

The Story of Intuition in Marriage and Family Therapy

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Dedication

This dissertation is dedicated to my husband and daughter and all our future dreams. Your love, laughter, and spirit are the most important parts of my story.

Abstract

Clinical intuition has been a subject of interest in the field of marriage and family therapy (MFT) for decades. Authors have theorized how intuition might be useful in the practice of MFT. Before understanding the place of intuition in the field, we must first explore the concept of intuition in MFT. The purpose of this study was to more deeply understand the phenomenon of intuition in MFT clinical work. The specific research question addressed in this study was: How have marriage and family therapists (MFTs) experienced intuition in their clinical work? Using a qualitative transcendental phenomenological approach, the researcher gathered and analyzed MFTs' stories of intuition in order to begin to make meaning of this phenomenon. Twelve participants shared 26 stories of intuition in their clinical work. Findings provided insight into the lived experience of intuition in MFT. Intuition allowed therapists to shift their attention to new possibilities, thus forming and offering interventions for clients to make significant changes and achieve their goals. Implications for future research and clinical practice are discussed.

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The Story of Intuition in Marriage and Family Therapy

Chapter I: Introduction

The heart has its reasons which reason does not know – Pascal

A hunch is creativity trying to tell you something – Frank Capra

Intuition will tell the thinking mind where to look next – Jonas Salk

Statement of the Problem

Though the phenomenon of intuition has been mentioned in literature for centuries, little is known about clinical intuition in psychotherapy (Dodge Rea, 2001; Garcia & Ford, 2001; Shirley & Langan-Fox, 1996; Welling, 2005). Intuition is a poorly understood phenomenon (Nyatanga & de Vocht, 2008). Specifically, the body of empirical literature on clinical intuition in marriage and family therapy (MFT) is in its infancy. The practice of MFT is fraught with ethical and clinical dilemmas that could benefit from intuitive judgments and decision-making. Perhaps it is for these reasons therapy theorists have encouraged clinicians to understand and embrace intuition (Berne, 1949; Berne, 1962; Corey, 1991; Eisengart & Faiver, 1996; Gill, 1982; Rogers, 1961). But despite the potential benefits of intuition, and the many theoretical articles touting its importance (Bove & Rizzi, 2009; Laub, 2006; Dodge Rea, 2001), other theorists caution us about the fallible nature of intuition (Polgar & Thomas, 1991; Williams & Irving, 1996). Only recently have we begun to empirically explore this concept in the field of MFT (Boss, 1987; Jeffrey, 2004; Jeffrey & Stone Fish, 2011; Keith, 1987; Pinjala, 2009; Rober, 1999; Weis, 2009). The most current research on intuition in the field of MFT has been to describe how marriage and family therapists (MFTs) think about or define

intuition in their clinical work (Jeffrey, 2004; Jeffrey & Stone Fish, 2011; Pinjala, 2009), but little is known about how MFTs are experiencing this phenomenon. Is it useful? Is it harmful? Is it even noticed? How is it being expressed or communicated or received? What is intuition and what is it not? How do we know when it is occurring and what to do with it? How does intuition show up in clinical work? Can we trust intuition? From experiences of intuition, what can we learn about this phenomenon?

Purpose of the Study

To fully understand how intuition might be useful in MFT, researchers and therapists must first explore the concept of intuition in MFT. Research exploring this phenomenon is warranted given the lack of empirical evidence in the literature. The purpose of this study was to more deeply understand the experience of intuition in MFT clinical work. Using a transcendental phenomenological approach, MFTs' stories of intuition were gathered and analyzed in order to begin to make meaning of this phenomenon. The specific research question addressed in this study was: How have MFTs experienced intuition in their clinical work?

Assumptions of the Study

There were several assumptions of this study that were informed by previous theoretical, empirical, and methodological literature:

- 1) Clinical intuition is a real phenomenon (Bohart, 1999; Boss, 1987; Bove & Rizzi, 2009; Buckingham & Adams, 2000; Davis-Floyd & Davis, 1996; Detsky, Redelmeir, & Abrams, 1987; Dodge Rea, 2001; Eisengart & Faiver, 1996; Garcia, 2001; Gerrity, 1987; Greenhalgh, 2002; Haddey, 2009; Jeffrey,

2004; Keith, 1987; Laquercia, 2005; Laub, 2006; Lum, 2002; Mitten & Piercy, 1993; Nichols & Schwartz, 2006; Piha, 2005; Pinjala, 2009; Rober, 1999; Shirley & Langan-Fox, 1996; Style, 1979; Timm & Blow, 1999; Weis, 2009; Welling, 2005; Young, 1987).

- 2) Though clinical intuition is often defined as an internal, usually rapid, process, it is somehow noticeable to the therapist either while it is happening or in hindsight (Bohart, 1999; Bove & Rizzi, 2009; Dodge Rea, 2001; Eisengart & Faiver, 1996; Garcia, 2001; Greenhalgh, 2002; Haddey, 2009; Laquercia, 2005; Laub, 2006; Lum, 2002; Mitten & Piercy, 1993; Piha, 2005; Shirley & Langan-Fox, 1996; Timm & Blow, 1999; Welling, 2005).
- 3) Because it is noticeable to the therapist, MFTs are able to describe examples or stories of these experiences (Moustakas, 1994; van Manen, 1990).
- 4) Stories of this phenomenon will provide insight into the experience of intuition in MFT (Moustakas, 1994; van Manen, 1990), thus contributing to greater understanding of intuition in MFT clinical practice.

Chapter II: Literature Review

Theoretical Background

The phenomenon of intuition has been addressed in various fields of study for centuries. Philosophy, one of the fields that birthed the beginnings of psychotherapy, addressed intuition as early as the 17th century when Descartes defined intuition as the process by which an unbiased and attentive mind might arrive at a clear and distinct idea (Hergenhahn, 2001). In the early days of psychotherapy and psychoanalysis, Freud, Jung,

and Rogers also heralded the importance of intuition (Bohart, 1999; Boss, 1987; Nichols & Schwartz, 2006). Since that time, attention has been placed on the phenomenon of intuition in the fields of business (Anderson, 2000; Brockmann & Anthony, 1998; Harper, 1988; Mitchell, 2005; Prietula & Simon, 1989; Sadler-Smith & Burke, 2009; Shapiro & Spence, 1997), education, (Harteis, Koch, & Morgenthaler, 2008), medicine (Detsky, Redelmeir, & Abrams, 1987; Style, 1979), nursing, (Buckingham & Adams, 2000; Gerrity, 1987; McCutcheon & Pincombe, 2001; Miller, 1995; Nyatanga & de Vocht, 2008; Rew, 1988; Smith, 2007; Welsh, 2001; Young, 1987), midwifery (Davis-Floyd & Davis, 1996; Jefford, Fahy, & Sundia, 2011), social work (Eichler & Halseth, 1992), other sciences such as psychology, sociology, and neurobiology (Bernstein, 2005; Damasio, 1994, 1999; Dijksterhuis, 2004; Dijksterhuis & Nordgren, 2006; Goddard, 2009; Khatri & Ng, 2000; Mayer, Naliboff, & Munakata, 2000; Reid, 1981; Sprenkle, 2005), philosophy (Fricker, 1995), mathematics (Reber, Brun, & Mitterndorfer, 2008), psychotherapy and psychoanalysis (Bohart, 1999; Bove & Rizzi, 2009; Dodge Rea, 2001; Eisengart & Faiver, 1996; Garcia, 2001; Greenhalgh, 2002; Haddey, 2009; Laquercia, 2005; Laub, 2006; Lum, 2002; Mitten & Piercy, 1993; Piha, 2005; Shirley & Langan-Fox, 1996; Timm & Blow, 1999; Welling, 2005), music therapy (Brescia, 2004), and more recently, marriage and family therapy (Boss, 1987; Jeffrey, 2004; Jeffrey & Stone Fish, 2011; Keith, 1987; Pinjala, 2009; Rober, 1999; Weis, 2009).

While previous research of this topic in the field of MFT has been to describe how MFTs view and think about intuition in their clinical work (Jeffrey & Stone Fish, 2011), there is no research on MFTs' experiences of intuition as rooted in their lived

stories. To fully understand how intuition might be useful in the therapy room, how it might affect client outcomes, and how training programs and supervisors might begin to hone this therapeutic skill as previous literature has suggested (Jeffrey, 2004; Jeffrey & Stone Fish, 2011; Pinjala, 2009), the field must first more deeply understand this phenomenon through examination of MFTs' lived experiences.

Importance of the Study

Clinical decisions are frequently made in difficult, highly charged situations in which clinicians are facing ethical and clinical dilemmas. Examples can be seen with end-of-life palliative care, parole boards, crisis hotlines, school social workers, and other places in which an individual or group need to make the best decision to protect a client or the public, but have limited information (Myers, 2010; Nyatanga & de Vocht, 2008). Clinical reasoning skills must ensure that patients receive the most appropriate treatment, in the shortest amount of time, with the least amount of unwanted effects (Jefford, Fahy, & Sundin, 2011). Authors have suggested that helping professionals of all kinds benefit from the informative and speedy nature of intuition (Jefford, Fahy, & Sundin, 2011; Reyna, 2004; Rew, 2000; Rew & Barrow, 2007). Others have acknowledged intuition's presence and potential, but have cautioned practitioners around it (Haidt, 2008; Polgar & Thomas, 1991; Williams & Irving, 1996). Perhaps every therapist has hunches, sudden insights, gut feelings, clues, guesses, glimpses, inklings, judgments, speculation, imagination, sixth sense, chooses direction in therapy without really knowing why, or has uncanny feelings that turn out to be significant in treatment, but this phenomenon is

poorly studied and little is published on it (Dodge Rea, 2001; Garcia & Ford, 2001; Shirley & Langan-Fox, 1996; Welling, 2005).

There may be several reasons why little has been published on this topic within the therapy literature. Keith (1987) argued that family therapists are rooted in the field of psychology and psychoanalysis, which in their efforts to become hard sciences, are rooted in positivism. He also wrote that intuition is often viewed, then, as mystical, spiritual, and even dangerous, historically. The dominant approach to clinical decision-making in health sciences and Western science is founded on a trust of rationalism and empiricism (Jefford, Fahy, & Sundin, 2011), which may not align with this view of intuition as mystical or spiritual. Garcia and Ford (2001) explained that the neglect of the topic of clinical intuition is rooted in our North American culture of positivism and emphasis of the five senses, but that there is a growing interest in the phenomenon of intuition given the immediacy and speed of intuitive knowing and the advent of managed care systems in which clinical knowing must happen more quickly. Intuition has been described as an “effortless, immediate, unreasoned sense of truth” (Myers, 2010, p. 371).

Many researchers and theorists have posited that intuition exists (Eisengart & Faiver, 1996; Lewicki, 1985; Lewicki, 1986; Lewicki, Czyzewska, & Hoffman, 1987; Lewicki & Hill, 1989; Lewicki, Hill, & Czyzewska, 1992; Mitchell & Beach, 1990; Simon, 1986). Empirical studies in various fields have suggested that intuition is a form of perception or decision-making that is rapid, informative, and a reflection of an individual’s expertise and ability to identify patterns or connect patterns in new ways (Ambady & Rosenthal, 1992, 1993; Crossan, Lane, & White, 1999; Dane & Pratt, 2007;

Elsbach & Barr, 1999; Isenberg, 1984; Mellers, Hertwig, & Kahneman, 2001; Myers, 2010; Nyatanga & de Vocht, 2008; Simon, 1992), and that even infants at one year of age can display gut level responses to others' behaviors (Bloom, 2010). Modern dual-process theories describe intuitive-like experiential processing systems that are unconscious, rapid, effortless, and associative (Kahneman, 2003; Sloman, 1996; Smith & DeCoster, 2000; Strack & Deutsch, 2004).

Most importantly, authors have suggested that intuition is central to understanding the therapeutic process (Berne, 1949; Berne, 1962; Corey, 1991; Eisengart & Faiver, 1996; Gill, 1982; Rogers, 1961). Because MFTs practice from a unique perspective due to their relational and theoretical training, MFTs might provide a perspective on intuition that is not yet described in the literature (Jeffrey & Stone Fish, 2011).

Defining Intuition

Definition of intuition across fields. Previous writings on the phenomenon of intuition have defined it in many ways. There are few phenomena in the history of psychology and psychotherapy that have so many definitions (Epstein, 2010). Sprenkle (2005) completed a comprehensive literature review and found over forty versions of the term in clinical theories. It has been called a “fuzzy” construct and difficult to grasp (Epstein, 2010, p.296). Some general definitions include drawing inferences, interpreting categories, determining emotional reactions, feeling love, forming impressions of people, thinking creatively, solving problems, having opinions, feelings, insights, recognition, or understanding (Lewicki, 1985, 1986; Lewicki, Czyzewska, & Hoffman, 1987; Lewicki & Hill, 1989; Lewicki, Hill, & Czyzewska, 1992; Simon, 1992). Several nursing studies

have linked intuition to gut feelings (Davis-Floyd & Davis, 1996; Khatri & Ng, 2000; McCutcheon & Pincombe, 2001; Rew, 1988). One definition offered in the nursing literature was that intuition is to understand something without a rationale (Benner & Tanner, 1987). The authors went on to argue that intuition and intuitive decision making is what separates a medical provider from a computer; that any computer can make choices based on a decision tree or logarithm, but the human component of intuition is what makes the difference. Damasio (1994, 1999) described somatic markers that form the basis of an unconscious automatic system that he called intuition; he argued that gut feelings are a non-cognitive way of knowing.

Ultimately, though there is no consensus on the definition of intuition (Shirley & Langan-Fox, 1996), repetitive themes emerge. Authors seem to regard intuition as a valuable component of experiential processing (Nyatanga & de Vocht, 2008), and that intuition is information acquired without rational, conscious, or deliberate reasoning (Epstein, 2010; Shirley & Langan-Fox, 1996). For therapists, intuition is often regarded as a common source of information in therapy (Garcia & Ford, 2001; Dodge Rea, 2001; Vaughan, 1979). Smith (2007) theorized that intuition causes a deep understanding of the total situation. Benner et al. (1996) described intuition as a process in which experts see the unexpected, that which is beyond the immediate clinical situation, the bigger picture. Authors often use words like hunch or sixth sense, suggesting how difficult it is to pinpoint the phenomenon of intuition (Nyatanga & de Vocht, 2008).

Definitions of intuition in psychotherapy. Therapists and therapy researchers have defined clinical intuition more specifically to the psychotherapy field. One

psychoanalyst compared intuition to gravity; that we know it exists but we cannot see it (Laub, 2006). She described intuition as the power of knowing immediately without being taught and that it is a valuable tool in therapy. Bohart (1999) studied intuition in psychotherapy and described intuition as coming from our concepts and schemas, our worldviews; that stimuli is filtered through our schemas, but we must constantly be modifying those concepts in order to function. This modification, the author argued, takes creativity that is grounded in tacit, bodily knowing; it is an experiential knowledge called intuition. Dodge Rea (2001) also argued that if we believe a therapist is more than a technician, and a client is more than a constellation of symptoms, then therapy is more than just treatment, and the defining element of the therapeutic relationship is intuition. Laquercia (2005) is another psychoanalyst that encouraged therapists to attune themselves to the unconscious communications of their clients. He defined intuition as an immediate knowing of an object without intervening reasoning processes. Greenhalgh (2002) described intuition as an unconscious decision making process. Hathaway (1956) described clinical intuition in psychotherapy as an inferential process that produces clinical inferences based on cues, in which the provider is unable to specify which cues or how the process occurred; that this phenomenon somehow goes beyond one's ability to rationally explain it. He also contrasted this with the experiences of clinical observations, projections, or compassions.

Though it may be difficult to identify an operational definition of intuition (Shirley & Langan-Fox, 1996; Sprenkle, 2005), seeing the variety of definitions of clinical intuition across time and fields does identify similarities that inform the construct

of intuition for this study. Clinical intuition was generally accepted by these researchers as a phenomenon that exists, that has an immediacy, is a way of knowing and interpreting, and is not quickly or easily explained, but offers significant value to a therapeutic process (Garcia & Ford, 2001; Dodge Rea, 2001; Vaughan, 1979). Previous literature has named this theme as “knowing but not knowing how one came to know” (Jeffrey & Stone-Fish, 2011, p. 349; Nyatanga & de Vocht, 2008). While open to all possible definitions and experiences of intuition, this research was conducted with this broad definition in mind.

Psychotherapy and Intuition

Psychotherapy as a general mental and behavioral health field has several writings on intuition both as a general phenomenon and a clinical experience. While Piha (2005) acknowledged that the experience of clinical intuition is not established in the research literature and has vague references, a small body of literature does exist. There are several examples of literature theorizing the importance of clinical intuition in psychotherapy, and a few studies on therapists’ ideas and descriptions of intuition, but none describe MFTs’ lived experiences and stories of intuition in their clinical work.

Welling (2005) had much to say on the topic of clinical intuition in psychotherapy and outlined several ways intuition can look in psychotherapy: as a method of detection, a dichotomous awareness, a related object, metaphorical solution, explicit verbal understanding, and more. He described intuition as a phased process that is necessary to understand if we are to use it more effectively as a field. Welling also argued that while

we ought to promote intuition for the improved outcomes of therapy clients, we must also recognize its fallibility and learn more about its role in decision making in therapy.

Other authors have made attempts to describe intuition in psychotherapy. Bohart's (1999) discussion of intuition in psychotherapy found that therapists described intuition as insight or inspiration that just hit them; that intuition is picking up on the rhythm or flow of the therapeutic conversation, a tacit understanding that cannot be explained or learned from a book. Laub (2006) described several ways clinical intuition can occur in psychoanalysis work: recognition, symbolic communication, metaphors, dreams, induction, nonverbal emotional communication, sensory perceptions, and more. She wrote that psychoanalysts are not trained to use their unconscious, but are required to undergo their own long term psychoanalysis to clear any unconscious issues that might muddle things in the therapeutic relationship in order to best help patients. So, in this way, intuition is a central aspect of psychoanalysis and yet it is not explicitly taught (Laub, 2006). In a more recent study of licensed professional counselors (LPCs), Weis (2009) found results that echo previous theories about clinical intuition. She found that therapists described their experiences of clinical intuition as a combination of conscious and unconscious observations and decisions, that there is immediacy to the knowing, a certain felt sense, and that it brings a feeling of certainty.

Garcia and Ford (2001) added that for intuition to be effective, there must be a sense of importance placed on trust in the therapeutic relationship; that there must be trust both internally in the clinician and externally between client and therapist because the use of intuition in therapy is a relational process. Bove and Rizzi (2009) added to this by

naming intuition as part of the therapeutic relationship and claimed that there needs to be more emphasis on this area if we are to better address the needs of our clients within this relationship.

Marriage and Family Therapy and Intuition

The body of literature on clinical intuition in psychotherapy suggests that intuition exists, is of value in the therapeutic process, and that it occurs within the therapeutic relationship. As relational and systemic therapists, MFTs also have a history of attending to this issue, but without much empirical data. Keith (1987) wrote that intuition is an important part of family therapy work for mature clinicians, that it is an informal and unconscious process that is necessary for appreciating and understanding the depth of relationships, thus vital for our work as relational therapists. Patterson, Miller, Carnes, and Wilson (2004) described intuition as part of the “usual sources of information” in MFT (p. 191).

Founding experiential family therapists like Gus Napier and Carl Whitaker also considered intuition a vital part of the therapeutic relationship. They advocated for evocative techniques in which the therapists’ own personalities create therapeutic encounters, that it is critical to follow one’s own emotional impulses (Nichols & Schwartz, 2006). In fact, Napier and Whitaker argued that intuition is a vital component of all successful therapy (Napier & Whitaker, 1978). Virginia Satir, another founding family therapist and experiential therapist described the importance of intuition as well. She posited that therapists who feel good about themselves and their use of self in therapy can better trust their intuition and be of better use to their clients (Lum, 2002).

Other experiential MFTs have described using intuition to make moment-to-moment decisions in family therapy (Mitten & Piercy, 1993).

Boss and her co-author described the importance of intuition in family therapy research, seeing intuition as a necessity (Boss, 1987; Dahl & Boss, 2005). From this perspective, intuition is an additional tool that can inform a researcher or therapist's clinical sensitivity. For example, if a line of questioning is too hurtful or if the clinician's presence is unwanted or even dangerous, intuition could inform the clinician of this issue. Boss also postulated that an intuitive feeling out of families may be as important as operationalizing, quantifying, randomizing, or testing our data; to ignore our intuition as researchers and clinicians is to not broaden our ways of knowing, to restrict ourselves. (Boss, 1987).

In the last fifteen years or so, more family therapists have attended to the use of intuition in clinical work. Rober (1999) agreed that intuition is an internal experience of the therapist, but distinguished this inner conversation of the therapist with the outer conversation with the family therapy client. He described attending to images, moods, emotions, associations, memories, and other informants of intuition as a constant source of information that can impact therapeutic decisions. Timm and Blow (1999) suggested that while it may be a risk to confront a family on an important issue based on a gut feeling, therapists must trust that impulse if they are to be effective in our work with clients. Connell (1996) described intuition as one of the "driving therapeutic forces" (p. 5) of therapy.

While most literature on intuition in MFT addressed the phenomenon with a theoretical discussion, there have been two empirical studies of intuition in the field of MFT. Jeffrey and Stone Fish (2011) completed a phenomenological study of the use and experience of intuition in MFTs who claim to experience it. They found that family therapists experience intuition as real and relational, that there was a need for training in this area, that intuition was also fallible, and that it was a neglected area of research that was important to pursue. Though a phenomenological study, these scholars' findings focused on (a) described nature of intuition, (b) therapist-client relationship, (c) spiritual process, (d) training and development, and (e) reluctance toward intuition. Under the first category (a) described nature of intuition, the authors collected (1) descriptions of intuition, (2) participants' views on its function, and (3) the described process of the experience of intuition. This third area is the only item related to the *experience* of intuition, but attended to (i) preparing for intuition, (ii) pathways of intuition, and (iii) fallibility of intuition. Only the brief description of the "pathways of intuition" attended to the participants' *experiences*, and included mostly descriptions of participants' thoughts about the pathways rather than descriptions of the lived experience of intuition. Very little of the final project and analyses concentrated on the experience of intuition in MFT clinical practice.

Pinjala (2009) found similar results in her qualitative study of MFTs' perspectives on intuition. Her participants reported that there were several attributes to an effective intuitive therapist, including: (a) belief and trust in intuition; (b) self-awareness and good self-care; (c) confidence; (d) attentiveness; (e) skills in building relationships with clients;

(f) that the experience of intuition in therapy can be cognitive, emotional, or physical (i.e., a stomach ache); and (g) that successfully intuitive family therapists check their intuitions with the clients themselves, often in the moment. While this study was also a phenomenological project, the findings included very little of the participants' experiences of intuition. Instead, the author focused on the therapists' ideas about intuition and characteristics of intuitive therapists.

Both of these empirical studies asked MFTs to describe their thoughts, feelings, and reflections about clinical intuition, some of which attended to MFTs' ideas about the experience of intuition. Neither study focused on the lived experience of intuition as a way to gather information about the phenomenon. Despite these important contributions, there remains a need to explore MFTs' lived experiences of intuition to better understand the phenomenon.

Guiding Frameworks

Phenomenology. As a philosophical framework, phenomenology is a post-positivist perspective that acknowledges that a "real" world exists. But in contrast to a positivist approach, it argues that "reality" cannot necessarily be known as it actually exists (Gale, 1993; Gehart, Ratliff, & Lyle, 2001). One cannot know the "reality" of the world because human bias is always clouding the lens with which we view the world (Gehart, Ratliff, & Lyle, 2001). Moustakas (1994) wrote of intersubjectivity: that by bringing a phenomenon into consciousness and having a dialogue about it (e.g., in a qualitative interview), the interviewer experiences the interviewee's experience. The experience becomes shared and then transformed because of that sharing.

Phenomenology as a research method is specific method of qualitative research that builds comprehensive description of a phenomenon by working inductively from the reported stories of those who have experienced a particular occurrence while attending to inherent human biases (Creswell, 2007; Lincoln & Gruba, 1985; Moustakas, 1994). The purpose of phenomenological methodology is to *describe* a phenomenon, rather than to *explain* a phenomenon (Moustakas, 1994; van Manen, 1990). While this method is described in detail in Chapter III, phenomenology as a philosophical framework guided this study in that the researcher was cautious about her own expectations and biases while she aimed to build a comprehensive description of the phenomenon of intuition in MFT. As is common practice in qualitative research, the voice of this document purposefully changes from third-person to first-person voice, and back again. The purpose of this practice is to highlight the presence of the researcher's own experience and perception so that readers of the document might be more aware of the presence of potential bias in order to make their own determinations about the findings.

Constructivism and social constructionism. Constructivism and social constructionism are branches of postmodernism. Unlike phenomenology, constructivism states that knowledge construction is about the real world at the individual and interpersonal levels (Gehart, Ratliff, & Lyle, 2001). Specifically, constructivism suggests that actual events are less influential on our responses to things than the meanings we assign to those events; instead, our beliefs and the meanings that underlie them govern our behavior (Piercy, Sprenkle, & Wetchler, 1996). Thus, reality is constructed. This

perspective considers the individual cognitive processes of knowledge construction (Gehart, Ratliff, & Lyle, 2001).

As a guiding framework, social constructionism adds to constructivism by being responsive to interpersonal aspects of meaning construction and interpretive process (Anderson, 1997; Gergen, 1994) by emphasizing social and intersubjective aspects of knowledge construction (Gerhart, Ratliff, & Lyle, 2001). Thus, reality is a shared construct of reality; meanings are made and changed in collaboration with others (Piercy, Sprenkle, & Wetchler, 1996). These realities are considered subjective and rooted in language systems (Whiting, 2007). While meanings that arise in conversations, whether shared or not, are considered to be socially negotiated (Gergen, 1999; Whiting, 2007).

Social constructionism as a therapeutic approach. Stories that emerge through interactions and conversation influence individuals and relationships by helping people create meaning (Goncalves, 1997; Whiting, 2007). Constructionist family therapy has an emphasis on patience and curiosity; these are helpful skills during the complex process of therapy (Whiting, 2007). One hallmark of social constructionist family therapy is that the therapeutic process is collaborative. Clients are seen as the experts on their lives, family, and the specific problem(s) that brings them to therapy, while therapists are seen as having expertise on working with problems in general (Piercy, Sprenkle, & Wetchler, 1996). The focus of therapy is on co-constructing a solution that works for the family. Another hallmark of this approach is that language is the medium of change; through language and dialogue, stories are created and modified (Anderson, 1997; Piercy,

Sprenkle, & Wetchler, 1996). As such, therapist curiosity becomes paramount (Nichols & Schwartz, 2006).

Social constructionism informed and guided this study by emphasizing the importance of: the interpersonal process of both the practice of MFT and the process of qualitative research; the importance of language in a shared and socially negotiated subjective reality; and the interpersonal process of meaning making that can influence client, therapist, and researcher.

Statement of Purpose and Research Question

To fully understand intuition's place in MFT, the phenomenon of intuition must be explored empirically. Many social constructionists advocate for qualitative methods in the field of family therapy (Kvale, 1996; Morris, Gawinski, & Joaning, 1994).

The purpose of this study was to more deeply understand and describe the experience of intuition in MFT clinical work. Using a transcendental phenomenological method, the researcher gathered and analyzed MFTs' stories of their experiences of intuition in order to begin to make meaning of this phenomenon. The specific research question addressed in this study was: How have MFTs experienced intuition in their clinical work?

Chapter III: Methodology

Transcendental Phenomenology

In order to answer the research question, it was appropriate to use a qualitative transcendental phenomenological approach to investigate MFTs' lived experiences of intuition. Others who have studied intuition support the employment of a qualitative methodology (e.g., Jeffrey & Stone Fish, 2011; Petitmengin-Peugeot, 1999).

Phenomenology is a specific method of qualitative research that builds comprehensive description of a phenomenon by working inductively from the reported stories of those who have experienced a particular occurrence (Creswell, 2007; Lincoln & Gruba, 1985; Moustakas, 1994). The focus of a phenomenological study is to:

describe the meaning for several individuals of their lived experiences of a concept of a phenomenon...to reduce individual experiences with a phenomenon to a description of the universal essence (Creswell, 2007, p.57).

Transcendental phenomenology as coined by Husserl and described by Moustakas (1994) as a branch of phenomenological research that focuses on the experience of a person, including senses, perceptions, and consciousness. Through the transcendental phenomenological method, the researcher can determine meanings and get insight into the essences of an experience or phenomenon. This method focuses on the self of the researcher and the importance of intentionally attending to that researcher's relationship with the subject and data. Transcendental phenomenology emphasizes the researcher's own biases and judgments, but also the important and essential role of intuition in research (Moustakas, 1994). Descartes named intuition as most important in the human experience of deriving knowledge, as did Husserl (Moustakas, 1994). Moustakas (1994) writes:

The challenge facing the human science researcher is to describe things in themselves, to permit what is before one to enter consciousness, and be understood in its meaning and essences in the light of intuition and self-reflection (p. 27).

The purpose of transcendental phenomenology is to “bring to light” (Moustakas, 1994, p. 27) an experience or phenomenon, to intentionally perceive the phenomenon as a way to deepen our understanding of its meaning. It makes no difference if the phenomenon being observed actually exists. By holding it in one’s consciousness and attending to it, veracity and authenticity are brought to the experience. Van Manen (1990) described transcendental phenomenology as an attempt to “bring mystery more fully into presence” (p. 50). Because the topic of this research was born from the researcher’s own experiences as a clinician, and the purpose of this study was to explore MFTs’ *experiences* of intuition in their clinical work in order to describe the phenomenon and essence of intuition in MFT, the chosen methodology was most fitting.

Epoche. Moustakas (1994) includes epoche as an essential component of transcendental phenomenology. Epoche is a process of self-reflection that the researcher undergoes in order to “refrain from judgment” so that one can “learn to see what stands before our eyes, what we can distinguish and describe” (p. 33). Meaning, that the transcendental phenomenological researcher must be able to identify, examine, and transcend her own values, beliefs, experiences, biases, and judgments in order to have a clear lens with which to examine and revisit the phenomenon “freshly, naively” (Moustakas, 1994, p. 33). Thus the *transcendence* component of this form of phenomenology might be reached through this process. Epoche requires the researcher to be transparent with herself, allowing her a quiet place to review her thoughts and feelings so that she is inclined to receptiveness in her study of a phenomenon (Moustakas, 1994).

Bracketing. A critical component of phenomenological research, and method of achieving epoche, is that of bracketing. Bracketing occurs when the researcher's prejudgments, values, and biases or personal experiences, are examined, shared, and suspended as part of the investigatory process (Creswell, 2007; Moustakas, 1994). Bracketing aids the researcher in qualifying her own biases and expectations separate from the data she is analyzing.

As an MFT who believes I have experienced intuition in my practice, my perspective is/was embedded in assumptions and biases. For this study, I kept a research journal before, during, and after each stage of the research process (including interviews, transcription, and analysis), attending to working hypotheses, assumptions, and expectations that could cloud the research process (van Manen, 1990). The process of writing and reflecting on journal entries helped me to continue to craft the research questions, including slight wording variations or additions of specific follow up questions that would help me to evoke more experiential descriptions from participants. More importantly, the practice of bracketing through journaling and discussions with my advisor and committee members helped me to be clear about what expectations or biases might be affecting the study. As Moustakas (1994) wrote, "As I came to know this thing before me, I also came to know myself as the being who intuits, reflects, judges, and understands" (p. 32). My own relationships with intuition and the research were allowed to be present and visible throughout the research process. Though I doubt I achieved a pure transcendent ego state, which even Moustakas (1994) acknowledges that "some things are not 'bracketable'" (p. 90), the transparency of acknowledging my own

expectations, experiences, and values throughout the process aided me in keeping these separate and visible when analyzing the data.

The bracketed. I am the designer and researcher of this study. As such, I find the topic of intuition in MFT to be real, significant, worthy of study, and fascinating. The inclusion criteria for participation (below) would have allowed me to participate in my own study. I have had my own experiences of intuition in MFT and consider myself an intuitive therapist and person. I am a white woman from German and Scotch-Irish descent in her early thirties, married to a man, mother of a daughter, licensed as a marriage and family therapist, owner of a small business, ordained interfaith minister, academian, researcher, professor, supervisor, and administrator. Intuition is not a word used in my family of origin, but it is a phenomenon that is respected and considered to be “passed down” from our great grandmother’s line. As a practicing clinician and supervisor, I was also noticing intuition in my clinical work while in the midst of the research. Even when interviewing participants, there was an urge to be therapeutic and ask intervention-like questions that were not within my role as a researcher. All of these things are part of the lens with which I examined this phenomenon.

Before meeting with the first participant, and with inspiration from my committee members, I made a list of my expectations for the research findings. Because I have had my own experiences of intuition in MFT, I wanted to be careful that I did not somehow set these experiences (for myself or the participants) as the standard by which other experiences are measured. I included these expectations here as an example of the biases that I attempted to bracket, so that I could be open to my participants’ experiences.

October 9, 2013. I expect many kinds of ways of intuiting that are mostly reflective of my own experiences in the past: some predictive of danger or behaviors; some rooted in a clinician's experience and expertise; some that are more about attuning to the client; and some that we might just call "woo woo." I believe that intuition is relational. I think that wherever intuition comes from, we check it out with the client (or a supervisor or self) and see how it plays out. Without this "confirmation", we might dismiss intuition as a stray thought and not even pay attention to it. I think there are probably several features of intuition. I think it is quick, that it happens in both the body and mind but I'm not sure it's simultaneously in both, and that intuition is about knowing. I'm curious if intuition is about both hindsight and foresight? I have my first interview in a couple of days. I've done what I can to ask everyone to come prepared to talk about one or more stories of intuition, but I'm still worried. I have a nagging feeling that they are ignoring that part of invitation to participate, even though I keep repeating it. Don't all therapists love to tell stories? I'm not sure why I'm concerned about it.

The method of bracketing to achieve epoche is a continual process needing several "clearings" (Moustakas, 1994, p. 89) along the way. Additional bracketing included journaling, reflection, and discussion with participants, advisor, and committee members about various themes that were emerging, as well as hypotheses, surprises, disappointments, and validations that occurred throughout the process. I consistently reflected on my own relationship to the research in order to allow the phenomenon of

intuition to emerge in such a way that the data best demonstrated its meanings and essences (van Manen, 1990).

Intentionality, noesis, and noema. Moustakas (1994) wrote “In phenomenology, perception is regarded as the primary source of knowledge, the course that cannot be doubted” (p. 52). Intentionality in transcendental phenomenology is the intentional act of perceiving consciousness of a phenomenon so that we might draw meanings and essences from the consciousness. This intentionality allows themes to become apparent (Moustakas, 1994).

Noesis and noema work together to bring understanding of a phenomenon. Noesis is the act of perceiving, feeling, sensing, or remembering a phenomenon with meanings hidden in that consciousness. For this study, noesis are the *examples* and *discussion* of stories of intuition in MFT; the participants in this study described remembrances and perceptions of intuition. Noema is that which is experienced: the phenomenon being researched or explored. For the purposes of this study, the noema is *intuition* in the practice of MFT. Both of these concepts begin to help separate the true meaning and the perceived meaning of the experience so that the researcher can describe the phenomenon (Giorgi, 1985) and its essences (Moustakas, 1994).

Participant Selection

Following approval of the research protocol from the University of Minnesota’s Institutional Review Board (IRB), participants were recruited using a non-probability volunteer sampling strategy. Specifically, they were recruited from colleagues of the researcher as well as from suggestions from other participants and the researcher’s

clinical doctoral committee members. Marriage and family therapists were invited to participate via email. After explaining the study's purpose and procedures, interested MFTs were asked to meet for about one hour to discuss their experiences of intuition with the researcher. Participants were also informed that they would be offered a second conversation to verify the accuracy of the data collected, discuss the analysis (member checking), and discuss new experiences or perspectives on intuition that emerged after the initial interview. Informed consent (Appendix A), a list of sample interview questions (Appendix B), and investigator contact information were sent as an attachment in the email invitation and provided again in hardcopy when meeting for the interview. Intuition was not defined for participants prior to the interview; they were invited to participate in a "study about intuition in MFT" leaving room for many possible definitions.

In order to participate in the study, all participants had to self-report that they had experienced the phenomenon and were willing to share their story(ies). Because experiences of intuition might have varied in unexpected ways, inclusion criteria focused around the professional status of the participants rather than participants' opinions, definitions, or experiences of intuition. Initial inclusion criteria for participants were that they must: a) hold a graduate degree in MFT from a Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) accredited program; b) be licensed as an MFT (or state equivalent) to practice independently; and c) self-report having the experience of intuition in clinical work. These criteria were modified with doctoral committee approval shortly after recruitment began. It was found that some

experienced clinicians who were interested in participating in the study completed their education prior to COAMFTE accreditation and/or prior to MFT licensure, or had alternative educational pathways to their licensure (such as post degree programs). As such, they were appropriate participants representing an important group of MFTs, but would have been excluded from participation without an adjustment to the inclusion criteria. The researcher and committee determined that it was not necessary for participants to have graduated from a COAMFTE accredited program, but must meet the other criteria and have marriage and family therapy training in their professional backgrounds.

Data Collection Procedures

Participants. Given the nature of this exploratory study, and that the interviewer was also responsible for data analysis (meaning the researcher needed to be familiar with the data as it was evolving (Glaser, 1965)), the sample size was planned to be capped when theoretical saturation had been reached (Daly, 2007; Glaser, 1965; Marshall, 1996; Strauss & Corbin, 1998). Though initially aiming to interview six to 10 participants for both initial and follow up interviews, 12 initial interviews were conducted. This was partially due to the enthusiasm of both the researcher and the participants. Also, participants were intentionally added to the sample to add diversity across age, gender, educational status, clinical specialization, sexuality, and spiritual or religious beliefs.

Because this is a small qualitative sample of 12 participants, broad generalizations cannot be made about the MFT field at large. Participant ages ranged from 31 to 63 years old (M=47). Eight of the participants identified as female, and four as male. While every

participant held a license as a marriage and family therapist, six also had doctorates in family studies or a related field, two had master of divinity degrees, and five held dual licensure as psychologists (LPs). In every case in which a participant was also an LP, the psychology license preceded the MFT license because MFT licensure was not yet available at that time. Licenses were acquired between the years 1979 and 2012 with training programs from institutions of higher learning that spanned across the United States. Nine participants taught at the undergraduate or graduate level at various universities. Eight were approved supervisors through the American Association for Marriage and Family Therapists (AAMFT). Clinical specializations included play therapy, sex therapy, high conflict couples, trauma, spirituality, adolescent mental health, community health, school based mental health, and more. While most of the participants reported that their work is informed by systems theory and experiential family therapy theories, each therapist described several informative theories that guide their work. Examples of guiding frameworks and theories included: structural, strategic, psychoeducation, narrative, gestalt, psychodynamic, ambiguous loss, feminist, emotionally focused, attachment, Jungian analysis, solution focused, symbolic interaction, cognitive behavioral, postmodern, integrative, Bowenian, contextual, Eye Movement Desensitization and Reprocessing (EMDR), human ecology, child and human development.

Because these 12 participants shared one to three (occasionally more) stories of intuition in the initial interviews, the final count of clinical intuition stories used for data analysis was 26. These stories of intuition included experiences in therapy sessions with

individuals, couples, and families, as well as supervision with individuals and groups.

Stories ranged from fairly recently (hours or days before the interview) to decades before the interview. Stories and findings will be shared in more detail in Chapter IV.

Initial interviews. Interview questions were written to address the specific research question of the study (Marshall & Rossman, 1999). Participating MFTs were asked to describe a time they experienced intuition in their clinical work. Open-ended questions best allowed these therapists' ideas to emerge (Creswell, 2007). Participants were encouraged to answer questions as thoroughly as they would like in order to gather thick, rich descriptions (Creswell & Miller, 2000) from which to assign clusters of meaning (Moustakas, 1994).

Participants were asked to share stories and examples of times they had experienced intuition, rather than to describe the experience of intuition in general or define intuition. Stories can provide insight into details of an experience that might have been otherwise overlooked; they involve researchers, participants, and those who read the research in personal ways; they turn us back to life as it was lived, rather than as it was thought about later; they bring vividness and transcend the particulars of a given situation (van Manen, 1990). Guided by this perspective on the use of stories in phenomenology, interviews were focused around the stories of intuition.

The study took place in the Twin Cities metro area of Minnesota; most respondents currently practice in this area. Participants were interviewed in a confidential environment of their choosing (e.g., clinical work site.). At the beginning of the interview, I reviewed informed consent (Appendix A), including the risks and

benefits of participating and letting participants know that they could discontinue participation at any time, and asked each participant to sign that they had read and understood the informed consent and had all of their questions answered. I also emailed all participants within one month of their interviews letting them know the status of the transcription and data analysis process, and asking for anything they would like to add while they waited for the final analysis. None of the participants offered more to the study at that time, but this communication did help maintain connection until they were sent the final analysis for member checking (see below).

The initial interviews followed a semi-structured interview schedule after gathering basic contextual information (e.g., participants' names, graduate degree and licensure status). The interview schedule was based on the main research question of this study (Appendix B). Participants were asked, "Could you tell me about a time you experienced intuition in your clinical work?" Following this initial question asking for examples and stories of intuition experiences, additional questions were asked in alignment with the study's methodology to gather contextual and structural descriptions of the experience(s). Because each interview added to my understanding of this phenomenon, and raised new questions, some questions were slightly altered as the interviews progressed.

The focus of the interviews was on the participants' stories and experiences of intuition, but also included discussion on the participants' overall thoughts, feelings, and reflections on the phenomenon. My goal was to give participants an opportunity to share experiences of intuition in their clinical work that allowed for their own definitions,

conceptualizations, words, and expression to shine through. While the interview questions may have occasionally guided the interaction, I did not want to limit participants to only discussing the questions I had prepared. The interview schedule helped to prepare me for the interview and served as a guide to the questions that I would have liked to ask (Smith, Flowers, & Larken, 2009), but I did not feel restricted to stay within any rigid bounds. The interviews themselves informed me of which questions might be more meaningful when exploring the phenomenon of intuition, or which questions could be modified for clarity. The prepared interview schedule allowed me to focus on engaging with the participants, knowing I could return to the list of questions as needed. Each interview ran between 55 and 75 minutes.

Transcription. Interviews were digitally recorded and transcribed by a combination of a confidential transcription service and undergraduate research assistants. Research assistants were trained on the importance of confidentiality and how to properly work with data, including example transcriptions, data deletion procedures, and de-identification of the data as needed (e.g., therapists' names or identifiers). Because it was necessary to protect both the confidentiality of participants and the confidentiality of any clients mentioned in the interviews, special care was taken in preparing to manage this at all stages of the research. As licensed mental health professionals who are familiar with client confidentiality, all participants also took measures to de-identify client information throughout the interviews (e.g., changing or omitting names, locations, and other identifiable client markers). Interviews were transcribed verbatim with the exception of small portions that were unable to be understood due to participant volume, rate of

speech, or other conversational idiosyncrasies. After each interview was complete, I listened to the interview recording as a whole. Following transcription, I listened to each recording again while verifying the transcripts for accuracy and making corrections. Finally, after verifying each transcript for accuracy and match to the recording, each transcript was read as a whole.

Member checking. Participants were sent individual summaries of their stories and the overall data analysis to give them the opportunity to review the data and to correct anything that they thought did not reflect their experiences (Guba & Lincoln, 1989). Participants were asked to verify the summary for accuracy, and to share any changes, additions, or deletions with the researcher. They were also invited to complete a follow up interview to discuss the data and/or any additional thoughts and experiences of intuition that they would like to add to the conversation since the original interview. Two follow up interviews were conducted, nine participants confirmed the analyses reflected their experience of the interview, and four participants wrote additional thoughts about intuition since the initial interview but declined to complete an in-person follow up interview. A total of three participants did not respond to the member check opportunity despite multiple contacts.

Data Analysis

Data. One of the unique strengths of transcendental phenomenology is that it allows for data to be analyzed both within individual cases and across cases. Though the purpose of the method is to uncover meanings and gain insight into essences of a phenomenon, each experience can also stand “in and for itself” (Moustakas, 1994, p. 34).

To obtain a final synthesis of meanings and essences of intuition, data were analyzed following key methods of transcendental phenomenological research proposed by Moustakas (1994) with a few modifications. The data were collected, transcribed, and then went through the process of epoche, reduction (modified), imaginative variation, and thematic analysis.

Two copies of each initial interview transcript were used for analysis. The first copy was the whole interview verbatim. The second transcript was reduced to the stories that participants shared of intuition in their MFT work. Each story was also summarized by the researcher and entered into a spreadsheet to compare contextual and structural details across intuition experiences. Spreadsheets included details such as the context of therapy, the system seeking services, the length of the therapeutic relationship, the type of intuition experience (i.e., the *what* the intuition was and the *how* it was experienced), the intuition processes, and the outcomes. The original verbatim transcripts, stories-only transcripts, individual story summaries, story summaries grid, and researcher journal entries all served as the data for analysis.

Modifications. Following the stance of self-reflection and epoche as described above, I chose not to undergo a next reduction step as articulated by Moustakas (1994) in which all relevant expressions are listed and repetitions are omitted. Reduction risks minimizing the statements that are most vivid and also deletes repetitive statements that could cause the researcher to lose sight of frequency and repeated events. Because of these risks, all statements were kept for analysis.

Textural and structural analysis. Instead of this reduction step, I focused analysis around the key textural and structural questions of transcendental phenomenology: What is the nature of this phenomenon (textural)? What are its qualities (textural)? How was this phenomenon experienced in emotions, cognitions, body awareness, within the therapy context and relationship, etc. (structural)?

Invariant constituents. The answers to these questions are what Moustakas (1994) called invariant constituents, or unique qualities of the experience, that provide insight on the phenomenon. Textural descriptions of intuition in MFT (the “what”: What is the nature? What are the qualities?), structural descriptions of intuition in MFT (the “how”: How did participants feel, sense, think, judge, imagine, recollect? And in what contextual time, space, and relationship to others?), and the relationship between these two descriptions were analyzed both within and across stories. The goal of imaginative variation is to grasp the structural essences of the experience, differentiating parts and relationships of the invariant constituents, and then integrate the parts into a vivid description of the phenomenon (Moustakas, 1994). Essentially, the researcher attends to the continual relationship between the possible structural (“how”) and textural (“what”) meanings of the phenomenon in order to recognize the underlying themes of contexts that account for the phenomenon.

Themes. These invariant constituents were then clustered in common themes. Themes were determined by elements that described an aspect of the lived experience of intuition in MFT that seemed to give shape, insight, or sense to the phenomenon of

intuition (van Manen, 1990). Themes were then integrated as a whole into meanings and essences (Moustakas, 1994) that described the experience of intuition for MFTs.

Intuition in research. It is important to note that some researchers have described phenomenological study as an exercise in intuition itself (Moustakas, 1994; van Manen, 1990); that to make meaning of experiences also requires a trust in hunches and instincts (Giorgi, 1997). Moustakas (1994) wrote, “The most significant understandings that I have come to I have not achieved from books or from others, but initially, at least, from my own direct perceptions, observations, and intuitions” (p. 41). Boss described intuition in phenomenology as an asset (Boss, 1987, 2005). Patterns of experiences were highlighted using vivid quotes so that the participants’ experiences might best be showcased (Aronson, 1994; Daly, 2007; Moustakas, 1994; van Manen, 1990).

Qualitative reliability and validity. Credibility of these findings was established when saturation was reached and the author no longer saw new information in the data, participant responses were continuing to support current themes, and no new themes were emerging (Daly, 2007; Lincoln & Guba, 1985). Because transcendental phenomenological methodology allows for important themes to emerge within an individual experience, one could argue that saturation might never be reached in this qualitative methodology; that something new might always emerge across the unlimited horizon of experience (Moustakas, 1994). Instead, credibility was determined when: participant responses continued to support current themes; findings resonated with the researcher, participants, advisor, and committee members; and participants acknowledged they had no more to share on the topic. In these ways, knowledge generated from this

study was legitimized communally by stakeholders of the study, and not just by the researcher herself (Atkinson, Heath, & Chenail, 1991; Gerhart, Ratliff, & Lyle, 2001).

While generalizability of qualitative data is not easily established (Daly, 2007; Golafshani, 2003), transferability of the findings (the ability to apply these findings to other family therapists in other contexts) was established with rich, thick descriptions and purposive sampling procedures (Lincoln & Guba, 1985). This study and its findings are dependable because of the detailed and consistent process notes (journal entries) that were created throughout the study (Daly, 2007; Lincoln & Guba, 1985). While this qualitative study cannot claim a lack of bias because of the emic nature of the project (Daly, 2007), the availability of an audit trail describing the researcher's conclusions, interpretations, and recommendations, as well as the availability and presentation of raw data, support the study's confirmability (Lincoln & Guba, 1985). Main themes were summarized and presented to participants via member checking so that participants had an opportunity to provide feedback on the accuracy of the researcher's interpretations (Guba & Lincoln, 1989). Participants were sent the textural and structural summaries, as well as the group analysis summary for open response. I asked participants if they had anything to add, change, remove, edit, and if they would like to talk in person, on the phone, or electronically to add anything that they have experienced or thought of since the initial interview. Based on the participants' feedback, I again reviewed the data and findings. Presenting the findings to participants, reviewing all forms of data including my own journal entries, and dialoguing with my advisor, committee members, and other

professionals was a form of triangulation and cross-checking of findings (Gerhart, Ratliff, & Lyle, 2001) which lends credibility to the study (Dahl & Boss, 2005).

Chapter IV: Findings

A Place to Begin

Van Manen (1990) recommended that a researcher provide her own account of a phenomenon as a starting point in phenomenological research. This fits with Moustakas' (1994) writings on the importance of epoche and bracketing in transcendental phenomenology. As someone who considers myself to be intuitive in my clinical work, it is difficult to come up with just one example. The example I chose to share here was one of my experiences of intuition that inspired this research study. It was an event that fit my assumptions about what intuition could look like in therapy and also prompted me to wonder if something like this had happened to/with/for other therapists.

Early in my career I worked with a woman who worked hard in therapy, but had difficulty moving in the direction she wanted to go in her life. For months she brought the same issues and concerns to the therapy room, and for months I had a sense that the things we were talking about were not “really the issue”; that we needed to go into her past and her childhood to understand why she was experiencing her life and relationships the way she was currently experiencing them. As a well-trained family therapist I tried to discuss her family of origin many times. She would give me conflicting pieces of information that did not add up, and she was not willing to discuss the discrepancies. Having a good relationship with the client, I even challenged her to think beyond her current

daily struggles into the larger processes and relationship patterns of her life.

Ultimately, I felt like we were covering surface issues and she was avoiding diving to the deeper places we needed to go in order for her to achieve lasting change.

Several months into our therapeutic work everything changed in the first five minutes of one session. As my client walked into the room and sat down on the couch in her usual spot, I suddenly thought about sea turtles. Ignoring the random thought, I went to sit down across from her and the thought got... stronger, "Sea turtles, sea turtles, sea turtles." I actually popped up from my chair, apologized, grabbed a thermos of water from the desk, and took a drink to center myself. I started imagining sea turtles jumping through waves. I think she was talking at this point, getting settled into her seat and describing the things she did before coming into the office that day, but I couldn't hear or focus on her. I kept thinking, "Sea turtles, sea turtles, sea turtles" while I imagined them hopping across waves in a sunset (I don't know if sea turtles actually do this, by the way, but they looked like cresting dolphins in my imagination). My body felt keyed up and anxious, my shoulders stiff, my hands fidgety, and I couldn't get comfortable in my chair, shifting from one hip to the other.

Finally, it felt like I was going to burst, I interrupted her mid-sentence and the words fell out of my mouth, "I'm so sorry, I have to interrupt you. Ever since you walked in the room, all I can think about are sea turtles! I know, I know, it's weird. Sea turtles?! I think if I just say it out loud, it'll go away. Ugh. Let's get

back to you. I'm so sorry. How are you?" Immediately my client started to weep. Thinking I had really made a mistake and feeling horrible, I watched in silence as she slowly bent towards her purse on the floor, unzipped it, dug around to the bottom, and pulled out a wrinkled, folded up piece of paper. She said, "Sam, today is the anniversary of my [family member's] death. When he retired he moved to [an ocean location] and loved to watch the sea turtles and the dolphins. He said that after he died that he was coming back as a sea turtle. This is the tattoo I'm getting in his honor later today." When she unfolded the piece of paper and held it up, it was an image of a sea turtle swimming in the ocean, splashing in waves framed by a sunset.

After I took a deep breath I was able to move forward and ask good therapeutic questions, all of the previous tension and distraction was gone. I say that this moment changed everything in our work together because the client then began to authentically open up about her family of origin in ways she had never acknowledged before, including sharing complex relationships and traumas that were very much affecting her current functioning. Though the actual "sea turtle" experience resonated for her, I also modeled authenticity (even when it felt bizarre), and she was then able to do the same. From this moment on, our work together changed. Her therapy goals were met and we closed our work not long after this session.

Prior to beginning this study, this story was an example of intuition for me because of the gut level knowing that there was something more going on than was

obvious, and then because of the immediate and mysterious inspiration of “sea turtles” that so deeply resonated with the client. I experienced the “knowing but knowing how one knows” theme that previous authors have described (Jeffrey & Stone Fish, 2011, p. 349).

After completing this research project, however, I see this experience through the lens of the data findings and can articulate the story differently. In light of the findings of this study, this was an example of intuition because I had a sense (intuition) for some time that there was something more going on than the client had been bringing to therapy. The sense was that we just were not quite getting at the core of things; this felt like a knowing that could not quite be explained from a deductive process. When the whole “sea turtle” distraction happened, it felt like it came from somewhere other than me or from any clinical training. These intuitions were very specific thoughts and visual images. Following the intuitions there was a decision point in which I could choose to pay attention to the intuition and share it with the client or not. I chose to pay attention to the intuition and share part of it with her. It was not a definitive fact about the client’s history that came to me as an intuition; I did not know that sea turtles represented an important family member who she had had a complicated relationship with, nor did I suddenly sense that the date was significant to her; I did not know she had suffered trauma related to a person she loved and missed. Instead it was a vague sense that something needed to be said, heard, and acknowledged. The outcome was that in sharing the intuition with the client, it became an intervention. The client determined and acknowledged the significance of the word and thus the usefulness of the intuition. As a

metaphor, it seemed that a key presented itself, and the client decided whether or not to use that key and on which door; the experience and sharing of intuition unlocked a door for her to be able to do deeper level work.

Stories of Intuition

With 12 total participants each sharing one to three (or more) stories of intuition in their clinical work, there were a total of 26 stories analyzed. Examples of intuition stories are included here. More information on the findings and themes follow in this chapter. For the consistency and ease of reading, findings will refer to “clients” but analysis also included stories of supervision of training therapists. Because the findings were consistent between stories of supervisees and clients the word “clients” is used exclusively here.

Contexts of intuition. In the 26 stories that were told for the purpose of this study, intuition presented itself across many kinds of contexts. Intuition occurred when doing therapy with individuals, couples, and families and in supervision with individuals, dyads, and groups. Clients’ presenting clinical issues were typical for the practice of MFT: parent/child conflict, couple conflict or affair, addiction, depression, and more. Stories ranged from fairly recently (hours or days before the interview) to decades before the interview, and from across participants’ career development (e.g., novice to advanced clinical experience). Intuition occurred within minutes of a very first session of therapy or across months and years of a therapeutic relationship. While most moments of intuition occurred in the presence of the clients and in session, one participant described an intuitive knowing that occurred before she even met the client, and some others

described intuitive moments between sessions. All participants' stories of intuition followed a consistent pattern of the experience in which the intuition created shifts in the therapists' attention and resulted in interventions for clients.

Example story: Pictures of youth. When working with a couple who were trying to recover from the male partner's affair, a therapist who participated in this study had a dream about the couple. Though she does not normally dream of her clients, she dreamt about this couple. She dreamed she was visiting them at a gathering or a party. At the celebration was a big outdoor movie screen and on it was playing a loop of all the important moments in their life as a couple. She said the dream "stuck with" her; that because she normally does not remember her dreams, she had to pay attention to it. Because it was unusual to dream about clients or to remember dreams, she made the choice to share the dream with her clients. When she shared the dream with the couple they acknowledged that the dream described their experience of recovering from the affair; that when it first happened and they were both so hurt and scared, they publicly told a lot of what was happening in their marriage with their neighbors and friends. Now that they were working on their marriage and reconciling, it felt as if their relationship was very public and open to scrutiny, like a movie playing for the all the neighbors to watch and pick apart. Through this response, the clients filled in the meaning of the intuition. As a result of this conversation, the couple brought pictures of their life together to the therapist and those photographs were eventually put in the clients' file after using them to explore the history of their relationship.

Much later in their work, the therapist and clients were continuing to work on the

marriage. They had come to a painful place in the couple's history in which they were pregnant as teenagers, and they chose to terminate the pregnancy. Not only did they have sorrow about this situation, but also lot of guilt and shame that was rooted in their values and beliefs about issues of sex and abortion. The therapist described that the sun was setting and a light bulb had burnt out in her office; her intuition was to "let the darkness come" and continue unpacking the story. She said in hindsight she could have easily grabbed a replacement bulb, but that in the moment her sense was to sit in the stillness and darkness. As the darkness fell over the room, the atmosphere changed, everyone's voices grew quieter. All of a sudden the therapist had the thought, "Wait a minute!" She paid attention, listening to the thought. She reached for the clients' file and rifled through it, pulling out a picture they had brought her long ago of the couple as teenagers, right around the time of the pregnancy. She held it up and said, "Now tell me the story of *them* having the abortion." The clients immediately responded, grabbing the photo, "Oh my God! We were so young!" The couple was able to talk through and "unpack" the story from a new perspective that allowed them to acknowledge what a difficult place they had been in their lives and release the pain and guilt of their past and from their relationship; they were able to remove the decades-old pain that had been standing between them.

Example story: A blanket of support. Another participant told a story about a client who had presented to therapy for sexual concerns and a history of trauma. At a particular moment in session, the client was sobbing. The therapist said that normally she would have put a hand on the client's shoulder in support, and had done so in the past, but that in that instant she had a sense not to touch the client. She noticed the sense in the

trunk of her body; “in my gut,” she said. Having experienced this kind of gut feeling in the center of her body before, she paid attention to it. Still feeling the need to comfort the client, she listened to the sense “no, don’t touch” and offered the client a blanket instead. The client accepted and wrapped the blanket around herself as she cried. Afterward, the therapist shared her experience with the client and asked her about her experience of being offered the blanket instead of a touch on the shoulder. The client told the therapist that in that moment she was re-experiencing some of the trauma that had happened to her and it was related to touch. The client said that in that moment she did not want to be touched by anyone and though it was normally something she took comfort in, would have been very harmful to her and the therapy process at that particular moment. She had been feeling child-like in that memory and very much wanted to curl up in a blanket like a child might, and be protected from the touch of others.

Example story: Mother’s music. Another MFT told a story about working with a mother of a young boy who had a mental health diagnosis. As part of the symptoms of the diagnosis he was struggling in school and at home. The therapist’s client was the mother and she had never met the child. During the second session with the mother, the client was describing her struggles and concerns about her son when “the intuition came.” The therapist described a feeling that she “should say ‘music.’” A nagging feeling occurred, like a weight of a hand on her shoulder; she felt a sensation in her belly, solar plexus, and heart. She even “saw” music notes. The intuition and body sensations encouraged her to pay attention. Finally, without knowing why, she just said one simple word in response to the mother’s story of feeling helpless, “Music.” The client lit up,

immediately acknowledged that when she was in school she had a lot of the same problems her child was facing, but that when she was able to listen to music it made a significant difference for her. This moment shifted the conversation from the hopelessness and devastation the client had been feeling and into a conversation of empowerment about what the mother already knows helps her son, and how she can advocate for those things for her child.

Example story: Contagion. An individual male client presented to another MFT participant with anxiety concerns; he was very worried about being infected and infecting others with some kind of contagious illness, but mostly wanted help for his “anxious thoughts.” The client had been to many specialists to determine what was physically wrong with him and was referred to therapy by the specialists who could not find any medical problems. The therapist reported that a few weeks into the relationship, he had a sense that there was more going on with this client than he was seeing, more than just anxiety, but he didn’t know what to do with that sense. The therapist worried that this sense of “something else is going on” was a sign he wasn’t accurately diagnosing or treating this client’s anxiety. Though the client presented with typical anxiety symptoms, he “didn’t have the same energy” as typical anxiety presentations. The intuition that there was something else going on, to pay attention, to “keep my antennae up,” led him to decide to continue to pay attention and to talk with the client about his intuition. He made the decision to continue to stay open to possibilities and made this plan explicit with the client. Much later in the therapeutic relationship, after the client had formed a strong therapeutic relationship with the therapist, he acknowledged the therapist’s

ongoing intuition that there was something more or different going on than anxiety; the client disclosed that he was sexually abused at a young age. Several decades of untreated trauma resulted in not only the anxiety symptoms but the “feeling infected.” The therapist described that the client was able to make this connection between “feeling infected” and the sexual abuse only because the therapist stayed open to the intuition and the possibility that there was more going on than was obvious, and because he had shared that intuition with the client. By sharing the intuition it allowed the client to also consider that there was more going on, more connections to be made.

Example story: Closet therapy. Another therapist told a story of working with a couple who presented for issues in their marriage, including sexual concerns. As they were discussing something particularly difficult and sensitive in the marriage, the therapist suddenly had a “sense.” Without any planning or forethought, she asked the female partner, “Would you like to be in the closet during this conversation?” And, without missing a beat, the client acknowledged that she would indeed like to do that. So the female partner stood inside the closed closet to continue, and deepen, the therapeutic conversation while her husband and therapist stood outside the slatted door. The intuitive question turned into an intervention that allowed the clients to come emotionally closer during a conversation that had the potential to push them apart; the closet created the physical distance and safety that the wife needed in order to attain the emotional closeness she and her partner wanted. The participant reported that she had never been taught a “closet therapy” technique and had never felt the urge to suggest it before or since. Her attunement and connection with the client created this unexpected and bizarre

intuitive suggestion that made a significant difference in the therapeutic process.

Themes from the Stories of Intuition in MFT

In order to more deeply understand the phenomenon of intuition in MFT, 26 stories of intuition from twelve MFTs were collected and analyzed. Heeding intuition allowed therapists to shift their attention to new potentials, thus creating interventions and opportunities for clients to make important changes in order to reach their goals. Findings were consistent across contexts and provided insight into the experience of intuition in MFT.

- 1) **Knowing and sensing:** intuition was experienced as a knowing or sensing without a cognitive reasoning process, this was accompanied by body sensations and/or thoughts.
- 2) **Attending:** there was a sense, or urge, to pay attention differently, to remain open to new possibilities that might redirect the therapy.
- 3) **Decision making:** paying attention to the intuition required a decision about if, when, and how to act on the intuition or integrate it into therapy. This sometimes included a decision to trust the intuition.
- 4) **Finding language:** therapists took care to share the intuition with clients in a way that the clients had an option to receive it, consider it, and/or reject it.
- 5) **Validation and meaning making:** there was observed or verbalized acknowledgment that the intuition was meaningful to the therapeutic process.

Intuition as knowing or sensing. Intuition was found to be experienced and described as a “sensing” or a “knowing” that did not have a clear explanation. One

participant described intuition as “more like a feeling than a cognition, but that’s not quite it either.” Intuitions were not facts about clients, but they were useful pieces of information or leads to follow. Participants called intuition a “sense”, a “gut sense”, or a “push”, often that “came out of the blue.” One participant described it this way: “So the feeling, or the sense, is not articulated. It’s like a “Hmm...” or a “Uh-oh” something; it’s like some kind of guttural ... something.”

Participants described things like cognitive thoughts, body sensations, visual images, dreams, emotions, inspirations, or questions, but these almost always occurred directly after the felt sense of intuition. Several therapists in the study described intuition as being felt in the trunk or center of their bodies. They even gestured to those parts of their body if not naming them aloud. Some experienced all of these things with intuition and others experienced just one of these things following intuition. “It’s a marriage of the feelings and then trusting of a sense. So, a sense of intuition, a body sensation, followed by thought.” One participant distinguished these things when she described how an intuitive sense comes before the thought process.

It was just a sense, like an ‘mmm,’ no words, nothing, just a sense ... Then I made sense of the feeling ... And that’s where my thought process came into play. As opposed to the intuitive part I would say was just that sense that says “pause, pay attention, do something different here,” I’m not quite sure, it doesn’t have a whole lot of message other than maybe “be still, wait,” something like that. Maybe that’s what that feeling gave me the opportunity to do. Like, “oh you’re having a feeling, ok notice that.”

In each story, intuition was experienced as a form of information or a knowing. As one participant described, “I think intuition is data.” Another therapist described an intuitive moment where he suddenly knew he needed to watch the client play a game with her child. The therapist noticed and followed this intuition, encouraging the clients to play a game together. The outcome of the game of checkers was clinical insight from both the therapist and mother that she really needed to “win” in the relationship with her daughter; that she was setting up a competition with her daughter that she would win at all costs. In this story he described a sense of knowing that important information could be learned if he watched them play a game together.

Overall, intuition presented itself as an awareness of something that needed attention. “Sometimes it represents an awareness that’s beyond words. I think that is partly how I’d characterize intuition. It’s strong feelings and I can’t always articulate what it is, but I know there’s something there.” And another described it this way: “I think you’re talking about cultivating a stance of deep openness. And so you’re receiving information from many, many channels. There’s so much information.” Intuition felt like a piece of information that needed to be followed, but it was not always clear where it would steer them. “The intuition piece is more of a lead; sometimes it can feel like a leap of faith.”

Attending to intuition. While telling stories of intuition, every participant identified a moment, thought, or sense that they should “pay attention” to their intuition. The intuition shifted their attention somehow. A participant said that intuition was intuition even in different forms. “Whether it’s taking an extra pause, asking a different

kind of question, considering some other options, or maybe even just saying, “Something feels weird.” Other participants described intuition as an invitation to shift their awareness. “Almost like intuition is the gateway of permission to look at more, believe more.”

Therapists in the study described intuition as a source of information, though it was not necessarily information in the form of facts. Intuition was experienced as information that must be attended to if they were to get at the core of the issues or resolve them. For example, although the discovery eventually became the uncovering of an affair, the intuition was “He’s not really in this [marriage].” A frequent missing piece of therapy was a history of sexual trauma that had not yet been disclosed or acknowledged. In these stories, intuition for therapists was “There is something more going on here than garden variety depression; pay attention” or “There’s more happening here than drinking alcohol; pay attention.” One participant described his sense of needing to keep paying attention to this source of information and keep gently questioning.

I just kept getting this, it really was just a feeling, that there’s something that I don’t know about her that I’m not understanding and that is part of her presentation, but I don’t know what it is. Because of that, I kept being serious and probing a little bit and it didn’t come out right away. Her secret did finally come out, which I had been sensing that there was something. About five or six sessions into meeting with her she started talking about a confusing experience in her life. As we explored it we found out she had been sexually abused by a neighbor boy when she was [a young girl]. I don’t think she ever would have

volunteered it without me kind of pressing a little bit more that there's something based on that intuition feeling that she wasn't telling me everything that was going on inside her psyche. We ended up having quite good therapy.

Participants who attended to intuition repeatedly discovered significant information that drastically shifted the therapeutic relationship or course of therapy. One participant described intuition encouraging her to pay more attention to what is missing, "I feel like there's a big hole. There's something I'm not being told." One participant used those particular words: "It changes the course of the session." Another participant described the importance of attending to some new awareness in intuitive moments. "It was, you know, paying attention to it, and going in a direction that I thought made sense and that at least needed to be wondered about." Participants frequently described how it felt to attend to intuition, to shift awareness and pay attention, when they were not certain what to pay look for.

The person, they have something more ... it's like communicating with a ghost. Someone is trying to tell me something and I'm not quite getting what it is yet, but there's a voice in my head that says, "Keep paying attention because there's something more here."

Decision making and intuition. The experience of intuition did not seem to inherently come with the need to make a decision; intuition did not present itself as a choice. Yet each participant described a process of decision making that occurred after the intuition emerged. Often participants experienced the need to "do something" with the intuition. They presented the intuition experience with decision components. First

came the choice to “pay attention” or not. But mostly, there was a decision of what to do with the intuition once they did pay attention to it. A participant described the questions he asks himself in determining what to do with intuition: “How do I share that? Or should I share that? Or what could be the impact on the client if I share that? Or even, if sharing it is for my information or for their help?” Sharing the intuition was one of the most common decisions that was made by therapists.

It's like, “Okay, this might not be right, but let me just put it out there and see what kind of thought and reaction I can get.” But I tend to trust my [intuitions] much more now. Again, I don't know where this came from, but it's not mine and it needs to be out there. A big part of intuition as the therapist is giving yourself permission to share.

These decisions always resulted in redirecting the flow of therapy even if only for therapist and his or her internal process.

I had gotten to this point where I can't be helpful. I don't know what's going on yet. Yet there was something in me that believed that she was telling me the truth. And so I went into session not having any idea what to do and so I said to her, “Here's what I feel.” I decided this. I decided I could tell her how I was feeling and what was going on.

In hindsight, when telling their stories, therapists articulated the dilemmas about “listening” to intuition and the difficulty in choosing to share it. They worried that their intuition was “not clinical enough” or that it might come across as unprofessional. One participant said, “I don't like any part of therapy to be mystical or magical because it feels

like then the client is powerless and we [therapists] have all of the power.” Sometimes the decision to act on intuition, or attend to it, felt risky, “And so sometimes we have to make that leap of faith or whatever to say, “I’m going to say this and I am going to go down this line.”

In its simplest form, intuition encouraged the therapists to make the decision to continue with curiosity and openness to what might come. One participant described a client’s response after she followed her intuition made the decision to pay attention to two seemingly unrelated life challenges. “The client kept saying, “No one else figured it out, but you figured it out.” All I did was ask her if she thought these things in her life were connected.” Participants described decisions to follow intuition when pieces did not fit together.

Internally, I was upset. You know, it was like, it was like inside me, the Lego pieces weren't connecting together. They were just missing each other. And I have learned enough in my life outside of therapy that when I had that feeling inside of me that things weren't clicking together that I was missing something and it was important to go find out what that something was in order for the things to click. And of course when the client [confirmed intuition and] said, "I was sexually abused," for me, inside, click, click, click happened, you know?

Often when therapists in the study experienced an intuitive sense that was more specific, for example to say a word or phrase or to make a suggestion to the client, the decision point was whether or not to share the intuition with clients and if so, how to do so. Some participants described making choices to suggest things like changing the

format of therapy after attending to intuition. One participant described the result of moving from couples work to individual sessions and back again. “It [intuition] caused me to ask the question. And that caused the therapy to change and her [the client] to change ... I think it had been stewing inside [the client] for 30 years before that.”

Participants described making the choice, even when feeling uncertain about the outcome, to take action on intuition by presenting their intuitive questions to clients to see what came of it.

Intuition was knowing something was wrong but having no life line, no rope, to get to it. How did we make that jump? That to me makes no logical sense ...there was nothing that pointed to what to do next other than intuition. There was no training for that. There was no guideline for that ... actually everything kind of went against that. I wanted to rely on “Keep doing everything you’ve done ... keep being an empathetic, warm source of unconditional positive regard and sooner or later this will come to be.” But no ... actually I needed to take an action. And I don’t know why ... but that’s what made the difference.

Pace of intuition. Each participant’s story painted a picture of intuition as occurring rapidly; that the knowing or sense occurred quickly and without warning. The choice to listen or pay attention to the intuition often happened rapidly, for example a blurting of a word or question. Other times noticing of the intuition was sudden, the choice to pay attention instant, but the decision on how to address it in session with clients was a longer internal process that the therapist wrestled with across time and sessions.

So, I'm not ready to say, "Oh yeah, this is what's going on." What I am ready to say is, "We have been given a lot of clues here. Let's put them together and see if that's what the case is."

As mentioned previously, this knowing might occur even before a therapist meets a client, or several years into the therapeutic process. One participant described, "Sometimes it's quick and sometimes it's slow." And another said, "Sometimes it's instantaneous."

The issue of pacing intuition in these stories was mostly around the therapist's timing and processing of the intuition. Some participants responded quickly, saying something out loud to the client even before they had time to decide to say it. Others told stories of sitting with the intuition for some time (e.g., several sessions, months, or more) before determining the right timing for the client or the right way to bring it up. One participant described his concerns about rule following as a reason to delay sharing his intuitive urge to self-disclose to a client.

I mean, I think it is different in the sense that I am on the other end of it now ... I wondered what's happening and for a few weeks it's like "Holy crap! Definitely not going to talk about that! That will turn you in to the [licensing] board." Anyway, what did I disclose? Not much. But I really broke that self-imposed rule of not putting myself into the session.

Participants described the importance of gauging timing with the clients' readiness. One participant described a story in which weeks after her intuitive questioning about sexual abuse a client confronted her and accused her of knowing about

the abuse before she disclosed it to the therapist. The therapist responded,

And I said, "You weren't ready to even be open to this possibility until now." I said, "I needed to wait until you're the one who said to me, 'Is it possible?' because you were the one opening the door [to the discussion]."

Another participant described the importance of timing with intuition and discerning a client's readiness to talk about the possibilities,

With that client, I'm in that pacing and leading mode, where and when do I think this person is ready for this? When I had those wonderings there was also a knowing that I haven't reached the time yet at which she's ready to discuss this.

Participants described the clinical timing of sharing some intuitions.

I've got to build some other things here before making this point. They're too fragile at that point, they can't infer what's going on. Yeah, I think a lot of it has to do with them not being ready to hear it. So I'll hold onto it for bit.

Other participants described feeling more willing to share intuitions right away with clients because they trusted the clients to determine the pace of integrating the intuition (or not) into therapy.

And it may not happen right away, so like seed planting, I've had to put it out there, and sometimes the client will come back a couple weeks later, or a couple months later, and say "Remember when you said this, that, and so and so?" I would ask them, "Well what did you hear me say," because I had no idea what I said! [Laughs] And it seemed to impact me sharing a little quicker with people. It was something to think about, or reflect on, in their own time.

Trusting intuition. Most participants talked about struggling with trusting intuition or intuition's accuracy and legitimacy at some point in their careers. There seemed to be a consensus that well-trained, ethical, competent licensed mental health professionals needed to find legitimacy in intuition before there was comfort in attending to it as a trusted way of knowing. "I'm still working on it, when to trust that feeling and when to just see what I've been taught and what seems like the right thing to do." More than one participant talked about rule breaking. "Sometimes you can feel like you're breaking the rules a little bit when you try to be more responsive to intuition." Another participant described wrestling with various ways of knowing and their legitimacy in the field.

I'm certain that I don't give enough credit to my intuition. Being in a world where facts and numbers speak, I find myself trying to "prove" what I feel, know, sense even to myself. I trust my goals (to be helpful, kind, compassionate, intentional, etc.) and try to rest on that ... that what I'm doing to reach those goals and live life that way doesn't matter whether it comes from facts, numbers, or intuition ... My "knowing" is valid, and with anything, I am willing to be wrong. I think I realized somewhere along the way that I would rather put a thought, feeling, idea out there even with the risk of being wrong or off the mark rather than not put things out there and find out later it could have supported my higher good or the higher good of somebody else.

Some participants talked about getting legitimacy early on in their graduate training from supervisors who helped them identify intuition and listen to it. When I

asked one participant how she learned to identify and trust intuition, her response echoed what other participants shared.

Practice and encouragement. Those two things. Having supervisors in my training program that said “Why did you do that?” And I’d be like, “Yeah, I don’t know.” And the supervisor I worked with said “Okay well, keep with that, that’s your intuition.”

Most participants, however, uncovered their trust for intuition as they slowly unveiled the phenomenon to themselves. Across years and clients, after seeing ways that intuition could be helpful, they began to trust themselves and their intuition(s).

What that brings up for me is that I respect in my own career that I kept balance. In other words, my commitment to keeping myself current professionally and academically, y’know, as people say, if you really want to learn something, teach it. And teaching family therapy, supervising in it, etc. which relies a lot on cognizant information and so forth, it gave me some feeling that I was ... that that was a trustworthy practice. And then I was merging what came up for me intuitively with maps I developed through theory and experience and talking about it and lingering in that formal way of knowing. Those more typical sources of knowledge, I would say, in our field. And so that actually, gave me, I think, more room to trust my ability to linger more in the intuitive.

Several more experienced clinicians talked about the importance of maturing as a person before they could mature enough as a professional to trust intuition. “I think it’s almost like a permission to trust intuition that comes with saying, ‘I’ve been doing this

for a decade.” Participants described the transformation in trusting intuition across the development of their careers.

I think when you go through graduate school, some of that [intuition] gets taken out of you during graduate school and maybe for a few years after, because you start focusing on people’s theories and techniques. I think you stop trusting yourself and start thinking you have to operate from this whole new set of knowledge. I think for me, when I first came out of graduate school, I was not working as intuitively as I am now, because I backed away from it. What I would say is in the last ten years that I’ve kind of come back and embraced it, so the first part is to say, “I’m going to pay more attention and trust more, not only what I observe, but how that resonates within me.” It is to give more attention to my own response to it, to give more attention to intuition.

Another participant described his development this way,

I think when I was a younger therapist, I wasn’t as confident about sharing those [intuitions] with clients, but I think that I have more maturity in my old age. [Laughs] I think I’m much more comfortable sharing now. They [intuitions] seem to come from a place that makes sense to me, and to the client.

Those who did not have mentorship in intuition early on in their careers talked about finding “like minded” colleagues with whom they could share their thoughts and feelings about intuition. One participant described his surprise at finding someone else who had had intuitive experiences and would consult about them. “Yeah, it was through discussion with colleagues where we’d would be like, ‘You too!?’” Another participant

described his work with a supervisor who embraced intuition and how this helped him do the same, “I think her emphasis on intuitive process as a supervisor really got me thinking about where I feel I had moved away from some of that in grad school and then I became more willing to trust myself.” And another talked about feeling as if they were part of a “secret club” when talking about intuition, “I think in our little cuddle group, after we leave school, we have someone to say, ‘Hey do you want to talk about this with me? Are you safe?’” Although the majority of participants seemed comfortable telling me stories about intuition in their clinical work, most had never shared these particular stories before.

Intuition fallibility and mistakes. Participants were asked about intuition mistakes and fallibility within the context of trusting the phenomenon and how it affected their decisions. Every participant reported that while each had made many mistakes around intuition, intuition itself was not defective or faulty.

There’s something in having it pan out ... It’s never been wrong at this point and that is really, to use that extreme language, significant. It’s significant to say that my intuition, when I felt it, it’s just never been wrong.

Despite their confidence in intuition and growing sense of trust in the phenomenon, participants still described the risk of certainty in intuition.

Nothing is standing out to me right now that when I followed my intuition that I was wrong. That being said, I don't think I ever approached a situation with certainty that I'm right. I hold the idea that I am human and so I may be affected by the pizza that I ate last night, the relational difficulties that I might be having,

the fact that I didn't sleep well. All kinds of things can affect my experience.

The fallibility and imperfection of intuition lied with how the therapist interpreted and communicated the intuition.

I don't hold tightly on to what comes up for me intuitively. So if I say something like, "Could it be, is it possible ..." And the client's like, "No, that doesn't fit for me." I have zero stake in it. And so is that a mistake? I don't think so. It would be a mistake if I believed it to be the Truth.

Participants shared examples of times that they blurted heavy and challenging things to clients who were not ready to hear them, or times they ignored intuition out of pride or stubbornness. Therapists described intuition mistakes as being times that they did not pay attention to intuition and missed something significant. These examples, too, were what supported their trust in intuition and what enhanced their own personal and professional development in order to better attend to intuition in therapy.

When I trust it, it works and when I don't trust it and I realize I should have trusted it ... I don't want to be the one who says, "I had this feeling and I didn't go with it" or "there was something inside me and I didn't pay attention." It seems like whenever someone begins a sentence that way, it never ends up well. "I had this feeling. I didn't pay any attention to it, but everything was fine." You never hear that.

Finding language to talk with clients about intuition. Every participant described stories in which they experienced intuition, attended to that intuition internally, and then found a way to bring that information into the therapeutic process. Most

participants brought the intuition into the therapy by literally sharing the intuition with the clients, but did so in a variety of ways. Participants described typical language that they relied on to talk about intuition, but almost no one called it *intuition* when speaking with clients. Instead, they offered “crazy thoughts”, or said things like “I wonder about ...” and “It seems to me ...” or “Here's what I feel ...” Most participants reported in their stories that while they did not necessarily use the “i-word” with clients, they often would say something like “I have a sense that ...” or “I’m sensing ...” as a way to bring intuitions into the conversation. They would start questions with caveats, such as “You can tell me if you think this is true for you or not ...”

Participants were very clear that they were cautious and gentle with intuitive language; that they did not presume to know more or better than the clients themselves. Several described not needing to be “right” when intuition was experienced.

You know, “Here’s my [intuitive] thought, but I don’t need to be right.” So that if they [clients] would need to offer something that comes up intuitively, but not have to have it be the truth, they could. That’s been a good combination for me because I like to work really collaboratively.

Therapists described how frequently they use this gentle language of possibilities and wonderings.

It becomes kind of a mantra in what I say, I probably said it five times in every session, “I could be totally wrong ...so correct me ...” or “I could be totally wrong, so tell me to shut up.” I say this all the time because I have started to develop a language around “I am going to throw things out that feel, in me, right

and I want to see if they resonate with you.” And I want to give us permission to be like, “I’ve been totally wrong.”

One participant told a story about working with an adult woman who survived childhood abuse. The client had very difficult feelings towards her mother who either did not see the abuse or did not protect her from it. The therapist described that early in her work with the client she could tell this was a rigid story, one that was hard to shift. During one particular session, the therapist felt that the client's mother was in the room with them, she could imagine looking at the client's mother and saw that she was abused too. Her interpretation was that the client's mother's own abuse was the reason she was unable to see it when her daughter needed her to see it; she could not tolerate thinking about the same experience for her daughter. She described how she addressed this certainty within herself, and then the possibility with the client.

And I mean it was literally like she was in the room telling me that [she was abused too] and then I could say to the client, “Could it be, is it possible, this happened to your mom, too?” I mean if I had to bet on it, even at that moment, I would have bet, for sure, something happened to her mom. But it [the intuition] doesn't present as an exact sort of like, “Oh, her mom was abused, too.” Just, I'm certain of it. And in fact I would say that I've worked to cultivate a practice of what some might call temporary certainty.

Repeatedly, participants described a similar experience in which intuition offered something new to attend to in therapy, but not necessarily in the form of definitive facts. Despite her sense of certainty, the participant from the story in this example offered the

idea as a question, a possibility, and an opening for the client to walk through rather than as a definitive truth.

I think that [intuition] is a guess, looking for feedback. You know, “Does this make sense to you? If it doesn’t make sense, okay then we’ll move on to something else.” But I think it’s that I’m feeling that, and if I’m feeling it, then my client is feeling it. And be it couple, individual, family therapy, whatever, if I’m sensing a tension, or a fear, or a happiness, or caring about somebody else, I check that out. I put that on the table, and try to see what’s going on and get some affirmation from them. Or they say “No, it doesn’t fit”, it’s a mistake that’s fine, we can move on. But a lot of time I’ve had clients come back later on, when they had thought about it, maybe even the next session, and say “Remember when you said that?”

Participants continued to use the word “possible” when describing intuition with clients.

“I try to not believe this is the ‘truth,’ rather a knowing about what’s possible, often viewed from another angle, introducing the unexpected.”

Validation and meaning of intuition. Every story of intuition had clear outcomes or validations in which the intuition was somehow acknowledged as meaningful, useful, or significant to the client or therapeutic process. Therapists found that after noticing the intuition, choosing to pay attention to it, and making a choice about how to bring the intuition into the therapy, there was always some observation or outcome that validated the intuition. One participant described this process and the risks of not seeking validation of intuition:

I could think of times I moved forward without really checking it [intuition] out and I was wrong and I may have lost them as a client because I made a presumption. I've learned that, I guess, intuitions need to be to some degree verified before you completely commit to them. You have to look for some signs of validation.

Participants described their own observations (e.g., a client making progress) or clients acknowledging that an intuition was “right on” or “helpful” or “accurate.” Several participants identified this validation from their clinical observations and clients’ responses as the way they learned about intuition in MFT.

What I would say about myself intuitively is that a lot of what I've come to know about being an intuitive person has come from feedback from other people ...I've learned to trust people saying, “I have really enjoyed our supervision,” or, “I get something so different from you than anybody else.” And I've gotten pretty good at saying, “Can you help me understand what that is?”

A participant described working with a couple in which his intuitive sense was that the wife was not presenting on the outside how she was feeling on the inside. His intuition urged him to meet with her individually in between the couple’s sessions. Like other participants, this therapist reported that without following the intuition, he would not have been able to help the client as well or as quickly.

So, to me, it's an example that sometimes with a couple like that, I wouldn't have met individually and I never would have found out [she didn't want to be in the

marriage], I might not have found out, but I was really following the intuitive feeling at that point.

Overall, participants described the importance of checking the intuition out in some way in order to determine its importance.

But I think the doubt piece is there in my mind and before I check it out. I have these wonderful intuitions that I keep to myself, or I test them out in a whole bunch of different ways. But I found it important to validate things with my clients in family and couple therapy. They're the experts and they'll tell you whether things are not making sense.

Participants frequently described the meaning and usefulness of intuition in therapy. Their stories included descriptions about how attending to intuition brought about important shifts for clients and the therapeutic relationship. The information that intuition added to the therapy process helped redirect therapy in a direction that the therapist and/or clients determined to be important and unlikely to be accessed, or accessed as quickly, without the intuition as an inspiration. One participant described her learnings from Carl Whitaker, a founder of the MFT field and experiential family therapy, and the relationship between meaning and intuition,

[Carl Whitaker said] "People come to me with pain, they want me to make their pain go away. But I hope when we are done their pain has meaning." That's what I am talking about: meaning makes it worth experiencing, and intuition often seems to direct me into meanings.

Participants continued to emphasize the pragmatic usefulness of intuition in MFT.

“I’m really not attached to whether or not it was right. It’s just whether or not it was useful.” Even when intuitions were misinterpreted or the timing was off, they were still helpful.

Part of it I think values more intuitions as crazy thoughts is that we share them more frequently, always within the context of “I might be wrong”, you know? But what if I’m right? I’ve had many times that they [intuitions] weren’t right that led to an interesting discussion. It led to a different view point for the client and for me. For the client, how did he get the intuition? What was I saying that caused him to think that? Do I need to think better and clearer about what I’m going to talk about? I don’t think that’s wrong, I think it was helpful for the therapy process.

Participants also reported that modeling the act of honoring their own intuition gave clients permission to honor themselves and their own intuitive experiences. Therapists described the gravity of the intuition and the significance to clients, “It was this very big moment, very sacred.” Participants described the meaning of trusting their own intuition; that trusting their intuition brought authenticity and integrity to the therapy room and gave permission for clients to be authentic too.

I think [therapists who use intuition] develop a different kind of connection with their client, a different relationship. And the client starts to become more creative with trusting their own intuition, and in some ways making it permissible to talk about the intuition piece ... This is a second order kind of change. We’re now not talking about the content piece; we’re talking about the process piece. And

that implies the impact on people emotionally, intimately with a relationship ... I think it's that whole sense of "that's a safe place to do that, safe place to share that" and I modeled that for them. It provides them another model for what they want out of their relationship.

Participants described other ways they thought intuition served clients. "Saying something about intuition is giving it voice when they were too afraid to ... They were so needing to be reminded of what they know too." Therapists who were willing to share their own thoughts and feelings, to take a risk and be vulnerable with clients by sharing intuitions that had no clear source or explanation, strengthened the therapeutic relationship. Clients felt a sense of safety and permission to be vulnerable too. Another participant described how the client had validated his intuitions over the course of their relationship and now they can talk about the importance of this in their therapeutic relationship.

What ultimately came to me was, and we actually talk about this now, was that our paths crossed on purpose. He will often joke, "I believe that you were put here, that you were the person to assist me." And I'm like, "Oh you think you're that important that God and everything just scooped me up and plopped me down in your community to have me?!" And he was like, "Isn't that possible?!" Well I guess it is possible. [Laughs].

Participants also described that clients felt seen and known by the therapist when they shared their intuitions; clients often accepted intuition as a sign that their therapists cared about their well-being. "[Clients] will feel safe because we can trust that sense of

self that we'll take care of them, that [intuition] it's not mystical and magical ... it is something we can rely on.” Several participants mentioned the safety that intuition can create. “I think listening to the intuition creates a safe environment for clients to accomplish things.” Another participant described intuition as something that deepens a therapeutic relationship. She described this from both her perspective as a client and a therapist.

It seems that whether or not the client could speak at it this way, it seems that that use of the intuition and acknowledging that creates a deeper well of safety. You know, like, we might be safe here [hand gesture near head level], but now we've also sort of dropped down here [hand gesture near heart and solar plexus] and now there's another level of security. You know, that is the hope. I remember when my therapist acknowledged something that she knew about me intuitively, I remember feeling, “Good, this isn't odd to me. You know that right now, I may not totally trust my intuition because all this stuff that's going on, I don't know who I am anymore, how nice to have someone else to have interest about me that I can trust.” And you know, I would imagine what it says to my clients is, “here's another caring person that knows me.”

Several participants described what attention and sharing of intuition communicated to clients. “Intuition says, ‘I’m going to pay very close attention to who you are as a whole person, more so than a diagnosis for insurance or someone paying for therapy.’”

Discerning intuition from other clinical skills or sources. Participants could sometimes more clearly articulate what intuition *was not* rather than what it *was*. They

said it was “not a cognitive deduction,” it was “not a rational decision or clinical assessment,” and it was “not an observation of clients’ nonverbals [behaviors] or cues.” Participants felt strongly that intuition was not clinical expertise, judgment, observation, or deductive reasoning, but that it was not completely removed from these clinical skills either. Instead, intuition worked collaboratively with other ways of knowing.

Well, one thing I would say is that I’ve come to know that I work out of intuition so primarily that sometimes I’m not really aware of where a certain notion starts. Whether it’s from in the gut part of my mind, or in the brain part of my mind. So there’s this interface between those. And it’s only been in educating myself about intuition that I’ve learned, “Oh, that’s where I get a lot of my information, I thought it was out of my head.” So, for example, through working with various families beginning to get aware of ways that there’s a sort of a, “One second ago I didn’t know it, and now all of a sudden I do.” That that’s a different process than, “I figured it out cognitively.”

Participants discerned the difference between intuition and having repeated experiences that inform therapy.

I think the expertise piece and the experience piece is, is more playful, more thought out. I think the intuition piece is something, again with an analogy of the light bulb, it just sort of pops up. Something there pushed buttons in my internal computer or whatever it was, so I ask about that, or comment on it. And I also believe that good therapists get confused a lot, and part of my intuition piece is for that confusion ... I think it’s a question of how do you balance the expertise

piece with the intuition.

Participants often told stories about clients who had presenting problems for which they had specialization or experience (e.g., a sex therapist told stories about a client with sexual concerns, a play therapist described a story of doing play therapy, a couples therapist working with a couple, a trauma therapist working with trauma), but they made a point to name how the intuition was not rooted in this expertise or previous experience.

That [intuition] it's a sense of ... It's a sense of "I get and I follow it." Some would say it's a hunch because it sounds a little like an educated guess and some people are more comfortable with that as opposed to "I know things" and they think it's like being psychic and it's too creepy and that sort of stuff ... I don't [think it's an educated guess] ... I think I know, and I don't know how I know.

Instead, most participants described how, as a source of information, intuition worked in collaboration with other therapy skills.

Experience, knowledge, expertise, they all co-inform. I would actually put experience, knowledge, formal, institutional kinds of academic training, thinking, and intuition in a triad, and I think without one of them it's weakened. So it's a three-legged stool, it's stable. And they co-inform and I would have a diagram with them, arrows going all which ways. And that if you lop off one, you're deeply restricting the growth of the other two. So, for example, I think that intuition is the resource that connects experience and knowledge, honestly.

Most often, participants described their learned-therapy-skills as confirming intuition or

intuition confirming what their other skills were contributing. Another participant also described intuition and its relationship to experience and clinical skill with a visual image:

You know when we see pictures of two words, or even four words and then, you know, the arrows are going both ways. It feels to me that intuition and experience or expertise, it's just arrows going back and forth. My intuition may influence my expertise, which influences my intuition. No, I don't think that they're separate at all. They inform each other.

Self of the Researcher, Findings from the Interview Experience

The analysis of participants' stories of intuition in MFT provided insight into the phenomenon of intuition. Despite a variety of differences in participants and in the content of the stories, there was tremendous consistency in the process of the lived experience of intuition. The stories were not the only source of data, however. It became clear to me early on in the interview process that there were findings to be discussed in this chapter that might continue to "bring mystery more fully into presence," (van Manen, 1990, p. 50), but that were not a direct result of the story analysis process.

Intuitive interviews. One of the first surprises I had in the interview process was that I did not have to ask most of the interview questions. I chalked this up to being well-informed about the topic, having an insider's view as a therapist/researcher, and being well-prepared. But as the interview process unfolded with participant after participant, I realized it was not necessarily that my questions were so appropriate or obvious that the participants naturally answered them, but that they might be intuiting the questions I was

planning on asking next. In an intuitive dance, many of the participants would be mid-sentence or mid-topic, and as I cognitively thought of the next question and made plans to ask, they would course-correct and interrupt themselves to jump to the next question before it was asked. They often said things like, “How did I get here [to this answer]?” or “I’m sorry, I’m off on a tangent” and “This is way off topic” when they actually were moving on to the next as-yet-unasked question, not changing the subject or getting distracted. Partially this confirmed that the questions I planned to ask were fitting for the topic, but what is uncertain is how intuition was playing a role in the research interviews themselves.

My own intuition was something that seemed glaringly obvious to me as I spoke with participants. By talking about the phenomenon of intuition the experience of it seemed highlighted. For example, my journal entry about the project before my first interview (found in Chapter III) identified my concern that despite multiple written and verbal clarifications that I wanted to discuss stories and experiences of intuition, only one participant had a prepared story when we began the interview. Every participant struggled to come up with a story at the beginning of the interview; each of them said they could discuss the phenomenon in general but that to pinpoint an experience was a challenge. They said things like, “It’s a little undocumentable... Intuition feels unquantifiable.” One participant described her struggle to try and think of an example of intuition.

I don't think of myself as an intuitive person. I think of myself more as a practical person and therapist. And yet when I say that, I think that the way that I usually

listen is intuition in the therapy all the time. And I think that if I told about it like from how to greet someone at the door, and how much time you give them, and bringing them into the session, and how much ... you know, where I put them, where I don't. All of that is intuition and I think, for me, it's a little bit more, like it's pervasive, but not in my face. You know? I can try to think of some examples though of the way that I've seen it sort of come to the surface where I know that it's intuition and it's about trusting my gut.

This only became a struggle in the case of two interviews in which we had to engage in the interview “out of order” by discussing intuition in general first, and then talked about examples of the experience second.

Interview evolution. Several participants seemed to go through an evolution through the interview process. They began by struggling to think of examples of intuition and struggled to find words to articulate some of the things they were trying to convey. Most said wonderfully collaborative things like, “I hope this is what you’re asking for,” or “Is this helpful?” Another said, “I’m not sure I’m describing this well ... I won’t be offended if you just say ‘Huh?’”

Through the conversation they became bolder and more certain of their uncertainty. After a while, participants would stop trying to apologize for their struggles to find words for intuition and say things like, “Language just doesn’t lend itself to this topic!” Another participant said, “I still doubt myself a little, because I feel silly describing this to you. Also, it’s hard to describe because most of my therapy feels like this [intuition] versus the few moments when I have a bit of research, or a book to point

to in guiding a client.” Another participant described her fear about sharing intuition and the sense of breaking the rules even in an interview about intuition,

I did have to unlearn a certain degree of intellectual learning to make room for my intuitive learning. Because I was very rewarded for being a good student and there's a part of me that's really a good rule follower as much as I can break rules, and wants approval, and wants to fit in, all those things.

Every participant laughed, rolled their eyes, groaned, or had some reaction to the difficulty of answering one of the final interview questions: “So what is intuition? Where does it come from? What does it do?” One participant asked, “Does everybody hate this question?”

There was also an evolution of the tone of the language across the interviews. Participants seemed to shift from talking in clinical terms to more non-clinical terms; almost all phrases related to spirituality, universal energy, or sacredness, came from the end of interviews rather than the beginning or middle of the conversations. In fact, none of these spiritual descriptions of intuition emerged until the very end of interviews, often in parting statements. Most participants eventually talked about intuition as a spiritual process or connection; that it came from somewhere “universal” or “divine” or “sacred.” Though participants described the sensation of intuition as experienced within them, towards the end of interviews they described intuition as coming from an external source.

I think of it more as like a universal energy. Like I think of ... I say universal energy because it comes from beyond myself. So it's not ... I can't really identify a place that it comes from, which is why I say universal, in that it feels like a sense,

like it's some sort of energetic thing. That's the best I can do. 'Cause I really don't know.

They described the source of intuition as coming from a “universal well of wisdom” or a “collective unconscious.” They described intuition as “part of ourselves that is beyond ego or identity,” that it was a combination of “soul, spirit, connection, and relationship; all the pieces lining up together.” One therapist described the experience of intuition as a form of joining with a client:

I think that part of that openness is a deeper version of what people naturally call joining; like we're literally joined or something ... I just thought of it as an openness and that energy can move between me and the client.

Some participants tried to integrate this spiritual language back into the clinical language they had been using earlier in the interview.

It comes from transcendence. I still believe it means being able to transcend the ego, it comes from being connected to everything, we are one, and so you can know what you don't know if you can step beyond the boundaries of your own lived experience, at least in this lifetime. And transcend, you can reach across time and space. So you might pick up someone else's feelings that are in the room with you, or are somewhere else. It's, so it's a, it's a receptor as much as a resource. I think about it that way.

During the member checking process and secondary interviews, participants continued to struggle with finding comfortable language to describe intuition.

My reaction to this summary is not dissimilar to the reaction I had during our interview: that words aren't adequate to describe what we're talking about, that something huge and profound becomes small and banal when reduced to words ... And when we try to describe what gets transmitted to us in this manner, we're using words developed to apply to things moving at a much different pace.

Participants reported that they had continued to think about intuition after the initial interviews, that the interview raised their noticing of intuition, but that it did not necessarily add new information or change what they had said previously on the topic.

I have found myself thinking about intuition, yes. I would describe it most frequently for me presenting as a story that suddenly tells itself to me intact ... As I have thought more about it these observations seem to flow from patterns that will suddenly make themselves appear to me, connecting or amplifying various details, etc. I would add that I have been more aware of things presenting themselves to me as metaphors, symbolic understories if you will, that are reflecting something deeper, more meaningful ... so this creates a sense of living at multiple levels of meaning. It's about noticing I guess. And your interview raised my noticing.

Another participant acknowledged that the summary captured her comments and experiences of intuition, and that asking the questions had “put the possibility more in front” of her, but that she continued to wrestle with finding language and answering the questions I had asked. She described an example of a recent couple's session in which

she used her intuition and realized that even as she noticed the experience unfolding, it did not bring her any more clarity around the phenomenon or its source.

I had a difficult couple session, more so for them than me. Not sure where this was going I settled in and listened to them and myself. At one point I said something that pulled things together for this couple and brought about a new way to think about their differences [about the presenting issue]. When the session was over and they were saying goodbye, he came over and shook my hand and said, "Your skills, wow!" There was a point in our session that I thought, "What is she going to do with this?" And then you pulled out this helpful comment and took us through it. Thank you." I said, "You're welcome," and didn't tell him that I had had the same question.

Chapter 5: Discussion and Conclusion

What was the story of intuition in MFT? Intuition was a common source of information for MFTs in this study, confirming findings found by other researchers (e.g., Garcia & Ford, 2001; Dodge Rea, 2001; Patterson, Miller, Carnes, & Wilson, 2004; Vaughan, 1979). Intuition was a knowing or a sensing that was not a clinical assessment or cognitive deduction, but it could compliment and inform both of those. Therapists in this study described intuition as recognizing things that were beyond the immediate clinical situation, similar to descriptions of intuition in two previous studies (Benner, Tanner, & Chesla, 1996; Simon, 1992). Intuition drew therapists' attention to new possibilities. The experience of intuition came as thoughts, emotions, ideas, curiosities, physical sensations, or more. There was a blend of cautious and tentative certainty in

intuition through which participants came to trust intuition implicitly, but were gentle and careful about when and how to engage and invite clients to help them interpret it.

Experiencing intuition in MFT created two decision-points for study participants. First, they had to decide whether or not to pay attention to the intuition, which was similar to therapists' experiences as described in other theoretical articles (Garcia & Ford, 2001; Lum, 2002; Timm & Blow, 1999). Participants' decisions to pay attention to intuition were often rooted in the level of trust in themselves and in the therapeutic relationship. Perhaps an explanation for this finding is rooted in what others have suggested that less seasoned, more cautious or uncertain clinicians, or those who had not been supported in trusting themselves and their instincts, tended to miss opportunities to pay attention to intuition. Like other studies, being rooted in a positivist field that trusts rationalism and empiricism made even those participants who embrace intuition feel cautious about its use (Jefford, Fahy, & Sundin, 2011; Welling, 2005). Despite a sense of certainty in the experience of intuition (as was noted by Weis (2009)), participants were aware that information from intuition was tentative and possibly fallible. These results echo findings from studies by Bruner (1961), Polgar & Thomas (1991) and Williams and Irving (1996). Participants described intuition as certain and truthful, but acknowledged their own human-ness and the large margin of error that could occur as intuition was filtered through their own lenses, perspectives, experiences, and biases.

If the therapists in this study did choose to pay attention to intuition, the second decision-point was how to integrate this knowing into the therapy. Most often, they used the intuition to create an intervention or ask a question of clients (also a form of

intervention). They found a way to pose the “possible” to clients at the right time. This is an example of the interplay between intuition, experience, and clinical decision making; therapists had to determine the appropriate thing to do with the intuition, like with any piece of information gathered through the therapeutic process. Participants described the use of a particular language to convey an intuition so that the client had permission and latitude to consider it and/or reject it. It was important to be continually respectful of clients’ autonomy. Though intuition was seen as valuable, it was never honored as better, or more important, than clients’ knowing or expertise in their own lives.

Although filtered through the therapists, participants articulated that the intuition seemed to belong to the clients; after the therapists’ expertise in determining how to integrate the intuition into the therapeutic process, the intuition belonged to the clients to keep or discard. Intuition was almost always validated or acknowledged, and even confirmed. Embedded in participants’ stories were outcomes or results, either in observations made by the therapist or in clients’ responses, which let the therapist know that the intuition was useful. This aligns with ideas from several previous articles on intuition that suggested that intuition needs confirmation (Bove & Rizzi, 2009; Berne, 1949; Dodge Rea, 2001; Garcia & Ford, 2001; Dodge Rea, 2001; Laub, 2006; Rogers, 1961; Vaughan, 1979).

Confirmation from clients’ responses and therapists’ observations was also what helped participants learn to recognize and trust intuition. Eventually they could recognize intuition as a source of information without needing to check it out with

clients, but the significance and usefulness of intuition was almost always confirmed by clients in some observable way.

It is uncertain where intuition comes from, but MFTs in this study often experienced it as a product of connection to clients, themselves, the universe, and something sacred or divine. Intuition occurred naturally in this connection and attunement, without training. The sense of intuition came unbidden and without instruction or warning. But learning to recognize, trust, and integrate intuition often took practice, supervision, and a willingness to have open conversations with clients about the therapeutic process. Feedback occurred in relationship with themselves, their mentors, and their clients, to inform participants about intuition. Across years of practice, therapists received permission from themselves or others to heed and trust intuition.

Something about the experience of intuition was not served well by language. Though MFTs might be natural story-tellers, intuition was a difficult concept to describe for the therapists in this study. Participants found it was hard to talk about, describe, or define. Intuition felt fluid and dynamic; trying to force the English language onto intuition ran the risk of speaking the phenomenon away. The difficulty of applying language to the phenomenon of intuition further convinced participants that intuition is not a cognitive process; like other senses or emotions, it is a challenging experience to describe intuition with words. We might feel love every day, for example, but can we describe it or define it easily? Most likely not. These findings align with what previous authors have noted: intuition is a difficult concept to grasp and describe (Epstein, 2010; Sprenkle, 2005).

Overall, when experiencing intuition, therapists reported that they shifted their attention, opening them to new possibilities in the therapeutic process. Paying attention to the intuition resulted in presenting the intuition to clients in a way that invited the clients to also shift their attention to new possibilities. By noticing and integrating intuition into their therapeutic work, MFTs in this study witnessed meaningful shifts that helped clients achieve significant change and goals.

Limitations

When considering the findings of this study it is important to also consider limitations. First, the sample for this study, though not small for a phenomenological study with 12 participants and 26 stories, was homogenous in some ways. There was no racial diversity in the sample; all participants identified as White. Seven of the 12 participants were doctoral level clinicians, and eight of the participants identified as female. There was also a lack of younger novice voices in the study. It is possible that these demographics may or may not represent the larger MFT community and as such, might have limited the possible perspectives on intuition.

Each of the participants was asked what their interest was in participating in the study. Because most were colleagues of mine, or because they were referred to the study from mutual colleagues, the answer was often twofold: 1) "It's you," they would say, "It's always good to spend time with you;" and 2) "Your study sounded interesting." Given all of this, it is worth considering whether those who participated in this study were somehow interested in the topic to begin with or perhaps there is something qualitatively different about those who self-selected to participate and those who did not.

A therapist who does not find meaning in intuition or who is unaware of it would probably not have been interested in participating in the study, thus further limiting the number and type of voices heard in these findings.

Lastly, though I took care as a researcher to be transparent with my intentions, biases, expectations, and methods, it is possibly and likely that I did not achieve full transcendence in this phenomenological study a la Moustakas (1994) and van Manen (1990). Planned methods were followed closely, creating space for member checking and consultation to have multiple perspectives on the study and its findings. However, being an MFT who embraces intuition in her clinical work and who had my own experiences with the phenomenon, could have created blind spots and expectations that no amount of bracketing could eliminate. Not all of my expectations of intuition were met in the findings of this study, but most were. While I would hope that this was a reflection on my knowledge of the topic, the logic of my methods, and good critical thinking and analysis skills, it is also possible that some personal, clinical, or research bias affected the study in unknown ways.

Implications for Research and Practice

Research implications. While this study has added to insight into the phenomenon of intuition in MFT by describing MFTs' experiences of intuition in their clinical work, more questions are yet to be addressed. The first things to be addressed in future research are the limitations of the current study. Because participants in this study also seemed to have shifts in their understanding about intuition through the interview process, it is interesting to consider what new insights could be gained from focus group

research or other conversational methods in which participants could develop ideas and language together through the process.

Future research should include a sample of participants that is more racially and ethnically diverse, namely including therapists who might have different experiences, meanings, and values of intuition as connected to their cultural, social, and political backgrounds. Five prospective participants that were recruited for the study declined to participate; four of those who declined are therapists of color. These four individuals were also the only four individuals who had no personal connections to me as the researcher, the members of the doctoral committee, or to the University of Minnesota or doctoral education in general. They also all serve as MFTs in parts of the Twin Cities community in which community members of color (specifically the African American, Native American, and Hispanic communities) have a negative historical relationship with the University and its researchers. While it is possible that other racially diverse therapists who do have some personal connection to the project would have been willing to participate, it brings up questions about how intuition might be perceived, defined, or experienced by ethnically and culturally diverse MFTs and how that research might best be conducted.

Though many have speculated about the importance of intuition in the field of psychotherapy (Bohart, 1999; Boss, 1987; Nichols & Schwartz, 2006), research has only begun to empirically explore this concept in the field of MFT (Boss, 1987; Jeffrey, 2004; Jeffrey & Stone Fish, 2011; Keith, 1987; Pinjala, 2009; Rober, 1999; Weis, 2009). In light of these research findings, I agree with those who have researched intuition in MFT

and have suggested that more exploration must be done to better understand how intuition might be useful in the therapy room, how it might affect client outcomes, and how training programs and supervisors might begin to nurture this therapeutic skill (Jeffrey, 2004; Jeffrey & Stone Fish, 2011; Pinjala, 2009). Though the definition of intuition continues to be broad and have many facets, can these facets be categorized for better understanding of the phenomenon? Are there other kinds of intuition in MFT or other kinds of experiences of intuition in MFT? Because finding language to describe intuition was challenging, and remembering and selecting stories to share seemed to be a struggle for some participants, what other research methods might help MFTs share experiences of intuition?

Practice implications. Based on these research findings, it seems premature to determine implications for practice, training, or supervision around issues of intuition in MFT. However, questions regarding these issues have emerged from this study, including: How is intuition taught, trained, or nurtured in therapists? If intuition is a skill to be honed or a human instinct to be tapped, how can that process be facilitated by educators and supervisors who are aiding training therapists to improve other clinical and relational skills? How are clients experiencing therapists' intuitions in therapy? What are clients' perspectives on the same stories that therapists shared? At such an early exploratory stage of research, there are many questions to be asked in the future of body of research on intuition in MFT.

Intuition is not necessarily the best, the right, or the only form of information in MFT, but what is clear from these findings is that intuition is possibly one important

source of information in MFT. Therapists who notice intuition need to cultivate a tentative certainty or an openness to many possibilities, including the possibility that their intuition could be wrong, misinterpreted, or just a poor fit for the client(s). When deciding to share intuition with clients, a therapist ought to work on developing a language that communicates this openness to the clients so that clients can maintain their own autonomy and agency in therapy. Integrating intuition must happen in tandem with other clinical skills. The therapist still must use sound clinical judgment around the therapeutic relevance, timing, ethics, and purpose of integrating intuition; it is not better or wiser than other skills, but it compliments them.

Conclusion

Through storytelling, therapists in this study described the experiential process of intuition in MFT. Findings fit with previous literature but added to the study of intuition by gaining insight on the lived experience of intuition in MFT. As authors have theorized, intuition seemed useful in the practice of MFT (Berne, 1949; Bove & Rizzi, 2009; Corey, 1991; Eisengart & Faiver, 1996; Gill, 1982; Laub, 3006; Rea, 2001; Rogers, 1961). MFTs benefited from the information and rapidity intuition (Jefford, Fahy, & Sundin, 2011; Jeffrey & Stone Fish, 2011; Reyna, 2004; Rew, 2000; Rew & Barrow, 2007). Most notably, understanding intuition was central in understanding the therapeutic process (Berne, 1949; Berne, 1962; Corey, 1991; Eisengart & Faiver, 1996; Gill, 1982; Rogers, 1961) because it was a typical source of information in therapy (Garcia & Ford, 2001; Rea, 2001; Vaughan, 1979).

Intuition was found to be a significant enough experience for MFTs and their clients that further research is indicated. Therapists and researchers have to try to understand the phenomenon of intuition, even with the limitations of language. Every story of intuition in this study, every discussion and interview, described intuition's role in helping clients shift, grow, heal, connect, and reach goals in lasting ways. Participants' stories repeatedly demonstrated that by attending to intuition in MFT, whether it was in subtle and/or surprising ways, the therapeutic process shifted and was enhanced. Integrity and authenticity were modeled when intuition was integrated into therapy and therapists opened their attention to new possibilities; it created space and safety for clients' authenticity. MFTs who practiced from all of who they were, accessed intuition, and integrated intuition in to therapy, had the honor of being witnesses to transformative change in the hearts, minds, spirits, bodies, and relationships of their clients.

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Appendix A

Consent Form **The Story of Intuition in Marriage and Family Therapy** **A Phenomenological Interview Study**

You are invited to be in a research study about how marriage and family therapists experience intuition in their clinical work. You were selected as a possible participant because you were identified as a Marriage and Family Therapist (MFT) who might have experienced intuition in their clinical work. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Samantha J. Zaid, University of Minnesota, Family Social Science Doctoral Candidate under consultation and advising by Advisor Catherine Solheim, PhD.

Background Information:

Intuition has been theorized as a significant component of the human experience, the scientific research process, and psychotherapy relationship for decades, but little is actually known about the phenomenon. With this research project we hope to go beyond these theoretical postulations. The purpose of this study is to learn more about the phenomenon of intuition in MFT by asking MFTs to describe stories of this experience. From this research we hope to contribute to the field of MFT by exploring the phenomenon of intuition, learning more about its role in MFT clinical work, and forming new questions for future research in this important area.

Procedures:

If you agree to be in this study, we would ask you to do the following things:

Consent to the study and the digital recording of a 45-90 minute initial interview.

Describe a time you experienced intuition in your clinical work. Specifically participants will describe experiences of intuition, what they thought and felt and experienced, how they responded, what they noticed before, during and after the experience, how it might have informed their clinical work or not, and how they might define or describe intuition in MFT.

Some background information will also be asked to gather more details of the story. All information is confidential and no identifying client information is necessary nor will it be documented.

Respond via email several weeks later to a summary of your intuition stories and experiences, verifying accuracy and adding or changing information that is missing or inaccurate.

Consider consenting to a second interview of 30-60 minutes to reflect on any changes to your thinking or experiences of intuition since the initial interview.

Risks and Benefits of being in the Study:

The study has no foreseeable risks for you though it is possible that discussing your experiences could bring up unexpected emotions, thoughts, or reflections that feel uncomfortable. Experiences of intuition may or may not be emotional experiences; telling these stories might elicit some of these uncomfortable feelings.

The study has no foreseeable risk for your clients though it is possible that discussing your clinical experiences might include some details about your clients. Any identifying information (such as client name, age, location, presenting issue, etc.) will be removed from the data or modified to protect clients' identities.

There are also no foreseeable benefits of participating in the study, though often participants report feeling positive about contributing to a scientific study that could benefit the field of MFT.

Compensation:

There is no compensation for participation in this study.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify an individual participant or their clients. Research records will be stored securely in a securely locked building, in password-protected computers with password protected and encrypted files and only researchers will have access to the records. The researchers and professional transcriber will be the only one with access to audio recordings, and they will be destroyed upon completion of the study.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is Samantha J. Zaid with Advisor Catherine Solheim, PhD. You may ask any questions you have at any time. If you have questions later, **you are encouraged** to contact the researcher or her Advisor at the University of Minnesota, riek0022@umn.edu 612-728-5140 or csolheim@umn.edu 612-625-1201.

If you have any questions or concerns regarding this study and would like to talk to

someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____

Date: _____

Signature of Investigator: _____

Date: _____

Appendix B

Semi-Structured Interview Schedule

Demographic information collected: names, ages, gender, license, length of time licensed and practicing MFT, name of graduate training program, theoretical approaches to MFT, therapeutic specialization/niche.

- 1) Could you tell me about a time you experienced intuition in your clinical work?

- 2) Follow up questions (to gather textural and structural information; to fill in gaps in the story; to expand upon the experience; to deepen the discussion of the experience)
 - What were you thinking/feeling/experiencing in your body when this happened?
 - When and where did this happen?
 - Who witnessed this experience?
 - How did you know or learn to recognize this experience as it was happening?
 - If you somehow acted on the intuition, how and why? What were the results?
 - What does this experience mean to you?
 - How did this experience inform or affect your work with the client(s)?
 - How did you experience your client(s) or your work *during* this event?
 - How did you experience your client or your work *after* this event?
 - How would you describe this experience of intuition from beginning to end?
 - Have you told this story before?
 - If so where? If not, why not?
 - How was this telling different?
 - How did you experience this at the time versus as you tell the story now?
 - How might the telling of the story change your understanding of this experience?
 - How did you come to choose this particular example of intuition?
 - Do you have other examples or stories of intuition in your clinical work?
 - Would you like to share those experiences?
 - How are these other stories the same or different than the first story you shared?
 - What was your interest in participating in this study of intuition in MFT?
 - Can you describe feelings of certainty or doubt or trust in the intuition during this experience?
 - Do you have examples of intuition failure or mistakes?

- 3) What is intuition? Where does it come from?

- 4) Is there anything else you would like to say or share about intuition that we have not talked about?