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Relationships among therapists' family background, personality traits, and therapeutic approach

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RELATIONSHIPS AMONG THERAPISTS' FAMILY BACKGROUND, PERSONALITY TRAITS, AND THERAPEUTIC APPROACH

A Dissertation

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by

Jeffrey Neil Van Pelt

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RELATIONSHIPS BETWEEN THERAPISTS' FAMILY BACKGROUND, PERSONALITY TRAITS, AND THERAPEUTIC APPROACH

by

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Approved October 1993

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Kevin Geoffroy, Ph.D.

Kathy Evans, Ph.D.

DEDICATION

This is dedicated to my parents, Neil and Louann Van Pelt; my wife, Sharon; and my children, Neil and Hannah. This accomplishment would not have been possible without the many years of nurturance and devotion I received from my parents, nor without the support and love of my wife. And my children, well, I'm just very fortunate to have them. I also owe thanks, for all their assistance, to the faculty of the Program in Counseling, School of Education, The College of William and Mary -- especially my advisor and dissertation committee chair, Dr. Charles Matthews.

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ABSTRACT

This study investigated whether therapists' health of family of origin, marital adjustment, and personality traits influence their approach to therapy in systematic and measurable ways. The personality traits measured were nurturance, needs for affiliation, dominance, achievement, and order, preferences for an affective-emotional and a rational-realistic mode of functioning, and male and female attributes. Approach to therapy referred to: (1) relative emphasis on clients' family of origin versus current presenting problems, and (2) preference for doing individual versus conjoint marital therapy.

This study employed a survey design. Questionnaires were mailed to a national random sample of 200 counselors from the membership of the National Board for Certified Counselors (NBCC). One hundred-six were returned, for a return rate of 53%. The following instruments were used to measure the variables in the study: therapists'

health of family of origin was measured by the Family of Origin Scale; therapists' level of marital adjustment was measured by the Locke-Wallace Marital Adjustment Test; therapists' personality traits were measured by The Adjective Check List; therapeutic approach was measured by the Therapeutic Focus Scale, an instrument created by the author for this study; and therapists' practice of marital as opposed to individual therapy was computed as the ratio of their average number of marital sessions conducted per week to their average number of individual sessions per week.

The results were not statistically significant for any of the hypotheses in the study. However, the relationship between therapists' family of origin and approach to therapy approached significance. That is, there was a trend for therapists from healthier families of origin to focus more on clients' current presenting problems, and for therapists from less healthy families of origin to focus more on clients' families of origin. The strongest relationship found, which was not one of the hypotheses in the study, was that therapists who held the doctorate were relatively more likely to focus on clients' current presenting problems, whereas holders of masters degrees were more likely to focus on clients' families of origin. It was suggested that perhaps by virtue of longer training, holders of the doctorate had

broader repertoires of therapeutic techniques, and hence were less likely to rely on any one technique, such as exploration of family of origin experiences. The overarching conclusion of this study, however, is that the influence of therapists' family background and personality traits on their therapeutic approach appears to be too complex and subtle to be easily categorized and measured.

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RELATIONSHIPS AMONG THERAPISTS' FAMILY BACKGROUND, PERSONALITY TRAITS, AND THERAPEUTIC APPROACH

Chapter 1

Introduction

Statement of the Problem

This study investigated how therapists' family of origin, marital adjustment, and personality traits are related to their approach to therapy.

Justification for the Study

Therapists bring to their work a host of factors which have nothing to do with theoretical orientation or therapeutic technique, but which nevertheless influence how they practice their art. Perhaps chief among these factors are their family background, past and present, and personality traits. If these factors remain unexamined, and hence unconscious, they can shape the therapist's ideas and behaviors in therapy in ways that are not always helpful for their clients. On the other hand, even though a therapist for the most part cannot escape his or her personality and family background,

an awareness of and appreciation for their effects can minimize harmful outcomes and even allow them to be utilized to clients' advantage.

Winter and Aponte (1987) make a case for the importance of therapists' family of origin and current family functioning for their work:

> For a clinician to effectively use himself within the therapeutic context, he must attempt to understand his own family, past and present, and resolve issues that trouble him and hamper his functioning ... lack of resolution of a practioner's family issues hampers his ability to think, act, and relate within the therapeutic context. The development of the person of the therapist, and his resolution of familial issues, is integral to successful treatment outcome. (p. 98)

In an extensive review of the literature, Beutler, Crago, and Arizmendi (1986) concluded that process and outcome in psychotherapy are significantly related to the following aspects of the therapist's personality: therapist well-being, democratic attitudes, relationship attitudes, social influence attributes, and expectations. In addition, they concluded that patient beliefs, attitudes, and values tend to become more similar to those of the therapist during the course of therapy. Consequently, therapists would do well to be aware of

both their family backgrounds and their personality traits, and how these issues are likely to affect their work with clients.

Beginning with the initial intake interview, therapists are faced with the crucial decision of what is relevant to talk about in therapy, and what is not. In doing therapy with adults, one dimension of this decision is how much to focus on family of origin issues, and how much on current presenting problems. Another crucial decision is whether to offer individual or conjoint therapy. These decisions, like all clinically significant issues, should ideally be made on the basis of either theory or implications from the research literature. To the extent that these decisions are influenced by factors such as family background and personality of the therapist, then that therapist is likely to be less effective than he or she otherwise could be (Winter & Aponte, 1987; Guerin & Hubbard, 1987; Catherall & Pinsoff, 1987).

If, as hypothesized in this study, it were found that therapists' family background and personality traits were related in predictable ways to their approach to therapy, this would be a significant source of unconscious bias in therapy. Therapists, therapists-in-training, and teachers and supervisors of therapists would all benefit by this knowledge, for to be aware of one's biases

is to be able to do something about them (Winter & Aponte, 1987; Guerin & Hubbard, 1987; Catherall & Pinsoff, 1987).

Another potential application of this research involves decisions by both therapists and employers of therapists about the likely fit between a given individual and job position. Community Mental Health Centers, managed mental health care providers, and many other counseling agencies now adhere to brief, problem-focused therapy models. These models, by design, emphasize solving clients' current life problems much more than understanding family of origin issues. If this research revealed that certain "types" of therapists prefered problem-focused therapy, and others prefered family of origin work, the implications might help inform both job-seeking and hiring decisions.

The purpose of this study was to investigate how therapists' family of origin, marital adjustment, and personality traits are related to their approach to therapy. Two aspects of therapeutic approach were studied. The first was the degree to which therapists focus on clients' family of origin as compared with their current life problems. The second was therapists' preference for conjoint marital therapy, as compared with individual therapy.

Theoretical Rationale

The problem in this study can be conceptualized via Aaron Beck's cognitive processing theory (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). This theory assumes that human functioning can be understood in terms of how environmental and internal information are processed and used. Ingram and Kendall (1986) describe the cognitive processing paradigm as providing an umbrella for many approaches which share similar assumptions concerning cognition and its role in human functioning. It has been called a bridge between experimental cognitive psychology and clinical cognitive psychology.

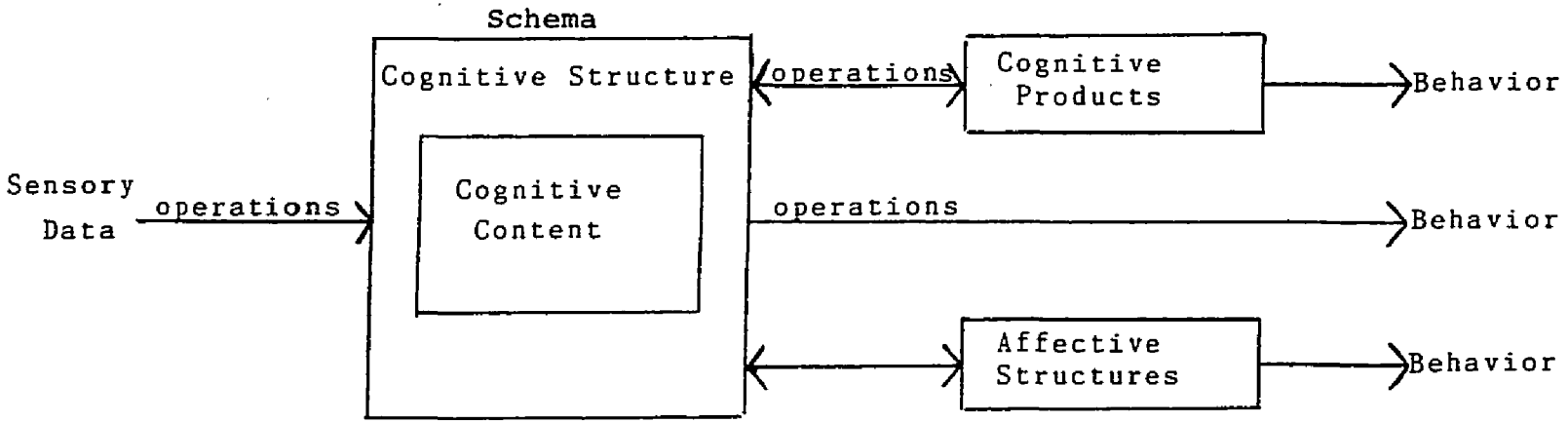
Beck's theory and its applications to the therapy of emotional disorders is probably the cognitive theory best known to professionals in the counseling field. The aspects of Becks' theory which are most relevant for this study are his views of how cognitive processes affect behavior and emotions. The construct of schema is central in this formulation. Beck et al. (1979) write:

> Any situation is composed of a plethora of stimuli. An individual selectively attends to specific stimuli, combines them in a pattern, and conceptualizes the situation. Although different persons may conceptualize the same situation in different ways, a particular person tends to be

> consistent in his responses to similar types of events. Relatively stable cognitive patterns form the bases for the regularity of interpretations of a particular set of situations. The term "schema" designates these stable cognitive patterns.

In Beck's model, schemas are cognitive structures which guide the processing of new information by directing attention to schema-congruent material, and providing the basis for screening out, differentiating, and coding stimuli that confront the individual. They also affect the retrieval of stored information by increasing the accessibility of schema-related memories. Thus, when an individual encounters a specific situation, a schema related to that situation is activated. That schema categorizes and evaluates the individual's experiences and guides his or her emotional and behavioral responses. A final important point in Beck's theory is that a schema can remain inactive for a long time and then be reactivated by environmental events. For example, a therapist who was severely criticized by his parents as a child may have early schemas triggered by a client who is critical of her child.

Ingram and Kendall (1986) elaborate further on Beck's cognitive processing model. Figure 1 is a diagram of the essential components of this model. Cognitive structures are the structures in which information is


Schema
Cognitive Structure
Cognitive Content
Sensory Data
operations
operations
Cognitive Products
Behavior
operations
Behavior
Affective Structures
Behavior

internally organized and represented. This construct subsumes both short- and long-term memory. However, it does not necessarily imply a physical counterpart.

Cognitive content is the information actually stored in the structure. It will be noted from the diagram that schemas encompass both structure and content. Cognitive operations, also called cognitive processes, are the various procedures by which the components of the system interact to function in the processing of information. These include attention, encoding and retrieval of information, activation, and transfer of information. Sensory data are the input from the environment.

As Figure 1 shows, schemas can affect behavior in any of three ways. First, they can do so through cognitive products, which refers to thoughts, cognitions, or beliefs. This pathway has received the most attention in the cognitive clinical literature. Second, schemas can affect behavior directly, which is similar to unconscious motivation in psychodynamic theories. Shiffrin and Schneider (1977) posit two different types of cognitive operations, controlled and automatic, which correspond to the above two pathways, respectively.

Finally, schemas can affect behavior via affective structures. According to Ingram and Kendall, the reason the arrow between schema and affective structures is

not labeled operations is that these procedures may not be primarily cognitive. It is also significant that the arrows between schema, and cognitive and affective structures, are bi-directional, signifying a reciprocal influence.

The subsequent writers reviewed in this section each expand on Beck's model in ways which are important to the present study. Winfrey and Goldfried (1986) summarized a great deal of the literature on the practical value of schemas, in terms of the advantages they bring to human functioning. Some of these advantages are that they (1) facilitate learning, in terms of the recognition, recall, and comprehension of information; (2) influence speed of information processing and problem-solving; (3) allow for the chunking of information into larger, more meaningful, and more readily retrieved units; (4) enable the perceiver to fill in missing data with the best guess; and (5) provide a basis for greater confidence in prediction and decision making.

However, this increased efficiency comes at a cost. When people are required to make a lot of complex decisions, they inevitably do so without all the relevant information, and this leads to systematic errors or biases (Turk & Salovey, 1986). Beck (1976) has named and described a number of cognitive distortions, or potential errors in the ways people process information.

Personalization refers to egocentricity, in the sense that the individual has an inordinate tendency to believe events refer to himself or herself. Polarized thinking is the tendency to think in black-and-white, all-or-nothing terms, failing to perceive nuances. Selective abstraction refers to abstracting a detail out of context and thus missing the significance of the total situation. Arbitrary inference is jumping to a conclusion without evidence. Overgeneralization refers to unjustified generalization from a single or a few incidents. Finally, catastrophizing is the tendency to predict extremely adverse outcomes.

Turk and Speers (1983) and Turk and Salovey (1986) describe three additional biases to which the human cognitive apparatus is heir, and which have particular relevance for therapists. The first is confirmatory bias. Pre-existing schemas filter incoming stimuli before any decision making process. That is, through training, theoretical orientation, and presumably many other factors, therapists develop certain expectancies about clients and tend to notice data which confirm their expectancies much more readily than data which disconfirm them. These schemas are necessary to sort out the plethora of data presented by clients and to make decisions reasonably quickly. However, they can also lead to errors and self-fulfilling prophecies.

Furthermore, initial judgments become the basis for later inferences, independent of the information upon which the judgment was originally based.

A second type of bias is the formation of "person prototypes" (Turk and Speers, 1983), which are a type of schema. Person prototypes "consist of relatively stable, abstract representations of a large set of more or less associated attributes, trait characteristics, (and) characteristic behaviors performed by a type of person..." Some examples are "preppie", "bag lady", "hysteric", and "workaholic." When the data coming in about a person tend to match one of the perceiver's prototypes, the perceiver tends to organize his or her perceptions around this prototype and may even embellish the objective data with attributes contained in the prototype. It is easy to see how this bias might operate in clinical assessment. In fact, Cantor, Smith, French, & Mezzich (1980) suggested that the Diagnostic and Statistical Manual of Mental Disorders may be viewed as a set of person prototypes.

Finally, Turk and Salovey (1986) describe an "illusory correlation" bias. This is the tendency to perceive associations between events as significant even when the association is only incidental. They discuss evidence that this often occurs in projective personality tests such as the Rorschach Inkblot Test and Draw-A-Person

Test.

The preceding cognitive distortions and biases provide examples of how errors can occur in the therapeutic process, just as in every other decision making process. This study will attempt to identify factors in therapists' family backgrounds and personalities which introduce predictable, systematic error into their practice of psychotherapy.

Research Hypotheses

The hypotheses in this study are as follows:

(1) The more dysfunctional therapists' family of origin was, the more likely they are to focus on clients' family of origin in therapy, as compared with clients' current life problems.

(2) There is a significant positive relationship between therapists' degree of marital adjustment and their preference for conjoint marital therapy as opposed to individual therapy.

(3) The higher therapists are on the traits of nurturance, need for affiliation, preference for an affective-emotional mode of functioning, and feminine attributes, the more likely they are to focus on clients' family of origin in therapy, as compared with clients' current life problems.

(4) The higher therapists are on the traits of need for dominance, need for achievement, need for order, preference for a rational-realistic mode of functioning, and masculine attributes, the less likely they are to focus on clients' family of origin in therapy, as compared with clients' current life problems.

Chapter 2

Review of the Literature

Research Using Cognitive Processing Theory

Cognitive processing theory in general, and schema theory in particular, continue to generate an enormous amount of research across a wide variety of problem areas. According to Thorndyke (1984), "there has been something of a stampede toward the adoption and development" of a schema theoretic framework to explain a broad range of psychological phenomena. The present section will review a sample of studies demonstrating the role schemas play in introducing bias into various forms of decision making. The application to bias in clinical decision making should be apparent.

Tversky and Kahneman (1980) demonstrated how causal schemas can introduce bias into judgments under conditions of uncertainty. The concept of causal schemas refers to our tendency to make sense of events by imposing ideas about cause and effect upon them. A causal schema implies a natural sequence from causes to consequences. Tversky

and Kahneman suggest that it is easier and more natural to follow this logical sequence, and reason from causes to effects, than to invert the sequence and reason from effects to causes. If this were the case, then one would expect people to infer effects from causes with greater confidence than causes from effects, even when the causes and effects provide the same amount of information about each other.

To test this hypothesis they posed a series of problems to 166 college students at the University of Oregon. Each problem had one part requiring inference from cause to effect, and one part requiring inference from effect to cause. Students were asked to judge which statement is the more probable. In each case the probabilities were in fact equal. The results of the study confirmed their hypothesis. Subjects were significantly more likely to make inferences from cause to effect than in reverse.

Taylor, Crocker, and D'Agostino (1978) provided evidence that people have schemas about types of personalities, which they use as bases for social problem-solving. When people encounter a new stimulus person they draw upon their schema for that type of person and use it both to fill in attributes of that person and to generate predictions about subsequent events. Information that does not fit their schemas is thought

to go unused.

To test this, they created a list-searching task such that if subjects were using schemas about types of people, their decision time should be slower than if they used a simple list-searching strategy. The results confirmed their predictions. The authors interpreted this as evidence that people use schemas in social problem-solving situations even though this sometimes slows down problem-solving and leads to errors. They suggest that we do so because schemas are usually helpful in structuring ambiguous situations and in enabling us to choose a point of attack on a problem.

Ross, Lepper, & Hubbard (1977) provided evidence of how a schema, once established, exhibits persistence in its influence on social explanation and expectation. They had subjects offer an explanation of events in a person's life, based on a supposed case history of that person. After they were told that the events did not really happen, subjects were asked to judge the likelihood that those events might happen to that person in the future. They rated this likelihood as significantly higher than did controls. These results were seen as evidence that an individual's act of providing a causal explanation of an event significantly increases that individual's subsequent belief in the likelihood of occurrence of that event. This finding is even more

robust given that it also occurred in a second experiement, wherein the subjects knew in advance that the event was hypothetical.

The authors point out the relevance of these findings for clinicians, educators, parole board members, military strategists, and other professionals. For instance, such professionals frequently are called on to discuss hypothetical but plausible scenarios, and to explain their causal inferences. The authors pose the following question for these professionals: Does the act of explaining a hypothetical event produce unwarranted subjective certainty about one's judgment? The evidence from the present study suggests that it might.

Snyder and Swann (1978) sought to answer the question, "What strategies do people use to test hypotheses about other individuals with whom they interact?" In trying to make judgments about the attributes of another, do people usually adopt confirmatory strategies and preferentially search for evidence that would confirm their hypotheses? Or do they adopt disconfirmatory strategies and search for evidence to disconfirm their beliefs? Or do they adopt "equal opportunity" strategies and search for confirming and disconfirming evidence with equal diligence? The authors also wanted to know how the chosen strategy affects the evidence that is gathered.

Subjects in this study were told they were going to interview other subjects to determine whether they possessed the trait of extraversion. The results indicated that subjects asked significantly more questions aimed at confirming their hypotheses than disconfirming them, thus lending support for the interpretation that there exists a confirmatory bias in social attribution. The authors also wanted to know whether these evidence-gathering procedures would generate behaviors that would confirm the hypotheses. Would interviewee-subjects who were being tested for extraversion actually come to behave in a more extraverted fashion during the interview? After all, the more one inquires about another's extraversion, the more opportunities the other has to provide instances of that behavior. That is in fact what happened, suggesting that a confirmatory hypothesis-testing strategy leads to finding hypothesis-confirming evidence.

Humans are capable of making meta-judgments; that is, after making a judgment they can then judge the probability that that judgment is correct. The latter are called confidence judgments. The appropriateness of peoples' confidence judgments can be measured by comparing their assessed probabilities with the observed frequencies of their being correct (Koriat, Lichtenstein, & Fischoff, 1980). An individual is well-calibrated

if, over the long run, for all answers assigned a given probability, the proportion correct approximates the probability assigned.

Previous investigations had established that the major systematic deviation from perfect calibration is overconfidence, an unwarranted belief in the correctness of one's answers (Lichtenstein, Fischoff, & Phillips, 1977). Koriat et al. (1980) set out to determine the origins of this unwarranted confidence in one's judgments, and to find a way to counteract it. They conducted a two-part experiment. The first part established that when subjects were required to write down all the possible reasons favoring and opposing their answers to general topic questions (e.g. literature, nature, history), their confidence judgments were superior to controls who simply recorded their answers.

The second part of the experiment established that it is the recording of <u>contradictory</u> evidence that improves performance on confidence judgments. Simply recording evidence favoring one's answers made no difference. These results were interpreted as evidence that overconfidence derives from the tendency to neglect contradictory evidence. The authors suggested that the reason recording favorable evidence made no difference is that it approximated what people do anyway; that is, look for confirmatory evidence.

Critique

As demonstrated by the foregoing studies, the viability of cognitive processing theory to guide our understanding of decision making and social attribution has been firmly established. Moreover, a great deal of evidence has been accumulated about the operation of various forms of bias, which are a consequence of the nature of the human cognitive apparatus. However, the majority of the research in this area has been laboratory analogue studies using college student volunteers. This research needs to be expanded into various applied settings, using more representative samples, and looking at real world kinds of decisions, in order to establish the boundary conditions of its applicability.

The present study attempted to address these gaps and add to our understanding of these issues in several ways. First, it focused on practicing psychotherapists in order to examine the applicability of the above findings to the work of this professional group. Second, it looked at clinical decision making rather than laboratory analogues. Finally, it used a randomly drawn sample, thereby reducing the external validity pitfalls of volunteer samples.

Therapist's Family of Origin

There is a good deal of literature describing therapists' families of origin (e.g. Henry, Sims, & Spray, 1971; Henry, Sims, & Spray, 1973; Burton, 1972; Piercy & Wetchler, 1978), and some studies relating therapist's family of origin to their choice of career (e.g. Racusin, Abramowitz, & Winter, 1981; Goldklank, 1986; Lackie, 1983). However, despite a great deal of theorizing (e.g. Piercy & Wetchler, 1978; Winter & Aponte, 1978), there does not appear to have been any empirical research looking at the relationship between therapist's family of origin and therapy process. The present review will look at the existing research on therapists' family of origin.

A number of biographical and autobiographical accounts (Burton, 1972; Mowrer, 1974; Viscott, 1972; Wheelis, 1958) have painted a picture of the psychotherapist as a wounded healer, someone who seeks to rectify a painful childhood by becoming a therapist. Racusin et al. (1981) found empirical evidence for this notion. Their sample was 14 therapists from the San Francisco Bay area who were nominated by colleagues "as comfortable with a high degree of self-disclosure." Via an intensive interview format, they found that all

14 families had at least one member with a physical or behavioral difficulty "involving presumed psychogenic factors." Furthermore, eight mothers, seven fathers, seven siblings, and four therapists themselves experienced psychological difficulties, mostly "a mixture of neurosis and character disorder."

The study's authors interpreted these conditions as manifestations of conflicts surrounding intimacy in therapists' families of origin. They drew the following dynamic conclusions from their results:

> (a) lack of nurturance encountered by future therapists in their families of origin generated feelings of helpless rage and ambivalence toward interpersonal intimacy, and (b) the choice of psychotherapy as a career represents a defense against that helplessness by ensuring control over intimacy.

However, the preponderance of research evidence runs counter to the conclusions of the preceding writers. In a now classic study, Henry, Sims, and Spray (1973) surveyed 3,992 psychiatrists, psychoanalysts, psychologists, and social workers in New York City, Chicago, and Los Angeles. They also conducted intensive interviews with 283 of these therapists. In general, therapists in this study reported adequate to positive relationships with their families of origin. There were

few significant differences between the four mental health professions surveyed. The incidence of trauma, loss, and mental illness in therapists' families of origin were found to be about the same as in the general population of college graduates. Sixty percent of respondents reported that their sibling relationships during childhood were positive or generally positive, while 24% said they were poor. These figures are about the same as for other members of their generation. Therapists did report being the dominant sibling more often than chance, and this held true especially for psychoanalysts. There was a higher incidence reported of having to rebel to achieve autonomy during adolescence, than in the general population. And finally, 43% said their parents' marriage was good, while 39% said it was poor, contradicting any attempts to pigeonhole this factor in one direction or the other.

Lackie (1983) looked at the families of origin of social workers in an attempt to explain their choice of career. He accepted the previous conclusion that families which produce social workers are not atypical of the general population. Instead he looked at the roles social workers enacted in their families of origin. In an empirical study of 1,577 social workers, over two-thirds described themselves as parentified children; that is, as overresponsible caretakers, mediators, and

"burden-bearers." Lackie interpreted this as evidence that caretaking roles in childhood influenced these individuals to choose a "caretaking" career. It is interesting to note that Lackie's findings are similar to Henry et al's (1973) finding that therapists reported themselves as dominant siblings more often than chance.

Goldklank (1986) wanted to sort myths from facts about family therapists' families of origin, also with the aim of explaining career choice. The hypotheses for which she found support were: (1) family therapists enacted roles in their families of origin which crossed the generational boundary; (2) they enacted parentified roles; and (3) they enacted high family esteem roles.

The sample in this study consisted of 59 family therapists in New York, Philadelphia, and New Jersey, 49 siblings of these therapists, and 51 non-mental-health professionals for comparison. The therapists' scores were significantly higher than the sibling group and other professional group on crossing the generational boundary and enacting a parentified role. The siblings, on the other hand, tended to adopt either secure "just kids" roles or "scapegoat/rescuer" roles. The therapists differed significantly from their siblings on high family esteem roles, but did not differ from the other professionals on this. Also, therapists and the other professional group differed significantly from the sibling

group on number of first-borns, but did not differ from each other. Significantly, all of the above findings are consistent with those of Henry et al. and Lackie.

Humphrey (1988) investigated the relationship between loss/transition events in therapists' families of origin, and their theoretical orientation. She compared family therapists from three orientations, Satir's Process Model, Minuchin's Structural Model, and Bowen's Systems Model, in terms of whether they differed from one another in the frequency of major loss or transition events in their families of origin. There were few differences, with two exceptions. Systems therapists were more likely to experience their mother's deaths during their adolescence than were therapists of the other two orientations. And a higher incidence of physical and emotional abuse was reported by the Structural therapists. The meaning of these results is unclear, however, for reasons discussed in the next section.

Critique

Each of the above studies has shortcomings that should be addressed by future research in this area. Racusin et al. (1981) used a sample which is likely to be too small to be representative, and was not randomly selected. It is not difficult to imagine how a group

of 14 therapists selected as described could be quite different in important ways from American therapists as a whole. Furthermore, there is a large inferential leap from the data reported to the dynamic interpretations of that data.

Probably the major drawback of Henry et al.'s (1973) study was their decision to restrict their sample to the three largest metropolitan areas of the country. As a consequence, 34% of the respondents were Jewish and 41% traced their origin to eastern Europe. Time may interact with this geographical factor to produce another source of bias in the sample. A little more than half their interview sample indicated Freudian as their theoretical orientation. More recent surveys (Smith, 1982; Young, Feller, and Witmer, 1989; Zook & Walton, 1989) indicate that that percentage would be far smaller today. Despite these limitations, however, this monolithic study remains the most ambitious in its scope and probably the most revealing in its findings about therapists' families of origin of any done before or since.

Lackie's (1983) study suffers from his failure to report such details as how the sample was obtained and how the data were gathered and analyzed. He also does not report the rate of parentified children in the general population, for comparison with his sample of social

workers. Consequently, we do not know whether his reported two-thirds parentified children among social workers is significant. Except for some undefined terms, Goldklank's study seems well-executed, and its results are consistent with those of Henry et al. and Lackie, adding credence to the findings in all three studies.

Humphrey's (1988) study suffers from the lack of directional hypotheses about the expected relationship(s) between loss/transition events in therapists' families of origin, and their theoretical orientation. Consequently, the meaning of the findings reported above is unclear. Another problem with this study is that theoretical orientation may be too global a construct to guide research (Beutler, Crago, & Arizmendi, 1986), since most therapists today describe themselves as eclectic. Also, it may be that single events in a person's life, such as losses and transitions, do not exert as great an influence on their development as ongoing factors like general psychological health of family of origin.

In summary, most of the literature on therapists' family of origin is either theoretical or simply a description of separate variables. A number of studies have looked at the relationship between therapists' family of origin and career choice, and one looked at the relationship with theoretical orientation. However,

there do not appear to have been any empirical studies looking at the relationship between therapists' family of origin and therapy process.

The current study attempted to address this state of affairs by, first, looking at family of origin in terms of overall psychological health of family functioning. Second, it looked at specific in-therapy behaviors of therapists, rather than theoretical orientation. Finally, this study used a randomly selected, nationwide sample.

Therapist's Personality Traits

Therapists' personality traits have been investigated from a number of different angles. Among these are simple descriptive profiles of therapists' personalities (Reich & Geller, 1976); relationships between therapist's personality and therapy outcome (reviewed by Beutler et al., 1986); and relationships between therapist's personality and theoretical orientation. This review will focus primarily on the latter, as that is most relevant to the hypotheses under investigation in this study.

Perry (1975) investigated the personality differences between clinical and experimental psychologists, using the Myers-Briggs Type Indicator (MBTI). His subjects

were 72 psychologists, divided into three groups: (1) clinical psychologists involved strictly in clinical work, (2) experimental psychologists involved strictly in research, and (3) a buffer group with interests in both areas. Of the four bi-polar dimensions of the MBTI (Introverson-Extraversion, Sensing-Intuiting, Thinking- Feeling, and Judging-Perceiving), he found differences on only one dimension. The experimental psychologists scored more toward the Thinking end, while clinical psychologists scored more toward the Feeling end. Thus, this study found both similarities and differences between these functional specialties within the field of psychology.

Authors have differed considerably on whether there is a relationship between therapists' personalities and the theoretical orientations they adopt. At one extreme, there are those who claim there is no relationship whatsoever (Lazarus, 1978). At the other extreme, there are those who posit a clear and direct relationship (Lindner, 1978; Ellis, 1978). The empirical literature bearing on this issue will be examined.

Using the MBTI, Levin (1978) looked at the personality differences of therapists from five different theoretical orientations: behavioral, Gestalt, psychoanalytic, rational-emotive (RET), and experiential. Using a sample of 91 therapists, he found a high occurence

of Intuitive types across all orientations. RET, experiential, and behavioral therapists were more Introverted than were Gestalt and psychoanalytic therapists. On the Thinking-Feeling dimension, behavioral and RET therapists were more often Thinking types, whereas therapists of the other three orientations were more often Feeling types. Finally, Gestalt and experiential therapists were more often characterized as Perceiving types, whereas behavioral, RET, and psychoanalytic therapists were more often Judging types. This study supports the hypothesis that there are personality differences across different theoretical orientations.

Walton (1978) sought to identify dimensions of self-concept that are distinctive among therapists of different orientations. He developed a 98-item semantic differential instrument which produced scores on eight factors. He administered it to 134 male therapists in the New York-New Jersey area, who comprised five theoretical orientations: behavioral, RET, psychodynamic, humanistic, and eclectic. He found significant relationships between three factors and three orientations. The psychodynamic therapists viewed themselves as more Serious and more Complex than did the RET therapists. RET therapists viewed themselves as higher on the Rationality factor than did eclectic therapists. This study adds to the evidence that there

are indeed personality differences between therapists of different orientations, and that there are large areas of overlap.

Another investigation into this area (Ahern, 1984) found generally nonsignificant results. Ahern used Jackson's Personality Research Form to look for psychogenic needs which differentiated therapists from three orientations: person-centered, behavioral, and RET. His sample consisted of 153 therapists from five Utah training programs. Less than 13.5% of the variance was accounted for by the personality variables under study. The only significant relationship was that person-centered therapists had a higher Need for Affiliation than did the other therapists.

Tremblay, Herron, & Schultz (1986) also asked the question: Is there a relationship between personality and theoretical orientation. However, their approach differed from most in that rather than select a random sample of therapists for the study, they wanted to make sure they were studying therapists who were committed to a given orientation. Consequently, they obtained candidates for the study from such sources as the Directory for the Association for the Advancement of Behavior Therapy, graduates from two psychoanalytic postdoctoral training programs, and the eastern regional convention for the Humanistic Psychology Association.

They used scores on the Personal Orientation Inventory as a measure of personality. The orientations looked at were behavioral, psychodynamic, and humanistic.

Humanistic therapists scored higher than the others overall on self-actualization. They differed from behaviorists in that they were higher on flexibility, acceptance of personal aggression, sensitivity to their own feelings, and the development of intimate relationships. They differed from both the behaviorists and psychodynamics in being more inner-directed, affirming of self-actualizing values, and expressing feelings in action.

The psychodynamic profile was completely a shared one. They were the same as behavior therapists, but different from humanistic therapists, on being outer-directed, limiting the affirmation of self-actualizing values, and limiting their expression of emotion. Behavior therapists had the most negative profile, with "negative" construed as the relative absence of what the POI considers healthy. The behavioral constellation was: relatively limited flexibility, limited acceptance of their own feelings, and limited development of intimate relationships, although only one of these was below the norm for self-actualized people.

The authors interpreted that the general picture for all three orientations is one of a healthy

personality, with separate personality patterns for each orientation. However, they also point out that these personality patterns are more overlapping with other orientations than they are unique. In summary, the gist of this study, and the accumulated evidence from research in this area, suggests that while there are significant differences between orientations, there also appears to be a core therapist personality that spans theoretical orientations.

Critique

Ahern's largely nonsignificant findings may in part be due to his use of students instead of experienced therapists, and his limiting the orientations under study to person-centered, RET, and behavioral. Indeed, RET and behavioral orientations share so much in common that one should not be surprised that there were no differences between the two. Both the Perry and the Levin studies may have been compromised by relatively small sample sizes. A more general problem with research in this area stems from the fact that a majority of therapists today are eclectic (Smith, 1982; Young et al., 1989; Zook & Walton, 1989). Even though it may be possible to identify "purists" from different orientations (e.g. Tremblay et al.), one must wonder how generalizable the

findings are.

Despite the above limitations, however, it appears that enough evidence has accumulated to conclude that there are both a great deal of overlap, and some significant differences, in personality traits between therapists of different theoretical orientations. At this point, it would seem to be more illuminating for future research to look at specific measures of therapeutic approach, in terms of hypothesized relationships with personality, and lay to rest the variable of theoretical orientation. The present study therefore investigated the relationships between therapists' personality traits and the degree to which they focus on clients' family of origin as compared with current life problems.

This author's reading of the preceding research findings led to the formulation of several of the hypotheses which were investigated in this study. The primary link between these research findings and the current research lies in the assumption that psychoanalytic or psychodynamic therapists, by definition, are more likely to focus on clients' family of origin in therapy, and behavioral and RET therapists are more likely to focus on clients' current life problems. The hypotheses which were derived from the above findings appear in Chapter 1 as Hypotheses 3 and 4. To reiterate,

they are as follows:

(3) The higher therapists are on the following traits the more likely they are to focus on clients' family of origin in therapy, as compared with clients' current life problems:

(a) Nurturance

(b) Need for Affiliation

(c) Preference for an Affective-Emotional Mode of Functioning

(d) Feminine Attributes

(4) The higher therapists are on the following traits the less likely they are to focus on clients' family of origin in therapy, as compared with clients' current life problems:

(a) Need for Dominance

(b) Need for Achievement

(c) Need for Order

(d) Preference for a Rational-Realistic Mode of Functioning

(e) Masculine Attributes

Levin's (1978) finding that behavioral and RET therapists were more Introverted than psychoanalytic therapists led to the hypothesis that there is a relationship between therapists' Need for Affiliation and a tendency to focus more on clients' family of origin as compared with current life problems. Levin also found

that behavioral and RET therapists were more often Thinking types, while psychoanalytic therapists were more often Feeling types. And Walton (1978) found that RET therapists viewed themselves as higher on Rationality than did other therapists. These findings led to the hypotheses that: (1) therapists who are higher on Nurturance and preference for an Affective-Emotional Mode of Functioning tend to focus more on clients' family of origin; and (2) therapists who are higher on Need for Order and preference for a Rational-Realistic Mode of Functioning tend to focus more of clients' current life problems.

Tremblay et al.'s findings that behavioral therapists had less Flexibility, less Acceptance of their own Feelings, and more limited development of Intimate Relationships than psychodynamic therapists led to several hypotheses. First, it was hypothesized that therapists higher on Feminine Attributes (regardless of gender) tend to focus more on clients' family of origin, whereas therapists higher on Masculine Attributes tend to focus more on clients' current life problems. Second, it was hypothesized that therapists who are higher on Need for Dominance and Achievement tend to focus more on clients' current life problems. These hypotheses stem from the fact that stereotypical feminine attributes tend to include greater flexibility, acceptance of feelings,

and emphasis on intimate relationships, whereas stereotypical masculine attributes tend to include more striving for dominance and achievement.

Therapist's Marital Adjustment

The empirical literature on therapists' marital adjustment is very scant. There are several surveys providing descriptions of this variable (Henry, Sims, & Spray, 1973; Piercy & Wetchler, 1987), but no studies could be located which examined the relationship between therapists' marital adjustment and a second variable. Consequently, in addition to the above two studies, this review will include a number of theoretical articles which suggest relationships of relevance for the current study.

The monolithic study by Henry et al. (1973) found therapists' marriages had high congruence between spouses in terms of religious adherence, cultural affinity, and political orientation. In general, their data depicted therapists' marriages as satisfying but lacking emotional intensity. The majority of therapists who felt positively about their marriages did so because of mutual consideration and respect, and shared professional, intellectual, social, and cultural interests. For most, the emotional interaction with

their spouse was positive and temperate.

There was also some evidence that therapists married spouses from unhappy families at a greater-than-chance rate. The authors speculated that this may be due to therapists' need to nurture. Interestingly, this is consistent with findings presented above that therapists tended to have been parentified children and to have enacted caretaker roles in their families of origin. Finally, using Murray's (1938) need construct, the respondents in the Henry et al. (1973) study most frequently described their spouses' personalities in terms of the following need structures: Understanding (49%), Competence (48%), Nurturant (34%), Blamavoidant (29%), Affiliative (29%), Aggressive (28%), and Active (24%).

Piercy and Wetchler (1987) investigated the stressors and enhancers of marital and family life for family therapists; that is, the negative and positive effects of work on family life. Their subjects were 110 members of the Indiana Association for Marriage and Family Therapy who responded to a state-wide membership survey. The respondents checked more than twice as many enhancers as stressors, indicating that they felt their work had a generally positive impact on their family lives. The enhancers most frequently checked were: "Acceptance of own part in marital/family problems," "Development

of communication skills," "Greater appreciation of own marital/family strengths," and "Greater ability to prevent potential family problems." The stressors checked most frequently were: "Little time left for own marriage/family," and "Little energy left for own marriage/family." The authors make the case that therapists need help in harnessing the enhancers and diminishing the stressors in their work/family interfaces.

Guerin and Hubbard (1987) hypothesized that three aspects of therapists' own family systems impact their clinical work. These are: (1) their basic level of operational autonomy, (2) management of reactivity, and (3) personal enrichment, or positive effects. They presented two therapist case histories to support their hypotheses.

First, these authors believe that the emotional freedom and operational autonomy therapists bring to their work can best be predicted by their level of differentiation and adaptive level of functioning within their own family system. Second, all therapists respond more intensely to certain client issues and behaviors than to others. The ones that precipitate unhealthy therapist responses are termed our clinical triggers. The authors maintain that a high percentage of these reactive responses can be traced to relationship experiences in our own families. And finally, the authors

present several examples of positive ways in which therapists' family systems can influence their work.

In a similar vein, Catherall and Pinsof (1987) hypothesized about the influence of several dimensions of family therapists' family life on their ability to be effective as therapists. First, therapists may find themselves re-enacting with client families their roles in their own families, unless they make a conscious effort not to do so. Second, every family possesses its own distinct emotional atmosphere, such as openly loving, or distant and reserved. Therapists from very expressive families may pursue conflicts prematurely, causing client families to feel unsafe. However, therapists from non-expressive families may be limited in their ability to engage in creating a facilitative emotional atmosphere.

The next two issues, triangulation and differentiation, are similar to Guerin and Hubbard's notion of operational autonomy. Therapists who are accustomed to being triangled or triangling others to avoid dealing directly with dyadic conflict, may fear the catastrophic consequences of allowing two individuals to work out their differences directly. Therapists who are poorly differentiated from their own families may have difficulty establishing a bond with client families that respects individual differences.

Unresolved interpersonal conflicts in therapists'

families can also interfere in therapy. For example, a therapist who desires more closeness with his or her spouse may try to establish a close loving relationship between two client spouses who have come to therapy over some other problem. The client couple may not be interested in greater marital closeness, nor require it to overcome the presenting problem. Finally, therapists' own current family developmental stage exerts an influence on their work.

Philpot (1987), like Piercy and Wetchler, looked at the impact of doing family therapy on the marriage and family life of therapists. She referred to her methodological approach as a case study, with her own family as the subject. Looking at the negative side of the ledger, Philpot stated that family members tend to seek psychological advice from their therapist-relative. This puts him or her in the awkward position of knowing the ethical dilemma of entering a dual relationship, and yet not wanting to anger a relative by refusing to help.

Another negative effect Philpot reported is the acquisition of unrealistic expectations about marriage. She stated that their work can lead therapists to expect perfectionistic levels of intimacy and warmth from their spouses. A related effect is that exposure to the intimate details of many marriages creates a large

comparison base for therapists' own marriages. This has both negative and positive effects. First, many marriages are bound to work at a lower level than the therapist's marriage, which makes the therapist's marriage seem more attractive. However, the reverse also occasionally occurs.

On the positive side of being a family therapist, Philpot stated that specific skills in conflict resolution, negotiation, decision making, communication, and behavioral contracting prove beneficial to therapists' marriages. She concluded that overall her experience was that being a family therapist does more to preserve a marriage than to undermine it.

Critique

The nonrepresentativeness of the Henry et al. study has already been discussed. A limitation of the Piercy and Wetchler study is that they received only a 43% rate of response to their questionnaires. It may be that the self-selection process eliminated disproportionately more therapists whose family life had been negatively affected by their work. However, the most significant limitation in this area of the literature is the almost total absence of empirical studies, which necessitated relying on theoretical

articles.

The above limitations notwithstanding, the literature in this area is supportive of the present study's hypothesis that there is a positive relationship between therapists' marital adjustment and their practice of conjoint marital therapy. The literature is ambivalent on the primary direction of the influence, however. For example, some findings (e.g. Guerin & Hubbard, 1987; Catherall & Pinsoff, 1987) imply that therapists' with high marital adjustment are more likely to gravitate toward conjoint therapy, while others (e.g. Piercy & Wetchler, 1987; Philpot, 1987) suggest that doing conjoint therapy is likely to increase therapists' marital adjustment. Of course, the influence could be reciprocal. The present study is a first step toward testing the above hypothesis empirically. However, the research design used cannot reveal the direction of influence.

Therapeutic Approach

A great deal of research has been done on the correlates of therapists' theoretical orientation (Sundland, 1977; Perry, 1975; Levin, 1978; Humphrey, 1988; Walton, 1978; Tremblay et al., 1986). However, this variable seems to have largely outlived its usefulness to guide research, for two reasons (Sundland,

1977). First, it is too global to provide much information about what a therapist actually does (Lambert et al., 1986), and second, most therapists today consider themselves eclectic (Smith, 1982; Young et al, 1989; Zook & Walton, 1989).

Instead of theoretical orientation per se, this study investigated a specific dimension of therapeutic approach. This dimension can be viewed as a continuum. At one extreme end of the continuum is exclusive focus in therapy on clients' family of origin. At the other end is exclusive focus on clients' current life problems. This dimension is obviously related to theoretical orientation. Different schools of therapy will fall at different points on this continuum. For example, the following orientations advocate the therapeutic benefits of exploring clients' family of origin: transgenerational family therapy (Bowen, 1978), psychoanalysis, transactional analysis (Berne, 1961), and the currently popular "inner child" approaches, which draw from the preceding three (Whitfield, 1987; Bradshaw, 1988). In contrast, the following orientations advocate more of a focus on clients' current life problems: strategic family therapy (Haley, 1976), structural family therapy (Minuchin & Fishman, 1981), the various cognitive and behavioral approaches, reality therapy (Glasser, 1965), and brief, solution-focused

approaches (de Shazer, 1985; Cade & O'Hanlon, 1993). One advantage of the proposed dimension over theoretical orientation per se is its greater specificity. Whether a therapist is eclectic or adheres to a particular school of therapy, his or her approach to therapy can be measured as a point on this continuum. Moreover, that measurement is likely to tell us more about how a therapist practices therapy than does global theoretical orientation.

Chapter 3

Data Collection

This study employed a mail survey for data collection. A questionnaire taking about 30 minutes to complete (see Appendix A) was mailed to a sample of 200 counselors. A follow-up mailing was necessary in order to achieve an acceptable response rate. The questionnaire consisted of demographic questions, followed by the instruments used to measure each of the variables under study. A consent form was included with the questionnaire in order to explain the project and obtain the informed consent of the participants (see Appendix B). The sample population and instrumentation are described in the following sections.

Population

A sample of 200 counselors was drawn from the membership of the National Board for Certified Counselors (NBCC). The NBCC has a nationwide membership of 16,020 counselors who have met the requirements of NBCC

certification. These requirements include at least a masters degree in counseling or a related field, with stringent criteria as to required courses. Candidates for certification must also pass a written examination designed to assess knowledge of generic counseling information and skills. NBCC members come from all 50 states, and represent a wide diversity in terms of years of experience and other demographic variables.

In order to minimize the number of nonclinical counselors in the sample (e.g. counselor educators), the target population was limited to NBCC members who were either licensed as professional counselors or certified as clinical mental health counselors. A computer-generated random sample of 200 was drawn from this target population.

Measurement Instruments

Therapists' preference for marital as opposed to individual therapy was computed as the ratio of their average number of marital sessions conducted per week, to their average number of individual sessions conducted per week. The following instruments were used to measure the other variables in the study.

Family of Origin Scale

Therapists' health of family of origin was measured by the Family of Origin Scale (FOS) (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). The FOS is a 40-item Likert-style questionnaire designed to measure level of perceived health in one's family of origin. Health is viewed as the ability to be close to and separate from significant others at the same time. The instrument yields a score from 40 to 200, with higher scores indicating higher levels of perceived health. Half the items are designed to reflect autonomy and half to reflect intimacy. The instrument yields separate scores on these two constructs if desired, and they are each in turn comprised of five components, also yielding separate scores. However, only the global score is relevant for the present study.

Test-retest reliability for the FOS is reported by the authors to have been .97 in a study with 41 psychology graduate students (Hovestadt et al., 1985). They report that content validity was established by having a panel of six nationally recognized authorities in family therapy rate 60 items, which the authors had generated, for the degree to which they reflect the appropriate constructs. In this way the item pool was narrowed to 40 items. With the final instrument, they

further demonstrated validity by showing that male members of alcohol-distressed marriages have significantly lower FOS scores than do normal controls.

In a subsequent study, Lee, Gordon, and O'Dell (1989) found that a group of 100 persons seeking therapy had lower FOS scores than 100 controls. They then wanted to know whether these lower FOS scores for persons seeking therapy actually reflect their families of origin, or whether these individuals by definition are just more disgruntled about their families. They therefore compared their scores with scores of persons who had completed therapy, inferring that if scores for the two groups were not significantly different, one could more confidently assume that FOS scores reflect something about one's family of origin. In fact, the two groups were not significantly different from one another, and both were significantly different from the controls.

Lee et al. also demonstrated with factor analysis that there may be only one factor of any importance being measured by the FOS. They therefore concluded that the twelve subscales lack demonstrable validity as separate scores. This is not seen as a problem for the present study, however, as only a single score is needed of overall perceived health of family of origin.

Locke-Wallace Marital Adjustment Test

Therapists' marital adjustment was measured by the Locke-Wallace Marital Adjustment Test (LWMAT) (Locke & Wallace, 1959). The authors created this 15-item questionnaire by selecting the most discriminant items from longer instruments available at the time. They defined marital adjustment as "accomodation of a husband and wife to each other at a given time." The LWMAT consists of one global adjustment question, eight questions measuring areas of disagreement, and six questions measuring conflict resolution, cohesion, and communication. Each response to each item is weighted according to the amount of difference discovered between groups of satisfied and problem couples answering each alternative. However, Hunt (1978) demonstrated that the LWMAT is just as reliable and valid using continuously weighted scores as it is using the original differentially weighted scores. Total adjustment scores range from 2 to 158 using the original weighting and from 0 to 60 with continuous weighting.

The sample consisted of 118 husbands and 118 wives not married to each other. The internal consistency reliability estimate for the LWMAT was .90. No test-retest reliabilities were reported. For the validity study 48 subjects from the sample who were known to be

maladjusted in marriage were compared with 48 subjects, matched for age and sex, who were judged to be exceptionally well-adjusted in marriage by friends who knew them well. The test discriminated significantly between the adjusted and maladjusted groups. The mean adjustment score for the well-adjusted group was 135.9, whereas the the mean score for the maladjusted group was 71.7. Only 17% of the maladjusted group scored 100 or more, whereas 96% of the adjusted group scored above 100.

Cross and Sharpley (1981) performed a study to determine whether the LWMAT remains valid both in terms of its original criteria and in the light of changing values. Their sample consisted of 37 men and 58 women who were not related to each other. They obtained an internal consistency reliability of .83. Discriminant analysis revealed that all items except for item 15 discriminated between placement in high and low adjustment groups. Principal factor analysis revealed two factors, the first of which accounted for 89% of the variance. They interpreted this factor as a global measure of marital adjustment. The second factor was less clear. These authors concluded that the LWMAT has satisfactory reliabilty and is still measuring marital adjustment in spite of changing values within society.

Two principal criticisms have been leveled against

the LWMAT and other measures of global marital adjustment. First, Edmonds (1972) argued that because the LWMAT correlates highly with a measure of conventionalization it is contaminated by social desirability bias. However, Hawkins (1966) and Murstein and Beck (1972) did not find social desirability to be a major contaminating factor. More recently, Schumm, Hess, Bollman, & Jurnich (1981) argued that Edmonds' approach involved inherent violations of two statistical assumptions underlying partial correlation and multiple regression techniques. They concluded that the impact of social desirability bias on marital adjustment measures appears to have been overstated.

The second criticism of global marital adjustment scales is that they combine conceptually distinct components (Johnson, White, Edwards, & Booth, 1986). Using factor analysis, Johnson et al. found a two-dimensional structure of marital quality. A positive dimension consists of marital happiness and interaction, and a negative dimension consists of marital problems, disagreement, and instability. They argue that scales which combine these two factors in one score confuse the issue. However, as important as these findings are, other factors must be weighed in choosing a measure of marital adjustment. First, differing results are reported in two other studies. In the Cross and Sharpley

study cited above, one factor accounted for 89% of the variance on the LWMAT. Second, Locke and Williamson (1958) used factor analysis to reveal five specific factors in marital adjustment. They also reached the conclusion that enough items loaded on more than one factor to justify a general index of marital adjustment. At any rate, until new, reliable and valid instruments are developed, which incorporate the Johnson et al. findings, one must choose from what is currently available. In a recent review of rating scales for marital adjustment, Harrison and Westhuis (1989) concluded of the LWMAT that "however much criticized, (it) still remains a virtual 'standard' measurement device in the field."

The Adjective Check List

Therapists' personality traits were assessed by The Adjective Check List (ACL) (Gough & Heilbrun, 1983). The ACL is a list of 300 adjectives commonly used to describe an individual's personality. It is self-administered and takes approximately 15 minutes to complete. The ACL provides standard scores on 37 scales, including 15 scales derived from Murray's (1938) need-press theory, five topical scales, four modus operandi scales, five Transactional Analysis scales,

and four origence-intellectence scales based on Welsh's (1975) work. The present study will use the following nine scales:

1. Nurturance
2. Affiliation
3. Dominance
4. Achievement
5. Order
6. High Origence-Low Intellectence
7. Low Origence-High Intellectence
8. Feminine Attributes
9. Masculine Attributes

The ACL was normed on a sample of 5,238 males and 4,144 females who were diversified in age, education, occupation, intelligence, and social status. The manual reports alpha coefficients for each of the 37 scales, which were calculated on a sample of 591 males and 588 females. For males they range from .56 to .95, with a median of .76. For females the range was from .53 to .94, with a median of .75.

Test-retest correlations were obtained on a sample of 199 males and 45 females. The range for males was .34 to .77, and the median was .65. For females the range was .45 to .86, and the median was .71. In a review of the ACL, Fekken (1984) stated that the internal consistency median coefficients were acceptable, and

the stability of the scores was quite strong.

The construct validity of the ACL was established by correlations with observer ratings, with scores on various personality inventories, the Edwards Social Desirability Scale, and a vocabulary measure. Fekken (1984) characterized its construct validity as modest, and suggested that more research be done to further establish its validity. Nevertheless, she concluded that the ACL is suited for research settings. Zarske (1985) and Teeter (1985) reached similar conclusions. Consequently, the ACL is judged to have acceptable reliability and validity for use as a measure of personality in the present study.

Therapeutic Focus Scale

At the time this study was done there did not appear to be any existing instruments which measure therapeutic focus as a continuum between clients' family of origin and current life problems. Consequently, the Therapeutic Focus Scale (TFS) was created by the author for that purpose. The TFS consists of twelve Likert-style items assessing therapists' attitudes toward the relative importance of focusing on clients' family of origin versus current life problems. The possible range of scores is from 12 to 60. Lower scores indicate a preference

for focus on current life problems in therapy, and higher scores a preference for focus on family of origin.

The TFS appears as part of Appendix A. A respondent's agreement with items 1, 4, 5, 8, 9, and 12 indicates a tendency to focus on clients' family of origin. These items were derived from the schools of therapy which stress a family of origin focus (see Chapter Two). Agreement with items 2, 3, 6, 7, 10, and 11 indicates a tendency to focus on clients' current life problems, and were derived from the schools of therapy which advocate that focus.

Content validity for this instrument was established by having a panel of three counseling professors at the College of William and Mary, plus two experienced family therapists, rate the original item pool on the degree to which they reflected the stated construct. On the basis of these ratings, weaker items were either eliminated or modified, to produce the final form of the instrument. A pilot study was then conducted to ascertain the instrument's test-retest reliability. The respondents were 14 graduate students at the College of William and Mary (all of whom were also practicing therapists), and 9 therapists employed by a managed mental health care company in Richmond, Virginia. There was approximately a two-week time interval between test and retest. The Pearson correlation coefficient between

test and retest was 0.945.

Inadvertently, evidence suggestive of the construct validity of the instrument was also obtained from this pilot study. The William and Mary students' mean score on the TFS was 41.4, and the managed care therapists' mean score was 23.5, indicating that the latter were much more likely to focus on current presenting problems than family of origin issues in therapy. This is consistent with managed care's strong emphasis on brief, problem-focused therapy.

Research Design and Statistical Procedure

This study employed a simple correlational design. This is generally the best-suited non-experimental design for exploring relationships between variables when one has continuous data on most variables (Borg & Gall, 1989). Two advantages of correlation over a causal-comparative design are that correlation has greater power to detect significant relationships, and that it provides information concerning the degree of relationship between two variables, which a causal comparative design does not.

The Pearson product-moment correlation coefficient is the most frequently used bivariate correlational technique when one's measures yield continuous scores

(Borg & Gall, 1989). This is because it is the most stable technique; that is, it has the smallest standard error. Since continuous scores were obtained on all the primary variables in this study, a Pearson product-moment correlation coefficient was computed for each hypothesized relationship, and an alpha level of .05 (adjusted for multiple relationships) was used to determine statistical significance. Certain demographic variables which did not have continuous scores required different statistical procedures. A point biserial correlation coefficient was used to look at the relationship between gender and therapeutic approach. Point biserial correlation is a simplified version of product-moment correlation, used when one of the variables (in this case gender) is dichotomous. A Spearman rank correlation coefficient was used to look at the relationship between highest degree earned and therapeutic approach. This is another shortcut version of the product-moment formula, and is used when one or more of the variables (in this case, highest degree earned) provides rank data. Finally, chi-square was used to look at the relationships of employment setting and theoretical orientation with therapeutic approach. This was necessitated by the fact that the two former variables produce only nominal data.

Statistical Hypotheses

The research hypotheses from Chapter 1 are restated below as null hypotheses to be tested:

(1) There is no relationship between therapists' health of family of origin, as measured by the Family of Origin Scale, and their focus on clients' family of origin in therapy, as measured by the Therapeutic Focus Scale.

(2) There is no relationship between therapists' degree of marital adjustment, as measured by the Locke-Wallace Marital Adjustment Test, and their practice of conjoint marital therapy, as measured by the ratio of marital to individual sessions per week.

(3) There is no relationship between therapists' nurturance, need for affiliation, preference for an affective-emotional mode of functioning, and feminine attributes, as measured by the Adjective Check List, and their focus on clients' family of origin in therapy, as measured by Therapeutic Focus Scale.

(4) There is no relationship between therapists' needs for dominance, achievement, and order, preference for a rational-realistic mode of functioning, and masculine attributes, as measured by the Adjective Check List, and their focus on clients' family of origin in therapy, as measured by the Therapeutic Focus Scale.

Ethical Considerations

Ethical guidelines for research, as set forth by the American Counseling Association, were followed in this study. In addition, a research proposal was submitted to the Committee for Research on Human Subjects at the College of William and Mary, and their approval for the study was obtained. Finally, in view of the sensitive nature of some of the questions on the questionnaire, anonymity of the respondents was preserved.

Chapter 4

Analysis of Results

Descriptive Statistics

After two mailings, 106 of the 200 questionnaires were returned, for a return rate of 53%. The respondents were exactly 50% male and 50% female. The mean age was 53, with a standard deviation of 9.2. The mean years of experience in counseling was 16.5, with a standard deviation of 6.3. One hundred four were Caucasian and one was African-American. Fifty-six percent held the doctoral degree, 4% held the Educational Specialist degree, and the remaining 40% held masters degrees. Seventy-four percent were married, 12% divorced, 6% never married, and 6% were unmarried and living with someone in a committed relationship.

The respondents came from 27 states, mainly in the East. Nineteen percent were from Virginia. This large proportion could be due to several things. Virginia was the first state to license professional counselors, and so has a relatively large number of the same residing

there. Therefore any national random sample of licensed counselors could be expected to yield a large proportion from Virginia. Second, the National Board for Certified Counselors, from whose membership the sample was drawn, was located in Alexandria, Virginia from its creation until its move to North Carolina just months before this sample was taken. This may have influenced more counselors from Virginia than from other states to join NBCC.

Forty percent of the respondents worked in private practice, 25% in colleges or universities, 8% in primary and secondary schools, 7% in Community Mental Health Centers, and 5% in other public not-for-profit agencies, such as courts or Catholic Family Services. Thirty percent gave their primary theoretical orientation as eclectic, integrative, or multimodal; 19% as cognitive-behavioral or Rational-Emotive; 19% as humanistic, existential, or person-centered; 8% as psychodynamic; 8% as family systems; and 5% as behavioral.

Correlation Coefficients for Statistical Hypotheses

In this section, each of the statistical, or null, hypotheses will be restated, followed by the results for that hypothesis.

(1) There is no relationship between therapists'

health of family of origin, as measured by the Family of Origin Scale, and their focus on clients' family of origin in therapy, as measured by the Therapeutic Focus Scale. The Pearson correlation coefficient $r = -0.221$, and $p = 0.023$. Because we are looking at ten correlations, the chosen alpha level for the study, 0.05, was adjusted to 0.016, using the Bonferroni correction. This is done in order to balance for the greater likelihood of making a Type I error when looking at so many correlations. At this level, although the correlation approaches significance and is in the predicted direction, we do not reject the null hypothesis.

(2) There is no relationship between therapists' degree of marital adjustment, as measured by the Locke-Wallace Marital Adjustment Test, and their practice of conjoint marital therapy, as measured by the ratio of marital to individual sessions conducted per week. The Pearson correlation coefficient $r = 0.025$, $n = 79$, and $p = 0.825$. The null hypothesis is not rejected. (The n for this correlation is smaller because not all respondents were married or living with someone in a committed relationship.)

(3) There is no relationship between therapists' nurturance, need for affiliation, preference for an affective-emotional mode of functioning, and feminine attributes, as measured by the Adjective Check List,

and their focus on clients' family of origin in therapy, as measured by the Therapeutic Focus Scale. The results are as follows:

Nurturance: Pearson r = 0.029, p = 0.769. Do not reject the null hypothesis.

Need for Affiliation: Pearson = -0.085, p = 0.395. Do not reject the null hypothesis.

Preference for an Affective-Emotional Mode of Functioning: Pearson r = -0.109, p = 0.271. Do not reject the null hypothesis.

Feminine Attributes: Pearson r = 0.014, p = 0.890. Do not reject the null hypothesis.

(4) There is no relationship between therapists' need for dominance, need for achievement, need for order, preference for a rational-realistic mode of functioning, and masculine attributes, as measured by the Adjective Check List, and their focus on clients' family of origin in therapy, as measured by the Therapeutic Focus Scale. The results are as follows:

Dominance: Pearson r = 0.043, p = 0.666. Do not reject the null hypothesis.

Achievement: Pearson r = 0.170, p = 0.086. Do not reject the null hypothesis.

Order: Pearson r = -0.123, p = 0.216. Do not reject the null hypothesis.

Preference for a Rational-Realistic Mode of

Functioning: Pearson r = 0.015, p = 0.883. Do not reject the null hypothesis.

Masculine Attributes: Pearson r = 0.029, p = 0.769. Do not reject the null hypothesis.

Additional Relationships

A number of additional relationships were looked at for any light they might shed on the correlates of therapeutic approach, as measured by the Therapeutic Focus Scale. Gender was significantly positively correlated with therapeutic approach (point biserial r = 0.259, p = 0.008). In other words, females in the sample were more likely to prefer a therapeutic approach which focuses on clients' family of origin, whereas males were more likely to prefer an approach which focuses on clients' current presenting problems. The explained variance was 6.7%.

There was a significant negative correlation between highest degree earned and therapeutic approach (Spearman r = -0.321, p < 0.001). That is, those who held the doctorate were more likely to prefer a focus on clients' current presenting problems, whereas those who held masters degrees were more likely to prefer a family of origin focus. The explained variance was 10.3%. However, because significantly more males than females in the

sample held the doctorate, it was unclear whether one of these variables (gender and degree) might be contaminating the other. To examine this further, a 2 X 2 factorial ANOVA was performed. The independent variables were gender and highest degree earned, and the dependent variable was therapeutic approach. Significant main effects were found for highest degree ($F = 4.994$, $p = 0.009$). No main effects were found for gender ($F = 0.607$, $p = 0.438$), and no interaction effects were found for degree by gender ($F = 0.118$, $p = 0.889$).

The following variables were not found to correlate with therapeutic approach: age (Pearson $r = 0.055$, $p = 0.577$); years of experience doing therapy (Pearson $r = -0.160$, $p = 0.119$); theoretical orientation (chi-square = 50.81, $p = 0.4135$); and employment setting (chi-square = 47.64, $p = 0.2380$).

A question was included in the questionnaire in order to gather tentative data on the correlates of therapists' comfort doing brief therapy. This variable is obviously related to therapeutic focus, as defined in this study, but is also somewhat different from it. The question read as follows (see Appendix A):

> How do you feel about doing brief or time-limited therapy (that is, focusing only on solving the presenting problem(s), and doing so as quickly as is possible)?

The respondents were asked to answer by circling a number from 1 (very uncomfortable) to 5 (very comfortable). Seventy-three percent of the respondents circled 4 or 5, indicating that they were at least somewhat comfortable about doing brief therapy. The mean response was 3.9.

As might be expected, this variable, comfort doing brief therapy, was significantly negatively correlated with scores on the Therapeutic Focus Scale (Pearson $r = -0.406$, $p < 0.001$). This variable also approached significance in its relationships with Need for Order (Pearson $r = 0.207$, $p = 0.035$) and Need for Dominance (Pearson $r = 0.191$, $p = 0.052$). The explained variances were, respectively, 4.3% and 3.6%. Because we are again looking at ten correlations, the alpha level is adjusted to 0.016 using the Bonferroni correction. Consequently, the null hypothesis is not rejected for either of these correlations.

Chapter 5

Conclusions

The only research hypothesis for which the data approached statistical significance was the hypothesis that the more dysfunctional therapists' family of origin was, the more likely they are to focus on clients' family of origin in therapy, as compared with current life problems. This correlation did not reach statistical significance but did approach significance and was in the predicted direction. As noted in Chapter 2, a literature review found no previous studies of the relationship between therapists' family of origin and therapeutic approach. While this study's results do not definitively add to our knowledge in this area, they are suggestive. In terms of cognitive processing theory, therapists' family of origin seems to introduce at most a weak source of bias into their preference for a focus on clients' family of origin versus current life problems. Nevertheless, the fact that such a correlation even approaches significance would seem to be important for our understanding of how we as therapists are influenced

in our work. Consequently, this may be a fruitful area for further research. Any future researchers would be well-advised to employ a larger sample in order to increase the power of the study to find significant results.

Previous research, reported in Chapter 2, found both sifnificant differences and large areas of overlap in personality traits between therapists of different theoretical orientations (Levin, 1978; Walton, 1978; Ahern, 1984; Tremblay et al., 1986). However, the present study was unable to extend these findings of significant differences to the issue of therapists' preference for focus on clients' family of origin versus current life problems. None of the hypotheses regarding correlations between therapists' personality traits and their approach to therapy were supported by the data. Thus this study found no evidence that therapists' personality traits are a significant source of bias in their choice of whether to focus more on clients' family of origin or current life problems.

As stated in Chapter 2, no previous studies were found which investigated the relationship between therapists' marital adjustment and therapeutic approach. Thus, this study broke new ground by testing the hypothesis that therapists' marital adjustment is correlated with their preference for conjoint couples

therapy as opposed to individual therapy. However, no evidence for this hypothesis was found. Therapists' degree of marital adjustment was not found to introduce systematic bias into their approach to therapy, in terms of the client-system with which they choose to work.

The two strongest correlations found in this study were not part of the research hypotheses, but came as surprises. These were the correlations between gender and therapeutic approach, and between highest degree earned and therapeutic approach. However, the results of the 2 X 2 ANOVA (see Chapter 4) indicate that the correlation between gender and therapeutic approach is probably a by-product of the fact that more males than females in the study held doctorates, and highest degree earned was correlated with therapeutic approach. In other words, only the correlation between highest degree earned and therapeutic approach is important. The correlation between gender and therapeutic approach is an artifact of the former correlation.

The direction of that correlation indicates that holders of the doctorate in this study expressed a greater preference for focusing on clients' current presenting problems, relative to holders of the masters degree, who expressed a greater preference for focusing on clients' family of origin. In attempting to explain this finding one hates to stereotype. However, it seems

likely that holders of the higher degree, by virtue of more extensive training, have larger repertoires of concepts and techniques from which to draw on in therapy. As a result they may be less likely to rely on any one approach, such as exploration of family of origin experiences. It can be concluded that an unexpected source of bias affecting therapeutic approach has been found. Further research seems warranted in order to explore the wider ramifications of this finding and perhaps shed some light on the reasons this relationship exists.

If the preceding correlations yielded few significant results, the correlations with therapists' comfort doing brief therapy yielded even fewer. It did, as expected, correlate significantly with scores on the Therapeutic Focus Scale. The only real significance of this is as a check on the concurrent validity of the TFS. One would expect that therapists who are comfortable doing brief therapy are more likely to focus on clients' current presenting problems as compared with their family of origin, whereas therapists who are not comfortable doing brief therapy would be more likely to do just the opposite. The negative correlation between TFS and comfort doing brief therapy supports that supposition.

The correlations of comfort doing brief therapy with need for order and need for dominance approached

significance in the expected direction. In other words, there is, perhaps, scant evidence that therapists who prefer doing brief therapy have a greater need for order in their lives, and a greater need to be dominant in their social relationships. However, if such relationships exist they appear to be so weak as to be negligible.

In summary, this study posed the question: Is there empirical evidence that therapists' family backgrounds and personality traits introduce systematic bias into their approach to doing therapy? The specific dimensions of therapeutic approach that were investigated were relative preference for focus on clients' current presenting problems versus family of origin experiences, and relative preference for doing couples therapy versus individual therapy. The aspects of family background which were hypothesized to introduce bias into one's therapeutic approach were therapists' perceived health of family of origin, and therapists' current degree of marital adjustment. The personality traits hypothesized to do the same were nurturance, needs for affiliation, dominance, achievement, and order, preferences for an affective-emotional and a rational-realistic mode of functioning, and male and female attributes. None of these hypothesized sources of bias were unequivocally supported by the data. Only one, perceived health of

therapists' family of origin, approached significance. However, an unexpected and potentially very important source of bias in one's therapeutic approach was found. That is, holders of the doctorate were more likely to focus on clients' current life problems; whereas holders of the masters degree were more likely to focus on clients' family of origin.

The overarching conclusion to be drawn from these results is that the effects of therapists' family background and personality factors on how they practice their art are probably too complex and subtle for easy explication and categorization. Few would disagree that our family backgrounds and personalities influence how we practice therapy; but, except for the possible influence of therapists' health of family of origin, it remains to be demonstrated just how this influence is manifested. On the other hand, the influence of therapists' level of training on how they practice therapy would seem to be an area where further research is warranted.

Limitations

Several possible limitations to the results of this study involve representativeness of the sample, and hence generalizability. First, the sample consisted entirely

of counselors. The other mental health disciplines, such as psychologists and clinical social workers, were not included. Further, the sample was skewed toward older, almost entirely white counselors, mostly from eastern states, many of whom were employed in academic settings. Finally, since the response rate to the questionnaire was only 53%, the results may be susceptible to the well-known biases of volunteer samples (Borg & Gall, 1989). One cannot be certain that the 53% who returned the questionnaires matches the 47% who did not, on all relevant variables.

One additional potential limitation is that the study relied entirely on self-report measures. Consequently, a social desirability bias might have been operating (Borg & Gall, 1989).

Appendix B

Consent Form

The purpose of this form is to request your assistance in a research study by completing the enclosed questionnaire and returning it. This form is to ensure that you understand what the project is about. There are no reasonably foreseeable risks or discomforts that may occur as a result of participating in this research. Please read carefully the following information, then sign in the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate.

Purpose of the Research

The purpose of this study is to investigate the relationships between therapists' family background, personality traits, and therapeutic approach. It is believed that the more we as counselors know about factors which may influence our approach to therapy, the better we will be able to meet our clients' needs. This study will investigate certain aspects of family background and personality traits that it is thought may influence one's approach to therapy.

Amount of Your Time Required

It is estimated that it will take no longer than 30 minutes of your time to complete the questionnaire.

Assurance of Confidentiality

All returned questionnaires will be kept in strictest confidence and anonymity. No one, not even the researcher, will identify the raw data by name of respondent. The questionnaires are numbered so that

nonresponders can be identified and a follow-up letter sent. However, the returned questionnaires will remain anonymous, and for purposes of analysis, only group data will be used.

Persons to Contact with Questions or Concerns

If you have any questons about this research or the research subjects' rights, or for help in the event of a research-related injury, you may contact either of the following individuals:

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(804) 739-4532

Charles Matthews, Ph.D., Associate Professor
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College of William and Mary
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A written summary of the results of this study will be made available upon request from Jeff Van Pelt.

Informed Voluntary Consent to Participate

I have been fully informed and hereby voluntarily consent to participate in the study outlined above. I understand that I have the right to decline to participate or to withdraw at any time without penalty.

_____ _____
Subject's Signature Date

_____ _____
Researcher's Signature Date

The mailing of this survey is part of research being conducted by Jeffrey Van Pelt, through the College of William and Mary, with the cooperation of the National Board for Certified Counselors. NBCC granted approval for the selection of a random sample of National Certified

Counselors to receive this survey. Jeff Van Pelt is solely responsible for the conduct of the research and for its conclusions.

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