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Paradigm Adherence and Personality Correlates Across Mental Health Professions

Laura Anne Rauscher
University of Missouri-St. Louis, larauscher@yahoo.com

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PARADIGM ADHERENCE AND PERSONALITY CORRELATES

ACROSS MENTAL HEALTH PROFESSIONS

by

LAURA ANNE RAUSCHER

M.Ed. Community Counseling, emphasis in Couples and Family Counseling, 2004

B.A. Psychology, with a minor in Communications, 2001

A DISSERTATION

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Advisory Committee

R. Rocco Cottone, Ph.D.
Chairperson

Susan Kashubeck-West, Ph.D.
Committee Member

Jennifer McAfee-Maag, Ph.D.
Committee Member

Janice Munro, Ed.D.
Committee Member

ABSTRACT

Paradigm adherence has been developed as a meta-theoretical approach to organize and to classify the multitude of different theories of counseling and psychotherapy. Four paradigms have been identified in the literature: The Organic-Medical, The Psychological, The Systemic-Relational, and the Social Constructivist paradigms. Only one other study to date has examined paradigm adherence of a group (Marriage and Family Therapists) and how it can be of value to the mental health professionals. This study examined the relationship between paradigm adherence and different characteristics of mental health professionals in the state of Missouri. In this study, Licensed Psychologists, Licensed Clinical Social Workers, and Licensed Professional Counselors were surveyed to investigate if there was paradigm alignment across professions. Demographic variables, supervisory experiences, and personality variables were also assessed to explore any correlates with paradigm adherence. Chi square analyses revealed that there was no significant relationship between paradigm adherence and the profession of the respondents. Chi square analyses also indicated that no relationship existed between paradigm adherence and one's supervisory experiences. Results of a discriminant analysis revealed that demographic variables did not contribute to discriminating among the paradigm adherence groups. Results on the personality assessment indicated that individuals that adhered to the Social Constructivist paradigm scored significantly higher on the Honesty-Humility scale than adherents to the Psychological paradigm, but there were no significant group differences on all six personality scales combined. Implications and suggestions for future research are provided.

DEDICATION

I would like to dedicate this dissertation to my fabulous family. First, I would like to dedicate this work to my brother, Matt Partridge, sister and brother-in-law, Karen and Matt Sifford, and my gorgeous niece, Mackenzie. I feel so blessed to have my family members be my best friends as well. I love you all and am thankful you are in my life!

This dissertation is also dedicated to my parents, Roy and Linda Partridge. I do not know how I will ever truly be able to express all of my love and gratitude for you. You have allowed me so much freedom, yet offered guidance when needed. You have created a respectful, cohesive family environment that provides an oasis in any and every storm. Thanks to you, I consistently know peace and serenity in my world. I thank you that you respected me, taught me how to respect myself, and encouraged me to never settle for anything less than what I desire. You are the most loving and unconditional people, and I thank my universe every day that you are my parents, my role models, and my best friends! Thank you for all that you have done and continue to do, especially in providing unconditional love, guidance, and support (and babysitting too!). I love you both very much!

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CHAPTER I

INTRODUCTION

Mental health professionals continually seek the best methods in working with clients. Given the multitude of educational and philosophical backgrounds of practitioners, it is typically suggested during graduate education that these professionals use a theory of counseling and psychotherapy to guide their practice (Fall, Holden, & Marquis, 2004; Halbur & Halbur, 2010). Although theory only accounts for approximately 15% of success in psychotherapy (Asay & Lambert, 1999), the use of theory enables practitioners to conceptualize and to treat their clients with a sense of direction and confidence (Gladding, 2007). It is estimated that there are over 400 different theories of counseling and psychotherapy in use today (Corsini & Wedding, 2005). These theories address issues as disparate as faulty cognitions (Beck, 1976), faulty interactional patterns (Haley, 1987), and "biologization" (Slife, 2001, p.xiv) for defining dysfunction. Newer ideas about the use of social constructivism in a therapeutic context have emerged, focusing on the meaning clients have constructed about their problems (Held, 2001). With the vast number of theories available and with such a wide range of underlying philosophies guiding these theories, various methods to classify these theories have been created to assist mental health practitioners in choosing and using a specific theory.

Halbur and Halbur (2010) developed a tool to identify theoretical orientation among six different schools of thought: Psychodynamic; Behavioral; Humanistic; Pragmatic; Constructivist; and Family Theories. This classification consists of individual theories under a specific school of thought, based on "related beliefs" (p. 47). Halbur and

Halbur (2010) provided a scale for counselors to identify their theoretical views and then to calculate their scores to provide the top three theories or schools of thought that correspond to their counseling beliefs.

Cottone (1992, 2007) outlined a paradigm model, based on six qualifying criteria, classifying the theories of counseling and psychotherapy into one of four paradigms: organic-medical; psychological; systemic-relational; and social constructivist. Cottone defined paradigms as "meta-theoretical frameworks" (Cottone, 1992, p. 20). These frameworks give practitioners a way to evaluate how to treat client problems based on "philosophical and meta-theoretical grounds" (Cottone, 2007, p. 190).

In addition to being philosophically distinct, each paradigm defined by Cottone (1992, 2007) must meet other criteria. Each must reframe the nature of cause and effect when assessing the etiology of mental health issues. Testability as a scientific theory and competition from another paradigm are also relevant. Specific therapies must also align with a paradigm. Finally, each paradigm must have a group of professionals that adheres primarily to the paradigm (Cottone, 1992, 2007). The organic-medical paradigm focuses on biological, physiological, and organic means for assessing, diagnosing, and treating mental health issues. The primary professional group that adheres to this paradigm is psychiatrists, based on the emphasis on the physical realm for causation and cessation of symptomology. The psychological paradigm, where psychologists are the primary professional adherents, emphasizes creating change by focusing on each individual's thoughts, behaviors, and/or feelings. In order to create change, something has to change with the individual's internal processes or by means of the external environment. It is believed that most counselors practice within this paradigm as well (Cottone, 2007). In

the systemic-relational paradigm, the focus is on relationships. Marriage and family therapists, the primary adherents to this paradigm, focus on the system, or network of relationships, as a means of problem definition and problem solution. The fourth paradigm, the social constructivist paradigm, focuses on creating change by exploring the socially constructed understanding of each client within a problem context. As a result, the emphasis is on the context of language and the client's social world to find a consensus for both assessment and treatment. Cottone (1992) proposed that professional counselors could be the primary adherents of this paradigm.

Much research has been generated examining the factors that might account for theoretical choice. Both personal and professional factors are thought to influence theoretical orientation, including personality traits, educational and training backgrounds, and years of clinical experience (Bitar, Bean, & Bermudez, 2007). One major factor that is thought to not only influence the initial choice of a theoretical orientation but to also guide a practitioner's lifelong use of a theory is that of the supervisory experience (Guest & Beutler, 1988). It is believed that the supervisor's theoretical orientation will aid therapists-in-training to choose and to utilize the theory consistent with the supervisor's theoretical preference (Murdock, Banta, Stomseth, Viene, & Brown, 1998; Putney, Worthington, & McCullough, 1992). Booth (1997) found that paradigm adherence was significantly related to the paradigm adherence of the participant's most recent clinical supervisor. Putney et al. (1992) ascertained that matching a supervisee and supervisor on both theoretical orientation and gender would increase the supervisee's rating of perceived supervisor effectiveness. Schacht, Howe, and Berman (1989) indicated that a supervisee and supervisor match based on theoretical orientation did increase perceived

supervisor effectiveness, as long as it was coupled with conditions within the supervisory relationship, such as empathy and unconditional positive regard.

Other research has suggested a relationship between theoretical orientation and personality factors. Arthur (2001) suggested that personality traits influence a practitioner's selection of a theoretical orientation; those same traits influence the consistent use of that orientation throughout practice as well. Numerous personality measures have been utilized in an attempt to identify the personality factors that relate to the selection of a theory, including the Myers-Briggs Typology Indicator (MBTI) (Erickson, 1993; Freeman, Hayes, Kuch, & Taub, 2007), the Keirsey Temperament Sorter II (KTSII) (Dodd & Bayne, 2006; Varlami & Bayne, 2007), the Millon Index of Personality Styles (MIPS) (Scragg, Bor, & Watts, 1999), the NEO Personality Inventory-Revised (NEO-PI-R) (Boswell, Castonguay, & Pincus, 2009; Scandell, Wlazelek, & Scandell, 1997) and the HEXACO-PI (Ogunfowora & Drapeau, 2008a). These studies suggested that individuals who have personality factors such as being directive, goal-oriented, and assertive are more likely to align with a Cognitive-Behavioral orientation, while individuals from a Humanistic or Psychodynamic approach are more likely to have personality traits such as being non-directive, open, and intuitive. Much of the literature does not extend beyond examining the Cognitive-Behavioral, Humanistic, and Psychodynamic approaches (Ogunfowora & Drapeau, 2008a).

Theories are an integral part of mental health practice. They are utilized to guide the course of treatment by providing both diagnostic ideologies and a rationale for specific treatment options. Numerous ideas have been proposed about how to organize these theories, such as Cottone's (2007) paradigm classification, which offers a unique

and meta-theoretical perspective to theory classification. Numerous ideas have also been generated on what factors will influence theoretical choice, examining both personal and professional qualities of mental health practitioners. Identifying which factors will help to predict theoretical orientation will aid ultimately in identifying paradigm adherence. Knowing one's adherence to a specific paradigm will help distinguish which underlying values and assumptions are influencing the therapist's practice, enabling the practitioner to practice competently and effectively for the client's benefit.

Statement of the Problem

The use of theory in mental health practice is encouraged for mental health professionals. However, there are numerous ways to classify these theories, including Cottone's (2007) paradigm classification, which organizes theories based on philosophical similarities. To date, there has only been one study that has measured with which paradigm mental health professionals, specifically marriage and family therapists, have aligned (see Booth, 1997); other licensed mental health professionals' paradigm adherence has not been assessed.

Most mental health ideology for psychologists, social workers, and professional counselors has emerged from educational and psychological ideas aligned with the psychological paradigm, but major philosophical developments in the field since the 1950s have produced approaches like Social Systems Theory (Bateson, Jackson, Haley, & Weakland, 1956; Bowen, 1961), Feminist Theories (Bograd, 1984), and Social Constructionism (Gergen, 1985) or Social Constructivism (Neimeyer & Mahoney, 1995). A timely question is whether mental health professionals are aligning primarily with the paradigms that are closely aligned with the history of their professions, or are they

adapting to new philosophical and theoretical developments? For example, professional counselors are trained to account for cultural and contextual differences among clients (Myers, Sweeney, & White, 2002), which coincides with social theoretical developments. An example of this would be the multicultural movement, spearheaded by the counseling profession, which requires awareness for both group and individual differences and the influence of society on these groups and individuals (Van Hesteren & Ivey, 1990). If professional counselors are trained to account for these differences, yet are still being educated with historical ideas, then they may be using social ideologies and practices without the education or awareness that they are doing so. An accounting of these philosophical and theoretical orientations seems justified then, especially in light of attempts to classify and to organize theories within larger frameworks (Cottone, 1992).

The examination of a supervisor's theoretical orientation and its influence on a supervisee's theoretical choice has been discussed briefly in the literature. Most research indicates that the supervisor's theoretical choice will influence their supervisee(s) (Murdock et al., 1998; Putney et al., 1992), but the available literature only indicates whether or not supervision was considered effective, as perceived by the supervisee. There has only been one study (Booth, 1997), to date, measuring the relationship between paradigm adherence and supervisor's preferred paradigm. These results indicated a significant relationship between these two factors, yet more research is needed to support this relationship as well as to explore if supervision is more influential at different stages in theoretical development. This current study examined the relationship between paradigm adherence and participant's pre- and post-graduate supervisory experiences.

In assessing which personality factors correlate with theoretical orientation, there have been numerous studies examining this relationship. Most of these studies coincide with each other, citing that therapists with direct, goal-oriented personality traits will choose a cognitive-behavioral framework while individuals with less structure and who are more intuitively-oriented will choose either a humanistic or psychodynamic framework (Arthur, 2000, 2001; Scandell et al., 1997; Scragg et al., 1999). Although there are numerous studies on this relationship, the majority of the literature focuses on the cognitive-behavioral, humanistic, and/or psychodynamic theories only (Ogunfowora & Drapeau, 2008a). There have not been any studies assessing the relationship between personality traits and paradigm adherence, so this study explored if there is a relationship between personality traits and paradigm adherence.

Significance of the Study

This dissertation was designed to identify meta-theoretical trends in mental health practice. The paradigm alignment of psychologists, social workers, and professional counselors was assessed. Alignment with a paradigm relates both to the philosophical or theoretical foundation of each profession and to education and training trends within a profession. For example, if professional counselors were to align with social constructivist ideas, restructuring educational and supervision experiences may need to be examined to ensure practice coincides with philosophies. Cottone's (1992) paradigm classification system also allows for an organizational tool to group the theories based on their underlying philosophies, which will also contribute to educating future mental health practitioners. Rye (2007) stated, "a paradigm assists professions to organize thoughts and professional components ensuring consistency and professional movement"

(p. 42). Utilizing Cottone's system as a teaching tool may ensure that mental health practitioners are being trained in such a consistent method.

To enhance the education and training of future practitioners, an examination of the influence of pre-graduate and post-graduate supervisory relationships was warranted. Identifying paradigm adherence for both the supervisee and the supervisor will allow a theoretical match to occur in the supervision dyad, which research suggests promotes perceived effectiveness of the supervision process (Putney et al., 1992; Schacht et al., 1989). Assessing paradigm adherence during an initial Theories course will be particularly helpful so that students can be matched with philosophically like-minded supervisors when they begin to develop their theoretical orientation and when they initially begin to work with clients.

Identifying which personality traits can predict paradigm adherence would also be beneficial to training and educational programs (Scandell et al., 1997). If specific personality traits will suggest that practitioners will adhere to one paradigm, those individuals can begin focusing their training and application of theory within that specific paradigm, early on in their graduate programs. This will also be helpful to assess early in training programs, especially while under supervision in practicum and internship courses, to ensure proper and effective guidance of utilizing the philosophies within a set paradigm.

Purpose of the Study

Although Cottone hypothesized about which professionals are well-suited to align with specific paradigms, there have not been any studies on the current paradigm adherence of practicing psychologists, social workers, and professional counselors. Booth

(1997) developed an instrument, the Paradigm Adherence Scale (PAS), to identify paradigm adherence from Cottone's (1992) paradigm classification and utilized that instrument to measure adherence of Marriage and Family Therapists. However, paradigm adherence of these other mental health professionals has not been measured. The purpose of this study was to measure paradigm adherence of individuals licensed in the state of Missouri as psychologists, social workers, or professional counselors. It also assessed the significance of educational and supervision experiences and the relationship of these variables to paradigm adherence. Additionally, personality and demographic factors were assessed in an attempt to determine which demographic and personality factors, if any, related to paradigm adherence of individuals within these professions. The specific research questions being examined were:

1. What relationship exists between age, gender, educational experiences, training experiences, supervisors' orientations, years of experience and paradigm adherence?

2. Will psychologists adhere to the psychological paradigm?

3. Will social workers adhere to the systemic-relational paradigm?

4. Will professional counselors adhere to the psychological paradigm?

5. What relationship exists between personality variables and paradigm adherence?

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Statement of the Hypotheses

</div>

Based on findings in the literature and the research questions, the hypotheses for this study were:

Hypothesis 1 (H1): Licensed Psychologists in the state of Missouri would primarily adhere to the Psychological paradigm.

Hypothesis 2 (H2): Licensed Clinical Social Workers in the state of Missouri would primarily adhere to the Systemic-Relational paradigm.

Hypothesis 3 (H3): Licensed Professional Counselors would primarily adhere to the Psychological paradigm as well, based on their educational and supervisory exposure to theories from the Psychological paradigm.

Hypothesis 4 (H4): In accordance with Booth's (1997) hypothesis, adherence to a specific paradigm would be related to the supervisory experiences of the mental health professional, indicated by their supervisors' preferred paradigms.

Summary

There have been very few organizational tools developed to organize theories used by mental health professionals. Theories are a vital component of these professionals' education, training, and practice, so an organizational tool to aid in preparing future mental health professionals would be useful for the effective and competent training of these individuals. One such tool is Cottone's (1992) meta-theory that identifies four paradigms: the organic-medical, the psychological, the systemic-relational, and the social constructivist. These paradigms organize the theories based on philosophical similarities. The purpose of this study was to identify to which paradigm licensed psychologists, social workers, and professional counselors in the state of Missouri adhere, as well as which characteristics helped to identify adherence to a specific paradigm. It was hypothesized that based on educational and supervisory experiences, licensed psychologists and licensed counselors would most likely adhere to the psychological paradigm while licensed social workers would adhere to the systemic-relational paradigm. Booth's (1997) research has already demonstrated an alignment of

Marriage and Family Therapists with the Systemic-Relational Paradigm, where almost

44% of the participants indicated primary adherence to this paradigm. It was also

hypothesized that paradigm adherence would be related to the supervisory experiences of

the mental health professional, indicated by their supervisors' preferred paradigms.

Examination of the relationship between paradigm adherence and demographic variables

was also explored, as well as the relationship between paradigm adherence and

personality variables.

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of current literature examining the history of counseling and psychotherapy and the introduction of the paradigm perspective to the field. Research is also provided on identifying how mental health professionals choose their theoretical orientation and the various factors involved in selecting a theory. Since this dissertation surveyed psychologists, social workers, and professional counselors, requirements for licensure in the state of Missouri for these three professions was also included, as well as standards for education programs accredited by these professions' respective accrediting bodies.

History of Counseling and Psychotherapy

The field of counseling and psychotherapy has experienced an evolution of ideas. Counseling practice has not only shifted from one theory to the next, but also its undergirding philosophy has evolved. Early schools of thought date back to the ideologies of Ancient Greece, introducing a variety of philosophical approaches on the causes and cures for mental illnesses, as well as important concepts and terminology still utilized throughout the counseling and psychotherapy field today (Hergenhahn, 2001). Hippocrates suggested that mental illness was a result of an imbalance of four bodily fluids, or "humors," which were black bile, yellow bile, blood, and phlegm; only if these were in balance was an individual considered healthy (Hergenhahn, 2001). Socrates introduced the idea of introspection, suggesting individuals look within, or "Know Thyself," to uncover mental health issues, rather than attributing mental illness to some biological influence (Hergenhahn, 2001). Plato suggested that the soul was comprised of

three different divisions which created a constant state of conflict for the person, while Aristotle focused on identifying the influences of memory, dreams, motivation, happiness, and emotions on humans (Hergenhahn, 2001). These contributions from Ancient Greek thought laid a philosophical foundation for humans to be evaluated as more than simple, organic beings (Myers, 2007).

In the early 19th century, the works of Wundt, James, Titchener, Pavlov and Watson gave rise to the introduction of psychology as a science. It was not until Freud, however, that psychiatry became a formalized mental health practice rather than a field solely comprised of laboratory research (Myers, 2007). Freud's work (1900, 1901) represents a shift from the biological perspective to the psychological perspective, not only in treatment modalities, but in the fundamental beliefs about what causes mental illness.

After Freud's introduction of psychoanalysis (1900, 1901), many theorists expanded upon his theory, adding their contributions to the field. Some theorists included Freud's fundamental beliefs about unconscious dynamics, while others began exploring the effects of other influences on disturbances of mental health. Neo-Freudian theorists such as Adler, Horney, and Erikson asserted that social and cultural factors contributed to mental health issues, while Humanist theorists, like Rogers (1951) and Maslow (1954) later posited that mental health was measured by one's psychological growth and ability towards self-actualizing tendencies (Feist & Feist, 2009). Other theories about the causes of mental health issues have developed over the years, including the focus on changing behaviors, changing cognitions and/or irrational thoughts, or focusing on existential

matters (see Ellis, 1971; May, 1961; Skinner, 1976). Subsequent to Freud, a number of approaches have been developed to treat the individual defined as having "a problem."

In the mid 1950s, theorists began shifting the focus about the causes of mental illness from the individual to the individual's entire network, or "system" of interpersonal relationships. These theorists believed that focusing solely on the individual limited not only the scope of practice, but also negated the true nature of the cause of the issue (Bateson, 1972). Bateson's (1972) work became foundational to what has evolved into what is known today as "social systems theory." Clinicians such as Satir (1967), Haley (1987), and Minuchin (1974) adopted the new perspective of social systems theory, providing relationship-focused marriage and family treatment modalities to the field of counseling and psychotherapy.

Based on various criticisms of systems theory, especially from feminist theorists who argued that systems theory ironically blames victims for their own abuse within a system due to a circular or reciprocal casual framework (e.g. Bograd, 1984), a new perspective or shift about the nature of mental health problems emerged. This view began to emphasize a new philosophy that one's understanding of reality is socially constructed and focused on how each individual interprets reality in order to create change (Neimeyer, 1995). This newer philosophy, known under the general titles of social constructionism (Gergen, 1985) or social constructivism (Cottone, 2001; Neimeyer & Mahoney, 1995), allowed for an integration of biological, social, and cultural factors as contributing causes of mental health issues, with an emphasis on the contextual effects of language (Puig, Koro-Ljungber, & Echevarria-Doan, 2008).

Overall, dating back to the early Greeks, many theoretical ideologies have emerged about the nature and causes of mental health issues. As these different conceptualizations have progressed over the years, so has the idea to classify these theories into different schools of thought. The following section will provide ideas of how to classify theories and what factors influence a mental health practitioner's adherence to a specific theoretical orientation.

Paradigms

As discussed in the preceding section, the history of theories of counseling and psychotherapy has continually evolved, shifting the focus of mental health issues and the direction of treatment from an organic perspective to the psychological attributes of an individual to a systemic-relational approach, and finally, to a focus on how one's understanding of experience is constructed within the context of biological, social, and cultural factors. Given the multitude of different theoretical assumptions in counseling and psychotherapy, theories about ways to organize and to classify the theories into groups with common properties began to develop. It is believed over 400 different theories of counseling and psychotherapy are available now (Corsini & Wedding, 2005); conceptualizing how to classify the different theories has provided a wide range of ideologies on how to organize these theories and on what properties.

Previous research has proposed classifying theories based on what psychological aspect of the individual the therapist focuses on to create change. Seligman (2006) classified approaches to counseling and psychotherapy into four categories: (a) thoughts; (b) actions; (c) emotions; and (d) a combination of categories (eclectic/integrative systems), suggesting that therapists mainly focus on one of the aforementioned

psychological elements to address the presenting mental health issue. More specifically, Richardson (1998) outlined the theoretical and conceptualization differences for therapists practicing solely within the cognitive framework, asserting there were four models of cognitive development. Gladding (2007) noted different "systems" of counseling, suggesting that two dominant systems, the Developmental/Wellness Approach and the Medical/Pathological Model, identify how mental health practitioners approach treatment. Halbur and Halbur (2010) established six schools of thought to help counselor identify their theoretical orientation. These schools of thought are: (a) psychodynamic; (b) behavioral; (c) humanistic; (d) pragmatic; (e) constructivist; and (f) family approaches. They have also developed a tool, the Selective Theory Sorter-Revised (STS-R) to aid in selecting a theory among these six dimensions (Halbur & Halbur, 2010).

Cottone (1992) developed a way to classify the various theories into what he termed "paradigms of counseling and psychotherapy," or "models that, to a larger degree, are mutually exclusive and *based on different professional, political, and philosophical positions* related to the nature of the psychotherapeutic enterprise" (p. 4). The identification of paradigms allows for philosophical ideologies and beliefs to be organized based on their common properties and to be used to guide future practice (Kuhn, 1970; Rye, 2007). Cottone (1992; 2007) classified theories into one of four paradigms, the Organic-Medical, Psychological, Systemic-Relational, or Social Constructivist, based on the underlying epistemological and ontological properties of that theory, allowing "for a definition of superordinate theoretical structures for classifying the nature and scope of counseling" (Cottone, 2007, p. 192).

In identifying the four different paradigms, six mandatory criteria were outlined for inclusion as a paradigm (Cottone, 1992). These six criteria are: (a) It must be testable as a scientific theory; (b) It must have competition from at least one other paradigm; (c) It must be philosophically distinct; (d) It must reframe the nature of cause and effect; (e) There must be professional adherents; and (f) It must have theories that fit within the framework. By identifying four paradigms of counseling and psychotherapy, each theory can now be a "subcategory" under one of the three primary paradigms, or a mix of paradigms (transitional/transparadigmatic), where the results indicate adherence to more than one paradigm. This presents professionals with a more distinct framework for organizing and classifying the various theories of counseling and psychotherapy based on philosophical differences rather than technical or practical applications.

Organic-Medical Paradigm

The first paradigm distinguished by Cottone (1992) is that of the Organic-Medical Paradigm. This paradigm has historically been the predominant ideology of explaining the causes of mental disorders. The ancient Greeks offered suppositions of organic causes and this belief dominated explanations of mental health until Freud emerged with his ideas of hysteria (Hergenhahn, 2001). The Organic-Medical paradigm focuses on the biological or physical makeup of the individual, asserting that there are organic causes to mental illness. It is believed that causes of mental illness are from biological predispositions and therefore, can be treated from medical interventions, suggesting a linear cause-and-effect, meaning that defining an organic cause will allow for conjecture of what symptoms will follow. Diagnosis is imperative, as focusing on the genetic, neurological, biochemical, and developmental characteristics of each individual will

provide practitioners with the proper course of treatment, typically medication, which has

its roots in science and the scientific method rather than philosophy or psychology. Given

the emphasis on the scientific method and medical interventions, professional adherents

of this group tend to be psychiatrists, medical doctors trained and supervised in biological

and chemical treatment modalities (Gerard, 2010). Mental health professionals that

practice within this paradigm would use Psychiatric Case Management, where they

would use the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,*

Text Revision (DSM-IV-TR) (APA, 2000) to identify the mental disorder and then work

to educate the client on the disorder and management of the symptoms.

Psychological Paradigm

The psychological paradigm outlined by Cottone (1992) has many characteristics

that help to classify those theories with psychologically-based ontological and

epistemological philosophies, mainly a focus on the individual and nonorganic influences

on behavior. This paradigm has its roots in Freud's works (1900; 1901). Freud found

non-physical causes for one's mental health, shifting thought from the organic-medical

paradigm where only medical causes were known. His works inspired numerous other

theorists to identify internal, non-physical causality for mental health issues. The

behavioral school also offered a psychological explanation of mental health issues, but

focused on the external environment (rather than internal factors) as the influential

determinant of mental health disorders (Cottone, 1992). In the psychological paradigm,

mental health issues are attributed to some psychological, non-physical aspect of the

individual, such as thoughts, feelings, and/or behaviors, and treatment focuses on

interventions to create change in the individual's psychological world. Cause-and-effect

is also linear, meaning that defining the internal or external environmental factors will allow for a prediction of subsequent symptoms and treatment modalities (Cottone, 1992). The therapies within this paradigm use a variety of approaches to assess the "cause" of problems and to create a different result or "effect" in the individual's circumstances. Examples of theories in the psychological paradigm include psychodynamic, person-centered, cognitive-behavioral, and behavioral theories. In the psychological paradigm, psychologists are the primary professional adherents. It is assumed most professional counselors would also practice within this paradigm based on current educational requirements (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009; Missouri Division of Professional Registration, 2011b).

Systemic-Relational Paradigm

From the Systemic-Relational paradigm, the epistemological and ontological foundations are the focus on relationships. The history of this paradigm is in general systems theory and the work of Bertalanffy (1952) which evolved into social systems theory after the inclusion of ideas from social psychology (see Lewin, 1951), the child guidance movement, social work ideologies, and group dynamics (Nichols, 2010). These influences suggested that a focus on the entire network of relationships was needed to identify causation and treatment approaches. Where the psychological paradigm focuses on the individual and linear cause-and-effect, the systemic-relational paradigm posits a circular causality, suggesting that humans are involved in an evolving network of social relationships, a system, and mental health issues are to be seen within the interactive, relational context rather than some "thing" causing the issue (i.e. faulty beliefs, environmental reinforcements, etc.) (Bateson, 1972; c.f. Bertalanffy, 1952). Systemic

schools of thought concentrate on the reciprocal interactions within a system and create

change to the system by focusing on the relational dynamics and the interplay between

system members, rather than on the thoughts, feelings, and behaviors of each individual

(Bateson, 1972). Well-known theorists in this field include Satir (1967), Minuchin

(1974), and Haley (1976), among many others.

Cottone (1989; 1992) outlined the tenets of the Systemic-Relational Paradigm: (a)

the focus is always on relationships; (b) relationships can be isolated for study and

defined; (c) cause is circular; (d) change always occurs through social relationships

(communication); and (e) individual traits, such as motivation or responsibility, are

redefined as reflecting the degree of engagement (fit) between interacting social systems,

as viewed from the perspective of one of the systems. Additionally, since adherents to the

Systemic-Relational Paradigm are primarily Marriage and Family Therapists (c.f., Booth,

1997), another proposition is that professionals practicing within this paradigm should

have training within a systemic-relational framework to ensure competence. This is

necessary, especially since therapists are only viewed as effective given how much they

affect the system, within the constraints of the socio-legal system, which is another

proposition. As such, therapists should also be closely linked to the socio-legal system,

which is also supported by training in a systemic-relational framework (Cottone, 1992).

Mental health professionals that fit into this paradigm are required to complete more

extensive training, specifically in Marriage and Family Therapy. Specific education,

training, and supervision requirements are outlined by the American Association for

Marriage and Family Therapy (AAMFT) to identify inclusion of professionals that meet

the criteria (AAMFT, 2011) and would, therefore, align with the systemic-relational

paradigm. It is also assumed that licensed clinical social workers would most closely align with this paradigm based on their educational requirements (these requirements are described later in this chapter).

As mentioned above, the primary adherents to this paradigm are Marriage and Family Therapists (MFTs). In surveying 204 clinical members of the American Association for Marriage and Family Therapy (AAMFT), Booth (1997) found that almost 44% of these marriage and family therapists practiced within the Systemic-Relational paradigm. Only one respondent aligned with the psychological paradigm, and almost 14% aligned with the social constructivist paradigm; 42% of the respondents identified as aligning from a combination of paradigms, with the majority of those respondents indicating a preference for both systemic-relational and social constructivist answers. This is not surprising, given the educational and training requirements for membership into AAMFT are heavily influenced with systemic theories (AAMFT, 2011).

Social Constructivist Paradigm

At this time, there is no clear consensus on the definition of social constructivism. There are many similar terms for "social constructivism." Previous terminology has included Gergen's (1985) "social constructionist," Maturana's, (1978) "structural determinism" and Cottone's (1992) "contextualism" (see Pepper, 1942); for the purpose of this dissertation, the term "social constructivism" will be used in accordance with the most recent works of Cottone (2001; 2007).

Given how difficult it has been to assign one term to this movement, it has been equally difficult in attempting to provide a definition for "constructivism" (Cottone, 2007). Even with the differing opinions in terminology and definitions, social

constructivism can be summarized based on common tenets of the theory. Social constructivism introduces an alternate way of thinking and "invites one to challenge the basis of conventional knowledge" (Gergen, 1985, p. 267). Rather than focusing on the environment outside of the person as reality, the focus is now on how people construct their understanding of reality (Neimeyer, 1995; Whitman, 1993). In other words, what is known has been constructed through, as Lyddon (1995) stated, "the context of shared language and meaning systems that develop, persist, and evolve over time" (p. 77). As such, psychological beliefs like the "self" are contextualized because there cannot be a "self" without language and relationships with others (Gergen, 1985; c.f., Smith, 1994). What is known is known through language and interpersonal relationships; there is no knowable, objective truth. Rather, what is "known" is based on social consensus and is "true" for those within a "consensual domain" (Maturana, 1978).

Cottone (2007) delineated the following propositions for the social constructivist paradigm: (a) focus of study is on human consensus; (b) change is viewed as fundamental and inevitable; (c) individuals are viewed as dynamic processes rather than static entities; (d) the nature of cause-and-effect can be either linear or circular, meaning that once the social consensus of clients is understood, the cause and effect can then be determined; (e) treatment is considered successful when change occurs to help people to fit within what is "acceptable" in the larger social context.

Mental Health Professions

The underlying philosophies of social constructivism assert that reality can only be known through linguistic and relational contexts; as such, defining what a mental health professional is and does is also contextually-based. In other words, a

"professional" must also be defined within what society has established as acceptable terms. Outlined below are the educational and training standards for mental health professionals licensed in the state of Missouri as psychologists, social workers, or professional counselors. Model licensure standards according to their respective credentialing bodies are also included.

The Psychology Profession

      Overview. As mentioned above, the profession of psychology emerged from the organic-medical paradigm, distinguishing itself from the profession of psychiatry. This emergence, marked historically by the seminal works of Freud (1900, 1901), allowed psychology to focus on internal or mental processes as the cause of health issues. The solidification of psychology as a profession is associated with World War II and the social and political needs at the time as well as the introduction of reimbursement from insurance companies (Benjamin & Baker, 2004; Olvey, Hogg, & Counts, 2002). Individuals within this field consider psychology a scientifically-grounded profession, using research to guide their practice and interventions (American Psychological Association [APA], 2011).

      American Psychological Association (APA). The requirements to become a psychologist are based on guidelines from the APA, an organization established in 1892, which is the largest membership organization for psychologists. The APA regulates educational and ethical standards among psychologists. To ensure those standards, the APA's Commission on Accreditation (CoA), the accrediting body for psychological education and training programs, created and continually maintains guidelines and principles for professional psychology programs. This commission sets the standards for

psychological doctoral programs, as well as postdoctoral residency and internship sites, ensuring consistency for training and educating psychologists. To date, there are over 700 programs accredited by the CoA (APA, 2011).

Doctoral programs accredited by the CoA require specific core areas to be studied. These areas include: (a) ethics; (b) theory and assessment; (c) cultural diversity; (d) bases of behavior; and (e) the development of attitudes for professional knowledge and practice (APA, 2007; Rubin et al., 2007). Additional practicum experiences are also required to ensure competencies and knowledge in these core areas.

Association of State and Provincial Psychology Boards (ASPPB). The ASPPB was created in 1961 and oversees the licensure and certification of psychologists in all 50 states as well as other territories and Canadian provinces. Since each state regulates the practice of psychology through their own psychological board, the ASPPB works to create regulatory and credentialing information about the field of psychology through information obtained from each state board. Initially, the ASPPB was designed to create a standardized exam for psychologists entering practice as well as to create guidelines for mobility of the profession, enabling psychologists to become licensed in other jurisdictions if needed. In addition to those actions, the ASPPB is also working towards creating consistency across jurisdictions regarding educational, legal, and professional standards for the practice of psychology (Association of State and Provincial Psychology Boards [ASPPB], 2011).

State of Missouri Licensure Requirements. In the state of Missouri, one must hold a doctorate degree from an approved program in Psychology in order to become licensed. The coursework from that program must include the following graduate

courses: (a) biological bases of behavior; (b) cognitive-affective bases of behavior; (c) social bases of behavior; (d) individual differences; and (e) research methodology for understanding behavior. One year of supervision is required before completion of the degree. An additional year of supervision is required post-degree, meeting a minimum of 1500 hours within a one year timeframe. Three examinations are also required for the state: (1) the Examination for Professional Practice in Psychology (EPPP); (2) a jurisprudence exam based on the rules and regulations for psychologists in the state of Missouri; and (3) an oral examination regarding different aspects of the profession of psychology (ASPPB, 2008; Missouri Secretary of State, 2009).

The Social Work Profession

Overview. The social work profession is guided by enhancing the well-being for both individuals and the community at large. By focusing on social, economic, and cultural ideals, this field works to ensure that human rights and diversity are encouraged through scientific study and assessment (Council on Social Work Education [CSWE], 2008; National Association of Social Workers [NASW], 2011). The history of Social Work as a separate profession began in the 19th century when the United States was experiencing tumultuous social changes, including housing, health, and occupational hardships (Reid & Edwards, 2006). The development of the Charity Organizational Society (COS) in 1877 provided a foundation for this profession by implementing social workers to investigate and coordinate social change. The overwhelming need to understand what was creating these social issues ignited the growth of the social work field. Individuals in the field sought out competent, professional individuals wanting to create change. This laid the foundation for implementing an educational framework for

Social Work to ensure individuals were properly trained for addressing the societal needs at the time. Having identified educational requirements allowed Social Work to emerge as a profession, citing influences from both psychiatry and psychology, designed to identify social issues and investigate solutions to create change ideal for the current social climate (Reid & Edwards, 2006). With the emphasis on social change, it is reasonable to conclude that social workers will adhere to the systems-relational paradigm, although no studies of paradigm adherence of social workers has been accomplished.

Council on Social Work Education (CSWE). The requirements to become a Social Worker are based on the guidelines from the only accrediting agency for social work education, the CSWE (CSWE, 2011). The CSWE, established in 1952, accredits both bachelor's and master's degree programs using the Educational Policy and Accreditation Standards (EPAS) to ensure competency and consistency across social work educational programs. To date, there are over 700 accredited programs at the bachelor's and master's degree levels (CSWE, 2008).

EPAS identifies four areas that must be addressed by a program in order to achieve accreditation. These areas are the program mission and goals; an explicit curriculum; an implicit curriculum; and assessment. Within the explicit curriculum area, there are 10 core competencies outlined required of social work programs. At the Bachelor's level, one must demonstrate mastery of the competencies; the Master's level requires the same mastery, but also incorporates mastery to a specific concentration area (CSWE, 2008). The core competencies are (a) identify as a professional social worker and conduct oneself accordingly; (b) apply social work ethical principles to guide professional practice; (c) apply critical thinking to inform and communicate professional

judgments; (d) engage diversity and difference in practice; (e) advance human rights and social and economic justice; (f) engage in research-informed practice and practice-informed research; (g) apply knowledge of human behavior and the social environment; (h) engage in policy practice to advance social and economic well-being and to deliver effective social work services; (i) respond to contexts that shape practice; and (j) engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities (CSWE, 2008).

National Association of Social Workers (NASW). In order to maintain professional standards and competency within the field, the NASW was created. The NASW is the largest membership organization and outlines educational and professional requirements for Social Workers (NASW, 2011). Although regulated by each individual state, most states require clinical social workers to have a master's degree from a social work program accredited by the CSWE, a minimum of two years or 3,000 hours of post-master's degree experience in a supervised clinical setting, a passing score on an exam that corresponds to the appropriate degree level administered by the Association of School Work Boards (ASWB), and a state license where practicing (NASW, 2005; Association of School Work Boards [ASWB], 2011).

State of Missouri Licensure Requirements. In the state of Missouri, specific requirements must be met in order to obtain a license in social work. An individual must have a degree from an educational program that is accredited by the CSWE and 3000 hours post-degree supervision by an approved state-licensed social worker (Missouri Secretary of State, 2011). Clinical Social Workers, who "represent the largest group of behavioral health practitioners in the nation" (p. 7) are typically required to obtain a

Master's degree in Social Work in order to perform psychotherapy and related counseling interventions, but this also varies by state regulations (NASW, 2005).

The Counseling Profession

  Overview. Cottone (1992) has suggested that professional counselors could be the primary adherents to the social constructivist paradigm since "professional counseling appears to be a hybrid of psychology, education, and mental health services" (p. 272). Although counseling programs are still heavily influenced by theories aligned with the psychological paradigm (see Capuzzi & Gross, 2009; Freeman, Hayes, Kuch, & Taub, 2007; Halbur & Halbur, 2010), the emphasis on training practitioners, rather than scientists, like in medical schools or psychology programs, coupled with the current social climate of managed care, community-based programs, and brief therapies (see de Shazer & Berg, 1992; DeJong & Berg, 2002; O'Hanlon & Weiner-Davis, 1989) has allowed professional counseling to emerge as a philosophically-distinct profession (Cottone, 1992, 2007; Van Hesteren & Ivey, 1990). Counseling has been influenced by numerous different disciplines in both theory and practice, yet it still maintains its own standards for education and practice (Rye, 2007). The foundation of counseling pulls from various areas of study including education, philosophy, psychology and sociology, yet counseling has expanded far beyond a simple helping profession (Gladding, 2007). Professional counselors have rigorous standards for education, research, and practice, allowing individuals in this field to compete on par with other mental health professionals (Sweeney, 2001). Van Hesteren and Ivey (1990) proposed that counseling is a unique profession due to four characteristics of the field: (a) the focus on positive change; (b) interventions at both the personal and systemic levels; (c) various specialties of practice;

and (d) an emphasis on multicultural awareness and sensitivity. The recognition of these characteristics asserts the validity of the counseling profession, enabling counselors to expand on the ideas of what defines a counselor, how to create change in both personal and social contexts, and where to implement those changes (Myers, Sweeney, & White, 2002; Van Hesteren & Ivey, 1990).

National Board of Certified Counselors. As the counseling profession has grown, so have the requirements to be a Professional Counselor. With the establishment of the NBCC, specific educational and professional requirements are mandated to ensure competency and consistency within the counseling field (Capuzzi & Gross, 2009). NBCC was established in 1982 to be an independent certifying, monitoring, and registry system for identifying and credentialing professional counselors (NBCC, 2011). This type of national certification as a professional counselor requires a master's degree in counseling or related discipline with a minimum of 48 credit hours, 3000 hours of supervision with a qualified supervisor, and a passing score on the National Counselor Exam (NCE) (NBCC, 2011). State licensure requirements vary by state but typically follow NBCC standards. 2010 marked a significant year in that a state license is now required to practice within this field in every state of the United States of America (ACA, 2010).

State of Missouri Licensure Requirements. In the state of Missouri, professional counselors must meet specific requirements in order to obtain a license. These requirements mirror those of the national certification and include a passing score on the National Counselor Examination (NCE), 3000 hours of post-master's degree supervised experience in a minimum two year time period, and a master's degree consisting of a minimum of 48 graduate hours in counseling or a related mental health

field. The educational areas of study include: (a) Human Growth and Development; (b)

Helping Relationship; (c) Professional Orientation; (d) Counseling Theory; (e) Group

Dynamics; (f) Appraisal of Individuals; (g) Group Dynamics; (h) Research Methods; and

(i) Social & Cultural Foundations. A minimum of five practicum hours are also required

to satisfy the degree requirements. Once the educational, examination, and supervisory

experiences have been completed, an application is submitted to the state committee for

review and approval (Missouri Division of Professional Registration, 2011; Missouri

Secretary of State, 2009).

    Council for Accreditation of Counseling and Related Educational Programs

(CACREP). As a means of establishing standards for counseling and other education-

related programs, an accrediting body was established to ensure these standards were

being met within graduate programs. This specialized accrediting body, the largest one

for counseling programs (Sweeney, 1995), is known as CACREP. Having CACREP

accreditation enables easier licensure, certification, and employment processes for its

graduates (Gladding, 2007). Adams (2005) suggested that graduates of CACREP

accredited programs demonstrate a higher level of knowledge as evidenced by higher

scores on the NCE than graduates of non-accredited CACREP programs. Gladding

(2007) stated, "overall, counselor education programs have become deeper in course

offerings and broader developmentally as a result of accreditation standards and

procedures," (p. 41).

    CACREP requires graduate programs to address eight main areas: (a) professional

orientation and ethical practice; (b) social and cultural diversity; (c) human growth and

development; (d) career development; (e) helping relationships; (f) group work; (g)

assessment; and (h) research and program evaluation. A 100 hour practicum and a 600 hour internship are also required under the supervision of qualified professionals (CACREP, 2009). CACREP accredits both Master's and Doctoral level programs and covers various specialty areas in the field of counseling (Capuzzi & Gross, 2009).

<div align="center">**Factors Associated with Theoretical Orientation**</div>

There are numerous variables that can influence one's theoretical orientation (Norcross & Prochaska, 1983). Bitar et al. (2007) highlighted that both personal and professional factors contribute to theory. These factors included personality characteristics, undergraduate and graduate courses, postgraduate training, supervision experiences, and clinical experience. Cultural factors, spirituality, and even learning styles can also influence what theory a counselor may choose (Bernard & Goodyear, 2004). The following sections will focus on these factors, examining the relationship between theoretical orientation and orientation of the supervisor of the mental health professional, personality, and other factors including gender, years of clinical experience, and other educational and training experiences.

Supervisor's Theoretical Orientation

One of the variables affecting theoretical orientation is that of clinical supervision. Much of the research on supervision in counseling described how the supervision relationship (e.g. the relationship between a clinical supervisor and a counselor-in-training) is one of the most influential aspects of a counselor's training (Bernard & Goodyear, 2004; Ellis, 1991). Given the significance of this relationship, research suggests that because of that relationship, a supervisor's theoretical orientation will influence the supervisee's choice of theory (Murdock, Banta, Stomseth, Viene, & Brown,

1998). Putney et al. (1992) suggested that the primary theoretical orientation of the supervisor will direct the course of supervision, rather than the supervisee's theory. Based on the value that supervisees place on the supervisory experience, it is believed that the influence of the supervisor's theory will have long-term effects on the supervisee's choice of theoretical orientation (Guest & Beutler, 1988).

In a qualitative study by Bitar et al.(2007), the researchers found that two common domains, the personal and the professional, emerged from their questions regarding the development of theoretical orientation. Their participants, five licensed marriage and family therapists, indicated that both personal factors (i.e., personality, personal relationships, values, etc.) and professional factors (i.e., undergraduate courses/professors, graduate training, professional development, etc.) aided in their theoretical orientation choice. Under the professional domain was the influence of their professors and supervisors in their training. Their supervisors' guidance, through questioning, modeling, and conceptualizing exercises, helped the participants in identifying their own theoretical orientation.

Putney et al. (1992) suggested that the supervisor's theory will direct the course of supervision. They studied 84 interns from APA-approved training sites, measuring their perceptions of supervision. Their findings indicated that interns perceived their supervision experience as more effective if they were a theoretical match to their supervisor. Effective supervision was also indicated when interns matched their supervisor in terms of gender, although female supervisors were perceived as more effective than their male counterparts. Based on these findings, the authors suggested that the interns had a theory in place pre-supervision, but matching the supervisor and

supervisee on both theory and gender increased the interns' perception of effective supervision.

Schacht et al. (1989) also found that interns' perception of effective supervision was based on a theoretical match between supervisor and supervisee. Their participants, who were 152 doctoral level, APA members, indicated that facilitative conditions, such as empathy, congruence, and unconditional positive regard, were also necessary during the supervision relationship. Although Putney et al. (1992) and Schacht et al. (1989) suggested that these interns had their theory in place, others posit that the interns' theoretical orientations are solidified due to the influence of their supervisor's theory and the implementation of this theory within the supervision context (Guest & Beutler, 1988; Norcross & Prochaska, 1983).

In examining paradigm adherence for members of the American Association of Marriage and Family Therapists (AAMFT), Booth (1997) found that the paradigm adherence was significantly related to their most recent supervisor's preferred paradigm. Sampling 204 AAMFT members, the findings indicated that participants, whose most current supervisor primarily adhered to the Systemic-Relational paradigm, would also show adherence to the Systemic-Relational paradigm. Booth's findings suggested that including the most recent supervisor's preferred paradigm, along with the participant's gender and years of clinical experience, could predict membership into a specific paradigm with an overall rate of 81.18%.

Personality

Personality can be defined as "a pattern of relatively permanent traits and unique characteristics that give both consistency and individuality to a person's behavior" (Feist

& Feist, 2009). Within the literature on personality, the focus has been on trying to identify which of these personality traits and characteristics will influence theoretical orientation choice. It is believed that examining the relationship between personality and theoretical orientation is important to not only help select an orientation but to help maintain that orientation throughout practice (Arthur, 2001). This will help to ensure that mental health professionals are being educated and trained accordingly and that future relationships with clients will be a good "fit" based on these personality variables (Kaplan & Garfinkel, 1999; Scragg, Bor, & Watts, 1999).

In studying personality and theoretical orientation, there have been numerous measures of personality used to assess this relationship. With regard to the Myers-Briggs Typology Indicator (MBTI) and personality, there have been conflicting results in the literature about whether a relationship exists. In a study (Freeman et al., 2007) of 132 graduate students enrolled in a beginning Theories course, personality types according to the Myers-Briggs Typology Indicator (MBTI) were assessed as a predictor of theoretical orientation. Theoretical orientation was divided into three separate orientations: affective, behavioral, or cognitive. Freeman et al. (2007) found that theoretical orientation could not be predicted from the MBTI results. Erickson (1993), however, in a study of 23 counselors, found that there was a link between Feeling types with affective approaches and Thinking types with cognitive approaches in practicing counselors.

Dodd and Bayne (2006) supported a relationship between orientation and the Keirsey Temperament Sorter II (KTSII), an alternative to the MBTI, by sampling 123 practicing counselors. They found that individuals with a Psychoanalytic orientation tended towards Feeling and Intuition preferences while those more CBT-oriented tended

towards the Sensing and Judging preferences. Individuals with an Eclectic orientation tended towards Extraversion and Intuition preferences.

Varlami and Bayne (2007) supported these findings in their study of 84 counseling psychology trainees in the United Kingdom. Their participants completed the KTSII and a demographic questionnaire, asking for them to designate their theoretical orientation. There were three primary orientations identified by the participants: 39.3% identified as CBT, 29.8% identified as Person-centered, and 27.4% identified as Psychodynamic. Only 3.6% identified as something other than one of these three orientations. The findings of this study suggested a relationship between CBT therapists and the Sensing and Judging preferences and psychodynamic therapists and the Intuition preferences. The authors also found a link between Person-centered orientations and Introvert and Perceiving preferences.

Also investigating the relationship between personality and theoretical orientation, Scragg et al. (1999) used the Millon Index of Personality Styles (MIPS) to assess theoretical orientation with 68 applicants to a Master's program in Counseling Psychology. Theoretical orientations were separated into one of two groups: (a) directive, which included CBT, REBT and systemic therapies; and (b) non-directive, which included psychodynamic, person-centered, and social constructivist theories. The results indicated that individuals with a directive orientation were higher on the Asserting, Conforming, and Systematizing scales, suggesting that these individuals prefer leadership roles, have a respect for authority, and could be considered systematic and efficient (Scragg et al., 1999). The individuals with a preference towards non-directive

orientations scored higher on the Intuiting Scale, suggesting these individuals had a preference for abstract and symbolic meaning rather than tangible experiences.

Arthur's (2000) findings supported the findings of Scragg et al., (1999). Also using the MIPS with 247 experienced therapists, Arthur (2000) found that those from the psychoanalytic perspective, like the non-directive individuals in the Scragg et al. (1999) study, tended towards intuitive and imaginative findings. Individuals in the Behaviorist perspective were more assertive and conforming. These findings were consistent among new and seasoned therapists (Arthur, 2000).

Other studies (Boswell, Castonguay, & Pincus, 2009; Scandell et al., 1997) utilized the NEO Personality Inventory-Revised (NEO-PI-R) to examine this relationship. Boswell et al., (2009) studied 46 students enrolled in either an APA-accredited clinical psychology or counseling psychology graduate program. They found that therapists-in-training who identified as humanistic were found to score higher on the Openness factor, especially Openness to Feelings and Openness to Values, while the psychodynamic individuals scored higher on Impulsiveness. The findings of Scandell et al. (1997) were in concordance with these findings, suggesting from the 41 participants studied, humanistic therapists scored higher on the Openness factor. Their findings also suggested that cognitive-behavioral therapists scored higher on the Agreeableness factor (Scandell et al., 1997).

Ogunfowora and Drapeau (2008a) studied almost 500 participants, both students and practitioners, using the HEXACO-PI to assess personality. Their study suggested that scores on the Conscientiousness factor predicted adherence to a cognitive-behavioral orientation for both therapists and students, while the Openness factor predicted

adherence by both practitioners and students to the Humanistic/Existential orientation and practitioners to the Psychodynamic orientation. These findings support previous research (Arthur, 2000, 2001; Scandell et al., 1997; Scragg et al., 1999) suggesting that individuals that adhere to a cognitive-behavioral orientation focus on structure- and goal-oriented means in order to match personality traits of being conscientious, concrete, and pragmatic. Similarly, individuals from both the psychodynamic and humanistic orientations exhibited a preference for Openness, indicating their desire for a non-structured, imaginative or intuitive, and less goal-oriented environment (Arthur, 2001; Ogunfowora & Drapeau, 2008a).

Other Factors Influencing Theoretical Orientation

In addition to supervisor's theoretical orientation and personality, there are other variables that have been documented in the literature as influencing theoretical orientation. These variables include gender, years of clinical experience, and other educational and training experiences such as type of degree and the profession in which the psychotherapist is engaged.

Gender. Past research indicates a relationship between theoretical preference and gender. It has been suggested that in the mental health field, societal and cultural influences encourage males to be problem-solvers while women are encouraged to focus on the social, emotional, and relational domains (Lecours, Bouchard, & Normandin, 1995). Werner-Wilson, Michaels, Thomas, and Thiesen (2003) proposed that women therapists are more likely to establish a therapeutic relationship with the clients due to their focus on the emotional and relational aspects while male therapists may negate this due to their emphasis on problem-solving. With this emphasis, women psychotherapists

have reported using relational and systemic therapies due to a higher interest in family therapy and/or working with children (Cassin, Singer, Dobson, & Altmaier, 2007; Snyder, McDermott, Leibowitz, Cheavens, 2000) while men tend to short-term or brief therapies (Levenson & Davidovitz, 2000) as well as biological-oriented therapies (Cassin et al., 2007). It has also been suggested that women are more likely to use feminist therapies (Ogunfowora & Drapeau, 2008b) and are more willing to implement therapies that do not have a high level of empirical support behind them (Pignotti, 2010).

In surveying 108 female and 90 male practitioners, Cassin et al. (2007) found that in addition to systemic therapies, women reported using Cognitive-Behavioral and Integrative approaches. Seventy-two percent of the male respondents also reported using Cognitive-Behavioral approaches, followed by Humanistic/Existential therapies. While there are a few studies like Cassin et al. (2007) that note gender differences, most studies do not address the gender differences in theoretical orientation. In their study of 41 therapists, Scandell et al. (1997) examined theoretical orientation and personality factors using the NEO-PI-R. Their results indicated that although there were gender differences on the personality variables, there were not any gender differences in regards to theoretical orientation.

Years of clinical experience. It is believed that the influence of experience has helped individuals choose a theoretical orientation more fitting to their needs, based on figuring out what has worked with clients and what has not (Boswell et al., 2009). In a study of LCSWs, Pignotti (2010) found that these therapists gave more weight to their clinical experience rather than literature or research findings. Orlinsky and Ronnestad (2005) found that of numerous variables, therapists believe that clinical experience is one

of the top influential factors on their theoretical orientation. An overwhelming finding of the literature suggested that beginning counselors, especially those still in training, adhere more strictly to a specific theory while more seasoned professionals utilize integrated or eclectic approaches (Ogunfowora & Drapeau, 2008a; Ogunfowora & Drapeau, 2008b; Orlinsky & Ronnestad, 2005).

Other educational and training experiences. Differences in educational and training experiences have also been shown to account for differences in theoretical orientation. In examining counselor education students, Freeman et al. (2007) found that 40% of these beginning graduate students identified person-centered, existential, and gestalt theories as their preferred approaches. Boswell et al. (2009) had similar findings in assessing predictors of theoretical orientation of therapists-in-training. They found that counseling psychology trainees would adhere more to the humanistic framework while clinical psychology trainees identified more with psychodynamic or Cognitive-Behavioral approaches. The authors attributed these findings to a difference in the "training philosophy" between the two types of programs (p. 308). Findings from Ogunfowora and Drapeau (2008b) supported that clinical psychologists utilize Cognitive-Behavioral therapies more frequently; however, their research did not suggest that there was a difference between counseling and clinical psychologists in the use of humanistic or psychodynamic approaches.

Although research has suggested that individuals in the counseling profession are more likely to adhere to the humanistic theories (Orlinsky & Ronnestad, 2005), it seems that Cognitive-Behavioral therapy is one of the most commonly chosen theories among all mental health professionals, regardless of training program, degree level, or specialty

(Cassin et al., 2007; Cook et al., 2010); this is most likely due to its empirical support

(Ogunfowora & Drapeau, 2008b) and its ease of understanding (Cook et al., 2010).

Integrative and/or Eclectic approaches were also reported to be widely accepted among

practitioners (Boswell et al., 2009; Cook et al., 2010; Cassin et al., 2007; Orlinsky &

Ronnestad, 2005).

Summary

A review of the evolution of counseling and psychotherapy theories was

described. Different classification systems for organizing these theories were presented,

with an emphasis on the arrangement of the theories into paradigms. Based on the work

of Cottone (1992, 2007), four paradigms, and the six criteria for inclusion into each

paradigm, were outlined. The paradigms, the Organic-Medical, Psychological, Systemic-

Relational, and the Social Constructivist, were summarized, delineating the specific

philosophical distinctions between each paradigm, based on Cottone's criteria. Reviews

of the psychology, social work, and counseling professions were also included,

highlighting requirements for national certifications and state licensures for these

professions. Finally, factors associated with theoretical orientation were also discussed,

including the theoretical orientation of a supervisor, gender, clinical, educational, and

training experiences, and personality factors.

CHAPTER III

METHODOLOGY

The purpose of this study was to examine which paradigm of counseling and psychotherapy Licensed Psychologists, Licensed Clinical Social Workers, and Licensed Professional Counselors in the State of Missouri utilize in counseling. This section outlines the measures and procedures used to identify paradigm adherence of participants, as well as to obtain demographics and personality variables of the participants. Demographics, including background information regarding the educational and supervisory experiences of each participant, were used to examine which associate with counseling paradigm alignment. Personality variables were assessed using the HEXACO-Personality Inventory-Revised (HEXACO-PI-R) to examine any correlates between personality variables and paradigm adherence.

Participants

Participants included individuals credentialed as a Licensed Psychologists, Licensed Clinical Social Workers, and Licensed Professional Counselors in the state of Missouri. These participants were limited to individuals that are registered with Missouri Division of Professional Registration in one of the aforementioned mental health professions as having an active and valid license. Credentials for licensure in the state of Missouri for each profession are described in Chapter Two. Documentation of one's education, supervision, and licensure examination scores, as well as background checks, are required for each applicant; all information is subject to approval by each profession's committee (Missouri Division of Professional Registration, 2011a).

Participants were invited to participate online. Purposive, nonrandom sampling was used to obtain participants. In the state of Missouri, there are a total of 1,846 Psychologists, 4,961 Clinical Social Workers, and 4,104 Professional Counselors who hold current and valid licenses as registered with the Missouri Division of Professional Registration (Missouri Division of Professional Registration, 2011b). However, the Missouri Division of Professional Registration does not share email addresses of its members, so invitations were sent to each profession's primary professional organizations in Missouri. These organizations were chosen because they are the statewide chapters of each profession's national organization. They are as follows: the Missouri Psychological Association (MOPA) comprised of 300 members (E. McLean, personal communication, September 8, 2011) the National Association for Social Workers-Missouri Chapter (NASW-MO) comprised of over 2,200 members (National Association of Social Workers-Missouri Chapter [NASW-MO], 2010); and the American Counseling Association of Missouri (ACAM) comprised of 120 members (D. Brauer, personal communication, June 11, 2011). The Missouri Mental Health Counselors Association (MMHCA), a statewide chapter of the American Mental Health Counselors Association (AMHCA) was also included, to increase the potential sample size of Licensed Professional Counselors. MMHCA has approximately 350 members (D. Holdinghaus, personal communication, August 19, 2011). With the exception of NASW-MO, the professional organizations forwarded the electronic research invitation to the members of the organization by email, inviting them to participate. NASW-MO would not forward any research items to their members without consent from the national headquarters. An electronic invitation was also sent to the psychology, social work, and

counseling programs at various statewide universities, asking licensed students and faculty to participate. An internet search of Licensed Psychologists, Licensed Social Workers, and Licensed Professional Counselors in the state of Missouri was performed for individuals that have provided their email address online or through their professional websites; a research invitation was sent to all individuals that qualified as potential participants through their online-provided email address. Additionally, the research invitation asked all participants to forward the research invitation to a minimum of three other qualified, potential participants. Also, electronic invitations were sent to colleagues of this author, inviting them to participate. The MMHCA conference was also attended to provide individuals with hard copies. Following the conference, MMHCA also provided the link to the study on their Facebook page.

To increase participation level, the participants were invited to enter a drawing for one of four $50 gift cards to Amazon.com. On-line participants had the option of choosing a separate link at the end of the study to enter their contact information for the drawing; this separate link ensured that their survey answers were not attached to their personal information. After they handed in their surveys, participants from the conference were provided with a separate form to provide their best email and phone number contacts to enter the drawing.

Measures

As a follow-up study of previous research on paradigm adherence (see Booth, 1997), this study used an instrument to measure paradigm adherence, as well as a personality inventory and demographics forms. Booth developed an instrument, the Paradigm Adherence Scale (PAS), to assess the theoretical framework of mental health

professionals, specifically Marriage and Family Therapists (MFTs). With permission

from the author (see Appendix E), this study used the PAS to assess the theoretical

framework of Licensed Psychologists, Licensed Clinical Social Workers, and Licensed

Professional Counselors in the State of Missouri. The 100-item HEXACO-Personality

Inventory-Revised (HEXACO-PI-R) (Lee & Ashton, 2004) was also utilized, with

permission from the authors (see Appendix F), to assess if there was a relationship

between the six personality variables on the HEXACO-PI-R and paradigm adherence.

Demographic Measures

The demographic measures were designed to collect information regarding age,

gender, ethnicity, years of experience, highest degree accomplished, and work setting, as

well as an indication of their licensed professional group membership (Social Worker,

Counselor, or Psychologist). An additional demographic item was used to determine

paradigm adherence to one of the four paradigm categories by the participant's Practicum

supervisor, Internship supervisor, and Licensure supervisor. Participants were also asked

to identify their own perceived paradigm adherence to further validate the PAS as an

instrument. If participants chose "Style D," indicating a combination of other paradigms

or styles, they were asked to provide which of the other paradigms were utilized by filling

in two or more of the other styles (see Appendix C). There were explicit instructions to

only complete these forms after they had finished the PAS.

Paradigm Adherence Scale (PAS)

The PAS (see Appendix B) is a self-report instrument that measures the

theoretical assumptions, beliefs, and techniques of a therapist practicing counseling and

psychotherapy. This 24-item scale was developed by Booth (1997) to assess adherence to

one of three counseling and psychotherapy paradigms outlined by Cottone (1992): the psychological, systemic, and the social constructivist paradigms. Each of the 24 items has three multiple choice answers available; each one of these multiple choice answers reflected either the psychological, systemic, or social constructivist paradigm. Individuals indicated which item "most" or "best fits" the way they act in the therapeutic context. Item responses were developed utilizing Cottone's (1992) description of each paradigm. The psychological paradigm items focused on addressing thoughts, feelings, and/or behaviors while the systemic-relational responses focused on relational causes and solutions. The social constructivist paradigm item responses indicated a use of meaning-making and consensus-building (Booth, 1997). The PAS did not include the fourth paradigm, the organic-medical paradigm, originally identified by Cottone (1992), since non-medical professionals are not able to legally provide a full range of organic-medical interventions (e.g., prescription of psychoactive medication). Based on the 24 items, paradigm adherence to one paradigm was indicated if at least 50% of the items (i.e., 12 items) are designated and no more than one-third (i.e., 8 items for each paradigm) is designated for either of the other two paradigms (Booth, 1997). Based on Booth's (1997) findings, some individuals did not meet these criteria and were, therefore, allocated to a fourth category. This fourth category is called the cross-paradigmatic category, indicating adherence across more than one paradigm.

Since this was a new instrument, numerous checks were conducted to assess the validity and reliability of this instrument. A content validity check was completed by four marriage and family experts, all at the doctoral level. These experts were given the PAS, consisting of 40 questions, as well as descriptions of each paradigm. Based on the

experts' reviews, the PAS was revised to 30 items that were more concise and theoretically-specific. The revised PAS was then given to 27 graduate students at the completion of an introductory to systems theory course. In this group, paradigm adherence was measured if half of the responses, or 15 items, indicated one primary paradigm and the other responses were one-third or less (i.e. 10 items) for the other two paradigms. This group of students yielded a response of 60% adhering to one paradigm while 40% were cross-paradigmatic (Booth, 1997).

According to Booth (1997) "some additional minor revisions were made to the PAS to increase clarity of items and responses following the first administration of the instrument" (p. 52). Another group of 33 graduate students, at the beginning of their introductory systems course, was administered the PAS. This administration included a validity check by means of the inclusion of a page, stapled closed to ensure it was not seen until after completion of the PAS, that provided descriptions of each of the three paradigms and the request for these participants to indicate which paradigm was most closely aligned to their therapeutic approach. This validity check yielded a result of two-thirds indicating a match between their PAS scores and their indicated paradigm preference. Once again, 60% demonstrated adherence to one paradigm while the remaining participants were cross-paradigmatic, meaning their scores indicated they practiced from a combination of paradigms (Booth, 1997).

To measure reliability, a group of 16 mental health professionals were administered the PAS twice, approximately two to three weeks apart. Agreement for item responses from the first distribution of the measure to the second was, on average, 74%. Based on the data from this administration, a final revision was completed studying each

item. This included items that indicated less than 65% agreement on the reliability check. It also included items that denoted less than 65% on indicated paradigm preference and actual PAS scores. This final review yielded the 24-item PAS measure that will be used in this study.

HEXACO Personality Inventory-Revised (HEXACO-PI-R)

The HEXACO-PI-R (see Appendix A) is a relatively new personality inventory designed to measure personality among six dimensions. Developed by Lee and Ashton (2004), the scale consists of six broad factor scales, each containing four facet scales. The HEXACO-PI-R is an alternative to the widely used five-factor model (FFM) based off of the "Big Five" personality traits and the NEO-PI-R which is a personality measure that uses the FFM (see Costa & McCrae, 1995; Goldberg, 1990). Based on cross-cultural studies of lexical research, six factors, rather than five, have emerged in 12 different languages (Ashton & Lee, 2007). As such, Lee and Ashton (2004) developed a tool encompassing the six dimensions of personality supported by these cross-cultural studies. These six dimensions have been identified as: Honesty-Humility (H), with high scores indicating high levels of altruism, social order, and honesty; Emotionality (E), with high scores indicating high anxiety and fearful responses to stress as well as dependence in their relationships; Extraversion (X), with high scores indicating positive feelings towards themselves and high confidence and sociability in their relationships and dealings with others; Agreeableness versus Anger (A), with high scores indicating cooperative, forgiving, and non-judgmental tendencies; Conscientiousness (C), with high scores indicating careful and deliberate organizational and decision-making tendencies; and Openness to Experience (O), with high scores indicating beauty- and knowledge-

seeking tendencies; these six factors provide the acronym of HEXACO (Ashton & Lee, 2007; Lee & Ashton, 2004). Within each of the six domain-level scales are four facet-level scales, designed to define the broader domain-level scales on longer versions of the assessment (see Ashton & Lee, 2009).

The HEXACO-PI-R (Lee & Ashton, 2004) is comprised of 200 questions in its full-length. Other versions of the HEXACO have become available, including the HEXACO-PI-R in its half-length, comprised of 100 questions, and the HEXACO-60, comprised of 60 questions (Ashton & Lee, 2009). The revised and briefer versions of the HEXACO differ from the original HEXACO-PI in that the Social Self-Esteem facet-level scale replaced the Expressiveness facet-level scale in the Extraversion domain in the revised version (Ashton & Lee, 2009). For purposes of research, in terms of time and practicability, the 100-item HEXACO-PI-R is recommended and was, therefore, used in this study (Lee & Ashton, 2011). On the HEXACO-PI-R, the respondent is asked to indicate how much they agree or disagree with statements based on a 5-point-Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). An example question from the scale is "I wouldn't use flattery to get a raise or promotion at work, even if I thought it would succeed" (Lee & Ashton, 2004). Higher scores within each factor indicate higher levels of the assessed factor. Factor scores are computed by adding up the score for each question within the factor and then dividing by the total number of questions within the factor; this provides mean scores for each of the six factors. In a sample of 1126 college students, the following means (M) and standard deviations (SD) were provided: Honesty-Humility (*M* = 3.19; *SD* = .62); Emotionality (*M* = 3.43; *SD* = .62); Extraversion (*M* =

3.50; *SD* = .57); Agreeableness (*M* = 2.94; *SD* = .58); Conscientiousness (*M* = 3.44; *SD* = .56); and Openness to Experience (*M* = 3.41; *SD* = .60) (Lee & Ashton, 2011).

In a sample of 409 undergraduate students, the HEXACO-PI demonstrated high internal-consistency reliability with coefficient alphas on the six broad factors ranging from .89 on the Conscientiousness factor to .92 on the Honesty-Humility factor (Lee & Ashton, 2004). Another study (Lee & Ashton, 2006) of 1,681 college students and 734 adults within a community indicated high internal consistency reliability for the HEXACO-PI with coefficient alphas ranging from .87 on Emotionality to .91 on Honesty-Humility. At the facet level, the coefficient alphas ranged from .75 on the Flexibility facet to .88 on the Forgiveness facet.

Lee and Ashton (2004) used five scales from the International Personality Item Pool (IPIP) (Goldberg, 1999) and the 16-item Primary Psychopathy scale (Levenson, Kiehl, & Fitzpatrick, 1995) to compare to the six scales on the HEXACO-PI to measure validity. They were studied to correlate as follows: Honesty-Humility scale to the Primary Psychopathy scale; Emotionality scale to the IPIP Imperturbability scale; Extraversion to the IPIP Extraversion scale; Agreeableness (versus Anger) to the IPIP Pleasantness scale; Conscientiousness to the IPIP Conscientiousness scale; and Openness to Experience to the IPIP Intellect/Imagination scale. Convergent validities were high between these scales, ranging from .68 for Openness to Experience scales to .86 for Extraversion scales. Discriminant validity was demonstrated by the low correlation scores of the other five scales to each of the six scales on the HEXACO-PI. For example, when computing the correlation between the Honesty-Humility scale and the Primary Psychopathy scale, the other five scales, each designed to correlate with one of the other

five scales of the HEXACO-PI, showed low correlations. The Honesty-Humility value

was reported as -.75 with the Primary Psychopathy scale, demonstrating a high

correlation, but as -.10 with the IPIP Imperturbability scale, -0.04 with the IPIP

Extraversion scale; 0.31 with the IPIP Pleasantness scale; 0.23 with the IPIP

Conscientiousness scale and 0.11 with the IPIP Intellect/Imagination scale, demonstrating

low correlations between the H scale and the other scales with which it was not intended

to demonstrate a high correlation (Lee & Ashton, 2004).

Procedures

Participants were invited to participate through email. This email was distributed

by the professional organizations ACAM and MMHCA; MOPA posted the research

invite on their website for individuals to participate. The NASW-MO would not forward

an email to their members without consent from the national association; the national

association required a fee per member in order to forward the email. As such, the

members of NASW-MO were not used in this study. Emails were also distributed to

licensed professionals in the state of Missouri that have provided their email through

online advertising or their own professional website. An email was distributed to local

universities, inviting participation from licensed students and faculty in their psychology,

social work, and counseling programs. This email invited participants to access

www.surveymonkey.com, a website utilized for research and other data gathering

purposes. Here, participants were provided with purpose of the study as well as eligibility

requirements. Informed consent was also provided here, including that there were no

risks of participating as well as the agreement to participate statements. The informed

consent also informed potential participants that they have the ability to withdraw from

the study at any time (Appendix D). Participants were able to request paper copies be mailed to them through the United States Postal Service (USPS) if needed or preferred. The MMHCA conference was also attended to obtain more participants. Participants of this conference were provided with hard copies of the survey. MMHCA also provided the link to the study on their Facebook page.

After completing the informed consent, participants completed the 100-item HEXACO-PI-R first, designed to assess personality traits on a six-factor scale. After the HEXACO-PI-R, participants completed the 24-item PAS, designed to assess paradigm adherence. Next, the participants were asked to complete a demographic form regarding age, gender, ethnicity, profession, highest degree completed, years of clinical experience and primary work setting. Another demographic form inquired about their supervisors' preferred paradigm, as assessed by the participant. The participant had one of four "Styles" to choose in assessing each supervisor, where Style A matched the Psychological Paradigm, Style B matched the Systemic-relational Paradigm, Style C matched the Social Constructivist Paradigm, and Style D indicated a combination of two or more of the other Styles. They were asked to rate their Practicum, Internship, and Licensure supervisors, as well as to provide an assessment of their own preferred Style.

The total expected time to complete the two measures and two demographic forms was approximately 20-30 minutes. The results of the study were anonymous. Participants were able to click on a link at the end of the survey that allowed them to enter a drawing for one of four $50 gift cards from Amazon.com. The link took the participants to a separate site to enter their personal contact information so that it was not linked to their survey responses. Individuals with a paper copy were provided with copies

of each of the measurements and the two demographic forms, and placed them in a box when completed. Participants then had the opportunity to provide their phone number and email address on a separate piece of paper to enter the Amazon.com drawing.

Summary

This study examined paradigm adherence of Licensed Psychologists, Licensed Social Workers, and Licensed Professional Counselors in the state of Missouri. The participants were invited to participate by email through membership in their statewide professional organizations, through employment at a university or college, or through their professional website contact information. Once subjects consented to participate, they were asked to complete the HEXACO-PI-R, to measure personality characteristics on six scales, and the Paradigm Adherence Scale (PAS), to measure adherence to a paradigm of counseling and psychotherapy. They were also asked to complete two demographic measures. Participation was voluntary and approximately 20-30 minutes was necessary to complete all measures.

CHAPTER IV

RESULTS

This study examined paradigm adherence among licensed mental health

professionals in the state of Missouri. Demographic variables and supervisory

experiences were assessed to see if they would associate with paradigm adherence.

Personality variables were also examined to see if there was a relationship between these

variables and paradigm adherence. This chapter is organized into six sections. The first

section outlines the descriptive statistics. The second section outlines the frequencies and

percentages of the Paradigm Adherence Scale (PAS) (Booth, 1997) and the supervisor

information form (Appendix C), and the means and standard deviations on the 100-item

HEXACO-PI-R (Lee & Ashton, 2004). The third section provides Chi square analyses,

and the fourth section provides a discriminant analysis. The fifth section provides

supplemental analyses of this research to gain a better understanding of the data. The

final section summarizes the results of this study.

Descriptive Statistics

A total of 239 individuals participated in this research. Individuals were

eliminated from the data analysis for not identifying their profession (n=49) or for not

completing the Paradigm Adherence Scale (n=50). This resulted in a total sample size of

189 participants. Descriptive statistics were computed for the demographic variables for

the total sample and for each profession. The majority of the participants were Licensed

Professional Counselors (*n*=127, 67.2%), with Licensed Clinical Social Workers

representing 16.9% (*n*=32) and Licensed Psychologists representing 15.9% (*n*=30). Table

1 provides the means and standard deviations for the demographic variables of age and

years of experience. Table 2 provides the frequencies and percentages for the demographic variables of gender, ethnicity, degree, and work setting.

Assessments

PAS

Adherence to a paradigm was determined by the participant indicating a minimum of 12 responses for one paradigm and no more than 8 responses for either of the other paradigms. If the participant indicated 8 responses for more than one paradigm or for all three paradigms, they were classified as cross-paradigmatic. For paradigm adherence, just over 50% of the sample identified as a combination of two or more paradigms, or cross paradigmatic (n=95, 50.3%). The systemic-relational paradigm accounted for 26.5% (n=50) of the paradigm adherents, 13.2% (n=25) identified as social constructivist, and 10.1% (n=19) identified as psychological paradigm adherents. The frequencies and percentages for the total sample are displayed in Table 3.

Of the cross-paradigmatic group (n=95), there were 56.8% that were a combination of the Systemic-Relational and Social Constructivist paradigms (n=54), 23.2% were a combination of the Psychological and Social Constructivist paradigms (n=22), 18.9% were a combination of the Psychological and Systemic Relational paradigms (n=18); only one individual was a combination of all three paradigms (0.8%).

HEXACO-PI-R

The HEXACO-PI-R mean scores and standard deviations were calculated for the total sample and were also separated by paradigm group. The total sample size for the HEXACO-PI-R was 189 participants, with the following participant numbers in each group: Psychological (n=19); Systemic-Relational (n=50); Social Constructivist (n=25);

Cross-Paradigmatic Group (*n*=95). The means and standard deviations for the HEXACO-PI-R subscales are provided in Table 4. One-sample t-tests were conducted to compare the means of the total sample with the means of the normed sample on the HEXACO-PI-R (see Lee & Ashton, 2011). Participants from this study scored statistically significantly higher on the Honesty-Humility, $t(188) = 13.19$, $p<.001$, the Extraversion, $t(188) = 5.82$, $p<.001$, the Agreeableness, $t(188) = 8.42$, $p<.001$, the Conscientiousness, $t(188) = 9.37$, $p<.001$, and Openness scales, $t(188) = 8.88$, $p<.001$, but statistically significantly lower on the Emotionality scale, $t(188) = 4.95$, $p<.001$.

Supervisor Information

The participants provided information regarding their supervisor's preferred paradigm, including their Practicum, Internship, and Licensure supervisors. Regarding their Practicum supervisors, the overall sample (*n*=189) indicated that 41.8% (*n*=79) of their Practicum supervisors adhered to the Psychological paradigm, 30.7% (*n*=58) adhered to the Systemic-Relational paradigm, 16.4% adhered to the Social Constructivist paradigm (*n*=31), and 11.1% adhered to more than one paradigm (*n*=21). The cross paradigmatic group was evaluated to explore which combination of paradigms the participants believed their Practicum supervisors were using. For those 21 participants, 28.6% indicated a combination of the Psychological and Systemic-Relational paradigms (*n*=6), 4.8% indicated a combination of the Psychological and Social Constructivist paradigms (*n*=1), 14.3% indicated a combination of the Systemic-Relational and Social Constructivist paradigms (*n*=3), and 14.3% indicated a combination of all three paradigms (*n*=3). The remaining participants indicated two or more theories *within* one paradigm, with 19% indicating two theories within the Psychological paradigm (*n*=4) and

4.8% indicated two theories within the Systemic-Relational paradigm (n=1). The remaining 14.3% indicated that they did not know from which combination of paradigms their supervisor was practicing (n=3).

The sample (n=186) indicated that for their Internship supervisors, 38.2% of their supervisors adhered to the Psychological paradigm (n=71), 31.7% adhered to the Systemic-Relational paradigm (n=59), 19.4% adhered to the Social Constructivist paradigm (n=36), and 10.8% adhered to more than one paradigm (n=20). The cross paradigmatic group was evaluated to explore which combination of paradigms the participants believed their Internship supervisors were using. For those 21 participants, 33.3% indicated a combination of the Psychological and Systemic-Relational paradigms (n=7), 4.8% indicated a combination of the Psychological and Social Constructivist paradigms (n=1), 19% indicated a combination of the Systemic-Relational and Social Constructivist paradigms (n=4), and 19% indicated a combination of all three paradigms (n=4). The remaining participants indicated two or more theories *within* one paradigm, with 9.5% indicating two theories within the Psychological paradigm (n=2) and 4.8% indicated two theories within the Social Constructivist paradigm (n=1). The remaining 9.5% indicated that they did not know from which combination of paradigms their supervisor was practicing (n=2).

The sample (n=182) indicated for their Licensure supervisor that 36.3% adhered to the Psychological paradigm (n=66), 25.8% adhered to the Systemic-Relational paradigm (n=47), 16.5% adhered to the Social Constructivist paradigm (n=30) and 21.4% adhered to one or more paradigms (n=39). The cross paradigmatic group was evaluated to explore which combination of paradigms the participants believed their Licensure

supervisors were using. For the 35 participants that completed the question, 31.4% indicated a combination of the Psychological and Systemic-Relational paradigms (n=11), 2.9% indicated a combination of the Psychological and Social Constructivist paradigms (n=1), 5.7% indicated a combination of the Systemic-Relational and Social Constructivist paradigms (n=2), and 34.3% indicated a combination of all three paradigms (n=12). The remaining participants indicated two or more theories *within* one paradigm, with 8.6% indicating two theories within the Psychological paradigm (n=3) and 11.4% indicated two theories within the Social Constructivist paradigm (n=4). The remaining 5.7% indicated that they did not know from which combination of paradigms their supervisor was practicing (n=2).

After indicating which paradigm they believed their supervisors adhered to, participants were also asked to indicate their own "Style," or paradigm choice. The sample (n= 184) indicated that 27.2% (n=50) of participants believed that they adhere to the Psychological paradigm, 20.1% (n=37) indicated the Systemic-Relational paradigm, 16.8% (n=31) indicated the Social Constructivist paradigm, 33.7% (n=62) indicated adherence to a combination of paradigms, and 2.2% indicated they did not know to which paradigms they adhere (n=4).

Chi Square Analyses

Chi square analyses are used when both variables being examined are categorical. The major assumptions of Chi square are that each category is mutually exclusive and each observation will be independent of other observations. Additionally, the sample size must be large enough so that the expected frequency in each cell is at least 2, with 5 being preferred (Huck, 2008; Michael, 2001).

An a priori power analysis for a Chi-square test was conducted in *G*Power* to determine a sufficient sample size using an alpha of 0.05, power of 0.80, a medium effect size ($w = 0.3$) and six (6) degrees of freedom (Faul, Erdfelder, Lang, & Buchner, 2007). Based on the aforementioned assumptions, the desired sample size was 152. With six (6) degrees of freedom, the chi-square needed for significance at the .05 level was 12.592 (Aron & Aron, 1999). To investigate the relationship between profession (social worker, professional counselor, or psychologist) and paradigm adherence (psychological, systemic-relational, social constructivist, or combination), the number of participants falling into the resulting 12 categories was recorded. This data is summarized into Table 5. It was hypothesized that Licensed Psychologists (**H1**) and Licensed Professional Counselors (**H3**) would adhere to the Psychological paradigm, while Licensed Clinical Social Workers (**H2**) would adhere to the Systemic-Relational paradigm. The frequencies of profession and paradigm adherence were analyzed with a Chi square. The results were not significant χ^2 (6, *N*= 189) = 6.20, *p*= .402. These results indicate that one's profession did not associate with paradigm adherence, and therefore, did not support **H1**, **H2**, or **H3**. A post hoc power analysis was conducted utilizing *G*Power*. With an alpha level of .05, a sample size of 189, and an effect size of .13, achieved power for the study was .22.

Supervisory Experiences

Chi square analyses were also conducted to investigate the relationship between supervisor's preferred paradigm choice and paradigm adherence. An a priori power analysis for a Chi-square test was conducted in *G*Power* to determine a sufficient sample size using an alpha of 0.05, power of 0.80, a medium effect size ($w = 0.3$) and 9 degrees of freedom (Faul et al., 2007). Based on the aforementioned assumptions, the desired

sample size was 174. With nine (9) degrees of freedom, the chi-square needed for significance at the .05 level was 16.919 (Aron & Aron, 1999). It was hypothesized that adherence to a specific paradigm would be related to the supervisory experiences of the mental health professional, indicated by their supervisor's preferred paradigm. Three different supervisory experiences were measured, assessing paradigm adherence for the Practicum, Internship, and Licensure supervisors. Each supervisor level is presented below.

Practicum Supervisor. The relationship between paradigm adherence (psychological, systemic-relational, social constructivist, or combination) and the participant's indication of his/her Practicum supervisor's paradigm choice was examined and the number of participants in each of the resulting 16 categories was recorded. This data is summarized in Table 6. These frequencies were analyzed and the results for this analysis were not significant, χ^2 (9, N=181) = 3.62, p = .935. A post hoc power analysis was conducted utilizing $G*Power$. With an alpha level of .05, a sample size of 181, and an effect size of .08, achieved power for the study was .09.

Internship Supervisor. The relationship between paradigm adherence (psychological, systemic-relational, social constructivist, or combination) and the participant's indication of his/her Internship supervisor's paradigm choice was examined and the number of participants in each of the resulting 16 categories was recorded. This data is summarized in Table 7. These frequencies were analyzed and the results for this analysis were not significant, χ^2 (9, N=178) = 9.22, p = .417. A post hoc power analysis was conducted utilizing $G*Power$. With an alpha level of .05, a sample size of 178, and an effect size of .13, achieved power for the study was .17.

Licensure Supervisor. The relationship between paradigm adherence (psychological, systemic-relational, social constructivist, or combination) and the participant's indication of his/her Licensure supervisor's paradigm choice was examined and the number of participants in each of the resulting 16 categories was recorded. This data is summarized in Table 8. These frequencies were analyzed and the results for this analysis were not significant, χ^2 (9, N=178) = 9.91, p = .358 A post hoc power analysis was conducted utilizing *G*Power*. With an alpha level of .05, a sample size of 178, and an effect size of .14, achieved power for the study was .20. Based on these three Chi square analyses, **H4** stating that the supervisor's preferred paradigm choice would influence the participant's paradigm choice was not supported.

Discriminant Analyses

A discriminant analysis was conducted to determine if the variables of age, gender, years of experience, ethnicity, degree, and work setting could discriminate between paradigm adherence groups. Using these characteristics as the independent variables allowed for simultaneous and independent analyses of the variables as predictors of group membership into one of the paradigms (Betz, 1987). The use of discriminant analysis was ideal since it helped to "indicate if group differences exist and precisely where they exist among the variables" (Sherry, 2006, p. 666). In other words, this method helped to identify how the paradigm groups differed based on the demographic variables, while identifying which of these variables contributed more significantly than the others to group differences.

Assumptions for Discriminant Analysis are normality, linearity, and homogeneity of variance (Kachigan, 1982; Mertler & Vannatta, 2005). The only assumption that was

violated was normality. The variable "years of experience" was positively skewed. This variable was transformed via a square root and the analysis was recomputed. Use of the transformed variable did not change the significance of the results; therefore, the original data was used in the analysis. The results of the discriminant analysis were not significant, $\Lambda = .940$, $\chi^2(18, N = 189) = 10.93$, $p = .897$, partial $\varepsilon^2 = .02$. A post hoc power analysis indicated the achieved power for the study was .42.These results indicate that the six demographic variables measured did not contribute to group differences among the four paradigm groups.

A discriminant analysis was also conducted to assess the relationship between personality variables and paradigm adherence. The six scales of the HEXACO-PI-R were run simultaneously to assess if any of the variables could aid in identifying differences among the group adherents (Hair, Anderson, Tatham, & Black, 1998; Liu & Salvendy, 2009). Based on a significance level of $p = .05$, these results indicated that only the Honesty-Humility scale discriminated between the groups (Wilks $\lambda = .947$, $F = 3.43$, df=3, $p = .018$). The discriminant function for the six personality variables together, however, was not statistically significant, $\Lambda = .866$, $\chi^2(18, N = 189) = 26.56$, $p = .092$, partial $\varepsilon^2 = .047$. A post hoc power analysis indicated the achieved power for the study was .89.

A one-way analysis of variance with a Tukey HSD post-hoc analysis was conducted to examine which paradigm groups differed on the Honesty-Humility scale. The analysis revealed that adherents to the Social Constructivist paradigm ($M = 3.88$, $SD = .39$) scored significantly higher on the Honesty-Humility scale than adherents to the Psychological paradigm ($M = 3.42$, $SD = .52$), $F(3,185) = 3.43$, $p = .018$. There were no significant differences between any of the other paradigm groups.

Supplemental Analyses

Supplemental Analysis A

An additional analysis of the cross-paradigmatic or combination group

(participants indicating more than one paradigm) and the relationship with profession was

included. From the total sample, 95 individuals indicated adherence to the cross-

paradigmatic group. When analyzed with profession, three cases were eliminated for not

indicating their profession. One other case was eliminated because his/her score on the

PAS indicated adherence to all three paradigms, receiving a score of eight in each of the

three paradigms. The relationship between the cross-paradigmatic groups (Systemic-

Relational and Social Constructivist combination, Psychological and Social

Constructivist combination, or Psychological and Systemic-Relational combination) and

the participant's profession was examined and the number of participants in each of the

resulting nine categories was recorded. This data is summarized in Table 9. These

frequencies were analyzed and although each profession had more adherents to the

Systemic-Relational and Social Constructivist cross-paradigmatic group, the results for

this analysis were not significant, χ^2 (4, N=91) = 4.33, p = .363. These results suggest

that like the analysis of one's profession and PAS results, profession is not related to

paradigm adherence among the cross-paradigmatic groups. A post hoc power analysis

was conducted utilizing *G*Power*. With an alpha level of .05, a sample size of 91, and an

effect size of .15, achieved power for the study was .17.

Supplemental Analysis B

An additional analysis of profession and paradigm adherence was included. This

analysis, however, excluded the cross-paradigmatic or combination group (participants

indicating more than one paradigm). These results were included to examine if one's profession would correlate if one adhered to a single paradigm, rather than to a combination of paradigms. The relationship between the three primary paradigms (Psychological, Systemic-Relational, or Social Constructivist) and the participant's profession was examined and the number of participants in each of the resulting nine categories was recorded. This data is summarized in Table 10. These frequencies were analyzed and the results were not significant, χ^2 (4, N=94) = 2.34, p = .674. These results suggest that even without the cross-paradigmatic group, profession is not related to paradigm adherence. A post hoc power analysis was conducted utilizing *G*Power*. With an alpha level of .05, a sample size of 94, and an effect size of .11, achieved power for the study was .11.

Supplemental Analysis C

This analysis was included to check for validity of the Paradigm Adherence Scale (PAS) since the initial validity checks (see Booth, 1997) suggested that only two thirds of the participants had a match between their actual PAS scores and their indicated paradigm preference. On the supervisor's form, an additional selection was available for the participant to indicate their "own" preferred style of practice, or paradigm choice. The four participants that indicated they did not know to which paradigm they adhered were excluded from this analysis The relationship between paradigm adherence (psychological, systemic-relational, social constructivist, or combination) and the participant's indication of his/her own paradigm choice was examined and the number of participants in each of the resulting 16 categories was recorded. This data is summarized in Table 11. These frequencies were analyzed and the results for this analysis were

significant, χ^2 (9, *N*=180) = 23.4, *p* = .005 (contingency coefficient of .34). The results indicated a relationship between responses on the PAS and the participant's self-reported indication of which paradigm they were adhering, with 36.7% of the participants providing matching responses between the PAS and their own indication of paradigm adherence.

Summary

Licensed mental health professionals were assessed to measure their paradigm adherence. The Chi Square analyses did not indicate a significant relationship between one's professional group and their adherence to a specific paradigm. Additional Chi Square analyses were conducted to determine if the supervisory experiences of the participants indicated to which paradigm they would adhere. These results did not indicate a significant relationship in supervisory experiences and paradigm adherence. Discriminant analyses were conducted to determine if demographic variables would aid in discriminating between the paradigm groups. The analyses did not indicate that these variables would discriminate between the paradigm groups. An additional Discriminant analysis was conducted on personality variables as measured on the HEXACO-PI-R. Although the adherents to the Social Constructivist paradigm did differ significantly from adherents to the Psychological paradigm on the Honesty-Humility scale, the overall discriminant function did not indicate significant group differences on these six personality variables. Supplemental analyses were also conducted for further exploration of the data. One analysis examined the cross-paradigmatic group, or combined paradigm group, with professional membership indicating non-significant results. Another analysis examined the relationship between the three primary paradigms (excluding the cross-

paradigmatic group) and professional membership, also indicating non-significant results. A final analysis examined the relationship between PAS answers and each participant's indicated paradigm choice; these results did produce significant results, with almost 37% of respondents indicating a match between paradigm choice and actual paradigm adherence.

CHAPTER V

DISCUSSION

With over 400 different theories in counseling and psychotherapy (Corsini &

Wedding, 2005), there have been various methods generated to classify these theories

into cohesive groups. Cottone (1992, 2007) developed four paradigms of counseling and

psychotherapy, which classified these numerous theories into distinct groups based on

their epistemological and ontological characteristics. The four paradigms included the

organic-medical, psychological, systemic-relational, and social constructivist paradigms;

each paradigm was identified based on six criteria, which highlighted the philosophical

differences between how paradigm adherents approach counseling and psychotherapy

(Cottone, 1992). In supplemental research, Booth (1997) developed the Paradigm

Adherence Scale (PAS) to measure adherence to one of Cottone's (1992, 2007)

paradigms, including the psychological, systemic-relational, or social constructivist

paradigms. The PAS excluded the organic-medical paradigm due to the nature of the

treatment methods aligning with individuals in the medical field rather than the non-

medical mental health professions (Cottone, 1992). In surveying AAMFT members and

their responses on the PAS, Booth (1997) found that almost 44% adhered to the

Systemic-Relational paradigm, while 42% adhered to a combination of paradigms. Of the

42% of cross-paradigmatic adherents, the majority indicated a preference for the

combination of the systemic-relational and the social constructivist paradigms.

As supplemental research to Cottone's (1992, 2007) and Booth's (1997) work, the

purpose of this study was to examine paradigm adherence of individuals licensed as non-

medical mental health professionals in the state of Missouri. Although Booth (1997)

surveyed marriage and family therapists, other mental health professionals have not been examined with regard to paradigm adherence. Identifying current trends in philosophy and practice of mental health professionals benefits the mental health field as a whole, by ensuring education, training, and supervision practices are progressive and valuable to professionals and clients alike.

Another purpose of this study was to examine if there were correlates between demographic variables and paradigm adherence. Although paradigm adherence has not been widely researched, theoretical orientation has been widely researched. Research has suggested that numerous personal and professional factors can contribute to theoretical choice, ranging from personality characteristics to clinical experience, to educational and supervisory experiences (Bernard & Goodyear, 2004; Bitar et al., 2007). This particular study explored both personal and professional variables to see if they contributed to paradigm adherence. Supervisory experiences were also examined, including each participant's assessment of which paradigm their practicum, internship, and licensure supervisors would adhere. Research has indicated that the supervisor's choice of theory typically guides the supervisory relationship, and therefore, influences the supervisee's choice of theory (Bernard & Goodyear, 2004; Ellis, 1991; Murdock et al., 1998; Putney et al., 1992). Personality variables were also examined to identify any association between those variables and paradigm adherence. Previous studies on personality and theoretical orientation have focused on Cognitive Behavioral, Psychodynamic, and Humanistic approaches, finding that Cognitive-Behavioral practitioners tend to be more conscientious and concrete while Psychodynamic and Humanistic practitioners tend to be more imaginative and non-structured (Arthur, 2000, 2001; Ogunfowora & Drapeau,

2008a ; Scandell et al., 1997; Scragg et al., 1999) . These three theoretical approaches, however, are all encompassed under the Psychological paradigm (Cottone, 1992, 2007), warranting the need for exploration beyond theoretical orientation into the realm of paradigm adherence.

Discussion of the Findings

The results of this study indicated that just over half (50.3%) of the participants adhered to the cross-paradigmatic group, followed by the Systemic-Relational paradigm (26.5%) and then the Social Constructivist paradigm (13.2%). The Psychological paradigm (10.1%) had the least amount of paradigm adherents; this was unexpected given the educational requirements of mental health professionals in Missouri focus on theories predominantly in the Psychological paradigm (CACREP, 2009; Cottone, 1992; Missouri Division of Professional Registration, 2011b). Booth's (1997) research found that almost 44% of AAMFT members adhered to the Systemic-Relational Paradigm, which was not surprising based on their emphasis and training in systems theory; the results of this study indicated that the Systemic-Relational Paradigm had more adherents than the Psychological and Social Constructivist paradigms combined, which was unexpected based on the majority of participants identifying as Licensed Professional Counselors, who are typically trained in psychologically-based theories.

In this study, an analysis of paradigm adherence by profession was examined. It was hypothesized that Licensed Psychologists in the state of Missouri would primarily adhere to the psychological paradigm, Licensed Clinical Social Workers would adhere to the systemic-relational paradigm, and Licensed Professional Counselors would adhere to the psychological paradigm. The results of this study did not support these hypotheses.

The results indicated that over half of the Licensed Clinical Social Workers (62.5%) and Licensed Professional Counselors (50.4%) identified as practicing from a combination of paradigms. Licensed Psychologists indicated paradigm adherence to the paradigm combination group (36.7%), as well as to the Systemic-Relational paradigm (36.7%). The incidence of over half of the total participants indicating adherence to two or more paradigms is supported by the literature that suggested that integrative and eclectic techniques were identified as popular choices by mental health practitioners (Boswell et al., 2009; Cook et al., 2010, Cassin et al., 2007, Orlinsky & Ronnestad, 2005).

The sample size of each of the three professions was small (LCSW, n=32; LPC, n=127; LP, n=30). Although the total number was sufficient for the statistical analyses used, the limited number of participants in each group could explain the lack of support for these hypotheses. The small numbers in group sizes and the difference between group sizes begs the question if a difference between the mental health profession groups could be detected with a larger, more equal sample size from each of the professions.

In further examination of the paradigm combination group, the results indicated that over half (56.8%) of all of the participants indicated a combination of the Systemic-Relational and Social Constructivist paradigms. Further analysis of the paradigm combination group by profession provided consistent results, with more participants from each profession adhering to the Systemic-Relational and Social Constructivist groups than other combination groups (see Table 4.9). This is consistent with Booth's (1997) findings where the majority of the Cross-paradigmatic group indicated adherence to the Systemic-Relational and Social Constructivist paradigms.

The combination of these two particular paradigms suggests that mental health professionals may be conceptualizing issues based on relational data (the Systemic-Relational paradigm), yet focusing on problem definitions consensualized *within* relationship groups (the Social Constructivist paradigm). Both of these paradigms include the idea that relationships and the larger system of society influence what will be identified and treated in the psychotherapeutic context (Cottone, 2007). The Multicultural and Feminist therapy movements (Bograd, 1984; Van Hesteren & Ivey, 1990) and short-term and Solution-focused therapies to appease third-party payers and time constraints tend to be grounded in Social Constructivist tenets (group consensualized truths). Both the Systemic-Relational and Social Constructivist paradigms are relationship-focused (versus individual-focused) which could also explain the combination of these two paradigms.

In a further breakdown of paradigm adherence by profession and by demographic variables, the Systemic-Relational paradigm consistently had the second highest number of adherents. Additionally, in the cross-paradigmatic group analysis, the combination group that had the most adherents included the Systemic-Relational paradigm. Consideration needs to be given that this might be an issue with the PAS since the original purpose of this assessment was to explore Marriage and Family Therapists' paradigm adherence. Possible issues with the questions and/or answers skewing towards the Systemic-Relational paradigm may be present, causing individuals to adhere to this paradigm more frequently. In other words, PAS item bias may be present, which needs to be explored as a validity issue with the PAS.

Another possible explanation is that the PAS, since it provides questions about what the practitioner would do in both theory and practice, illuminates that mental health practitioners truly are practicing from a combination of paradigms, theoretically and technically speaking. The profession of counseling seems to have emerged from ideologies at the base of the psychology and social work professions, incorporating psychological theories with practical approaches aligned with both the psychological and social work fields (Gladding, 2007; Van Hesteren & Ivey, 1990). Developments from the counseling profession, such as the multicultural movement, have allowed counselors to emphasize an awareness of, and a focus on, cultural and contextual differences, thus providing new ideologies for other mental health professionals to incorporate into their professions (Myers et al., 2002; Rye, 2007; Van Hesteren & Ivey, 1990). This suggests the possibility that regardless of personal or professional variables, mental health professionals are more similar than different, and many practitioners will use a variety of theoretical and technical approaches in an attempt to help their client(s). The results of this current study suggest this possibility, and, as a result, provide ideas for future research to address the current educational emphases on theories within in the Psychological paradigm. These results also suggest the need to identify new approaches that combine theoretical ideologies and technical applications into a cross-paradigmatic approach.

Assuming that the PAS is validly measuring paradigm adherence, another possible explanation for the low numbers of psychological paradigm adherents may be the waning of the psychological paradigm. The psychological paradigm is aging, with newer, more relational approaches being addressed in the literature. In practice, social

factors may prevail. This needs to be at least considered, especially in future research addressing theoretical orientation and associated factors.

Demographic variables. Demographic variables were analyzed to see if they could aid in discriminating between the paradigm adherence groups. The results of this analysis were not significant, indicating that the six demographic variables of age, gender, years of experience, ethnicity, degree, and work setting did not contribute to group differences among the four paradigm groups.

Past research indicated that more seasoned professionals use integrated or eclectic approaches (Ogunfowora & Drapeau, 2008a; Ogunfowora & Drapeau, 2008b; Orlinsky & Ronnestad, 2005); this could explain why differences were not found between the paradigm groups regarding age and years of experience. Older professionals with more experience may feel more comfortable in their abilities to integrate or combine different theories and techniques to best serve their clients. As a whole, this group presented as seasoned professionals, with the average age of all the participants being 44.36 years with an average of 11.71 years of clinical experiences. This suggests that this sample may have been more comfortable in integrating different theories due to their age and years of experience as a mental health professional.

The literature for the role of gender on theoretical orientation choice suggested that women will tend towards Cognitive-Behavioral, Systemic, Feminist, or Integrative approaches (Cassin et al., 2007; Ogunfowora & Drapeau, 2008b; Snyder et al., 2000), while male therapists tend towards Cognitive-Behavioral and Brief or Solution-focused therapies (Cassin et al., 2007; Levenson & Davidovitz, 2000). Although past research indicated a difference in gender and theoretical choice, the research suggested the

different genders would adhere to only one theoretical choice, which would translate into

one paradigm choice; only Cassin et al., (2007) suggested an integrative approach for

female practitioners, which would suggest a cross-paradigmatic choice. The results of

this study indicated that one's gender did not contribute to differences between the

paradigm adherence groups; rather, the majority of both genders adhered to the cross-

paradigmatic group. Booth (1997) also found that one's gender alone did not contribute

to differences in paradigm adherence; Booth suggested that differences in gender

theoretical orientation are more of a stylistic issue rather than a theoretical one. Other

research (Pignotti, 2010;Werner-Wilson et al., 2003) supported that the way in which

genders differ in theory and practice may be stylistic, since women therapists tend to

focus more on the therapeutic relationship. If the emphasis is on the relationship rather

than a technical application, than a cross-paradigmatic approach would make sense in

discerning which approach would help to establish that relationship with clients. This

would apply to male therapists as well, since their approach has historically been focused

on problem-solving with shorter term therapies (Levenson & Davidovitz, 2000; Werner-

Wilson et al., 2003). A cross-paradigmatic approach would assist these practitioners since

they would be able to utilize theoretical approaches and techniques from multiple

paradigms in an effort to quickly address the client's needs.

Supervisory Experiences. Another hypothesis examined was that adherence to a

specific paradigm would be related to the supervisory experiences of the mental health

professional. Three supervisory experiences were assessed, at the Practicum, Internship,

and Licensure levels. For all three supervisors, the participants indicated that their former

supervisors were primarily adhering to the Psychological paradigm, followed by the

Systemic-Relational paradigm. This is a contrary finding to the results on the PAS since half of the participants indicated adherence to the Cross-Paradigmatic group, yet indicated that their supervisors were adhering to only one paradigm, rather than from a combination of paradigms. These findings are also contrary to past research findings which identified the supervisor's theoretical orientation as a major contributor to their supervisee's theoretical orientation (Guest & Beutler, 1988; Murdock et al., 1998). The supervisor's theoretical orientation helps to provide effective supervision sessions as well as to influence what theory supervisees will choose (Guest & Beutler, 1988; Norcross & Prochaska, 1983; Putney et al, 1992; Schacht et al., 1989). Booth (1997) also found significant results indicating a relationship between the most recent supervisor's paradigm adherence and the participant's paradigm adherence.

One reason for the contrary findings of this study may be that supervisors are teaching true paradigmatic philosophies, but with years of clinical experiences (Ogunfowora & Drapeau, 2008a; Ogunfowora & Drapeau, 2008b; Orlinsky & Ronnestad, 2005), the participants are now confident enough to integrate different theoretical and technical components into their own approach. In other words, supervisors are providing paradigm-consistent training, but mental health professionals are combining the training from their supervisory experiences into their own method of treatment, thus becoming adherents to a combination of paradigms. Additionally, since newer theories like Multicultural, Feminist, and short-term therapies have recently been introduced to the mental health field, more recently trained professionals may be combining these approaches into their training from paradigmatically-pure training from their supervisors, once again making them adherents to a combination of paradigms.

In further analysis of the paradigms by supervisory experiences, all three levels of supervision indicated that the Systemic-Relational paradigm had the second most adherents (second to the Cross-Paradigm group). Additionally, in the cross-paradigmatic group analysis of each supervisory level, the Practicum and Internship supervisors indicated a combination group that included the Systemic-Relational paradigm (with the Psychological paradigm). For Licensure supervisors in the cross-paradigmatic group, the combination group with the most adherents was a combination of all three paradigms, followed closely by the combination group of the Psychological and Systemic-Relational paradigms. As mentioned previously, consideration needs to be given that issues with the PAS may have affected the results of the participant's paradigm adherence, and therefore, it was not able to accurately measure the relationship between paradigm adherence and supervisory experiences.

Personality variables. Due to the gap in the literature on the topic of paradigm adherence, one research question of this study was to examine if there was a relationship between paradigm adherence and personality variables. Numerous assessments have been utilized in examining the relationship between personality and theoretical orientation, but this is the first study to explore personality variables with paradigm adherence. Arthur (2001) suggested that an understanding of one's personality will aid in selecting and maintaining a specific theory, so the goal of this study was to extend that to paradigm adherence as well.

On the HEXACO-PI-R, the Honesty-Humility scale was the only scale that differentiated significantly between different paradigm groups, with Social Constructivist paradigm adherents scoring statistically significantly higher than Psychological paradigm

adherents. The discriminant functions for these scales however, did not provide significant results, indicating that these six scales together could not aid in discriminating between the four paradigm groups. This is not surprising since more than half of the participants indicated adherence to the cross-paradigmatic group.

It is difficult to draw conclusions from these current findings to past findings in the literature. Past research has suggested that personality traits such as being non-directive, open, and intuitive are associated with the Humanistic or Psychodynamic approaches (Arthur, 2001; Ogunfowora & Drapeau, 2008a) where traits such as being directive, goal-oriented, and assertive correlate with a Cognitive-Behavioral orientation (Arthur, 2000, 2001; Scandell et al., 1997; Scragg et al., 1999). Past research, however, has primarily focused on theories within the psychological paradigm. An understanding of how these personality variables will relate to the underlying philosophies of each paradigm is not known without more studies on personality variables and paradigm adherence. What extends paradigm adherence beyond theoretical orientation is the underlying philosophical position guiding practice. For example, one can use a Cognitive-Behavioral approach from either the Psychological or the Systemic-Relational paradigms, but under the Psychological paradigm the focus will be on changing faulty beliefs within the individual whereas the Systemic-Relational paradigm philosophy will focus on addressing the faulty beliefs within an entire system. Since the theories themselves can be used under different paradigms, an analysis of personality variables looking at specific theories will not provide information about personality variables' contribution to paradigm adherence.

Limitations

There are some limitations to note in this study. These limitations include threats to the internal validity and the external validity of the study, as well as other limitations. These limitations and how they could affect the results of the study are discussed below.

Threats to Validity

This research study examined three different populations in naturally occurring groups, which were already formed based on profession choice. Based on these naturally formed groups of the participants' profession, random assignment was not an option, creating a threat to the internal validity of this study. This study was a descriptive field design, which also affected the internal validity due to the lack of variable manipulations by the researcher.

Mono-method bias, or having only one method of measurement, is also a threat to the construct validity of this study (Heppner et al., 1999). The study consisted of two assessments and two demographic forms, all of which were self-reports (mono-method). Answering in a socially desirable manner becomes a threat to validity because the participant would want to answer in a way where they are perceived in a more socially desirable way, which would affect the outcome scores on the assessments. Evaluation apprehension may have influenced participants to answer in a socially desirable way as well, since the survey was asking the participant to provide their perceptions of their personalities. For example, individuals in the mental health professions may not want to honestly answer a question like "I sometimes feel that I am a worthless person," (Q76 on the HEXACO-PI-R) believing that feeling that way may not be appropriate for a mental

health professional. Although anonymous, their concerns about being assessed may have biased their self-report of their true responses.

Another threat to the validity of this study is that of mono-operation bias, or when only one measure of a full construct is used (Heppner et al., 1999). The HEXACO-PI-R was the only scale used to measure the construct of personality. This is a threat to the construct validity because the construct of personality may not have been accurately represented by this one measurement. The PAS was also the only scale used to measure paradigm adherence, creating the same threat to construct validity.

Issues with the PAS may have also affected the validity of this study. In the original validity checks of the PAS, Booth (1997) found that only two thirds of the participants' indicated paradigm adherence matched their responses on the PAS. This study found a moderate, but statistically significant, correlation between participants' responses on the PAS and their identified paradigm choice on the demographic form, with almost 37% of participants identifying the same adherence to the paradigm that their PAS scores indicated. In an analysis of paradigm adherence by profession, by demographic variables, and by supervisory experiences, however, the Systemic-Relational paradigm had the second highest amount of adherents for each variable (second to the paradigm combination group). Additionally, examination of the cross-paradigmatic groups for each of these variables indicated that the combination group with the most adherents always included the Systemic-Relational paradigm. At its inception, the PAS was intended to explore Marriage and Family Therapists' paradigm adherence, and validity checks were performed with students enrolled in courses on Systems theory and with practicing Marriage and Family Therapists. Questions arise regarding the

content validity of this instrument to accurately measure paradigm adherence across the three different paradigm groups, given the high response rate within the Systemic-Relational paradigm.

Another limitation to this study was the power of the study. With the exception of the analysis of the personality variables, each statistical test was underpowered. An a priori power analysis indicated that this study would have 80% power with an estimated medium-sized effect of .30, an alpha level of .05, and 174 participants. This estimated effect size was too high, however, which lowered the actual power of this study. Since the power of a study is the ability to detect an effect when one truly exists, more participants would be needed to achieve a power level of 80%, given the same alpha level and the *actual* effect size parameters.

In addition to these threats to the validity of this study, there were also some threats to the external validity. One main issue is that of the population sampled. The population sampled included licensed professionals from three specific mental health professions within a specific geographical region. Additionally, only individuals that participated in their profession's state organization were included, which affected the generalizability even further since not every licensed professional will join these organizations and there may be different participation requirements for statewide professional organizations in other states.

Another concern with the population was that the participants were invited to participate through electronic communication, with the exception of 23 participants that completed paper copies at a statewide conference for counselors. All other participants were sent email invitations to participate; this is a threat to external validity since not

everyone may have access to a computer or the understanding of how to operate and complete online surveys. Additionally, those that did complete the survey did so on a volunteer basis, and individuals that do volunteer present with different characteristics than individuals that choose not to volunteer.

Implications for Mental Health Professionals

The results of this study did not provide significant results on any of the hypotheses. As complementary research to Booth's (1997) work, this study examined if paradigm adherence could be predicted based on demographic and personality variables. It also examined choice of profession and supervisory experiences to see if significant differences existed between three different types of mental health professions and paradigm adherence. Although significant differences did not exist between the groups, examining variables like these as possible contributors to paradigm adherence can have implications for mental health education, training, and practice.

One implication for mental health professionals based on this research is that it appears that regardless of profession, or personal and other professional variables, these mental health professionals are providing treatment for clients in similar ways. Since the majority of these participants are practicing from a combination of paradigms, training in all three paradigms is warranted. Included in this training should be how to incorporate these philosophical ideologies into professional training programs. Instead of an emphasis on the philosophy within one paradigm, educational programs could focus on incorporating all three paradigms into training experiences. These experiences could educate and train mental health professionals on how to work from each of the three paradigms and could address cross-paradigmatic training as well (e.g., focusing on how

the individual is affected by immediate relational systems which are affected by society or larger cultural systems). The results of this study suggest these professionals are practicing cross-paradigmatically anyway, so evaluation of the education and training programs will ensure that training programs and actual practice align.

A cross-paradigmatic approach can be useful in providing training to mental health professional supervisors as well. Educating pre-and post-graduate supervisors with the different paradigms of counseling and psychotherapy will allow for a comprehensive understanding of how theories are organized. This will help to identify the underlying philosophy and conceptualization process of their supervisee(s). With this, the supervisor can nurture a supervisee's growth in solidifying adherence to a paradigm or a combination of paradigms and the practical application of the theories and techniques within each one.

Recommendations for Future Research

Based on the limitations of this study, future research could focus on a more representative sample of the mental health professions. The sample in this study was comprised primarily of Caucasian participants, with an average age of 44 years, who were licensed in a specified Midwest state. Future studies could focus on a national sample of professionals from the three different populations with a more representative sample of the demographic make-up of those professions. With that national sample, including the current demographic variables of this study, as well as other variables, will aid in identifying what characteristics actually contribute to paradigm adherence. This could include a more extensive look into educational and training aspects that may affect the underlying philosophy of psychotherapy practice.

Future validation of the PAS is also recommended. Booth's (1997) study indicated that only two thirds of the participants' responses matched their indicated paradigm choice. This study suggested a moderate correlation between participants' responses on the PAS and their identified paradigm choice on the demographic form. Future research could include a wider range of mental health professionals in the validation process and possible revisions of the PAS if the samples differ in their answers on the PAS. Examination of the skewed data towards the Systemic-Relational paradigm would need to be examined as well, to ensure each paradigm was adequately represented within the PAS. Consideration should also be given to including the fourth paradigm, the Organic-Medical paradigm, into the PAS as well. It may be that some non-medical professionals are operating from an Organic-Medical approach. In addition, including two measures to assess paradigm adherence and the other variables studied may provide more information on the relationship between these variables and paradigm selection.

Future studies could also examine mental health practitioners and their supervisors directly. The goal would be to have the supervisors and their former supervisees complete the PAS and have both also indicate their paradigm choice. Analysis of the indicated paradigm choice could offer more insight into the influential aspect of the supervisory relationship on the mental health participant's paradigm adherence as well as offering further validation of the PAS as an instrument to measure paradigm adherence.

Another suggestion includes a study that uses both quantitative and qualitative means. Paradigm adherence and demographic variables could still be assessed using quantitative methods and then an in-depth, qualitative exploration of each participant's

explanation of "why" they adhere to a specific paradigm and their perception of influential aspects that impact their adherence to one or multiple paradigms. Inclusion of qualitative and quantitative measures of personality would aid in further understanding of these variables to paradigm adherence as well. This type of study could help guide quantitative studies, by elucidating other variables and characteristics that need to be measured as possible contributing factors to paradigm adherence.

Conclusion

The purpose of this research was to examine if one's mental health profession, personality variables, past supervisory experiences, and demographic variables could aid in identifying paradigm adherence. Cottone's (1992; 2007) work on the paradigms of counseling and psychotherapy is a recent contribution to the field, and to date, there is only one other study measuring mental health professionals and paradigm adherence (see Booth, 1997). The aim of this study was to provide additional information to this theory and examine contributing factors to paradigm adherence.

A major goal of this study was to examine group differences in paradigm adherence, however, the majority of participants indicated a combination of paradigms. As a result, trying to identify which personal and professional variables would discriminate among each of the paradigm groups proved difficult since the majority of participants adhered to more than one paradigm. The lack of significant results among the professions was interesting however, suggesting that if paradigm adherence was similar among these three different groups, a reevaluation of the educational and training procedures for these three professions needs to be examined.

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APPENDIX A

HEXACO-Personality Inventory-Revised (HEXACO-PI-R)

HEXACO-PI-R

(SELF REPORT FORM)

DIRECTIONS

On the following pages you will find a series of statements about you. Please read each statement and decide how much you agree or disagree with that statement. Then write your response in the space next to the statement using the following scale:

> 5 = strongly agree
>
> 4 = agree
>
> 3 = neutral (neither agree nor disagree)
>
> 2 = disagree
>
> 1 = strongly disagree

Please answer every statement, even if you are not completely sure of your response.

1 _____ I would be quite bored by a visit to an art gallery.

2 _____ I clean my office or home quite frequently.

3 _____ I rarely hold a grudge, even against people who have badly wronged me.

4 _____ I feel reasonably satisfied with myself overall.

5 _____ I would feel afraid if I had to travel in bad weather conditions.

6 _____ If I want something from a person I dislike, I will act very nicely toward that person in order to get it.

7 _____ I'm interested in learning about the history and politics of other countries.

8 _____ When working, I often set ambitious goals for myself.

9 _____ People sometimes tell me that I am too critical of others.

10 _____ I rarely express my opinions in group meetings.

11 _____ I sometimes can't help worrying about little things.

12 _____ If I knew that I could never get caught, I would be willing to steal a million dollars.

13 _____ I would like a job that requires following a routine rather than being creative.

14 _____ I often check my work over repeatedly to find any mistakes.

15 _____ People sometimes tell me that I'm too stubborn.

16 _____ I avoid making "small talk" with people.

17 _____ When I suffer from a painful experience, I need someone to make me feel comfortable.

18 _____ Having a lot of money is not especially important to me.

19 _____ I think that paying attention to radical ideas is a waste of time.

20 _____ I make decisions based on the feeling of the moment rather than on careful thought.

21 _____ People think of me as someone who has a quick temper.

22 _____ I am energetic nearly all the time.

23 _____ I feel like crying when I see other people crying.

24 _____ I am an ordinary person who is no better than others.

25 _____ I wouldn't spend my time reading a book of poetry.

26 _____ I plan ahead and organize things, to avoid scrambling at the last minute.

27 _____ My attitude toward people who have treated me badly is "forgive and forget".

28 _____ I think that most people like some aspects of my personality.

29 _____ I don't mind doing jobs that involve dangerous work.

30 _____ I wouldn't use flattery to get a raise or promotion at work, even if I thought it would succeed.

31 _____ I enjoy looking at maps of different places.

32 _____ I often push myself very hard when trying to achieve a goal.

33 _____ I generally accept people's faults without complaining about them.

34 _____ In social situations, I'm usually the one who makes the first move.

35 _____ I worry a lot less than most people do.

36 _____ I would be tempted to buy stolen property if I were financially tight.

37 _____ I would enjoy creating a work of art, such as a novel, a song, or a painting.

38 _____ When working on something, I don't pay much attention to small details.

39 _____ I am usually quite flexible in my opinions when people disagree with me.

40 _____ I enjoy having lots of people around to talk with.

41 _____ I can handle difficult situations without needing emotional support from anyone else.

42 _____ I would like to live in a very expensive, high-class neighborhood.

43 _____ I like people who have unconventional views.

44 _____ I make a lot of mistakes because I don't think before I act.

45 _____ I rarely feel anger, even when people treat me quite badly.

46 _____ On most days, I feel cheerful and optimistic.

47 _____ When someone I know well is unhappy, I can almost feel that person's pain myself.

48 _____ I wouldn't want people to treat me as though I were superior to them.

49 _____ If I had the opportunity, I would like to attend a classical music concert.

50 _____ People often joke with me about the messiness of my room or desk.

51 _____ If someone has cheated me once, I will always feel suspicious of that person.

52 _____ I feel that I am an unpopular person.

53 _____ When it comes to physical danger, I am very fearful.

54 _____ If I want something from someone, I will laugh at that person's worst jokes.

55 _____ I would be very bored by a book about the history of science and technology.

56 _____ Often when I set a goal, I end up quitting without having reached it.

57 _____ I tend to be lenient in judging other people.

58 _____ When I'm in a group of people, I'm often the one who speaks on behalf of the group.

59 _____ I rarely, if ever, have trouble sleeping due to stress or anxiety.

60 _____ I would never accept a bribe, even if it were very large.

61 _____ People have often told me that I have a good imagination.

62 _____ I always try to be accurate in my work, even at the expense of time.

63 _____ When people tell me that I'm wrong, my first reaction is to argue with them.

64 _____ I prefer jobs that involve active social interaction to those that involve working alone.

65 _____ Whenever I feel worried about something, I want to share my concern with another person.

66 _____ I would like to be seen driving around in a very expensive car.

67 _____ I think of myself as a somewhat eccentric person.

68 _____ I don't allow my impulses to govern my behavior.

69 _____ Most people tend to get angry more quickly than I do.

70 _____ People often tell me that I should try to cheer up.

71 _____ I feel strong emotions when someone close to me is going away for a long time.

72 _____ I think that I am entitled to more respect than the average person is.

73 _____ Sometimes I like to just watch the wind as it blows through the trees.

74 _____ When working, I sometimes have difficulties due to being disorganized.

75 _____ I find it hard to fully forgive someone who has done something mean to me.

76 _____ I sometimes feel that I am a worthless person.

77 _____ Even in an emergency I wouldn't feel like panicking.

78 _____ I wouldn't pretend to like someone just to get that person to do favors for me.

79 _____ I've never really enjoyed looking through an encyclopedia.

80 _____ I do only the minimum amount of work needed to get by.

81 _____ Even when people make a lot of mistakes, I rarely say anything negative.

82 _____ I tend to feel quite self-conscious when speaking in front of a group of people.

83 _____ I get very anxious when waiting to hear about an important decision.

84 _____ I'd be tempted to use counterfeit money, if I were sure I could get away with it.

85 _____ I don't think of myself as the artistic or creative type.

86 _____ People often call me a perfectionist.

87 _____ I find it hard to compromise with people when I really think I'm right.

88 _____ The first thing that I always do in a new place is to make friends.

89 _____ I rarely discuss my problems with other people.

90 _____ I would get a lot of pleasure from owning expensive luxury goods.

91 _____ I find it boring to discuss philosophy.

92 _____ I prefer to do whatever comes to mind, rather than stick to a plan.

93 _____ I find it hard to keep my temper when people insult me.

94 _____ Most people are more upbeat and dynamic than I generally am.

95 _____ I remain unemotional even in situations where most people get very sentimental.

96 _____ I want people to know that I am an important person of high status.

97 _____ I have sympathy for people who are less fortunate than I am.

98 _____ I try to give generously to those in need.

99 _____ It wouldn't bother me to harm someone I didn't like.

100 _____ People see me as a hard-hearted person.

APPENDIX B

Paradigm Adherence Scale (PAS)

Please indicate which statement you most agree with or

best fits your point of view by circling only <u>one</u> response.

1. Mr. and Mrs. Smith are frustrated about their child's problematic behaviors at home and take him to a therapist. The therapist is likely to hypothesize that:

a. The child and each parent may have multiple, possibly competing, perspectives about the "problem behavior."

b. The child may be inadvertently benefitting from misbehavior.

c. The child's behaviors may be symptomatic of parental discord.

2. A client comes to therapy with complaints of feeling anxious and having relationship problems. The therapist believes the client may feel less anxious after:

a. Discussing and negotiating a different view of relationships with self and others.

b. Engaging in counseling and experiencing a positive change in his or her relationships.

c. Identifying and modifying thoughts, feelings, or behaviors associated with the anxiety.

3. A client attends the first meeting with a therapist. The therapist should ask about:

a. The client's ideas about the problem and significant meanings the problem has for him or her.

b. The description of the problem, including the frequency and duration of symptoms experienced by the client.

c. Who is involved in the problem and the interactional patterns around the problem.

4. Family members each tell a therapist their account of what happened during a recent family conflict. The therapist:

a. Wishes he or she had been "a fly on the wall" during the conflict in order to know who was really at fault.

b. Believes that each member of the family participated in the creation of the problem.

c. Believes that each person's version of what happened is equally valid and plausible, and that negotiation would need to occur in order to reach a conclusion about the problem.

5. A therapist who was assisting a family struggling with a problem assumed that:

a. Family members can change only after they understand and deal with their individual problems.

b. Getting different interactions to occur can lead to healthy changes in family relationships.

c. Discussing and negotiating ideas for solutions with family members can lead to positive changes.

6. When working with parents and misbehaving teenagers, it is most helpful for the therapist to try to:

a. Foster more consensus about appropriate behaviors and develop agreements about how to resolve differences.

b. Assist the parents with behavior management and assist the teenager in modifying feelings, thoughts, or behaviors so that he or she may function in a healthy way.

c. Change family interactional sequences within which the problem is being maintained.

7. When parents seek therapy related to managing their child's behaviors at home, an

effective therapeutic intervention is:

a. Setting up a program whose goal is to help the parents modify the child's behaviors.

b. Facilitating discussions whose goal is to create agreement about the nature of the problem

and proposed solutions.

c. Making assignments whose goal is to alter family structure and hierarchy.

8. A husband and wife bring their child to a therapist saying that the girl has low self-esteem

and seems depressed. The therapist decides it would be best to:

a. Define characteristics of "depressed" and "not depressed" with the family members and

help them to emphasize and expand their experiences of "not depressed."

b. Examine the family relationships and, having discovered how being depressed serves to

maintain balance in the family system, work to facilitate a new balance that does not

require depression.

c. See the girl individually to examine and to treat the self-esteem problems and depression

and to include the parents to facilitate their understanding of these interventions.

9. Mr. and Mrs. Jones are having problems in their marriage. The therapist believes the

problem is most likely due to:

a. Unsuccessful attempts to negotiate mutually acceptable ideas for change.

b. A difficulty in how they are relating to each other and in how they are attempting to solve the problem.

c. A psychological disturbance of one or both of the partners.

10. Family members were seeking the advice of a therapist about problems getting along together. The therapist believed it was her or his job to:

a. Understand the interpersonal parameters of the problem and perhaps assign tasks for family members.

b. Assess and to assist in modifying each family member's thoughts, feelings, and/or behaviors to facilitate a healthier adjustment to others in the household.

c. Help the family members to come to some agreement about how to resolve differences and improve family functioning.

11. In meeting with clients, therapists:

a. Assume that they cannot help but influence and be influenced by the description and meaning of a problem brought to therapy.

b. Can maintain an objective stance about the client's symptoms, problems, and ways to treat these given their expertise in the area of human behavior.

c. Are aware that they may become part of the client's or family's "system," but can still maintain objectivity about what is going on an how best to intervene.

12. A primary general goal of therapy when seeing a couple for marriage counseling is:

a. To facilitate a change in each partner's feelings, thoughts, and behaviors.

b. To facilitate change in the relationship through alteration of interactional sequences.

c. To facilitate change through consensus-building about what needs to happen for the relationship to improve.

13. In order to help clients, it is important to:

a. Try to get at the cause of the problem so that it may be solved.

b. Focus on constructing with clients a future where the problem does not occur.

c. See that problems occur in reciprocal interactions and focus on patterns of interaction for finding solutions.

14. The therapist's role in working with individuals, couples, or families is to:

a. Facilitate change in and resolution of problematic patterns of interaction.

b. Emphasize and expand processes of change which are already occurring with clients.

c. Assess clients and suggest interventions designed to produce healthier feelings, thoughts, and/or behaviors.

15. Couples will find therapy to be helpful when:

a. Each person gains an understanding of the other's motivations or feelings behind particular behaviors.

b. Both experience a positive change in their way of interacting.

c. They are able to construct a new definition of a good relationship.

16. A marriage therapist in the initial stages of therapy should:

a. Discuss with the couple ideas regarding the problem and proposed solutions.

b. Observe the couple's interactional dynamics around the presenting problem.

c. Assess each partner's personality style before proceeding with therapy.

17. A therapist addressing a problem within a family context should:

a. Work on altering relationship patterns occurring between family members.

b. Negotiate with family members how to guide the process of change in a more satisfying direction.

c. Attempt to intervene in those emotional, behavioral, or belief processes causing problems for family members.

18. In couples therapy, the therapist should as the clients to:

a. Create agreements about how to change the relationship.

b. Modify internal beliefs or expectations and change behaviors to facilitate adjustment to the partner's personality.

c. Engage in interactional tasks either during or outside of the session that interrupt current interpersonal patterns.

19. A family involved in therapy because one of the children is having school problems would observe the therapist:

a. Viewing the identified child as the symptom bearer for the family and helping the family change their interactions.

b. Enlisting the family's help in getting the child to a higher level of emotional and behavioral functioning at school.

c. Seeking input from the child, family, school, and any others involved with the problem in order to develop a consensus about how it should be solved.

20. A client tells a therapist that he is depressed and nervous because his wife constantly nags at him. It would be helpful for the therapist:

a. To explore a variety of equally plausible explanations for the client's depression.

b. To consider the client's depression and the wife's nagging behavior as two important components of a reciprocal interactional sequence in which each affects the other.

c. To view the client's depression as caused by the marital distress as well as problematic internal feelings and beliefs.

21. A therapist is working with a couple and the partners have reported ongoing arguing and bickering with each other. The therapist may assume that:

a. The partners have been unable to come to agreement on the nature of their problems and solutions for change.

b. They have not learned ways to accept each partner's limitations.

c. The partners are "stuck" in a conflictual relationship pattern.

22. A therapist meets with a family after the parents have expressed concern about the children's constant fighting with each other. The therapist is likely to focus on:

a. Identifying the children's beliefs and feelings underlying the fighting behavior and having the parents provide incentives for getting along.

b. Negotiating common ground for how interactions could be more satisfying.

c. Sequences of behavior around the fights and facilitating new patterns of interaction.

23. When clients report feeling anxious the therapist should:

a. Assess the relationship context within which the anxiety is manifested.

b. Ask about definitions of anxiety and what it would take to agree that anxiety is no longer a problem.

c. Assess the feelings, thoughts, or behaviors that are related to the anxiety.

24. A therapist:

a. Should assist families with finding solutions through negotiation and consensus-building in order to be helpful to them.

b. Should get to know the structural characteristics and interactional patterns of the whole family in order to be helpful to clients.

c. Needs to examine the internal and external processes occurring with family members in order to be helpful to clients.

APPENDIX C

Demographic Data Sheet

Please complete this sheet only <u>after</u> finishing the PAS.

1. Age: _____ (in years)

2. Gender: _____ Male _____ Female

3. Which of the following best describes your race/ethnicity?
_____ African-American/Black (A)
_____Hispanic-American/Latino/Chicano (B)
_____Native-American/American Indian (C)
_____Asian-American (D)
_____Caucasian/European-American/White (E)
_____Multiracial (please specify) _____
_____Other (please specify) _____

4. Profession:

      Licensed Clinical Social Worker _____
      Licensed Professional Counselor _____
      Licensed Psychologist_____

5. Highest Degree Completed: _____Bachelor's _____ Master's

        _____Ph.D. _____Psy.D. _____Ed.D.

6. Years of Clinical Experience

(since receiving mental health graduate degree): _____

7. Primary Work Setting:

____outpatient mental health _____ private practice _____hospital

____social service agency _____university _____school

_____residential treatment _____EAP _____other

_____training institute _____managed care

Demographic Data Sheet (Con't.)

Please read the brief descriptions of four different styles of therapy (A, B, C, and D) and indicate which description best represented the perspective of your clinical supervisor, based on what occurred during supervision sessions.

Style A: This practitioner focuses on the individual and intrapersonal processes, whether it is individual, group, couples, or family counseling. Therapeutic change occurs through interventions designed to facilitate changing a person's thoughts, feelings, and/or behaviors. Clients are assessed and diagnosed using DSM-IV or other psychological criteria. Treatment decisions are made based on the results of this assessment which identifies causes of problems and the target of intervention.

Style B: This practitioner focuses on relationships and interpersonal processes. Individual concerns are usually redefined to a relational context. Therapeutic change occurs through social relationships, as problems brought to therapy are viewed as symptomatic of what is wrong in the client's relationships of significance. Social and familial interactions tend to be the primary targets for therapeutic interventions.

Style C: This practitioner focuses on the social and language processes that lead to clients (and therapists) deciding that a problem exists. Attention is given to the various perspectives and "realities" about the problem and its solutions, and ways in which these different views may be acknowledged and coordinated. The client may be an individual, a whole family, or varying groups of family members or significant others. Solutions in therapy usually arise through negotiating, creating agreements, constructing alternatives, and other consensus-building processes.

Style D: A combination of other styles.

Please indicate which style of therapy best represented the perspective of:

Therapy Style

1. Your Practicum supervisor.   A   B   C   D* (_____)

2. Your Internship supervisor.   A   B   C   D* (_____)

3. Your Licensure supervisor.   A   B   C   D* (_____)

4. Your own perspective.   A   B   C   D* (_____)

*If you selected Style D for any of the above, please indicate on the line next to "D" which of the other Styles, either A, B, or C, best represents the combination of styles practiced by that individual or yourself.

APPENDIX D

Dear Mental Health Professional:

You are being asked to participate in a dissertation research study regarding various theoretical frameworks and therapeutic techniques utilized by Licensed Mental Health Professionals. Should you agree to participate, you will be asked to complete two measures and two demographic/background information sheets.

One measure is the HEXACO-Personality Inventory-Revised (HEXACO-PI-R). This is a personality inventory that assesses personality characteristics among six dimensions. The Paradigm Adherence Scale (PAS) focuses on theoretical assumptions and beliefs related to various therapeutic techniques and interventions employed in clinical practice. If you choose to participate, you will complete the 100-item HEXACO-PI-R first, then the 24-item PAS, and finally, the demographic data sheets.

By completing these measures, you will contribute to knowledge about contemporary theoretical and practical trends in the field as well as the contribution of personality traits to theoretical orientation. The responses to this survey are anonymous. There are no anticipated risks in your participation in the study and you are free to withdraw from the study at any time. Participation should take approximately 20- 30 minutes of your time.

Should you desire further information, or if you have any questions about the research, please contact the principal investigator at the number or email address below.

Laura A. Rauscher, M.Ed., LPC, NCC, ACS

Principal Investigator & Doctoral Candidate

314.749.9432

lrauscher5@gmail.com

R. Rocco Cottone, Ph.D

Dissertation Chairperson

314.516.6094

cottone@umsl.edu

Division of Counseling and Family Therapy

One University Blvd.
St. Louis, Missouri 63121-4499
Telephone: 314-516-5782
Fax: 314-516-5784
E-mail: lrauscher5@gmail.com

Informed Consent for Participation in Research Activities
Paradigm Adherence and Personality Correlates Across Mental Health Professions

Participant _____ HSC Approval Number: 258997-2_____

Principal Investigator: Laura A. Rauscher PI's Phone Number:

1. You are invited to participate in a research study conducted by Laura A. Rauscher and Dr. R. Rocco Cottone. The purpose of this research is to examine various theoretical frameworks and therapeutic techniques utilized by Licensed Mental Health Professionals.

2. a) Your participation will involve
   ➤ Accessing www.surveymonkey.com where you will be asked to complete two psychometric measures and two demographic forms. One measure, the HEXACO-PI-R, is a 100-item measure that assesses personality characteristics among six variables. The Paradigm Adherence Scale is a 24-item measure that assesses theoretical techniques and ideologies utilized in practice. One demographic form is designed to collect background information, including age, gender, and years of clinical experience. The final demographic form assesses your supervision experiences, pre- and post-graduate.

   ➤ Participation is completely anonymous and subjects will be assigned to groups based on their mental health profession. Approximately 174 participants may be involved in this research.

   b) The amount of time involved in your participation will be approximately 30 minutes total. The HEXACO-PI-R will take approximately 15 minutes, the PAS will take approximately 10 minutes, and the demographic forms will take approximately 5 minutes. If interested, participants will be able to enter into a drawing for one of four Amazon $50 gift cards. Participants will be able to click on a separate link to enter this drawing so their survey data cannot be connected to their identifying information.

3. There are no anticipated risks associated with this research.

4. There are no direct benefits for you participating in this study. However, your participation will contribute to the knowledge about differences in personality characteristics and mental health professionals and how those relate to theoretical orientation choice.

5. **Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer.** You will NOT be penalized in any way should you choose not to participate or to withdraw.

6. By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer and/or in a locked office.

7. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Laura A. Rauscher at (314) 749-9432 or the Faculty Advisor, Dr. R. Rocco Cottone at (314) 516-6094. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 516-5897.
I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I consent to my participation in the research described above.
   By clicking on "Continue" I hereby consent to participate in the study.

Participant's Signature	Date	Participant's Printed Name

Signature of Investigator or Designee	Date	Investigator/Designee Printed Name

APPENDIX E

May 23, 2012

Laura A. Rauscher
UM-St. Louis Doctoral Candidate
Lrauscher5@gmail.com

Dear Laura,

As follow-up to both our email and phone conversation, I authorize you to use the Paradigm Adherence Scale (PAS) as an instrument for your study. Please provide a summary of your findings once your study is complete.

Thanks,

Therese J. Booth, Ed.D,
Licensed Psychologist
758 Chamberlain Pl., Suite 201
Webster Groves, MO 63119
314-610-3232
tpbooth@sbcglobal.net

APPENDIX F

Friday, May 27, 2011 10:18 AM
Hi, Laura:

Thank you for your interest in our inventory. For research and educational purposes, researchers can use our inventory without permission. The relevant materials can be downloaded from http://hexaco.org.
Good luck with your research.

Best, Kibeom

From: Laura Rauscher
Sent: May-27-11 9:04 AM
To: kibeom@ucalgary.ca
Subject: Permission to use the HEXACO Personality Inventory

Dr. Ashton and Dr. Lee,
 Hello! I am a doctoral candidate at the University of Missouri-St. Louis. I am working on completing my dissertation assessing Paradigm Adherence and Personality Variables in Licensed Psychologists, Social Workers, and Professional Counselors in the state of Missouri. In order to assess personality variables, I was inquiring to see if I could have permission to utilize the HEXACO as the measure for personality? If this is acceptable, are there specific forms or steps needed in order to verify your permission has been given?

Thank you so much!

Laura A. Rauscher, M.Ed., LPC, NCC, ACS
Licensed Professional Counselor
National Certified Counselor
Approved Clinical Supervisor

Table 1

Descriptive Statistics for Continuous Variables of Age and Years of Experience

Profession	Age		Years of Experience	
	Mean	*SD*	*Mean*	*SD*
LCSW	42.56	10.60	12.44	8.44
LPC	44.43	12.61	10.30	8.90
LP	45.97	11.36	16.80	10.53
TOTAL	44.36	12.08	11.71	9.36

Note. LCSW= Licensed Clinical Social Worker; LPC=Licensed Professional Counselor; LP=Licensed Psychologist; TOTAL=Total Sample.

Table 2

Descriptive Statistics for Categorical Variables of Gender, Ethnicity, Degree, and Work

Setting

Variable	LCSW	LPC	LP	TOTAL SAMPLE
	n(%)	*n(%)*	*n(%)*	*n(%)*
Gender				
Females	19(10.3)	94(50.8)	12(6.5)	125(67.6)
Males	13(7.0)	29(15.7)	18(9.7)	60(32.4)
Ethnicity				
African Am.	2(1.1)	5(2.6)	2(1.1)	9(4.8)
Caucasian	24(12.7)	118(62.4)	26(13.8)	168(88.9)
Latino	2(1.1)	1(.5)	1(.5)	4(2.1)
Multiracial	1(.5)	2(1.1)	---	3(1.6)
Native Am.	3(1.6)	1(.5)	---	4(2.1)
Other	---	---	1(.5)	1(.5)
Degree				
Bachelor's	1(.5)	4(2.1)	---	5(2.6)
Master's	26(13.8)	104(55.0)	4(2.1)	134(70.9)
Ph.D.	5(2.6)	17(9.0)	22(11.6)	44(23.3)
Psy.D.	---	---	4(2.1)	4(2.1)
Ed.D	---	2(1.1)	---	2(1.1)
Work Setting				
Outpatient Facility	4(2.1)	15(7.9)	3(1.6)	22(11.6)
Private Practice	5(2.6)	38(20.1)	11(5.8)	54(28.6)
Hospital	3(1.6)	6(3.2)	4(2.1)	13(6.9)
Social Service Agency	10(5.3)	20(10.6)	2(1.1)	32(16.9)
University	4(2.1)	18(9.5)	7(3.7)	29(15.3)
School	---	11(5.8)	---	11(5.8)
Residential Facility	2(1.1)	3(1.6)	1(.5)	6(3.2)
EAP	1(.5)	3(1.6)	---	4(2.1)
Training Institute	---	1(.5)	---	1(.5)
Managed Care Program	---	4(2.1)	---	4(2.1)
Other	3(1.6)	8(4.2)	2(1.1)	13(6.9)

*Note .*Cells with a dash indicates there were not any participants in that category.

Table 3

*Paradigm Adherence Frequencies and Percentages*_____

Paradigm	Frequency	Percent
Psychological	19	10.1
Systemic-Relational	50	26.5
Social Constructivist	25	13.2
Cross-Paradigmatic	95	50.3
Total	189	100.0

Table 4

Means and Standard Deviations for the HEXACO-PI-R subscales by Paradigm

Paradigm	Subscale	Mean	Std. Deviation
Psychological	Honesty	3.42	.52
	Emotionality	3.17	.48
	Extraversion	3.72	.58
	Agreeableness	3.47	.44
	Conscientiousness	3.66	.41
	Openness	3.76	.42
Systemic-Relational	Honesty	3.68	.46
	Emotionality	3.31	.50
	Extraversion	3.66	.46
	Agreeableness	3.22	.47
	Conscientiousness	3.81	.40
	Openness	3.65	.54
Social Constructivist	Honesty	3.88	.39
	Emotionality	3.31	.52
	Extraversion	3.76	.49
	Agreeableness	3.34	.43
	Conscientiousness	3.69	.36
	Openness	3.69	.48
Cross-Paradigmatic	Honesty	3.65	.51
	Emotionality	3.21	.49
	Extraversion	3.73	.54
	Agreeableness	3.18	.51
	Conscientiousness	3.73	.48
	Openness	3.76	.47
TOTAL	Honesty	3.66	.49
	Emotionality	3.25	.50
	Extraversion	3.72	.52
	Agreeableness	3.24	.49
	Conscientiousness	3.74	.44
	Openness	3.72	.48

Note. *N*=189 for HEXACO-PI-R

Table 5

*Crosstabulation of Paradigm Adherence and Profession*_____

Paradigm*	Profession			
	LCSW	LPC	LP	χ2
PSYCH	4	11	4	6.20**
	(3.2)	(12.8)	(3.0)	
SR	6	33	11	
	(8.5)	(33.6)	(7.9)	
SC	2	19	4	
	(4.2)	(16.8)	(4.0)	
CROSS	20	64	11	
	(16.1)	(63.8)	(15.1)	

Note. *= p = .402.** Expected frequency count appears in parentheses below group frequencies.

Table 6

*Crosstabulation of Paradigm Adherence and Practicum Supervisor*_____

Paradigm* _____Practicum_____

	PSYCH	SR	SC	CROSS	χ2
PSYCH	8	7	2	1	3.62**
	(7.7)	(5.6)	(2.8)	(2.0)	
SR	20	17	5	6	
	(20.4)	(14.9)	(7.4)	(5.3)	
SC	9	7	5	3	
	(10.2)	(7.4)	(3.7)	(2.7)	
CROSS	40	25	16	10	
	(38.7)	(28.2)	(14.1)	(10.1)	

Note. *= p = .935.** Expected frequency count appears in parentheses below group frequencies.

Table 7

*Crosstabulation of Paradigm Adherence and Internship Supervisor*_____

Paradigm*   Internship_____

	PSYCH	SR	SC	CROSS	χ2
PSYCH	4	5	7	2	9.22**
	(6.9)	(5.8)	(3.4)	(1.9)	
SR	18	19	6	4	
	(18.0)	(15.1)	(9.0)	(5.0)	
SC	12	5	4	3	
	(9.2)	(7.7)	(4.6)	(2.6)	
CROSS	34	28	17	10	
	(34.0)	(28.5)	(17.0)	(9.5)	

Note. *= p = .417.** Expected frequency count appears in parentheses below group frequencies.

Table 8

*Crosstabulation of Paradigm Adherence and Licensure Supervisor*_____

Paradigm*			Licensure		
	PSYCH	SR	SC	CROSS	χ2
PSYCH	5	5	6	2	9.91**
	(6.5)	(4.8)	(2.8)	(3.9)	
SR	21	10	5	11	
	(16.9)	(12.4)	(7.4)	(10.3)	
SC	7	5	4	8	
	(8.6)	(6.3)	(3.8)	(5.3)	
CROSS	31	27	13	18	
	(32.0)	(23.5)	(14.0)	(19.5)	

Note. *= p = .358.** Expected frequency count appears in parentheses below group frequencies.

Table 9

Crosstabulation of Profession and Cross-Paradigmatic Group

Paradigm*		Profession		
	LCSW	LPC	LP	χ2
SR & SC	14	31	5	4.33**
	(10.4)	(33.5)	(6.0)	
P & SC	4	17	3	
	(5.1)	(16.1)	(2.9)	
P & SR	1	13	3	
	(3.6)	(11.4)	(2.1)	

Note. *= p = .363.** Expected frequency count appears in parentheses below group frequencies. SR & SC = Systemic-Relational & Social Constructivist Group, P & SC = Psychological & Social Constructivist Group, P & SR = Psychological & Systemic Relational Group.

Table 10

Crosstabulation of Paradigm Adherence and Profession without Cross-Paradigm Group

Paradigm*		Profession		
	LCSW	LPC	LP	$\chi 2$
PSYCH	4	11	4	2.34**
	(2.4)	(12.7)	(3.8)	
SR	6	33	11	
	(6.4)	(33.5)	(10.1)	
SC	2	19	4	
	(3.2)	(16.8)	(5.1)	

Note. *= p = .674.** Expected frequency count appears in parentheses below group frequencies.

Table 11

Crosstabulation of Paradigm Adherence and OWN perceived choice of Paradigm

Adherence

Paradigm*	OWN Paradigm Choice				
	PSYCH	SR	SC	CROSS	χ2
PSYCH	10	2	5	2	23.43**
	(5.2)	(3.9)	(3.3)	(6.5)	
SR	10	13	6	17	
	(12.8)	(9.5)	(7.9)	(15.8)	
SC	3	2	9	9	
	(6.4)	(4.7)	(4.0)	(7.9)	
CROSS	27	20	11	34	
	(25.6)	(18.9)	(15.8)	(31.7)	

Note. *= p = .005.** Expected frequency count appears in parentheses below group frequencies.