate functionally equivalent replacement behaviors and treatment plans (Cooper et al., 2007). Furthermore, FAs are often conducted in more contrived settings, such as clinic or office settings; whereas, FBAs are conducted in more naturalistic settings, such as the school or home. The function of a behavior is the reason the behavior is occurring, which is determined based on the maintaining consequence (Cooper et al., 2007). Information for FBAs is gathered through direct and indirect methods of data collection (Gresham, Watson, & Skinner, 2001), by means of interviews of parents, caregivers, teachers, or childcare personnel. Direct methods include direct observation, data

collection, and administering skill acquisition assessments. An FBA helps to establish the patterns and relationships between the antecedent, behavior, and consequence. Once the FBA is complete, a behavior plan and skill acquisition programs can be written for each individual.

Trusell, Lewis, and Stichter (2008) looked at the impact of FBA-based interventions on problem behaviors in a classroom setting, and demonstrated that using FBA-based interventions helped to reduce problem behaviors more effectively than the use of other interventions alone. Similar to a FA, an FBA can also take its toll on a family, as family members need to disclose and discuss the challenges they face with their child. Without a skilled interviewer, who can guide the family in answering questions and providing descriptions when conducting the FBA, a family can be left in dismay.

Behavioral research and observation aim to quantify behaviors by operationally defining them. An operational definition clearly depicts the topography of the behavior, inclusive of the magnitude being exhibited (Cooper et al., 2007). An operational definition is one element contributing to reliability in behavior research and observation. It is an objective statement used to measure the behavior and to measure agreement between observers. Direct measurement of the target behaviors by multiple observers looks at the level of agreement between the observers to determine interobserver agreement (IOA, Cooper et al., 2007).

The literature places high emphasis on the efficacy of discrete trial training (DTT), which is a systematic method of instruction, whereby learning opportunities are maximized based on the principles of ABA (Ghezzi, 2007), based on training and

implementation by the facilitators of the sessions (Babel, Martin, Fazzio, Arnal, & Thomson, 2008; Dib & Sturmey, 2007; Tsiouri, Schoen Simmons, & Paul, 2012). The results of the studies demonstrate accurate implementation of DTT increases response rates in students, in addition to response accuracy (McBride & Schwartz, 2003; Reed, Reed, Baez, & Maguire, 2011).

It is evident that DTT is an effective method of instruction for individuals with ASD. The studies demonstrated a wide range of skills that could be taught through the utilization of DTT (Ghezzi, 2007; McBride & Schwartz, 2003; Reed, Reed, Baez, & Maguire, 2011). All of the studies examined yielded results that failed to reject the efficacy of the use of DTT to teach new acquisition skills to students with ASD (Babel et al., 2008; Dib & Sturmey, 2007; McBride & Schwartz, 2003; Reed, Reed, Baez, & Maguire, 2011; Tsiouri et al., 2012). All of the studies reviewed support earlier research, which validates the effectiveness of DTT to teach communication, receptive language, imitation, and social skills to name a few—although there are many more skills that can be taught with the implementation of DTT (Lovaas, 1987).

Lovaas (1987) discussed the use of DTT across all skill levels and the array skills that can be taught. According to Ghezzi, (2007), individualized DTT instruction can be used for any and all students with ASD with the addition of appropriate supplemental methods, such as prompting and reinforcement.

Research has been conducted on numerous early interventions for children with ASD. This research covers a vast range of treatments, methods, measures, and targeted skills. Much of the research focuses on communication-based interventions, exploring initiation of joint attention, requesting, spontaneous communication, and turn taking

(Lawton & Kasari, 2012; Gordon et al., 2011; Yoder & Stone, 2006). It is widely agreed that deficits in communication and language skills are the core characteristics of ASD and are an essential element in early intervention programs for children with ASD (Lim, 2009; Paul, 2008; Prizant & Wetherby, 2005). Additional research on communication development and language skills target these skills through the use of Skinner's (1957) verbal behavior (VB), which is an applied behavior analytic (ABA) approach to communication, speech, and language.

Both Sallows and Graupner (2005) and Lovaas (1987) focused on increasing the overall functioning level of young children with ASD to *near normal* functioning based on intelligence quotients (IQ). In addition, ABA is commonly used to decrease inappropriate or unwanted behaviors (Ulke-Kurkcuoglu & Kircaali-Iftar, 2010), especially in the classroom setting. Researchers also place an emphasis on reducing automatically reinforced behaviors through sensory integration (Hodgetts, Magill-Evans, & Misiaszek, 2011) and response interruption and redirection (Ahrens, Lerman, Kodak, Worsdell, & Keegan, 2011).

A study by McPhilemy and Dillenburger (2013) looked at the experiences of parents of a child with ASD and ABA-based interventions. The study explored the experiences of 15 families implementing ABA in a home-based program. The researchers found that parents had positive experiences with ABA in the areas of skills acquisition, challenging behavior, communication, and independence. Parents also reported a positive impact on quality of life and feeling hopeful for the future.

Relationship Systems in Marriage and Family Therapy

Maturana (1988) states there are two explanatory paths—objectivity without parenthesis and objectivity in parenthesis. In the former, individuals see existence as an independent entity, where they do not have an effect on the world around them. Thus, Maturana (1988) goes on to explain that this path is blind. In the latter explanatory path, individuals see themselves as part of their environment, and as having an effect on it. Therefore, in this path, he explains that the individual believes in multiple realities.

Varela (1984) has a similar view to that of Maturana (1988), as Varela suggests there is a "paradox unless I am willing to let go of the need to choose between true or false" (p. 4). He believes the paradox lies in the difficulty of stepping outside one's own level of meaning and examining the larger domain. Varela (1984) also believes in the circularity of operations and products. He refers to a tangled structure, where levels of meaning and linguistics intertwine.

Maturana (1988) and Varela (1984) both view reality, linguistics, and levels of meaning and understanding as being circular and intertwined, where one may affect all and all may affect one. Both would agree that an individual conducting therapy is as much a part of the therapy session as the client(s) they are working with. When one applies this to diagnosis, it can be inferred that both would discourage therapists from being blind by taking the path of objectivity without parenthesis and allowing the paradox of being tangled to make them choose between true or false.

While diagnosing can be beneficial to the individual seeking diagnosis or the family seeking a reason as to why *this* is happening, Maturana (1988) and Varela (1984) would take the path of objectivity with parenthesis and avoid becoming blind by being

certain. Gergen, Hoffman, and Anderson (1996) describe diagnosis as a "naming bind" (p. 2). The researchers explain how there is this socially constructed notion of real versus not real, and how many clinicians have the perception that diagnosis is the way to help clients and make the diagnosis and symptoms a part of their reality.

Going back to taking the path of objectivity with parenthesis, we see that what makes something real may not be the diagnosis itself; it may simply be having the view that multiple realities exist and that the clients' reality is real. When we diagnose, we may be silencing the child who never had a say in how he or she was feeling and what was going on, or the adult who is just going through a hard time, or the elder person who is adjusting to his or her new reality of getting older and reminiscing on the past.

Even though diagnosing can create stigmas and blinded certainty and uni-perceptional realities, "diagnostic systems give a sense of legitimacy, confidence, and predictability both to the professional and to the client" (Gergen, Hoffman, & Anderson, 1996, p. 3). Take, for example, the family with a child with ASD. The diagnosis may help them receive services such as occupational therapy, speech-language therapy, and behavior therapy. It may help them get their child into schools more appropriate to their needs and get help to pay for all of this from their insurance company.

Brown (2004) argued that there can be some benefits to diagnosing. Now the question is: To whom is diagnosing beneficial? Diagnosing is beneficial to everyone in the system. As postmodern clinicians, we believe that individuals are part of a larger system. Thus, a diagnosis may be beneficial to everyone involved in the system of the individual. A family with a child with ASD may benefit from a diagnosis because the diagnosis will externalize the problem (White & Epston, 1990). It may change the

family's and the child's worldview from the child being a "bad child" to the child being challenged by ASD.

Postmodernism is the philosophy of accepting other schools of thought and other practices, while, at the same time, questioning the efficacy and validity of them (Shawver, n.d.). In our attempts to be postmodern clinicians, it is important that we take into consideration how diagnosing would affect the client and his or her system (whether beneficial or not), and, also, how evidence-based treatment in collaboration with MFT may be useful. If the language of evidence-based treatment is of interest to our clients, then who are we to say that they are incorrect? Instead, we should continue to conduct therapy as we do—as a linguistic system (Anderson & Goolishian, 1988)—and take the non-expert stance that our clients know what is best for them to create a balance between evidence-based practice and staying true to our non-expert role.

As systemic and postmodern thinkers, we acknowledge and accept the existence and practice of other models and we can use this language to build a collaborative relationship with the other disciplines (Shawver, n.d.). As such, individuals trained as both behavior analysts and marriage and family therapists may experience working with families with children with ASD differently than clinicians trained in only one discipline. Research indicates the potential benefits and pitfalls of each discipline, but it does not explore the experiences of individuals dually trained when working with families with children with ASD.

Benefits of Utilizing a Both/And Lens

Kelly and Tincani (2013) identified a lack of research in the area of collaboration for the practice of ABA. The researchers surveyed 302 behavioral professionals regarding

their collaborative training, if any, and how they collaborate in practice. Of the professionals surveyed, 95% worked with individuals with ASD. Kelly and Tincani (2013) found that while the ABA professionals frequently collaborate, most reported little to no formal training in collaboration, a tendency to make, but not adopt treatment recommendations, and lowered ratings in the value of collaboration within their practice. The researchers indicated a strong need for collaborative training amongst ABA professionals to achieve best outcomes.

Two areas that tend to have more collaboration are speech-language pathology (SLP) and special education. The history of collaboration between ABA and SLP dates back to the early 90s, with clinicians with expertise in both fields creating evidence-based approaches (Dyer & Kohland, 1991; Frost & Bondy, 2001; Koegel & Koegel, 1996; Reichle & Wacker, 1993). The *Journal of Speech-Language Pathology and Applied Behavior Analysis* focuses on the collaboration between these two fields, focusing on SLP utilizing behavioral strategies during the implementation of therapy (Cautilli & Koenig, 2006).

Koenig and Gerenser (2006) address the collaboration between speech-language pathologists and behavior analysts through a historical sketch. These researchers looked at the importance of the collaboration due to the overlap of concerns addressed by each field and the shared interest in improving communication. Koenig and Gerenser (2006) highlight the advantages of collaboration as increased support and evidence-based interventions. The researchers identified shared treatment efficacy, shared procedures, and shared concerns among the recommendations they delineated for collaboration.

In another study by Simons (2014), ABA and SLP were merged during the training of SLP graduate students. In this study, the researcher utilized ABA strategies to train the graduate students when working with individuals with ASD. Simons (2014) trained them in basic concepts of ABA and then provided coaching during therapy sessions to the graduate students. The study found an increase in the implementation of behavioral strategies during therapy sessions, making it more effective to manage challenging behaviors and promote desired behaviors.

Another discipline that has been merged with ABA is special education. Loiacono and Allen (2008), explored the integration of ABA into special education classrooms, and the preparing and training of teachers to support such classrooms. The researchers found very low percentages of special education teachers trained in ABA. They found that school districts in the area studied do offer workshops and staff development trainings in ABA to teachers; however, only 25% of the colleges and universities examined offered ABA training within the special education program.

Furthermore, Bateson (1972) views difference as change and believes that change in hard sciences is brought about by concrete events and change in soft sciences is "brought about by differences" (p. 458). Keeping this belief in mind, the researcher considered how these different fields, these different epistemologies, played a role in what we know; how they are distinct and not included in one another and how they are in a homeostatic balance, allowing for questions to be asked in a certain order. Thus, the question arose—why is it that these two epistemologies cannot be included in one another?

According to Bateson (1979), epistemology is defined by "how particular organisms or aggregates of organisms know, think and decide" (p. 228). That is to say that epistemology is the study of how we know what we know. We know there are lineal and non-lineal epistemologies, where interrelation and context are the focus, and relationships and systems are emphasized, respectively (Keeney, 1983). We also know that in a lineal epistemology there is a cause and effect way of thinking; whereas, in a non-lineal epistemology, thinking is circular, recursive. There is a distinction made between a lineal epistemology and a non-lineal epistemology.

The distinction that is drawn here between these two epistemologies suggests that they are distinct and not included in one another. However, who is to say that Bateson (1979) is correct and that this distinction is a distinction without inclusion, and that a therapist cannot hold parts of both epistemologies? Take ABA, for example, which is considered to be a lineal epistemology. If you look at who is involved in the process, the goals of the interventions, and how behavior analysts view change, you will notice that on the surface it seems very lineal, but, in reality, it is quite systemic and circular.

Research Question

What are the experiences of clinicians dually-trained in behavior analysis and family therapy working with families facing autism?

CHAPTER III: METHODOLOGY

Qualitative Paradigm

Qualitative research allows us to identify variables that cannot be easily measured (Creswell, 2013). "We conduct qualitative research because a problem or issue needs to be explored" (Creswell, 2013, p. 47). It further allows us to gather complex, detailed understanding and meaning of an issue, which can only be established through direct observation and interviews of the people experiencing the issue (Creswell, 2013). Creswell (2013) further explains that we conduct qualitative research to "empower individuals to share their stories" (p. 48) and make sense of the context in which problems or phenomenon are occurring. As qualitative researchers, we then use these stories to develop theories, themes, and patterns, which cannot be quantified or statistically analyzed (Creswell, 2013).

Qualitative research is grounded in the philosophical assumptions of the qualitative paradigm (Creswell, 2013). Qualitative research consists of a process of inquiry; whereby, the researcher uses a qualitative approach to collect data in a natural setting and analyze the data to establish patterns of themes (Creswell, 2013). Unlike quantitative research, qualitative research places an emphasis on social and/or human problems to establish patterns and themes and interpret the problem (Creswell, 2013).

Some of the characteristics of qualitative research are natural setting, the researcher as a key instrument, complex reasoning, and participants' meanings (Creswell, 2013). Qualitative researchers often study, observe, or collect data in naturalistic settings, where the participants experience the problem or phenomenon (Creswell, 2013).

Researchers are a key instrument in qualitative research, as researchers collect the data themselves through self-designed, open-ended research questions (Creswell, 2013). Complex reasoning occurs through methods of inductive and deductive reasoning (Creswell, 2013). Researchers move back and forth between participants' responses and data collection and the themes they are developing to shape the themes (Creswell, 2013). Throughout the entire qualitative research process, the researchers attend to learning and understanding the meaning the participants hold about the problem or phenomenon, which suggests multiple perspectives (Creswell, 2013).

Phenomenological Research Design

Phenomenology was pioneered by Edmond Husserl (1999), who described phenomenology as ". . . a new kind of descriptive method which made a breakthrough in philosophy at the turn of the century . . . a science which is intended to supply the basic instrument (Organon) for a rigorously scientific philosophy" (p. 323). Phenomenology is the idea of capturing experiences from a first-person account. Moustakas (1994) explains:

> Phenomenology . . . attempts to eliminate everything that represents a prejudgment, setting aside presuppositions, and reaching a transcendental state of freshness and openness, a readiness to see in an unfettered way, not threatened by the customs, beliefs, and prejudices of normal science, by the habits of the natural world or by knowledge based on unreflected everyday experience. (p. 41)

Society plays a huge role in how individuals view the world. Phenomenology allows us to put aside presuppositions and norms through reflection. This premise of taking first-person accounts allows the researcher to understand the perceived norms of working with families with an individual with ASD from both an ABA and systemic lens. Furthermore,

this process will allow the researcher to "grasp the corresponding subjective experiences in which we become 'conscious' of them . . ." (Husserl, 1999, p. 323).

Phenomenological Research Procedures

Transcendental phenomenology relies on three "core processes that facilitate the derivation of knowledge: Epoché, Transcendental-Phenomenological Reduction, and Imaginative Variation" (Moustakas, 1994, p. 33). In this study, these processes allowed the researcher to develop patterns and themes from the experiences of participants. In this section, the researcher will discuss the aforementioned core processes of transcendental phenomenology. Moustakas (1994) asserts that Scanlon (1989) views transcendental phenomenology as one of the approaches to learning about human experience, but not the only one. Furthermore, Moustakas (1994) posits that Husserl's (1999) transcendental phenomenology is "a science of pure possibilities carried out with systematic concreteness and that it precedes, and makes possible, the empirical sciences, the sciences of actualities" (p. 28).

Epoché. Epoché is a state in which judgments are suspended. "Epoché requires the elimination of suppositions and the raising of knowledge above every possible doubt" (Moustakas, 1994, p. 26). "Epoché is a Greek word meaning to refrain from judgment or abstain from everyday, ordinary ways of perceiving things" (Moustakas, 1994, p. 33). According to Moustakas (1994), ". . . epoché requires a new way of looking at things, a way that requires that we learn to see what stands before our eyes, what we can distinguish and describe" (p. 33). This is a significant tool in phenomenological research, as it provides a lens for us to view things without biases. Moustakas (1994) refers to epoché as a "pure ego" (p. 34). "In the Epoché, the everyday understandings, judgments,

and knowings are set aside, and phenomena are revisited, freshly, naively, in a wide open sense, from the vantage point of pure or transcendental ego" (Moustakas, 1994, p. 33).

Epoché is important for the researcher to become mindful of assumptions and presuppositions about the phenomenon. Bracketing is this concept presented by Husserl (1999) in which the researcher brackets his or her assumptions and presuppositions in order to obtain a reflective stance. Bracketing assists the researcher in achieving subjectivity.

Within epoché lies the researcher's biases. In the researcher's work as a behavior analyst, combining both ABA and systemic thinking has given her a different way of connecting with clients and their families, and assisting them in reaching their goals. She has developed a process for working with families living with ASD, which is unique and has continuously demonstrated significant improvements overall.

The researcher meets new families with an initial consultation. This consultation is for parents only. In this consultation, we discuss the strengths and weaknesses of the individual with ASD, and for that reason the researcher prefers that the child not be present. It is important to the researcher that parents and/or family members have a safe place to discuss what is going on, their goals, what has worked, what has not worked, and how the researcher can be helpful. The next step is to meet the *identified client,* the individual with ASD and assess his or her behaviors.

The researcher conducts a FBA, which identifies the patterns maintaining socially inappropriate behaviors. A FBA uses a baseline data collection method, A-B-C data; where the A is the antecedent, the B is the behavior, and the C is the consequence. The antecedent is the event that takes place immediately before the behavior. The B is a

description of the topography of the behavior, what it looks like. In behaviorism, the consequence is not considered to be positive or negative. It is simply what happens after the occurrence of a behavior. These patterns are then used to hypothesize the function, or reason, for a behavior (Cooper et al., 2007).

Once the FBA is completed, the researcher meets with the family again for a review of the findings and to finalize a treatment plan. It is key for the researcher to include the family in this part of the process because their involvement is crucial. During the review, we discuss the patterns observed that are maintaining the behaviors and the interventions to put in place to reduce behaviors. Interventions are developed as both antecedent and consequence approaches. The former to establish changes in interactions with the individual and presenting behaviors, and the latter as responses to target behaviors (Cooper et al., 2007). Skill acquisition goals are also developed to teach new and replacement behaviors (Cooper et al., 2007). As previously stated, a FBA looks at patterns of behavior and their maintaining consequence (Cooper et al., 2007). Replacement behaviors are developed to meet the function of the current maladaptive behavior, while new skills are taught to further enhance an individual's repertoire of skills, reducing the need to engage in maladaptive behaviors (Cooper et al., 2007).

This review gives the researcher the opportunity to present her treatment plan to the family and get their feedback. In theory, the researcher can easily develop a plan, hand it to the family, and inform them they need to implement it. However, her philosophy is that the treatment plan needs to fit into the family's lifestyle and schedule. A list of researcher biases and assumptions follows:

1. Therapists who implement a both/and lens, utilizing both ABA and systemic thinking, achieve more positive experiences with families with children diagnosed with ASD.

2. Families with children diagnosed with ASD receiving only ABA do not have as positive an experience as those receiving a combination of ABA and systemic thinking.

3. Applied behavior analysis implemented individually does not address the entire family system.

4. Families with children diagnosed with ASD benefit from the support that therapy using systemic thinking can provide.

5. Children diagnosed with ASD receiving ABA demonstrate improvement in the reduction of challenging behaviors, increases in functional communication, and increases in social skills.

Delineating biases, or bracketing, helps the researcher to keep those biases in mind while conducting the study (Moustakas, 1994). A notable bias is that of the researcher being both a behavior analyst, implementing ABA and a registered Marriage and Family Therapy Intern, working from a systemic perspective. These biases will be peer reviewed by the dissertation committee.

The dissertation committee helps to "keep the researcher honest; ask hard questions about methods, meanings, and interpretations; and provide the researcher with the opportunity for catharsis by sympathetically listening to the researcher's findings" (Creswell, 2013, p. 251). The researcher shared thoughts and feelings throughout the entire process of the study with the dissertation committee weekly.

Transcendental phenomenological reduction. Epoché paves the way for transcendental-phenomenological reduction by allowing the researcher to see things as they are without biases. "Through the Transcendental-Phenomenological Reduction we derive a textural description of the meanings and essences of the phenomenon, the constituents that comprise the experience in consciousness, from the vantage point of an open self" (Moustakas, 1994, p. 34). This allows the researcher to uncover themes and meanings to capture experiences through data analysis.

The researcher prepared a textual and structural description of each participant's experience to gain an overall idea of the lived experience. The textual and structural descriptions were bracketed and horizonalized into themes and responses were analyzed. Bracketing is the concept of grouping experiences or ideas into categories or themes (Moustakas, 1994). Horizonalizing reduces the phenomenon into textual meaning (Moustakas, 1994). Textual descriptions recognize the participants' reality is in fact reality, while structural descriptions acknowledge how participants interpret and conceptualize their experience (Moustakas, 1994). According to Moustakas (1994):

In the Transcendental-Phenomenological Reduction, each experience is considered in its singularity, in and for itself. The phenomenon is perceived and described in its totality, in a fresh and open way. A complete description is given of its essential constituents, variations of perceptions, thoughts, feelings, sounds, colors, and shapes. (p. 33)

Imaginative variation and synthesis. Imaginative variation is intended to grasp the structural essences of the experience (Moustakas, 1994). The function of Imaginative Variation is to derive structural descriptions of the experience to develop multiple frames

to synthesize the phenomenon (Moustakas, 1994). The four steps to Imaginative Variation are: (1) systematic varying of structural meanings, (2) recognizing the theme of the phenomena, (3) taking into account the universal structures, and (4) exemplifications illustrating the theme of the phenomena. The goal "is to arrive at a structural differentiation among the infinite multiplicities of actual and possible cognitions, that relate to the object in question and thus can somehow go together to make up the unity of an identifying synthesis" (Scanlon, 1989, p. 63).

In this process, the researcher gained a structural description of the essences of the experience. Themes were developed to synthesize the meaning of the experience of the phenomenon. According to Moustakas (1994), ". . . the structural essences of the Imaginative Variation are then integrated with the textual essences of the Transcendental-Phenomenological Reduction in order to arrive at a textual-structural synthesis of meanings and essences of the phenomenon or experience being investigated" (p. 36). Once the themes were created, the researcher analyzed the meaning to capture the experience of the phenomenon.

Data Collection

Participant selection. The researcher used purposeful sampling and word of mouth to select five participants. Participants were recruited through email using a Letter of Invite (Appendix A). Those that volunteered to participate in the study were then provided with the Informed Consent (Appendix B). Once the Informed Consent was signed by the participant, received and reviewed by the researcher, the participant was contacted to schedule an interview. Participant interviews took place either in-person or via video conference to account for scheduling and location conflicts.

Inclusion criteria. The researcher recruited participants who met the following inclusion criteria:

1. Participants held at least a Master's degree

2. Participants had at least 2 years of experience implementing both ABA and systemic thinking with families living with an individual with ASD.

3. Participants were licensed and/or certified either as a Board Certified assistant Behavior Analyst (BCaBA), Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst-Doctoral (BCBA-D) or Licensed Marriage and Family Therapist (LMFT).

4. Participants who were able to meet for a live interview (either in-person or via video conference) for 1 hour.

5. Participants had access to video conferencing, if unable to meet in-person.

6. Participants were willing to sign a consent form.

In order to be certified as a BCaBA, participants must have completed a bachelor's degree in a social science (e.g., psychology, ABA, counseling, education); completed the required coursework in ABA; completed 1000 hours of supervised clinical experience under a certified, qualified supervisor; and passed the board certification exam (Behavior Analysis Certification Board [BACB®], 2018). To be certified as a BCBA, participants must have completed a master's degree in a social science (e.g., psychology, ABA, counseling, education); completed the coursework for ABA; completed 1500 hours of supervised clinical experience under a certified, qualified supervisor; and passed the board certification exam (BACB®, 2018). The certification of a BCBA-D is a designation given to those who are BCBAs and have also completed a doctoral degree in

an eligible field from an accredited program (BACB®, 2018). To be licensed as a LMFT, participants must have completed at least a master's degree in MFT; completed 2 years of clinical experience under a qualified, licensed clinical supervisor; and passed the state licensing exam (Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling, 2018). Individuals who did not meet the inclusion criteria were excluded from the study.

Informed consent. The researcher obtained written consent. The Informed Consent document explained the nature and aim of the study, as well as the potential risks and benefits of the study. The Informed Consent explained that the principal investigator would be conducting a study through digitally-audio recorded live interviews (either in-person or via video conference) and that the study posed minimal psychological and emotional risks. It also included the participants have a right to revoke consent at any time with no risk. Once the consent was signed and reviewed by the researcher, the researcher contacted each participant to schedule the interview.

Interviewing. The researcher worked with each participant to schedule a day and time for the interview. To account for scheduling and location conflicts, interviews were conducted either in-person or via video conference. Upon commencing each interview, the participants were notified when the interview began and that the digital-audio recorder had been pressed to begin recording the interview.

Participants were digitally-audio recorded during the interview, which lasted between approximately 15 minutes and 1 hour. The researcher conducted all of the interviews in a secured location within the researcher's private practice located in Weston, FL and identified participants by numbers (i.e., 1, 2, 3, 4). Semi-structured open-

ended questions were utilized to capture the experiences surrounding the phenomena. These questions served as a guide during the interview process. Open-ended questions are listed in Appendix C.

The researcher followed the epoché principle of phenomenology by utilizing a journal. After each interview, the researcher processed the interview by interpreting information discussed in the journal.

Interview Setting. The interviews were conducted by the researcher in a secured location within the researcher's private practice in Weston, FL. Both in-person and video conference interviews took place at this location.

Confidentiality. To maintain confidentiality, participants' names remained anonymous when conducting the interviews. Participants were assigned a number to maintain anonymity. Numbers were assigned based on the order in which the participants' interviews were completed. For example, the first participant to complete the interview was assigned number 1. During the data collection session and onwards, only the researcher, the dissertation committee, and the Institutional Review Board (IRB) had access to the data. Data was stored in a secured, password-protected electronic file and will continue to be stored in this manner for 36 months from the time the study was completed and then destroyed.

Interview questions. The demographic questions were developed to gather background information on the participants for the study (See Appendix C). The research questions were framed in a semi-structured, open-ended format to gain a better understanding of each participant's experience of the phenomena. The research questions sought to explore the experiences of participants trained as both behavior analysts and

marriage and family therapists in their work with families of children diagnosed with ASD (See Appendix C). The researcher asked additional follow up and/or clarifying questions to the participants to gain better insight into their experiences of the phenomena.

Data Analysis Procedures

The data analysis process began once all the interviews had been completed. The researcher reviewed and transcribed the participant responses by replaying the digital-audio recordings on slow speed using headphones to maintain confidentiality. The recordings were transcribed using a Microsoft Word© document on a password-protected computer stored in a secured location.

The researcher then used Transcendental Phenomenological Reduction to derive textual descriptions of the meanings and essences of the phenomenon. Through the use of Moustakas' (1994) organization of data, "the procedures include horizonalizing the data and regarding every horizon or statement relevant to the topic and question as having equal value" (p. 118). The researcher highlighted significant statements from the responses provided by each participant. This provided an understanding of how the participants described their experience of the phenomena. This allowed the researcher to capture significant statements that related specifically to the research question.

The researcher then coded and analyzed the data into themes and clusters, which allowed the researcher to "remove overlapping and repetitive statements" (Moustakas, 1994, p. 118). Structural descriptions were gathered, which were the researcher's reflection and interpretation of the participant's experience. The researcher compared the essences of the experience of each of the participants. An integration of textures and

structures were combined to create meanings and essences of the phenomenon that were constructed (Moustakas, 1994).

Validation and verification of data. Validity is important in a phenomenological research study (Creswell, 2013). Once the data had been collected and analyzed, the researcher presented the findings and analysis to the dissertation chair and committee to support the integrity of the research. Verification of the data was conducted by reviewing the answers to the research questions from the interviews multiple times.

The researcher also contacted the participants via E-mail to ask if they would participate in a voluntary meeting to review the analysis of the data collected from the interviews. All four participants took part in the follow-up meeting. The researcher reviewed the synthesis of textual-structural descriptions gathered from the interviews. This review served as member checking to clarify and validate the meanings that were ascribed, and provided an opportunity to participants to correct or add to the researcher's synthesis (Creswell, 2013). All four of the participants agreed with the researcher's synthesis.

Ethical considerations. All participants of the study were treated in accordance with the ethical guidelines of the American Association of Marriage and Family Therapy (AAMFT), the Behavior Analysis Certification Board (BACB®), and the Nova Southeastern University Institutional Review Board (IRB). "Human science researchers are guided by the ethical principles on research with human participants" (Moustakas, 1994, p. 109). This study established clear agreements with the research participants through the Informed Consent. Participants were fully informed of confidentiality and the procedures of the study. Participants volunteered to be a part of the study and were

informed of the qualitative nature of the study and their right to revoke participation at any time. Additionally, participants were able to provide open-ended answers to the research questions. The importance of self-report was emphasized to allow participants to feel their response and participation was valuable to the study. Information provided to the participants included:

1. The nature of the study;

2. Rationale for participation in the study;

3. Participant roles toward findings;

4. Description of any potential danger to participants;

5. Detailed benefits to participants, if any;

6. Financial obligation or reward for participation in the study;

7. Confidentiality of information;

8. Participant ability to leave the study at any time;

9. Confidentiality of answers from participants' questions pre-, during, and post-research study; and

10. Voluntary nature of participant consent in the study.

Summary

This chapter reviewed the qualitative paradigm and the phenomenological research design. The researcher discussed the research procedures, data collection process, and the data analysis procedures.

CHAPTER IV: RESEARCH FINDINGS

The purpose of this study was to explore the experiences of individuals trained as behavior analysts and marriage and family therapists working with families with children diagnosed with ASD. Findings of this inquiry included participant profiles, methods of reducing and interpreting the experiences of these individuals with the phenomena, as well as an analysis of themes.

Participant Profiles

Of the five participants the researcher invited to participate in this study, only four signed and returned the consent form. Therefore, these four participants were interviewed by the researcher and their responses were included in the data analysis. These participants ranged in age from 27-to-47-years old and three out of four of the participants practiced in the South Florida area. Table 4.1 contains demographic information for all participants.

Participant 1. Participant 1 is a 36-year-old female, living and practicing in the Pennsylvania and New York areas. She has been working with families with a child with autism for 13 years. Participant 1 was trained in ABA prior to receiving her training as a family therapist; however, due to her education, she identifies as having received systemic thinking training first. She holds a Behavior Specialist Certification, is a LMFT, BCBA-D, and Licensed Behavior Analyst (LBA). Participant 1 received her training in South Florida at Nova Southeastern University. She currently practices both ABA and family therapy.

Participant 2. Participant 2 is a 30-year-old male, living and practicing in South Florida. He was trained in ABA in South Florida at Nova Southeastern University prior

to receiving training in systemic thinking through the organization he works for. Participant 2 has been implementing both ABA and systemic thinking for 5 years and continues to do so. He is a BCBA. Participant 2 is not licensed and/or certification as a marriage and family therapist, but practices from a dual perspective, using systemic thinking in his current position.

  Participant 3. Participant 3 is 47-year-old female, living and practicing in the South Florida area. She received training in systemic thinking through a family therapy program in South Florida at Nova Southeastern University prior to receiving ABA training through the organization she works for. Participant 3 has been implementing a dual perspective, utilizing both ABA and systemic thinking for the past 2 years. Although she is not certified as a behavior analyst, Participant 3 is currently working for an ABA organization as a lead analyst, supervising behavior therapists working directly with individuals with autism. She is a LMFT.

  Participant 4. Participant 4 is a 27-year-old female, living and practicing in the South Florida area. She has been trained in ABA for 7 years, working with families with a child with autism. Participant 4 received her ABA training prior to receiving training in systemic thinking through a family therapy program in South Florida at Nova Southeastern University. She has been implementing a dual perspective in ABA and systemic thinking for 2 years and continues to do so. Participant 4 is a BCaBA and Licensed Mental Health Counselor (LMHC). She is not a LMFT.

Table 4.1

Participant Demographics

Demographic Information	Participant 1	Participant 2	Participant 3	Participant 4
Age	36	30	47	27
Gender	Female	Male	Female	Female
Race/Ethnicity	Caucasian	Caucasian	Caucasian	Hispanic
Years Active	13	7	8	7
City, State of Practice	Elmira, NY Athens, PA	Weston, FL	Sweetwater, FL	Ft. Lauderdale, FL Miami, FL
Years Trained in ABA	10	7	2	7
Years Trained in Systemic Thinking	9	5	7	2
Years dually trained	13	5	2	2
Initial Training	Systemic thinking	ABA	Systemic thinking	ABA
Licenses/Certifications Held	BCBA-D, LMFT, Behavior Specialist Certification, LBA	BCBA	LMFT	BCaBA, LMHC
Year licensed as BCaBA, BCBCA, or BCBA-D	2008	2016	0	2014
Years licensed as LMFT	2009	0	2016	0

Reducing and Interpreting Lived Experiences

Utilizing Moustakas (1994) phenomenological reduction of data, the researcher developed a textual description of each participant's lived experience, along with a structural description of the phenomenon for reflection and interpretation (Moustakas, 1994); thus, accomplishing Moustakas's (1994) view of phenomenology as a method of reduction and interpretation of lived experiences.

Textual Descriptions

The textual descriptions derived from each participants' responses were intended to gather a description of his or her lived experience to capture what he or she actually experiences. Textual descriptions for this research study were organized by the response each participant provided for each of the questions asked. The researcher chose to use Microsoft Excel© as a data analysis tool. Microsoft Excel© allowed the researcher to create various tables—one for each of the three questions asked to participants—to enter the original text of the responses, review the responses, and sort the responses. These tables were reviewed along with the Microsoft Word© document containing the transcriptions to ensure original texts were entered accurately. The textual descriptions were then organized as seen in Table 4.2, Table 4.3, and Table 4.4.

The researcher then horizonalized the data by rereading the transcriptions and highlighting the statements that were relevant to each of the three questions asked and were applicable to the research question. Horizonalizing allowed the researcher to extract meaning units or horizons relevant to the topic (Moustakas, 1994), as shown below in Table 4.5, Table 4.6, and Table 4.7.

Table 4.2

Textual Descriptions: Question1

Question 1	Participant 1	Participant 2	Participant 3	Participant 4
How do you identify as a clinician with regards to the license and/or certification you hold and how you practice?	Depends on the type of therapy I'm doing	Behavior analyst	Systemic-thinking lead analyst	Behavioral therapist, mental health counselor, and family therapist
	Governed by state regulations and how the contract's laid out		That means that I am able to take a larger perspective of what's going on within the home, within the context of the child's school, within the context of the child's life, and I am able to impart training, uh, as to what might be beneficial for the child after doing an assessment.	I hold onto the behavioral principles, um, while understanding the individual, which is more my mental health practice, and still looking at the treatment or whatever I'm doing with my clients in a systemic way.
	When I'm working with individuals with autism, that's a BCBA-D. Um, I'm doing FBAs in the school, BCBA-D. So I jst kind of keep it for um in terms of following ethical codes, rules and regulations, um, and to keep the work load manageable. But, for example, in New York, if I wanted to work with an individual with ADHD, then its under the LMFT systemic therapy hat.		I'm able to understand maybe a little bit more of the family background, uh, where as we had discussed before how, maybe, rigid those with ABA background typically are. Um, and I feel like I can offer a broader perspective to those family members to explain a little bit more and be more supportive to the whole family, overall.	I still look at the individual and some pathological sort of dynamics that we might say like OCD or anxiety in that language…um…while then taking a step back and looking at a systemic perspective when it comes to how we treat them or how it is that I work with them.

Furthermore, the researcher asked follow-up and/or clarifying questions to the participants. These follow-up questions served to gather a better understanding of the lived experience of the participants when working with families with children diagnosed with ASD. It should be noted that not all participants were asked all follow-up and/or clarifying questions. The researcher asked these questions based on participant response to gain further insight into the essence of the phenomenon.

Table 4.3

Textual Descriptions: Question 2

Question 2	Participant 1	Participant 2	Participant 3	Participant 4
What do you notice about dual perspective?	I will bring in ABA principles in terms of like reinforcement, reinforcing prosocial changes, positive changes, prompting, prompt fading, looking at, you know, breaking large skills up into smaller skills.	It takes time to get use to doing things from that way and that every now and then you kind of have to remind yourself to take that step back and refocus.	I'm much more valuable than most. I'm sorry if that sounds a little pompous, but I think I am. I think I can offer a much richer perspective than most	Its very different than other ABA practitioners, mental health practitioners, or family therapists.
	I incorporate ABA in my LMFT work, definitely with identifying the target behavior or identified problem, making it operational and measurable so that this is what we're looking at for our treatment plans…looking at reinforcing. So in our talk therapy reinforcement. Psychotherapy calls that validation	I have a harder time not viewing everything and just being more of a straight forward, like how the analyst should see it as.		ABA-they're not very big on either pathologizing or emotions or individual talk. In that way it's a lot more scientific. In regards to my mental health, we don't really look in a systemic perspective, so I'm different than those practitioners. And as family therapists, their probably the closest to my philosophy. We do think systemically and there are learning principles within some of the theories. But family therapy practitioners often don't understand the behavioral principles. So when they work with kids with autism or families, they work in a completely different way.
	I do say that I do bring it in but I, in New York, unless I have a diagnosis of autism and a prescription for ABA, I will not be doing discrete trials, pivotal response training, incidental teaching, or conducting an FBA.			I think I more often than not will interchange them. You'll see it in the questions that I ask when I'm doing intakes or reassessing treatment plans. Um. Where I'll go into behavioral principles, but then I'll kind of take it off and ask a very relational, systemic question and there's a purpose for it and then I'll come back to my behavioral thing of how do I use behavioral principles to take us to whatever it is the we figured out. I don't think that they sit on top of each other very well and so I have to kind of go back and forth. I mostly go back and forth between systemic and behavioral, not so much mental health.
	I would say that I have noticed that with individuals that are more math and science brain, with individuals that more routinized, ritualized behaviors, and with individuals with anxiety, I get better outcomes. I first start off doing my assessment and then looking at behavioral strategies kind of that first order change and I'm able to get buy in. I'm able to get therapeutic alliance. They're seeing change. That positive change, they're reinforced by it. So then we're able to go deeper into say "how have these executive functioning impairments, inability to cope, lack of social skills affected your relationship? And may have contributed to increased anxiety and depression?" And that's where we can get that second order change.			

Table 4.4

Textual Descriptions: Question 3

Question 3	Participant 1	Participant 2	Participant 3	Participant 4
How do you engage families in the process?	So parent training, classic ABA. Parent training is effective especially for skill acquisition, managing challenging behaviors, things like that. Um, family therapy I pull a lot. Sometimes, I pull from a structural approach just to, you know, align the parents together. And then, you know, so that we have an appropriate familial hierarchy…um, but then, reinforcement from parents, token systems, contingencies…all of those things I bring into family therapy. Applying foundational principles of ABA and operant conditioning.	I'm trying to be as confident as I can with whatever I'm saying cause I feel like that helps ease them. Um…whether its just validating something they've already said or presenting a new idea. And just trying to more uhh straight forward with them so its not too much for them to overthink.	I ask a lot of questions.I'll really hit on the main points of really trying to understand what the issues are with the child. Spend a lot more time with the parents.	I use a lot more of my family therapy skills to engage them even in just in the conversation. Um. And that in itself engages them in the process. And a lot of the goals, protocols, dynamics, whatever we want to call it, will usually be based on their values and what they want and that comes through sort of these questions that we don't normally ask as ABA therapists and so the clients are more inclined to want to do them.
		I absolutely tell them the importance of the whole family being involved.	Usually, I'll do two parts to the assessment. that way the first time I could really watch the child as an observer and talk to the parents to get all their information and what's going on. What's really going on. And the next time I'm more interactive with the child because now I'm not, necessarily, a stranger—they've seen me before. So I get a little bit closer, maybe, and the parent is more relaxed now, too. Because I've asked them bunch of…I feel like we've joined well from the first session.	Also looking at it from a solution-focused perspective, where I really do kind of examine their exceptions and do an ABC on that and then they're more like "hey, I can do that". They're more excited about it. So I try to get them excited by going into their values, understanding what they've done well. Um and then they kind of want to do that more. So that's what what I try to do to engage them.

Table 4.5

Horizonalized Statements: Question 1

Question 1	Participant 1	Participant 2	Participant 3	Participant 4
How do you identify as a clinician with regards to the license and/or certification you hold and how you practice?	Depends on the type of therapy I'm doing.	Behavior analyst	Systemic-thinking lead analyst	Behavioral therapist, mental health counselor, and family therapist
	BCBA-D or LMFT systemic therapy hat		That means that I am able to take a larger perspective of what's going on	I hold onto the behavioral principles, while understanding the individual, which is more my mental health practice, and still looking at the treatment or whatever I'm doing with my clients in a systemic way.

Table 4.6

Horizonalized Statements: Question 2

Question 2	Participant 1	Participant 2	Participant 3	Participant 4
What do you notice about dual perspective?	I incorporate ABA in my LMFT work, definitely with identifying the target behavior or identified problem, making it operational and measurable so that this is what we're looking at for our treatment plans.	It takes time to get use to doing things from that way and that every now and then you kind of have to remind yourself to take that step back and refocus.	I'm much more valuable than most.	Its very different than other ABA practitioners, mental health practitioners, or family therapists.
	I get better outcomes. I first start off doing my assessment and then looking at behavioral strategies kind of that first order change.	I have a harder time not viewing everything and just being more of a straight forward, like how the analyst should see it as.	I think I can offer a much richer perspective than most.	I think I more often than not will interchange them.
	So then we're able to go deeper into say "how have these executive functioning impairments, inability to cope, lack of social skills affected your relationship? And may have contributed to increased anxiety and depression?" And that's where we can get that second order change.			Where I'll go into behavioral principles, but then I'll kind of take it off and ask a very relational, systemic question
				I don't think that they sit on top of each other very well and so I have to kind of go back and forth.

Table 4.7

Horizonalized Statements: Question 3

Question 3	Participant 1	Participant 2	Participant 3	Participant 4
How do you engage families in the process?	Parent training is effective…my client is the family system and what is your part in the system.	I absolutely tell them the importance of the whole family being involved.	I ask a lot of questions.I'll really hit on the main points of really trying to understand what the issues are with the child. Spend a lot more time with the parents.	I use a lot more of my family therapy skills to engage them even in just in the conversation.
	Reinforcement from parents, token systems, contingencies…all of those things I bring into family therapy.			Also looking at it from a solution-focused perspective, where I really do kind of examine their exceptions and do an ABC on that.
	Applying foundational principles of ABA and operant conditioning.			So I try to get them excited by going into their values, understanding what they've done well.

The textual descriptions of the follow-up and/or clarifying questions were horizonalized by the researcher. This allowed for the researcher to look for horizon units the represented the essence of the meaning relevant to the phenomenon (see Table 4.8).

Structural Descriptions

The researcher identified structural descriptions through structural statements taken from the textual descriptions. Per Moustakas (1994), structural descriptions allowed the researcher to validate the interpretation of the lived experience of the phenomenon. Interviews were listened to again while reading the transcriptions to capture connecting and overlapping ideas (Moustakas, 1994). These ideas were tracked and entered into Microsoft Excel©. This analysis of data led to the process of imaginative variation; whereby, the researcher interpreted participant responses to generate themes. All of the themes captured from the analysis were typed into Microsoft Excel© and then combined into larger themes. The larger themes were then entered into another Microsoft Excel© table next to participant responses. Themes were compared to statements within the transcripts. The researcher also reviewed the relevant literature for this dissertation and

derived additional ideas to acquire a richer meaning from the statements of the participants.

Participants were sent an E-mail requesting their participation in a voluntary follow-up interview to review the interpretations of the researcher. Three out of four of the participants volunteered to attend the follow-up interview. During the follow-up interviews, the researcher reviewed the researcher's interpretations of their responses to ensure there were no misinterpretations of their experiences. This process of member checking allowed the researcher to verify and validate the data and participants to comment on the interpretation (Creswell, 2007; Moustakas, 1994). All three participants agreed the interpretations captured their experiences and provided no further comments. The analysis was completed by creating a composite list of themes, as shown in Table 4.9.

Description of Themes

Three central themes and two subordinate themes emerged from this study as outlined in Table 4.9: Participants noted boundaries that influence a dual perspective, Participants found it useful to use a dual perspective, Participants noted this is a different approach not shared by others, Participants found it useful to apply ABA and systemic thinking in a specific order, and Participants found it useful to identify systems. This establishes shared experiences of the phenomenon by the participants.

Table 4.8

Horizonalized Statements: Follow-Up/Clarifying Questions

Questions	Participant 1	Participant 2	Participant 3	Participant 4
Do you find using a dual perspective is beneficial?	It's very beneficial because I'm able to make it individualized.	I think its just beneficial, overall—to clients, to the parents.	I'm able to implement change within the whole system... And so I feel like that's a real…that's something that's not addressed, often. And they really like that. So that change is seen. So the RBT is able to see things a little bit more systemically, as well as, the parent is brought more in and they feel more a part of the process.	
Are there any challenges to using a dual perspective?	I think its personality. I'm think a person that likes structure, routine. I think, you know, I flocked to the BCBA because, you know, I definitely believe in, you know, looking at function-based behavior and looking environmental variables and contextual stuff. I got to apply my LMFT [during externships] with individuals, families, either diagnosed with autism or doing ABA and my dissertation was in parent training.	Just like I said, reminding to like, kind of, taking that step back.	Not at all. It's very fluid. I don't have a separate boundary. Um, I feel like its all in one. So it's a very fluid process for me. And I join really well with both.	Sometimes because its something newer that there's not a book for and no one has come up with a theory that combines them, I'm kind of going into it seeing what works um and then holding onto these things and how do I integrate these perspectives um and that's sometimes a challenge because there is no fundamental to it and there's not a lot of practitioners that do it.
Does the perspective (single or dual) depend on who you are working with?		Supervision you're not personally doing it as far as like with working with the client one-on-one, but once I feel like you could work with either the actual client or the parent of the client, that's when I see more of like a take-in, more of the personal, rather than just keep it from an analyst perspective.	I feel like I also train them [therapists I supervise] in a systemic light. So that they are now able to see things, that they would never have known to look for before.	Yes, because the…since most of the families I work with, more than autism, they usually have pretty severe behavioral concerns.
How do families respond?	Yes, [families respond well] its very concrete. And then the LMFT is really the therapeutic alliance and, you know, looking at the family system as a whole, engaging.	More often than not, they're positive about it.		
Who do you identify as the client?	My client is the family system and what is your part in the system.	The whole family at the end of the day is the client.		
How has it impacted treatment outcome?	I would say that using both I get, you know, best outcomes.	Now that you kind of take that systemic perspective its, there's a lot more benefit to it.	I feel like once the parent is more on board because they like what's happening, they like being included and involved, they're more willing to stick with the schedule and the programs that we create. And they really like that idea that I'm talking to them. It's a very interesting phenomenon that's happening.	
How do you handle competing response when dealing with being the expert vs non-expert?				I try to combat that dynamic by kind of digging into their values. And being really curious, which I think is what I learned from family therapy.

Table 4.9

List of Themes

Themes and Subordinate Themes	Participant 1	Participant 2	Participant 3	Participant 4
Participants noted boundaries that influence a dual perspective	x			x
Participants found it useful to use a dual perspective	x	x	x	x
Participants noted this is a different approach not shared by others			x	x
Participants found it useful to apply ABA and systemic thinking in a specific order	x	x		x
Participants found a larger systems perspective useful	x	x	x	x

Participants noted boundaries that influence a dual perspective. Two out of four of the participants discussed the role boundaries play in their practice with families with individuals with ASD. Both of these participants are the most experienced in ABA. Participant 1 has the most experience, overall, across both fields.

More specifically, the boundaries presented by their licenses and/or certifications, as well as state regulations and source of funding. For these two participants, the modality employed was highly dependent on aforementioned factors. Both participants expressed these factors are barriers to the implementation of a dual perspective, Participant 1 stated "in New York because it's so rigid, when I'm working with individuals with autism, that's a BCBA-D" and "yes, I would say because of regulations and insurance billing, I do feel like my hands are tied and paralyzed, sometimes." Participant 4 expressed, "with private clients I get the opportunity to kind of mix."

These two participants implemented a dual perspective of ABA and systemic thinking when these boundaries were not present, asserting that there's more flexibility with the methodologies when practicing—Participant 1 added "and then that's very beneficial because I'm able to make it individualized." These experiences open the doors to the impact outside factors have on the therapeutic process and what works best for clients, in particular, families with children diagnosed with ASD.

Participants found it useful to use a dual perspective. All four participants discussed the usefulness of a dual perspective within their responses. Within this theme, participants identified their application of a dual perspective, the benefits of it, and the challenges they may encounter. Participant 1 stated, "I incorporate ABA in my LMFT," but explained that both were not necessarily used simultaneously. Participant 2 identified

that while a dual perspective was beneficial, "it takes time to get used to doing things from that way and that every now and then you kind of have to remind yourself to take that step back and refocus." He also provided, "I have a harder time not viewing everything and just being more of a straight forward, like how the analyst should see it as."

Participant 3 described that, to her, implementing both ABA and systemic thinking, is "It's very fluid. I don't have a separate boundary. Um, I feel like it's all in one. So it's a very fluid process for me." She also added, "I think it's very challenging. I'm very interested in, um, seeing how over time how my cases will continue to improve." Participant 4 provided, "I still look at the individual and some pathological sort of dynamics . . . while then taking a step back and looking at a systemic perspective when it comes to how we treat them or how it is that I work with them." This participant also added "I think I more often than not I will interchange them." The responses representing this theme bring to light various takes on duality and the benefits and challenges of it. Furthermore, within this them there are two subordinate themes: Participants noted this is a different approach not shared by others and Participants found it useful to apply ABA and systemic thinking in a specific order.

Participants noted this is a different approach not shared by others. Two out of four of the participants identified the utilization of both ABA and systemic thinking as different. These two participants are the least experienced with regards to the number of years each has been dually trained in ABA and systemic thinking.

Participant 4 reported, "It's very different than other ABA practitioners, mental health practitioners, or family therapists." Participant 3 added, "Different than most?

Absolutely." This same participant provided, "they're also very receptive, but they could see things a little bit differently" with regards to the difference in training she provides to the Registered Behavior Technicians (RBTs) using a dual perspective. In highlighting this difference, Participant 4 discussed the perspective of dual ideologies as:

> It's something newer that there's not a book for and no one has come up with a theory that combines them, I'm kind of going into it seeing what works um and then holding onto these things and how do I integrate these perspectives um and that's sometimes a challenge because there is no fundamental to it and there's not a lot of practitioners that do it . . . . It's not a lot of conversations you can have with other people. So it's kind of figuring it out as you go.

> Participant 3 exclaimed, "It's a very interesting phenomenon that's happening."

These responses shed light on the possibility that the difference surfaced by the implementation of a dual perspective may have high prospects moving forward in these two fields.

   Participants found it useful to apply ABA and systemic thinking in a specific order. Three out of four participants indicated a specific order in which they first look at cases of families with children diagnosed with ASD. Each of these participants reported they initiate these cases with a more behavior analytic lens—completing assessments (FBAs) and identifying target behaviors and treatment goals—prior to bringing in the systemic thinking perspective. Participant 1 explained:

> I first start off doing my assessment and then looking at behavioral strategies kind of that first order change and I'm able to get buy in. I'm able to get therapeutic alliance. They're seeing change. That positive change, they're reinforced by it.

Um, kind of that self-reinforcing, you know, they're able to implement one of my strategies and they say, "Oh, this works!" And then, you know, as the therapy goes on we're able to do a little more, you know, go a little deeper and more systemically . . . into say "How have these executive functioning impairments, inability to cope, um lack of social skills affected your relationship and may have contributed to increased anxiety and depression?' And that's where we can get that second order change.

Participants reported that with this population, starting with ABA gives them a sense of the behaviors of concern, allowing them to then look at the larger system. Participant 4 stated:

When I can start with ABA and kind of see . . . sometimes parents . . . I work a lot with parents. So when parents are really able to kind of absorb it and take it and they're doing it in a way that's working and BST is working. Um . . . then I can stay in the behavioral route of what works. It's when it deviates and behavioral skills training is just not working and they're not catching on to these things or they're not following the protocols and stuff like that, that I then kind of switch into it and see how we can switch the dynamic to a little bit more systemic.

These participants indicated that they typically add systemic questions to their ABA assessments in order to get more information from the responses and build rapport with the parents. One participant specified that she also asks questions more systemically.

Participants found a larger systems perspective useful. All four participants elaborated on the importance of systems when working with families with children diagnosed with autism. Participants agree that there are various systems at work and that

a systems perspective is more beneficial. Participant 1 mentioned, "I'm practicing from a systemic point of view." Participant 2 explained, "I absolutely tell them the importance of the whole family being involved." This same participant went on to add:

> Yeah, the whole family at the end of the day is the client because they all need to be trained and, you know, learn how to do the exact same things we're doing with the client and cause, you know, we spend, what, 10% with them. So everyone is involved, as well.

Additionally, all four participants viewed their role as a systemic one. Regardless of the various parts of their role they were engaging in throughout the day, all four participants considered their role a systemic one. Participant 1 mentioned, "And I present that to them from the start—that relational, systemic perspective . . . and that's, to me, the essence of systemic therapy and I do present that to them."

Participant 3 discussed that she also trains her RBTs to be systemic thinkers when applying ABA practice, as they are a part of the system as well. She added, "I also train them in a systemic light. I'm able to implement change within the whole system." While Participant 4 explained how she views her role, at times, depending on the perspective she's taking by stating, "Some family therapists wouldn't agree with me cause I jump into their system with them. I have to. As a behavior analyst that's what we do—we go into their homes, we go into their environments."

Utilization of the Researcher's Journal

The Researcher's Journal served as a tool for the researcher to process each of the interviews. After transcribing and analyzing the data, the researcher reviewed the Researcher's Journal to further capture the essence of the phenomenon. In addition to the

three interview questions, the researcher chose to ask participants follow- up and/or clarifying questions, which may or may not have persuaded their responses.

The utilization of a journal afforded the researcher a place to channel thoughts, biases, and the impact of each of the interviews. In reviewing the journal, it was noted that the researcher processed each interview differently, and a theme was present within the journal—language.

The language participants used when referring to themselves, discussing their utilization or non-utilization of a dual perspective, or even how they conveyed their responses to questions were noted in the researcher's journal. Language proved to be meaningful during each of the interviews.

One of the most impactful uses of language the researcher noted for all participants was how they referred to themselves, not as clinicians or individuals, but with relation to the two schools of thought—ABA and systemic thinking. This was curious for the researcher with regards to how participants identified as clinicians and that differed from or resembled their use of pronouns when discussing each of the ideologies. This finding prompted the researcher to reflect on her own relationship with each of these epistemologies and be mindful of researcher bias when asking questions, summarizing, and providing encouragers during the interviews.

Summary

In this chapter, the researcher discussed how the study was conducted and the findings of the study. The findings captured the essence of the experiences of individuals dually trained in ABA and systemic thinking working with families with an individual

diagnosed with ASD. Themes derived from the participant's experiences, as well as the

utilization of the Researcher's Journal were also discussed.

CHAPTER V: FINDINGS AND IMPLICATIONS

Working with families with children diagnosed with ASD continues to be a growing community need. While numerous studies have demonstrated treatment with these families from either an ABA perspective or a systemic thinking perspective, no study has explored the use of a dual methodology from the perspective of the clinician. Therefore, the researcher chose to conduct a phenomenological study to capture the experiences of trained behavior analysts and marriage and family therapists when working with families with children with ASD.

The research question for this study was, "What are the experiences of trained behavior analysts and marriage and family therapists working with families of children diagnosed with ASD?" The researcher was specifically interested in the methodology utilized by clinicians when working with this population. In answering this question, the researcher hoped to gain an understanding of how dually trained clinicians identified with regards to their practice, what they notice about the utilization of a dual perspective, and how clinicians engage families in the process of treatment. The essence of the lived experience of each participant with the phenomenon was revealed.

Discussion of the Lived Experiences

In this discussion, the researcher will review each of the overarching and subordinate themes revealed in the findings of this study: Participants noted boundaries that influence a dual perspective, Participants found it useful to use a dual perspective, Participants noted this is a different approach not shared by others, Participants found it useful to apply ABA and systemic thinking in a specific order, and Participants found it useful to identify systems. These themes collectively constructed the overall lived

experiences of the four participants when working with families with children diagnosed with ASD, and they provided important insight for professionals.

Participants Noted Boundaries That Influence a Dual Perspective

This emergent theme of revealed the barriers at play in providing services. These barriers present challenges for professionals working with families with children diagnosed with ASD. State regulations and restrictions play an immense part in the provision of both ABA and systemic thinking. Insurance funding also imparts a large authority over what services can or cannot be rendered by questioning need for services, delaying or denying services, and even making treatment decisions (Ginsberg, 2017; Worthy, 2017).

This was not something found in the literature, specifically related to service provisions for ASD, nor was it considered as an area to explore by the researcher prior to conducting the study. Ginsberg (2017) and Worthy (2017) discuss the difficulties of working with insurances, in general, as a provider in the medical and/or mental health fields. This may be an area to be explored by future research.

Participants 1 and 4 indicated that they must practice within the boundaries and that this prohibits them from being able to implement a dual perspective. The two participants that brought this theme to light, are the more seasoned clinicians in ABA. Both have been certified as behavior analysts the longest out of all four participants, and one of them credentialed longest, overall in both fields. Conceivably, these participants could have more knowledge and a greater understanding of the technicalities of scope of licensure or certification. They may also have a broader insight as to the standards of insurance funding. It should also be noted that specific geographic location does not seem

to be a factor, as Participant 1 practices in New York and Pennsylvania and Participant 4 practices in the South Florida area. This could indicate a larger challenge with the employment of individualized services to families facing ASD, as it is reported in multiple states. These boundaries can have a negative impact on the provision of services to families with individuals with ASD.

Participants Found It Useful to Use a Dual Perspective

This emergent theme of was present for all participants. While all four agreed that using a dual perspective improved treatment outcome and was, overall, more beneficial, three of the four participants, Participants 1, 2, and 4, alternate the "hat" they wear when practicing. These three participants all have certification in behavior analysis— Participant 1 is a BCBA-D, Participant 2 is a BCBA, and Participant 4 is a BCaBA. Perhaps, the knowledge and/or training they have received as behavior analysts inclines them to alternate between the two perspectives. It could also be due to the ABA certification taking place prior to the training, formal or informal, of systemic thinking. These three participants identified as clinicians in part. That is to say, they identified with regards to how they are licensed or certified.

Participant 3 implements a dual perspective simultaneously. Curiously, this participant discusses the use of a dual perspective simultaneously and also identifies as a both/and clinician. This participant described herself as a "systemic thinking lead analyst", viewing herself through a dual lens. Participant 3 has the least experience implementing a dual perspective and the least experience with ABA. In her current role, she practices as a lead analyst; however, is not certified as a behavior analyst. It may be

her systemic thinking foundation that brings forth the dual perspective both in her identification of self and her implementation of modalities.

Generally, participants felt that utilizing a dual perspective was beneficial in involving the family in the process of therapy. All four participants indicated that a dual perspective was necessary to join with families and build a therapeutic alliance. This is true for the child with ASD as well—the clinician must join and build a rapport in order for the therapeutic process to begin and be effective. Moreover, participants implement a dual perspective in the questions they ask and how they ask them, which does not support the literature reviewed, as ABA questions and assessments are typically formulated to be direct (Iwata et al., 1994; Lang et al., 2010). Implementing a dual perspective allows for clinicians to gather the behavioral information needed, while gaining insight into the system through systemic thinking in how the questions are asked. Kelly and Tincani (2013) identify the importance of collaboration in ABA.

This idea of implementing a dual perspective was exemplified in the literature by Keeney (1983) in that he describes that linear epistemologies, like that of ABA, and circular epistemologies, like that of systemic thinking, emphasize cause and effect and circularity, respectively and create a homeostatic balance. It also supports other literature reviewed focused on the merging of ABA and SLP, and ABA and special education (Cautilli & Koenig, 2006; Dyer & Kohland, 1991; Frost & Bondy, 2001; Koegel & Koegel, 1996; Koenig & Gerenser, (2006); Loiacano & Vito, 2008; Reichle & Wacker, 1993; Simons, 2014), which found an, overall, improvement in treatment outcome and therapist or teacher preparation. When employing a dual perspective, the participants are gathering the cause and effect information from the foundation of the system—the

child—through an ABA lens and then shifting their lens to the circularity of what is taking place in the entire system through systemic lens.

This theme supports the researcher's bias of employing a dual perspective and was an expected finding of the study. A curious dynamic identified, though, was that of simultaneous implementation of a dual perspective and alternating between each modality. It was the researcher's assumption that implementing a dual perspective meant utilizing both an ABA lens and systemic lens at all times. Yet, it appears that most of the participants employ a both/and perspective throughout their work with a family with a child with ASD, but wear the "hat" that is most appropriate or beneficial for which aspect of the system they are engaged in.

Participants noted this is a different approach not shared by others. The emergent theme of a different approach explored the concept of a dual perspective when working with families with children with ASD. This theme revealed the difference of implementing both ABA and systemic thinking. This supports the research in that ABA tends to lack in the area of collaboration (Kelly & Tincani, 2013). Participants 3 and 4 discussed the novelty of this both/and perspective and how it is different for each field, but also something different for the population. Participants 3 and 4 have the least amount of experience implementing a dual perspective. It could be this short period of time that increases the novelty of the concept of practicing from a dual perspective.

While this finding supports Bateson's (1972) discussion of difference, whereby he emphasizes that difference is a change in perspective, there was no study reviewed in the literature that discusses the use of this different approach. By applying a dual perspective,

clinicians are creating the "difference which makes a difference" (Bateson, 1972, p. 459) and potentially paving the way for new constructs (Keeney, 1983).

Furthermore, Participant 3 explained how it is also applied in the training of RBTs and this different perspective, when training, has allowed for RBTs to more accurately report to the supervising behavior analyst. This could also be a factor in the increase in outcome when implementing a dual perspective—all providing services are employing the dual perspective, providing more systemic treatment.

Perhaps, another noted difference between Participants 3 and 4 and their colleagues stems from attending graduate programs in the more recent years, where training may be more postmodern and more systemic. A more postmodern training would fall in line with Shawver (n.d.) in accepting other schools of thought.

Additionally, it was not an expected finding by the researcher. While the researcher's bias is that this approach *is* different, she did not expect for participants to highlight this as a theme as it is what and how the clinicians practice. That is to say, the researcher was surprised at the participants' revelation of a both/and perspective being different. As well, it may increase the value of practice within the fields as such few individuals are implementing a dual perspective.

Participants found it useful to apply ABA and systemic thinking in a specific order. This emergent theme revealed that while all the participants found a dual perspective beneficial, three out of four of these participants—Participants 1, 2, and 4— placed emphasis on the order in which they provided treatment with regards to the modalities. These three participants exercise ABA initially and use the ABA framework

to inform or determine the need to apply the dual perspective. Whereas, Participant 4 described she implements both from the start.

The use of ABA as an initial modality supports previous research in that ABA allows the clinician to gather information about the problem behavior(s)—what the behaviors are, what they look like, what happens before and after the behavior, and what the maintaining function is (Iwata et al., 1994; Lang et al., 2010; Mace, 1994; McCord et al., 2001; Neef & Iwata, 1994; Piazza et al., 2003). This provides an, overall, concept of the patterns of behavior, which can then help to determine the course of treatment.

The researcher identified a possible connection within this theme tied to the overarching theme: Participants found it useful to use a dual perspective. Participants 1, 2, and 4 are all certified behavior analysts. Perhaps their behavior analytic training is at the forefront, providing them with information on the case and then determining the need. As aforementioned, Participants 1, 2, and 4 identify as a clinician in parts, while Participant 4 identifies as a both/and clinician, which could demonstrate that how professionals identify as clinicians may influence how they practice. This is emphasized by Maturana (1988) and Varela (1984) through their discussion of systems and how clinicians are a part of the system and must also see the different systems that make up the larger system.

Utilizing a specific order during treatment was not an initial expected outcome of the study, as the researcher's bias is to apply a dual perspective throughout. However, as participants provided their responses of alternating "hats", the researcher assumed the employment of a dual perspective would result in a specific order.

Participants Found a Larger Systems Perspective Useful

This emergent theme was present in the responses of all four participants. Each of the participants stressed the importance of a larger systems perspective. The systems that were identified were the family system, couple system, therapy system, and client system. Participants felt that the whole family was the system and not just the client, illustrating systemic thinking. This was an anticipated outcome of the study as the researcher was aware of significant emphasis on larger systems within the training of the participants. Additionally, the setting in which each of the participants practice allows for a larger systems perspective, as they are working with RBTs, parents, the identified client, and possibly other behavior analysts.

The views of all four participants in their utilization of a larger systems perspective aligns with those of Maturana (1988) and Varela (1984), as one system can affect the larger system at play. By taking a larger systems perspective, these clinicians are more understanding that they, too, are a part of the system and how intertwined each level of the system is with the next and with the whole (Maturana, 1988; Varela, 1984).

Limitations of the Study

While the results of the research represent the experiences of trained behavior analysts and marriage and family therapists, some limitations impact the study. First, the participants from this study were all trained at the same university. Second, three out of four participants live and practice in the South Florida area. Third, only four participants were interviewed for this study. It would be important for additional research to consider these limitations to increase the diversity and breadth of the study, as well as its impact on the field.

Another factor, which could be considered a limitation to the study, is researcher bias. The researcher implements a dual perspective in her practice and how she trains those she supervises. While the researcher utilized a journal throughout the process of the interviews, it was noted that the interview questions chosen for the study may reflect researcher bias, which could have contributed to the responses given by participants.

Implications for Future Research

Previous literature discusses the importance of implementing ABA with children with ASD (Cohen et al., 2006; Howard et al., 2005), the stress and lack of support families with a child diagnosed with ASD experience (Boyd, 2002; Meadan et al., 2010; Pottie & Ingram, 2008), and the use of systemic thinking within relationship systems (Keeney, 1983). Yet, it does not explore the experiences of therapists implementing a dual perspective. This is the first known study to explore the experiences of individuals trained in behavior analysis and marriage and family therapy working with families with facing ASD.

The results of this study indicate that when working with families with children diagnosed with ASD, dually trained behavior analysts and marriage and family therapists tend to implement a both/and perspective, which supports Keeney's (1983) emphasis on creating homeostasis by employing both linear and circular epistemologies. Future studies are needed, however, to expand on these findings. In particular, a larger sample size would increase the understanding of the experiences of the phenomenon. Additionally, future research should look to recruit participants from a variety of training programs and geographical locations in order to diversify the findings.

Further research should vary and/or increase the questions asked in order to account for possible researcher bias and allow participants to have a wider arena to share their experiences with this population. The literature reviewed identifies positive experiences from families facing autism receiving ABA-based interventions (McPhilemy & Dillenburger (2013). This should be broadened to look at this phenomenon of a dual perspective with these two epistemologies to gather the experiences of the families or a mixed methodologies study, where researchers can explore the qualitative experiences of the families and the quantitative outcomes of the children with ASD. Additionally, the quantitative outcomes of families, such as parental stress index, perceived control, and self-efficacy.

Research should also be broaden to incorporate the utilization of a both/and lens with other disciplines, as identified by various studies (Cautilli & Koenig, 2006; Koenig & Gerenser, 2006; Loiacano & Allen, 2008; Simons, 2014) in the literature review, merging ABA with SLP and special education. This research could help to further the ideas of collaboration and enhancing the, overall, treatment outcome of families facing autism.

Due to the limited research surrounding the challenges in the provisions of services for individuals with ASD through insurance funding and/or state regulations as identified by Participants 1 and 4 and supported by Ginsberg (2017) and Worthy (2017), boundaries presented by insurances and/or state regulations should also be explored. This could continue to present an enormous boundary for clinicians to provide the most effective services to families with children with ASD.

Implications for Future Practice and Training

Several implications for therapeutic practice and training arise from this study. First, the responses of participants indicate benefits of utilizing a dual perspective when working with families with children diagnosed with ASD. Accordingly, clinicians practicing with this population should incorporate a dual perspective to improve treatment outcomes. Second, participant responses reflect more positive engagement from families with the employment of a dual perspective. As such, perhaps, facilities, organization, and/or agencies providing services to this population could provide additional trainings to clinicians to expand their knowledge of either epistemology to more effectively and positively impact the system. It is recommended that clinicians working with this population familiarize themselves with both ABA principles and fundamentals and systemic thinking to better serve families with children diagnosed with ASD.

Furthermore, it is recommended that these ideologies be introduced during earlier phases, such as classes and/or continuing education courses. This has already been identified as a need by Kelly and Tincani (2013) in the ABA community. Based on the findings of their study, ABA practitioners receive little to no training in collaboration. Indicating, a significant need in the field for collaborative trainings, whether formal or informal. Currently, the Verified Course Sequence (VCS) provided by the BACB® does not encompass the family or other systems. It would be interesting to see if there are any changes to how ABA is disseminated if systemic thinking were to be incorporated into the course sequence or if it were offered as a continuing education course. At the same time, ABA is not address in family therapy programs teaching systemic thinking. A

university class or continuing education course provided for MFTs about ABA may help to introduce the ideas to students and/or clinicians interested in working with the ASD population. It would be interesting to see the receptiveness of both fields to this potential change or difference, as Bateson (1972) would refer to it.

As previously identified by Koenig and Gerenser (2006) in the literature review, utilizing a both/and lens also allows for broader procedural interventions and data. The merging of fields would lend to increased efficacy, more targeted goals, and the ability to develop more innovative interventions and strategies.

Summary

This chapter described the five themes captured in this study. The themes revealed that participants find the utilization of a dual perspective beneficial when working with families with children with ASD. Participants do experience challenges with a dual perspective, but the outcomes of treatment seem to outweigh those. The researcher discussed the limitations and implications of this study for future research and practice.

References

Abbeduto, I., Seltzer, M. M., Shattuck, P., Krauss, M. W., Orsmond, G., & Murphy, M. M. (2004). Psychological well-being and coping in mothers of youths with autism, Down syndrome, or Fragile X syndrome. *American Journal of Mental Retardation, 109*, 237-254.

Ahrens, E. N., Lerman, D. C., Kodak, T., Worsdell, A. S., & Keegan, C. (2011). Further evaluation of response interruption and redirection as treatment for stereotypy. *Journal of Applied Behavior Analysis, 44*(1), 95-108.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anderson, H. (1994). Rethinking family therapy: A delicate balance. *Journal of Marital and Family Therapy, 20*, 145-150.

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

Babel, D. A., Martin, G. L., Fazzio, D., Arnal, L., & Thomson, K. (2008). Assessment of the reliability and validity of the discrete-trials teaching evaluation form. *Developmental Disabilities Bulletin, 36*(1 & 2), 67-80.

Baker-Ericzen, M. J., Brookman-Frazee, L., & Stahmer, A. (2005). Stress levels and adaptability in parents of toddlers with and without autism spectrum disorders. *Research and Practice for Persons with Severe Disabilities, 30*, 194-204.

Baker, J. K., Seltzer, M. M., & Greenberg, J. S. (2011). Longitudinal effects of
adaptability on behavior problems and maternal depression in families of
adolescents with autism. *Journal of Family Psychology, 25*(4), 601-609. doi:
10.1037/a0024409

Bateson, G. (1972). *Steps to an ecology of mind.* Chicago, IL: University of Chicago
Press.

Bateson, G. (1979). *Mind and nature: A necessary unity*. New York, NY: E. P. Dutton.

Behavior Analysis Certification Board. (2018). Retrieved from https://www.bacb.com/

Boyd, B. A. (2002). Examining the relationship between stress and lack of social support
in mothers of children with autism. *Focus on Autism and Other Developmental
Disabilities, 17*(4), 208-215. https://doi.org/10.1177/10883576020170040301

Brown, F. (2004). Scientific narratives and ADHD. *Clinical Psychology, 40*, 17-20.

Bruininks, R., Woodcock, R., Weatherman, R., & Hill, B. (1996). *Scales of Independent
Behavior—Revised.* Itasca, IL: Riverside.

Carr, E. G., & Durand, V. M. (1985). Reducing behavior problems through functional
communication training. *Journal of Applied Behavior Analysis, 18*(2), 111-126.

Cautilli, J., & Koenig, M. (2006). Welcome readers of slp-aba!. *Journal of Speech and
Language Pathology-Applied Behavior Analysis, 1*(1), 1.

Centers for Disease Control and Prevention. (2018). Retrieved from
https://www.cdc.gov/ncbddd/autism/new-data.html

Cohen, H., Amerine-Dickens, M., & Smith, T. (2006). Early intensive behavioral
treatment: Replication of the UCLA model in a community setting. *Journal of
Developmental and Behavioral Pediatrics, 27*, S145-S155.

Cooper, J. O., Heron, T. E., & Heward, W. L. (2007). *Applied behavior analysis.* (2nd ed.). Upper Saddle River, NJ: Pearson.

Creswell, J. W. (2013). *Research design: qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

Crnic, K., Friedrich, W., & Greenberg, M. (1983). Adaptation of families with mentally retarded children: A model of stress, coping, and family ecology. *American Journal of Mental Deficiency*, *88*, 125-138.

Dattilio, F. M., & Epstein, N. B. (2005). Introduction to the special section: The role of cognitive-behavioral interventions in couple and family therapy. *Journal of Marital and Family Therapy, 31*(1), 7-13.

Dib, N., & Sturmey, P. (2007). Reducing student stereotypy by improving teachers' implementation of discrete-trial teaching. *Journal of Applied Behavior Analysis, 40*(2), 339-343.

Downs, A., Downs, R. C., Johansen, M., & Fossum, M. (2007). Using discrete trial teaching within a public preschool program to facilitate skill development in students with development disabilities. *Education and Treatment of Children, 30*(3), 1-27.

Dyer, K., & Kohland, K. A. (1991). Communication training at the May Center's integrated preschool: Assessment, structured teaching, and naturalistic generalization strategies. In E. Cipani (Ed.), *A guide to developing language competence in preschool children with severe and moderate handicaps* (pp. 162-200). Springfield, IL, England: Charles C Thomas, Publisher.

Flemons, D. (1991). *Completing distinctions*. Boston, MA: Shambhala.

Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health

  Counseling. (2018). Retrieved from

  https://floridasmentalhealthprofessions.gov/licensing/licensed-marriage-and-

  family-therapist/

Frost, L., & Bondy, A. (2001). *The picture exchange communication system* (2nd ed.).

  Newark, DE: Pyramid Educational Products.

Gergen, K. J., Hoffman, L., & Anderson, H. (1996). Is diagnosis a disaster? A

  constructionist trialogue. In F. W. Kaslow (Ed.), *Wiley series in couples and*

  family dynamics and treatment. Handbook of relational diagnosis and

  dysfunctional family patterns (pp. 102-118). Oxford, England: John Wiley &

  Sons.

Gergen, K. J. (2009). *An invitation to social construction* (2nd ed.). Los Angeles, CA:

  Sage Publications Lawrence Erlbaum.

Ghezzi, P. (2007). Discrete trials teaching. *Psychology in the Schools, 44*, 667-679.

Ginsberg, S.D. (2017). 5 ways insurance companies meddle in your mental health care.

  Retrieved from https://health.usnews.com/health-care/for-better/articles/2017-07-

  13/5-ways-insurance-companies-meddle-in-your-health-care

Gordon, K., Pasco, G., McElduff, F., Wade, A., Howlin, P., & Charman, T. (2011). A

  communication-based intervention for nonverbal children with autism: What

  changes? Who benefits? *Journal of Consulting and Clinical Psychology, 79*, 447-

  457. doi: 10.1037/a0024379

Gresham, F. M., Watson, T. S., & Skinner, C. H. (2001). Functional behavior assessment: Principles, procedures and future directions. *School Psychology Review, 30*, 156-172.

Hastings, R. P., Kovshoff, Ward, N. J., Espinosa, F. D., Brown, T., & Remington, B. (2005). Systems analysis of stress and positive perceptions in mothers and fathers of pre-school children with autism. *Journal of Autism and Developmental Disorders, 35*, 635-644.

Hodgetts, S., Magill-Evans, J., & Misiaszek, J. E. (2011). Weighted vests, stereotyped behaviors and arousal in children with autism. *Journal of Autism and Developmental Disorders, 41*, 805-814. doi: 10.1007/s10803-010-1104-x

Howard, J. S., Sparkman, C. R., Cohen, H. G., Green, G., & Stanislaw, H. (2005). A comparison of intensive behavior analytic and eclectic treatments for young children with autism. *Research in Developmental Disabilities*, *26*, 359-383.

Husserl, E. (1999). *The essential Husserl: Basic writings in transcendental phenomenology*. D. Welton (Ed.). Bloomington, IN: Indiana University Press.

Ireys, H. T., & Silver, F. J. (1996). Perception of the impact of a child's chronic illness: Does it predict maternal mental health? *Developmental and Behavioral Pediatrics, 17*, 77-83.

Iwata, B. A., Dorsey, M. F., Slifer, K. J., Bauman, K. E., & Richman, G. S. (1994). Toward a functional analysis of self-injury. *Journal of Applied Behavior Analysis, 27*, 197-209. (Reprinted from Analysis and Intervention in *Developmental Disabilities, 2*, 3-20, 1982)

Keeney, B. P. (1983). *Aesthetics of change.* New York, NY: Guilford Press.

Kelly, A., & Tincani, M. (2013). Collaborative training and practice among applied behavior analysts who support individuals with autism spectrum disorder. *Education and Training in Autism and Developmental Disabilities, 48*(1), 120-131.

Koegel, R. L. & Koegel, L. K. (1996). *Teaching children with autism: Strategies for initiating positive interactions and improving learning opportunities*. Baltimore: Paul Brookes Publishing Co.

Koenig, M., & Gerenser, J. (2006). SLP-ABA: Collaborating to support individuals with communication impairments. *The Journal of Speech and Language Pathology – Applied Behavior Analysis, 1*(1), 2-10.

Lang, R., Sigafoos, J., Lancioni, G., Didden, R., & Rispoli, M. (2010). Influence of assessment setting on the results of functional analyses of problem behavior. *Journal of Applied Behavior Analysis, 43*(3), 565-567.

Lawton, K., & Kasari, C. (2012). Teacher-implemented joint attention intervention: Pilot randomized controlled study for preschoolers with autism. *Journal of Consulting and Clinical Psychology, 80*, 687-693. doi: 10.1037/a0028506

Lim, H. A. (2009). Use of music to improve speech production in children with autism spectrum disorders: Theoretical orientation. *Music Therapy Perspectives, 27*(2), 103-114.

Loiacano, V., & Allen, B. (2008). Are special education teachers prepared to teach the increasing number of students diagnosed with autism? *International Journal of Special Education, 23*(2), 120-127.

Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual

functioning in young autistic children. *Journal of Consulting and Clinical Psychology, 55*(1), 3–9.

Mace, F. C. (1994). The significance and future of functional analysis methodologies. *Journal of Applied Behavior Analysis, 27*(2), 385-392.

Matson, J. L., & Kozlowski, A. M. (2011). The increasing prevalence of autism spectrum disorders. *Research in Autism Spectrum Disorders, 5*(1), 418-425.

Maturana, H. (1988). Reality: The search for objectivity or the quest for a compelling argument. *The Irish Journal of Psychology, 9*(1), 25-82.

McBride, B. J., & Schwartz, I. S. (2003). Effects of teaching early interventionists to use discrete trials during ongoing classroom activities. *Topics in Early Childhood Special Education, 23*(1), 5-17.

McCord, B. E., Thomson, R. J., & Iwata, B. A. (2001). Functional analysis and treatment of self-injury associated with transitions. *Journal of Applied Behavior Analysis, 34*(2), 195-210.

McPhilemy, C., & Dillenburger, K. (2013). Parents' experiences of applied behaviour analysis (ABA)-based interventions for children diagnosed with autistic spectrum disorder. *Applied Behaviour Analysis, 40*(4), 154-161. https://doi.org/10.1111/1467-8578.12038

Meadan, H., Hale, J. W., & Ebata, A. T. (2010). Families who have children with autism spectrum disorders: Stress and support. *Exceptional Children, 77*(1), 7-36.

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

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage

Publications.

Neef, N. A., & Iwata, B. A. (1994). Current research on functional analysis

methodologies: An introduction. *Journal of Applied Behavior Analysis, 27*(2),

211-214.

Nichols, M.P. (2011). *The essentials of family therapy* (5th ed.). Boston, MA: Pearson.

Olson, D., Sprenkle, D., & Russell, C. (1979). Circumplex model of marital and family

systems I: Cohesion and adaptability dimensions, family types and clinical

applications. *Family Process, 18,* 3-28. doi:10.1111/j.1545-5300.1979.00003.x.

Paul, R. (2008). Communication development and assessment. In K. Chawarska, A. Klin,

& F. R. Volkmar (Eds.), *Autism spectrum disorders in infants and toddlers:*

Diagnosis, assessment, and treatment (pp. 76-103). New York, NY: Guildford

Press.

Piazza, C. C., Fisher, W. W., Brown, K. A., Shore, B. A., Patel, M. R., Katz, R. M.,

Blakely-Smith, A. (2003). Functional analysis of inappropriate mealtime

behaviors. *Journal of Applied Behavior Analysis, 36*(2), 187-204.

Pottie, C. G., & Ingram, K. M. (2008). Daily stress, coping, and well-being in parents of

children with autism: A multilevel modeling approach. *Journal of Family*

Psychology, 22(6), 855-864. doi: 10.1037/a0013604

Prizant, B. M., & Wetherby, A. M. (2005). Critical issues in enhancing communication

abilities for persons with autism spectrum disorders. In F. R. Volkmar, R. Paul, A.

Klin, & D. Cohen (Eds.), *Handbook of autism and pervasive developmental*

disorders: Assessment, interventions, and policy (pp. 925-945). Hoboken, NJ:

John Wiley & Sons Inc.

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401. doi:10.1177/014662167700100306.

Reed, F. D. D., Reed, D. D., Baez, C. N., & Maguire, H. (2011). A parametric analysis of errors of commission during discrete trial training. *Journal of Applied Behavior Analysis, 44*(3), 611-615.

Reichle, J. & & Wacker, D. P. (1993). *Communicative alternatives to challenging behavior: Integrating functional assessment and intervention strategies*. Baltimore: Paul Brookes Publishing Company.

Rogers, M. L., & Hogan, D. P. (2003). Family life with children with disabilities: The key role of rehabilitation. *Journal of Marriage and Family Therapy, 64*(4), 818-833.

Sallows, G. O., & Graupner, T. D. (2005). Intensive behavior treatment for children with autism: Four-year outcome and predictors. *American Journal on Mental Retardation, 110*(6), 417-438.

Scanlon, J. (1989). Edmund Husserl, Logische Untersuchungen: Zweiter Band, Erster Teil; Zweiter Band, Zweiter Teil (Husserliana XIX/1, XIX/2). In U. P. (Eds.), The Hague: Nijhoff (958). *Journal of Phenomenological Psychology, 20*(1), 100-103. doi:10.1163/156916289x00157

Scorgie, K., Wilgosh, L., & McDonald, L. (1998). Stress and coping in families of children with disabilities. *Developmental Disabilities Bulletin, 26,* 22-42.

Shawver, L. (n.d.). What is postmodernism and what does it have to do with

therapy, anyway? An interview with Lois Shawver. Retrieved from

    http://newtherapist.com/lois6.html

Simons, E. (2014). Merge of behavior analysis procedures into a speech-language

    pathology autism clinic (Masters thesis). Retrieved from

    https://commons.lib.jmu.edu/master201019/327

Skinner, B. F. (1957). *Verbal behavior*. England/Cliffs, NJ: Prentice Hall.

Stone, A. A., & Neale, J. M. (1984). New measure of daily coping: Development and

    preliminary results. *Journal of Personality and Social Psychology, 46,* 892-906.

Tiger, J. H., Fisher, W. W., & Bouxsein, K. J. (2009). Therapist- and self-monitored

    DRO contingencies as a treatment for the self-injurious skin picking of a young

    man with Asperger syndrome. *Journal of Applied Behavior Analysis, 42*(2), 315-

    9.

Timimi, S. (2004). Helping children and adolescents who could be diagnosed with

    ADHD and their families: Oscillating between modernist and post-modernist

    perspectives. *Clinical Psychology, 40*, 24-27.

Trusell, R. P., Lewis, T. J., & Stichter, J. P. (2008). The impact of target classroom

    interventions and function-based behavior interventions on problem behaviors of

    students with emotional/behavioral disorders. *Behavioral Disorders, 33*(3), 153-

    166.

Tsiouri, I., Schoen Simmons, E., & Paul, R. (2012). Enhancing the application and

    evaluation of a discrete trial intervention package for eliciting first words in

    preverbal preschoolers with ASD. *Journal of Autism and Developmental

    Disorders, 42*(7), 1281-93. doi: 10.1007/s10803-011-1358-y

Ulke-Kurkcuoglu, B., & Kircaali-Iftar, G. (2010). A comparison of the effects of

    providing activity and material choice to children with autism spectrum disorders.

    Journal of Applied Behavior Analysis, 43, 717-721. doi: 10.1901/jaba.2010.43-

    717

Varela, F. J. (1984). The creative circle: Sketches on the natural history of circularity. In

    P. Watzlawick (Ed.) *The invented reality: Contributions to constructivism* (pp.

    309-325). New York, NY: W. W. Norton. http://cepa.info/2089

Waters, M. B., Lerman, D. C., & Hovanetz, A. N. (2009). Separate and combined effects

    of visual schedules and extinction plus differential reinforcement on problem

    behavior occasioned by transitions. *Journal of Applied Behavior Analysis, 42*(2),

    309-13.

Weiss, M. J. (2002). Hardiness and social support as predictors of stress in mothers of

    typical children, children with autism, and children with mental retardation.

    Autism, 6, 115-130.

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

    W. W. Norton & Company, Inc.

Worthy, S. (2017). Doctors, not insurance companies, should take medical decisions.

    Retrieved from https://www.newsweek.com/doctors-not-insurance-companies-

    should-take-medical-decisions-650872

Yoder, P. & Stone, W. L. (2006). Randomized comparison of two communication

    interventions for preschoolers with autism spectrum disorders. *Journal of*

    Consulting and Clinical Psychology, 74, 426-435. doi: 10.1037/0022-

    006X.74.3.426

Zablotsky, B., Black, L.I., Maenner, M.J., Schieve, L.A., & Blumberg, S.J. (2015).

Estimated prevalence of autism and other developmental disabilities following

questionnaire changes in the 2014 national health interview survey. *National*

Health Statistics Report, 84, 1-20. Retrieved from

https://www.cdc.gov/nchs/data/nhsr/nhsr087.pdf

Appendices

Appendix A

Letter of Invitation

YOU ARE INVITED TO PARTICIPATE IN A RESEARCH STUDY: Exploring the Experiences of Trained Behavior Analysts and Marriage and Family Therapists Working With Families of Children Diagnosed With Autism Spectrum Disorder Through Transcendental Phenomenology

Dear Potential Participant,

I am a doctoral student at Nova Southeastern University in the Marriage and Family Therapy program. This research is to be submitted as a partial fulfillment of my degree plan. I have chosen this topic to explore the experience of individuals working with families of children diagnosed with Autism Spectrum Disorder (ASD) that are trained Behavior Analysts and Marriage and Family Therapists.

This research will attempt to serve as a tool for capturing the essence of the phenomena of the experiences of trained Behavior Analysts and Marriage and Family Therapists when working with families of children diagnosed with ASD.

I would like to invite you to participate in my study. The information and data necessary will be gathered by means of a live one-hour interview, which can be conducted either in-person or via videoconference, consisting of some demographic questions followed by research questions related to your experience working with families of children diagnosed with ASD. Participation is entirely voluntary, and you may revoke your participation at any time. If you choose to participate, you will be sent the confidentiality and consent forms, followed by an email to schedule an interview.

Thank you in advance for your time. If you have any questions, please contact me via E-mail at djanessa@mynsu.nova.edu or telephone 754-246-0655.

Sincerely,

Janessa Dominguez, M.S., BCBA, Ph. D. (candidate)

Appendix B

Consent Form

General Informed Consent Form
NSU Consent to be in a Research Study Entitled
Exploring the Experiences of Trained Behavior Analysts and Marriage and Family Therapists
Working With Families of Children Diagnosed With Autism Spectrum Disorder Through
Transcendental Phenomenology

Who is doing this research study?

College: College of Arts, Humanities, and Social Sciences: Department of Family Therapy

Principal Investigator: Janessa Dominguez, M.S., BCBA

Faculty Advisor/Dissertation Chair: Tommie V. Boyd, Ph. D

Co-Investigator(s): N/A

Site Information: Shaping Change, LLC. 2800 Weston Rd., Ste. 100, Weston, FL 33331

Funding: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this research study is to explore the experiences of trained Behavior Analysts and Marriage and Family Therapists (MFTs) when working with families of children diagnosed with Autism Spectrum Disorder (ASD). This study will help to gain further insight into how dually trained professionals work with families with children with ASD and what their experiences are compared to other dually trained professionals.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you are trained as both a Behavior Analyst and Marriage and Family Therapist in a role where you work with families with children diagnosed with Autism Spectrum Disorder. There will be approximately 5 participants in this study.

This study will include about 5 people.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, you will participate in a one-hour digitally-audio recorded live interview, which can be conducted either in-person or via video conference (Skype or Facetime) to account for scheduling and location conflicts with Ms. Dominguez. As a participant, the principal investigator (PI), Ms. Dominguez, will ask demographic questions about you and your scope of practice, as well as open-ended questions related to your experience working with families with children diagnosed with Autism Spectrum Disorder. Interviews will be conducted in a private and closed room within the PI's private practice, Shaping Change, LLC, at a time that is mutually agreed upon. Once analysis is drawn from the interview, you may choose to review it to add further comments or clarification. This second meeting will last approximately 30 minutes and will take place at the same location as the initial interview. This

second meeting is optional and will not be recorded. You may stop the interview at any point if you no longer wish to participate.

Research Study Procedures - as a participant, this is what you will be doing:

You will be participating in a one-hour digitally-audio recorded live interview, which can be conducted either in-person or via video conference (Skype or Facetime) with Ms. Dominguez. You will be asked demographic questions about you and your scope of practice, as well as open-ended questions related to your experience working with families with children diagnosed with Autism Spectrum Disorder. Interviews will be conducted in a private and closed room within the PI's private practice, Shaping Change, LLC, at a time that is mutually agreed upon. Once analysis is drawn from the interview, you may choose to review it to add further comments or clarification. This second meeting will last approximately 30 minutes and will take place at the same location as the initial interview. This second meeting is optional and will not be recorded.

<u>Are there possible risks and discomforts to me?</u>

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

Sharing your experiences about your work as a clinician with families with individuals living with Autism Spectrum Disorder may be challenging if you have experienced difficult cases.

Another potential risk is confidentially. The likelihood of a breach in confidentiality is minimal, as procedures are in place to secure information. Names will not be utilized; Ms. Dominguez will assign numbers to participants in the order in which interviews are completed. Audio recordings will be transcribed in Ms. Dominguez's private home office with headphones. Information gathered and analyzed from the interviews will not utilize names and will be stored in a secured password-protected file in a password-protected computer only accessible by Ms. Dominguez. All materials will be kept in a locked cabinet.

<u>What happens if I do not want to be in this research study?</u>
You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study before it is over, any information about you that was collected **<u>before</u>** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?
If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

<u>Are there any benefits for taking part in this research study?</u>

There are no direct benefits from being in this research study. We hope the information learned from this study will be a catalyst for gaining further insight to your experiences working with families with children diagnosed with Autism Spectrum Disorder and how your experience compares to that of other clinicians.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

Ask the researchers if you have any questions about what it will cost you to take part in this research study.

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. The researcher will not include any information that will make you identifiable. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely The interview transcripts will be secured in a file for the review of the researchers only. The information gathered will be stored in a secured password-protected file in a password-protected computer only accessible by the researcher within her private home office. All materials will be kept in a locked cabinet in the researcher's private home office. All data will be kept for 36 months from the end of the study and destroyed after that time by shredding all paper related to the research, deleting the audio file from the digital-audio recorder, deleting the files on the computer, and emptying the trash bin of the computer.

Will there be any Audio or Video Recording?
This research study involves audio recording. This recording will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any of the people who gave the researcher money to do the study (if applicable). The recording will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to or viewing the recording. The researcher will transcribe the interviews in a private room in her personal residence using earphones to further guard the participants' privacy.

Whom can I contact if I have questions, concerns, comments, or complaints?
If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:
Janessa Dominguez, M.S., BCBA can be reached at (954) 589-1038

If primary is not available, contact:
Tommie V. Boyd, Ph. D can be reached at (954) 262-3027

Research Participants Rights
For questions/concerns regarding your research rights, please contact:

Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

All space below was intentionally left blank.

Research Consent & Authorization Signature Section

<u>Voluntary Participation</u> - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:
- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

<div style="border:1px solid black; padding:10px;">

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant	Signature of Participant	Date
Printed Name of Person Obtaining Consent and Authorization	Signature of Person Obtaining Consent & Authorization	Date

</div>

-

Appendix C

Letter of Approval

NSU NOVA SOUTHEASTERN UNIVERSITY
Institutional Review Board

MEMORANDUM

To:	**Janessa Dominguez**
From:	**Angela Yehl, Psy.D.,** **Center Representative, Institutional Review Board**
Date:	**August 15, 2018**
Re:	**IRB #: 2018-412; Title, "Exploring the Experiences of Trained Behavior Analysts and Marriage and Family Therapists Working With Families of Children Diagnosed With Autism Spectrum Disorder Through Transcendental Phenomenology"**

I have reviewed the above-referenced research protocol at the center level. Based on the information provided, I have determined that this study is exempt from further IRB review under **45 CFR 46.101(b) (Exempt 2: Interviews, surveys, focus groups, observations of public behavior, and other similar methodologies)**. You may proceed with your study as described to the IRB. As principal investigator, you must adhere to the following requirements:

1) CONSENT: If recruitment procedures include consent forms, they must be obtained in such a manner that they are clearly understood by the subjects and the process affords subjects the opportunity to ask questions, obtain detailed answers from those directly involved in the research, and have sufficient time to consider their participation after they have been provided this information. The subjects must be given a copy of the signed consent document, and a copy must be placed in a secure file separate from de-identified participant information. Record of informed consent must be retained for a minimum of three years from the conclusion of the study.

2) ADVERSE EVENTS/UNANTICIPATED PROBLEMS: The principal investigator is required to notify the IRB chair and me (954-262-5369 and Angela Yehl, Psy.D., respectively) of any adverse reactions or unanticipated events that may develop as a result of this study. Reactions or events may include, but are not limited to, injury, depression as a result of participation in the study, life-threatening situation, death, or loss of confidentiality/anonymity of subject. Approval may be withdrawn if the problem is serious.

3) AMENDMENTS: Any changes in the study (e.g., procedures, number or types of subjects, consent forms, investigators, etc.) must be approved by the IRB prior to implementation. Please be advised that changes in a study may require further review depending on the nature of the change. Please contact me with any questions regarding amendments or changes to your study.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Cc: Tommie Boyd, Ph.D.

Appendix D

Research Questions for Research Study Entitled
Exploring the Experiences of Clinicians Dually-trained in Behavior Analysis and Family Therapy Working with Families Facing Autism

Demographic Questions

1. What is your age?

2. What is your gender?

3. Which race/ethnicity best describes you?

4. How many years have you been in practice?

5. Where are do currently practice? (City, State)

6. How long have you been trained both ABA and systemic thinking?

7. Which training came first, ABA or systemic thinking?

8. How long have you been practicing each?

9. What licenses and/or certifications do you hold?

10. How long have you been licensed and/or certified?

Interview Questions

11. How do you identify as a clinician with regards to the license and/or certification you hold and how you practice?

12. What do you notice about dual perspective?

13. How do you engage families in the process?

Biographical Sketch

Janessa Dominguez was born in Miami, Florida to immigrant Cuban parents. Ms. Dominguez is first-born generation here in the United States. She is the first in her family to earn both a bachelor's degree and master's degree. Ms. Dominguez earned a bachelor's in psychology with a minor in business from Nova Southeastern University. She went on to pursue a master's degree in counseling with an advanced concentration in Applied Behavior Analysis from Nova Southeastern University after being afforded the opportunity to work as a behavior therapist with individuals diagnosed with ASD and related disabilities. From here, she went on to work in various capacities at the Baudhuin Preschool at the Mailman Segal Center for Human Development on Nova Southeastern University's campus.

It was during this time, that Ms. Dominguez found her passion for working with individuals with disabilities. It was also during this time that she discovered the growing need to not only provide services to these individuals with disabilities, but also to their families. This led to her pursuing her doctoral degree in family therapy from Nova Southeastern University.

Ms. Dominguez is a Board Certified Behavior Analyst, Licensed Marriage and Family Therapist, and Registered Intern with the State of Florida for Mental Health Counseling. She is the owner and Clinical Director of Shaping Change, LLC.—a multidisciplinary clinic in South Florida, which provides services to individuals with a variety of mental health disorders, specializing in the treatment of Autism Spectrum Disorder, and their families. Ms. Dominguez provides training throughout the national

and international communities to increase the awareness and acceptance of autism and to highlight the importance of working with the families, too.

Ms. Dominguez has been invited to present at the American Association for Marriage and Family Therapy's (AAMFT) National Conference in Portland, Oregon and the Solution-Focused Brief Therapy Association's Conference in Toronto, Canada on "Relational Backpacking for Family Journeys with Autism", which emphasizes family journeys with a child with autism throughout various phases of life, while highlighting the strengths and exceptions from a solution-focused lens. She has also been invited to present at the American Family Therapy Academy's Annual Meeting and Open Conference in Chicago, Illinois on "Multicultural Couples: A Mosaic", focusing on the importance of individual cultures being represented through a cultural mosaic in a couple dyad.