THE SCIENTIST-PRACTITIONER MODEL IN MARRIAGE AND FAMILY THERAPY DOCTORAL PROGRAMS: CURRENT STATUS

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We discuss the status of the scientist-practitioner model in marriage and family therapy (MFT) doctoral programs. Issues discussed include a lack of faculty research role models in doctoral programs, "farming out" the majority of research courses to other disciplines, problems with curriculum, and how the culture of MFT does not support research. We also present suggestions for improving doctoral research training. The goal is to improve the quality of research training in doctoral programs. We hope that this will help change the culture of MFT to include research as one of its primary goals and greatest assets.

The purpose of this article is to discuss the current status of research training in Marriage and Family Therapy (MFT) doctoral programs. The scientist-practitioner model of training is taken from clinical psychology as the model of choice in the design and implementation of doctoral programs within the discipline of MFT.

After a brief overview of the scientist-practitioner model, the article has two main sections: Current obstacles to implementing this model in MFT doctoral programs and suggestions for overcoming the obstacles.

Several key factors are at work to provide obstacles to the implementation of more rigorous research training: A general MFT culture that does not value research, faculty lack role models of highly effective
researchers within their own discipline, the current curriculum offered by doctoral programs is inadequate to produce high quality research directly related to MFT issues and concerns, programs often place too much responsibility for doctoral education in the hands of faculty outside of MFT.

The article presents several suggestions for ways in which doctoral programs can improve the research training provided to their doctoral students. These include encouraging accredited master's programs to provide more extensive research training, increasing the number of MFT-specific courses offered to doctoral students, improving faculty models of productive researchers, adopting a postbachelor's model of doctoral education, adapting a clinical supervision model of clinical training to research, and providing more explicit direction and support to students entering doctoral programs.

Brief Overview of the Scientist-Practitioner Model

The scientist–practitioner model is the term used to describe a perspective of clinical education and practice that emphasizes the three interrelated roles of mental health practitioners. These include the roles of consumer of new research findings, evaluator of one's own clinical practices, and researcher who contributes to the professional literature through evaluation of one's own clinical work.

The tradition of the scientist–practitioner has grown out of doctoral training programs in clinical psychology. As early as 1949, clinical academics, researchers and representatives from the federal government sought to address ways in which doctoral training in clinical psychology could combine both clinical and research traditions (American Psychological Association [APA], 2000). In what was to become known as the “Boulder Model” of training, the goal is to provide doctoral education where the separate traditions of research and clinical training could be combined in ways to reduce the gap between research and clinical practice.

The goal of training is to equip doctoral graduates with two sets of skills, those of a clinician and those of a researcher. Advocates of this model of training have argued that both types of training are possible and necessary. Others argue that such training is not possible and argue for two distinct tracks for doctoral training, one for clinicians and the other for researchers. In this article, we argue that not only are both types of training possible and necessary, they are also possible and imperative if MFT is to advance as a profession and a practice.

The scientist–practitioner model of training has been widely discussed in the field of clinical psychology (e.g., Borders, Bloss, Cashwell, & Rainey, 1995; Forsyth & Leary, 1997; Hayes, Barlow, & Nelson-Gray, 1999; Trierweiler & Stricker, 1997), but not very often in MFT. For example, a review of the research course work for the accredited doctoral programs reveals that the term “scientist–practitioner” is not found in any of the available course descriptions of any of the doctoral programs. In addition, a word search of the current accreditation standards (Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE], in press) found no instances of the terms scientist–practitioner, scientist, nor science, although in this latest revision, the word “empirical” has been added in reference to models that must be taught. Consequently, one could argue that the concept is not an explicit focus of most doctoral programs or of the accrediting body of the profession.

Struggles with implementing the scientist–practitioner model are not unique to MFT. The same issues about the integration of science and practice are raised in medicine, social work, psychology, and other clinical fields (Davison, 1997; Garfield, 1998; Rychlak, 1998; Wakefield & Kirk, 1996). The purpose of the article is to begin a discussion about the application of the aims of the scientist–practitioner model in doctoral training programs in MFT.

Obstacles to Implementing the Scientist–Practitioner Model of Training

The culture does not support research. Ours remains a field in which it is still possible for a highly charismatic individual to create a model of family therapy, become successful on the workshop circuit, and get lucrative book contracts to promulgate the model without offering evidence for its efficacy beyond personal testimony. In many ways, rock-star status is accorded the clinical model developers and the “master” therapists. Researchers, when contrasted with the “stars,” are at best warm-up acts, and at worst bit players.
This culture of charisma has deep roots in our history. Family therapy began as a maverick discipline, which was “oppositionally defiant” to the prevailing, individualistic, psychotherapeutic zeitgeist. Although many of these founders started with a strong focus on research, they did not seem to pursue research after they had developed their models. Perhaps because they were rebels, many of the discipline’s founders were strong, active personalities and powerful salespersons. Schools of family therapy were built around these compelling figures. The culture of the field has always depended far more on intuitive appeal than on solid research evidence (Nichols & Schwartz, 1995). At least until the early to mid 1980s the field could be described as a coterie of competing religions. A. J. Werry wrote as late as 1989:

Sadly, at the moment, family therapy has many of the hallmarks of a religion with several competing sects led by feuding charismatic prophets each claiming to have a premium on the truth, but few of the attributes of a professional endeavor rooted in ethics and skepticism. (p. 7).

Unfortunately, with a few notable exceptions, once people get famous in family therapy, they seemed to submit less frequently to journals, rather than more (unless they are asked). With publishers eager to market their work, the culture does not even require peer review, let alone data, to keep someone in the forefront of our field. Although there is some evidence that the star system has waned in the last decade as integrative and multi disciplinary approaches have gained more influence, there seems to be only modest evidence that the culture is changing to value research and make ours a true social science.

MFT researchers lack role models within their own discipline. Most well-known MFT researchers identify with MFT as a practice and not as a profession. Those promoting the profession of MFT have eagerly claimed the family-oriented clinical research done by those whose professional identity is with a field other than MFT and used that research and those researchers to gain credibility for our field. Unfortunately, this has allowed those of us identified with the profession of MFT to take little to no responsibility for establishing a research base for MFT. As a result, there are few role models of MFT researchers within our own discipline. It is our belief that the scientist–practitioner model will not take hold in MFT as a profession until we differentiate ourselves as researchers from our parent disciplines of psychology, sociology, and psychiatry.

We can claim those fine researchers all we want. They will not claim us as one of them. By now, this “us–them” language may be making the reader uncomfortable, but it is time to stop the pretense of no difference between those researchers whose primary professional identity is with MFT and those whose primary professional identity is with another discipline. Yes, we all do MFT research, but those whose degree and training are from COAMFTE-accredited programs are rarely, if ever, recognized by other family therapy researchers as representing a separate and legitimate profession. We have faced the profession-versus-practice issue on the clinical side, and it is time we face it on the research side as well.

Thinking of those whose only professional identity is MFT as a minority group helps to identify and clarify the problem and generate solutions. Viewing MFT as a minority group does not mean that the profession of MFT has faced the pervasive oppression experienced by minority groups in society as a whole. Yet, the profession is in an oppressed position in the context of other mental health professions. Several examples might help. Those of us identified with the profession claim distinguished researchers like John Gottman and the late Neil Jacobson as representatives of our profession. Yet, in their recent book, When Men Batter Women, they (Jacobson & Gottman, 1998) explicitly advise against seeking couples therapy and do not distinguish, as many MFTs would, between conjoint therapy and relationally oriented individual therapy. When referring to psychotherapy professionals they name “psychiatrists, psychologists, and social workers,” (Jacobson & Gottman, 1998, p. 224) and, as a source for professional referral, recommend contacting the Association for the Advancement of Behavior Therapy (p. 261). What is the problem? It is not with the authors of this wonderful book, which is an exemplar of what can be accomplished by those adhering to the scientist–practitioner model. The problem is with the profession depending solely on researchers who do not recognize the status of MFT as a profession to establish the research base for the field.

As a second example, not one of the 21 authors included in the special issue of the Journal of Marital and Family Therapy (October, 1995) on the effectiveness of MFT research is associated with accredited doctoral programs in MFT. This is not the fault of the distinguished editors, William Pinsof and Lyman...
Wynne. They chose the best-known researchers with the best track records. The editors recognized part of the problem when they stated the principle that “Marriage and family therapists and researchers should not be proprietary about the practice and scientific investigation of marriage and family therapy” (Pinsof & Wynne, 1995, p. 609) and noted that “most of the research [in the special issue] has been conducted by researchers who would not define themselves as working within the field of marital and family therapy research” (p. 610). The real problem is that the editors then go on to state that “marital and family therapy is in fact an interdisciplinary field that crosses the boundaries of family, child, and clinical psychology, psychiatry, and social work” (Pinsof & Wynne, 1995, p. 610). Again, those of us whose primary professional identity and training is within MFT are not included in the family of MFT researchers. How can we be included as a profession under the rubric of “interdisciplinary” by those who see themselves as MFT researchers, but who have another discipline as a home base?

It is our responsibility as the minority to raise the consciousness of others to a point that such a special issue of the official journal of our association would not be possible without including a heavy representation of those whose primary professional identity is MFT. The first step is to see ourselves as different and to be proud of it instead of feeling “less than.” We attempt to “blend in,” but by doing so we lose our voice. Unfortunately, when the majority group has identified us as a group, it has often been in reference to a characterization of the inferiority of our training and research. Success by a single MFT researcher does not generalize to the minority group as a whole to change stereotypes; instead, he or she is viewed as an exception.

It is difficult to speak out on this issue without seeming ungrateful to our parent disciplines. Researchers identified with the profession of MFT might feel more than a bit exposed when looking at what has been accomplished to date compared to our parent disciplines of psychology and psychiatry. As a field, we are not grown up. That is reality. But, like other minority groups in the early phases of consciousness raising and “coming out,” we have also internalized the beliefs of the majority about the unworthiness of our training, our research, and our profession without questioning them.

As long as we pretend that our research is no different than that done by family psychologists, family sociologists, family psychiatrists, or others, we will not be included and valued where it counts. We have to take responsibility for setting the research agenda and training the requisite MFT researchers and stop depending on other disciplines to do it for us. No one else will do research on the models of MFT used by our students. No one else will do research on MFT training. No one else will do research on matters that are uniquely important to MFTs. Once we start thinking about our unique strengths as a profession, new opportunities for research become apparent.

Our current doctoral research curriculum is inadequate. To determine what courses doctoral students in MFT are required to take, all of the published materials on course requirements for each accredited doctoral program were reviewed. The accreditation standards require four research courses, one of which must have specific MFT focus (COAMFTE, in press). These four courses are in addition to the research course from the standard curriculum and an MFT-related dissertation.

Findings from this review reveal that all programs provide the required one course “with a specific focus on marriage and family therapy” (COAMFTE, in press). All of the programs must do this to be accredited. However, almost all other required course work is taken from disciplines outside of MFT. Ranked in terms of frequency, these include: Family studies, psychology, statistics, educational psychology, counseling, education, and others.

Because the majority of the research training in MFT doctoral programs is “farmed out” to disciplines other than MFT, students will miss an opportunity to hear examples of interesting research related to their own discipline. Students may actually be being trained to do research on topics and in disciplines other than their own. Also, students may never receive exposure to the day-to-day world of an ongoing MFT research program. As a result, students may not have good models of active MFT researchers on which to base their own research careers.

Finally, course work taken from a number of different disciplines often provides a chaotic exposure to the research process. For example, students may take research methods in one semester in one department
and several semesters later, take a statistics course from a different department. If research and statistics
courses are taken outside of the program, students may find it difficult to integrate what they have learned
in theory and practice with their education in research. As a result, the activities of clinical practice and
research remain separate from one another both conceptually and practically.

Collateral studies versus specific MFT training. Accreditation standards allow programs to offer
doctoral course work in theory, clinical practice, and individual development and human relations
(COAMFTE, in press).

Observations of the curriculum of the accredited doctoral programs lend themselves to the conclusion
that many do not provide additional MFT clinical or MFT theoretical course work beyond the standard,
master’s-level curriculum; rather, the bulk of the additional doctoral level training students receive may be
related to other disciplines such as individual and child development, family studies, or counseling.

There are several possible negative outcomes of this practice. For example, students may be given a
fine exposure to general issues in the other disciplines but have little opportunity for advanced study of MFT
theory, clinical, or research issues. In addition, students may be encouraged to pursue research in these
collateral areas as opposed to specific MFT topics. Finally, programs may be inadvertently preparing
students for research careers as specialists in individual and child development, family studies, or counseling
instead of MFT. Although this may contribute to the development of these collateral disciplines, they do not
add to the advancement of MFT theory, clinical practice, or research.

Changing the culture is difficult. Why is changing the culture so difficult? First, most family therapists
are master’s-level clinicians, and we do a poor job of speaking with them. For example, a recent study
showed that the profile of those who submitted articles to the Journal of Marital and Family Therapy were
the virtual mirror-opposite image of the membership of AAMFT. The prototypical submitter was a male
PhD, working in a university setting, and submitting papers likely to be classified as research; whereas the
prototypical AAMFT member is female, has a master’s degree, works in a clinical setting, and has interests
more likely to be defined as clinical (Sprenkle, Bailey, Lyness, & Mills, 1997). More importantly, most
researchers are not very good at making our work accessible to clinicians. It is often difficult to get
researchers to spell out clearly and engagingly the clinical implications of their work. Many just do not seem
to be able to do it.

Second, most of the students who enter our programs do not come to us with a research orientation,
interests, or personality. Most have a social service orientation. They are interested primarily in clinical work
and often lack the necessary mathematical and research background to smoothly transition into a doctoral-
level research degree program. Although there are no direct data to support this assertion, Dr. Kevin Kelly
(personal communication, June, 1999) of Purdue University’s Counseling Psychology Program is an expert
on career psychology. Using John Holland’s (1973) six-factor personality/career interest typology, Kelly
notes that an investigative orientation, which is associated with research interests and research oriented
careers, is the primary orientation of only 5% of counseling psychology master’s students. This small
percentage with an investigative orientation tend not only to be quite different from their peers, but are not
even liked by their colleagues! Eighty percent of masters students have a predominant “social” orientation.
They are primarily oriented toward people—helping others and teaching others. Among doctoral students,
only 30% are primarily investigative and the rest are “social” and “artistic.” It would be surprising if more
than 30% of doctoral students in MFT are predominately “investigative.”

Hopeful Signs

Interest in the development of the scientist–practitioner model surfaced within discussions of the
AAMFT Board of Directors in 1997. By 1998, the AAMFT Board of Directors adopted a strategic plan for
the profession of MFT. The Board stated that the core purpose of AAMFT is to promote and advance the
common professional interests of MFTs. The strategic plan identified six key goals related to the profession,
including promotion of the scientist–practitioner model among COAMFTE-accredited doctoral programs.
Inclusion of the scientist–practitioner model in the plan was an attempt to elevate our profession’s awareness
that this training model has the greatest likelihood of educating a new generation of professionals in MFT
science, research, and scholarship. The organization seeks to generate family-therapy related research from
competent scientist-practitioners who identify themselves as MFTs. The Board emphasized that increased research on therapeutic efficacy and outcome is essential for the continued development of the field of MFT. More knowledgeable clients and third-party payers are seeking, justifiably, evidence that therapeutic interventions benefit clients and resolve presenting complaints.

Along with the development of AAMFT’s strategic plan, other recent events have stirred interest in research within the profession of MFT. For example, there has been a series of small research conferences sponsored by AAMFT to help investigators develop research programs. Also, the recently revised standards for accredited doctoral programs now allow for persons with strong clinical backgrounds to pursue a research based internship, rather than focusing primarily on clinical experience (COAMFTE, in press). This will allow new scholars to focus more intently on developing their research agenda as they complete their doctoral degree requirements.

In addition, the *Journal of Marital and Family Therapy (JMFT)* Special Issue on the Effectiveness of Marital and Family Therapy (Pinsof & Wynne, 1995), provided clinicians and researchers alike with state of the art information on effective treatments. The theme has been emphasized by the inclusion of research reports in the *Family Therapy News* and the program of the AAMFT 2001 Annual Conference that focused on “Evidence-Based Therapy.” Although the scientist-practitioner model and the development of evidence-based therapy are not synonymous, these are important steps in a long uphill journey.

**Suggestions for Overcoming the Obstacles**

**The effect of training in accredited master’s programs.** Because graduates of these programs are potential candidates for doctoral programs, what happens in the master’s programs directly affects doctoral programs. Unfortunately, many graduates of these programs do not have adequate research training to begin a research career as part of their doctoral program. All programs offer one research course with MFT material, but few require statistics courses or a hands-on research experience similar to a master’s thesis. For example, in a recent survey of programs, the majority of MFT master’s degree programs that responded \( n = 44 \) do not require a thesis \( n = 24 \), a small number offer a thesis as an option \( n = 11 \), and only a small minority \( n = 9 \) require a thesis experience as part of the master’s degree. As a consequence, many students who reach MFT doctoral programs from the accredited master’s programs often need extensive additional coursework and experience to become capable of a doctoral dissertation. In terms of research skills, they are often behind those doctoral students who come from other disciplines, such as family and human development, psychology, or sociology. If more master’s programs would require a thesis, their students would have a better exposure to research and potentially be more inclined to seek advanced research training in doctoral programs.

**In doctoral research training.** Students need an opportunity to integrate theory, research, and computer technology in an MFT context. A year-long practicum in research would be ideal as a vehicle for walking students through the application of the courses they have taken in research and statistics. The process of learning to apply research principles is invaluable to students. For example, most students report that the majority of their in-depth learning about research comes from working on research projects. Issues such as research design, survey construction, data collection, and statistical analysis are best learned in a “hands-on” experience. The more students are involved in research, the more they learn. In other words, courses are necessary, but not sufficient, experiences for students to be able to apply what they have learned.

A year-long research practicum course could help students integrate their research methods, statistics, computer skills, and clinical theory courses in a meaningful way. Among other things, we could guide students through an entire research project, from conceptualization to implementation, to human subjects committee approval, to data collection, analysis, and write up. This may well demonstrate that research is interesting, exciting, empowering, and fun.

**Collateral studies versus specific MFT training.** The faculty could offer more specific MFT course work as resources allow. For example, students could benefit from training in what systematically based treatments have been found to be effective for what types of emotional and relational problems (e.g., Alexander, Holtzworth-Monroe, & Jameson, 1994; Carr, 2000; Sandberg et al., 1997). In an era of managed care and increased accountability for clinical treatment and outcomes, such exposure is a necessary part of
clinical training. Alternatively, if program resources do not allow faculty to teach such courses, programs could offer a “capstone” experience where material from the collateral areas, such as family studies, individual and child development, and counseling could be applied to MFT clinical problems and concerns. This experience could allow the integration of these other materials with MFT theory and research.

Faculty models of research. MFT faculty are the primary role models of clinical practice for our doctoral students. The same should be true for our research programs. Faculty members would benefit from developing a clearly identified research agenda and inviting students to join in the project. The most productive researchers seem to those who pursue their own agendas and involve interested students.

Several faculty at the same institution could join together to form a research center or laboratory that is well-equipped with computer terminals, the latest in research software (both qualitative and quantitative), copies of all major instruments, and some exemplary clinical data sets. Such centers could also solicit contracts from local social service agencies so that students could gain experience conducting research in applied settings.

There are, however, serious resource issues for most MFT doctoral programs. The demands of course work instruction, clinical supervision, program and clinic administration, institutional needs for large numbers of students, and the small number of faculty in MFT programs present formidable obstacles for faculty developing intensive research programs of their own. Faculty often feel overworked and undersupported in their multiple tasks. It seems necessary for there to be higher levels of institutional support for MFT doctoral programs to allow at least some faculty to concentrate on their research programs.

The design of doctoral programs. There are two distinct approaches to doctoral training. These include the post-master’s and the postbachelor’s approaches. The post-master’s approach requires students to have completed a master’s degree before entering doctoral training. This type of program attracts students of two types, those from a COAMFTE-accredited master’s program and those from other fields.

Those from COAMFTE-accredited programs typically have not completed a master’s thesis. Consequently, their doctoral research training suffers as faculty try to make up for this deficit. However, their extensive clinical experience in systemic treatments makes their clinical training efficient at the doctoral level as no specific clinical hours requirements exist beyond the doctoral internship.

The most difficult research and clinical training are done with those whose master’s degrees are from other fields. These students may have completed a master’s thesis and bring that experience with them. Unfortunately, most have no research experience at all. In addition to starting at the beginning in terms of their research training, they are also required to complete the entire standard curriculum including 500 hrs of clinical experience prior to beginning doctoral level training. Consequently, they often have little time for developing a research agenda.

A postbachelor’s doctoral program takes students directly from completing their undergraduate degree into the doctoral program. This is done in two stages. First, the student completes the COAMFTE “standard curriculum” with a thesis and receives the master’s degree and then applies to continue directly into the doctoral curriculum. At this stage, the application process is minimal and is designed primarily to allow the faculty to evaluate the candidate’s research potential for doctoral training.

There are several advantages to the postbachelor’s model. First, it allows MFT programs to compete directly with other disciplines, such as medicine, counseling, and clinical psychology where this enrollment pattern is common. Second, it allows faculties to select students who are motivated to pursue doctoral-level MFT training without adding an additional application hurdle of first pursuing a master’s degree and then applying for a doctoral program from another institution. Third, students have more time to develop a personal research program. They can begin working toward this in the first 2 years with the master’s thesis becoming the first step. They then have time in their third and fourth years to take the doctoral course work and to continue to pursue their research agenda. Their fifth year is then free for them to complete their internship and dissertation. Fourth, it allows some economy of training. Students may take additional, doctoral-level course work in their master’s program. For example, in off-peak enrollment periods, such as summer terms, they can take courses to meet the doctoral degree requirements more quickly. This saves students time and money.

Applying a clinical training model to research. Programs that are COAMFTE-accredited adhere to an
excellent model of clinical training. From day one, the strong clinical preference of MFT students is reinforced by involving them in intensive clinical experiences characterized by high accountability in terms of counting face to face contact with clients; active, intense, and ongoing individual and group supervision by faculty; direct observation of the student’s work; and a supportive and collaborative atmosphere including both faculty supervisors and student colleagues.

It is likely that students would become much more motivated and confident with respect to research if research experiences were structured into the MFT training program to the same extent as clinical experiences. Like clinical work, research can be built in through required research seminars attended by MFT faculty and students. Just as in clinical supervision, each student could be assigned to a faculty research supervisor. This faculty supervisor would see the student through an initial research experience that would perhaps result in a manuscript submitted for publication.

In addition to individual meetings, students could meet in small groups with their faculty research advisor, perhaps, alternating with the large group research seminar. These groups might include students at all stages from first-year master’s to dissertation students. These meetings parallel group clinical supervision and have many benefits over and above individual faculty supervision of research. A high level of support, interest and encouragement from other students, more discussion of research in clinical practicum, and more discussion of clinical work in the research group all support a more positive research orientation emphasizing the integration of research and practice. The students can come to know and value each other’s research to the extent that they know and value each other’s clinical work. The groups could also help students learn more about the research mentoring process. Beginning students may take hope from hearing growth stories from others who are farther along in research, just as they love to hear how more senior students struggled in the clinic at first.

The clinical model so well understood and valued by MFT students can be used to help these same students understand and value the research process. Commonly, students view research as something they must get “right” on their own the first time without any practice. They are convinced that they are going to make terrible, embarrassing mistakes and be held up for public ridicule, ruining any future chances for credibility and competence. As these views about research are raised, they can be challenged using parallels from student’s own clinical experience. “So, it sounds like you don’t get to practice research and make mistakes. Is that how you approach your clinical work? Are you saying that the research project has to be perfect before you start it? Is that how you think about becoming a clinician? It sounds like you want to get it pretty far along before you show it to your advisor. Do you only bring your completed, successful cases to your supervisor?” Applying the language of clinical work to research can make the research process much more accessible to MFT students.

Orienting new students. It is unlikely and possibly undesirable that we change the type of person applying to our programs. However, if we are serious about research, we ought to be more “up-front” about the fact that research training is a major emphasis in our programs and that the PhD is a research degree.

There are a number of simple, yet potentially powerful, ways that this “up-front” orientation could take place. First, as a field, we should give serious consideration to encouraging our master’s-level programs to require a thesis so that doctoral students are better trained in the research process. Second, a course could be taught early in the doctoral training on preparing manuscripts for publication. This course is currently being taught in some form at a number of doctoral programs and teaches students about the process of publishing professional research. Further, almost any course, syllabus, and assignment can be structured to stimulate and require research questions that might result in publishable manuscripts (Piercy, McDaniel, & Sprenkle, 1996). Third, supervision time can be used to help students answer their own clinical questions, hypotheses, and “gut feelings” by formulating research questions. Often these questions can be answered by using data from the clinic’s own database.

Summary

The purpose of this article was to present some ideas about the current status of the scientist–practitioner model in marriage and family therapy doctoral programs. Problems with curriculum, “farming out” research courses, and obstacles in developing a scientist–practitioner identity in our doctoral programs.
Finally, we made several suggestions for improving research training. We hope that there may be an emerging discussion of ways to implement the scientist-practitioner model in MFT doctoral programs. Such steps will help change the culture of MFT to include research as one of its primary goals and greatest assets.

REFERENCES


