

Utah State University

DigitalCommons@USU

All Graduate Theses and Dissertations

Graduate Studies

5-1998

Relationship of Therapist Age and Gender to Couples' Communication in Marriage and Family Therapy

Norman E. Thibault
Utah State University

Follow this and additional works at: <https://digitalcommons.usu.edu/etd>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Thibault, Norman E., "Relationship of Therapist Age and Gender to Couples' Communication in Marriage and Family Therapy" (1998). *All Graduate Theses and Dissertations*. 2542.

<https://digitalcommons.usu.edu/etd/2542>

This Thesis is brought to you for free and open access by the Graduate Studies at DigitalCommons@USU. It has been accepted for inclusion in All Graduate Theses and Dissertations by an authorized administrator of DigitalCommons@USU. For more information, please contact digitalcommons@usu.edu.



RELATIONSHIP OF THERAPIST AGE AND GENDER TO COUPLES'
COMMUNICATION IN MARRIAGE AND FAMILY
THERAPY

by

Norman E. Thibault

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family and Human Development

Copyright © Norman E. Thibault 1988

All Rights Reserved

ABSTRACT

Relationship of Therapist Age and Gender to Couples'
Communication in Marriage and Family Therapy

by

Norman E. Thibault, Master of Science

Utah State University, 1998

Major Professor: Scot M. Allgood, Ph.D.
Department: Family and Human Development

The purpose of this study was to determine if therapist age and gender have a relationship with the influence tactics used by the therapist in marital therapy, and if this relationship influences the communication behaviors of couples in marital therapy. There has been much research conducted on couples' communication behaviors in therapy, yet none of the research relates the relationship of the age and the gender of therapists with couples' communication behaviors in therapy. This is an exploratory study to examine this relationship.

Forty-four 10-minute videotaped segments of marital therapy were coded to examine the influence tactics used by the therapists, as well as the communication behaviors of the couples in session. Results indicate that therapist age and gender do not have a statistically significant relationship with the influence tactics used by the therapist in marital therapy. In addition, the influence tactics that were used by therapists do not have a

statistically significant relationship with the communication behaviors of the couple in marital therapy.

(64 pages)

ACKNOWLEDGMENTS

I thank Glenna Payne for her graciousness and Thane Palmer for his moral support. I am especially grateful to Dr. Scot Allgood for all of the assistance that he has provided to me in the development of this research.

I also thank my mother, Elizabeth Burrous, for her encouragement. Special thanks goes to my wife, Meg, and my sons, David and Jacob, for their patience, encouragement, and support. I could not have done this work without their dedication to this entire process.

Norman E. Thibault

CONTENTS

vi

	Page
ABSTRACT	iii
ACKNOWLEDGMENTS	v
LIST OF TABLES	viii
CHAPTER	
I. INTRODUCTION	1
Rationale	1
Conceptual Framework	2
Statement of Purpose	3
II. REVIEW OF LITERATURE	4
Marital Communication	4
Therapist Influence on Clients	10
Therapist Age as Variable	14
Therapist Gender as Variable	18
Null Hypotheses	21
III. METHODOLOGY	22
Design	22
Sample	22
Procedure	23
Therapists	24
Ethical Considerations	24
Instrumentation	25
IV. RESULTS	29
V. DISCUSSION	37
Therapist Age and Influence Tactics	37
Therapist Gender and Influence Tactics	38
Therapist Tactics and Couple Behaviors	40
Therapist Gender and Couple Communication	42
Limitations	43
Implications	44

Recommendations	45
VI. REFERENCES	46
VII. APPENDICES	51
Appendix A. Marital Interaction Coding System--Global (MICS--G) Scoring Sheet.....	52
Appendix B. Coding Influence Tactics	55

LIST OF TABLES

Table	Page
1. Age of Therapists and Clients	24
2. Frequencies of Grouped Therapist Influence Tactics	29
3. Means and Standard Deviations of Therapist Age in Comparison with Therapist Influence Tactics	30
4. Percentages of Male Therapist and Female Therapist Influence Tactics	31
5. Means and Standard Deviations of Husbands' and Wives' Problem-Solving Compared with Therapist Influence Tactics	32
6. Means and Standard Deviations of Husbands' and Wives' Validation Compared with Therapist Influence Tactics	33
7. Means and Standard Deviations of Husbands' and Wives' Facilitation Compared with Therapist Influence Tactics	34
8. Means, Standard Deviations, and t-Values by Therapist Gender	35

CHAPTER I

INTRODUCTION

Rationale

Two elements are present in the therapeutic relationship that are often found in the analysis of social power. They are "(a) the influencing agent's possession of scarce resources, in this instance, the therapist's expert and referent power bases and (b) the client's or target's dependency on these resources" (Cooke & Kipnis, 1986, p. 22). The therapist has the expertise and/or resources for change and the client desires these. It is the presence of these components – the therapist's expert stance and power – that allows the therapist to exercise influence in the therapeutic relationship, and these influence tactics are designed to bring about the desired change (Cooke & Kipnis, 1986). What is not fully understood is the role that gender and age of the therapist may play in this influence, especially as it pertains to the communication patterns of couples in marital therapy.

The communication skill level between partners is the most dominant indicator of all relationship behaviors of satisfied or dissatisfied couples (Jacobson, Waldron, & Moore, 1980). Indeed, it has been suggested that in order to understand a relationship, one must examine the communication patterns between the partners (Noller & Fitzpatrick, 1993).

In many therapy modalities, such as behavioral family therapy, Mental Research Institute (MRI) therapy, strategic family therapy, structural family therapy, and solution-focused therapy, the therapist is considered to be the expert and must be granted the power to exert influence when he or she feels necessary (Colapinto, 1991; Falloon, 1991; Fisch, Weakland, & Segal, 1982; Madanes, 1991). Yet this power may be influenced by age and gender of the therapist, as well as the social symbols that they represent. For example, some studies have suggested that clients are more receptive to older therapists (Chevron, Rounsaville, Rothblum, & Weissman, 1983; Lauber & Drevenstedt, 1993), while others

proffer that clients are more satisfied with therapists similar to themselves in age (Robiner, 1987; Tall & Ross, 1991). In regards to therapist gender, some studies have found that males and females differ in their preferences for the gender of their therapist (Stamler, Christiansen, Staley, & Macagno-Shang, 1991); that female therapists are more effective (Jones, Krupnick, & Kerig, 1987; Nelson, 1993); and that male therapists use more power-tactics in session (DeVaris, 1994; Shields & McDaniel, 1992).

Most of the research conducted on these variables has been done with individual clients. There is a dearth of information examining the influence of the age and gender of the therapist on a couple's communication patterns in marriage therapy.

Conceptual Framework

Symbolic interactionism concerns itself with the link between symbols and interactions. The framework focuses on how humans together create symbolic worlds through perceptions and meanings and how these worlds then influence human behavior (LaRossa & Reitzes, 1993). Symbolic interactionism suggests that individual identities are composed through their interactions with a variety of social groups and institutions. Meanings are constructed through these interactions and people thus create their experience of the world around them through these meanings. When people confront this world, they must act based on their interpretation of the meanings; how a person symbolizes his or her experiences will then lead to acting in certain ways while in certain situations. Hence, there is a relationship between personal and social meaning such that a crisis may be termed both personal and social. It is personal in that it is disruptive to the individual and it is social because an individual's culture defines what the crisis means and thus, what steps should be taken to correct it, such as marital, family, or individual therapy (Greene, 1994).

A critical question addressed by symbolic interaction theory is, "How do people experience themselves and others?" (Greene & Ephross, 1991). This is a major thrust behind symbolic-experiential family therapy, in which the goal of the therapy is "to aid the family to develop its own customs more freely, without being bound to carry values or goals set in the past or to make up for the past" (Roberto, 1991, p. 461). In this modality, change comes through repositioning of the clients with their significant others and, as a result, the clients experience themselves differently (Roberto, 1991). In the case of a therapist and client relationship, it could be argued that age and gender influence the experience of both the client and the therapist, thus influencing the process and outcome of therapy itself.

Statement of Purpose

The purpose of this study was to explore if therapist age and gender are related to the influence tactics used by the therapist in marital therapy. Further, this study explored if this relationship is associated with the communication behaviors of couples in marital therapy.

CHAPTER II

REVIEW OF LITERATURE

The review of literature will cover marital communication, the influence tactics used by the therapist, therapist age, and therapist gender. Relations between these variables are reviewed and used to develop research questions.

Marital Communication

The most dominant indicator of satisfied or dissatisfied couples is the communication skill level between partners (Jacobson et al., 1980). Further, it has been stated that in order to understand a marital relationship, one must examine the communication patterns between the partners (Noller & Fitzpatrick, 1993).

Communication between partners is examined in a variety of ways in studying marital satisfaction. For example, Krokoff (1991) has examined negative affect in consideration of a couple's communication orientation; Pollock, Die, and Marriott (1990) examined communication style and marital role expectations; Haefner, Notarius, and Pelligrini (1991) simply examined marital discussions; and Gottman (1994) examined the link between physiological changes within partners while communicating. Overall, these researchers have found that couples who have a higher level of negative exchanges and increased emotional distress express more dissatisfaction in their marriages.

Negative Communication Patterns

Levenson and Gottman (1983) studied 30 married couples in a naturalistic setting to determine how affective and physiological patterns could account for variation in marital

satisfaction. They found "less positive affect and more negative affect in dissatisfied marriages, especially when the topic turned to a problem area in the marriage" (Levenson & Gottman, 1983, p. 595). In other words, couples who interact in negative ways are more likely to have unsatisfactory marriages. These results are consistent with Gottman's (1979) research on distressed couples.

Gottman and Krokoff (1989) examined differences between happy marriages and those that are unhappy by looking at marital interaction. In their research, 25 couples were studied over a 3-year period. The authors reported that couples should address their differences and engage in conflict, but not to the point where the husband becomes defensive, stubborn, or withdrawn. These cases, according to Gottman and Krokoff (1989), are perhaps the most harmful to marital satisfaction over the course of the marriage. The findings are also consistent with Levenson and Gottman's (1985) research indicating that when marriages are declining in satisfaction, it is usually the husband who first begins to withdraw emotionally and he does so much earlier than his wife.

Krokoff (1991) studied the impact that strong negative affect has on marital satisfaction when considering the couple's communication orientation. Krokoff found that for conflict-avoidant wives ($N = 52$) being able to express disgust or contempt may prove beneficial over the course of the marriage, whereas with conflict-engaging wives, such behaviors may lead to decreased satisfaction, especially if the spouses continue to escalate anger through their responses. In essence then, conflict may mean different things for a conflict-engaging wife than for a conflict-avoidant wife and this difference influences marital satisfaction. They add, however, that conflict-engagers view negative affect as detrimental

to a relationship. This research is important to the present study as it relates the salience of negative affect within marriage to the marital couples' communication style.

Markman (1991), in a review of marital communication literature, found that compared to nondistressed couples, distressed couples displayed more negative affect, negative escalation, complaining, and withdrawal. These types of verbal and nonverbal behaviors have traditionally been recognized in literature as dysfunctional and at the very least, as variables of distress. In addition, "high levels of emotional invalidation (for men and women) and problem-solving inhibition (for men), and low levels of problem-solving facilitation (for men) predict both divorce and marital distress five years later" (p. 85). Markman went on to say that based on the interaction of the couple and in looking at who is receiving invalidation in a relationship, he can predict (with over 80% accuracy) who will divorce. His research presents a strong case that marital communication is a powerful variable in assessing marital satisfaction.

Noller and Fitzpatrick (1993) have stated that marital satisfaction appears to be impacted by the processes that couples go through as they seek to resolve differences; that destructive methods have far-reaching effects, especially as the conflict is not resolved and feelings of hurt, resentment, and anger are present. They added that "the positive behaviors of agreement, approval, assent, humor, and laughter are used more by the nondistressed couples than the other couples," whereas in distressed couples the use of negative communication behaviors, such as "command, disagreement, criticism, put down, and excuse," are used more often (Noller & Fitzpatrick, 1993, p. 115).

The studies reviewed to this point illustrate how negative communication habits and patterns can negatively influence a relationship. They help to clarify the salience of the

study of marital communication in regards to marital satisfaction. The examination of positive communication patterns would also be beneficial in studying marital communication in regards to marital satisfaction.

Positive Communication Patterns

Burleson and Denton (1992) examined communication skills in regards to their impact on attraction. They hypothesized that the more similar a couple is in their communication skills, the more likely they are to have enjoyable interactions and an increased attraction to one another. They studied 60 couples whose mean age was 32.6 (range 18-53) and their results were consistent with their hypothesis, such that spouses who had similar communication skills reported greater attraction to one another. Thus, similar communication patterns may be one indication of a satisfactory marital relationship.

Haefner et al. (1991) explored communication by looking at marital discussions. Their sample included 27 couples who were married an average of 22.8 years, and whose average age was 48.8 years. They found that couples who reported greater marital satisfaction appeared to engage in more problem-solving facilitation and less problem-solving inhibiting behaviors. These results indicate that marital satisfaction may be predicated upon the manner in which problem-solving is addressed; hence communication may play an important role in marital satisfaction.

Gladding (1995) reported that good communication patterns are an important quality in healthy families. He stated that in healthy families, members are aware of one another and understand each other's cues, whereas in dysfunctional families, there is competition between members to speak or maintain silence and although messages are sent, they are not often received appropriately.

The research cited on positive communication patterns indicates that couples who exhibit these attributes report greater marital satisfaction than couples who do not exhibit positive communication patterns. Thus it would appear that in studying marital satisfaction, one would do well to address the communication patterns between spouses.

Gottman (1994) summed up his twenty-plus years of research on marriages and marital satisfaction by classifying marriages into three groups based on how they resolve conflict: validating marriage, in which problems are calmly addressed and worked out in a manner satisfactory to both partners; conflict-avoiding marriage, with partners who rarely address their conflicts; and volatile marriage, in which there are often heated disputes between the partners (p. 28). Gottman stated that each of these styles may work equally well in predicting future success of the marriage, but they will not guarantee a happy marriage. He proffered that the basic formula for a happy marriage is this: "No matter what style your marriage follows, you must have at least five times as many positive as negative moments together if your marriage is to be stable" (p. 29).

Gottman (1994) went on to describe communication patterns that predict marital dissatisfaction and resolution. These he termed "The Four Horsemen of the Apocalypse" (p. 29). They are criticism, which amounts to attacking one's spouse and not the spouse's behavior; contempt, which is the intention to insult and emotionally abuse one's spouse; defensiveness consists of a variety of behaviors, including denying responsibility, making excuses, disagreeing with negative mind reading (when one's spouse makes assumptions in a negative manner), cross complaining (meeting a complaint from your spouse with one of your own), whining, and repeating oneself over and over again; and withdrawal, in which one or both partners turns very silent and does not respond to messages conveyed by the other

partner. Gottman stated that this progression is much more common in men and once it becomes a common fixture in a marriage, it is very difficult to reverse the downward spiral of the marriage (1994).

In follow-up research to his work, Gottman, Coan, Carrere, and Swanson (1998) examined the marital interaction processes that are predictive of divorce or marital stability. They followed 130 newlywed couples over a 6-year period, examining their interactions using seven process variables: anger as a dangerous emotion, active listening, negative affect reciprocity at start-up by the wife (where the wife responds to a negative message from the husband with a negative reaction back), de-escalation (using techniques to diffuse a tense situation), positive affect variables (humor, affection, and interest), and physiological soothing of the male (by the wife to calm her husband). Of the subjects, 17 couples divorced. The researchers found that anger as a dangerous emotion was not supported as a factor in divorce, nor was active listening or negative affect reciprocity. They did find that the husbands' rejecting their wives' influence, negative startup by wives, a lack of de-escalation, and a lack of physiological soothing of the male are all specific types of communication and were predictors of divorce. The researchers reported that they predicted with 83% accuracy which of the marriages would divorce and which resulted in marital stability.

A major theme throughout this research on marital satisfaction and communication is that couples who have a higher level of negative exchanges express more dissatisfaction in their marriages. In addition, the inverse is true, such that couples who have a higher level of positive communication express more satisfaction in their marriages.

Many modalities in Marriage and Family Therapy recognize this link between marital communication and marital satisfaction. One of the main foci of assessment and treatment in these modalities is to change problematic communication behaviors between couples, thus increasing their marital satisfaction (Baucom & Epstein, 1990; Falloon, 1991; Minuchin, 1974; Satir, 1988). As stated above, in order to bring about this change, the therapist must have an influence on the couple in therapy.

Therapist Influence on Clients

As mentioned above, the therapist's expert stance and the client's reliance on this resource are variables similar to those involved in the analysis of social power (Cooke & Kipnis, 1986). The therapist has the expertise and/or resources for change, and the client desires these. It is the presence of these components that allows the therapist to exercise influence in the therapeutic relationship.

In regards to this influence, Cooke and Kipnis (1986) examined those conditions that affected the therapists' attempts to influence their clients. They studied 11 psychotherapists, of whom six were male and five were female. Each therapist provided two tapes of therapy sessions involving themselves and one client of either sex for a total of 22 tapes. The researchers defined influence as an attempt to modify the clients' thoughts, feelings, and behaviors. As the therapist sought to influence the client in session, the researchers focused on the therapists' verbal statements. Two dimensions of influence were coded: strength of the influence attempt, and the goals of the influence (see Appendix B). Cooke and Kipnis (1986) found that there were certain characteristics common among therapists. For example, they discovered that all of the therapists used subtle tactics to

influence the clients at the beginning of therapy, while in later sessions they used more active attempts. Additionally, they reported that male therapists attempted more influencing acts and interrupted their clients more than did female therapists, while the female therapists spent more time listening to their clients. Finally, Cooke and Kipnis reported that differential treatment was accorded based on the sex of the client. Specifically, therapists made more direct attempts to instruct female clients what to do directly, while they explained the process to males. In addition, the direction given to females was rated as stronger than that given to males; this held true for both male and female therapists. These findings are of critical import, as they address gender differences in the influence that is present in the relationship between therapist and client. As will be discussed below, it is this influence that allows the therapist to take his/her role as expert and use that role in conducting therapy.

The role of the therapist in marriage and family therapy is largely determined by the theory of change to which the particular therapist subscribes. Inherent in this role is the amount of influence that the therapist holds over the course of treatment, over the direction of the session, and over the clients themselves. This influence can be expressed in a variety of ways, from assessing the family in therapy to arranging the seating in session; from deciding which theory to use to handling financial arrangements. As previously discussed, one of the ways in which couples may improve their relationship is in enhancing their communication skills and patterns, and this is an important area in which the therapist may intervene.

Behavioral Marital Therapy

In behavioral marital therapy, the therapist is considered a facilitator of treatment: "The role of the therapist...is to facilitate efforts to overcome manifest deficits and to improve the efficiency of the family members' responses" (Falloon, 1991, p. 84). In addition, the therapist is charged with setting the atmosphere and structure for change (Holtzworth-Munroe & Jacobsen, 1991). The therapist teaches the family how to communicate and function by his/her own example and through the use of specific skills taught in session, and is free to use his/her influence to identify behaviors exhibited by the family that are displeasing to the therapist (Falloon, 1991).

Mental Research Institute Therapy

Others have suggested that the therapist must be considered the expert in session, thus allowing the therapist to exert his/her influence whenever and wherever necessary (Colapinto, 1991; Fisch et al., 1982; Madanes, 1991; Segal, 1991). The Mental Research Institute (MRI) approach states that the therapist must be free to exercise his/her position at will, to the point where the therapist should be willing to "fire" the client if the therapist does not have this influence (Segal, 1991, pp. 179-180). In addition, this approach states that the therapist must be "an active agent of change," considering the behaviors that maintain the problem and the strategic solutions to the problem (Fisch et al., 1982, p. 19).

Strategic Family Therapy

Madanes (1991) has suggested that in strategic family therapy, the therapist's influence extends so far as to organize the plan to solve the client's problems and to set the goals of therapy for the client. Haley (1973) added that in this therapy, the therapist must

have the power to initiate what happens during the session and to then construct an approach to each problem. Hence, considerable freedom is accorded the therapist in this modality.

Structural Family Therapy

Structural family therapy maintains that the therapist is "the instrument of change," rather than the technique or theory used (Colapinto, 1991, p. 435). In this modality, the therapist is considered the "producer" of the conditions that will make therapy possible, the "stage director," who challenges the family's structure, the "protagonist," who intervenes directly in family transactions, and the "narrator," who "coauthors" the new way in which the family interacts (Colapinto, 1991, pp. 435-436). Minuchin and Fishman (1981) state that in Structural Family Therapy, the therapist "is free to do whatever feels right, as long as he remains within the harmonic structure. That is how things are" (p. 3).

Solution-Focused Therapy

Other modalities propose that the therapist has influence in ways other than being expert. Berg (1994) stated that in solution-focused therapy, the therapist must be willing to become a part of the client's family system through the use of very specific questions that are geared to form goals and solutions. Others have stated that the therapist exerts influence in solution-focused therapy when "the therapist controls the course of the session, raises and drops issues, and influences the mood of the session through his or her own behavior" (Furman & Ahola, 1992, p. 11).

In a variety of ways, therapists are constantly influencing their clients. Through the use of their ascribed power, therapists may dictate the structure, the treatment, and the

goals of therapy. Yet within this presumption lies another variable that may play a role in the way that the power is exerted: that of age.

Therapist Age as Variable

Chevron et al. (1983) examined the relationship between therapist age and skill level. They studied 27 therapists (15 MDs, 11 Ph.D.s, and one Ed.D. degree in counseling). Their study emphasized the use of short-term interpersonal psychotherapy as a treatment modality, and they focused their criterion for therapist skills on the ability to use this therapy and on the ability of the therapist to be empathic in session. Empathy ratings were based on the therapist seeming to understand the client, working with the client in a joint effort, respecting the client as a person, in attempting to see things as the client does, and in relaying this understanding to the client. These were each rated from 1 to 10, with higher scores indicative of greater empathy. The ability to practice using short-term interpersonal psychotherapy was rated based on the therapist skill at helping the client disclose intimate information, the willingness of the therapist to engage the client in a discussion of interpersonal difficulties, therapist ability to maintain focus, and in refraining from techniques not used in the modality. These were each rated from 1 to 10, with higher scores being indicative of greater potential to use short-term interpersonal psychotherapy. Results indicated that therapist age is significantly ($r = .94$, $p < .001$) correlated with the ability to practice using short-term interpersonal psychotherapy, as well as with the therapist's use of empathic behaviors in session. Specifically, older psychotherapists were rated as demonstrating higher levels of empathy and more potential for the use of short-term interpersonal psychotherapy than were younger therapists (Chevron et al., 1983).

In regards to the age of the therapist when dealing with older adults, Lauber and Drevenstedt (1993), in their study of 60 subjects (30 male, 30 female) age 60 or older, determined that the respondents preferred older therapists to younger therapists. In using the age matching hypothesis, they were able to state that the older adults preferred a therapist of the same age. "These older adults expressed beliefs that [the] therapist had undergone many of the same life events and experiences as the older adult client" (p. 23); hence, the clients were more willing to work with these therapists.

Hayslip, Schneider, and Bryant (1989) also looked at the perception of older persons on therapist age; however, they focused solely on female clients and female therapists. Their study of 96 female clients, age 69 or older, indicated that the women reported greater satisfaction in therapy with older counselors when less intimate concerns were discussed (i.e., doing community work, developing hobbies, etc.) rather than high intimacy issues (i.e., marital communication, inhibited sexual desire, etc.). Interestingly, both younger and older therapists were perceived as being similar in anticipated overall satisfaction with therapy (Hayslip et al., 1989).

Robiner (1987) conducted what he termed the "first systematic study that attempts to explore transference role projections in old and young clients using social psychological methods" (p. 306). He examined age effects in therapy by using three hypotheses. Specifically, Robiner hypothesized that:

1. Therapist age affects clients' view of therapists. Older therapists are more likely to be viewed as parents. Younger therapists are more likely to be viewed as children.

2. Client age affects client's views of therapists. Older clients are more likely to view therapists as peers or children. Younger clients are more likely to view therapists as parents.
3. Similarity or discrepancy of age between clients and therapist affects client perceptions of therapists. (1987, p. 308)

Robiner found that "age-similarity between clients and therapists appears to influence client impressions of therapists, helping to define the relationship within the context of other important personal relationships, even though it does not appear to affect rapport or client satisfaction" (1987, p. 309). Robiner added that this impression of therapists, influenced by age, resulted in such a way that "older clients more readily saw similarity between therapists and children, whereas young clients were very reluctant to see either older or young therapists as children" (p. 309). Conversely, the findings did not indicate that younger clients viewed older therapists as parental figures (1987).

Tall and Ross (1991) hypothesized that "prospective clients would perceive a psychotherapist similar in age more favorably than a therapist dissimilar in age" (p. 197). For their sample, they used 72 female subjects ranging in age from 18-30 years for the young group, 40-50 years for the middle-aged group, and 60-71 years for the older group. There were 24 persons in each group and no explanation was given in the literature as to why females alone were used. They were asked to rate six therapists on four dimensions (counseling climate, willingness to disclose to the therapist, counselor competence, and counselor preference) based on written descriptions of each, with two levels of experience (low, high) and three levels of age (young, middle-aged, older). Gender of the therapists was not revealed. Tall and Ross found that "the young and the older subjects consistently

preferred high experienced to low experienced therapists" (p. 205). They added that the middle-aged subjects did not express a preference for therapists based on experience. Interestingly, "on the preference for a therapist and the willingness to disclose dimensions, young subjects gave the least positive ratings to the most dissimilar aged therapist" (p. 206). This pattern was similar to that observed by the older subjects, who rated the youngest therapists less positively on the willingness to disclose and therapist competence dimensions.

Weisz, Weiss, and Langmeyer (1987) sought to determine whether therapist age played a factor in child psychotherapy dropout rates. They examined 469 children, aged 6-17 years, who were seen at a public mental health clinic. Of these, 166 were identified as dropouts. The research did not find any statistically significant relationships between therapist age and whether or not children dropped out. A possible explanation for the contradiction between these findings and others previously discussed could rest in the simple fact that the subjects were children (Weisz et al., 1987).

In his book Diffusion of Innovations, Rogers (1983) synthesized approximately 3,100 publications on change agents. In so doing, he outlined factors that play a role in facilitating change in regards to others. Among the variables mentioned, Rogers pointed out that homophily with the client is of critical import to successful change. The closer the agent of change (i.e., the therapist) is to the client in a variety of areas – including age – the greater the chance for success in change. This evidence indicates that therapist-client age and gender similarities facilitate change.

Therapist Gender as Variable

As discussed above, therapy is an arena in which considerable influence may be exerted by the therapist. In examining this influence, it is imperative to consider gender as an influential variable in itself.

Stamler et al. (1991) investigated client's initial preference for therapist gender. Their participants ($N=495$) were clients who received an intake interview for individual therapy. There were 350 females and 145 males in the sample. The authors stated that female clients were more likely to express a preference for therapist gender, whether the gender was male or female. In addition, the sex of the intake counselor played an important role such that those who had a female intake counselor were twice as likely to express a preference for gender as those who saw a male intake counselor. When the intake counselor was a male, male clients who expressed a preference wanted a male therapist, while women expressing a preference and seeing a male intake counselor wanted a female therapist (1991). Hence, males and females do differ in their expression of preference for the gender of their therapist.

Nelson (1993) reviewed literature pertaining to the impact of the clients' and therapists' gender in counseling sessions. In examining differences in client outcome based on gender, she concluded that "some gender differences in the direction of better outcomes for female clients have been observed" (p. 202). She speculated that this may be due to therapists' using stronger influence tactics with female clients than with male clients. Nelson also sought to examine the impact of same-gender and opposite-gender pairings in therapy in her review of literature. She found contradictions in the outcome studies, stating that some studies indicate that clients of both genders do better with female therapists,

whereas other studies state that clients have more positive outcomes with same-gender therapists, and yet other studies have found that clients may benefit from opposite-gender pairings. Nelson (1993) indicated that the findings are inconclusive in regards to which gender-pairing works best for the client.

Jones et al. (1987) investigated gender effects on brief psychotherapy. In their research, 40 female clients were divided into two equal groups, each of which saw either a male or a female therapist ($N=25$; 11 female therapists and 14 male therapists). The mean age of the clients was 40 years. Their findings indicated that the gender of the therapist impacted the process and the outcome of therapy, such that clients who were seen by a female therapist reported more symptomatic improvement and were more satisfied with therapy. In follow-up, those who were seen by female therapists continued to improve. Interestingly, Jones et al. (1987) found that the therapists did not fit the stereotypical image of female and male therapists. The female therapists were not found to be more supportive, sensitive, or nurturing; the male therapists were not more aloof, condescending, or impatient. Although gender did have an impact on therapeutic outcome, the best predictor of successful outcome was the client's pretreatment level of functioning.

DeVaris (1994) examined the dynamics behind gender influences in session from a feminist viewpoint. She stated that gender plays a hidden, yet salient role in the therapeutic relationship, such that when the therapist or client is male, he is accorded more socially prescribed power than is the female, whether she be therapist or client. DeVaris stated that the only way that the power balance may be equal is when the therapist and client are of the same gender. Clearly then, DeVaris believes that in being a male, whether as a therapist or client, one is ascribed a power that creates an imbalance in the therapeutic relationship.

The previously discussed findings of Cooke and Kipnis (1986) are paralleled by Nelson and Holloway (1990), who also examined the relationship of gender in regards to power and involvement in therapist supervision. They used audiotaped supervision sessions from 40 master's-level therapist trainees and their 40 practicum-site supervisors. They found that supervisors of both sexes did not support the female trainees when they assumed power in the supervision session and that female trainees defer power more often to an authority figure than do male trainees. These findings suggest that when female trainees attempt to assume the role of expert, they are not often supported. And if they are supported, they often relinquish that power. The authors stated that individuals who are considered expert, no matter the gender, assume more power with female subordinates by either exerting stronger influence with females, or by withholding support from them.

Zygmund and Denton (1988) looked at the impact of gender bias on clinical decision making. Their study of 64 therapists indicated that while client gender did not impact prognostic decisions, therapist gender did have an influence, such that the prognostic decisions made were arrived at by using different cognitive dimensions based on gender. This would indicate that men and women perceive situations differently.

Shields and McDaniel (1992) studied the process differences between male and female therapists in the context of a first interview with a client family. In their between-groups design, 63 families were seen by 22 different therapists. Of the first sessions, 33 were seen by men and 30 by women. Their results appear to agree with DeVaris (above), as they indicated that "male therapists tend to be more instrumental or directive than female therapists. Both the male therapists and the families they worked with seemed to engage in more of a 'battle for structure'" (p. 149). In particular, Shields and McDaniel (1992) found

that clients made more controlling statements to a male therapist than to a female therapist. In addition, they found that family members were more likely to express disagreement between themselves when the therapist was female. The researchers offered an explanation for this behavior, such that "male therapists are more instrumental and take control of the family, whereas female therapists are more facilitative and allow the family to be themselves" (p. 150).

In summary, research indicates that marital communication patterns and behaviors may be used as indicators of relationship strength or weakness. It also appears that the age and gender of the therapist may have a relationship with the therapeutic process and eventual therapeutic outcomes.

Null Hypotheses

In this review of literature, marital communication, therapist influence, therapist age, and gender of therapist have been examined, leading to the following null hypotheses:

1. There will be no association between age and the therapists use of instruction, explanation, focusing, reinforcing, and supporting their clients in therapy.
2. There will be no gender differences in the use of influence tactics by therapists.
3. There will be no relationship between couples problem-solving, validation, and facilitation and the use of instruction, explanation, focusing, reinforcing, supporting, and interruption by therapists.
4. There will be no difference in couples' communication based on therapist gender.

CHAPTER III

METHODOLOGY

This chapter will address the research design, sampling, measures, and the research procedure. This is intended to provide a means by which the reader may replicate this research.

Design

This study is correlational (Miller, 1986). It examines the relationship between the age and gender of the therapist, and the influence tactics used by the therapist, all of which are independent variables, and the communication behaviors of couples in marital therapy, which are dependent variables.

Sample

Videotapes of 44 male and female therapists conducting marital therapy were used in this research. The videotapes came from the Utah State University Marriage and Family Therapy Clinic in Logan, Utah ($N = 20$) and the Auburn University Marriage and Family Therapy Clinic in Auburn, Alabama ($N = 24$). Both universities have master's-level Marriage and Family Therapy programs. The Utah State University Marriage and Family Therapy program and the Auburn University Marriage and Family Therapy program are accredited by the American Association for Marriage and Family Therapy (AAMFT). Both institutions are land-grant institutions and are housed in relatively rural areas with a city population around 30,000 persons. Although the clinics are located on the campuses of each university, the clients seen are regularly referred through advertisements placed in

community newspapers or on local radio stations. Each of the clients used in this research presented to therapy with issues relating to their marriage. These included the decision to divorce, communication difficulties, or stress in their relationship. The videotapes from Auburn are part of an unrelated research project conducted by the author's major professor.

Procedure

Couples utilized in the research called to make a therapy appointment at their respective location and were assigned to the next available therapist. At the outset of their first session, the couples read and signed the informed consent form, which detailed their rights as clients and as subjects in research. This form also outlined the responsibility of the researchers regarding confidentiality.

Therapy was conducted with the couples until the couples terminated the therapeutic process for reasons of their own volition. All cases lasted at least three sessions and all sessions with the couples were videotaped. The videotapes were kept in the locked office of the Family Life Center and were available only to those who are trained coders participating in this research. The videotapes were checked out by the secretary of the Family Life Center to the coders, who took them to an on-site observation room for coding. No tapes left the Family Life Center.

The clients at both locations were not systematically assigned to therapists. As they called to make an appointment, they were assigned to the therapist who was next on the list to be scheduled.

Therapists

The therapists were second-year master's students enrolled in a marriage and family therapy program. Twenty-eight therapists are female and 16 are male, with ages ranging from 24 - 43, and a mean age of 31. (Refer to Table 1.) There are no statistically significant differences between the Auburn and Utah State samples in regards to therapist or client ages.

Ethical Considerations

Each of the couples was given an informed consent form before beginning therapy. This form stated that the therapy sessions would be videotaped for research and supervision purposes. In addition, it stated that the clients could terminate their participation in the research or in therapy at any time. If they so chose, alternative therapeutic options would have been made available to them.

Table 1

Age of Therapists and Clients

Subjects	N	M	SD
Male therapist	16	27.44	4.27
Female therapist	28	32.64	6.56
Male client	44	35.58	11.08
Female client	44	34.30	10.93

The videotapes were held in a locked room at the Family Life Center at Utah State University. The researcher does not know the names of the clients on the videotapes. Coders were given explicit instructions as to confidentiality of the clients and they were also instructed not to watch or code a tape in which they recognized the participants.

Instrumentation

The videotapes were coded using the Marital Interaction Coding System--Global (MICS--G; Weiss & Tollman, 1990) and an as yet unnamed classification scheme developed solely to code the influence tactics used by therapists (Cooke & Kipnis, 1986).

The Marital Interaction Coding System--Global

The MICS--G is a coding system for analyzing couples' behaviors. Six different areas were rated in regards to a couple's functioning: conflict, problem-solving, validation, invalidation, facilitation, and withdrawal. See Appendix A for the subcategories that elucidate these variables.

Each of these variables was rated separately for each spouse. Couples were rated according to how representative their behavior was in regards to each of six categories, not necessarily how often a particular behavior was seen. For example, while a spouse may exhibit every behavior on a certain scale and score very high, another spouse may exhibit one or two behaviors and do so with such force and energy that he/she also obtains a particularly high score. Each category of communication has an overall score ranging from zero to five. A score of zero indicates that the spouse has not demonstrated any of the behaviors from that category. A score of three indicates that the spouses' behaviors from

that category occur fairly often or with some intensity. A score of five from a category means that the spouses' behavior appeared most of the time and/or was very intense.

Therapist Influence

The coding scheme developed by Cooke and Kipnis (1986) was established solely to focus on influence tactics used by therapists. They defined influence as an attempt to modify the clients' thoughts, feelings, and behaviors. A critical aspect of their coding system examines the goals of the influence, as based on the verbal statements of the therapist. Each time the therapist spoke, the statements that conveyed a single goal of influence were coded, and thus one code could constitute one word or many. From this, a dominant form of influence for each therapist is derived (see Appendix B). Since the creation of this coding scheme, it has been used by other researchers to examine constructions of therapeutic process by therapists and clients (Heppner, Rosenberg, & Hedgespeth, 1992), as well as being suggested for use in coding therapists' cognitive styles in training (Barone & Hutchings, 1993), and in training mental health practitioners in psychiatric rehabilitation (Rogers, Cohen, Danley, Hutchinson, & Anthony, 1986).

The goals of influence outlined by Cooke and Kipnis (1986) were used to code the influence tactics of the therapist in this research. These goals of influence are outlined in Appendix B.

Coding

To avoid treatment effects, each videotape contains a 10-minute section that was randomly selected from one of the first three sessions of therapy for each client through the use of a random-number table. These sections were coded using the MICS--G to examine

the couple, and the influence coding scheme developed by Cooke and Kipnis (1986) to examine the therapist. The data were then compiled and stored on floppy disk.

Reliability

Marital Interaction Coding System--Global. In order to use the MICS--G for another research project, four upper-division undergraduate students majoring in family and human development at Utah State University were trained as coders according to Weiss and Tolman's (1990) instruction booklet. Initially, these students trained for one quarter on videos that were not used in this research. They were instructed to watch the videos in pairs for one week and together produce composite scores. The partners were rotated every week in the training meeting and the various teams worked on their coding until they reached agreement. The initial training used a simple agree/disagree ratio; when the scores between coders reached 90% agreement or greater, the coders were assigned research tapes to code.

Each of the four coders examined the same segments of the first three tapes used in the research and Kappa reliabilities were computed. Each team of coders had a Kappa reliability of $> .80$, with the exception of the team in which one particular coder was a member. When this coder participated in the training, the Kappa reliability fell below $.80$ for his team, no matter his partner. In looking at the differences between the coders, it was found that the coder who had the dyads with the lower Kappa reliability had not reviewed the instruction manual. The coder was subsequently retrained; still, the Kappa reliability scores were less than $.80$. Consequently, the coder reported that the task was too difficult and asked to be removed from the project. Three coders remained.

The Kappa reliability for every sixth tape coded by the remaining three coders ranged from .79 to .86. Every 2 weeks during the quarter, a refresher course on coding procedures and definitions was held to minimize drift in the systematic way that the tapes were coded.

Therapist influence tactics. Two upper-division undergraduate students majoring in family and human development were trained to code therapist influence according to guidelines offered by Cooke and Kipnis (1986). The coders were trained over the course of one quarter using videotapes at the Family Life Center that were not a part of the original research. The coders were taught to recognize the six communication areas of the MICS--G and the affective cues associated with them, as well as the nine goals of influence as outlined by Cooke and Kipnis. Working individually, the coders' scores were compared with one another weekly; by the third week of training, there were no disagreements in any of the 13 segments of videotape coded and the students began to code the project videotapes. Kappa reliabilities were assessed with every sixth videotape coded and the lowest Kappa total was .90.

CHAPTER IV

RESULTS

The coding scheme outlined by Cooke and Kipnis (1986) was used to code therapists' influence tactics in this research as to the goal of the therapists' influence. Due to the small number of tactics that were actually used by the therapists in this sample, some of the influence variables were combined with similar influence tactics to allow an examination of the hypotheses in this study (see Table 2).

The therapists' use of instruction and information providing was combined as a single variable, insight, because the goal of both of these influence tactics is to modify client behaviors through insight. The variable explanation was retained. The influence tactics focusing and information seeking were combined as one variable, behavioral focus. The goal of these influences is to focus the client on their behaviors and the content of the session in regards to those behaviors. The variable verbal reinforcement was retained.

Table 2

Frequencies of Grouped Therapist Influence Tactics

Therapist influence tactics	Frequency	Percent
Insight	9	20.4
Explanation	10	22.7
Behavioral focus	9	20.4
Verbal reinforcement	16	36.4
Total	44	100.0

There were no cases where the predominant influence was therapist support. Table 2 shows the frequency of influence tactics for therapists in this sample after grouping the variables as described above.

The first null hypothesis was that there would be no association between age and therapists' use of instruction, explanation, focusing, reinforcing, and supporting their clients in therapy. As stated above, therapists' support as an influence tactic was not used with any clients in the present study. Given that age is an interval-level variable and that the influence tactics are nominal, a one-way analysis of variance was used to test the hypothesis. The means and standard deviations of therapist influence tactics by therapist age are reported in Table 3.

Table 3

Means and Standard Deviations of Therapist Age in Comparison with Therapist Influence Tactics

Therapist influence tactic	Therapist age		
	<u>N</u>	<u>M</u>	<u>SD</u>
Insight	9	31.11	5.28
Explanation	10	32.50	8.45
Behavioral focus	9	30.78	7.10
Verbal reinforcement	16	28.13	3.12
Total	44		

The ANOVA revealed no statistically significant relationship between the age of the therapists and their use of these influence tactics, $F(3, 31) = 1.21$, $p = .32$ (mean squares between groups = 40.55; mean squares within groups = 33.48). Although therapists who used verbal reinforcement tended to be younger than therapists who used other tactics, none of the comparisons were statistically significant at the .05 level. The null hypothesis was retained.

The second null hypothesis stated that there would be no gender differences in the use of influence tactics by therapists ($N = 44$, 16 male, 28 female). Both gender and the influence tactics are nominal-level variables. Given the level of measurement for these variables, chi-square was considered for the analysis. However, a major assumption is that there be a minimum of five cases per cell. This assumption was not met with the data for this hypothesis (see Table 4). Visual inspection of the distribution of variables, however, provides information such that the data appear to support the null hypothesis. Where one

Table 4

Percentages of Male Therapist and Female Therapist Influence Tactics

Therapist influence tactic	Male therapist n (%)	Female therapist n (%)	N (%)
Insight	2 (12)	8 (29)	10 (24)
Explanation	3 (19)	6 (21)	9 (20)
Behavioral focus	3 (19)	6 (21)	9 (20)
Verbal reinforcement	8 (50)	8 (29)	16 (36)
Total	16 (100)	28 (100)	44 (100)

might expect the male therapists to focus on behaviors or provide insight, the predominant influence tactic used by male therapists (50%) was verbal reinforcement, compared to 29% of female therapists. In addition, note that the female therapists were using tactics thought to be used more commonly by male therapists.

The third hypothesis was that there would be no relationship between couples' problem-solving, validation, and facilitation and the use of instruction, explanation, focusing, reinforcing, and supporting by therapists. The variables involving the couples' communication behaviors yielded interval-level data; the influence tactics used by the therapists yielded nominal-level data. A one-way analysis of variance with each of the couples' behaviors was used for the analysis.

Results indicate that there is not a statistically significant relationship between influence tactics and the husbands' problem-solving, $F(3, 40) = .14, p > .05$ (mean squares between groups = .30; mean squares within groups = 2.15; see Table 5). This also held true

Table 5

Means and Standard Deviations of Husbands' and Wives' Problem-Solving Compared with Therapist Influence Tactics

	N	Husband		Wife	
		<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Insight	9	2.00	1.58	2.22	2.05
Explanation	10	1.90	1.60	2.30	1.25
Behavioral focus	9	2.00	1.22	3.11	1.69
Verbal reinforcement	16	2.25	1.44	2.63	1.31

for the relationship between therapist influence tactics and the wives' problem-solving in session, $F(3, 40) = .14, p > .05$ (mean squares between groups = 1.50; mean squares within groups = 2.40). Note, however, that the wives' mean problem solving tended to be higher when therapists used a behavioral focus in their influence tactic ($M = 3.11$), although this mean was not statistically significant from the others.

Results comparing the validation behaviors with the couple to the therapists' influence used are summarized in Table 6. Husbands' validation was not found to be statistically significant with the influence tactics used by the therapists, $F(3, 40) = .04, p > .05$ (mean squares between groups = .09; mean squares within groups = 2.24). This was also the case in regards to the relationship between the wives' validation and the therapists' influence tactics, $F(3, 40) = .33, p > .05$ (mean squares between groups = .97; mean squares within groups = 2.95).

Table 6

Means and Standard Deviations of Husbands' and Wives' Validation Compared with Therapist Influence Tactics

Therapist influence tactic	N	Husband		Wife	
		M	SD	M	SD
Insight	9	1.56	1.67	2.22	1.79
Explanation	10	1.60	1.35	1.70	1.77
Behavioral focus	9	1.78	1.30	2.44	1.74
Verbal reinforcement	16	1.69	1.58	2.00	1.63

In regards to the facilitation behaviors of the couple in session, results (see Table 7) indicate that husbands' facilitation was statistically significant with the therapists' influence tactics, $F(3, 40) = 3.06$, $p < .05$ (mean squares between groups = 6.73; mean squares within groups = 2.20). Husbands in session were less likely to use behaviors that facilitate healthy communication behaviors if the therapist used verbal reinforcement as an influence tactic. Wives' facilitation was not statistically significant to the therapists' influence tactics, $F(3, 40) = 2.29$, $p > .05$ (mean squares between groups = 4.95; mean squares within groups = 2.16). With the exception of the husbands' facilitation, no other facilitation behaviors were statistically significant. Hence, the null hypothesis was supported by this research.

The fourth hypothesis stated that there would be no differences in couples' communication behaviors based on the gender of the therapist. Thus t tests were used to test the hypotheses (see Table 8). Results of this analysis do not indicate a statistically significant

Table 7

Means and Standard Deviations of Husband's and Wives' Facilitation Compared with Therapist Influence Tactics

Therapist influence tactic	N	Husband		Wife	
		<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Insight	9	2.00	1.22	2.11	1.36
Explanation	10	2.30	2.21	2.50	2.07
Behavioral focus	9	2.11	1.36	2.00	1.12
Verbal reinforcement	16	.75	1.06	1.06	1.24

Table 8

Means, Standard Deviations, and t-Values by Therapist Gender

	Male therapist <u>n</u> = 16		Female therapist <u>n</u> = 28		<u>t</u>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
Communication behavior					
Wife conflict	2.38	1.86	2.71	1.89	-.58
Husband conflict	1.56	1.90	2.39	1.77	-1.46
Wife facilitation	1.63	1.31	1.89	1.66	-.55
Husband facilitation	1.31	1.30	1.82	1.72	-1.02
Wife validation	2.31	1.58	1.93	1.75	.73
Husband validation	1.50	1.21	1.75	1.58	-.55
Wife withdrawal	2.25	1.69	1.71	1.58	1.05
Husband withdrawal	2.63	1.63	1.89	1.75	1.37
Wife invalidation	2.00	1.67	1.82	1.98	.30
Husband invalidation	1.38	1.63	2.00	1.49	-1.29
Wife problem-solving	2.50	1.71	2.60	1.45	-.22
Husband problem-solving	2.06	1.39	2.07	1.46	-.02

relationship between any of the communication behaviors of the couple and the therapists' gender. The fourth null hypothesis was supported.

In summary, results from this research indicate that there was not a statistically significant relationship between the influence tactics used by the therapists and the communication behaviors of the couples in marital therapy. There was one exception with

the lower facilitation behaviors used by husbands when the therapist conducting the session used verbal reinforcement as an influence tactic.

CHAPTER V

DISCUSSION

The purpose of this study was to determine if therapist age and gender have a relationship with the influence tactics used by the therapist in marital therapy. Further, it sought to examine if this relationship is associated with the communication behaviors of couples in therapy.

Therapist Age and Influence Tactics

The first hypothesis was that there would be no association between therapists' age and their use of instruction, explanation, focusing, reinforcing, and supporting their clients in therapy. There were no statistically significant differences in the use of influence tactics of therapists based on ages. Though not statistically significant, there was a tendency for younger therapists to be more likely to use verbal reinforcement as an influence tactic than their older counterparts. This seems to differ from the findings of Chevron et al. (1983), who found that older therapists are more likely to help individual clients disclose intimate information, are more willing to engage the client in a discussion of interpersonal difficulties, and are able to maintain focus better than their younger counterparts. Yet, according to this study, neither older nor younger therapists seek to exert more influence than do their counterparts.

The fact that the therapists in the present study were all at approximately the same level of training in their profession may have masked any age differences that could have been derived from a different, more experienced sample of professionals. The age range of the therapists in the present study is truncated, ranging only from 24 to 43, and could very

well have limited the ability of this research to fully examine this hypothesis. In addition, the sample size of therapists was relatively small, thus limiting the power of the analysis.

Therapist Gender and Influence Tactics

The second hypothesis, that there would be no gender differences in the use of influence tactics by therapists, was not statistically tested in this study due to violations in the assumptions of the chi-square test. Nevertheless, the data reveal interesting trends in regards to the hypothesis. Percentages indicate that half of the male therapists used verbal reinforcement as their primary influence tactic, while 29% of the female therapists used verbal reinforcement. This seems to agree with Shields and McDaniel (1992), who found that "male therapists tend to be more instrumental or directive than female therapists" (p. 149). The goal of verbal reinforcement is to direct clients such that they remain on task in session, which half the male therapists did in this research.

Another pattern in the data lies in the influence tactics used by the female therapists. The percentages of the influence tactics indicate that female therapists are using tactics thought to be used primarily by male therapists, such as explanation and focusing on behaviors. This contradicts the findings of Cooke and Kipnis (1986), who found that male therapists used more types of influence tactics than did female therapists. It should be noted that all of the clients in the Cooke and Kipnis study were female and seen on an individual basis. The present study includes couples and the difference in dynamics of having both male and female clients may account for some of the difference between the two studies. In addition, the present study had more than twice as many female therapists ($n = 28$) as did the Cooke and Kipnis study ($n = 11$). Other sample differences in the two

studies could account for this discrepancy as well. Cooke and Kipnis had therapists in their sample who had already completed their training and were psychiatrists and Ph.D.- and M.A.- level psychologists, while the sample in the present study consisted of 44 marriage and family therapy trainees at the master's degree level. Therapists at this level would not normally possess the skills of therapists who have completed their training and who have been active in the profession.

Another difference between this research and the Cooke and Kipnis (1986) study may lie in the presenting issues of the clients in the two samples: The therapists studied by Cooke and Kipnis had clients with diagnoses of anxiety disorder, depression, adjustment problems, and personality disorders, which may require a more direct, influential approach than the issues treated by the therapists in the present study, which consisted solely of marital problems. It is possible that there may be different interpersonal dynamics existing in marital therapy that are not present in therapy involving individuals, thus requiring different therapist approaches and influence tactics.

If the female therapists are using a variety of influence tactics, as indicated by the percentages, the findings of the present study would also contradict Shields and McDaniel (1992), who stated that male therapists tend to take control of the couple, while female therapists allow the couple to be themselves. From this research, it appears that therapists of both sexes seek to exert some form of influence over the family. It also seems to contradict DeVaris (1994), who hypothesized that male therapists are accorded more socially prescribed power in the therapy than are female therapists. Again, these differences may be best accounted for by the differences in sample characteristics, such as the therapists' training level, sample size and age-range, and the issues presented by the client.

Another possible influence on the difference between this research and the aforementioned studies in regards to gender could lie in changes instituted by the American Association for Marriage and Family Therapy (AAMFT), the governing body of marriage and family therapy (MFT) training. The AAMFT has recently required all MFT training programs to incorporate the topic of gender in every class (AAMFT, 1997). Many of the therapists involved in this study have all been recipients of this training; it may be assumed that most of the therapists involved in the other studies have not, because gender as an element in the therapeutic process has only recently become addressed in mental health education. It is possible that the recent MFT emphasis on gender could account for some of the differences between the present study and those already cited, such that the therapists in this research may have been sensitized in such a way that no differences were detected.

Therapist Tactics and Couple Behaviors

The third null hypothesis was that there would be no relationship between couples' problem-solving, validation, and facilitation, and the use of instruction, explanation, focusing, reinforcing, and supporting by therapists. While the null hypothesis was supported by the results, there are salient points that emerge regarding these relationships. Husband facilitation was statistically significant when compared with the influence tactic of verbal reinforcement as used by the therapists. An examination of the means of the data reveals that the husbands in this study were less likely to use behaviors that facilitate healthy communication if the therapist used verbal reinforcement. While not statistically significant, wife facilitation was also the least used communication behavior when the therapist used verbal reinforcement. This may be explained in examining the goal of the influence tactic,

which is to keep the couple on task. Contrast this with the purpose of communication facilitating behaviors, which may be considered more of a distraction in session (i.e., humor, positive physical contact, smiling/laughing). If a couple senses, through the therapist's verbal reinforcement, that the therapist wants to continue to work through issues, then they may be less willing to exhibit some of the facilitating behaviors and remain on task.

In regards to problem-solving communication, it is interesting to note that the wives' problem-solving behaviors appeared most often when the therapist focused on behaviors as an influence tactic. This is consistent with current research, indicating that focusing on one's behavior facilitates problem-solving communication behaviors (Gottman, 1994; Gottman et al., 1998). Gottman (1994) stated that when behaviors are addressed, rather than the personal attributes of the individual, the person in question is less likely to be defensive and retaliate. Instead, the person is more likely to address the problems mentioned, and work through them in a calm fashion.

Gottman (1994) and Gottman et al. (1998) stated that positive communication behaviors by the couple itself are health promoting. This statement and the present findings seem to contradict the notion that in order for a therapist to be effective, he or she must have power to influence the couple (Calapinto, 1991; Fisch et al., 1982; Madanes, 1991; Segal, 1991). Nelson's (1993) speculation that females have better therapy outcomes because therapists use stronger influence tactics with them also appears to be contradicted, as the influence tactics used here seem to have had no statistically significant relationship with healthy communication between the couple.

It is plausible that the experience level of the therapists may have confounded their use of influence and hence, the use of health-promoting communication by the couple. In

addition, the timing of the sample in the therapy process may influence the use of health-promoting communication. Cooke and Kipnis (1986) found that therapists are less likely to use influence tactics on couples earlier in the therapy process. And if the couple is in the early stages of therapy, one could assume that the couple would be less apt to use these types of communication than if they have participated and worked with these behaviors over time. The couples in this study were observed during one of their first three therapy sessions.

Therapist Gender and Couple Communication

The final hypothesis that there would be no difference in couples' communication based on therapist gender was also supported by this research. There was not a statistically significant relationship between the communication behaviors exhibited by the couples and the gender of the therapists. However, there are some salient points that can be drawn from the data. As Shields and McDaniel (1992) found in their research, both the husband and the wife in this study seemed more likely to express disagreement between themselves when the therapist was female. As previously stated, this may be related to the female therapists intervening less than the male therapists in the couple dynamic. The findings of the present study also seem to indicate that husbands withdraw more frequently when the therapist is a male. Shields and McDaniel have suggested that there is more struggle for structure in therapy sessions when the therapist is male; perhaps the withdrawal of the husbands in the present study is related to this struggle.

In one way, these findings appear to be similar to those of Jones, Krupnick, and Kerig (1987), who found that the therapists they studied did not fit gender stereotypes, and that therapists of both genders had basically the same attributes according to their clients.

Similarly, none of the couples' communication behaviors in this research significantly differed by the gender of the therapist.

In summary, in this research, the age and gender of the therapist did not have a statistically significant relationship with the influence tactics used by the therapist. In addition, the influence tactics used did not have a relationship with the communication behaviors of the couples in marital therapy. The characteristics of the therapists used in the study, especially their inexperience and relatively young age, as well as the characteristics of the clients, may have obscured any influence and/or communication effects.

Limitations

A major limitation in this study is that of the age of the therapists. The restricted age range did not allow comparisons with older therapists and the concurrent influence tactics that they may have used. In addition, the experience level of the therapists in this research limited the scope of the study. They were beginning therapists with but 1 to 2 years of experience. This sample limitation could possibly sway the amount and type of influence used by the therapists in session. In addition, this limits the generalizability of this study solely to other marriage and family therapy master's-level programs.

All of the subjects in this research received therapy in front of a large, one-way mirror with video cameras in the corners of the room. The therapists, as students, identified themselves as such. Together, these factors may have influenced the couple such that they could have altered behaviors that might not have occurred in other settings.

Also, there could certainly be limitations imposed by the measures used to code both the communication behaviors of the couples and the influence tactics of the therapists. Some possible limitations are having to group the influence tactics coded in

order to statistically test the hypotheses, as well as not having more specific information in regards to communication within the therapy setting. For example, in the session, to whom was the therapist directing the influence tactic, husband or wife? To whom was the husband or wife speaking when their communication behavior was coded, the therapist or their spouse? The answers to these questions may provide important information in addition to that which was derived by the present research.

Implications

This study raises additional questions regarding both the relationship of age and gender of the therapist with the influence tactics that the therapist uses, and the role of therapist influence tactics on couples' communication behaviors in therapy. As the field of marriage and family therapy continues to expand, it is important to further the knowledge of the relationships of these variables in the therapeutic arena. This study seems to agree with that of Nelson (1993), who indicated that her findings are inconclusive in regards to which gender pairing works best for the client.

The role of therapist influence and power as constituted in the present research is inconclusive. There were no statistically significant findings regarding these variables, but some data patterns were observed consistent with past research regarding the influence tactics used by the therapist.

The results of the present study, however, indicate that the age and the gender of the therapist do not have a statistically significant relationship with the influence tactics used by the therapist. In addition, the influence tactics used by the therapists in this research do not have a statistically significant relationship with the communication patterns of couples in therapy. The limitations in this study include the truncated age range of the therapists,

the limited experience of the therapists, the similarity in therapist training, the limited client sample, and the difficulty in assessing and coding behaviors in marital therapy.

Recommendations

Future studies in this area would benefit by using a larger and more diverse therapist sample. Having a larger age range for the therapists studied would be most beneficial. Including therapists who have not been trained in the same therapeutic modality (i.e., marriage and family therapy) may provide some variability. Because the Auburn University and Utah State University MFT programs teach similar therapy models, including therapists representative of different types of MFT training programs may prove beneficial to the research. Having more experienced therapists might also serve the research well in examining any differences in therapist experience and their use of influence tactics.

Other recommendations for continued research in this area include having a larger, more varied client sample. The areas from which the clients were drawn for this research are rather conservative, rural communities; having a sample from a variety of community types may enhance the generalizability of the research. It would also be helpful to have sessions of the same type (i.e., individual or marital sessions) to which one could compare with previous research. As explained, much of the previous research cited in this study was comprised of sessions of varying types.

REFERENCES

- American Association for Marriage and Family Therapy. (1997). Committee on Accreditation for Marriage and Family Therapy education manual (9th ed.). Washington, DC: Author.
- Barone, D. F., & Hutchings, P. S. (1993). Cognitive elaboration: Basic research and clinical application. Clinical Psychology Review, 13, 187-201.
- Baucom, D. H., & Epstein, N. (1990). Cognitive-behavioral marital therapy. New York: Brunner/Mazel.
- Berg, I. K. (1994). Family based services. New York: Norton.
- Burleson, B. R., & Denton, W. H. (1992). A new look at similarity and attraction in marriage. Similarities in social-cognitive and communication skills as predictors of attraction and satisfaction. Communication Monographs, 59, 268-287.
- Chevron, E. S., Rounsaville, B. J., Rothblum, E. D., & Weissman, M. M. (1983). Selecting psychotherapists to participate in psychotherapy outcome studies: Relationship between psychotherapist characteristics and assessment of clinical skills. The Journal of Nervous and Mental Disease, 171, 348-353.
- Colapinto, J. (1991). Structural family therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy (Vol. 2, pp. 417-443). New York: Brunner/Mazel.
- Cooke, M., & Kipnis, D. (1986). Influence tactics in psychotherapy. Journal of Consulting and Clinical Psychology, 54, 22-26.
- DeVaris, J. (1994). The dynamics of power in psychotherapy. Psychotherapy, 31, 588-593.
- Falloon, I. R. (1991). Behavioral family therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy (Vol. 2, pp. 65-95). New York: Brunner/Mazel.

- Fisch, R., Weakland, J. H., & Segal, L. (1982). The tactics of change: Doing therapy briefly. San Francisco: Jossey-Bass.
- Furman, B., & Ahola, T. (1992). Solution talk: Hosting therapeutic conversations. New York: Norton.
- Gladding, S. T. (1995). Family therapy: History, theory and practice. Englewood Cliffs, NJ: Prentice-Hall.
- Gottman, J. M. (1979). Marital interaction: Experimental investigations. New York: Academic Press.
- Gottman, J. M. (1994). Why marriages succeed or fail. New York: Fireside.
- Gottman, J. M., Coan, J., Carrere, S., & Swanson, C. (1998). Predicting marital happiness and stability from newlywed interactions. Journal of Marriage and the Family, 60, 5-22.
- Gottman, J. M., & Krokoff, L. (1989). Marital interaction and satisfaction: A longitudinal view. Journal of Consulting and Clinical Psychology, 57, 47-52.
- Greene, R. R. (1994). Human behavior theory. New York: Aldine de Gruyter.
- Greene, R. R., & Ephros, P. H. (1991). Human behavior theory and social work practice. New York: Aldine de Gruyter.
- Haefner, P. T., Notarius, C. I., & Pelligrini, D. S. (1991). Determinants of satisfaction with marital discussion: An exploration of husband-wife differences. Behavioral Assessment, 13, 67-82.
- Haley, J. (1973). Uncommon therapy. New York: Norton.
- Hayslip, B., Jr., Schneider, L. J., & Bryant, K. (1989). Older women's perceptions of female

- counselors: The influence of therapist age and problem intimacy. The Gerontologist, 29, 239-244.
- Hepner, P. P., Rosenberg, J. I., & Hedgespeth, J. (1992). Three methods in measuring the therapeutic process: Clients' and counselors' constructions of the therapeutic process versus actual therapeutic events. Journal of Counseling Psychology, 39, 20-31.
- Holtzworth-Munroe, A., & Jacobson, N. S. (1991). Behavioral marital therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy (Vol. 2, pp. 96-133). New York: Brunner/Mazel.
- Jacobson, N. S., Waldron, H., & Moore, D. (1980). Toward a behavioral profile of marital distress. Journal of Consulting and Clinical Psychology, 53, 696-703.
- Jones, E. E., Krupnick, J. L., & Keri, P. K. (1987). Some gender effects in brief psychotherapy. Psychotherapy, 24, 336-352.
- Krokoff, L. J. (1991). Communication orientation as a moderator between strong negative affect and marital satisfaction. Behavioral Assessment, 13, 51-65.
- LaRossa, R., & Reitzes, D. C. (1993). Symbolic interactionism and family studies. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.), Sourcebook of family theories and methods: A contextual approach (pp. 135-162). New York: Plenum Press.
- Laub, B. M., & Drevstedt, J. (1993). Older adults' preferences for age and sex of a therapist. Clinical Gerontologist, 14, 13-26.
- Levenson, R. W., & Gottman, J. M. (1983). Marital interaction: Physiological linkage and affective exchange. Journal of Personality and Social Psychology, 45, 587-597.

- Levenson, R. W., & Gottman, J. M. (1985). Physiological and affective predictors of change in relationship satisfaction. Journal of Personality and Social Psychology, 49, 85-94.
- Madanes, C. (1991). Strategic family therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy (Vol. 2, pp. 396-416). New York: Brunner/Mazel.
- Markman, H. J. (1991). Constructive marital conflict is not an oxymoron. Behavioral Assessment, 13, 83-96.
- Miller, B. C. (1986). Family research methods. Newbury Park, CA: Sage.
- Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.
- Minuchin, S., & Fischman, H. C. (1981). Family therapy techniques. Cambridge, MA: Harvard University Press.
- Nelson, M. L. (1993). A current perspective on gender differences: Implications for research in counseling. Journal of Counseling Psychology, 40, 200-209.
- Nelson, M. L., & Holloway, E. L. (1990). Relation of gender to power and involvement in supervision. Journal of Counseling Psychology, 37, 473-481.
- Noller, P., & Fitzpatrick, M. A. (1993). Communication in family relationships. Englewood Cliffs, NJ: Prentice-Hall.
- Pollock, A. D., Die, A. H., & Marriott, R. G. (1990). Relationship of communication style to egalitarian marital role expectations. Journal of Social Psychology, 130, 619-624.
- Roberto, L. G. (1991). In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy (Vol. 2, pp. 444-476). New York: Brunner/Mazel.
- Robiner, W. N. (1987). An experimental inquiry into transference roles and age.

- Psychology and Aging, 2, 306-311.
- Rogers, E. M. (1983). Diffusion of innovations (3rd ed.). New York: Free Press.
- Rogers, E. S., Cohen, B. F., Danley, K. S., Hutchinson, D., & Anthony, W. A. (1986).
Training mental health workers in psychiatric rehabilitation. Schizophrenia Bulletin,
12, 709-719.
- Satir, V. (1988). The new peoplemaking. Mountain View, CA: Science and Behavior
Books.
- Segal, L. (1991). Brief therapy: The MRI approach. In A. Gurman & D. Kniskern (Eds.),
Handbook of family therapy (Vol. 2, pp. 171-199). New York: Brunner/Mazel.
- Shields, C. G., & McDaniel, S. H. (1992). Process differences between male and female
therapists in a first family interview. Journal of Marital and Family Therapy, 18,
143-151.
- Stamler, V. L., Christiansen, M. D., Staley, K. H., & Macagno-Shang, L. (1991). Client
preference for counselor gender. Psychology of Women Quarterly, 15, 317-321.
- Tall, K. M., & Ross, M. J. (1991). The effects of therapist-client age similarity on pretherapy
expectations. Journal of Contemporary Psychotherapy, 21, 197-209.
- Weiss, R. L., & Tolman, A. O. (1990). The marital interaction coding system-global (MICS-
G): A global companion to the MICS. Behavioral Assessment, 12, 271-294.
- Weisz, J. R., Weiss, B., & Langmeyer, D. B. (1987). Giving up on child psychotherapy:
Who drops out? Journal of Consulting and Clinical Psychology, 55, 916-918.
- Zygmund, M. J., & Denton, W. (1988). Gender bias in marital therapy: A multidimensional
scaling analysis. The American Journal of Family Therapy, 16, 262-272.

APPENDICES

Appendix A

Marital Interaction Coding System--Global (MICS--G)

Scoring Sheet

	Cue Impression		Category Rating	
	Husband	Wife	Husband	Wife
Conflict				
1. complain	----	----	----	----
2. criticize	----	----		
3. negative mind-reading	----	----		
4. Put downs/ insults	----	----		
5. negative commands	----	----		
6. hostility	----	----		
7. sarcasm	----	----		
8. angry/bitter voice	----	----		
Problem-solving				
1. problem description	----	----	----	----
2. proposing solution	----	----		
3. compromise	----	----		
4. reasonableness	----	----		
Validation				
1. agreement	----	----	----	----
2. approval	----	----		
3. accept responsibility	----	----		

4. assent ---- ----

5. receptivity ---- ----

6. encouragement ---- ----

Invalidation

1. disagreement ---- ---- ---- ----

2. denial of responsibility ---- ----

3. changing of subject ---- ----

4. consistent interruption ---- ----

5. turn-off behaviors ---- ----

6. domineering behaviors ---- ----

Facilitation

1. positive mind reading ---- ---- ---- ----

2. paraphrasing ---- ----

3. humor ---- ----

4. positive physical contact ---- ----

5. smile/laugh ---- ----

6. open posture ---- ----

Withdrawal

1. negation ---- ---- ---- ----

2. no response ---- ----

3. turns away ---- ----

4. increased distance ---- ----

5. erects barriers ---- ----

6. noncontributive

Note:

Weiss, R. L., & Tolman, A. O. (1990). The marital interaction coding system-global (MICS-G): A global companion to the MICS. Behavioral Assessment, 12, 271-294.

Appendix B

Coding Influence Tactics

Goals of Influence classifications according to Cooke and Kipnis (1986, p. 23):

1. Instruction: This included attempts to change the client's behavior. For example, "Try to speak to your mother when you go home."
2. Explanation: This included attempts to change the client's thinking by means of explanations about the client's feelings, thinking, or behavior. For example, "Maybe he makes you feel the way your father used to make you feel."
3. Focusing: This included attempts to make the client reflect on his or her own behavior. For example, "Well, what do you think?" or "Are you very upset by that?"
4. Verbal reinforcement: This included attempts to keep the client talking about the topic of presumed interest to the therapist. For example "Um huh."
5. Information seeking: This included clarification of specific details. For example, "How long were you married?"
6. Information providing: This included supplying information regarding, for example, employment, birth control, and so forth.
7. Support: This included attempts to change the client's feelings about himself or herself through encouragement and empathy. For example, "You are really sounding more confident since the last time I saw you." This could be used alone or in addition to another goal.
8. Therapist's interruption: Whenever the therapist interrupted the client, this code was entered in addition to the goal of the attempt.
9. Noncodable (e.g., inaudible statements).

Note:

Cooke, M., & Kipnis, D. (1986). Influence tactics in psychotherapy. Journal of Consulting and Clinical Psychology, 54, 22-26.