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The Relationship between Counselor-in-Training Personality Traits, Family-of-Origin Characteristics and Working Alliance

Anthony W. Tatman
Western Michigan University

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THE RELATIONSHIP BETWEEN COUNSELOR-IN-TRAINING PERSONALITY
TRAITS, FAMILY-OF-ORIGIN CHARACTERISTICS
AND WORKING ALLIANCE

by

Anthony W. Tatman

A Dissertation
Submitted to the
Faculty of The Graduate College
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Alan J. Hovestadt, Ed.D.

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The relationship between counselor-in-training personality traits, family-of-origin characteristics and working alliance

Anthony W. Tatman, Ph.D.
Western Michigan University, 2005

Research has revealed that the working alliance between counselors-in-training (CITs) and their clients predict therapeutic outcome (Horvath & Symonds, 1991; Parish & Eagle, 2003). The amount of research is limited, however, concerning CIT traits that facilitate the development of the working alliance (Ackerman & Hilsenroth, 2001; Ligiero & Gelso, 2002; Wampold, 2001). The purpose of the present study was to identify the degree to which CIT personality traits and family-of-origin (FOO) characteristics are associated with working alliance evaluations. This study utilized the 5 domains of personality, measured by the NEO-FFI (Costa & McCrae, 1992), and alexithymia, measured by the TAS-20 (Bagby, Parker et al., 1994), as CIT personality predictor variables. CIT FOO predictor variables consisted of general family functioning in the FOO, measured by the FAD-GFS (Epstein et al., 1983), and (2) emotional expressiveness within the FOO, measured by the FOEAS (Yelsma et al., 2000). The 2 criterion variables consisted of CIT evaluations of the working alliance with their client, measured by the CIT WAI-S (Tracey & Kokotovic, 1989), and client evaluations of the working alliance with their CIT, measured by the Client WAI-S.
The sample consisted of 33 CIT-client dyads, (27 female and 6 male CITs; and 23 female and 10 male clients). Data was analyzed with a combination of stepwise regression and correlation analyses. Eight hypotheses were proposed, with 1 being partially accepted, revealing that as CIT Neuroticism scores on the NEO-FFI increased and reached a T score of 62, client working alliance evaluations increased and were significantly predicted. A post hoc analysis revealed that as CIT Neuroticism scores on the NEO-FFI increased and reached a T score of 62, as well as when CITs had positive perceptions about the general functioning within their FOO, positive client working alliance evaluations increased and were significantly predicted. Self of the therapist literature was used to explain, make conclusions, and generate implications for CIT training, supervision, and future research.
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Anthony W. Tatman
TABLE OF CONTENTS

ACKNOWLEDGEMENTS ........................................................................................................ ii

LIST OF TABLES ................................................................................................................ xi

CHAPTER

I. INTRODUCTION ........................................................................................................ 1

Statement of the Problem ................................................................ 1

Background of the Problem ............................................................. 2

Purpose and Importance of the Study ........................................... 6

    Use of a comprehensive assessment measure of personality. 7

    Greater understanding of FOO characteristics...................... 7

    Self of the therapist work for CITs..................................... 9

    Aiding graduate training admission’s processes ................. 10

Rationale and Theoretical Framework ........................................ 11

Personality traits........................................................................ 11

    Five-factor model......................................................... 11

    Alexithymia.................................................................... 12
Table of Contents – Continued

CHAPTER

Relationship between alexithymia and the five-factor model.......................... 13

FOO characteristics.............................................................. 14

General functioning in the FOO......................... 14

Emotional expressiveness in the FOO....................... 15

Statement of the Research Hypotheses................................. 16

Definition of Terms.......................................................... 17

II. REVIEW OF RELATED LITERATURE...................................... 20

Introduction........................................................................ 20

Working Alliance.............................................................. 20

Personality........................................................................ 22

Five-factor model of personality ................................. 24

Alexithymia................................................................. 25

Five-factor model and alexithymia................................. 27

Family of Origin............................................................... 31
Table of Contents – Continued

CHAPTER

Intergenerational Family System Theory......................... 31

FOO and CITs................................................................. 31

Family Assessment Device.............................................. 35

Emotional expressiveness in the FOO.................. 36

Emotional expressiveness in the FOO and alexithymia...... 37

Conclusion.......................................................... 38

III. METHODOLOGY AND DESIGN................................. 40

Introduction......................................................... 40

Statistical Analyses.................................................. 40

Procedures.......................................................... 41

Power analysis...................................................... 41

Data collection process............................................. 41

Locations of data collection............................. 41

CIT participation................................................. 42

Client participation............................................. 43
# Table of Contents – Continued

## CHAPTER

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIT and client protection and anonymity</td>
<td>43</td>
</tr>
<tr>
<td>Sample</td>
<td>44</td>
</tr>
<tr>
<td>CIT participants</td>
<td>44</td>
</tr>
<tr>
<td>Client participants</td>
<td>45</td>
</tr>
<tr>
<td>Instruments</td>
<td>46</td>
</tr>
<tr>
<td>Working Alliance Inventory – Short</td>
<td>46</td>
</tr>
<tr>
<td>Reliability</td>
<td>48</td>
</tr>
<tr>
<td>Validity</td>
<td>49</td>
</tr>
<tr>
<td>NEO Five-Factor Inventory</td>
<td>49</td>
</tr>
<tr>
<td>Reliability</td>
<td>51</td>
</tr>
<tr>
<td>Validity</td>
<td>53</td>
</tr>
<tr>
<td>Twenty-Item Toronto Alexithymia Scale</td>
<td>54</td>
</tr>
<tr>
<td>Reliability</td>
<td>55</td>
</tr>
<tr>
<td>Validity</td>
<td>55</td>
</tr>
<tr>
<td>Family Assessment Device – General Functioning Scale</td>
<td>56</td>
</tr>
<tr>
<td>Reliability</td>
<td>57</td>
</tr>
<tr>
<td>Validity</td>
<td>57</td>
</tr>
</tbody>
</table>

vii
Table of Contents – Continued

CHAPTER

Family-of-Origin Expressive Atmosphere Scale.................. 57
Reliability and Validity................................................. 58
CIT and client sociodemographic form............................. 59
Hypotheses........................................................................ 59
Limitations....................................................................... 60

IV. RESULTS........................................................................ 62

Multiple regression assumptions................................. 63
Multicolinearity............................................................. 63
Independence................................................................. 63
Linearity, normality, and outliers..................................... 64

Internal consistency, scale means, and scale standard deviations......................................................... 66

Hypotheses Results.......................................................... 69
Post Hoc Analysis......................................................... 75
Summary........................................................................... 76

V. DISCUSSION................................................................ 77

Introduction..................................................................... 77
Summary of Methodology............................................... 77
Findings and Interpretations........................................... 78

viii
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIT Neuroticism predicting client evaluations of the working alliance</td>
<td>78</td>
</tr>
<tr>
<td>CIT Neuroticism and FOO experiences predicting client evaluations of the</td>
<td>82</td>
</tr>
<tr>
<td>working alliance</td>
<td></td>
</tr>
<tr>
<td>Limitations</td>
<td>85</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>87</td>
</tr>
<tr>
<td>General Conclusion</td>
<td>89</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPENDICES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Working Alliance Inventory-Short, Client version</td>
<td>92</td>
</tr>
<tr>
<td>B. Working Alliance Inventory-Short, Client version</td>
<td>94</td>
</tr>
<tr>
<td>C. Twenty-Item Toronto Alexithymia Scale</td>
<td>96</td>
</tr>
<tr>
<td>D. McMaster Family Assessment Device - General Functioning Scale</td>
<td>98</td>
</tr>
<tr>
<td>E. Family-of-Origin Expressive Atmosphere Scale</td>
<td>100</td>
</tr>
<tr>
<td>F. Human Subject Institutional Review Board approval, Western Michigan</td>
<td>103</td>
</tr>
<tr>
<td>University</td>
<td></td>
</tr>
<tr>
<td>G. Human Subject Institutional Review Board approval, University of</td>
<td>105</td>
</tr>
<tr>
<td>Missouri-Kansas City</td>
<td></td>
</tr>
<tr>
<td>H. CIT Informed Consent, Western Michigan University</td>
<td>108</td>
</tr>
<tr>
<td>I. CIT Informed Consent, University of Missouri-Kansas City</td>
<td>111</td>
</tr>
<tr>
<td>J. CIT Sociodemographic Form</td>
<td>114</td>
</tr>
<tr>
<td>K. Client Informed Consent, Western Michigan University</td>
<td>116</td>
</tr>
</tbody>
</table>
Table of Contents – Continued

APPENDICES

L. Client Informed Consent, University of Missouri-Kansas City .......... 118
M. Client Sociodemographic Form .............................................................. 120

BIBLIOGRAPHY ........................................................................................................ 122
LIST OF TABLES

1. Alpha Reliability Coefficients for the NEO-FFI ............................................... 51
2. Mean Reliability Coefficients and Standard Deviations for the NEO-FFI (Caruso, 2000) ................................................................. 53
3. Scale Reliability, Means, and Standard Deviations ............................................. 67
4. Correlation Matrix for Predictor and Criterion Variables ................................. 68
5. Linear and Non-linear Regression Equation Results ............................................ 71
CHAPTER I

INTRODUCTION

Statement of the Problem

Research has revealed that the ability of counselors-in-training (CITs) and clients to develop a working alliance is significantly related to the outcome of therapy (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Information is limited, however, regarding what facilitates the working alliance (Eames & Roth, 2000). Although there are both client factors and CIT factors that have been identified and investigated as contributing to the working alliance, CIT factors have received considerably less empirical attention than client factors (Ackerman & Hilsenroth, 2001; Dunkle & Friedlander, 1996; Hersoug, Hogland, Monsen, & Haik, 2001; Horvath, 2000; Horvath & Luborsky, 1993; Ligiero & Gelso, 2002; Mallinckrodt, 1991; Wampold, 2001). To date, relatively little is known about what CIT factors contribute to the working alliance and the extent to which they contribute to the alliance between them and their clients.

This study attempted to identify several CIT factors that predict levels of the working alliance, and investigated the degree to which CIT personality traits and family-of-origin (FOO) characteristics influence the working alliance with clients. Given the significance in which the working alliance is related to therapeutic outcome, an understanding of CIT factors that facilitate the working alliance may be beneficial to CIT training and supervision, as well as to the processes for admitting individuals into graduate counseling training programs.
Background of the Problem

The working alliance is a theoretical construct that encapsulates the collaborative and interactive exchange between two or more individuals. The working alliance construct constitutes a specific theoretical definition of the therapeutic alliance, and is one of the most comprehensive and widely applicable constructs for conceptualizing the alliance between mental health professionals and their clients (Horvath & Greenberg, 1989; Martin et al., 2000). Originating from psychoanalytic theory, the working alliance has gradually evolved into a construct applicable to “all change-inducing relationships” (Horvath & Greenberg, p. 224). The discussion below will provide an outline of the development and evolution of the working alliance concept, followed by a synopsis of the state of the current working alliance research literature.

Bordin (1979) introduced the working alliance definition that is widely accepted today. Its roots, however, date back to the early 1900s. Since the writings of Sigmund Freud, mental health practitioners have been aware of the considerable influence the therapeutic relationship between the counselor and client has on the process and outcome of therapy (Freud, 1912/1966; Parish & Eagle, 2003). Freud was one of the first to propose that the relationship between the counselor and client was the pivotal component to successful therapy. Through concepts such as transference and countertransference, Freud showed the psychotherapy community that the way in which the counselor and client view each other and work together influences the process of therapy.

The significance of the therapeutic relationship was later acknowledged by, and integrated into, the work and theoretical orientation of Carl Rogers (1951). As did Freud, Rogers believed that the relationship between the counselor and client was the
quintessential factor influencing the outcome of therapy. Rogers’ view of the therapeutic relationship differed from Freud’s, however, in two important ways. First, Rogers believed that specific contributions of the therapist are key to evoking change. When therapists offer higher levels of empathy, genuineness, and unconditional positive regard they may influence clients to “activate their innate healing and growth potential native to every person” (Bachelor & Horvath, 2002, p. 134). Second, Rogers conceptualized the relationship as an existential encounter between two equals, a partnership rather than a hierarchy of power and influence. Freud, by contrast, viewed the therapist as being in an authoritative position to the client.

Recently published research on therapeutic “common factors” has further substantiated Freud’s and Roger’s belief in the significance of the therapeutic relationship (Greencavage & Norcross, 1990; Lambert, 1992; Lambert & Bergin, 1994). The common factors construct has provoked considerable clinical interest and empirical research on the impact the working alliance has on therapy outcomes (Lambert & Bergin; Martin et al., 2000). Although the notion of common factors was first introduced in 1936 (Rosenzweig, 1936), it gained widespread attention in the mid to late 1970s through meta-analytic studies of therapeutic outcome. Luborsky, Singer, and Luborsky (1975), as well as Smith and Glass (1977), for example, revealed that no significant differences in therapy outcome were observable based on the therapist’s theoretical orientation or clinical approaches. Contingent on these findings, the conclusion was made that the effectiveness of different types of therapeutic approaches may have more to do with their common elements than with the theoretical tenets on which they are based. Five therapeutic common factors are widely accepted today as encompassing the variables that influence
the therapeutic process. These factors are (1) client characteristics (e.g., client level of
distress), (2) therapist qualities (e.g., warmth, positive regard), (3) change processes (e.g.,
gaining insight, strategy development), (4) treatment structures (e.g., techniques and
models used), and (5) relationship elements (e.g., working alliance) (Greencavage &

During the time when the therapeutic common factors concept was being
introduced to the field of psychology, Bordin (1979) introduced the working alliance
concept, a more comprehensive definition of counselor-client interaction. The term
"working alliance" was originally introduced by Greenson (1965). When it was
introduced, the working alliance concept was primarily a psychoanalytically-oriented
definition of the client’s ability and willingness to engage in the therapeutic process.
Bordin (1979) expanded on Greenson’s theoretical definition and modified it to
capsulate the collaboration and interactive process between the counselor and client
throughout the therapy process. Bordin’s working alliance construct also includes the
therapeutic relationship concept that Freud and Rogers put forth as a crucial component
to successful therapy. The three components of Bordin’s working alliance construct
include (1) the agreement between counselor and client on the therapeutic goals, (2) the
agreement between counselor and client on the tasks or activities in therapy, and (3) the
development of a personal bond between counselor and client. Since its development, the
working alliance paradigm has been one of the most researched and respected constructs
conceptualizing the interaction between therapists and clients (Hanson, Curry, &
Bandalos, 2002; Horvath & Greenberg, 1989; Martin et al., 2000).

Because of the many different constructs and definitions available to
conceptualize the alliance between counselors and clients, the term “working alliance” will be used throughout this paper utilizing the definition put forth by Bordin (1979). References to studies that use different, more general definitions for the therapeutic relationship of therapeutic alliance will be denoted throughout the remainder of this paper as the “therapeutic alliance.”

Empirical studies and meta-analyses have concluded that the working alliance not only is a significant component of the therapeutic process, but also predicts the outcome of therapy (Gelso & Carter, 1985; Horvath & Greenberg, 1989; Horvath & Symonds, 1991; Kokotovic & Tracey, 1990; Martin et al., 2000; Parish & Eagle, 2003). In their meta-analysis of 24 studies that assess the relationship between the working alliance and therapeutic outcome, Horvath and Symonds (1991) revealed that 26% of the outcome of therapy is attributable to the working alliance, a finding very similar to Lambert’s (1992). A more recent meta-analysis also revealed similar effect sizes connecting working alliance to therapeutic outcome. In their review of 79 studies, Martin et al. (2000) revealed an average effect size correlation of .23, slightly lower, but similar to that of previous studies.

Although research has concluded that the working alliance predicts therapy outcome, “relatively little is known about the factors which contribute to the establishment of a good alliance” (Eames & Roth, 2000, p. 421). Also, based on the extensive evidence suggesting that the working alliance predicts therapeutic outcome, Hilliard, Henry and Strupp (2000) advocate that research address the underlying elements that facilitate the working alliance. In response to these recommendations, working alliance research has shifted from investigating the relationship between the working
alliance and therapy outcome to investigating the factors that facilitate the working alliance between counselors and clients.

Subsequent research has resulted in investigations of both client factors and counselor factors that contribute to the working alliance. Client factors that influence the working alliance have received considerably more attention in the research literature than counselors-in-training (CIT) factors (Ackerman & Hilsenroth, 2001; Dunkle & Friedlander, 1996; Hersoug et al., 2001; Ligiero & Gelso, 2002; Mallinckrodt, 1991; Wampold, 2001). Literature on counselor factors has primarily focused on factors inherent in CITs, rather than on practicing mental health professionals. Two CIT factors have been identified as impacting the working alliance: personality traits and FOO characteristics. Although not explicitly stated, this tendency toward investigating CITs may be due, in part, to the relative ease with which the sample can be obtained, as well as the potential application of findings to CIT training and professional development.

Purpose and Importance of the Study

Acknowledging that levels of the working alliance predict therapy outcome, Kaufman (2000) suggests that the field of mental health counseling should capitalize on these findings and incorporate them into CIT training. "If the therapist’s ability to form an alliance is so vital to therapeutic effectiveness, developing training methods to enhance the attainment of capacities found to facilitate the development of the therapeutic [working] alliance would be paramount" (Kaufman, p. 42). The amount of research, however, is limited in regard to CIT factors that facilitate the development of the working alliance (Ackerman & Hilsenroth, 2001; Dunkle & Friedlander, 1996; Hersoug et al., 2001; Horvath, 2000; Horvath & Luborsky, 1993; Ligiero & Gelso, 2002; Mallinckrodt,
Identifying CIT personality traits and FOO characteristics that predict the working alliance may be useful to researchers, clinicians, CITs, educators, and supervisors by (1) using a comprehensive method of assessing multiple domains of CIT personality in relation to the working alliance, a method of assessment yet to be conducted within the literature. (2) This research may provide the scientific literature with an understanding of CIT FOO characteristics that influence the working alliance, and (3) provide further validation for self of the therapist work by CITs. (4) This study may also support the assessment of CIT personality and FOO characteristics during the graduate school admission’s process. Each of these four points will be discussed in greater detail below.

Use of a comprehensive assessment measure of personality

Previous studies have assessed CIT personality traits in relation to the working alliance exclusively through the use of single-construct personality measures, such as hostility, attachment style, and interpersonal interaction style (Dunkle & Friedlander, 1996; Hersoug et al., 2001; Kokotovic & Tracey, 1990; Satterfield & Lyddon, 1995). Research has yet to utilize a comprehensive method of assessing multiple domains of CIT personality in relation to the working alliance. Acknowledging this limited aspect of the research, this study investigated the relationship between the five domains of the Five-Factor Model (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness; Costa & McCrae, 1992), also referred to as the Big Five, and the working alliance.

Greater understanding of FOO characteristics

Another major purpose of this study was to contribute to the scientific literature
an understanding of CIT FOO characteristics that influence the working alliance. A demonstration of these factors may provide further validation of the importance for CITs to acknowledge and process FOO experiences during graduate training and supervision. Although a considerable amount of research supports the practice of CITs investigating and processing their personal FOO experiences (Aponte, 1994; Bowen, 1978; Braverman, 1982; 1997; Framo, 1976; Getz & Protinsky, 1994; Lawson & Gaushell, 1988; Napier & Whitaker, 1978; Timm & Blow, 1999), little is known about what specific CIT FOO characteristics tend to influence either positive or negative working alliances with clients.

In his Intergenerational Theory, Bowen (1978) argued that mental health professionals and CITs must address their FOO experiences to maximize successful therapy outcomes. Bowen stated “A therapist brings to his work the heritage of his past family experiences and the effects of his current family functioning” (Winter & Aponte, 1987, p. 97). It has also been stated that “Every person has some degree of unresolved emotional attachment to their parental family. This unresolved attachment to the [FOO] parallels one’s level of differentiation” (Kerr, 1984, p. 8). Differentiation is “an individual’s capacity to be aware of the difference between their intellectually determined and their emotionally determined functioning, and to have some choice about the degree to which each type of functioning governs their behavior” (Kerr, p. 8). Therefore, the more emotionally attached a person is to aspects of their FOO the less differentiated they are. The less differentiated a person is the more likely they will respond to situations emotionally, rather than rationally. Without a process of exploration and processing of such FOO experiences, CITs will remain largely unaware of the degree
to which past experiences impact therapeutic processes and the working alliance.

Envision, for example, a CIT who has a covert aversion to drug usage from watching a parent’s, sibling’s, or loved one’s life disintegrate from drug abuse. Upon encountering a client who uses or abuses chemicals, this CIT may inadvertently resort to behaviors and cognitions commensurate with how he or she handled the use/abuse in their own FOO. This reactionary behavior could dramatically influence the working alliance and, therefore, the outcome of therapy.

Self of the therapist work for CITs

An additional purpose for investigating the relationship between CIT personality traits and FOO characteristics and the working alliance is the personal insight that might be gained by a CIT from this information. Through the process of self of the therapist work (Timm & Blow, 1999) or personal psychotherapy (Ackerman & Hilsenroth, 2001) a CIT could assess how their specific personality trait(s) may serve as a resource or restraint in the working alliance, and ultimately the outcome of therapy. Timm and Blow defined the process of self of the therapist work as “the willingness of a therapist to participate in a process that requires introspective work on issues in his or her own life, that has an impact on the process of therapy in both positive and negative ways” (p. 333).

Results obtained from this study may provide an understanding of how a CIT’s five domains of personality and alexithymia could influence the working alliance. For example, the present study may find that CIT’s low in Agreeableness tend to perceive the working alliance as low, as well as received low working alliance scores from their clients. After completing the personality measures used in this study, a particular CIT may find that they answered the questions in a way that revealed a low Agreeableness
score. Based on the information ‘found’ in this study regarding Agreeableness and the working alliance, a CIT can collaboratively process with their supervisor how their potentially low Agreeableness may impede the working alliance, and therefore the process of therapy.

Aiding graduate training admission’s processes

Although CITs’ personality traits and FOO characteristics have been implicated in influencing the working alliance, substantive research on this topic is scarce. A greater understanding of CITs’ personality traits and FOO characteristics that influence the quality of the working alliance may be of significant value to counselor educators and admissions committees concerning CIT selection into graduation training (Chwalisz, 2001; Stein & Lambert, 1995). Graduate Record Exam (GRE) scores and Grade Point Averages (GPAs) are criteria by which most CITs are selected for graduate school admission. This method of selection, however, has been debated for some time. Weaver (2000), for example, comments that research has yet to conclude convincingly that GPA and GRE scores are predictive of graduate school performance and clinical effectiveness. CIT personality traits, on the other hand, have been identified as having significant relationships with graduate school performance and clinical effectiveness (Daehnert & Carter, 1987; Weaver). The proposition of evaluating personality traits in the admissions process was suggested over thirty years ago, however, has yet to gain widespread use. Carkuff (1969) favored a process of CIT selection based on an assessment of personal factors, rather than on GPA or other test scores. Carkuff (p. 49) suggested that training programs admit applicants who “exhibit a sincere regard for others, tolerance and ability to accept people with values different from one’s own, a healthy regard for self, a warmth

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and sensitivity in dealing with others, and a capacity for empathy.” Therefore, a purpose of the present study is to identify CIT personality traits that predict levels of the working alliance, which may help provide added justification for their consideration in the selection process for admission into graduate training.

To summarize, this study proposes to identify CIT personality traits and FOO characteristics that predict levels of the working alliance. Further understanding of these CIT factors may contribute to CIT education and professional development, to the paucity of scholarly literature on the influence such factors have on the working alliance, as well as to the process of CIT selection for graduate training.

Rationale and Theoretical Framework

A review of the literature revealed that several CIT personality traits and FOO characteristics influence the working alliance. The six personality factors that will be part of this study include (1) Neuroticism, (2) Extraversion, (3) Openness, (4) Agreeableness, (5) Conscientiousness, and (6) alexithymia. The two FOO characteristic factors that will be considered in this study include (1) general functioning within the FOO, and (2) the emotional expressive atmosphere within the FOO.

Personality traits

Five-factor model.

Research has provided evidence that CIT personality traits impact the working alliance (Dunkle & Friedlander, 1996; Hersoug et al., 2001; Kokotovic & Tracey, 1990; Satterfield & Lyddon, 1995). This study will utilize the Five-Factor Model consisting of the following five domains of personality: Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness. The Five-Factor Model was developed by
personality researchers who concluded from a process of factor analysis that a considerable majority, if not all, of the adjectives used to characterize personality traits fall into a taxonomy of five major personality domains (Costa & McCrae, 1992; Goldberg, 1990; John, 1990; John, Angleitner, & Ostendorf, 1988). The comprehensive taxonomy of personality traits the Five-Factor Model provides, combined with the extensive research supporting its factor structure and utility as a personality measure (Costa & McCrae; John), makes this an appropriate model of personality for inclusion in the present study.

*Alexithymia.*

Alexithymia is also a personality trait that can affect the working alliance. Alexithymia is characterized by the degree to which an individual is able to identify and describe feelings; their ability to differentiate between emotional feelings and physical sensations; creativity; and by their tendencies toward externally oriented thinking (Taylor, 2000). Theoretically, levels of these aforementioned characteristics found in counselors would undeniably influence their ability to initiate and maintain a working alliance with clients. To illustrate, we would expect that counselors with high levels of alexithymia (e.g., less able to identify feelings) may have deficiencies in their ability to identify or conceptualize emotional pain exhibited by a client. It would also be expected that such counselors may be oblivious to their own personal emotional reactions to a client’s emotions. Such a situation potentially would negatively impact the working alliance and therapeutic outcome.

Alexithymia may also influence the degree to which counselors can correctly identify the level of alliance with their client(s), an awareness that has been shown to
influence the outcome of therapy (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). It can be expected that counselors will encounter clients where either the alliance is low from the beginning or has been strained or has declined from a previously healthy, positive level. For whatever reason the decline in alliance has occurred, a counselor can salvage the therapeutic relationship by first recognizing the decline, acknowledging the problem with the decline, and taking actions to repair the alliance (Safran, 1993; Safran & Muran, 2000; Watson & Greenberg, 2000). If conducted, this process of acknowledging and conjointly processing the decline or strain in the alliance may actually be a growth opportunity for client change. An inability or deficiency to identify and describe the feelings and emotions of both self and others, characteristics of alexithymia, may considerably diminish the degree to which a counselor can recognize a low working alliance and therefore take action to correct it, ultimately impinging on the therapeutic process.

*Relationship between alexithymia and the five-factor model.*

Alexithymia has been frequently researched in relationship to the Five-Factor Model of personality. Research has revealed that alexithymia has a significant, positive relationship with Neuroticism, while having a negative relationship with Extraversion, Openness, Agreeableness, and Conscientiousness for both clinical and non-clinical populations (Bagby, Taylor, & Parker, 1994; Mann, Wise, Trinidad, & Kohanski, 1994; Wise, Mann, & Shay, 1992). Although correlations have been revealed between alexithymia and each of the five domains of the Five-Factor Model, alexithymia appears to correlate strongest and most consistently with Neuroticism, Extraversion, and Openness (Luminet, Bagby, Wagner, Taylor, & Parker, 1999; Parker, Taylor, & Bagby,
Further detail on correlates found between these five domains and alexithymia can be found in Chapter II.

**FOO characteristics**

FOO characteristics of counselors constitute an additional set of variables identified in the literature that have an affect on CITs' interactions and relationships with clients (Lawson & Brossart, 2003; Mallinckrodt, 1991; Simpson & Rholes, 1998). Research has revealed that the relationships CITs had with their parents was significantly correlated with clinical effectiveness (Wilcoxon, Walker, & Hovestadt, 1989; Wittmer, Sword, & Loesch, 1973; Watts, Trusty, Canada, and Harvill, 1995). Lawson, Gaushell, McCune, and McCune (1995) revealed that various aspects of the therapeutic process were correlated with CIT FOO experiences. More specific to the purpose and hypotheses proposed in the present study, research has revealed that CITs' interactions with their parents were significant predictors of client perceptions of the working alliance (Lawson & Brossart; Lawson & Sivo, 1998).

**General functioning in the FOO.**

Intergenerational family theory (Bowen, 1978) provides a framework in which CITs' FOO experiences can be theoretically conceptualized as impacting the working alliance with clients. Intergenerational family theory hypothesizes that adult functioning is influenced by FOO experiences such as problem solving, communication, roles within the family, emotional responsiveness, emotional expressiveness, beliefs, and interpersonal interactions (Bowen; Kerr & Bowen, 1988). These familial factors have been defined by Epstein, Baldwin, and Bishop (1983) as influential in family functioning. Kerr (1984) proposed that effective therapy is contingent on the CITs' awareness of the
functioning within their FOO, and on their ability to assess how these factors impact their
own emotional and behavioral functioning. Theoretically, for example, the more
emotionally enmeshed (i.e., less differentiated) therapists are in their FOO the less likely
they are able to think and act objectively, resulting in countertherapeutic interactions with
clients. While the influence a CIT's family functioning has on current, adult functioning
has been shown, its impact on the working alliance has yet to be assessed, and therefore
warrants its inclusion in this study.

*Emotional expressiveness in the FOO.*

Emotional expressiveness in the FOO is the second FOO characteristic included
in this study as predictive of the working alliance. Emotional expressiveness in the FOO
refers to the degree to which emotions and affect are communicated, either verbally or
physically, within the family unit (Yelsma, Hovestadt, Anderson, & Nilsson, 2000).
Research reveals that overall quality of the expressive atmosphere in the FOO
experienced by children influences later adult emotional expressiveness, communication
skills, and interpersonal relationships (Booth-Butterfield & Booth-Butterfield, 1990).
This finding adds further support to the theoretical tenets of Bowen's Intergenerational
Theory (Bowen, 1978) by validating the impact FOO dynamics have on later adult
functioning. While the influence emotional expressiveness in the FOO has on adult
functioning has been shown, its impact on CITs’ interactions with clients and the working
alliance has yet to be assessed, and therefore warrants further investigation.
Statement of the Research Hypotheses

The following hypotheses are proposed:

1a-e. CIT (a) Neuroticism, (b) Extraversion, (c) Openness, (d) Agreeableness, and (e) Conscientiousness, either in combination with each other or alone, will predict CIT perceptions of the working alliance.

2a-e. CIT (a) Neuroticism, (b) Extraversion, (c) Openness, (d) Agreeableness, and (e) Conscientiousness, either in combination with each other or alone, will predict client perceptions of the working alliance.

3. CIT alexithymia will significantly correlate with CIT perceptions of the working alliance.

4. CIT alexithymia will significantly correlate with client perceptions of the working alliance.

5. CIT perceptions of the general function within their FOO will significantly correlate with CIT perceptions of the working alliance.

6. CIT perceptions of the general function within their FOO will significantly correlate with client perceptions of the working alliance.

7. CIT perceptions of the emotional expressiveness within their FOO will significantly correlate with CIT perceptions of the working alliance.

8. CIT perceptions of the emotional expressiveness within their FOO will significantly correlate with client perceptions of the working alliance.
Definition of Terms

This study will utilize terminology intended to convey specific meanings that may require explicit description. These terms and definitions are provided below.

Agreeableness: Agreeableness includes personality traits such as altruism, egocentrism, skepticism, competitiveness, and critical thinking. Agreeableness is measured objectively in the present study by scores in the Agreeableness domain of the NEO Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992). Higher scores represent higher levels of Agreeableness.

Alexithymia: Alexithymia is defined as an “affective and cognitive difficulty experiencing and expressing emotions” (Yelsma et al., 2000, p. 357). Alexithymia is measured objectively in the present study by total scores on the twenty-item Toronto Alexithymia Scale (Taylor, 1994). Higher scores represent higher levels of alexithymia.

Average level of Neuroticism or feelings of apprehension, frustration, sadness, and discouragement: The word “average” will be capitalized when referring to a specific personality domain level developed by Costa and McCrae (1992), which is used to differentiate levels of personality on the NEO-FFI.

Conscientiousness: Conscientiousness includes personality traits such as purposefulness, strong will, determination, and organization. Conscientiousness is measured objectively in the present study by scores in the Conscientiousness domain of the NEO-FFI (Costa & McCrae, 1992). Higher scores represent higher levels of conscientiousness.

Counselor-in-Training (CIT): Students pursuing master’s and doctoral degrees in
counselor education, counseling psychology, or marriage and family therapy.

*Expressive Atmosphere in the Family-of-Origin*: The degree to which an individual perceives that their feelings, wants, needs, and likes/dislikes were adequately communicated within their FOO. Expressive atmosphere in the FOO is measured objectively in the present study by scores obtained on the Family-of-Origin Expressiveness Atmosphere Scale (Yelsma et al., 2000). Higher scores represent higher levels of emotional expressiveness.

*Extraversion*: Extraversion includes personality traits such as extraversion / introversion, preferred activity levels, and comfort level socializing with others. Extraversion is objectively measured in this study by scores in the Extraversion domain of the NEO-FFI (Costa & McCrae, 1992). Higher scores represent higher levels of expressiveness.

*Family of Origin (FOO)*: FOO will be defined in the present study as the family in which the participant was primarily raised. In the case of adoptive or foster family situations, the FOO is the family the participant feels contributed most to the participant’s development.

*General family functioning in the FOO*: General family functioning in the FOO includes the (a) problem solving, (b) communication, (c) roles, (d) affective responsiveness, (e) affective involvement, and (f) behavioral control experienced within the CITs’ FOO. General family functioning in the FOO is measured objectively in the present study by scores on the Family Assessment Device - General Functioning Scale (FAD-GFS; Epstein et al., 1983).
Neuroticism: Neuroticism includes personality traits such as apprehension, frustration, sadness, and discouragement. Neuroticism is measured objectively in the present study by scores in the Neuroticism domain of the NEO-FFI (Costa & McCrae, 1992). Higher scores represent higher levels of Neuroticism.

Openness: Openness includes personality traits such as active imagination, being open to different experiences, attentiveness to inner feelings, and intellectual curiosity. Openness is measured objectively in the present study by scores in the Openness domain of the NEO-FFI (Costa & McCrae, 1992). Higher scores represent higher levels of Openness.

Working Alliance: The working alliance consists of the therapeutic relationship, level of agreement between CIT and client(s) on activities engaged in during therapy, and the level of agreement regarding goals for therapy. Working alliance will be measured objectively in the present study by total scores obtained from the Working Alliance Inventory - Short (WAI-S; Tracey & Kokotovic, 1989). Higher scores represent higher amounts of working alliance.
CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

The purpose of this chapter is to provide a review of the literature on personality traits and family of origin (FOO) characteristics of counselors-in-training (CITs) in relation to the working alliance. This chapter begins with a review of the working alliance literature, followed by a review of the applicable literature on personality traits and the FOO.

Working Alliance

The idea that the therapeutic relationship is of significant importance to the process and outcome of therapy has its origins dating back to the writings of Sigmund Freud. Freud introduced the importance of the counselor-client relationship through constructs such as transference and countertransference (Freud, 1912/1966). In 1934, Sterba introduced the term “ego alliance,” a construct intended to capture the required alliance between the counselor and client, and the client’s ability to actively engage in the therapeutic process. Building on Freud’s and Sterba’s ideas about the counselor-client relationship, Greenon (1965) developed the working alliance construct. Gatson (1990, p. 144) states, “Greenson viewed the alliance as consisting both of the patient’s affectionate feelings toward the therapist and the patient’s capacity to work in therapy.” The working alliance commonly referenced and identified within the current literature is based on Bordin’s (1979) adaptation of Greenson’s earlier definition. Bordin conceptualized the working alliance as consisting of three components: (1) the bond between the counselor and client, (2) perceptions about the goals for therapy, and (3) perceptions about the tasks
used during therapy. Horvath (1994) stated that Bordin's conceptualization of the working alliance provides an important bridge between the 'relationship' and 'technique' aspect of therapy. Goals negotiated and agreed on frame the client's wishes within the therapist's theoretical and practical wisdom, the Tasks represent both the means to achieve these ends and the client's willingness to engage in solving the problem in a new way. This relationship is not seen as a separate or predictor process, but as a form of active collaboration, the development of which is directly linked to the therapeutic agenda (p. 111).

Through Bordin's reconceptualization and modification of previous alliance theories, the working alliance concept has transitioned from a primarily psychoanalytic notion to one applicable to "all change-inducing relationships" (Horvath & Greenberg, 1989, p. 224).

Recent literature on therapeutic common factors have supported Horvath and Greenberg's (1989) claim that the working alliance is a universal agent of change within all therapeutic approaches (Frank & Frank, 1991; Grencavage & Norcross, 1990; Hubble, Duncan, & Miller, 1999; Lambert, 1992; Miller, Duncan, & Hubble, 1997). Common factors have been defined as "variables that contribute to change in psychotherapy that are not the province of any specific theoretical approach or model" (Sprenkle & Blow, 2004, p. 114). These therapeutic common factors have been identified by Grencavage and Norcross as: (a) Client Characteristics (e.g., client level of distress), (b) Therapist Qualities (e.g., warmth, positive regard), (c) Change Processes (e.g., gaining insight, strategy development), (d) Treatment Structures (e.g., techniques and models used), and (e) Relationship Elements (e.g., working alliance). Wampold (2001) has revealed that
70% of therapy outcome variance can be explained by the therapeutic common factors. Extensive meta-analyses have revealed that the working alliance is one of the most significant factors associated with treatment outcome regardless of therapeutic approach used, a finding supported by subsequent meta-analyses (Horvath & Symonds, 1991; Martin et al., 2000; Orlinsky & Howard, 1986).

Acknowledging that the working alliance significantly predicts therapy outcome, researchers have begun to investigate factors that facilitate the working alliance between counselors and clients. Within the subsequent research, however, client factors contributing to the working alliance have received considerably more attention in the literature than that of counselor factors (Dunkle & Friedlander, 1996; Hersoug et al., 2001; Ligiero & Gelso, 2002; Mallinckrodt, 1991; Wampold, 2001). The majority of research investigating counselor traits that influence the working alliance used a sample population of counselors-in-training (CITs). Two variables identified within this line of research as contributing to the working alliance consist of CIT personality traits and FOO characteristics. The following discussion will provide a deeper understanding into the literature specific to each of these two variables.

**Personality**

This section gives a background of the research identifying the influence CIT personality traits have on the working alliance. This background information will include a description of the personality traits outlined by the Five Factor Model and alexithymia, as well as discuss the rationale for choosing them for this study.

Because of the necessity for interpersonal interactions with clients, it would be naïve to postulate that personality traits of CITs would not influence their relationship
with clients in some way. Empirical research has supported this contention by revealing that the therapeutic relationship with clients is impacted by the CIT’s need for approval (Bandura, Lipsher, & Miller, 1960), need for acceptance by others (Mills & Abeles, 1965), and anxiety level (Milliken & Kirchner, 1971). Henry and Strupp (1994) found that counselors with greater tendencies toward being self-critical and neglectful (negative self-representations) were more likely to engage in subtle hostility and controlling interactions with clients than were therapists with positive self-representations. Similarly, counselors who were perceived as being more rigid, self-focused, hostile, critical, belittling, blaming, aloof, and less involved in the therapeutic process were perceived as less understanding and had a low therapeutic alliance with their clients (Marmar, Weiss, & Gaston, 1989; Price & Jones, 1998). Counselor hesitancy and anxiousness have also been found to impact the therapeutic alliance with clients. The therapeutic relationship has also been found to be negatively influenced by the CIT’s self-directed hostility (Dunkle & Friedlander, 1996), introjections (i.e. how therapists treat themselves based on how they were treated by people of perceived importance) (Henry, Schacht, & Strupp, 1990; Hersoug et al., 2001; Hilliard et al., 2000), attachment style (Dozier, Cue, & Barnett, 1994; Ligiero & Gelso, 2002), as well as social skills and psychological-mindedness (Crowley, 2001).

Due to the largely popular theoretical orientation of Humanism proposed by Carl Rogers, positive CIT personality traits such as empathy and warmth have “generated an extensive body of studies that dominated research on the [therapeutic] relationship for more than three decades” (Bachelor & Horvath, 2002, p. 142). In a comprehensive literature review, Ackerman and Hilsenroth (2003) revealed that counselor attributes such
as being flexible, honest, respectful, trustworthy, confident, alert, warm, interested and open were found to contribute positively to the alliance.

Although studies have supported the contention that counselor personality traits influence the working alliance, research has yet to utilize a comprehensive model of personality to substantiate this claim. The Five-Factor Model of personality may address this limitation. The Five-Factor Model is an empirically validated, comprehensive taxonomy of personality traits that could facilitate a greater understanding of CITs’ personality traits.

_Five-factor model of personality_

Psychologists have developed “hundreds of scales to measure personality trait constructs derived from theory and research” (McCrae & Costa, 1991, p. 367). However, convergent factor analysis research has shown that most adjectives used to characterize personality traits fall into one of five basic domains (Costa & McCrae, 1992; Goldberg, 1990; John, 1990; John et al., 1988). These domains have been labeled Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness, which constitute the Five-Factor Model of personality. The Five-Factor Model, or otherwise referred to as the Big Five, has received considerable attention within the empirical literature and found to be a theoretically sound and comprehensive taxonomy of personality traits (see Costa & McCrae, 1992 for an extensive list of references). Based on the Five-Factor Model’s capacity to facilitate a comprehensive understanding of an individual’s personality traits, it is appropriate for investigating the personality domains of CITs in this study.

Multiple personality measures exist that employ the Five-Factor Model’s theoretical assumptions, propositions, and methodology. Of these instruments, the NEO
Five-Factor Inventory (NEO-FFI) is one of the most researched, reliable and validated of the Big Five-based assessment measures (Costa & McCrae, 1992). Despite its validated factor structure, psychometric properties, and widespread use in research with clinical populations and organizational settings, the Five-Factor Model has yet to be utilized to assess personality traits associated with the working alliance between CITs and their clients.

*Alexithymia*

In 1973, Sifneos observed that psychosomatic patients had difficulty expressing their feelings. Sifneos described this phenomenon as alexithymia. Since this construct has been introduced it has undergone minor refinements in its definition. Currently, alexithymia is a multidimensional construct which includes the following four distinct dimensions: (1) difficulty identifying and describing feelings, (2) difficulty distinguishing between feelings and bodily sensations that accompany emotional arousal, (3) reduced ability to create fantasies, and (4) externally-oriented thinking and impaired symbolic activity (Nemiah, Freyberg, & Sifneos, 1976; Nemiah & Sifneos, 1970; Taylor, 2000; Taylor, Bagby, & Parker, 1997).

Personality traits descriptive of alexithymia include difficulties relating to and dealing with information concerning affect and personal feelings. Krystal (1993, p. 251) went so far as to say that individuals high in alexithymia have “little or no capacity for empathy.” Such individuals tend to be fact oriented and preoccupied with specific details regarding the outside world, approach situations analytically, have poor interpersonal relationship skills, and typically respond to adverse situations reactively rather than through the rational expression of emotions (Hadley, 1983; Krystal, 1990; 1993).
Individuals with high levels of alexithymia also tend to rely on external sources to meet their needs and on other people to make decisions for them (Krystal, 1982). Parker, Taylor, and Bagby (1993) observed that individuals with alexithymic tendencies have a decreased ability to recognize facial expressions of emotions displayed by others.

Alexithymia positively correlates with a number of psychiatric problems such as depression, substance abuse, anxiety, posttraumatic stress, and panic disorders (Hendryx, Haviland, & Shaw, 1991; Haviland, Hendryx, Shaw, & Henry, 1994; Parker, Taylor, Bagby, & Acklin, 1993; Taylor, Bagby, & Parker, 1991). Other authors speculated, however, as to whether alexithymia is a result of depression, anxiety, and other negative life experiences, or whether it is a stable personality trait (Lumley, Stettner, & Wehner, 1996). Subsequent research has concluded that alexithymia is a constant personality trait and is not influenced by state characteristics (Martinez-Sanchez, Ato, Corcoles, Huedo, & Selva, 1998; Martinez-Sanchez, Ato-Garcia, & Ortiz-Soria, 2003; Porcelli, Leoci, Guerra, Taylor, & Bagby, 1996; Salminen, Saarijarvi, Aarela, & Tamminen, 1994).

Taylor (1994) and Yelsma (1996) revealed that alexithymia is not only illustrative of dysfunction, but can be found at varying levels within members of the general public (i.e., is normally distributed). Yelsma (as cited by Taylor) showed that individuals with high, but not clinical, levels of alexithymia tend to lack an awareness of emotional cues within interpersonal dialogue. Suffice it to say, these personality qualities may not be well suited to mental health professionals or advantageous to the working alliance. Yet interestingly, the relationship between alexithymia and the working alliance between CITs and clients has received little attention in the research literature.

Through an extensive electronic literature search, only one published study was...
found that investigated the relationship between CIT alexithymia and the working alliance. This particular study investigated the degree to which client levels of alexithymia influenced the working alliance (Holvey, 1995). To investigate this relationship, a sample of 52 outpatient mental health clients and their respective counselors (N=12) were utilized. Both the counselor and their clients completed the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), while only the clients completed the twenty-item Toronto Alexithymia Scale (TAS-20; Bagby, Parker, & Taylor, 1994). Results revealed an inverse relationship between clients who had difficulty identifying feelings and counselor WAI task subscale scores. In other words, higher client difficulty identifying feelings was associated with lower counselor working alliance evaluations.

Although Holvey (1995) contributes to our knowledge of the relationships between client alexithymia and the working alliance, it did not investigate the effect of CITs' alexithymia on the working alliance. It is plausible that CITs with high levels of alexithymia may have difficulty identifying and communicating about both the CIT's own, as well as their client's, feelings while in therapy. This deficiency identifying and discussing feelings may result in the CIT having a problem relating to, and bonding with, clients who are expressing emotions, ultimately impacting the working alliance. This proposition, however, has yet to be investigated. Therefore, this study will fill this gap in the literature by investigating the degree to which CIT alexithymia is related to the working alliance with their clients.

*Five-factor model and alexithymia*

Numerous studies have identified alexithymia as being represented by a cluster of
traits from across the Five-Factor Model domains (Gustavsson, Jonsson, Linder, & Weinryb, 2002; Luminet et al., 1999; Luminet, Zech, Rime, & Wagner, 2000; Mann et al., 1994; 1995; Taylor, 1994; Taylor, Bagby, Parker, 1993; Wise et al., 1992). In one of the first studies to investigate the relationship between alexithymia and the Big Five, Wise et al. (1992) utilized the Toronto Alexithymia Scale (TAS; Taylor, Bagby, Ryan, & Parker, 1990) and NEO-FFI on a sample of psychiatric outpatients (N=114) and non-clinical volunteers (N=71). After controlling for depression, Wise et al. found that scores on the Neuroticism, Extraversion, and Openness domains significantly predicted TAS total scores for both sample populations.

In a study of convergent and discriminate validity of the TAS-20 and NEO Personality Inventory, Bagby, Taylor, and Parker (1994) revealed that TAS-20 scores were positively correlated with Neuroticism ($r = .27, p < .05$) and negatively correlated with Openness ($r = -.49, p < .01$). No significant correlations were observed with Extraversion, Agreeableness, and Conscientiousness. Mann et al. (1994), on the other hand, using the TAS and the NEO-FFI with a sample of 62 hospital staff volunteers, found significant correlations between alexithymia and all 5 of the Big Five domains. To differentiate levels of alexithymia in relation to NEO-FFI scores, Mann et al. categorized participant scores into low (scores of 49 or lower), medium (50-57), and high (58 or higher). Consistent with the alexithymia construct, results revealed that participants scoring high on the TAS (N=21) scored significantly higher on the Neuroticism domain, than did participants with low TAS scores (N=22). Also, low scores on the TAS were positively correlated with scores on Extraversion, Openness, Agreeableness, and Conscientiousness.
Mann et al., (1995) partially replicated the findings they obtained in their 1994 study. However, this study utilized a sample of 40 substance abusers, as compared to psychiatric patients used in the previous study, and a comparison group of 40 non-clinical "normal" volunteers. As in their 1994 study, the instruments used to assess alexithymia and personality consisted of the TAS and NEO-FFI, respectively. The volunteers’ TAS scores positively correlated with the Neuroticism domain scores \( (r = .50, p < .01) \), and negatively correlated with the Extraversion \( (r = -.55, p < .01) \), Openness \( (r = -.51, p < .01) \) and Agreeableness \( (r = -.41, p < .01) \) domain scores. Interestingly, TAS scores for the substance abusers were not significantly correlated with any of the five NEO-FFI domains.

As one can see from the aforementioned studies, results are varied regarding correlations between alexithymia and the various Big Five domains of personality. A level of agreement is building in the literature, however, regarding the correlations of the personality domains of Neuroticism, Extraversion, and Openness and the alexithymia scores on the TAS-20 (Luminet et al., 1999; Parker, Taylor, & Bagby, 1993; Taylor, 1994). Luminet et al. revealed that scores on the TAS-20 were positively correlated with Neuroticism \( (r = .38, p < .001) \), and negatively correlated with Extraversion \( (r = -.36, p < .001) \), and Openness \( (r = -.41, p < .001) \). Luminet et al. also conducted stepwise regression analyses predicting TAS-20 scores from NEO PI-R scores. This analysis revealed that scores on the Neuroticism \( (B = .38, p <.001) \), Extraversion \( (B = -.36, p <.001) \), and Openness \( (B = -.41, p <.001) \) domains significantly predicted TAS-20 scores. Taylor found similar results to those revealed by Luminet et al., but used the NEO Personality Inventory (NEO PI), the predecessor of the NEO PI-R, rather than the NEO
PI-R used by Luminet et al. Using a sample of 83 undergraduate students, Taylor revealed that TAS-20 scores correlated positively with Neuroticism domain scores \((r = .27, p < .05)\), and negatively correlated with Openness \((r = -.49, p < .01)\). Extraversion was negatively correlated with TAS-20 scores, although not at a significant level \((r = -.21)\).

Gustavsson and his colleagues recognized this association between the alexithymia construct and the Five-Factor Model and developed a personality inventory, the HP5i, which incorporates these two concepts (Gustavsson et al., 2002). The HP5i is a 20-item inventory (represented by the “i” in HP5i), which is applicable to health research (represented by the H), assesses personality traits (represented by the P), and corresponds with the Five-Factor Model (represented by the 5). Consistent with the theoretical assumptions of the alexithymia construct and Five-Factor Model, the HP5i investigates levels of personality that may “both be important predictors of health and treatment outcome, as well as a confounding or intervening variable blurring the association between treatment and outcome” (Gustavsson et al., 2002, p. 85). Gustavsson et al.’s argument that the Five-Factor Model’s domains of personality and alexithymia confound or intervene in treatment, and should therefore be assessed, has direct application to the present study. Expanding on Gustavsson et al.’s proposition, does a CITs’ personality and alexithymia facilitate, or confound, the working alliance, and ultimately the success in therapy? Gustavsson et al.’s proposition supports the present study’s contention that the personality domains of the Five-Factor Model and alexithymia may be important predictors of the working alliance, and therefore justifies further empirical investigation into the relationship between these three variables.
Family of Origin

*Intergenerational Family Systems Theory*

"It is likely that therapists' personal histories have some influence on the capacity to develop a good therapeutic alliance" (Horvath & Luborsky, 1993, p. 566).

Intergenerational family systems theory regards the FOO as one of the most important social groups in a person's history and development, and considerably influences their current functioning (Harvey & Bray, 1991). Bowen (1978) proposed that people continue to be influenced by their FOO long into their adult lives. Bowen further believed that mental health professionals are as vulnerable to the effects of their FOO dynamics as is the general population. Therefore, the FOO can have a considerable influence on the therapeutic process and, although not explicitly stated, the working alliance with clients. Other clinicians and authors have supported this proposition (Bordin, 1979; Framo, 1976; Henry & Strupp, 1994; Horvath, 2000; Orlinsky & Howard, 1986). For example, Winter and Aponte (1987, p. 97) stated, "A therapist brings to his [or her] work the heritage of his past family experiences and the effects of his current family functioning."

*FOO and CITs*

Researchers have investigated various aspects of CITs' FOO relationships that influence their clinical effectiveness, the therapeutic relationship, and the working alliance. Wittmer et al. (1973) conducted one of the earliest studies on FOO characteristics and counselor effectiveness. Wittmer et al. investigated the degree to which CITs' parent-child relationships impacted their clinical effectiveness. The perceived parent-child relationships of 40 CITs were assessed with the Parent-Child Relations Questionnaire (PCR; Roe & Siegelman, 1963). Clinical effectiveness was
measured by each of the CITs’ supervisors completing the Counselor Evaluation Rating Scale (CERS; Myrick & Kelly, 1971). Although no differences in scores on the PCR were found between less effective and the more effective CITs, gender differences were revealed. Females who were rated by supervisors as more effective perceived their fathers as significantly more rejecting, more neglectful, and less loving than did female CITs rated by supervisors as less effective. No significant differences were found among the females in regard to perceptions of their mothers. Male CITs, on the other hand, whom their supervisors rated as more effective perceived their mothers as significantly less over-protective, less rejecting, less demanding, and less neglectful than did males rated as less effective. As for male CITs perceptions of their fathers, the more effective male CITs perceived their fathers as significantly more strict and formal than did less effective males.

Wilcoxon et al. (1989) assessed the FOO experiences of 50 CITs through the use of the Family-of-Origin Scale (FOS; Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). CIT clinical skills were evaluated on the Gross Ratings of Facilitative Interpersonal Functioning Scale (GRFIFS; Carkuff, 1969). Results revealed a significantly negative correlation between the total FOS score and scores on the GRFIFS ($r = -.347; p < .05$). Wilcoxon et al.’s results suggested that CITs who perceived their FOO experiences as less healthy were perceived by their supervisors as having more advanced counseling skills. Wilcoxon et al. suggested that this relationship supports Rollo May’s (1985) notion of the wounded healer, in that “overcoming negative FOO experiences may positively affect facilitation skills of CITs” (Wilcoxon et al., p. 228).

Results revealed by Watts et al. (1995) also support the wounded healer concept.
Watts et al. revealed that more effective counselors perceived the interactions with their parents as less positive and healthy than did less effective counselors. The participants in Watts et al.'s study included 54 CITs enrolled in their final counseling practicum course. These CITs' FOO experiences were assessed with the use of the Perceived Early Childhood Family Influence Scale (PECFIS; Chandler & Willingham, 1986), and were evaluated for clinical effectiveness by their respective supervisors using the CERS.

Lawson et al. (1995) investigated the relationship between CITs' FOO experiences and aspects of the therapeutic process. Lawson et al.'s study, however, deviated from investigating general CIT clinical effectiveness to investigating more specifically the alliance between counselors and clients. Lawson et al. utilized a sample population of 67 CITs enrolled in their first counseling practicum course and 67 clients. Family dynamics were assessed by each CIT completing the Personal Authority in the Family System Questionnaire (PAFS-Q; Bray, Williamson, & Malone, 1984). Their supervisors rated them on attractiveness (i.e., the degree to which the supervisor finds the CIT to be likeable), expertise, and trustworthiness by using the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983). The therapeutic alliance between the CIT and their client was assessed by each CIT completing the Individual Therapeutic Alliance Scale (IAS; Pinsof & Catherall, 1986). Results revealed significant, positive correlations between scores on the PAFS-Q and scores on the CRF-S, suggesting that CITs who were rated more positively on the CRF-S perceived their interactions in their FOOs as more positive. Lawson et al., however, did not observe a significant correlation between the PAFS-Q and the IAS.

Lawson and Brossart (2003) continued this line of research on the FOO and the
alliance between the counselor and client, by conducting the only known investigation of CITs’ FOO characteristics in relation to the working alliance construct. Lawson and Brossart utilized 20 doctoral students enrolled in an advanced counseling practicum course, and 20 of their clients. The CITs’ FOO experiences were assessed by each CIT completing the following PAFS-Q scales (a) Intergenerational Fusion/Individuation, (b) Intergenerational Triangulation, and (c) Personal Authority. Working alliance was assessed by each client completing the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). CITs completed the PAFS-Q once within the first three weeks of therapy. Each client completed the WAI after the third, seventh, and final counseling session. This study revealed that CIT perceptions of their FOO were significant predictors of client responses to the WAI after both the third ($F = 3.50, p < .04$) and seventh ($F = 4.0, p = .026$) therapy sessions. These researchers concluded that CITs’ “ability to interact with parents in an intimate and individual manner (personal authority), while also feeling less autonomy (more fusion), was related to the client’s report of positive working alliance” (Lawson & Brossart, p. 390). Lawson and Brossart explain the counterintuitive finding regarding greater CIT fusion with parents was related to positive client working alliance evaluations by hypothesizing that fusion with the FOO may transcend into the therapeutic environment, potentially being perceived by the client as a strong alliance.

Although Lawson and Brossart’s (2003) study was highly innovative and contributed greatly to the extant literature on the contribution of counselors’ FOO characteristics to the working alliance, it possesses some methodological limitations that should be ameliorated in future research. The first limitation is the relatively small
(N=20) and restricted (doctoral students only) sample. Second, CIT perceptions of the working alliance were not assessed. Third, the scope of the study was restricted to relationships between the therapists and their parents. Interactions among and experiences with other family members were not included. Acknowledging some of these limitations, Lawson and Brossart recommended that future research incorporate larger and more diverse sample sizes, and that different CIT FOO characteristics be investigated as possible variables of influence in the working alliance. Research has yet to be conducted that addresses these methodological limitations and future research recommendations.

*Family Assessment Device*

A review of the literature was conducted by this researcher in order to identify a FOO assessment measure that would assess varied FOO dynamics. Based on this literature review, the Family Assessment Device (FAD; Epstein et al., 1983) was identified to be one of the most reliable, valid, and comprehensive assessment instruments of FOO characteristics (Byles, Byrne, Boyle, & Offord, 1988; Epstein et al., 1983; Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990; Miller, Epstein, Bishop, & Keitner, 1985; Sawin & Harrigan, 1995).

The FAD bases its assessment of family functioning on the McMaster Model of Family Functioning (MMFF; Epstein, Bishop, & Levin, 1978). The MMFF utilizes a General Systems Theory approach to describe the structure, organization, and patterns of interaction in the family unit (Epstein et al., 1978). The MMFF is one of the oldest and most researched family functioning projects and, as a result, has produced an assessment instrument of FOO characteristics based on a sound foundation of theory and supporting
literature (Sawin & Harrigan, 1995). The MMFF encompasses the following six dimensions of family functioning: (1) problem solving (i.e., the family's ability to resolve problems at a healthy and functional level); (2) communication (i.e., the degree to which the exchange of information among family members is clear and direct); (3) roles (i.e., patterns of behavior for emotional, developmental and physical support); (4) affective responsiveness (i.e., the extent to which individuals are able to experience contextually appropriate feelings); (5) affective involvement (i.e., the degree to which family members are interested in and care about activities and concerns in other family members' lives); and (6) behavior control (i.e., the way in which standards and expectations are expressed and maintained in the family regarding individual behavior) (Epstein et al.).

The FAD consists of a comprehensive measure of FOO characteristics by assessing six dimensions of family functioning consistent with the six dimensions of the MMFF. In addition to the six dimensions assessed, the FAD contains a seventh General Functioning Scale (FAD-GFS). The FAD-GFS provides a comprehensive, yet concise, summary of each of the FAD's six dimensions by which to evaluate the overall health/pathology of the family (Epstein et al., 1983). Because the FAD-GFS is a concise and efficiently administered inventory, as well as its strong standing in the research literature, it will be used in this study to assess CIT FOO functioning. Greater detail about the FAD-GFS will be provided in Chapter III.

*Emotional expressiveness in the FOO*

Emotional expressiveness in the FOO refers to the degree to which emotions and affect are communicated, either verbally or physically, within the family unit (Yelsma et al., 2000). Research has demonstrated that expressiveness in the FOO impacts the
emotional expressive tendencies and overall communication skills of children. Children’s emotional expressions were identified in one study as having been influenced by the emotional expressiveness exhibited by family members (Bornstein, Fitzgerald, Briones, Pieniadz, & D’Ari, 1993). More specifically, children from highly expressive families tend to have a greater range of emotional expressiveness and more developed communication skills than children from less expressive families (Hablerstadt, Fox, & Jones, 1993). It has been suggested that what we learn about emotional expression while growing up influences later adult functioning and interpersonal relationships (Booth-Butterfield & Booth-Butterfield, 1990; Bowen, 1978).

Although emotional expressiveness in the FOO has been postulated as influencing later adult functioning and interpersonal relationships, little is known about how this FOO characteristic influences the therapeutic process. Research has yet to investigate the relationship emotional expressiveness in a CITs’ FOO has with the working alliance they have with their clients.

Emotional expressiveness in the FOO and alexithymia

Levels of alexithymia may be considerably influenced by the degree to which emotional expression occurs in the FOO, or vice versa. As described above, emotional expressiveness in the FOO deals with the ability of family members to communicate their emotions with others. Similarly, alexithymia consists of an individual’s ability to identify and describe personal feelings. This researcher found only one study that has explicitly investigated alexithymia in relation to emotional expression in the FOO (Yelsma et al., 2000). Yelsma et al. utilized a sample of 295 undergraduate and graduate students who completed the TAS-20 and Family-of-Origin-Expressive Atmosphere Scale (FOEAS;
Yelsma et al.). Results revealed a significant, negative relationship between TAS-20 scores and scores on the FOEAS ($r = -0.44, p < .0001$). A further examination of the three factors of the TAS-20 also revealed that the ability to identify feelings ($r = -0.37, p < .0001$), the ability to describe feelings ($r = -0.42, p < .0001$), and externally oriented thinking ($r = -0.21, p < .0001$) were significantly correlated with scores on the FOEAS. These results would suggest that the degree of emotional expressiveness experienced within the FOO is inversely related to propensities for displaying alexithymia. Although Yelsma et al. revealed some interesting relationships between the FOO and alexithymia, research has yet to expand on these findings. Of particular interest to the present study, research has yet to investigate the relationship between emotional expressiveness in the FOO and alexithymia in CIT populations, and the relationship emotional expressiveness in the FOO has with the working alliance.

Conclusion

This review of the extant literature supports the hypothesis put forth in the present study that personality traits and FOO characteristics influence CITs' ability to initiate and maintain a healthy and productive working alliance with their clients. The degree to which personality traits and FOO characteristics influence the working alliance is, however, primarily theoretical. Little research has been done to support this relationship.

While the literature is extensive regarding the Big Five personality traits of Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness, it is sparse in relation to CITs and the working alliance. Similarly, literature is extensive regarding the personality trait of alexithymia, however, it is tenuous in relation to CITs and the working alliance. Because of their theoretical association with the working alliance, the
Big Five personality domains and alexithymia were chosen for inclusion in this study.

In regard to the FOO, extensive literature is available discussing the influence of CITs' FOO characteristics on the therapeutic process. There is a paucity of literature, however, assessing the CITs' relationship between FOO characteristics and the working alliance with their clients. Because of the extensive amount of research supporting the validity, reliability and efficiency of the FAD-GFS, it was included as a FOO assessment instrument for this study. Literature has also theorized that emotional expressiveness within the FOO may influence CITs' ability to effectively interact with their clients. Therefore, the FOEAS was chosen for this study to assess the expressive atmosphere in the CITs' FOO.

By investigating the degree to which the above mentioned CIT variables are associated with the working alliance, this study may not only contribute to the extant literature, but also contribute to the body of knowledge applicable to the selection, education, and training of future CITs and mental health professionals.
CHAPTER III
METHODOLOGY AND DESIGN

Introduction

The present study was designed to identify counselor-in-training (CIT) personality traits and family-of-origin (FOO) characteristics that would significantly predict and correlate with CIT evaluations of the working alliance. This study was also designed to identify CIT personality traits and FOO characteristics that would significantly predict and correlate with client evaluations of the working alliance.

Statistical Analyses

This analytical variable study utilized stepwise multiple regression and correlational analyses. Stepwise regression procedures were chosen for use with analyses utilizing more than one predictor variable (e.g., the 5 NEO-FFI domains) to answer the question “What CIT personality traits contribute to the working alliance?” and “What is the order of influence these CIT variables have on the working alliance?” Due to the present study being the first known investigation to assess CIT personality traits and FOO characteristics concurrently with the working alliance, an a priori determination of the order at which the variables significantly contribute to the working alliance could not be determined. Therefore, a stepwise regression was utilized, rather than a hierarchical regression analysis. For analyses utilizing one predictor variable (e.g., Alexithymia) and one criterion variable, correlational analyses were used. Data was analyzed with a SPSS statistical package.

The criterion variable for this study consisted of the working alliance, as measured by the Working Alliance Inventory - Short Form (WAI-S; Tracey &
Kokotovic, 1989). CIT perceptions of the working alliance were assessed with the CIT WAI-S (Appendix A), while client perceptions of the working alliance were assessed with the Client WAI-S (Appendix B). Personality traits and FOO characteristics of CITs consisted of the eight predictor variables. The six personality variables consisted of: (1) Neuroticism, (2) Extraversion, (3) Openness, (4) Agreeableness, and (5) Conscientiousness, as measured by the NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992), and (6) Alexithymia, as measured by the twenty-item Toronto Alexithymia Scale (TAS-20; Taylor, 1994; Appendix C). The two predictor variables assessing FOO characteristics consisted of: (7) general family functioning in the FOO, as measured by the Family Assessment Device - General Functioning Scale (FAD-GFS; Epstein et al., 1983; Appendix D), and (8) emotional expressiveness within the FOO, as measured by the Family-of-Origin Expressive Atmosphere Scale (FOEAS; Yelsma et al., 2000; Appendix E).

Procedures

Power analysis

The sample size for this study was determined using variances ($R^2$) reported by Lawson and Brossart (2003; $R^2 = .40$) and Softas-Nall, Baldo, and Williams (2001; $R^2 = .42$). Based on these variance scores, alpha equal to .05, and power equal to .80, a sample size of 16 is recommended (Jaccard & Becker, 1997).

Data collection process

Locations of data collection.

In order to obtain a widely representative sample population of CITs and clients, three different data collection sites were used. The first two locations consisted of two
Western Michigan University (WMU) counseling centers, located in Kalamazoo and Grand Rapids, Michigan. Clients within the Kalamazoo counseling center consist primarily of community referrals and WMU students, while the client base for the Grand Rapids center consists primarily of community referrals and court mandated clients. The third location for data collection consisted of the University Counseling Center located at the University of Missouri-Kansas City (UMKC), in Kansas City, Missouri. Clients within the UMKC Counseling Center consist entirely of UMKC students, staff and faculty.

*CIT participation.*

The study was introduced to potential CIT participants by the student researcher reading the CIT informed consent, which was approved by WMU and UMKC’s respective Human Subject Institutional Review Board prior to participant recruitment (Appendix F and G, respectively). The informed consents for WMU and UMKC can be viewed in Appendix H and I, respectively. During the reading of the informed consent, CIT participants were encouraged to complete the sociodemographic form (Appendix J), NEO-FFI, TAS-20, FOEAS, and FAD-GFS some time during the day in which the study was introduced. In accordance with previous research (Dunkle & Friedlander, 1996; Lawson et al., 2003; Ligiero et al., 2002; Satterfield & Lyddon, 1995), CITs were instructed to complete the CIT WAI-S anytime after conclusion of the third through 7th counseling session with their client. For example, after the 4th counseling session, a participating CIT would complete the CIT WAI-S in response to their interactions with that particular client. There was no predetermined minimum or maximum number of clients that could participate in this study. CITs were instructed that they could complete
the CIT WAI-S on individual clients, couples, or family units. In regard to relational
counseling (couple and family), participating CITs were instructed to complete separate
CIT WAI-S forms for each person, given that they were 18 years of age or older.

Client participation.

To measure the working alliance from both sides of the relationship, participating
CITs were instructed to invite the clients for which the CIT completed the CIT WAI-S on
to also evaluate the working alliance. For example, after the 4th counseling session the
CIT completes the CIT WAI-S on client X. This CIT will then invite that client to also
evaluate the working alliance. The CIT was instructed to invite the respective client to
participate in this study by giving the client a copy of the informed consent directed
toward client participants (Appendix K and L), and reading it aloud to them. CITs also
gave prospective client participants a one-page client demographic questionnaire
(Appendix M), the Client WAI-S, and a blank envelope to return the materials in. This
consent form outlined the intentions of the study, the voluntary nature of participation in
the study, and the process by which clients will remain anonymous.

CIT and client protection and anonymity

CITs and clients were asked to refrain from putting any identifying information
on the assessment materials (e.g., name, address, phone number, social security number).
For purposes of organization, a three-digit code number was placed on all assessment
instruments. To maintain the anonymity of CIT participation, all CITs were given a
packet of materials, regardless of the intention to participate. CITs were asked to seal the
completed, or non-completed, battery in the envelope provided by the researcher and
deposit the packet in the designated receptacle for materials for this study.
Similar to the process for CITs, client anonymity was maintained by requesting them to refrain from putting any identifying information on the assessment materials. Regardless of participation, clients were asked to seal their demographic questionnaire and Client WAI-S in the envelope provided by this research, and deposit the envelope in the receptacle designated for this study. All materials were stored in a locked file cabinet in this researcher's office, and will be maintained for a minimum of three years, after which all raw data will be destroyed.

Sample

The sample population of CITs used for this study consisted of masters and doctoral level students in counselor education and counseling psychology at WMU and UMKC. Masters level CITs in marriage and family therapy (MFT) at WMU were also included in this sample. At the time of data collection, each CIT was enrolled in their respective counseling practicum course. Prior to collecting data, permission to request CIT participants was granted from each of the respective training center directors.

CIT participants

Eighty-three CITs were invited to participate, of which 34 returned fully completed batteries, resulting in a response rate of 41%. After excluding one outlier from the data set, 33 CIT participants made up the population for this study. The outlier excluded from this data set is discussed in greater detail on page 65 of this manuscript. Of these 33 participating CITs, 27 were female and 6 were male. Ages ranged from 22 to 52, with a mean age of 31 and mode age of 24. In regard to marital status, 16 were married, 10 were single, 3 were divorced, 3 had a live-in-partner, and 1 did not specify. This sample included 26 European/Caucasian, 3 African American, 1 Asian/Pacific, and 1
Latino(a)/Hispanic participants. One participant indicated that their ethnicity was “other,” reporting that they were bi-racial: African American and Korean. One participant did not specify their ethnicity. Fifteen participants reported that their biological parents remain married, 14 reported that their parents are divorced, while 3 indicated “Other.” All CITs reporting “Other” specified that their father was deceased. Of the 14 individuals who indicated that their parents were divorced, the age at which they divorced ranged from 1 to 27 years of age (mean = 13.5 years). One CIT participant did not specify parental marital status. The program of study in which the CITs indicated being enrolled in at the time of the study included 9 CITs in a doctoral level counseling psychology program, 7 in a masters level community counseling program, 5 in a masters level school counseling program, 6 in a masters level counseling psychology program, 2 in a masters level marriage and family therapy program, 2 in a doctoral level counselor education and supervision program, and 1 in a masters level student affairs program. One participant did not identify their program of study. CIT clinical experience ranged from 10 CITs reporting “none,” 1 reporting “under 6 months,” 4 reporting “6 months – under 1 year,” 9 reporting “1-2 years,” 4 reporting “3-5 years,” 2 reporting “6-8 years,” and 2 reporting “9 + years.” One CIT did not report her clinical experience.

Client participants

Due to the inability to identify how many clients each CIT invited to participate, the response rate of client participation is unknown. Sixty-four clients returned fully completed forms. The number of clients seen by each CIT ranged from 1 to 13, ultimately producing 64 CIT-client dyads. In order to meet the independency assumption for multiple regression, this researcher randomly selected one dyad pair from those CITs.
who had multiple clients, reducing the N to 34. The final N was further reduced to 33 after one outlier was excluded from the data set.

The 33 clients included in this study consisted of 23 females and 10 males. Ages ranged from 18 to 48, with a mean age of 28 and a mode age of 22. Nineteen clients were single, 9 were married, 2 were divorced, 2 had live-in-partners, while 1 indicated "other" without specifying. Twenty-eight of these clients classified themselves as European/Caucasian, 2 were African American, 1 was Asian/Pacific, 1 was Native American, and 1 did not specify. The highest level or grade of education for this sample of clients consisted of 5 completing high school, 4 Freshmen in college, 3 Sophomores, 5 Juniors, 11 Seniors, and 5 enrolled in a masters degree program. Seventeen clients indicated that they had received counseling prior to the mental health services they were currently receiving from their respective CIT, while 16 clients reported that this current counseling experience was their first. Of the 17 clients who reported receiving previous counseling services, 3 reported working with 1 counselor, 6 reported working with 2 different counselors, 3 reported working with 3 different counselors, 2 reported working with 4 different counselors, and 3 reported working with 6 different counselors before this current counseling experience. The number of sessions each CIT had with their clients at the time this battery was completed ranged from 3 to 7, with a mean of 4.67, and a median and mode of 4.

Instruments

*Working Alliance Inventory - Short*

The Working Alliance Inventory - Short (WAI-S; Appendix A and B) was chosen for this study as the measure of working alliance for the following reasons: (a) the 12-
item WAI-S was derived through a factor analysis from one of the most researched and utilized measures of working alliance (Busseri & Tyler, 2003; Martin et al., 2000); (b) it has been shown to be significantly similar to its 36-item predecessor (Busseri & Tyler; Tracey & Kokotovic, 1989); (c) total and subscale scores it provides have been found to have greater reliability than its 36-item predecessor (Hanson et al., 2002); (d) has been identified as the “most popular measure of working alliance available” (Hanson et al., pg. 660); and (e) because the WAI-S is a public domain instrument, making it easily accessible by researchers and clinicians.

The WAI-S was developed by Tracey and Kokotovic (1989) from a factor analysis of the original Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The WAI-S consists of 12 items, each of which is responded to by using a 7-point Likert scale (1 = never, and 7 = always). The total score for the WAI-S ranges from 12 (low working alliance) to 84 (high working alliance). The WAI-S assesses one general scale (General Alliance or Total) and 3 subscales. The three subscales include the Tasks performed in therapy (i.e., the extent to which a counselor and client agree on what is occurring during the counseling process – interventions used); the therapeutic Bond (i.e., the extent to which a counselor and client possess a bond or therapeutic relationship); and the goals sought out for therapy (i.e. the extent to which a counselor and client agree on the Goals or outcome of the therapy). Although the WAI-S can identify three working alliance subscales (Goals, Bond and Tasks), in addition to the overall working alliance, research has revealed that these three subscales do not measure unique components of the working alliance (Horvath & Greenberg, 1989; Mallinckrodt & Nelson, 1991; Tracey & Kokotovic). Rather, research has found that the three WAI-S subscales are highly
correlated, therefore measuring essentially the same construct. Therefore, only the WAI-S total score will be used in this study. The WAI-S can be used with clients and counselors through parallel versions of the scale. In order to assess the working alliance from the CIT’s and client’s perspective, the CIT version of the WAI-S (CIT WAI-S) and client version of the WAI-S (Client WAI-S), respectively, were used in this study.

Reliability.

Research on the reliability for the WAI-S has been conducted in several studies. Researchers have revealed Cronbach alpha coefficients of .91, .95, and .90 for the total CIT WAI-S (Busseri & Tyler, 2003; Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002). Client WAI-S Cronbach alpha coefficients of .91, .94, and .98 have also been reported (Busseri & Tyler; Dunkle & Friedlander; Tracey & Kokotovic, 1989).

Of more significance perhaps are the reliability findings obtained from a reliability generalization analysis conducted by Hanson et al. (2002). Hanson et al. used meta-analytic methods to examine the reliability generalization for the WAI-S. Hanson et al. explained that alpha reliabilities are different from generalized reliability in that individual alpha reliability scores are indicative of only that specific study and with that sample from which they were derived. In other words, a test is neither reliable nor unreliable. Rather, reliability is a function of the scores on a test for a particular group of examinees (Crocker & Algina, 1986). The process of reliability generalization identifies the mean measurement error across studies, providing an evaluation of the “robustness of a given test’s score reliability” (Hanson et al., p. 661). Hanson et al. concluded that the reliability for the WAI-S is “uniformly high,” “varied only minimally across different samples,” and that it is “relatively stable” (Hanson et al., p. 668). Specifically, Hanson et
al. found that the total score for the CIT version of the WAI-S had an average reliability of .92, while the total score for the client version had an average reliability of .97.

**Validity.**

Research has also supported the validity of the WAI-S. First, consistent with the theoretical assumptions that the working alliance influences therapy outcome, the WAI-S has been identified as being able to predict therapy effectiveness. For example, Busseri and Tyler (2003) revealed correlations of .42 and .34 (p < .01) between scores on the Post Therapy Questionnaire, a scale assessing therapy effectiveness (Mintz, Luborsky, & Christoph, 1979), and total scores from the CIT and Client versions of the WAI-S.

Convergent and construct validity for the WAI-S have also been reported. In regard to convergent validity, Parish and Eagle (2003), as well as Ligiero and Gelso (2002), revealed that scores obtained from the WAI-S significantly correlated with scores from several, similar measures of attachment and the therapeutic relationship. In regard to construct validity, the full-scale WAI, the measure from which items for the WAI-S were derived, was originally developed using expert raters in the field of working alliance and multitrait-multimethod analyses (Horvath & Greenberg, 1989). Based on the WAI-S being derived through factor analysis from the WAI, and on the validated finding that it assesses the same construct, one can postulate that the construct validity held by the WAI can also apply to the WAI-S.

**NEO Five-Factor Inventory**

The NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992) is a copyrighted instrument, published by Psychological Assessment Resources, Inc., and permission was not received to include it in the Appendices of this study. The NEO-FFI
was chosen as one of the measures of CIT personality in this study due to its (a) extensive research base and widespread use as an assessment measure of personality, (b) being developed through a process that makes it appropriate for ‘normal,’ non-clinical sample populations, and (c) being a psychometrically validated and reliable 60-item alternative to the 240-item NEO Personality Inventory-Revised (NEO PI-R; Costa & McCrae, 1992).

Research on the NEO PI-R and NEO-FFI has been documented extensively within the research literature. Well over 200 studies have been conducted that have either assessed the validity and reliability of the NEO PI-R or NEO-FFI, or utilized them to assess personality traits (Costa & McCrae, 1992).

The NEO-FFI was developed with the intention of being the short form for the NEO Personality Inventory (NEO PI), and the more recent NEO PI-R (Costa & McCrae, 2003). It was constructed through a validimax factor analysis of the NEO PI, an instrument based on the theoretical assumptions proposed by the Five Factor Model of personality (Costa & McCrae, 2003). Constructs for the NEO PI were originally derived from literally “thousands of words… used to describe individuals and hundreds of psychological constructs” (Costa & McCrae, 1992, p. 39). Consistent with the Five Factor Model, Costa and McCrae (1992, p. 39) identified a “great deal of redundancy in personality descriptors.” From this extensive collection of descriptors and psychological constructs, a factor analysis was conducted, resulting in five general factors that represent the breadth of individual personality traits. These five factors or domains consist of Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness. The NEO-FFI measures these 5 domains of personality utilizing a total of 60 items, with 12 items assessing each domain. A 5-point Likert-scale ranging from 1 (strongly disagree) to 5
(strongly agree) is used to respond to each item. T scores for each domain can be gender specific (Male or Female categories) or Combined into a non-gender specific category. CIT NEO-FFI score obtained in this study will utilize the Combined T score categorization. Despite the categorization schema, T scores range from Very Low ($\geq 25 - 34$), Low (35 - 44), Average (45 - 55), High (56 - 65) to Very High (66 - $\geq 75$).

Reliability.

Internal consistency for the NEO-FFI has been empirically examined. Utilizing a sample population of 1,539, Costa and McCrae (1992) identified internal consistency coefficients of .86 for Neuroticism; .77 for Extraversion; .73 for Openness; .68 for Agreeableness; and .81 for Conscientiousness. According to Briggs and Creek (1986), coefficients around .4 indicate good internal consistency for personality scales, therefore strongly supporting the internal consistency for the five NEO-FFI domains. Alpha coefficients derived from other studies for the NEO-FFI are provided in Table 1.

Table 1

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Neuroticism</td>
<td>.90</td>
<td>.86</td>
<td>.83</td>
</tr>
<tr>
<td>Extraversion</td>
<td>.78</td>
<td>.79</td>
<td>.73</td>
</tr>
<tr>
<td>Openness</td>
<td>.76</td>
<td>.72</td>
<td>.63</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.86</td>
<td>.76</td>
<td>.77</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>.90</td>
<td>.86</td>
<td>.90</td>
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</table>
Similar to the reliability generalization analysis conducted on the WAI-S discussed previously, the reliability of the NEO-FFI also has been investigated using this meta-analytic method. In a review of 51 articles, Caruso (2000) revealed that scores derived from the five domains have relatively high reliability coefficients and low standard deviations. This would suggest that the five domains of personality assessed by the NEO-FFI are relatively consistent and reliable in gauging their specific personality constructs. Table 2 provides the reliability coefficient means and standard deviations for each of the five domains revealed by Caruso. As expected, by differentiating between the three versions of the NEO (NEO PI-R = 240 items; NEO PI = 181 items, and NEO-FFI = 60 items), Caruso observed that the reliability scores for the NEO-FFI were less than those found in the longer versions of the inventory. However, Caruso used an analysis of variance (ANOVA) to answer the question “Would the NEO version differ with respect to score reliability if they were all the length of the NEO PI-R?” (Caruso, p. 246). Results of this analysis showed that when the length of the instrument was controlled, the NEO-FFI provided the highest score reliability of all three of the NEO inventories, indicating that the reliability is a function of scale length, not item characteristics. Caruso further concluded that it is of little surprise that the NEO-FFI would produce scores with the highest reliability, given that it was developed from a factor analysis in which only the best items of the NEO PI were selected for inclusion. Means and standard deviations corrected for scale length are also provided in Table 2.
Table 2
Mean Reliability Coefficients and Standard Deviations for the NEO-FFI (Caruso, 2000)

<table>
<thead>
<tr>
<th>Statistic</th>
<th>N</th>
<th>E</th>
<th>O</th>
<th>A</th>
<th>C</th>
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</thead>
<tbody>
<tr>
<td>Mean</td>
<td>.83</td>
<td>.75</td>
<td>.65</td>
<td>.67</td>
<td>.80</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.06</td>
<td>.07</td>
<td>.12</td>
<td>.08</td>
<td>.06</td>
</tr>
<tr>
<td>Corrected Mean</td>
<td>.95</td>
<td>.92</td>
<td>.88</td>
<td>.89</td>
<td>.94</td>
</tr>
<tr>
<td>Corrected SD</td>
<td>.02</td>
<td>.03</td>
<td>.08</td>
<td>.07</td>
<td>.02</td>
</tr>
</tbody>
</table>

Caruso (2000) also provides a generalized test-retest reliability coefficient for the NEO-FFI. Based on four studies that conducted test-retest reliability analyses, Caruso found that the average of these coefficients was .82 for Neuroticism, .81 for Extraversion, .78 for Openness, .58 for Agreeableness, and .76 for Conscientiousness.

Validity.

Research has established the NEO-FFI as a valid personality assessment inventory. In regard to convergent validity, domain scores from the NEO-FFI were correlated with the domain scores from the NEO PI-R revealed Pearson correlations of .92 for Neuroticism; .90 for Extraversion; .91 for Openness; .77 for Agreeableness; and .87 for Conscientiousness (Costa & McCrae, 1992). Construct validity for the NEO-FFI has also been established in the research literature. The five domains of the NEO-FFI have significantly correlated with different personality scales that assess similar personality constructs. For example, Costa and McCrae (1986) found that the Neuroticism and Extraversion domains of the NEO-FFI strongly correlated with the Neuroticism and Extraversion scales of the Eysenck Personality Inventory (Eysenck & Eysenck, 1964). Similarly, scores from the California Q-set (Block, 1961) and Hogan...
Personality Inventory (Hogan, 1986), two instruments utilizing the five-factor model, have been found to correlate with scores from the five domains of the NEO-FFI (Goldberg, 1990; McCrae, Costa, & Busch, 1986).

Twenty-Item Toronto Alexithymia Scale

In order to adequately describe the twenty-item Toronto Alexithymia Scale (TAS-20; Bagby, Parker et al., 1994; Appendix E), its development and brief history must first be discussed. The original TAS was developed by Taylor et al. (1985) using a rational and empirical scale construction strategy. Based on existing literature on the alexithymia construct, Taylor and his colleagues developed a five-factor structure. These factors consisted of (1) difficulty describing feelings, (2) difficulty distinguishing between emotions and body sensations, (3) lack of introspection, (4) social conformity, and (5) limited fantasy life and dream recall (Taylor, Bagby, Ryan, & Parker, 1990). This initial version of the TAS showed good internal consistency and test-retest reliability (Taylor et al., 1990), as well as construct validity (Bagby, Taylor, & Parker, 1988; Taylor, Parker, & Bagby, 1990). Subsequent factor analytic strategies, however, revealed that “social conformity, difficulty recalling dreams, and a tendency to action instead of reflection did not emerge as essential facets of the construct” (Taylor, 1994, p. 65).

Acknowledging this limitation of the facets describing the alexithymia construct used for the TAS, Taylor and his colleagues re-examined and revised the TAS, resulting in the Revised Toronto Alexithymia Scale (TAS-R; Taylor, Bagby, & Parker, 1992). A two-factor model emerged as the dominant model for the TAS-R, congruent with the major constructs of alexithymia: difficulty identifying and expressing feelings. However, subsequent analyses of the factor structure again failed to support this proposed two-
factor structure (Taylor, 1994). Rather, a three-factor structure consistently resulted as the better model, which led to the development of the most recent version of the TAS-20.

The TAS-20 assesses alexithymia and its three sub-factors: (1) difficulty identifying feelings; (2) difficulty describing feelings; and (3) externally-oriented thinking. Respondents use the 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree), to respond to each item on the TAS-20. The present study will utilize the TAS-20 total score to assess for alexithymia. Total scores for the TAS-20 range from 20 to 100, with higher scores indicating higher levels of alexithymia. (Bagby, Parker et al., 1994).

Reliability.

Research has demonstrated high reliability coefficients for the TAS-20. Alpha coefficients of .81 (Bagby, Parker et al., 1994), .79 (Krueger, 1997), and .78 (Martinez-Sanchez, 2003) have been reported for the TAS-20. Kooiman, Spinhoven and Trijsburg (2002) computed alpha reliability coefficients for male and female psychiatric outpatients, and revealed that male psychiatric patients had an alpha of .79, while females had an alpha of .82. Kooiman et al. (2002) also computed alpha coefficients for non-clinical students, and found that non-clinical males had an alpha of .82, while non-clinical females had a alpha of .81. Test-retest reliability coefficients of .77 (1 week; Bagby, Parker et al.), .71 (19 weeks; Martinez-Sanchez), and .74 (3 months; Kooiman et al., 2002) have also been reported.

Validity.

Consensual and concurrent validity have been documented for the TAS-20. Bagby, Taylor, et al., (1994) examined the relationship between TAS-20 scores with
alexithymia ratings by external observers using the Beth Israel Hospital Psychosomatic Questionnaire (BIQ; Sifneos, 1973). Taylor (1994) states that “The findings of strong positive correlations between the TAS-20 and the total BIQ... provides compelling evidence for the concurrent validity of the TAS-20 and the consensual validity of the alexithymia construct” (p. 67). Concurrent validity of the TAS-20 also has been supported by research revealing considerable overlap between scores on the TAS-20 and scores on the Neuroticism domain of the NEO PI-R (Bagby, Taylor et al., 1994; Luminet et al., 1999).

The TAS-20 has solid documentation of its sound reliability and validity, and has been identified as the most widely used measure of the alexithymia construct (Taylor et al., 1997). Therefore, inclusion of the TAS-20 as the means by which this study will assess levels of alexithymia in CITs is justified.

**Family Assessment Device-General Functioning Scale**

The 12-items of the McMaster Family Assessment Device-General Functioning Scale (FAD-GFS; Epstein et al., 1983; Appendix D) were originally written for the 6 FAD scales, however, correlated so highly with other scales that they were removed from their original scale to create the FAD-GFS. One item came from the Problem Solving scale, 4 from the Communication scale, 2 from the Roles scale, 1 from the Affective Responsiveness scale, 3 from the Affective Involvement scale, and 1 from the Behavioral Control scale. The FAD-GFS has been found to be a reliable alternative to the full-scale, 60 item FAD (Byles et al., 1988; Kabacoff et al., 1990; Ridenour, Daley, & Reich, 1999; Sawin & Harrigan, 1995), and provides a reliable and concise summary of the 6 FAD scales (i.e. problem solving, communication, roles, affective responsiveness, affective...
involvement, and behavioral control). The FAD-GFS utilizes a 4-point Likert scale, ranging from 1 (strongly agree) to 4 (strongly disagree). Total scores are divided by 12, and therefore range from 1.0 to 4.0, with higher scores indicating greater family pathology and dysfunction. A cutoff point of 2.0 has been established to differentiate between healthy and unhealthy family functioning (Miller et al., 1985).

**Reliability.**

The FAD-GFS has demonstrated sound internal consistency reliability. Alpha coefficients of .92 (Epstein et al., 1983), .86 (Byles et al., 1988), and .83 (Kabacoff et al., 1990) have been reported. FAD-GFS scores have also been found to be relatively stable, as observed by a one-week interval, test-retest reliability coefficient of .71 (Miller et al., 1985).

**Validity.**

Considerable amounts of research conducted on the FAD-GFS support its predictive and construct validity (Byles et al., 1988; Kabacoff et al., 1990), as well as its concurrent (Miller et al., 1985) and convergent validity, when compared with other, similar family assessment instruments (Fristad, 1989; Hinde & Akistar, 1995). Sawyer, Sarris, Baghurst, Cross, and Kalucy (1988) have also supported the FAD-GFS's discriminative validity by differentiating between clinical families and non-clinical families, and families with and without a psychiatric patient as a family member.

**Family-of-Origin Expressive Atmosphere Scale**

To adequately describe The Family-of-Origin Expressive Atmosphere Scale (FOEAS; Yelsma et al., 2000; Appendix E) a brief discussion of its history and evolution will be provided. The Family-of-Origin Scale (FOS; Hovestadt et al., 1985), the
FOEAS's predecessor, was developed to "measure the perceived levels of autonomy and intimacy in one's family of origin" (p. 288). The FOS, in addition to assessing two primary constructs (autonomy and intimacy), renders a total score that indicates the respondents' general perceptions of functional health within their FOO. Hovestadt et al. reported adequate test-retest reliability ($r = .97, p < .001$) over a two-week interval, internal consistency ($a = .75$), and concurrent validity. After considerable research and scholarly debate was conducted on the factor structure of the FOS, it was concluded that the FOS assessed only one concept, rather than the two initially proposed (Gavin & Wamboldt, 1992; Kline & Newman, 1994; Lee, Gordon, & O'Dell, 1989; Mazer, Mangrum, Hovestadt, & Brashear, 1990; Saunders, Schudy, Searight, Russo, Rogers, et al., 1994). In response to these findings, Yelsma et al., through a process of factor analysis of the FOS, developed the unidimensional FOEAS, which measures the "individual's perceived level of expressive atmosphere in his/her family-of-origin" (Yelsma et al., p. 357).

The FOEAS assesses perceived emotional expressiveness within the FOO with 22 items, utilizing a 5-point Likert scale ranging from 1 (Strongly Agree) to 5 (Strongly Disagree). Total scores range from 22 (low emotional expressiveness) to 110 (high emotional expressiveness).

Reliability and validity.

Research indicates that scores on the FOEAS have adequate internal consistency ($a = .97$) and a Guttman split-half alpha reliability of .94 (Yelsma et al., 2000). Based on the strong internal consistency, split-half reliability, and factorial validity, Yelsma et al. suggest that the FOEAS is appropriate for empirical research.
CIT and client sociodemographic form

The CIT and client sociodemographic forms (Appendix H and K) was developed by this researcher to obtain CIT demographic information, type and level of training, and amount of clinical experience.

Hypotheses

1a-e. CIT (a) Neuroticism, (b) Extraversion, (c) Openness, (d) Agreeableness, and (e) Conscientiousness, measured by the NEO-FFI, either in combination with each other or alone, will predict CIT perceptions of the working alliance, measured by the CIT WAI-S.

2a-e. CIT (a) Neuroticism, (b) Extraversion, (c) Openness, (d) Agreeableness, and (e) Conscientiousness, measured by the NEO-FFI, either in combination with each other or alone, will predict client perceptions of the working alliance, measured by the Client WAI-S.

3. CIT alexithymia, measured by the TAS-20, will significantly correlate with CIT perceptions of the working alliance, measured by the CIT WAI-S.

4. CIT alexithymia, measured by the TAS-20, will significantly correlate with client perceptions of the working alliance, measured by the Client WAI-S.

5. CIT perceptions of the general function within their FOO, as measured by the FAD-GFS, will significantly correlate with CIT perceptions of the working alliance, measured by the CIT WAI-S.

6. CIT perceptions of the general function within their FOO, as measured by the FAD-GFS, will significantly correlate with client perceptions of the working alliance, measured by the Client WAI-S.
7. CIT perceptions of the emotional expressiveness within their FOO, as measured by the FOEAS, will significantly correlate with CIT perceptions of the working alliance, measured by the CIT WAI-S.

8. CIT perceptions of the emotional expressiveness within their FOO, as measured by the FOEAS, will significantly correlate with client perceptions of the working alliance, measured by the Client WAI-S.

Limitations

A few limitations must be considered regarding the methodology used in this study. First, this study was based exclusively on the self-reports of its participants. Given the sufficient reliability and validity of the instruments chosen for this study, the degree of measurement error contingent on the nature of the instruments is foreseen to be no greater than in other studies using self-report measures. Second, the racial/ethnic demographics of the student population on which this study was based may be considered an additional limitation of this study. The sample population used in this study were derived from university programs that were comprised largely of students from Caucasian descent. Therefore, generalizations of results received may be most appropriate for students from racial/ethnic backgrounds similar to those in this study. The third limitation of this study may be that participants were made up entirely of counselors-in-training. Although this demographic was the predetermined intention for this study, results gleaned from this population may not generalize to the larger population of more experienced and licensed mental health professionals. The last observable limitation of this methodology is in regard to the process used for selecting CIT-client dyads. In order to minimize the possibility for CITs to choose their “best”
client, and therefore biasing the data, CITs were allowed to invite multiple clients to participate in this study. From these multiple clients, one client was randomly selected to be associated with their respective CIT. Although the random selection of one client was conducted to meet the independence assumption for multiple regression, this process resulted in many client data (N = 30) not being analyzed.
CHAPTER IV

RESULTS

The present study was designed to identify selected variables that would predict counselors-in-training (CITs) and client perceptions of the working alliance. The working alliance between the CIT and client, measured by the Working Alliance Inventory – Short (WAI-S; Tracey & Kokotovic, 1989), was the criterion variable used in this study. Both CIT and client evaluations of the working alliance were assessed using the CIT version of the WAI-S (CIT WAI-S; Tracey & Kokotovic) and client version of the WAI-S (Client WAI-S; Tracey & Kokotovic), respectively. Six personality variables and two family-of-origin (FOO) variables made up the eight predictor variables used in this study. The six CIT personality variables were: (1) Neuroticism, (2) Extraversion, (3) Openness, (4) Agreeableness, (5) Conscientiousness, measured by the NEO-Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992), and (6) alexithymia, measured by the Twenty-Item Toronto Alexithymia Scale (TAS-20; Bagby, Parker et al., 1994). The two CIT FOO predictor variables were: (1) general family functioning in the FOO, measured by the McMaster Family Assessment Device – General Functioning Scale (FAD-GFS; Epstein et al., 1983), and (2) emotional expression within the FOO, measured by the Family-of-Origin Expressive Atmosphere Scale (FOEAS; Yelsma et al., 2000).

SPSS software was used to conduct all statistical analyses in this study. T-tests were conducted between male and female CIT mean scores on the criterion and predictor variables, revealing no significant gender differences on any of the variables. Therefore, male and female CIT scores were combined for the following analyses.
Multiple regression assumptions

Before the main analyses were conducted, the data was checked for the following assumptions: Multicolinearity, independence, linearity, normality, and outliers.

Multicolinearity.

Multicolinearity exists when predictor variables are highly correlated with each other (r ≥ .70; Tabachnick & Fidell, 1996). An inspection of the intercorrelations of predictor variables in the present study revealed that two variables had correlations higher than .70 recommended by Tabachnick and Fidell. Not surprisingly, the relationship between the FOO measures (FAD-GFS and FOEAS) was highly correlated (r = -.92). Due to the scoring method used for each of these FOO measures, the inverse relationship is expected. This would suggest that the FAD-GFS and the FOEAS measure essentially the same construct. However, both FOO scales were retained in this study for purposes of comparison between an instrument which has received a considerable amount of empirical support (i.e., FAD-GFS) and the FOEAS.

Independence.

The independence assumption dictates that each participant or observation in a data set must be independent from each other. Recalling that the initial data set in this study consisted of 34 CITs and 64 clients, some CITs were associated with multiple clients. Including one CIT's information and responses in the data set multiple times violates the independence assumption for multiple regression. For example, if CIT A saw four clients, the CIT's personality traits and FOO characteristics would be included in the data set four times in order to correspond with each of their four clients. By including a CIT's personality traits and FOO characteristics in the data set four times, the...
independence assumption is violated. In order to satisfy this critical assumption, one pair of CIT and Client WAI-S scores was randomly selected. Therefore, for CITs who had multiple clients, one client was randomly selected to be associated with their respective CIT. Clients were randomly chosen with the use of a table of random numbers. By following this process of random selection, the data set was reduced to 34 CIT-client dyads.

Linearity, normality, and outliers.

Utilizing the data set of 34 CIT-client dyads, an inspection of each variable’s residual scatter plot revealed that the residuals fell on a straight, diagonal line, suggesting that the data is linear in nature. In regard to normality of the data, descriptive statistics for each variable were computed, and revealed that the predictor variable of CIT Agreeableness had a significant \((p = .000)\) Kolmogorov-Smirnov value, suggesting non-normality. The direction and degree of skew for Agreeableness would suggest that the sample population of CITs was not normally distributed, but rather skewed toward being highly agreeable. Based on a visual inspection of Agreeableness items on the NEO-FFI (e.g., “I try to be courteous to everyone I meet,” “I would rather cooperate with others than compete with them,” and I generally try to be thoughtful and considerate”), it would be anticipated that CITs would respond in ways observed in this study. Therefore, the non-normality observed for CIT Agreeableness is deemed acceptable.

Last, an assessment for outliers was conducted. A visual inspection of the predictor and criterion variable’s box plots revealed that three variables possessed outliers (Agreeableness, one outlier; alexithymia, two outliers; and Client WAI-S, one outlier). Each of these three variables’ histograms was inspected to assess the degree to
which these four outliers were impacting their respective distributions. This analysis was conducted by visually inspecting each variable’s histogram and assessing whether the identified outlying data point was sitting alone from the rest of the distribution (Pallant, 2001). These histogram analyses revealed that the outlier for Agreeableness and alexithymia were not sitting alone, and therefore deemed as not considerably influencing the normality of the distribution. However, this inspection did reveal that the outlier for Client WAI-S was clearly outside of the distribution (extremely low score; Client WAI-S = 38) and was considerably influencing the normality of the distribution. Therefore, it was decided to leave the outlying Agreeableness and alexithymia cases intact, and to delete the outlier for Client WAI-S from the data set, leaving a final, paired N of 33 CIT-client dyads.

The client associated with the outlying Client WAI-S score was a 22 year old, single, Caucasian male, who indicated being in counseling for 3 sessions with their current CIT, having one CIT/counselor prior to working with their current CIT, and being a senior in college. The CIT providing services to this particular client was a 23 year old, married, Caucasian female, who reported being enrolled in the school counseling masters program, and having “1 to 2 years” of clinical experience. Neuroticism (T = 49), Extraversion (T = 50), Agreeableness (T = 55), and Conscientiousness (T = 46) for this particular CIT fell within the Average range on the NEO-FFI. Openness was observed to fall within the High range (T = 57). This CIT’s TAS-20 total score of 36 suggest low levels of alexithymia, and her FOO measures revealed that she perceived the functioning within her FOO as generally healthy (FAD-GFS=1.67) and highly emotionally expressive (FOEAS = 93). Interestingly, this CIT evaluated the working alliance with their client as
relatively positive (CIT WAI-S = 75; 12 = low and 84 = high working alliance), resulting in a relatively large discrepancy with their respective client's working alliance evaluations.

Based on the above-mentioned decisions and actions, it was decided that the assumptions for multiple regression, as well as for correlational analyses, were met. Therefore, data corresponding to the CIT-client dyad sample of 33 was analyzed using stepwise multiple regression and Pearson correlation analyses.

**Internal consistency, scale means, and scale standard deviations**

Internal consistency for the measures used in this study were investigated. Chronbach alpha coefficients, means, and standard deviations for the scales used in this study are presented in Table 3. The coefficient alphas for each scale appear to be consistent with previous research findings (Busseri & Tyler, 2003; Epstein et al., 1983; Kabacoff et al., 1990; Martinez-Sanchez et al., 2003; Paunonen, 2003; Yelsma et al., 2000).
Table 3

Scale Reliability, Means, and Standard Deviations

<table>
<thead>
<tr>
<th>Scale</th>
<th>Alpha</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIT WAI-S</td>
<td>.93</td>
<td>67.11</td>
<td>9.08</td>
</tr>
<tr>
<td>Client WAI-S</td>
<td>.91</td>
<td>71.39</td>
<td>9.34</td>
</tr>
<tr>
<td>NEO-FFI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>.75</td>
<td>16.09</td>
<td>5.50</td>
</tr>
<tr>
<td>Extraversion</td>
<td>.79</td>
<td>31.85</td>
<td>5.73</td>
</tr>
<tr>
<td>Openness</td>
<td>.76</td>
<td>32.25</td>
<td>5.68</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.79</td>
<td>35.47</td>
<td>5.32</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>.75</td>
<td>37.50</td>
<td>4.44</td>
</tr>
<tr>
<td>TAS-20</td>
<td>.74</td>
<td>34.00</td>
<td>6.49</td>
</tr>
<tr>
<td>FAD-GFS</td>
<td>.93</td>
<td>2.05</td>
<td>.69</td>
</tr>
<tr>
<td>FOEAS</td>
<td>.98</td>
<td>77.06</td>
<td>21.80</td>
</tr>
</tbody>
</table>

A comparison between CIT and Client WAI-S scores revealed that CITs reported lower working alliance scores than their clients. An independent samples \( t \) test revealed that these means were not significantly different from one another \( (t = 1.887, df = 64, p = .064) \). Using the distribution of scale scores developed by Costa and McCrae (1992), mean scores for the NEO-FFI domains revealed that CITs self-reported an Average level of Neuroticism, Agreeableness, and Conscientiousness, and a High level of Extraversion and Openness. Mean scores also indicate that CITs reported relatively low alexithymia scores, suggesting a limited amount of difficulty identifying and describing personal emotions. In regard to FAD-GFS mean score, their mean score of 2.05 was just over the scales 2.0 cut-off (Miller et al., 1985), suggesting that these CITs’ FOO experiences were neither clearly healthy nor dysfunctional, but rather equally balanced between the two.
Mean scores for the FOEAS fell above the scales average of 55, suggesting an elevated tendency for CITs to perceive their FOO as being emotionally expressive. A correlation matrix for the predictor and criterion variables used in this study was also computed and displayed in Table 4.

Table 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Neuroticism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Extraversion</td>
<td>-.54**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Openness</td>
<td>-.18</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Agreeableness</td>
<td>-.22</td>
<td>.57**</td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Conscientiousness</td>
<td>-.12</td>
<td>-.02</td>
<td>.04</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Alexithymia</td>
<td>.25</td>
<td>-.28</td>
<td>-.30</td>
<td>-.39*</td>
<td>-.21</td>
<td></td>
<td></td>
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<tr>
<td>7. FAD-GFS</td>
<td>.07</td>
<td>-.19</td>
<td>.40*</td>
<td>-.07</td>
<td>-.20</td>
<td>-.15</td>
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<td>8. FOEAS</td>
<td>-.12</td>
<td>.17</td>
<td>-.36*</td>
<td>.07</td>
<td>.14</td>
<td>.09</td>
<td>-.92**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. CIT WAI-S*</td>
<td>-.20</td>
<td>.12</td>
<td>.29</td>
<td>.03</td>
<td>.11</td>
<td>-.07</td>
<td>-.06</td>
<td>.06</td>
<td></td>
</tr>
<tr>
<td>10. Client WAI-S*</td>
<td>.49**</td>
<td>-.29</td>
<td>-.25</td>
<td>-.23</td>
<td>-.01</td>
<td>.17</td>
<td>-.28</td>
<td>.15</td>
<td>.06</td>
</tr>
</tbody>
</table>

* Criterion Variables
* Correlation is sig. at the .05 level (2-tailed).
** Correlation is sig. at the .01 level (2-tailed).

Bold correlation coefficients indicate a statistically significant relationship.
Hypotheses Results

Hypothesis 1a-e. (a) Neuroticism, (b) Extraversion, (c) Openness, (d) Agreeableness, and (e) Conscientiousness, measured by the NEO-FFI, either in combination with each other or alone, will predict CIT perceptions of the working alliance, measured by the CIT WAI-S.

To investigate the degree to which the five NEO-FFI domains predict CIT perceptions about the working alliance, the five NEO-FFI domains were entered into a stepwise multiple regression equation with CIT WAI-S as the criterion variable. This regression revealed that the five domains, in combination or independently, did not significantly predict CIT WAI-S scores. This finding suggests that CIT personality traits do not predict their perceptions of the working alliance ($F = .917, df = 28, R^2 = .116, \text{ Adj } R^2 = -.010, p = .468$). Hypothesis 1a-e is rejected.

Hypothesis 2a-e: (a) Neuroticism, (b) Extraversion, (c) Openness, (d) Agreeableness, and (e) Conscientiousness, measured by the NEO-FFI, either in combination with each other or alone, will predict client perceptions of the working alliance, measured by the Client WAI-S.

To investigate the degree to which the 5 NEO-FFI domains predict client perceptions of the working alliance, the five NEO-FFI domains were entered into a stepwise equation with Client WAI-S as the criterion variable. The most inclusive model to emerge ($F = 9.893, df = 31, R^2 = .242, \text{ Adj } R^2 = .217, p = .004$) identified Neuroticism (standardized $B = .492, p = .004$) as the significant predictor of Client WAI-S. This result may suggest that as CIT feelings of apprehension, frustration, sadness, and
discouragement increase, positive client evaluations of the working alliance also increase and can be significantly predicted. Therefore, hypothesis 1a was retained, while hypothesis 1b-e were rejected.

Due to the counterintuitive nature of this finding that CIT Neuroticism predicted positive client evaluations of the WAI-S, data producing this relationship were further examined. Using the NEO-FFI profile developed by Costa and McCrae (1992), the range and means of Neuroticism scores for the CITs in this study were further investigated and revealed that all but three CITs had Neuroticism scores at or below the Average range (T scores between 45 and 55). More specifically, 2 CITs (6%) were in the Very Low range of Neuroticism (T scores between ≤ 25 and 34), 12 CITs (36%) were in the Low range (T scores between 35 and 44), 16 (48%) were in the Average range, while 3 (9%) were in the High range (T scores between 56 and 65). The highest observed Neuroticism T score was 62, of which was reported by one male and one female CIT. Concurrently, the mean CIT Neuroticism score was 16, placing the average CIT within the Low range of Neuroticism, and about 90% of this population of CITs fell within the Low to Average range of Neuroticism, suggesting a generally healthy and well-adjusted sample population. Readers are encouraged to consider the CIT sample used in this study as being generally healthy and well adjusted, rather than "neurotic" as the NEO-FFI label "Neuroticism" may imply. Therefore, based on this more detailed information on the distribution of CIT Neuroticism scores, concluding that "as CIT feelings of apprehension, frustration, sadness, and discouragement increase, positive client evaluations of the working alliance also increase and can be significantly predicted," stated above, may be misleading. Based on the more detailed investigation of the data above, a more
appropriate, and specific way in which to interpret this particular finding may be that as CIT Neuroticism scores on the NEO-FFI increase and reach a T score of 62, client evaluations of the working alliance also increase and can be significantly predicted.

By stating, “as CIT Neuroticism scores on the NEO-FFI increase and reach a T score of 62, client evaluations of the working alliance also increase and can be significantly predicted,” a non-linear relationship can be inferred. It would be counterintuitive to conceptualize that CITs in the High (T scores between 56 and 65) or Very High (T scores between 66 and ≥ 75) range of Neuroticism on the NEO-FFI would continue to receive increasingly positive client evaluations. It is probable that as CITs increase from the Average (T scores between 45 and 55) to Very High range of Neuroticism that their clients’ evaluations of the working alliance may begin to decrease, ultimately resulting in a non-linear relationship. Therefore, to test this theory a post hoc quadratic equation was conducted. CIT Neuroticism was entered into a quadratic regression equation with Client WAI-S as the criterion variable. Table 5 provides results from this quadratic equation, as well as findings revealed from the stepwise linear regression conducted previously in order to facilitate comparison.

Table 5
Linear and Non-linear Regression Equation Results

<table>
<thead>
<tr>
<th>Model</th>
<th>F</th>
<th>Adjusted $R^2$</th>
<th>Standard Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear</td>
<td>9.893 ($p = .004, df=31$)</td>
<td>.217</td>
<td>8.504</td>
</tr>
<tr>
<td>Non-linear</td>
<td>5.087 ($p = .013, df=31$)</td>
<td>.203</td>
<td>8.579</td>
</tr>
</tbody>
</table>

Although the quadratic equation revealed a significant relationship between CIT
Neuroticism and Client WAI-S, the degree of this relationship, and level of significance, is less than the linear regression model. Also, the amount of variance explained by the linear model (i.e., adjusted $R^2$) is greater than that explained by the non-linear model. Therefore, the results obtained from this quadratic regression equation do not support the theory that the relationship between CIT Neuroticism and client working alliance evaluations is better explained by a non-linear model.

Since the non-linear relationship between CIT Neuroticism and client working alliance was significant, it warrants a degree of further attention. A couple of factors may have contributed to this non-linear model being less influential in its predictive ability. The size of this sample population, and distribution of Neuroticism scores, may have influenced the predictability of this model. Thirty-one CITs were between the Very Low (T scores between ≤ 25 and 34) and Average (T scores between 45 and 55) ranges of Neuroticism on the NEO-FFI, with only three CITs in the High range (T scores between 56 and 65). Due to the low number of CITs within the High (n = 3) or Very High (n = 0) Neuroticism range (T scores between 66 and ≥ 75), the relationship between High and Very High levels of CIT Neuroticism with client working alliance remains largely unknown. Therefore, further research is needed to identify how High and/or Very High CIT Neuroticism is related to client working alliance in order to clearly identify if this relationship is linear or non-linear in nature.
Hypothesis 3: CIT alexithymia, measured by the TAS-20, will significantly correlate with CIT perceptions of the working alliance, measured by the CIT WAI-S.

To test this hypothesis the correlation between the TAS-20 and CIT WAI-S was computed and revealed that this relationship was not statistically significant ($r = -.07, p = .72$). This finding suggests that a CIT’s alexithymia is not significantly related to their perceptions of the working alliance. Hypothesis 3 is rejected.

Hypothesis 4: CIT alexithymia, measured by the TAS-20, will significantly correlate with client perceptions of the working alliance, measured by the Client WAI-S.

To test this hypothesis the correlation between the TAS-20 and Client WAI-S was computed and revealed that this relationship was not statistically significant ($r = .17, p = .339$). This finding suggests that a CIT’s alexithymia is not significantly related to client perceptions of the working alliance. Hypothesis 4 is rejected.

Hypothesis 5. CIT perceptions of the general function within their FOO, as measured by the FAD-GFS, will significantly correlate with CIT perceptions of the working alliance, measured by the CIT WAI-S.

To test this hypothesis the correlation between the FAD-GFS and CIT WAI-S was computed and revealed that this relationship was not statistically significant ($r = -.06, p = .73$). This finding suggests that a CIT’s perception of the general functioning in their FOO is not significantly related to their own perceptions of the working alliance. Hypothesis 5 is rejected.
Hypothesis 6: CIT perceptions of the general function within their FOO, as measured by the FAD-GFS, will significantly correlate with client perceptions of the working alliance, measured by the Client WAI-S.

To test this hypothesis the correlation between the FAD-GFS and Client WAI-S was computed and revealed that this relationship was not statistically significant ($r = -.28, p = .11$). This finding suggests that a CIT's perception of the general functioning in their FOO is not significantly related to their client's perceptions of the working alliance. Hypothesis 6 is rejected.

Hypothesis 7: CIT perceptions of the emotional expressiveness within their FOO, as measured by the FOEAS, will significantly correlate with CIT perceptions of the working alliance, measured by the CIT WAI-S.

To test this hypothesis the correlation between the FOEAS and CIT WAI-S was computed and revealed that this relationship was not statistically significant ($r = .06, p = .73$). This finding suggests that a CIT's perception of the emotional expressiveness within their FOO is not significantly related to their own perceptions of the working alliance. Hypothesis 7 is rejected.

Hypothesis 8: CIT perceptions of the emotional expressiveness within their FOO, as measured by the FOEAS, will significantly correlate with client perceptions of the working alliance, measured by the Client WAI-S.

To test this hypothesis the correlation between the FOEAS and Client WAI-S was computed and revealed that this relationship was not statistically significant ($r = .15, p = .

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This finding suggests that a CIT’s perception of the emotional expressiveness within their FOO is not significantly related to their client’s perceptions of the working alliance. Hypothesis 8 is rejected.

Post Hoc Analysis

Due to hypothesis 2a revealing that CIT Neuroticism significantly predicted client evaluations of the working alliance, this researcher questioned the degree to which alexithymia, CIT perceptions of the general function within their FOO, and CIT perceptions of the emotional expressiveness within their FOO contribute to a prediction model of client evaluations of the working alliance. To investigate this question a post hoc, stepwise regression analysis was computed. CIT Neuroticism, the TAS-20, the FAD-GFS, and the FOEAS were entered into this regression model with Client WAI-S as the criterion variable. The most inclusive model to emerge \( F = 7.762, df = 30, R^2 = .341 \), \( \text{Adj } R^2 = .297, p = .002 \) identified Neuroticism (standardized \( B = .514, p = .002 \)) and FAD-GFS (standardized \( B = -.316, p = .04 \)) as significant predictors of the Client WAI-S. In regard to the amount of shared variance explained by these two variables, this analysis revealed that CIT Neuroticism explained 24% of the Client WAI-S variance. When the FAD-GFS was added to the model an additional 10% of the variance was explained, resulting in 34% of the variance for Client WAI-S being explained by the combination of CIT Neuroticism and CIT perceptions of general FOO functioning. This analysis revealed that, although CIT Neuroticism was the most significant predictor of client evaluations of the working alliance, CIT perceptions of general FOO functioning significantly contributed to the model’s predictive ability of client working alliance evaluations. This finding suggests that as CIT Neuroticism scores on the NEO-FFI increase and reach a
score of 62, as well as when CITs had positive perceptions about the general functioning within their FOO, positive client evaluations about the working alliance increase and can be significantly predicted.

Summary

Data in this study were analyzed with stepwise regression models and correlation analyses. This study proposed eight hypotheses, of which only one was partially accepted. Results from this particular hypothesis revealed that as CIT Neuroticism scores on the NEO-FFI (Costa & McCrae, 1992) increased and reached a T score of 62, client evaluations of the working alliance increased and were significantly predicted. A post hoc analysis revealed that as CIT Neuroticism scores on the NEO-FFI increased and reached a T score of 62, as well as when CITs had positive perceptions about the general functioning within their FOO, positive client working alliance evaluations increased and were significantly predicted.
CHAPTER V
DISCUSSION

Introduction

Empirical research has revealed that the working alliance between counselors and their clients is significantly related to the outcome of therapy (Gelso & Carter, 1985; Horvath & Greenberg, 1989; Horvath & Symonds, 1991; Kokotovic & Tracey, 1990; Martin et al., 2000; Parish & Eagle, 2003). The amount and quality of research is limited, however, concerning counselor traits and characteristics that facilitate the development of the working alliance (Ackerman & Hilsenroth, 2001; Dunkle & Friedlander, 1996; Eames & Roth, 2000; Hersoug et al., 2001; Horvath, 2000; Horvath & Luborsky, 1993; Ligiero & Gelso, 2002; Mallinckrodt, 1991; Wampold, 2001). A review of the literature revealed that counselor-in-training (CIT) personality traits and family-of-origin (FOO) characteristics have an influence on the working alliance. This study investigated the degree to which CIT personality traits and FOO characteristics are associated with CIT perceptions of the working alliance, measured by the CIT WAI-S (Tracey & Kokotovic, 1989). This study also investigated the degree to which CIT personality traits and FOO characteristics are associated with client perceptions of the working alliance, measured by the Client WAI-S (Tracey & Kokotovic). Identifying CIT personality traits and FOO characteristics that predict perceptions of the working alliance may contribute to the selection, training and supervision of CITs, as well as add to related literature.

Summary of Methodology

This study utilized students in masters and doctoral level programs in marriage and family therapy, counselor education, and counseling psychology who were enrolled
in two different Midwestern universities. Data in this study were derived from 33 CIT-client dyads, and analyzed with stepwise multiple regression models and correlational analyses. CITs completed a demographic form, the NEO-FFI (Costa & McCrae, 1992), the TAS-20 (Bagby, Parker et al., 1994), the FAD-GFS (Epstein et al., 1983), the FOEAS (Yelsma et al., 2000), and the CIT WAI-S (Tracey & Kokotovic, 1989). CIT clients completed a demographic form and the Client WAI-S (Tracey & Kokotovic).

Findings and Interpretations

This study revealed interesting findings regarding the degree to which CIT personality traits and FOO characteristics significantly predict their client’s perceptions of the working alliance. Readers should be reminded here that this study utilized an observational design, and that the significant relationships described below should not be interpreted as a cause and effect relationship.

_CIT Neuroticism predicting client evaluations of the working alliance_

This study revealed that as CIT Neuroticism scores on the NEO-FFI (Costa & McCrae, 1992) increased and reached a T score of 62, positive client evaluations of the working alliance increased and were significantly predicted. This relationship suggests that as CIT feelings of apprehension, frustration, sadness, and discouragement (i.e., Neuroticism) increase, client evaluations of the working alliance also increase. At first glance this relationship appears counterintuitive. This counterintuitive relationship may be explained by conceptualizing that CITs who are in the Average to High range (T scores between 45 and 62) of Neuroticism on the NEO-FFI may be more aware of, and comfortable acknowledging, personal issues, as well as be more personally congruent with their thoughts and feelings, than CITs who are in the Very Low to Low range (T
scores between \( \leq 25 \) and 44). This increased degree of CIT self-awareness and personal congruence may help to facilitate positive client evaluations of the working alliance. The theoretical concept of the self of the therapist, and its supporting literature, (Aponte, 1994; Aponte & Winter, 1987; Bowen, 1978; Roberto, 1992; Satir & Baldwin, 1983; Satir, Banmen, Gerber, & Gomori, 1991; Whitaker & Keith, 1981) will be used to help substantiate this proposition.

"The development of the self of the therapist is a significant aspect to becoming an effective therapist" (Lum, 2002, p. 181), and has been recognized as being the single most important factor in developing the therapeutic relationship and enhancing the therapeutic process (Andolfi, Ellenwood, & Wendt, 1993; Baldwin, 2000; Bowen, 1978; Guerin & Hubbard, 1987; Lum, 2002; 2000; Napier & Whitaker, 1978). Self of the therapist work has also been found to enhance client exploration and processing of personal issues (Banmen, 1997; Timm & Blow, 1999). Timm and Blow defined the process of self of the therapist work as "the willingness of a therapist to participate in a process that requires introspective work on issues in his or her own life that have an impact on the process of therapy in both positive and negative ways" (p. 333). Through this process of introspection into personal and FOO issues, CITs develop a heightened level of personal awareness, ultimately allowing them to use themselves in a deliberate way during the therapeutic process. Virginia Satir proposed that a counselor's ability to be self aware, as well as accepting of their personal and FOO issues, enables them to be more fully present and connected with their clients without internal distractions (Lum, 2002; Satir et al., 1991). Satir labeled this process of becoming more aware of one's self as becoming more personally congruent with their thoughts and feelings. Satir's concept
of personal congruence is similar to Bowen’s concept of differentiation in its focus toward being aware of the difference between one’s cognitive and emotional processes. By developing greater congruence and differentiation through self of the therapist work, counselors become more fully present with their clients, are less distracted in session by un/subconscious personal issues, and have less emotional reactivity to client behaviors or stories based on their own FOO dynamics.

How, then, is self of the therapist work and personal congruence applicable to this finding that as CIT Neuroticism scores on the NEO-FFI increased and reached a T score of 62, client evaluations of the working alliance also increased and were significantly predicted? CITs who were in the Average to High range (T scores between 45 and 62) of Neuroticism on the NEO-FFI may have been more self-aware and personally congruent than CITs who were in the Low (T scores between 35 and 44) to Very Low range of Neuroticism (T scores between ≤ 25 and 34). Research supports this proposition by identifying that the ability to be introspective, to become more self-aware and personally congruent may allow CITs to acknowledge and process personal feelings of apprehension, frustration, sadness, and discouragement (i.e., Neuroticism), ultimately facilitating positive working alliances with their clients (Andolfi et al., 1993; Baldwin; 2000; Banmen, 1997; Bowen, 1978; Guerin & Hubbard, 1987; Lum, 2002; 2000; Napier & Whitaker, 1978; Satir et al., 1991; Timm & Blow, 1999).

It would make intuitive sense that CITs who are (a) more aware of their personal issues, (b) open to looking at them, and (c) perhaps accepting of them, may be more prone to acknowledging that they sometimes feel apprehension, frustration, sadness, and discouragement. On the other hand, it would also be reasonable that a CIT who is not
aware of their personal issues, or is choosing not to address them out of fear, resistance or denial, may be unaware of, or even denying, their personal feelings. CITs with low awareness of personal issues may answer questions from the NEO-FFI Neuroticism domain in a manner which indicates that they “Very Rarely” or “Never” (Costa & McCrae, 1992) feel apprehension, frustration, sadness, or discouragement.

The proposition that CITs who are more self aware and congruent with their thoughts and feelings tend to facilitate positive client evaluations of the working alliance, has implications for counselor training programs and clinical supervision. Based on the findings reported in this study and subsequent propositions, this study provides some empirical support for the inclusion of additional attention to self of the therapist work within counselor training programs and clinical supervision. Despite the theoretical framework, and supporting empirical research, on the self of the therapist, the process of facilitating CIT growth through self of the therapist work has been largely neglected in counselor training programs (Baldwin, 2000; Kramer, 2000; Shadley, 2000). By neglecting the process and importance of CITs’ gaining greater personal awareness, CITs may inadvertently receive a message that it is acceptable to minimize, or even ignore, the influence their unresolved issues have on their personal and professional development (Shadley). Counselor training programs and clinical supervisors are encouraged to incorporate self of the therapist training into their curricula and supervision in order to possibly help facilitate greater CIT self-awareness and personal development, while also enabling greater working alliances with their clients.
CIT Neuroticism and FOO experiences predicting client evaluations of the working alliance

A post hoc analysis conducted in this study revealed that the FAD-GFS significantly contributed to CIT Neuroticism in its ability to significantly predict client evaluations of the working alliance. This finding suggests that when CIT perceptions of the general functioning within their FOO (i.e., FAD-GFS) is taken into consideration with CIT Neuroticism on the NEO-FFI, positive client evaluations of the working alliance can be predicted to a greater degree than when CIT Neuroticism is accounted for alone. Discussion has been devoted above to the relationship between CIT Neuroticism and client evaluations of the working alliance. Therefore, the following discussion will specifically address the relationship between CIT FOO experiences and client working alliance evaluations.

This finding that positive CIT perceptions of the general functioning in their FOO significantly predicts positive client working alliance differs from previous research comparing CIT FOO experiences and working alliance. For example, Lawson and Brossart (2003) found that “less healthy therapist – parent relationship patterns (i.e., fusion and triangulation) were associated with a positive working alliance with clients” (p. 390). The contradiction between Lawson and Brossart and the present study’s findings may have occurred for a couple of different reasons. The first difference consists of the assessment measures used. Lawson and Brossart utilized the Intergenerational Fusion/Individuation, Intergenerational Triangulation, and Personal Authority scales of the PAFS-Q (Bray et al., 1984) to assess the CIT’s FOO. The present study’s findings were based on data generated from the FAD-GFS. Second, in regard to working alliance
evaluations, Lawson and Brossart used the full Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), while this study utilized the shorter WAI-S. Although empirical studies have declared that the WAI-S is statistically similar to the WAI (Busseri & Tyler, 2003; Tracey & Kokotovic, 1989), and that the WAI-S provides greater reliability than the WAI (Hanson et al., 2002), this difference in instrumentation must be acknowledged. The third difference consists of the sample populations used. Although both studies used CITs, Lawson and Brossart’s sample consisted of doctoral CITs, while the present study used 24 masters and nine doctoral students from a variety of mental health disciplines.

Although the present finding contradicts Lawson and Brossart (2003), it does correspond with intergenerational family theory (Bowen, 1978; Kerr & Bowen, 1988; Timm & Blow; 1999), which emphasizes the considerable influence the FOO has on a person’s development. Although the theory is applicable to both healthy and unhealthy FOO relationship patterns and experiences, considerably more literature has been devoted to the influence negative FOO experiences have on CIT development and the therapeutic process, than on positive experiences (Timm & Blow). Timm and Blow have attempted to balance the equation by calling attention to this difference, stating that positive FOO experiences can be as influential to CITs and the therapeutic process as negative FOO experiences, and therefore should be given equal consideration. The present finding that positive CIT FOO experiences predict positive client evaluations provides some empirical evidence supporting Timm and Blow’s proposition.

This relationship between positive CIT FOO experiences and positive client evaluations of the working alliance may be explained by the CIT’s subjective
countertransference (Kiesler, 2001). Kiesler expanded on Freud's concept of
countertransference by suggesting that two different types of countertransference occur:
subject and objective countertransference. Subjective countertransference occurs when
"the therapist’s reactions to the client originate from the therapist’s own unresolved
conflicts and anxieties" (Ligiero & Gelso, 2002, p. 4). Objective countertransference, on
the other hand, occurs when "therapist’s reactions to the client are evoked primarily by
the client’s maladaptive behavior" (Ligiero & Gelso, p. 4). By incorporating Bowen's
(1978) intergenerational theory with Kiesler’s concept of subjective countertransference,
one could postulate from the finding in the present study that CITs who experience
relatively positive FOO experiences may interact with their clients with less subjective
countertransference (i.e., emotionally react to client stories and presentations based on the
CIT's unresolved FOO issues). Less subjective countertransference may be facilitating
positive client evaluations of the working alliance by the CIT being more emotionally
available to the client, and serving more of the client's needs due to having fewer
unresolved FOO conflicts and anxieties.

To summarize, it has been proposed here that the relationship between CIT
Neuroticism and positive client evaluations can be explained by CIT self-awareness and
personal congruence (Andolfi et al., 1993; Baldwin; 2000; Bowen, 1978; Guerin &
Hubbard, 1987; Lum, 2002; 2000; Napier & Whitaker, 1978; Satir et al., 1991). It has
also been proposed within this study that the relationship between positive CIT FOO
experiences and positive client evaluations can be explained by less subjective
countertransference stemming from healthy FOO experiences (Bowen; Henry & Strupp,
1994; Kerr & Bowen, 1988; Kiesler’s, 2001; Ligiero & Gelso, 2002; Teyber, 2000).
Therefore, this particular finding that as CIT Neuroticism increased and reached a T score of 62, combined with positive CIT perceptions about the general functioning within their FOO, positive client working alliance evaluations increased and were significantly predicted, may suggest that when a CIT is more self-aware and personally congruent with their thoughts and feelings, as well as interacts with their clients with less subjective countertransference, positive client working alliance evaluations may increase and be predicted. Implications for this post hoc finding further support the value in, and need for, self of the therapist work in counselor training programs and clinical supervision.

Limitations

A few limitations must be considered regarding the methodology and subsequent findings revealed in this study. First, these findings are based exclusively on self-reports from the CIT and client participants. Given the sufficient reliability and validity of the instruments chosen for this study, the degree of measurement error contingent on the nature of the instruments is foreseen to be no greater than in other studies using self-report measures.

Second, the racial/ethnic demographics of the student population from which these findings are based on may be considered an additional limitation of this study. The sample population used in this study was derived from university programs comprised largely of students from Caucasian descent. Therefore, generalizations made from these results may be most appropriate for students from racial/ethnic backgrounds similar to those in this study.

Third, findings from this study are based entirely on CIT participants. Although this demographic was the predetermined intention for this study, results gleaned from this
population may not generalize to more experienced mental health professionals.

Fourth, the process used for selecting CIT-client dyads may also be a limitation of this study. In order to minimize the possibility for CITs to choose their “best” client, and therefore contributing biased data, CITs were allowed to invite multiple clients to participate in this study. Therefore, one CIT could have multiple clients involved in this study. To satisfy the independence assumption for multiple regression, one client was randomly selected to be associated with the respective counselor. Although the random selection of one client was necessary, this process resulted in data from 30 clients not being analyzed.

Fifth, although the interpretations and propositions made regarding the meaning behind the significant relationships found in this study are supported by empirical research, they were not explicitly investigated within this study. For example, the relationship between CIT FOO experiences and client working alliance evaluations was interpreted using Kiesler’s (2001) concept of subjective countertransference. However, this study did not directly evaluate the degree to which subjective countertransference contributes to this relationship. Therefore, future research is recommended to directly investigate the degree to which CIT subjective countertransference, as well as self-awareness and personal congruence, is related to client evaluations of the working alliance.

Sixth, excluding an outlier from this data set must also be acknowledged as a potential limitation of this study. This particular data point consisted of a Client WAI-S score that fell considerably outside of the normal distribution (an extremely low Client WAI-S score). Although it was statistically appropriate, excluding this outlier modified
the data used, and therefore may have also modified the results revealed.

Last, the differences in the number of CITs/counselors some clients had verses other clients may also be a limitation to this study. Seventeen clients used in this study reported receiving counseling prior to working with their current CIT. Of these 17 clients, 3 reported working with 1 CIT/counselor, 6 reported working with 2 different CITs/counselors, 3 reported working with 3 different CITs/counselors, 2 reported working with 4 different CITs/counselors, and 3 reported working with 6 different CITs/counselors before working with their current CIT. The multiple CITs/counselors seen by these clients may have impacted Client WAI-S evaluations by providing a means of comparison, a reference point not available to clients in their first counseling experience. Therefore, the evaluations made by clients with multiple, different counseling experiences may be contextually different than evaluations from clients in their first counseling experience.

Recommendations for Future Research

The following are recommendations for future research.

1. Researchers are encouraged to consider replicating the present study utilizing a sample population that consists of more experienced mental health professionals, as well as CIT/counselor and client populations that are more racially and ethnically diverse.

2. The concepts of the self of the therapist and subjective countertransference were used to provide explanation and meaning to the findings revealed in this study. However, these two concepts were not explicitly investigated. In order to validate these propositions, researchers are encouraged to directly investigate the degree to which self of the therapist work by CITs and subjective countertransference are associated with
client working alliance evaluations.

3. This study investigated what CIT personality traits and FOO characteristics predicted CIT and client working alliance evaluations. Future research is encouraged to assess what CIT factors facilitate CIT working alliance evaluations that are similar to, and/or significantly differ from, client evaluations. In other words, what facilitates CIT and client agreement on the working alliance? What facilitates disagreement?

4. This study investigated the working alliance between the CIT and client between the 3rd and 7th session. Future researchers are encouraged to investigate how CIT personality traits and FOO characteristics are associated with more long-term therapy (e.g., 10th, 15th, or 20th session), or very brief therapy (1 through 3 sessions).

5. Future research may find it beneficial to examine more specific NEO-FFI personality traits as potentially predicting CIT and client working alliance evaluations. The limited degree to which the five NEO-FFI domains were found to predict WAI-S evaluations may be explained by the facet structure of the five domains, and how scores in one facet may balance out scores from another facet. To illustrate, the NEO-FFI was developed from a factor analysis of the NEO PI (Costa & McCrae, 1992). In addition to the five domains, the NEO PI-R contains six facets which correspond with each individual domain. For example, the Neuroticism domain contains the facets Anxiety, Angry Hostility, Depression, Self-consciousness, Impulsivity, and Vulnerability. The NEO-FFI’s Neuroticism domain contains items derived from factor analyses from these six facets to provide the user with a general Neuroticism score. It is possible, under this scoring procedure, that high scores in Depression, for example, could be ‘balanced out’ by low scores in Impulsivity or Anxiety. Therefore, the NEO-FFI’s limited ability to
predict WAI-S scores may be due to its restriction toward reporting more global personality domains (e.g., Neuroticism), rather than more specific personality traits (e.g., anxiety). Therefore, future research is recommended that investigates the degree to which more specific NEO-FFI or NEO PI-R personality traits predict working alliance evaluations. Researchers using the NEO-FFI to further investigate this relationship are encouraged to utilize Saucier’s (1998) 13 NEO-FFI subcomponents as a means to identify specific personality traits that may predict CIT and client working alliance evaluations.

6. The statistically significant correlation between the FOO measures (FAD-GFS and FOEAS) and the Openness domain of the NEO-FFI (Table 4) warrants additional attention. Based upon a comprehensive computer-based review of the literature, this relationship is the first known comparison between FOO dynamics and domains of personality outlined by the NEO-FFI. Due to the direction of these relationships, these findings may suggest that CITs who perceive their FOO as having high amounts of dysfunction, as well as difficulties being emotionally expressive, may have higher levels of openness to diversity, other’s opinions, and new experiences. Further research into this relationship may contribute to FOO and personality literature. Consistent with the scope of this paper, additional research into this relationship may also contribute information to how FOO dynamics impact personality traits of openness within CITs, and how these traits influence the process of therapy.

General Conclusion

The findings revealed in this study may contribute to efficacy and common factors research. A debate exists in efficacy research in regard to what facilitates
therapeutic change: specific ingredients or common factors (Hubble et al., 1999; Sprenkle, 2003; Sprenkle & Blow, 2004; Wampold, 2000; 2001). Extensive meta-analyses have concluded that common mechanisms for change (i.e., Client Characteristics, Therapist Qualities, Change Processes, Treatment Structures, Relationship Elements; Grencavage & Norcross, 1990) account for much more of the therapeutic outcome variance than explained by unique models of therapy (e.g., cognitive behavioral therapy or object relations) (Hubble et al., 1999; Wampold, 2000; 2001). In other words, “changes that clients make are largely related to the relationship or alliance they have with their therapist, rather than to the specific model or methods employed by the therapist” (Johnson, Wright, & Ketting, 2002, p. 93). Findings revealed from the present study provide empirical support for the common factors model. Specifically, supporting Grencavage and Norcross, this study contributes empirical evidence that Therapist Qualities (i.e., personality traits and FOO characteristics) significantly enhance the working alliance with their clients. Based on meta-analyses on working alliance research revealing that the working alliance significantly predicts therapeutic outcomes (Horvath & Symonds, 1991; Martin et al., 2000), it can be conceptualized that CIT personality traits and FOO characteristics may facilitate therapeutic outcomes. This hypothesis and conceptualization may inform future efficacy research about the influence specific therapist qualities have in facilitating successful therapy.

In addition to the contribution these findings have for common factors and efficacy research, they may also inform CIT educators and clinical supervisors on ways in which to provide CITs with processes to facilitate stronger working alliances between them and their clients. Researchers have suggested that in order to learn how to enhance
the working alliance, CITs should receive training on the “skills of alliance building” (Johnson et al., 2002, p. 99), suggesting the need for acquiring specific skills, interventions, or methods in order to develop the working alliance. However, findings revealed from the present study may suggest alternative CIT training methods for enhancing the working alliance. Propositions made in this study hypothesize that greater CIT self-awareness and personal congruence significantly contribute to client evaluations of the working alliance. Based on the findings revealed and subsequent propositions made in this study, developing a working alliance with clients may be more of a function of a CIT’s self-knowledge and personal congruence, than their knowledge of particular alliance building skills. Counselor training programs and clinical supervisors are encouraged to incorporate self of the therapist training into their curricula and supervision, respectively, in order to potentially help facilitate greater CIT self-awareness and personal development, while concurrently enabling greater working alliances with their clients.
Appendix A

Working Alliance Inventory-Short

CIT version
CIT WAI-S

Following are sentences that describe some of the different ways a person might think or feel about his or her client. Using the scale provided as a guide, please answer each item by CIRCLING the appropriate NUMBER. Give only one answer for each statement.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>

1. This client and I agree about the steps to be taken to improve his/her situation.  
   1 2 3 4 5 6 7

2. This client and I both feel confident about the usefulness of our current activity in therapy.  
   1 2 3 4 5 6 7

3. I believe this client likes me.  
   1 2 3 4 5 6 7

4. I have doubts about what we are trying to accomplish in therapy.  
   1 2 3 4 5 6 7

5. I am confident in my ability to help this client.  
   1 2 3 4 5 6 7

6. We are working towards mutually agreed upon goals.  
   1 2 3 4 5 6 7

7. I appreciate this client as a person.  
   1 2 3 4 5 6 7

8. We agree on what is important for this client to work on.  
   1 2 3 4 5 6 7

9. This client and I have built a mutual trust.  
   1 2 3 4 5 6 7

10. This client and I have different ideas on what his/her real problems are.  
    1 2 3 4 5 6 7

11. We have established a good understanding between us of the kind of changes that would be good for this client.  
    1 2 3 4 5 6 7

12. This client believes the way we are working with his/her problems are correct.  
    1 2 3 4 5 6 7
Appendix B

Working Alliance Inventory-Short

Client version
**Client WAI-S**

Following are sentences that describe some of the different ways a person might think or feel about his or her therapist. Using the scale provided as a guide, please answer each item by CIRCLING the appropriate NUMBER. Give only one answer for each statement.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

1. My counselor and I agree about the things that I need to do in therapy to help improve my situation.
   - 1 2 3 4 5 6 7

2. What I am doing in therapy gives me new ways of looking at my problems.
   - 1 2 3 4 5 6 7

3. I believe my therapist likes me.
   - 1 2 3 4 5 6 7

4. My therapist does not understand what I am trying to accomplish in therapy.
   - 1 2 3 4 5 6 7

5. I am confident in my therapist’s ability to help me.
   - 1 2 3 4 5 6 7

6. My therapist and I are working towards mutually agreed upon goals.
   - 1 2 3 4 5 6 7

7. I feel that my therapist appreciates me.
   - 1 2 3 4 5 6 7

8. We agree on what is important for me to work on.
   - 1 2 3 4 5 6 7

9. My therapist and I trust one another.
   - 1 2 3 4 5 6 7

10. My therapist and I have different ideas on what my real problems are.
    - 1 2 3 4 5 6 7

11. We have established a good understanding of the kind of changes that would be good for me.
    - 1 2 3 4 5 6 7

12. I believe the way we are working with my problems are correct.
    - 1 2 3 4 5 6 7

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Appendix C

Twenty-Item Toronto Alexithymia Scale

The TAS-20 is reprinted by permission of the authors Graeme J. Taylor, MD, R. Michael Bagby, Ph.D., and James D. A. Parker, Ph.D. who own the copyright for which there is a fee. This information may not be reproduced without permission from the authors. Information for obtaining the TAS-20 may be found at www.gtaylorpsychiatry.org.
Twenty-Item Toronto Alexithymia Scale

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by CIRCLING the appropriate NUMBER. Give only one answer for each statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Neither Disagree or Agree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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Appendix D

McMaster Family Assessment Device - General Functioning Scale
McMaster Family Assessment Device – General Functioning Scale

These items contain statements about families. Please read each statement carefully, and decide how well it describes your own family. You should answer according to how you see your family that you grew up with. Using the scale provided as a guide, please answer each item by CIRCLING the appropriate NUMBER. Give only one answer for each statement.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</table>

1. Planning family activities was difficult because we misunderstood each other. 1 2 3 4
2. In times of crisis we could turn to each other for support. 1 2 3 4
3. We could not talk to each other about the sadness we feel. 1 2 3 4
4. Individuals were accepted for what they were. 1 2 3 4
5. We avoided discussing our fears and concerns. 1 2 3 4
6. We could express feelings to each other. 1 2 3 4
7. There were lots of bad feelings in the family. 1 2 3 4
8. We felt accepted for what we were. 1 2 3 4
9. Making decisions was a problem for my family. 1 2 3 4
10. We were able to make decisions about how to solve problems. 1 2 3 4
11. We didn’t get along well together. 1 2 3 4
12. We confided in each other. 1 2 3 4
Appendix E

Family-of-Origin Expressive Atmosphere Scale
Family-of-Origion Expressive Atmosphere Scale

Directions: The family-of-origin is the family with which you spent most or all of your childhood years. This scale is designed to help you recall how your family of origin functioned. Each family is unique and has its own ways of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can. In reading the following statements, apply them to your family of origin, as you remember it. Using the following scale, circle the appropriate number. Please respond to each statement.

1 (SD) = Strongly disagree that it describes my family-of-origin
2 (D) = Disagree that it describes my family-of-origin
3 (N) = Neutral
4 (A) = Agree that it describes my family-of-origin
5 (SA) = Strongly agree that it describes my family-of-origin

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<tr>
<td>1. The atmosphere in my family usually was unpleasant.</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
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<td>2. My parents encouraged family members to listen to one another.</td>
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<td>3. Conflicts in my family never got resolved.</td>
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<td>4. My parents openly admitted it when they were wrong.</td>
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<td>5. My parents encouraged me to express my views openly.</td>
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<td>6. My attitudes and my feelings frequently were ignored or criticized in my family.</td>
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<td>7. In my family I felt free to express my own opinions.</td>
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<td>8. Sometimes in my family I did not have to say anything, but I felt understood.</td>
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<td>9. The atmosphere in my family was cold and negative.</td>
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<td>10. The members of my family were not very receptive to one another's view.</td>
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<td>11. In my family I felt that I could talk things out and settle conflicts.</td>
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<td>12. I found it difficult to express my own opinions in my family.</td>
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1. Mealtimes in my home usually were friendly and pleasant. 
2. In my family no one cared about the feelings of other family members. 
3. We usually were able to work out conflicts in my family. 
4. In my family certain feelings were not allowed to be expressed. 
5. I found it easy in my family to express what I thought and how I felt. 
6. My family members usually were sensitive to one another's feelings. 
7. My parents discouraged us from expressing views different from theirs. 
8. In my family people took responsibility for what they did. 
9. My family had an unwritten rule: Don't express your feelings. 
10. I remember my family as being warm and supportive.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
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<th>SA</th>
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Appendix F

Human Subject Institutional Review Board approval

Western Michigan University
Date: March 18, 2004

To: Alan Hovestadt, Principal Investigator
   Anthony Tatman, Student Investigator for dissertation

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 04-03-14

This letter will serve as confirmation that your research project entitled "The Relationship Between Counselors'-in-Training Personality Traits and Family of Origin Characteristics with the Working Alliance" has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 18, 2005
Appendix G

Human Subject Institutional Review Board approval

University of Missouri-Kansas City
July 27, 2004

Anthony W. Tatman
10619 Mastin, Apt. C
Overland Park, KS. 66212

RE: Protocol # 040707: The Relationship Between Counselor’s-in-Training Family of Origin Characteristics and Personality Traits with the Working Alliance

Dear Mr. Tatman:

This is to inform you that your project proposal listed above was reviewed through the Social Sciences Institutional Review Board’s expedited review process and has received approval under category 7 of the categories of research that may receive expedited review. You may therefore proceed with your study. Notwithstanding the SSIRB’s approval to conduct the study, in the following situations you must provide timely additional information in order to maintain the SSIRB’s approval.

1. The SSIRB cannot approve studies for more than one year. Unless the SSIRB renews its approval, your authority to conduct this study will expire on the anniversary of this letter. To request a continuation of your authority to conduct the study you will need to submit a completed Progress Report Form to the SSIRB office. Your authority to conduct the study cannot be continued until your completed Progress Report form has received the necessary SSIRB review and approval. Therefore, you need to submit the completed Progress Report Form at least one month prior to the anniversary date of your project’s approval/reapproval. (The date of this letter is the approval date for your study. However, if your study requires more than one extension, the applicable anniversary date may change from year-to-year. Consult your most recent approval/reapproval letter for the applicable anniversary date. Call the SSIRB office if you have questions about this.)

2. If you want to make a change to the study, you must obtain the SSIRB’s prior approval of the change.

3. If you want to add or delete investigators from your study, you must obtain the SSIRB’s prior approval of the addition or deletion.
4. If a participant in your study is injured in connection with their participation, you must inform the SSIRB regarding this adverse event in a timely way.

Please inform the SSIRB when you complete the study.

If we can be of further assistance, please don't hesitate to call the SSIRB Chair, Chris Brown, Ph.D. (816-235-2491) or me (816-235-1764). Best wishes for a successful study.

Very truly yours,

Cori Brown
SSIRB Administrator

Enclosure

C: Megan Good
   Alan J. Hovestadt, Ed.D
Appendix H

CIT Informed Consent

Western Michigan University
Dear Counselor:

You are invited to participate in a research project designed to assess the relationship between counselors'-in-training (CITs') personality traits and family-of-origin (FOO) characteristics with the working alliance between counselors and clients. Your participation is voluntary and your responses will be ANONYMOUS. Returning the battery indicates your consent for use of the answers you give for purposes of this study. Your decision about participation in the study will in NO WAY affect your grade in the course. There will be no ramifications for not participating in this study.

You will be asked to complete an assessment battery including two personality measures: the NEO Five-Factor Inventory (NEO FFI; Costa & McCrae, 1992) and Twenty-Item Toronto Alexithymia Scale (TAS-20; Taylor, 1994). The battery will also include two FOO measures: the McMaster Family Assessment Device-General Functioning Scale (FAD-GFS; Epstein, Baldwin, & Bishop, 1983) and the Family-of-Origin Expressiveness Atmosphere Scale (FOEAS; Yelsma, Hovestadt, Anderson, & Nilsson, 2000). The third component of the battery will include an inventory assessing the working alliance between you and a client: the Working Alliance Inventory - Short (WAI-S; Tracey & Kokotovic, 1989). There are two versions of the WAI-S, a CIT WAI-S (white copy), which you will complete and a Client WAI-S (blue copy), which you will invite your clients to complete. Demographic information from you and your clients will be assessed with their respective demographic forms. Instruments will not be allowed to be taken out of the practicum setting.

If you volunteer to participate in this study you will be asked to do 3 things: 1) complete the personality and FOO assessment inventories on the day the study is introduced, 2) complete the CIT WAI-S on the clients you see throughout your practicum, and 3) invite your clients to participate in this study by completing the Client WAI-S.

1) If you decide to participate in the study please complete everything in your packet of assessment materials, except the WAI-S evaluations, on the day the study is introduced. After completing these particular inventories, seal them in the envelope in which the assessment materials came in and deposit the envelope in the receptacle designated for this study located near the clinic receptionist’s desk. If you decide not to participate, seal the uncompleted assessment battery in the envelope in which it came and deposit it in the same receptacle. These instruments should take you approximately 20 minutes to complete.

2) You will also be asked to complete the CIT WAI-S on all the clients you see during your practicum. There is one criterion that must be meet before the CIT WAI-S can be completed: The CIT WAI-S must be completed on a client after whom you have conducted at least 3, but no more than 7, counseling sessions with. Therefore, the CIT WAI-S can only be completed for a particular client after you have completed 3, but no more than 7, counseling sessions. In addition to completing your CIT WAI-S on individual clients, you will also complete separate CIT WAI-S evaluations for each individual in couple or family therapy, if applicable. CIT WAI-S will only be completed for clients 18 years of age or older.
3) To investigate your clients’ perceptions of the working alliance, you will invite all of the clients (18 years of age or older) you see throughout your practicum to complete the Client WAI-S. To correspond with your evaluations, clients are to be invited to complete the Client WAI-S on the same day you complete the CIT WAI-S. Therefore, both you and your client(s) will complete your own WAI-S evaluations after the SAME counseling session. You will invite clients to participate by giving them the Client Invitation and reading it aloud to them. Individuals in couple or family therapy will complete separate Client WAI-S forms. After you read the Client Invitation you will leave the room to allow them to answer the inventory, if they decide to, in private. Do not ask your clients if they have participated in this study. Clients will have instructions in their informed consent on how to complete their evaluation. Completion of the Client WAI-S and client demographic form should take your clients approximately 2 to 4 minutes to complete.

Safeguards have been implemented to maintain you and your clients’ anonymity. You and your client are not to write any identifying information (name, address, phone number, email, or social security number) on this informed consent or on the assessment battery. To minimize potential ramifications from not participating, everyone will be given a packet of assessment materials, regardless of the intent to participate.

For purposes of organization, a code number has been placed on all of your materials. Due to your answers being anonymous, this number can in no way be used to identify who you are. All data received from you will be locked in the principal investigator’s office, and fellow study investigators will only have access to assessment materials for purposes of this research.

If you would like to know the results of this study please contact the Student Investigator by email and the overall results of the study will be emailed to you. By taking advantage of this option, you may benefit from this study by gaining insight into how aspects of counselor-in-trainings’ personality traits and family of origin characteristics are associated with the working alliance.

If you have any questions that arise during the course of this study, you may contact the Student Investigator, Tony Tatman, at 329-2987 or email at tonytatman@yahoo.com or the Principal Investigator, Alan Hovestadt, Ed.D., at 387-5117 or email at hovestadt@wmich.edu. Participants may also contact the Human Subjects Institutional Review Board Chair at 387-8293, or the Vice president for Research at 387-8298 if questions or problems arise during the course of the study.

This document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

If you choose to participate in this study, please hold onto this invitation for your personal records.

Thank you,

Alan Hovestadt, Ed.D.
Principal Investigator

\[\&\]

Tony Tatman, M.S.
Student Investigator

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Appendix I

CIT Informed Consent

University of Missouri-Kansas City
The Relationship Between Counselors' in Training Personality Traits and Family of Origin Characteristics with the Working Alliance

Counselor-in-training Invitation - UMKC

Principal Investigator: Tony Tatman, MS
Faculty Advisor: Alan Hovestadt, Ed.D.

Dear Counselor:

You are invited to participate in a research project designed to assess the relationship between counselors' in training (CITs') personality traits and family-of-origin (FOO) characteristics with the working alliance between counselors and clients. Your participation is voluntary and your responses will be ANONYMOUS. Returning the battery indicates your consent for use of the answers you give for purposes of this study. Your decision about participation in the study will in NO way affect your grade in the course. There will be no ramifications for not participating in this study.

You will be asked to complete an assessment battery including two personality measures: the NEO Five-Factor Inventory (NEO FFI; Costa & McCrae, 1992) and Twenty-Item Toronto Alexithymia Scale (TAS-20; Taylor, 1994). The battery will also include two FOO measures: the McMaster Family Assessment Device-General Functioning Scale (FAD-GFS; Epstein, Baldwin, & Bishop, 1983) and the Family-of-Origin Expressiveness Atmosphere Scale (FOEAS; Yelsma, Hovestadt, Anderson, & Nilsson, 2000). The third component of the battery will include an inventory assessing the working alliance between you and a client: the Working Alliance Inventory – Short (WAI-S; Tracey & Kokotovic, 1989). There are two versions of the WAI-S, a CIT WAI-S (white copy), which you will complete and a Client WAI-S (blue copy), which you will invite your clients to complete. Demographic information from you and your clients will be assessed with their respective demographic forms. Instruments will not be allowed to be taken out of the practicum setting.

If you volunteer to participate in this study you will be asked to do 3 things: 1) complete the personality and FOO assessment inventories on the day the study is introduced, 2) complete the CIT WAI-S on the clients you see throughout your practicum, and 3) invite your clients to participate in this study by completing the Client WAI-S.

1) If you decide to participate in the study please complete everything in your packet of assessment materials, except the WAI-S evaluations, on the day the study is introduced. After completing these particular inventories, seal them in the envelope in which the assessment materials came in and deposit the envelope in the receptacle designated for this study located near the clinic receptionist's desk. If you decide not to participate, seal the uncompleted assessment battery in the envelope in which it came and deposit it in the same receptacle. These instruments should take you approximately 20 minutes to complete.

2) You will also be asked to complete the CIT WAI-S on all the clients you see during your practicum. There is one criterion that must be meet before the CIT WAI-S can be completed: The CIT WAI-S must be completed on a client after whom you have conducted at least 3, but no more than 7, counseling sessions with. Therefore, the CIT WAI-S can only be completed for a particular client after you have completed 3, but no more than 7, counseling sessions. In addition to completing your CIT WAI-S on individual clients, you will also complete separate CIT WAI-S evaluations for each individual in couple or family therapy, if applicable. CIT WAI-S will only be completed for clients 18 years of age or older.
3) To investigate your clients' perceptions of the working alliance, you will invite all of the clients (18 years of age or older) you see throughout your practicum to complete the Client WAI-S. To correspond with your evaluations, clients are to be invited to complete the Client WAI-S on the same day you complete the CIT WAI-S. Therefore, both you and your client(s) will complete your own WAI-S evaluations after the same counseling session. You will invite clients to participate by giving them the Client Invitation and reading it aloud to them. Individuals in couple or family therapy will complete separate Client WAI-S forms. After you read the Client Invitation you will leave the room to allow them to answer the inventory, if they decide to, in private. Do not ask your clients if they have participated in this study. Clients will have instructions in their informed consent on how to complete their evaluation. Completion of the Client WAI-S and client demographic form should take your clients approximately 2 to 4 minutes to complete.

Safeguards have been implemented to maintain you and your clients' anonymity. You and your client are not to write any identifying information (name, address, phone number, email, or social security number) on this informed consent or on the assessment battery. To minimize potential ramifications from not participating, everyone will be given a packet of assessment materials, regardless of the intent to participate.

For purposes of organization, a code number has been placed on all of your materials. Due to your answers being anonymous, this number can in no way be used to identify who you are. All data received from you will be locked in the principal investigator's office, and fellow study investigators will only have access to assessment materials for purposes of this research.

If you would like to know the results of this study please contact the Principal Investigator by email and the overall results of the study will be emailed to you. By taking advantage of this option, you may benefit from this study by gaining insight into how aspects of counselor-in-trainings' personality traits and family of origin characteristics are associated with the working alliance.

The University of Missouri-Kansas City appreciates the participation of people who help it carry out its function of developing knowledge through research. If you have any questions about the research you are participating in you are encouraged to call the Principal Investigator, Tony Tatman, at tonytatman@yahoo.com. Although it is not the policy of the University of Missouri-Kansas City to compensate or provide medical treatment for human participants in the event the research results in physical injury, if you feel you have suffered an injury as a result of your participation in this research, please call Chris Brown, Ph.D., SSIRB Chair at (816) 235-2491 who can review the matter with you.

If you choose to participate in this study, please hold onto this invitation for your personal records.

Thank you,

Tony Tatman, M.S.
Principal Investigator
tonytatman@yahoo.com

&

Alan Hovestadt, Ed.D.
Faculty Advisor
Appendix J

CIT Sociodemographic Form
Counselor-in-Training Demographic Form

PLEASE DO NOT WRITE YOUR NAME ON THIS FORM

AGE: _____

SEX: Male _____ Female _____

CURRENT MARITAL STATUS (check one):

Single _____ Married _____ Divorced _____ Widowed _____

Separated _____ Have a live-in partner _____

Ethnic / Racial Background (check one):

African American _____ Asian / Pacific _____ European / Caucasian _____

Latino / Hispanic _____ Native American _____ Other (specify): ______________

Your Biological Parents are (check one):

Married _____ *Divorced _____ *Separated _____ Other (specify): ______________

If * Above is Checked, Please Indicate Your Approximate Age at the Given Time: _________ years old

Educational Program You are Enrolled in (check one):

Counselor Education - MA (4 Options):

Community Counseling _____ School Counseling _____

Rehabilitation Counseling _____ Student Affairs in Higher Education _____

Counselor Education - Ph.D. / Ed.D. (3 Options):

Counseling Education and Supervision _____ Counseling and Leadership _____

Student Affairs in Higher Education _____

Counseling Psychology: MA _____ Ph.D. _____

Marriage and Family Therapy: _____

Indicate the duration of your counseling experience, not including this current practicum course (check one):

None _____ Under 6 months _____ 6 months to under 1 year _____ 1 to 2 years _____

3 to 5 years _____ 6 to 8 years _____ 9 or more years _____
Appendix K

Client Informed Consent

Western Michigan University
You are invited to participate in a research project designed to investigate counselor-in-training factors that influence the working alliance with clients. The study is being conducted by Alan J. Hovestadt, Ed.D and Tony Tatman, MS from Western Michigan University, Department of Counselor Education and Counseling Psychology. This research is being conducted as part of the dissertation requirements for Tony Tatman. Participation is voluntary.

The Client Working Alliance Inventory-Short is comprised of 12 questions and will take approximately 1 minute to complete. Your replies will be completely ANONYMOUS. Your counselor will not see your responses to this inventory. Do not put your name anywhere on this invitation or on the inventory.

If you choose to participate, 1) please complete the inventory, 2) put it in the envelope provided and deposit it in the receptacle designated for this study located near the clinic secretaries desk, and 3) hold onto this invitation for your own personal records.

If you choose to not participate in this study, to minimize potential repercussions for not participating, please put the uncompleted inventory in the envelope provided and deposit it in the same receptacle mentioned above. Returning the survey indicates your consent for use of the answers you give for purposes of this study.

The code number in the upper right corner of the inventory is included to allow the results of your inventory to be compared with the results from your counselor's assessment information, whose participation is also anonymous.

If you have any questions, you may contact Dr. Alan Hovestadt at 387-5117, Tony Tatman at 329-2987, the Human Subjects Institutional Review Board at 269-387-8293, or the vice president for research at 269-387-8298.

This document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the stamped date is more than one year old.

Thank you,

Alan Hovestadt, Ed.D.
Principal Investigator

&

Tony Tatman, M.S.
Student Investigator
Appendix L

Client Informed Consent

University of Missouri-Kansas City
Client Invitation - UMKC

Principal Investigator: Tony Tatman, MS
Faculty Advisor: Alan Hovestadt, Ed.D.

You are invited to participate in a research project designed to investigate counselor-in-training factors that influence the working alliance with clients. The study is being conducted by Alan J. Hovestadt, Ed.D and Tony Tatman, MS from Western Michigan University, Department of Counselor Education and Counseling Psychology. This research is being conducted as part of the dissertation requirements for Tony Tatman. Participation is voluntary.

The Client Working Alliance Inventory-Short is comprised of 12 questions and will take approximately 1 minute to complete. Your replies will be completely ANONYMOUS. Your counselor will not see your responses to this inventory. Do not put your name anywhere on this invitation or on the inventory.

If you choose to participate, 1) please complete the inventory, 2) put it in the envelope provided and deposit it in the receptacle designated for this study located near the clinic secretaries desk, and 3) hold onto this invitation for your own personal records.

If you choose to not participate in this study, to minimize potential repercussions for not participating, please put the uncompleted inventory in the envelope provided and deposit it in the same receptacle mentioned above. Returning the survey indicates your consent for use of the answers you give for purposes of this study.

The code number in the upper right corner of the inventory is included to allow the results of your inventory to be compared with the results from your counselor's assessment information, whose participation is also anonymous.

The University of Missouri-Kansas City appreciates the participation of people who help it carry out its function of developing knowledge through research. If you have any questions about the research you are participating in you are encouraged to call the Principal Investigator, Tony Tatman, at tonytatman@yahoo.com. Although it is not the policy of the University of Missouri-Kansas City to compensate or provide medical treatment for human participants in the event the research results in physical injury, if you feel you have suffered an injury as a result of your participation in this research, please call Chris Brown, Ph.D., SSIRB Chair at (816) 235-2491 who can review the matter with you.

Thank you,

Tony Tatman, M.S.
Principal Investigator

&

Alan Hovestadt, Ed.D.
Faculty Advisor
Appendix M

Client Sociodemographic Form
Client Sociodemographic Form

DO NOT PUT YOUR NAME ON THIS FORM

Number of counseling sessions you have seen this counselor for: _____

Have you been in counseling before? *Yes _____ No _____

If “Yes,” how many different counselors have you seen? __________________________

If “Yes,” how long was the duration of your past counseling? ____________________

Age: _____

Sex: Male _____ Female _____

Current Marital Status (check one):
Married _____ Single _____ Divorced _____ Widowed _____
Live-in-partner _____

Level of Education (check highest completed):

Did not complete high school Complete high school _____
Freshman in college _____ Sophomore in college _____
Junior in college _____ Senior in college _____
Graduate student: masters _____ Ed.D., JD., Ph.D., Psy. D., MD _____

Ethnic / Racial Background (check one):

African American _____ Asian / Pacific _____ European / Caucasian _____
Latino / Hispanic _____ Native American _____ Other (specify): __________
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