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MARITAL THERAPISTS' OWN MARITAL DISTRESS AND ITS PERCEIVED IMPACT ON THEIR CLINICAL WORK

by

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(ABSTRACT)

This research investigated basically two questions: 1. the incidence and distribution of marital distress, including the response to distress among marital therapists and 2. how therapists view their personal experience of marital distress and its perceived impact on their clinical work. A questionnaire was designed to address these issues. One thousand members of the American Association for Marriage and Family Therapy were selected through systematic procedures and mailed a questionnaire. A response rate of 58% was achieved. In addition to the questionnaire, five in-depth interviews were conducted to more fully understand the complex phenomenology of marital therapists' own marital distress and the various ways this may be perceived to impact on their clinical work.

The results begin to dispel the myth that marital therapists have "high" divorce rates. Their marriages are of longer duration (those that terminate in divorce) and male therapists, in particular, are less likely to be divorced at any given time, as compared to the survey information supplied by the U.S. Census Bureau. Female marital

therapists may be more vulnerable to distress and divorce than other females in the public, but this study did not determine if those findings are just a function of being a marital therapist; the literature indicates that other factors are probably influential.

Cluster analysis revealed that three stable typologies characterize this sample, which provided hierarchical levels of distress and support: low distress with low support, moderate distress with high support and high distress with moderate support. All three clusters are significantly different ($p < .001$ when submitted to a discriminant function analysis. A factorial analysis of variance tested the effects of 1. cluster membership, that is, levels of distress, 2. sex, 3. marital status, and 4. benefits of therapy together on therapists' clinical work. All the effects were significant ($p < .001$) with the exception of sex. Most importantly, impact scores overall were low, but the interviews support the assumption that any difference in the marital life of the therapist which influences his or his clinical work is a difference that matters.

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A dissertation is not an entity in and of itself but is the culmination of years of effort, expectation, desire and frustration. Jim Keller has been more than my mentor; he has been a trusted friend who has shared in my joys, encouraged my growth, and supported me through innumerable self-doubts and even tears. I would like to thank the rest of my committee: Joe Maxwell, Bud Protinsky, Linda Thompson, who served such an important role in the early development of the study, and to Rosemary Blieszner who so willingly replaced Linda when necessary. deserves special recognition; not only has he helped me to understand the "black holes in golden rings" but has allowed me to think divergently while challenging me to think convergently.

were my panel of experts who thoughtfully reviewed the questionnaire and were interviewed to help me understand the complexities of this research. Their expertise contributed more than answers; their insights refined interpretations and created new questions. Not only are they all experts in the field of marital and family therapy, they're experts in giving encouragement, particularly when its needed most.

I'd still be proofreading for 'typos' if it were not for the skillful assistance of whose helping heart is even greater than her helping hands. not only helped with the many hours of stuffing envelopes and mailing, but did it cheerfully. My sister,

one of my favorite companions, was literally at my side in the early phase of typing address labels. My daughter, also helped with the mailing (thank goodness likes to lick stamps); she worked diligently and made this a family project, including some assistance from her younger brother . provided statistical consultation for the data, and reassurance for my anxieties, and I am deeply grateful for her perseverance. I'd also like to thank

who helped to provide a home environment in which I could study and write.

The value of this study is not only attributable to the many marital therapists who so generously and often enthusiastically responded to the questionnaire; the true value will only be realized if it has relevance in their own lives, personally and professionally. It is a study not only about therapists; hopefully it is for therapists.

Most of all, I'd like to gratefully acknowledge the support of my family: My parents who have never really known who I am or understood what I am doing, but love me anyway; my children, , who hopefully will not often have to hear: "not now, Mommy's too busy", and, with love, to my husband .

"The nature of this work is very difficult during times of marital distress. As a therapist, I feel we are vulnerable since our work is not a place to escape problems but to expose ourselves to our own concerns hour after hour. Our ability to make our own marriages work is an expression not only of our personal success, but ourselves as professionals. It's a tough dilemma."

- Respondent

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A STUDY OF THE MARITAL THERAPIST'S OWN MARITAL DISTRESS

"We must not cease from our exploration; and the end of all our searching will be to arrive where we started and know the place for the first time."

T. S. Elliott

STATEMENT OF THE PROBLEM

Martin Buber (1973) the existentialist and Jewish theologian wrote: "I am what I do." If, indeed, we are what we do, what do marital therapists do when they experience marital distress in their own lives? It is known that marital distress and dissolution does occur among marital therapists. It has been speculated that there is a high rate of divorce among marriage and family therapists (Broderick, 1983, Charney, 1982, Framo, 1975, 1979, Kaslow, 1984). In fact, Broderick has issued a warning that the practice of marital therapy may be dangerous to the therapist's marital health. Various influences resulting from the therapist's training and practice may actually intensify the probability of marital or family dysfunction (Charney).

What is not known is how marital therapists experience marital distress and what the effects are personally, as well as professionally. Nichols (1968, p. 85) states: "the therapist's own marriage and family life affect his learning and functioning as a psychotherapist and are an integral part of his professional well-being." When the therapist's own marriage is deeply troubled, it may be difficult to conduct therapy sessions. Some therapists, whose own marriages are falling apart, seem

to be able to manage effectively as marital therapists, somehow maintaining that professional boundary from their personal lives. However, there are therapists, who when distressed, bring biases and distortions into a therapy session with uncertain effects. Critics of the marital therapy profession, as well as patients, have declared that if therapists couldn't help their own marriages, how can they hope to help anyone else's? How do therapists deal with their own feelings regarding their personal marital situations? Framo (1975, p. 27) asks the question: "What do you do during a down phase in your marriage when you are treating a couple whose marriage relationship is in better shape than your own?" How do therapists relate to couples who seem to be expending more energy in terms of preserving the viability of their own marriages than therapists felt they did in their own? How do marital therapists contend with the problems they see in their office being re-enacted in their own marriages and discover that the same creative problem-solving skills are to no avail and, in fact, are criticized as: "more of your psychology nonsense and jargon" (Kaslow, p. 96). Can therapists' own struggle make them more sensitive and empathetic to those who are also in a marital crisis? Do they say to themselves: "I know your pain, I've been there too." The experience of suffering may then be useful in the therapist's clinical work and the stigma of marital distress and dissolution may become a "potentially positive asset" (Rippere & Williams, 1985, p. 6).

Many reknowned leaders in marriage and family therapy have been divorced; for some, it was experienced as a "failure to make life

meaningful in the personal sphere," where for others the divorce represented "growth and triumph" (Kaslow, 1984, p. 96). What makes the difference? As Kaslow states: "Were we able to do some...research on their personal families histories and dissatisfactions," we might be able to answer these questions. Most importantly, what do marital therapists do regarding their own marital distress? Do therapists attempt to "heal thyself" or do they seek supervision and/or therapy and, if so, what kind: individual or marital therapy? Are marital therapists not only disciples, but also doubting Thomases when it comes to the perceived effectiveness of marital therapy for themselves? What influences their decisions and how do therapists experience the outcome of their own therapy? Do marital therapists, like physicians who have difficulty being patients, also have difficulty being clients (Gillespie & Gillespie, 1983)? Why would marital therapists choose individual therapy rather than a conjoint-marital approach? This is an important question because many marital therapists are frequently trained that not only may marital problems remain unresolved through individual therapy, but they may even be created (Hurvitz, 1967). "Where the marital tie is weak and divorce threatens, intervention with one of the pair seems routinely to be disruptive. We are impressed that moving unilaterally into a marriage relationship, taking one of the two as a patient and referring or ignoring the mate is very often a tactical blunder" (Whitaker and Miller, 1969). Beyond a tactical blunder, Wells and Giannetti (1986) in a critical reappraisal of individual marital therapy stated that most theoreticians, practitioners and researchers regard

conjoint marital therapy as by far the most effective mode of marital therapy and individual marital therapy not only as ineffective but possibly dangerous and damaging. They argue that the inferiority of individual marital therapy has become "an article of faith" (p. 43) in the profession. Their review concludes that given the "inadequate evidence available" no judgment can be made regarding the effectiveness or ineffectiveness of individual marital therapy. Given this controversy, what do therapists prescribe for themselves?

Framo (1979) believes that therapy trainees should be encouraged (not required) to participate in marital or family therapy because it can be among the best experiences in terms of preparation for becoming a family therapist. Ferber (1972) goes a step further in stating that work with one's own family is crucial to becoming a competent family therapist. The importance of this study is in the contribution that it will make in furthering our understanding of therapists' characteristics, notably therapists' own marital health. This study may also indicate the need for providing an experience in marital and/or family therapy for the trainee (Guldner, 1978). One clinical training program has responded to this need by developing a program entitled: The Person and Practice of the Therapist. This innovative model is based on the understanding that therapists are most effective when they utilize themselves for the mutual progress of both the client and themselves. The program is predicated on the assumption that therapists not only employ their clinical skills and theoretical sensitivity in therapy, but that they also rely on their personal life experiences and

own value systems. A significant difference in this Person-Practice model as compared to many others is that it attends to the vital links between therapists' personal lives and their actual clinical work (Aponte and Winter, 1986).

The literature reveals a need for an examination of these issues but a concomitant void of research. As discussed, the literature implies a relationship between the therapist's own marital health and therapeutic effectiveness. It then behooves us as a profession to critically examine ourselves and our own struggles so as to more effectively treat those who come to us for help. To quote Charney (1982, p. 46): "Nobody really knows fully why human experiences and relationships are so troubled, but it seems like a worthwhile exercise to try to understand the particular problems family (marital) therapists face in their own lives, not only because we are human like everyone else, but because we are therapists in general and family (marital) therapists in particular."

The systemic interaction and interdependence that develops between the therapist and client needs to be examined. "The therapist can no longer be seen as 'impacting' on the client or family . . . the therapist is not an agent and the client is not a subject. Both are part of a larger field in which therapist, family and any number of other elements act and react upon each other in unpredictable ways" (Hoffman, 1981, p. 8). Minuchin and Fishman (1982, p. 2) further emphasize the systemic importance of the use of self: "Family therapy

requires a use of self. A family therapist cannot observe and probe without."

Therapists are observers, but there is a subjective self of the therapist who participates in that process of observation. Rollo May has stated: "The human dilemma is that which emerges out of our capacity to experience ourselves as both subject and object at the same time" (May, 1967). It is precisely this dilemma which demands an understanding of therapists' phenomenological experiences of marital distress. This distress, particularly in such a vital aspect of therapists' lives, may influence their concept of "self" and therefore the therapists' capacity for subjectivity and objectivity.

The therapeutic use of self can be an effective tool in therapy or as one author stated: "myself as an instrument" (Shapiro, 1967). Does marital distress significantly dull or blunt this instrument? Whitaker goes a step further in stating that the person of the therapist is inseparable from the therapy process and influences its outcome (Neill and Kniskern, 1982). Whitaker has often stated: "Therapists are born, not made." A candle can be easily made, but it is not functional, giving neither light nor warmth, until it is lit. Does the experience of marital distress affect therapists' ability to function optimally perhaps even to the point of the therapists questioning their self confidence in their work thus leading to the candle being "burned out"?

Of particular relevance for this study is Jerome Frank's concept of the assumptive world, which is: "a short hand expression for a highly structured, complex, interacting set of values, expectations, and images

of oneself and others, which guide...a person's perceptions and behavior" (Frank, 1961). Therapists' assumptive worlds are intimately related to their own emotional states and feelings of well-being. A major determinant of one's assumptive world is one's concept of self within a marital relationship. Consequently, marital distress may influence therapists' assumptive worlds, hence their well-being and consequently the capacity for subjectivity and objectivity in their clinical work.

When the therapist's emotional well being has been compromised due to marital distress, is the therapist a "wounded healer" who then has difficulty entering the world of the other (Havens, 1974)? This is an important question as it is often speculated in the literature that the decision to become a marital and family therapist may be based on unresolved conflict from families of origin or even marital difficulties. In the words of Groesbeck and Taylor (1977): "...the need to cure our inner wounds and unresolved conflicts, cannot be overestimated." June (1966) felt this may explain why the patient's projections are often so painful; therapists often fail to differentiate their own psychology from that of the patient's, or in marital therapy terms, the patient's marriage becomes enmeshed with the therapist's marriage. When the therapist is absorbed with his or her own dilemmas and pain he may be more easily distracted and less emotionally present to the patient. This distraction may increase the therapist's projections and the inability to be aware of them. This turmoil will more than likely increase the therapist's fatigue as well.

Aponte and Winter (p. 10) claim that it is "inevitable" that both the patient and the therapist bring into the therapy session each person's real and psychological bonds with their respective lives which bear all the scars of their past along with the wounds suffered in their present lives. Additionally, family therapists are known to have an active role in the therapy session and are thus perhaps less insulated from the passivity of the analyst; thereby more likely to transmit or impose their own values and struggles on the patient, particularly if the patient's difficulties closely identify with the therapist's (Aponte, 1985). Therefore the obligations of the therapist to the patient should include the resolution of his or her own personal issues that may affect the work and secondly to become aware of his or her identity, wounds, and scars (Aponte, 1982).

However, is the "wound" only a detriment to the therapy process, which must be denied or protected and its ugliness hidden by layers of bandages? Paradoxically, in the history of healing, it was only the wounded healer who had the gift and power of healing. This is particularly evident in cultures where there were Shamans, who were expected to have suffered in order to heal (Bennett, 1979). The wound is a reminder of human frailty and may actually facilitate entry into the patient's pain.

The experienced clinician by being cognizant of what he or she is bringing into the therapeutic process, both strengths and attributes as well as weaknesses and wounds, can enhance the patient's growth and capacity for change. Aponte and Winter (p. 12) state aware therapists

who discover their own individual struggles are an impediment to the client's growth will recognize that and a "sense of discomfort develops," a stretching of the adhesions surrounding the wound occurs and, depending on the age of the wound and the state of healing, will affect not only its vulnerability but its flexibility as well. They further maintain that the use of self and a concomitant focus on the therapist's personal development, while also permitting greater accessibility to the patient's world, reduces the prospect of burnout, although they do not substantiate that claim.

The therapeutic encounter often recreates a mirror image of an aspect of the therapist's life; wounds are nudged, stretched and pulled. However, Aponte and Winter claim this process may act as an impetus for the therapist to continue to work on his or her own life struggles, particularly when they are reflected in the problems the patient brings to therapy. Doing therapy often provides the therapist with a unique opportunity for his or her own growth. As Whitaker (Neill and Kriskern) defends: therapy works well for the patient when it is working well for the therapist.

And finally, in a paper on a death in the life of a therapist and its impact on therapy the authors state that an important loss will profoundly affect a therapist's work in both general and specific ways (Givelbar & Simon, 1981). Marital distress and dissolution is frequently referred to in the literature as a loss. While in the process of grieving the therapist is less apt than normally to maintain the delicate balance between subjectivity and objectivity, but responds

primarily based on his or her own internal needs and pressures. At some point in the mourning process, there can be a positive outcome as the listener hears in a keener and more sensitive way. The wound heals, or in words that were attributed to St. Peter: "By his wounds, you have been healed" (I Peter 2:24).

There are no empirical data to provide answers for many of the issues and questions which have been raised. This study, while emphasizing the importance of these questions, cannot purport to answer them all. In a book entitled: Heal Thyself; The Health of Health Care Professionals, the authors (Scott & Hawk, 1986, p. vii) state there are two primary reasons why we must address these questions: first of all, an impaired professional, such as a therapist, is "an enormous drain on society's assets. . . secondly, health professionals' well-being is related to the overall good functioning of the health care enterprise. A close relationship exists between the condition of professionals' lives and how they work, a relationship that is mediated through life styles." Furthermore, this is an age of accountability for the health care system and therapists must not only be accountable to their patients but must be willing to examine themselves.

The purpose of this study is to examine marital distress among marital therapists and additionally to explore therapists' conceptions of how their own marital distress may influence their clinical work. The two overriding questions that will be addressed are the following:

1. What is the incidence and distribution of marital distress, including the response to distress among marital therapists?

2. How do therapists view their personal experience of marital distress and its perceived impact on their clinical work?

Through these questions, patterns and themes will be identified, enabling the development of theoretical generalizations in future research that will indicate not only the need for more investigation, but will form the basis for it.

LITERATURE REVIEW

The poet, E. C. Cummings, wrote: "Well, here's looking at ourselves." Apparently this has been difficult for the profession to do as there are no studies reported in the literature on marital therapists' own marital health. Since an examination of marital therapists' own marital health has not been done, it may be useful to review studies of other helping professionals' marriages.

The past few years reveal some interest in the marriages of clergy and physicians. Both are high risk professions in terms of stress and share with marital therapy the perceived public importance of being "exemplary role models" (Houts, 1982, p. 142; Wilson & Larson, 1981). Houts reported that while headlines scream that clergy marriages are in trouble, statistics do vary, but it is apparent that more clergy marriages are ending in divorce than ten years ago. However, the percentage of distressed clergy marriages which seek therapy as compared to distressed marriages in the general population which seek marital therapy is not known.

Hutchison, et al. (1981), based on a survey of 176 protestant clergy, reported that there was an overlap between the minister's marital and professional roles. This overlap consequently affected the divorce and adjustment process. One notable finding was the concern expressed by the divorced clergy for the impact their divorce had on their occupational role. These authors further stated that a divorced minister is probably unique in threatening his occupation because of his

divorce. In the immediate aftermath of divorce, nearly two-thirds of the respondents in this survey felt that their ministry was somewhat adversely affected; thirty-six percent of the clergy found that this detrimental effect lasted more than a year. Some respondents felt that more emotional difficulties were experienced following separation as opposed to the finality of the divorce. One fifth of the ministers, however, did believe that their work was positively affected following divorce. As one respondent commented: "I feel divorce has enhanced my life and ministry by giving me greater sensitivity and personal understanding, and a sense of the grace of God experienced. I think it has enhanced my ministry to potential or actual divorces, especially, and to crisis situations" (p. 90). The authors attribute the adjustment to divorce in some cases to be related to a successful therapy experience; in ninety percent of the cases, at least one spouse received therapy; both persons were in therapy either individually or conjointly in approximately three-fourths of the divorces. This "high proportion of persons" seeking treatment may be related to the belief of church officials that therapy was "strongly advisable".

Regarding the status of physician marriages, the literature reveals opposing conclusions, some stating rather dramatically: "Medical Marriages: To Have (for a while) and to Hold (not for long)" (Schindler, 1973). However, the work of Rose and Rosow (1972) reveals that in terms of the divorce rate, medical marriages are more stable than those of the population in general. In reviewing 57,514 complaints for divorce, separation or annulment filed in California during the

first six months of 1968, it was determined that the rate of marital instability, as reflected in the complaints, was forty-one percent greater in the general population than among medical marriages. Rose and Rosow did find that female physicians had a forty-eight percent greater risk of marital instability than their male physician colleagues. Medical specialties also indicated variation with the orthopedic surgeons, psychiatrists, and dermatologists having the highest incidence of complaints and the preventive medicine/public health specialists having the lowest.

Divorce statistics are only one (albeit major) criterion of marital distress. Do physicians and their spouses stay in unsatisfactory marriages rather than divorce due to such factors as financial considerations, concerns regarding their social status in the community, or even denial that there is marital distress? One physician stated: There are powerful social, cultural, and economic pressures on a doctor and his wife not to divorce. One of the occupational hazards of physicians is marital misery, but it's hidden by the mask of marital conformity (Manber, 1979). Vaillant, et al. (1972) found that when physicians are matched with controls they are indeed more likely to have "poor" marriages.

Krell and Miles (1976) addressed the issue of doing marital therapy when the husband is a physician. Based on their clinical experiences, and with data from a ten couple sample, they elaborated there are hindrances to early referral, such as self diagnosis and self treatment. Furthermore, they contended that the long delay between awareness of the

distress and actual referral for therapy may permit the development of intellectualization and a cognitive understanding of their difficulties which may not be conducive to change. These authors also issue a warning that the intelligence and "apparent psychologic-mindedness" of the physician may make him appear to be a candidate for individual therapy. In summary, the doctor-patient who is distressed emotionally may not recognize the marital problems and, even when he does, frequently chooses individual therapy for himself or his wife. However, "almost invariably, the capacity for change was less within the individual than within his relationship with his wife" (1976, p. 273).

Another related area of the literature which may be germane to this study is the research on the particular problems of the physician as patient. Several studies have even identified the physician as the "special patient" (Waring, 1977, p. 161) or the "problem patient" (Medical World News, 1976, p. 58). Waring concluded that there is evidence that physicians do "make the worst patients" (p. 164) and related this to their reluctance to initiate therapy. Physicians, Waring added, often receive unsatisfactory psychiatric care because:

1. physicians seldom seek professional help early in the course of their distress,

2. "special patient" labels may produce adverse staff reactions,

3. transference and counter-transference problems often occur between psychiatrists and other medical professionals.

Other special management problems have been reported by Devin (1977). In 1976, the National Association of Private Psychiatric

Hospitals distributed a questionnaire to its members which dealt with the treatment of physician-patients. Some of the identified unique problems in treating physician patients were the following:

1. most frequently mentioned was the reluctance of the physician to accept the role of patient, together with their self-prescriptions.

2. delay in treatment until advanced stages,

3. physician-patient's concern with confidentiality and professional image,

4. physician-patient's feelings of guilt and shame,

5. the therapist over-identifying with the patient, with the staff relating to the patient as a "special case" because he is a physician,

6. the staff experiencing anxiety and feelings of being threatened.

Other reports in the literature have commented on the problem of delay in seeking therapy and resistance to treatment (Vincent, et al, 1969; Pearson & Strecker, 1960; and Dorr, et al, 1983). Vincent, et al stated: "Paradoxically, the healing profession paid little attention to its own morbidity for years" (p. 403). The same can be said for the marital therapy profession; only the lack of attention to the marital therapists' marital morbidity continues.

Two studies did begin to attend to this lack and thus merit discussion. The first study (Henry, et al., 1973) represents the most comprehensive nationwide investigation of psychotherapists. A large sample of four thousand respondents from three metropolitan areas--New York,

Chicago and Los Angeles--was intensively studied through a general survey instrument and an additional three hundred participants were interviewed in depth. The investigation examined the public and private lives of psychotherapists. One of the many conclusions was that regarding the private lives of therapists, their growth and development is not dissimilar from most educated persons. The investigators found few variables that could distinguish therapists from other professionals. A notable finding is that while the marital and family life of the therapist is generally satisfying that it was frequently described by the investigators as "lacking intensity" (p. 158). This led to their conclusion that the emotional gratification realized in the therapeutic relationship may often be used by the therapist to offset any perceived deprivation experienced within his or her own marriage or family life.

The second major study (Marx & Spray, 1970) involved mental health professionals (psychiatrists and psychologists) in three metropolitan communities. This study examined the interactions between marital status, professional experience and receiving personal psychotherapy and their effect on occupational success. Analysis was only done with males but the findings indicate that success is strongly related to marriage, but not to marital stability. Furthermore, success (which was measured by computing median annual income and the median number of articles published by psychiatrists and psychologists, then ranking the respondents accordingly) is also correlated to whether or not therapists have received personal psychotherapy but, more definitively, to the

reasons for having therapy. The study concluded that: "personal relations, professional experiences and occupational success form a network of relationships which integrate the occupational and nonoccupational role of highly specialized practitioners" (p. 110).

This review would not be complete without mentioning that in the past couple of years, two books have made significant contributions to our understanding of this subject: Psychotherapy with Psychotherapists (Kaslow, 1984), which includes a chapter on "Treatment of Marital and Family Therapists" and Wounded Healers: Mental Health Workers' Experiences of Depression (Rippere & Williams, 1985). The latter book is a collection of nineteen very personal vignettes of severe depression in mental health professionals. It was the editors' intent that these essays would focus on the phenomenology of depression in order to increase our understanding. There was a void in the literature concerning the possibility that overcoming depression may actually enhance a therapist's skills and empathy with patients, so this was included as a topic of inquiry in the study. The five questions were:

1. What sort of experience of depression had they had?
2. Under what circumstances had they become depressed?
3. What did they do about it themselves and what did others, whether lay or professional, do about it?
4. What of all this did they personally find helpful and what did they find unhelpful?

5. Having survived to tell the tale, what did they feel they learned from the experience, both personally and in their subsequent work as therapists?

The conclusions of this study are rich and quite varied as qualitative data tend to be, and it would be unfair to summarize the findings in the brevity of this review. Interestingly, the last question was the most difficult for their contributing authors to answer. However, a statement made in some form by most of the subjects was: "It's about time someone looked into this" (p. 5).

Someone has begun to look into this but the results weren't published until the summer of 1986, almost a year after this present study was proposed. Wetchler and Piercy (1986) investigated the marital/family life of family therapists and various factors which may be stressors and enhancers. Their preliminary study looked at the number and relative strength of the stressors and enhancers of marital and family life of family therapists in Indiana. Their results indicate a significantly greater number of enhancers than stressors. Wetchler and Piercy (p. 106) used many of the same supportive rationale for the importance of their research as have been cited in this study, including: "This issue is particularly important, considering the evidence that psychotherapists' emotional problems probably spill over into their therapy and have a negative impact on clients."

The Wetchler and Piercy (1986) study basically asked two questions: "How has being a family therapist uniquely strengthened your own marriage/family?" and "How has being a family therapist been uniquely

stressful to your own marriage/ family?" While Wetchler and Piercy acknowledge that virtually little or nothing has been written about the various marital/family life stressors and enhancers associated with being a family therapist, this author further contends that unexplored issue is only one aspect of the systemic whole. Therapists must also investigate, not only how clinical practice and being a therapist affects their marital and family lives, but how their marital and family lives influence their clinical work. These are separate but related issues; the one issue merits investigation for therapists personally, the second demands investigation for therapists professionally, but most importantly for those who are entrusted to their care.

In summary, major studies in this area of research are few; there are several (Hutchison, et al., 1981; Rose and Rosow, 1972; and Vaillant, et al., 1972) which investigate the marital lives of clery and physicians. In particular, Hutchison et al. reported that there is an overlap between marital and professional roles. A comprehensive investigation (Henry, et al., 1973) of psychotherapists and a major study (Marx & Spray, 1970) of mental health professionals examined the private and professional lives of the participants. Marx and Spray concluded that there is an integration but little is known about the nature of this interaction. Wetchler and Piercy (1986) attempted to explore this interaction, but only from one direction: how being a family therapist strengthened the therapist's own family or marriage and how it has been stressful. Interest in the public and private lives of mental health professionals, including marital therapists, is beginning

to develop. Little is known about the purported relationship between therapists' personal and professional lives. Most importantly, it is not known if that relationship would be deleterious or conducive to therapeutic effectiveness. Consequently, more needs to be understood about the purported relationship between therapists' personal and professional lives. The next step would be to investigate if this has an effect on the patient and, finally, to evaluate that effect on the therapy process and outcome. To reiterate: it's about time someone looked into this.

METHODOLOGY

Preliminary Study

An exploratory pilot study was conducted with a group (n=93) of therapy professionals at a conference entitled "Marriages in Crisis" in April, 1982. A five-item questionnaire (see Appendix A) was handed out to the registrants prior to the opening session. The purpose of the survey was to gather information regarding the ways in which psychotherapists' own marital problems are managed in their clinical work. The results of the pilot study are included in the appendix. From the study, it was determined that "therapeutic effectiveness" is a difficult variable to define and measure. Very elementary analysis was conducted on the data primarily for the purpose of supplying the conference registrants with feedback. The findings reveal that the divorce rate was 35 (n=37) percent; interestingly, approximately one half of those who were divorced were divorced at least twice. Most reported that the degree to which distress hindered or hurt therapeutic effectiveness was only 2 on a Likert scale of 7, but the degree to which the distress helped therapeutic effectiveness was 5. Some of the comments to an open-ended question are revealing and included in the appendix. Several suggestions were made regarding the clarity of the wording. This preliminary investigation indicated a high proportion of therapists who denied that their therapeutic effectiveness was hindered and the degree to which therapists felt it was beneficial. This led to a desire to know what factors might be related to these results.

Design

This study utilized a combination of quantitative and qualitative research methods. A large survey was conducted which was enhanced with in-depth and unstructured interviewing of a small sample. Survey research aims to derive the incidence, distribution, and relationship of characteristics among a population. This decision to combine research methods, was based on the types of questions posed in this study and the lack of prior studies in the area. The premature isolation of specific variables and elimination of others may preclude an understanding of the diversified phenomenology and complex dynamics of the marital therapists' experience of marital distress. Therefore, an exploratory inductive method which does not begin with specific hypotheses was chosen (Piotrkowski, 1978).

The first question: What is the incidence and distribution of marital distress, including the response to distress among marital therapists was most appropriately addressed through survey methodology. Items were designed in the questionnaire to describe the incidence of distress, what therapists do about it (whether or not they seek support, supervision and/or therapy) and to investigate the factors that may influence these responses. The second question in the study is: how do therapists view their personal experience of marital distress and its perceived impact on their clinical work? Questionnaire items were developed to measure impact on clinical work; however, this is a very subjective measurement and little is known from the literature about the factors that constitute "impact" or felt influence, Therefore, to more

fully understand the phenomenology of marital distress and how it may relate to therapists' clinical work, qualitative methodology was also selected. Open-ended questionnaire items typically are not very fruitful; consequently, the in-depth interviewing with a small sample was conducted to enrich the data and enhance a phenomenological understanding.

This inductive, exploratory design was selected to prevent the researcher from assuming too much, to include as much information as possible, and to preserve the "integrity of the peoples' real life experiences" (p. 289). Qualitative research permits the generation of intimate knowledge (Piotrkowski). This phenomenological perspective is at the heart of the researcher's concern in qualitative research.

The question of generalizability may be raised, but the survey with systematic sampling should provide quantitative data to support generalizing. Description is an essential component of this study and, while it is often seen as inferior to "explanation" and statistical significance, it is the first step when a population is undefined and only speculation is offered in the literature. As Piotrkowski (p. 29) stated: "When descriptions help us to see relationships that had previously escaped notice, they are pointing to an explanation".

Subjects

For the purposes of this study, marital therapists were defined as persons who have met appropriate educational and training standards as set forth by the American Association for Marriage and Family Therapy

which have been deemed necessary for the clinical practice of marital and family therapy. When a membership roster exists it is often advisable to do systematic sampling from the list in which every Kth member on the list is selected for the sample. The procedure entails the determination first of a sample size and then the sampling fraction. This procedure also ensures sampling throughout the population by spacing the subjects over the entire membership list. Systematic sampling provides ever member with an equal probability of being selected (Hinkle, et al., 1979).

Due to the limitations of not being able to accurately identify subjects in advance that fit the criteria under investigation, and also due to the possibility of a low return rate, given the experience of other investigators who have surveyed within the membership of A.A.M.F.T., (Knapp, 1975) 1000 subjects were selected from the 12,000 members. Consequently, every twelfth subject was selected from the membership roster. By using a table for determining sample size from a given population, in order to achieve representativeness, a sample size of 370 subjects would be needed (Krejcie & Morgan, 1970). It was anticipated that a least a forty per cent response rate can be achieved by utilizing methods recommended by Dillman (1978).

Informed consent was given through a statement of consent on the title page of the questionnaire which read: I have been informed of the nature and purpose of this research. I have been reassured regarding confidentiality. By filling out the questionnaire and returning it, I am consenting to participate. The subjects were assured of confiden-

tiality in the cover letter (Appendix C), along with an explanation of the purpose of the study and its relevance to them personally, as well as professionally. Additionally, due to the sensitive nature of the topic of investigation, all subjects were given permission to refrain from filling out the questionnaire at any point if doing so created considerable anxiety. The investigator of this study also made herself available by phone or correspondence to answer any comments, questions or concerns regarding the questionnaire.

The subjects for the in-depth interviewing were selected utilizing a modified method recommended by Douglas (1985) and Piotrkowski (1978). Douglas' (p. 23) method (see Appendix G) is based on the premise that the more difficulty subjects have "in discovering the truth about themselves and in communicating the truth to anyone else, the more creative the researcher must become in the situations of discovery and the communication processes by which the truth is discovered". After utilizing one's knowledge of self, Douglas recommends that the researcher proceed next to friends with whom rapport and trust have already been established. The basic rule is: "go from the most trustworthy informant and the most experienced to the less" (p. 45). After this phase, the researcher selects a few "superinformants"; in this study, a few nationally recognized expert marital therapists were contacted who have served in this capacity and were interviewed. The use of "superinformants" as recommended by Douglas has been modified in that their expertise has been utilized throughout the investigative process. Several marital therapists with known interest and expertise

on this topic were contacted for resources. They also made contributions to the development of questionnaire items. Further modifications were made regarding the method recommended by Douglas in that no negative searches were deemed necessary. The process of the in-depth unstructured interviewing will permit the discovery of any "oppositional" information in that its purpose is to understand, not prove or disprove, the phenomenology of therapists' own experience of marital distress and the perceived impact on their clinical work.

Piotrkowski defined her method as "convenience" sampling, in which personal resources are used to locate subjects. By including participants who are acquaintances, the depth of rapport and understanding is enhanced. Utilizing one's acquaintances may create a problem with bias, but it is not "an entirely undesirable condition" (p. 294). A problem may occur with "over-rapport" (Miller, 1952), but can be minimized, Piotrkowski states, by utilizing acquaintances, not friends, particularly if the topics of discussion are threatening to the relationship.

Given careful attention to the above issues, the in-depth interviewing included a sample of five acquaintance-friends. The interviewees were chosen on a basis of convenience, willingness to participate and most importantly to represent varying degrees of marital distress. The first is a male, age 38, who is currently a minister with an interest and background in marriage and family therapy. He is in his first marriage of 16 years and has three children, ages 14, 12, and 10. He describes his marriage now as mildly distressed with periods of severe distress, particularly a couple of years ago. The second interviewee is

a 35 year old female, currently in her first marriage of 14 years who has two children, ages 8 and 4. She is a marital and family therapist and describes her marriage as severely distressed this past year, but as mildly distressed throughout the marriage. The third interviewee is a 40 year old male; currently in his first marriage of 17 years and has two children ages 13 and 10. He is a marriage and family therapist and characterizes his marriage as having no distress. The fourth interviewee is a 52 year old male who is currently divorced for the past four years from a first marriage of 27 years. His children are ages 25, 22, and 17. His primary identification is a minister with marriage and family therapist secondarily. The fifth interviewee is a 40 year old female who has been separated for seven months with divorce pending from a first marriage of almost seven years. She has four children, ages $3\frac{1}{2}$, $5\frac{1}{2}$, $11\frac{1}{2}$ and 14. The latter two interviewees described their marriages as having periods of severe distress, often for prolonged duration. In summary, these marriages can be classified as having no distress, mild to moderate distress, severe distress and severe distress terminating in separation and divorce. The geographic representation of the interviewees included Virginia, South Carolina and Florida.

The interviews were done by the author and lasted one to two hours. The questionnaire was used as a basis for discussion; however, the subjects were instructed to digress, elaborate, disagree and, most importantly, encouraged to tell their own story. All interviews were recorded and later transcribed.

Measures

In designing the questionnaire, the literature was reviewed for key measures and concepts. Most importantly, in-depth interviews were conducted with marital therapists who have experienced distress and those currently experiencing distress or dissolution to obtain information which was utilized in question development. These face to face interviews were unstructured and primarily for the purpose of gathering data for constructing questionnaire items. This "first hand" information provided some of the variables in the questionnaire along with items that the therapists felt made a difference in their responses to the marital distress, such as their choice of therapy and the importance of supervision. Two therapists were interviewed in-depth during a two hour session; one therapist was interviewed prior to the development of the questionnaire and one after the first draft. The second interview consequently led to refinement of several items, along with new items being added.

In an attempt to increase reliability of key measures, when feasible, and without being redundant, questions were rephrased and reasked. Validity, compared to reliability, as is frequently recognized with survey research, "is a more difficult problem" (Kidder, 1981, p. 147). Again, if the intent is to obtain incidence and distribution of characteristics along with their relationships, Kidder believes, internal validity should not be an issue. External validity is enhanced through probability sampling. Bateson (1984, p. 32) stated:

> "...survey data are valid to the extent that they meet the needs for knowledge of the survey client (and hence are 'relevant') and, at the same time, represent the social world (and hence are 'accurate')".

Regarding construct validity of marital distress, the author assumed that a marital therapist would know what that concept is, particularly in their own experience. Construct validity could be tested with other marital satisfaction inventories for convergence. However, Bateson states that construct validation is not appropriate in general for survey data. Face validity was assessed by having a panel of experts in marital therapy evaluate the questionnaire to see if, in their opinion, it measures what it claims to measure.

One methodological problem with this design is that of socially desirable responses. This is particularly germane to this study which involves very sensitive questions which may be perceived as threatening to therapists' personal and professional images. Marriage tends to be a very highly valued social institution and marital therapists recognizing that and also due to their professional status may want to present a favorable evaluation of their marriages and the impact of it on their clinical work in a very favorable light. Social desirability response bias can be decreased through the reassurance of confidentiality and the anonymity of a survey. Paulhus (1984) discussed the issue of self-deception in which the respondent actually believes his or her positive self reports and, secondly, impression management in which the respondent consciously dissembles. He concluded that attention should be given to both factors. However, in some instances, only one

component should be controlled. The question relevant to this study is that of self deception which may be an intrinsic aspect of a construct that is being measured. Denial is often seen with marital distress and, since what is being studied is the marital therapist's own experience of marital distress and how that impacts on his or her work, self deception should not be controlled.

The questionnaire was pretested on twelve Virginia A.A.M.F.T. members during a state meeting (see questionnaire instructions in Appendix B). The pretest resulted in several questions being deleted or reworded. A couple of new items were added and the questionnaire format was revised (see final revision, Appendix H). The questionnaire consists of four sections: demographic data, therapists' own experience of marital distress, therapists' own experience of being in therapy and the perceived impact on clinical work. Respondents are asked to rate the degree of marital distress, whether no distress, mild, moderate or severe they have experienced in this past week, month, year and throughout their marriage. Questionnaire items are based on the respondents' current marriage. If never married, the questionnaire is not appropriate, but subjects are still requested to return it for accuracy in describing the sample. For those respondent's who are recently separated or divorced (less than a year), they are asked to fill out the questionnaire based on their last marriage. Marital distress is also characterized as to whether its duration is for brief, intermittent periods or for chronic and prolonged periods. Other factors which describe the nature, source of and response to marital distress are also included.

Issues of support, disclosure, supervision and therapy are also covered. These items have been designed to answer the first research question.

Whereas marital distress is frequently a dependent variable in research, in this study it is an independent or predictor variable. The second research question this study addresses is: how do therapists view the impact of their own experience of marital distress on their clinical work? The impact on clinical work is the dependent variable. An impact score will be obtained from the questionnaire items which relate to the frequency that therapists felt themselves to be distracted, fatigued, questioning their effectiveness, etc.

A separate section of the questionnaire was devoted to therapists' own experience of being in therapy because it was felt to be an important response to marital distress. This section included information regarding initiation and timing of therapy and factors that may have influenced the initiation being somewhat or too late. Subjects were asked to rate the outcome of therapy as well as factors that may have influenced it. Subjects were also asked what modality of therapy they chose and if their choice was individual instead of (or in addition to) conjoint marital therapy. The reasons for their choice were explored. Also it may be an important predictor variable in terms of impact on clinical work. The impact on therapy may be affected by whether the therapy was individual or conjoint, marital and most importantly whether or not it was felt to be beneficial. Other predictor variables may be sex, age, number of years in practice, length of marriage. Professional identity, as well as theoretical orientation

may also be predictors. Again, since this research is basically exploratory, the importance of distribution and description needs to be highlighted.

Understanding of the phenomemonology of marital therapists' marital distress and the perceived impact on their clinical work was enhanced through the unstructured in-depth interviewing. The format for the interviewing followed the methods of "creative interviewing" (Douglas, 1985). The questions of this study provided the basis for the interview, and the unstructured interviews permitted the researcher freedom to clarify and probe.

Data Collection

A cover letter (Appendix C) prefaced the questionnaire. It explained the relevance of the study and insured the confidentiality of all participants, and offered the results of the study. Participants were asked to return the completed items within two weeks. Those participants who did not respond by this deadline were mailed a postcard (Appendix D) as a reminder. Participants who still hadn't responded within a week were sent a letter (Appendix E) restating the relevance of the study, not only for researchers, but for clinicians and were requested to please return the questionnaire. A second postcard (Appendix E) was also enclosed. This was for respondents who refused to participate. However, since it is important to know if those who did respond are different from those who did not and the reasons why, it was felt returning a postcard with that information was the most efficient

and inexpensive manner to collect that data. Respondents were also asked to check on the postcard if they wanted another questionnaire if they had misplaced theirs. For those respondents a second questionnaire was mailed with a third cover letter (Appendix F). All respondents were sent a thank you card confirming their participation.

Analysis

Statistical analyses were conducted in five major phases:

(1) to describe the characteristics of the sample,

(2) to establish (or create) a composite variable that measures the nature and degree of marital distress as reported by the sample,

(3) to validate and to describe the composite variable using a different statistical procedure which will provide another prospective,

(4) among subgroups, to determine the difference in average impact of their own marital distress on their professional practice,

(5) to further explore the phenomenology and complex relationships between marital distress and the perceived impact it may have on therapists' clinical work.

Simple descriptive statistics, including frequency distributions and crosstabulations, were used to characterize the sample.

Cluster analysis was the next procedure. It groups cases that are similar and consequently is an efficient means of data reduction. Furthermore, it is useful in explanation, particularly in exploratory

research and the generation of hypotheses (Everett, 1970). Variables for the hierarchical cluster-analytic procedure were selected on the basis of logic and a review of the literature. As opposed to discriminate analysis, the groups are not known a priori; therefore the steps in performing cluster analysis are as follows: to choose a measure of similarity, to select a method for forming subgroups once the indices of similarity/dissimilarity have been obtained and then to construct a hierarchical arrangement (dendogram) of homogeneous subgroups (Lorr, 1983). Cluster analysis, for this study with a large mass of data which were collected on numerous cases using many measures, helped to summarize the data with minimal loss of information, while concomitantly providing a taxonomy which furthered an understanding of any patterns of distress. Using multidimensional clusters, rather than a univariate index, strengthened the findings and generalizability.

It is recommended that the groupings which emerge be replicated on a new set of observations (Lorr, 1983). Since the data set on this study was so large, the sample systematically split in half by selecting every other case for each half. The cluster procedure was run on each sample until the typology patterns were stable and similar. This provides further support for the replicability and stability of the clusters. Furthermore, cluster analysis assumes that the subjects within homogeneous groups are similar with regard to predictor dimensions. This can be tested by submitting the clusters to discriminant function analysis. The third major phase of analysis therefore was discriminant function analysis to validate the clusters and to

identify the particular dimensions that separate or discriminate among them. The set of criteria and resulting functions could also be employed in describing the clusters.

The fourth major phase of analysis was a multifactor analysis of variance with the dependent variable being the average score over the twelve items (Question #29, see questionnaire in Appendix H) which reflect the frequency or degree to which marital therapists' personal marital distress may be perceived to impact on their clinical work. The analysis of variance determined if there were any differences in impact scores among the subgroups of the cluster analysis (that is levels of distress), together with other independent variables that have been identified in the literature to be important in the therapy process and outcome: (2) sex, (3) marital status, (4) personal psychotherapy, (5) therapist's orientation and (6) length of work experience.

Given the exploratory nature of this study it was anticipated that the twelve items mentioned above would not encompass the complexity of the possible relationships between therapists own marital distress and their clinical work. A richer understanding of this experience was best realized through the in-depth interviewing. Thematic analysis, such as recommended by Glaser (1978) was utilized. The purpose of the thematic analysis was to permit the data to "speak for themselves" without a priori assumptions being imposed by the researcher.

RESULTS

Response Rate

A thousand questionnaires were mailed to a systematic sample of A.A.M.F.T. clinical membership. This provided representation, including respondents from the United States, Canada, Japan, Argentina, and England. Within eight weeks, five hundred and twenty-six questionnaires had been returned. Seven other questionnaires were returned after the cut off date and thus were not included in the analysis. Even though a 1984-85 membership list was used, seventy-nine mailed questionnaires were returned: forwarding order expired. Information was received from attorneys' or family members which stated that three of the subjects were deceased. When these (the unanswered returned questionnaires) are subtracted from 1000, a response rate of fifty-eight percent was achieved. The returned questionnaires from Japan and Argentina were not included due to the cultural differences regarding marital distress. The questionnaire from London was left in the sample due to the similarities with our culture. There were five widowed subjects, all female, and, because the n was so small and their marital distress may retrospectively be influenced by the death of the spouse, they were also dropped from the sample.

The response rate was far greater than anticipated. This response rate may partially be explained by the use of Dillman's survey methodology but additionally may be influenced by the interest in the topic. Subjects were asked if they had ever pondered the questions in

the survey and if they had ever been interested in this topic. Eighty-nine percent responded yes and eleven percent said no. Furthermore, indications of the interest generated by the survey are the comments that were received. Open-ended questions were not used because typically they are not very effective. Therefore, only a comments section was included; and this proved to be quite fruitful. Subjects often volunteered added information and frequently commented on the importance of the study. Many felt the questionnaire was well constructed and most requested a copy of the results. There were a few critical comments, but the majority were sensitive and supportive. The comments have been reproduced in their entirety (in Appendix I) because of the richness of the data which provide enhanced understanding of the topic under investigation. Also, many of the comments regarding questionnaire design lend some credence to construct validity. Regarding the relevance of the study, the data speak well for themselves and are represented by these examples: "questionnaire is well constructed and should provide much insight into the needs of our colleagues." "Worthy topic--very valid and necessary research."

The third mailing, which included another request for the original questionnaire and a return postcard which provided for an explanation of their nonparticipation and marital status generated an increase in returns. Approximately five hundred postcards were mailed and one hundred and ten were returned, for a response rate of 22%. A comparison was run on the sample who returned questionnaires and those who did not, but did return a postcard. It was found that those who participated and

those who did not participate, but returned the postcard, did not differ significantly on marital status (χ^2 = 1.0306, df = 2, $p < .05$). The frequencies for reasons of nonparticipation are presented in Table 1.

Following are other nonparticipation reasons that were cited: illness, retired, out of country (n=6), misplaced or never received questionnaire (n=13), concern about confidentiality and not a good research tool (n=3). There were approximately 300 subjects (about a third of original sample) who were never heard from by questionnaire or postcard.

Demographic Description of Sample

The sample is composed of sixty percent males and forty percent females. The range of their dates of birth are from 1911 to 1956, with a mean age of 49. This breakdown is similar to Wetchler and Piercey's study of the Indiana Association of Marital and Family Therapy membership which was comprised of 60% males and 40% females with a mean age of 43.6 years. This sample is slightly older. According to instructions those subjects who were never married were to have returned a blank questionnaire, since the questions did not apply to them. Twenty-five blank questionnaires were received indicating that less than 5 percent of those who responded were never married. Current marital status revealed the following: currently married in first marriage, 69%; currently married in second marriage 16%; currently married in third marriage 3%, currently married in fourth marriage, less than 1%;

TABLE 1

Reason for Nonparticipation Frequencies

	n	percent
Too busy	20	27%
Married and never experienced any marital distress	2	3%
Study does not apply to me personally	3	4%
Study does not apply to me professionally	2	3%
Simply not interested in research	2	3%
Questionnaire too lengthy	2	3%
Other	24	32%
Checked more than one category[a]	19	26%

[a] This category consists primarily of the combination of: Too busy and Questionnaire too lengthy.

currently separated 3%, currently divorced, 9% and currently widowed less than 1%. The breakdown of marital status by sex is depicted in Table 2. It should be noted that the numbers on percentages throughout this discussion will vary slightly depending on the missing cases.

An interesting comparison can be made between males and females who are currently in their third and fourth marriages as compared to those who are currently divorced from their third and fourth marriages. There are ten males (3.5% of males) but only four females who are in their third marriage, with none in their fourth; however, there are no males who are currently divorced from a third or fourth marriage, but there are six females (3.2% of females). The total number of male therapists who are currently married is 263 (55.3%) and the total number of female therapists who are currently married is 155 (32.5%) [these numbers do not reflect the twenty-six never married who were not included in the total n]. The divorce rate reflects further sex differences. Out of the 45 subjects (9.4% of total sample) who are currently divorced at the time of the survey, 14 are males and 31 are females. Of the 28 who are currently divorced from a first marriage, 18 (64.3%) are females and ten (35.7%) are males. Clearly there are considerably more females than males who are currently divorced and divorced more frequently.

To compare this group to the general population has its limitation but is an important step in the analysis: is divorce more frequent among marital therapists as compared to the divorce rate among the general population? It has been well established that an inverse relationship exists between socioeconomic status and divorce rates

TABLE 2

Marital Status and Sex

Count Row Pct Col Pct Tot Pct	Sex Male	 Female	Row Total
Currently married in first marriage	211 64.1% 74.0% 44.4%	118 35.9% 62.1% 24.8%	329 69.3%
Currently married in second marriage	42 56.0% 14.7% 8.8%	33 46.0% 17.4% 6.9%	75 15.8%
Currently married in third marriage	6 66.7% 2.8% 1.7%	4 33.3% 2.1% .8%	12 2.5%
Currently married in fourth marriage	2 100.0% .7% .4%	0 .0% .0% .0%	2 .4%
Currently separated from first marriage	6 55.7% 2.1% 1.3%	1 14.3% .5% .2%	7 1.5%
Currently separated from second marriage	2 40.0% .7% .4%	3 60.0% 1.6% .6%	5 1.1%
Currently divorced from first marriage	10 35.7% 3.5% 2.1%	13 64.3% 9.5% 3.8%	28 5.9%

TABLE 2 (Continued)

Count Row Pct Col Pct Tot Pct	Sex Male	 Female	Row Total
Currently divorced from second marriage	4 36.4% 1.4% .8%	7 63.6% 3.7% 1.5%	11 2.3%
Currently divorced from third marriage	0 .0% .0% .0%	3 100.0% 1.6% .6%	3 .6%
Currently divorced from fourth marriage	0 .0% .0% .0%	3 100.0% 1.6% .6%	3 .6%
COLUMN TOTAL	285 60.0%	190 40.0%	475 100.0%

$\chi^2 = 25.601$ with 9 df., $p < .05$

(Goode, 1956 and Bernard, 1966). However, recent comparisons between the 1960 and 1970 census data indicate a variation in the distribution so that the status differences are less remarkable. Lower status groups still account for more of the divorces, but the percentage increase in divorce is greater among higher status groups (Norton and Glick, 1979).

Based on a current population survey (U.S. Bureau of the Census) as of March, 1984, ever-married persons 25-54 years old who were divorced or separated at the time of the survey revealed that, in 1984, of the sample 10% of the white males were divorced and 2.2% were separated. In this study, at the time of the survey, 4.9% of the male therapists were divorced and 2.8% were separated. For white females the population survey indicated that 12.1% were divorced and 3.2% were separated at time of survey, whereas this study showed 16.4% of female therapists were divorced and 2.1% were separated. Age categories that are similar to the census survey, were created for comparison and are presented in Table 3. Divorce is more frequent among the young and the early years of marriage. Furthermore, higher education strongly relates to later age of marriage. With graduate-school experience, women who become or are divorced are more likely than less well-educated women to remain divorced and perhaps devote themselves to their careers (Carter and Glick, 1976). This study, as in the study by Rose and Rosow (p. 591) found that if female therapists are married, they are more likely to get divorced. "Thus, women do have a harder time of it. They simply get married less and divorced more." As Rose and Rosow emphasize these findings are not peculiar to female physicians (or therapists) but to

TABLE 3

A Comparison with Ever-Married Persons 25-54 Years Old Who Were Divorced or Separated at Time of Survey[a]

	U.S. Census Bureau Ever Married (in thousands)	Separated & Divorced	A.A.M.F.T. Sample Ever Married	Separated & Divorced
Male	Number	Percentage	Number	Percentage
25-34	12,428	12.2%	12	(n=1)
35-44	11,709	12.5%	96	12.5%
45-54	8,939	10.7%	94	6.4%
Total	33,076	11.8%	202	9.5%
Female				
25-34	14,084	15.5%	6	-
35-44	12,420	16.8%	57	15.8%
45-54	9,537	14.7%	64	21.9%
Total	36,041	15.7%	127	18.9%

$\chi^2 = 3.0897$ with 3 df, $p < .05$

Note: Only census bureau information on white males and females were used for these comparisons. Information on race was not collected by this author.

a. Source: U.S. Bureau of the Census

female professionals in general. According to the U.S. Bureau of the Census in 1964 of females in the top 12 professions, 35% are single and 50% are married.

Caution must be heeded with the interpretation of these findings and when the two surveys are compared they are not significantly different ($p > .05$). When the individual age categories are examined, however, there are important differences. In the 35-44 year category for males the proportion of separated and divorced males is the same. In the 45-54 category females in the population are more likely to be divorced than male therapists ($z = 76.68$, $p < .01$). Female marital therapists are more likely than the general population to be divorced in the 45-54 age range ($z = 48.09$, $p < .01$). It is interesting to compare males and females in this (45-54) age category in the A.A.M.F.T. sample. Female therapists are more than three times as likely to be divorced as male therapists!

When the population is general is looked at (without sex and age being controlled) Table 4 indicates that there are no differences in divorce rates.

A final look at marital status, by profession within the sample, is interesting. Table 5 provides some control of socioeconomic factors in that the groups should be fairly similar. This table represents the respondents' primary professional identity; yet, they are all, of course, clinical members of A.A.M.F.T. It should be recalled that some who are categorizing themselves primarily as marital and family therapists are also ministers, psychologists, social workers, etc.

TABLE 4

A Comparison with the Marital Status of the Population

1984 U.S. Bureau of the Census			Gillespie Report	
	Number in millions[a]		Number	
Married	107.1	(80.08%)	438	(89.8%)
Divorced	12.3	(9.28%)	45	(9.2%)

Note Source: U.S. Bureau of the Census

[a]. Singles (and widows) are not included in this table

TABLE 5

A Comparison of Marital Status by Professions Within the Sample

	Professions					
	Psychologist	Social Workers	Minister	Marital and Family Therapist	Educator[a]	Row Total
Marital Status						
Married n	43	21	24	63	5	158
Row %	27.2	13.3	15.2	39.9	3.2	58.7
Column %	58.9	58.3	75.0	55.3	55.6	
Total%	16.0	7.8	8.9	23.4	1.9	
Remarried n	18	5	6	27	1	60
Row %	30.0	8.3	10.0	45.0	1.7	22.3
Column %	24.7	13.9	18.8	23.7	11.1	
Total %	6.7	1.9	2.2	10.0	.4	
Separated and and Divorced n	12	10	2	24	3	51
Row %	23.5	19.6	3.9	47.1	5.9	19.0
Column %	16.4	27.8	6.3	21.1	33.3	
Total %	4.5	3.7	.7	8.9	1.1	
Column Total	73	36	32	114	9	269
	27.1	13.4	11.9	42.4	3.4	100.0

Note: Physicians and Nurses were dropped because cell means were less than 2 with none being separated or divorced.

[a]Please note that some cell means are very small.

Nevertheless, in a comparison of marital therapists with the other professions, more educators and social workers were separated or divorced at the time of this survey than the marital therapists.

Divorce rates and marital status are not the only indicators of marital stability, the duration of the marriage is revealing as well as the marital history. The marital histories, with the range of years married and the means are presented in Table 6 with the duration of marriage by marital status in Table 7. Since age is correlated with the length of marriage (0.77), the effects of age were removed and there were significant differences ($p < .001$) in the length of the first marriage for therapists who are currently in their first marriage, those who are remarried and those who are currently separated or divorced. Remarried therapists' first marriages lasted an average of 7.8 years less than the sample mean deviation from the grand mean (20.75). Information from the National Center for Health Statistics for 1983 indicates that the duration of dissolving marriage was 9.6 years. In comparison with this data it seems that therapists' first marriage which terminate in divorce last longer than the average duration as reported by the National Center for Health Statistics.

The sample was equally split as to whether their children were currently living with them: 170 (46%) said yes they were, 170 (46%) said no and 33 (9%) said their children lived with them part-time. Seventy-eight subjects had from one to three or more stepchildren, of this number only 17 reported that their stepchildren lived with them and three subjects have stepchildren living with them on a part-time basis.

TABLE 6

Marital History

	Range	n	$\bar{x}$	S.D.
First marriage lasted number of years	0-52	470	20.711	11.246
Separated and divorced number of years	0-39	123	4.902	5.899
Second marriage lasted number of years	0-32	103	9.126	7.400
Separated and divorced number of years	0-12	30	3.933	3.868
Third marriage lasted number of years	0-10	17	3.53	3.020
Separated and divorced number of years	0-16	7	7.714	6.775
Fourth marriage lasted number of years	0-2	4	.750	.957
Separated and divorced	1-11	3	5.667	5.033

TABLE 7

Average Duration of First Marriage by Current Marital Status

	Currently in Marriage	Remarried	Separated or Divorced (Length of Last Marriage)
Duration in years	23.72 (n = 317)	14.29 (n = 85)	13.48 (n = 54)

The number and ages of children of the sample members are presented in Table 8.

Variables that define the sample in terms of their primary professional identity, theoretical orientation (based on training) and their work site are presented in Tables 9, 10 and 11. This sample is an experienced professional group with the range of years in practice from 2 to 45, with a mean of 14. This is not surprising given the average age of the respondents and that the sample is from a clinical membership list which is indicative of experience. When asked if therapy should be required during training, 71% responded affirmatively with 29% responding no. Those who believe therapy for the therapist in training should be mandatory were then asked what kind of therapy should be required. The results are presented in Table 12. Respondents were asked to check all therapy experiences where involvement as a patient was required of them during training. Those results are presented in Table 13. It is not surprising that so many therapists responded that therapy should be mandatory; for one reason, many of them were required to have it as a part of their own training and several commented that it had been helpful.

Therapists' Own Experience of Marital Distress

"There is no marriage that doesn't have stress and tension."
Panelist[1]

The results to the first item on the questionnaire in this section asked therapists to rate the degree of marital distress they experienced

TABLE 8

Number and Age of Children

Number of Children	0		1		2		3 or more	
Results:	n = 53	11%	n = 50	11%	n = 189	40%	n = 180	38%

Age of oldest child	Range 1 - 45 yrs	$\bar{x}$ = 22.175
Age of youngest child	Range less than 1 - 39	$\bar{x}$ = 17.305

TABLE 9

Primary Professional Identity

Marriage and Family Therapist	n = 196	(43%)
Psychologist	n = 111	(25%)
Social Worker	n = 64	(14%)
Minister	n = 54	(12%)
Educator	n = 19	(4%)
Physician	n = 5	(1%)
Nurse	n = 3	(1%)

Note: Computer Approximations to nearest percent.

TABLE 10

Primary Theoretical Orientation

Systemic	n = 180	(38%)
Psychodynamic	n = 160	(34%)
Experiential	n = 45	(9%)
Behavioral	n = 25	(5%)
Other	n = 65	(14%)

TABLE 11

Primary Work Site

Private Practice	n = 246	(51%)
Mental Health Agency	n = 63	(13%)
Academic	n = 38	(8%)
Hospital	n = 20	(4%)
Other	n = 68	(14%)

TABLE 12

Therapy Modality Which Should be Required During Training

Therapy Modality	n	percentage
Individual	278	63%
Conjoint Marital	108	24%
Family	97	22%
Group	164	37%

Note: Percentage total exceeds 100 as more than one modality was frequently checked.

TABLE 13

Therapy Experiences as a Training Requirement

Therapy Modality	n	percentage
Individual	226	48%
Conjoint Marital	60	13%
Family	53	11%
Group	202	43%

Note: Percentage total exceeds 100 as more than one modality was frequently checked

for each time period ranging from the past week to the entire marriage. Table 14 represents the findings. Please note that all indices were on a one to four point scale, unless otherwise noted.

In measuring marital distress not only is the degree of distress crucial, but the duration of the distress may be significant in how it is experienced, and its perceived impact. As one respondent commented:

> "I notice that a distinction was made in my mind between on-going marital discomfort and severe marital distress. To me, the degree is significant - when elevated to 'severe' the circumstances change significantly."

Therefore, subjects were asked to check the one category that is or was most characteristic of their marriage. Three hundred and seventy-nine (84%) responded that brief periods of intermittent marital distress were most representative of their marriages and 71 (16%) replied that their marriages could best be categorized as having chronic and prolonged periods of marital distress.

These two items are pivotal to the study and various analysis were applied to insure an understanding of these dimensions. First, it can readily be seen from the distributions (Table 14) that as distress proceeds over time the degree of distress seemingly increases. This is not surprising; however, what was unexpected was the finding that approximately a third (32%) of the sample responded that moderate to

---

[1]For purposes of clarification in the remaining discussion, comments will be used to highlight the data. If the comment was made by one of the marital therapy experts, the identification will be as "panelist", "interviewee" will be used to identify a comment made by a therapist who was interviewed and a comment that was written by a subject will be identified as "respondent".

TABLE 14

Degree of Distress

		No Distress	Mild Distress	Moderate Distress	Severe Distress	$\bar{x}$	SD
This past week	n =	242 (57%)	121 (29%)	43 (10%)	16 (4%)	1.604	.820
This past month	n =	144 (34%)	191 (46%)	69 (16%)	15 (4%)	1.893	.801
This past year	n =	83 (20%)	204 (48%)	99 (24%)	35 (8%)	2.204	.851
Throughout marriage	n =	36 (8%)	259 (59%)	118 (27%)	23 (5%)	2.294	.692

severe distress was most characteristic throughout their marriages. surprising; however, what was unexpected was the finding that approximately a third (32%) of the sample responded that moderate to severe distress was most characteristic throughout their marriages. Given the mean age (49) of this sample it was thought there might be a "mellowing" effect as one retrospectively looked back at their marriage. It was felt that as one averaged distress over the span of the duration of the marriage that the effects of the distress would be moderated. A crosstabulation was done with degree of distress and duration of distress in an attempt to further understand this finding, which is presented in Table 15.

Table 15 indicates that over half of this sample (58.3%) experience only mild distress throughout their marriages for brief and intermittent periods. Most importantly, even though a third of this sample identified the distress throughout their marriages as moderate to severe, over two-thirds identified the moderate distress as brief and intermittent. When the distress was severe throughout the marriage, however, most respondents (83%) also said it was chronic and prolonged. Over 13% of the sample identified chronic distress throughout their marriage that is moderate to severe. Therefore, the findings imply that many marital therapists only experience mild distress for brief and intermittent periods throughout their marriage; if they do experience moderate distress, it is most likely to be brief and intermittent; however, when distress is severe it will most often be chronic and prolonged. When things are bad, they're really bad. These numbers can

TABLE 15

Duration and Level of Distress Throughout the Marriage

Count Row Pct Col Pct Tot Pct	Brief	Cronic	Raw Total
Level of Distress			
No Distress	25 100.0% 7.0% 6.0%	0 .0% .0% .0%	25 6.0%
Mild Distress	243 96.0% 69.4% 58.3%	10 4.0% 14.9% 2.4%	253 60.7%
Moderate Distress	78 67.2% 22.3% 18.7%	38 32.8% 56.7% 9.1%	116 27.8%
Severe Distress	4 17.4% 1.1% 1.0%	19 82.6% 28.4% 4.6%	23 5.5%
Column Total	350 83.9%	67 16.1%	417 100.0%

be further understood by the clarification provided by the subjects and interviewees through their comments.

> "...I had put mild distress for the last month and then I put more distress further back from that...I kind of have a tendency to think that most of my marital distress was in the past but maybe there's more now than I realize and than I'm admitting...so that question did come to my mind: have things really gotten that much better or am I still denying?"
>
> Interviewee

There are some interesting sex differences regarding the degree and duration of distress over the various time periods. No significant differences occur between men and women as to how they rate recent levels of distress for this past week and month; however of all the subjects who scored a moderate level of distress over the past year 74% are males, compared to 26% females. Females (57%) are more likely to rate the last year as characterized by severe distress, compared to males (43%). This trend holds throughout the marriage but the difference decreases at the moderate level and increases even more at the severe distress level: 55% of all the subjects who scored moderate levels of distress throughout their marriage were males and 45% were females; 39% of all the subjects who scored severe distress were males and 61% were females, which correlates with their higher divorce rates. One female subject provided her own interpretation:

> "As a feminist and therapist, I believe every woman experiences marital distress. Male/female socialization creates power conflict that needs to be addressed by men and women."

In summary, as women reflect on the past, they tend to report more severe distress than men, and the longer the time span and the more

distant the period being described, the larger the proportion of women who report distress. For recent time periods, however, men and women reported about the same levels of distress. Deutsch (1984) found that women therapists reported more stress than did men on four of seven factors. The study investigated sources of stress for psychotherapists that originate in client sessions and the professional role. Deutsch suggests that there may be at least three plausible explanations for female respondents to report higher stress than men. The following explanations may apply to the findings in this study: (1) Women may use scales differently than men due to gender-related response patterns, (2) On self-report measures, higher scores may indicate greater self-disclosure on the part of women (women may not be more severely distressed than man), but may be more willing to acknowledge or remember it and (3) women may indeed be more distressed throughout their marriages. Given that female therapists are more likely to be divorced, as compared to their male colleagues, it is reasonable to conclude that women do experience more distress.

As can be seen in Tables 16, 17 and 18, those therapists who are currently separated or divorced report more frequent and intense degrees of marital distress and are much more likely to attempt to keep this distress to themselves. These therapists report a marked elevation, as compared to their married and remarried colleagues in communication problems as a source of distress. Fortunately, because they seemingly needed it the most they also reported that they felt more support and from many sources.

TABLE 16

Average Frequencies of Distress by Marital Status

(Scale 1-4)	1		2		3	
Currently:	In First Marriage		Remarried		Separated or Divorced	
Sex: Males	n = 211	(64%)	n = 52	(58%)	n = 22	(39%)
Females	n = 118	(36%)	n = 38	(42%)	n = 35	(61%)
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Average distress throughout the past year[a]	1.85	.65	2.00	.63	2.60	.95
Average distress throughout marriage	2.25	.66	2.18	.64	2.85	.76
Duration of distress (Brief or Chronic)[b]	1.11	.30	1.13	.34	1.51	.51
Frequency of behaviors related to distress[c]	1.86	.47	1.79	.53	2.54	.53
Frequency of trying self-help" measures for distress	2.65	.91	2.88	.94	2.95	.99
Frequency of attempting to keep distress to self	2.70	.88	2.51	1.05	3.31	.94

Footnote: [a]This item refers to questionnaire number 12, the first three categories were averaged to provide an indication of marital distress throughout the past year.

[b]This item refers to questionnaire number 13. Subjects were to check the one category regarding duration of distress that is (or was) most characteristic in their mariage. It is only scored on a two point scale, in comparison with the others which are all on four point scales.

TABLE 16 (Continued)

Footnotes: (cont)

[c]This item refers to questionnaire number 14. An average was obtained for six of the eight items. How often subjects tried self-help measures for their own marital distress and and how frequently they attempted to keep marital distress to themselves were analyzed separately due to their importance.

Note: It should be noted that for simplification of interpretations and due to several small cell samples, the marital status groups as defined formerly in Table 2 have been combined. Status group one still represents all therapists who are currently married in their first marriage; status group two is all therapists who are currently remarried, whether its the second, third or fourth marriage (combining groups 2, 3 and 4) and the new status group three represents all therapists who are currently separated or divorced, whether it's from a first, second, third or fourth divorce (combining former groups 5 through 10).

TABLE 17

Average Rating of Sources of Distress by Marital Status

(Scale 1-4) Currently:	1 In First Marriage		2 Remarried		3 Separated or Divorced	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Conflict over family of origin	1.80	.79	1.65	.89	1.95	1.04
Conflict over finances	2.03	.87	2.00	.93	2.36	1.06
Conflict over children	2.02	.89	2.39	1.00	2.22	1.18
Conflict over work	1.94	.83	1.92	.93	1.91	.98
Conflict over use of leisure time	1.81	.83	1.74	.92	2.10	.96
Communication problems	2.26	.90	2.08	.91	3.07	1.03
Sexual problems	2.01	.90	1.74	.82	2.31	1.17

TABLE 18

Average Rating of Degrees of Support by Marital Status

(Scale 1-4) Currently:	1 In First Marriage		2 Remarried		3 Separated or Divorced	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Degree of support from family member	1.75	1.06	1.96	1.17	2.38	1.21
Degree of Support from lay friend	2.33	1.20	2.36	1.26	2.83	1.16
Degree of support from professional colleague	2.60	1.22	2.56	1.29	2.98	1.14
Degree of support from supervisor	1.47	.90	1.41	.95	1.74	1.18
Degree of support from therapist	2.52	1.34	2.55	2.31	3.09	1.06
Degree of support from minister	1.42	.87	1.38	.84	1.47	.87

There are further curious differences between those who are currently in their first marriages and their remarried colleagues. Those in first marriages report slightly less distress throughout the past year than therapists who are remarried; yet slightly more distress throughout their marriages. Perhaps therapists are trying harder in their second marriages (and indeed do report more frequent use of "self-help" techniques) or have learned to resolve some of the sources of marital conflict (in all categories they are lower than those in first marriages with the exception of conflict over children which is a frequent source of distress in blended families in general and apparently also true of therapists who are remarried).

The next items on the questionnaire were designed to further describe the nature of the marital distress and what the therapist does about it. A set of questions asked respondents to rate the frequency of occurrence of eight behaviors related to marital distress on a four-point scale. The mean scores on questionnaire number 14 (see Table 1, Appendix J) were all rather low (below 2.5) with the following exceptions: the mean frequency for trying "self-help" measures for their own marital distress was 2.6; the mean frequency for attempting to keep marital distress to themselves was 2.7. Denial and distress were frequently commented on during the interviews and on the questionnaires. The following are relevant comments:

> "I think I did quite a bit of denial...that my marital problems were so severe until the affair and I knew from my knowledge of marriage and family behavior that that was a pretty severe sign of distress. It was like it didn't feel like

> distress to me, but I said: 'My God, I've committed an affair. That's pretty serious.' I mean there's something wrong with my marriage."
>
> Interviewee

> "I think for the longest amount of time I just wouldn't want to admit that I had a marital problem and it was funny because being surrounded by therapists, I mean, my marital problem probably really began when I went back to school. The people I was in school with were so much more perceptive about the fact that I had a problem and I literally would not accept the idea that I had a problem at all...I was just vehemently denying it."
>
> Interviewee

> "...feel more helpless in a situation where they think they shouldn't be, wondering why the things they say to their patients are not working....to be able to say you have a problem is almost as if it is first you are required to somehow know there is some kind of solution or the possibility of a solution. If we have a problem, for example, for which there is no solution, most frequently it doesn't get identified as a problem. The identification of a problem comes about when one gets the possibility of a solution."
>
> Panelist

When the therapist does not deny the distress, to what factors is the distress most often attributed? Responses indicate that the most frequent source was communication problems with a mean score of 2.311. This was rather surprising as marital therapists are often trained in communication skills, but it seemed that either they have difficulty applying their skills in their own lives or this is a catch all category. Several respondents elaborated on their "communication problems" and indicated that training in this area had been quite useful and these difficulties are continuing to be worked on.

> "The last fifteen years of our life together were deeply satisfying. One factor in that was our taking couple communications program training as instructors and teaching other couples. We found it helpful to them and helpful to us."
> Respondent

> "The communication problems which are part of the dynamics of my marriage (and those of both families of origin) are gradually being worked on."
> Respondent

Table 19 presents, in descending order of intensity, the severity of sources of marital distress that are experienced by marital therapists.

A frequent comment on this item was that it was not comprehensive. One respondent rather emphatically wrote: "Everything's a source of distress at one time or another." Another requested that in future research, the issue of a major external crisis which may preceed marital distress be addressed. Other respondents more specifically commented on the sources of their distress:

> "The stress identified in this survey results from the fact that my wife has a chronic and terminal illness--ALS (Lou Gehrig) disease."
> Respondent

> "Many of my 'marital distress" issues stemmed from being the adult child of an alcoholic."
> Respondent

> "The greatest help from my spouse and for reducing marital stress came when she was diagnosed as having P.M.S. and put on medication."
> Respondent

> "Main stress in mine was a child's death."
> Respondent

> "The suicide of my son--age 23--was the focal point that brought about my second divorce."
> Respondent

TABLE 19

Average Rating of the Severity of Distress from Seven Sources

		(4 = Severe)		
		(n)	$\bar{x}$	SD
Source:	Communication problem	(465)	2.318	.957
	Conflict over children	(459)	2.113	.958
	Conflict over finances	(465)	2.063	.913
	Sexual problems	(462)	1.994	.933
	Conflict over work	(456)	1.934	.867
	Conflict over use of leisure time	(457)	1.821	.863
	Conflict over family of origin	(461)	1.790	.848

> "My husband is a recovered alcoholic (23 years sober). My severe marital distress occurred during the twelve years when he was drinking, especially the last six."

It's rather intriguing that many respondents clarified or provided another source of conflict which led to distress; yet not one mentioned an affair (with the exception of two that occurred between female respondents and their therapists while in therapy). However, this was a frequent topic of discussion during the interview and the disclosure was always initiated by the interviewee, never solicited by the interviewer. It may be that the rapport and trust which was established (prior to) and during the intimacy of the interview helped to promote the disclosure. As will be demonstrated below, when therapists disclose it is most often with a professional colleague and the interviewer in most cases was identified (or known) by the interviewee as a peer. Even the anonymity of the questionnaire apparently did not permit respondents to disclose or to voluntarily contribute the occurrence of an affair. The incidence of sexual problems (mean:1.966) may provide a clue, but it can not be interpreted beyond that. This may be an indication for further research. As one respondent commented:

> "One question you did not ask was--If you had a need not satisfied in the marriage, how did you deal with it?"

Given the nature and degree of marital distress that marital therapists experience, what do they do about it? The majority seek therapy, but that deserves a separate discussion. Therapists feel that they received some support, primarily from their professional

colleagues. Table 20 represents respondents' average ratings of the support received from 6 possible sources in descending order from the most helpful person in terms of support to the least helpful (or not approached).

Findings suggest that the degree of disclosure varies with whom the therapist is sharing; however, even when the therapist is with a friend, (which was the highest reported degree of disclosure) the mean is 2.591, between little and moderate sharing. Colleague peers were next; thus not only do therapists disclose to their colleagues, albeit little is shared, but they also feel they are supportive and moderately helpful.

Therapists reported that with male and female patients there is little, if any, disclosure. The question, unfortunately, did not clarify that it referred only to disclosure in times of marital distress. The question is rephrased later in the questionnaire and can thus be interpreted with greater confidence. Once again the data speak well through the words of the interviewees:

> "I knew in the small community that I'm in, and having a solo practice, I was very much aware of the fact that a divorced therapist in my community was not looked on--a marital therapist especially--that would not be good for business for one thing.... And I really couldn't confide. It made it more difficult probably to confide in people, because I'd think--and it may not be true--but I felt there was the expectation that I shouldn't be having these kinds of problems. After all, I was supposed to have some kind of expertise in this area. There I was, you know, with everything kind of falling apart...It was also very difficult for me because I knew all the other therapists there in my town so well...it kept me from going to someone in my own community because of all the politics and the expectations and so forth that were involved in

TABLE 20

Average Ratings of Degree of Support Received

From:	(n)	$\bar{x}$ (Most Helpful = 4)	SD
Professional Colleague	(459)	2.636	1.226
Therapist	(456)	2.594	1.333
Lay Friend	(457)	2.394	1.213
Family Member	(455)	1.866	1.117
Supervisor	(458)	1.493	.951
Minister	(452)	1.416	.856

> that....My expectation of myself, my feeling that the community had an expectation of me and then my feeling that people I might have gone and confided...you know, I didn't want to allow them to know that I was having that kind of problem. Yeah, I think it was more difficult."
>
> Interviewee

Even though the pain is poignantly expressed in the latter comment, are the concerns of failed expectations and colleague criticism unfounded and irrational? Before that question is answered the following comments should be read.

> "Any person who has a stressful marriage has obviously not solved his or her problems and has no business trying to remedy in others what he/she cannot remedy in self."
>
> Respondent

> "I feel strongly that MFT's should be willing to work as hard on their marital issues as we ask our clients to work, and be accountable for our own personal issues."
>
> Respondent

> "I believe a distressed therapist must ethically and morally seek supervision and/or therapy. A surgeon with a hangover should postpone therapy. A therapist with a damaged self and sensorium should select his/her cases, postpone 'touchy' ones and reduce caseload. It's bad enough to screw up your own life; one has no right to do it to one's patients."
>
> Respondent

Not only were there comments which bordered on belittling the therapist who experienced distress in his or her marriage, but the competency of their clinical work was also questioned by some.

> "A good therapist should be able to put personal problems aside and deal with each case as a new challenge."
>
> Respondent

> "...Obvious too that a 'happy' therapist is more effective than a 'stressed', angry one."
>
> Respondent

> "I don't know...when one struggles with a problem of earthshattering dimensions as in the future case of one's own marriage, if there is very much peripheral room around the edge of your goggles with which to look at the rest of the world...And what I'm saying is that I'm not sure I'd want to go to the sick physician, I don't blame the physicians for being sick, and I don't think there's anything he can particularly do necessarily about being sick, nor that that should go against him at all. Maybe the same analogy would be if I were to choose to sit down and listen to a very fine pianist play Beethoven, I'd kind of like the guy who had use of all ten of his fingers. And if he breaks a finger, I don't particularly think he's a bad pianist, but he will not play as good a music...And about the same for the marital therapist. And we have a huge obligation to keep ourselves feeling good. Not because we are so much more effective when we feel good, but perhaps we are less destructive."
>
> Panelist

In light of the above comments its not so surprising that therapists tend to keep distress to themselves. An examination of the results on the perceived impact of marital distress on clinical work may help to either justify or refute the validity of these criticisms and reprovals. However, whether or not the therapist has therapy needs to be considered.

Therapist's Own Experience of Therapy

> "I thought he (therapist) did an excellent job with our marriage. He really saved my ass...I think just knowing what it feels like to go in and sit down in therapy is different...going in as a client and going in as a therapist. It's a humbling experience. And you're scared shitless and you know how people feel when they come it, they're scared shitless."
>
> Interviewee

Sixty percent of the sample claim to have been in therapy some time during their current marriage (or last marriage if divorced) for marital distress. This seems rather high, especially given that almost 60% of the sample admit to only experiencing mild distress throughout their marriages. These findings can best be understood by crosstabulations; the first represented in Table 21 is the incidence of therapy for marital distress according to marital status.

There aren't many surprises in Table 21; it was expected that as marital distress increases, as interpreted by marital status, the incidence of therapy for marital distress would also increase. This is well demonstrated by the findings. However, it is curious that one out of every ten subjects who are currently separated or divorced, did not have any marital therapy for their own marital problems. Some respondents wrote in that the reason for this was spouse refusal. It would not be accurate to add those remarried and those separated or divorced together to state that out of all therapists who have experienced a divorce at some time over a third (35.2%) do not have marital therapy because subjects were instructed to answer all questions based on their current marriage. Therefore, regarding the 26.1% who are remarried and claiming that they have not had marital therapy (should be basing that on this marriage); does not mean they didn't receive marital therapy during a previous marriage, which terminated in divorce. Indeed, many respondents indicated that this was true of their experience; they received marital therapy in a previous marriage, but not in their current marriage. This highlights a limitation of this

TABLE 21

Incidence of Therapy for Marital Distress by Marital Status

Marital Status	Therapy No	Therapy Yes	Row Totals
Currently in First Marriage	n = 160 (49.2%)	n = 165 (50.8%)	n = 325 (69.4%)
Currently Remarried	n = 23 (26.1%)	n = 65 (73.9%)	n = 88 (18.8%)
Currently Separated or Divorced	n = 5 (9.1%)	n = 50 (90.9%)	n = 55 (11.8%)
Column Total	n = 188 (40.2%)	n = 280 (59.8%)	n = 468 (100%)

$\chi^2 = 40.41696$, df = 2, $p < 0.001$

TABLE 22

Proportions of Men and Women with Brief or Chronic Distress who Experience Therapy

	Males		Females	
Distress:	Brief	Chronic	Brief	Chronic
Therapy No.	n = 121	n = 2	n = 49	n = 5
Row %'s	98.4%	1.6%	90.7%	9.3%
Column %'s	50.6%	6.5%	36.8%	13.2%
Total %'s	44.8%	0.7%	28.7%	2.9%
Therapy Yes	n = 118	n = 29	n = 84	n = 33
Row %'s	80.3%	19.7%	71.8%	28.2%
Column %'s	49.4%	93.5%	63.2%	86.8%
Total %'s	43.7%	10.7%	49.1%	19.3%

χ^2 (3, N = 441) = 26.46, p. < .001

Note: Percentages are calculated separately for men and women.

study that reoccurs in the data elsewhere and was frequently commented on by respondents.

> "As long as you were gathering data, you should have asked about marriage prior to current."
> Respondent

> "My current marriage is too 'new' to be relevant to your survey. Had I answered in terms of my previous marriage, the data would be significantly different."
> Respondent

Data were lost, often relevant data to this topic, by not also investigating previous marriages. However, this loss and limitation can be interpreted to lend further strength and support to some of the findings in the data that were not included reflecting prior marriages which were terminated in divorce and thus indicative of marital distress and prior marital therapy experiences. This limitation was known and an acceptable compromise to gain efficiency and reduce methodological complexity in that this is an exploratory design.

One further rather intriguing finding is that slightly over half (50.8%) of all those in their first marriages had therapy. Does this mean that at least half of those who are in their first marriage experienced distress that was severe enough to warrant therapy (however, recall from Table 16 that this group is only reporting a mean score of 2.25 of distress throughout their marriage) or was it merely preventative in nature, or even an enrichment experience? Therapy could also have been crisis intervention oriented for a brief period of severe marital distress, which occurred in the past and the effects of that

particular crisis had diminished. This question should be explored in future research.

Examining the duration of marital distress provides further clarification. When distress is brief there is little difference between not seeking therapy (45.5%) and having therapy (54.5%). The frequency of therapy, however, as already described, changes with marital status. A dramatic effect is noted when marital distress is chronic and prolonged; therapists who have never sought therapy represent only ten percent as compared to ninety percent who do. Clearly, one important variable is whether or not therapists seek therapy for marital distress is how the distress is characterized by its duration.

Information supplied by the entire crosstabulation is further revealing of the differences between men and women, in seeking therapy for marital distress. Of the male therapists who experience brief and intermittent periods of marital distress, 49% had therapy as compared to 63% of the females with similar distress. However, males (93.5%) with chronic and prolonged distress were slightly more likely than females (86.8%) with chronic distress to have therapy. It is commonly known that females as compared to males will more frequently procure therapy, which is supported by these findings, but this seemingly applies only when marital distress is brief and intermittent. Perhaps the male therapist, influenced by sex role differences is more likely to feel that when distress is mild to moderate he should be able to "handle it himself". However, when distress is severe, particularly chronic in

nature he, like his female colleagues (and slightly more so), recognizes the necessity for therapy.

Of those who received therapy for marital distress 44% experienced a combination of therapy modalities (primarily individual and conjoint marital therapy); 15% marked that they had individual therapy for marital distress, 30% were in conjoint marital therapy; 4% had family therapy and the remaining 1% had some other type of modality for marital distress. Of those who have never had marital therapy, when asked if their marital distress were to increase a far greater percentage indicated that they would choose conjoint marital therapy (57%); however there still remains a fair percentage who would choose a combination of individual therapy and conjoint marital therapy (19%), as well as 12% who would still prefer individual therapy for marital distress. It is interesting to note that there is a marked discrepancy between what therapists actually do choose and what they claim they would choose.

Little support was found for some of the concerns that are mentioned in the literature as potential problems or sources of discomfort when the therapist becomes the patient. On a four point scale from none to severe, therapists said in therapy they experienced only slight fears regarding self disclosure ($\bar{x}$ = 1.794). Perhaps therapy is one domain in which the therapist can disclose. They do feel slightly more pressure to be a good, insightful patient ($\bar{x}$ = 2.181) and some difficulty accepting the patient role ($\bar{x}$ = 1.918) but most were rarely concerned with confidentiality during therapy ($\bar{x}$ = 1.408). Approximately two-thirds (64%) of therapists in this study have treated

marital therapists for marital problems and of that number almost half (49%) admit to being more desirous of a "successful" outcome as compared to their other marital therapy cases. It's interesting to contemplate the possible effects of this desire: does the therapist then work harder and is this perceived by the client, if so how?

A fascinating and very strong finding is in regards to who initiated treatment. Sixty-five percent of therapists take credit themselves for initiating therapy; twenty-five percent stated it was a joint decision with spouse; six percent marked other; but only four percent (12 therapists) attribute the initiation of therapy to their spouse! This is a striking difference and perhaps it is due in part to self deception or to a socially desirable response; however, it is doubtful that would account for such disparity. Could it be that when there is marital distress in a therapist's marriage, the spouse does not want to propose a solution that is in the therapist's realm? Yet, when asked if therapist's spouse ever feared their collusion with the therapist the findings reveal that this fear was very slight ($\bar{x}$ = 1.782); however, it must be remembered that the therapist answered the questionnaire in terms of what they thought their spouse felt. The same is true of the question regarding spouse's motivation for therapy, which may help to interpret this finding and will be examined later in the discussion. It is such a striking difference that it would be a provocative topic for further research. As one respondent said: "While being a 'therapist' and a spouse/parent is difficult, being married to one must be equally as difficult."

Another interesting and crucial finding in this section is in regards to the timing of therapy. Most therapists recognize and support that the timing of all therapeutic endeavors is crucial to the effectiveness and outcome of the therapy. It is not uncommon to hear therapists lament: "By the time they got to me the marriage was really dead." Unfortunately, the therapist's own marriage is often dying before therapy is initiated. Sixty-two percent rated the timing of therapy as appropriate; twenty-nine percent said it was somewhat late and eight percent said it was too late. Why do therapists, whose theoretical skills and intuitive awareness guide them so well in the timing of their clinical work, fail so miserably when time truly counts? The respondents answer this best in the degree to which they felt the factors in Table 23 contributed to the ill-timing of therapy for themselves. These factors are listed in order of contribution, from being a major factor to a minor factor.

Once therapists get into therapy how do they rate the outcome? By far the vast majority felt it was beneficial, especially to themselves personally and few felt it was destructive. In the few cases where it was seen to be destructive, the marriage was most likely to be the target. Table 24 represents the perceived outcome of therapy: the degree of benefit and harm. The scale was from one to four, from not beneficial or destructive to extremely beneficial or destructive.

One possible explanation of the difference in outcome, both positive and negative for the marriage may be based on the timing. If therapy is initiated somewhat or too late, the marriage may be beyond

TABLE 23

Average Importance of Contributing Factors to Timing of Therapy

Factors	$\bar{x}$	SD
Tried to solve own problems	3.083	.913
Spouse delayed	2.592	1.293
Denied as long as possible	2.331	1.055
Couldn't find a trustworthy, competent therapist	1.940	1.139
Financial reasons	1.752	.918
Threat to professional status	1.588	.838

TABLE 24

Average Rating of Perceived Outcome of Therapy

	Beneficial		Destructive	
Area of Impact	$\bar{x}$	SD	$\bar{x}$	SD
Personally	3.025	.878	1.142	.500
To the marriage	2.554	1.076	1.165	.481
To clinical work	2.850	1.070	1.008	.087

'salvaging', but the therapy can still be perceived as helpful to the individuals and also to the therapist's clinical work. An analysis of variance does indicate that the benefits of therapy (each item individually as well as when averaged together over the three items in question number 25) are significantly different ($p < .01$) by the timing of therapy. The earlier the timing, the more beneficial therapy is. A Scheffe procedure indicated that when therapy is too late it is significantly different ($p < .05$) in terms of the benefit received from therapy as compared to being appropriately timed or somewhat late. The cell means of benefit from therapy by timing are presented in Table 25.

Furthermore, it is enlightening to look at what factors therapists felt contributed the most to the therapy outcome. Therapists, in a sense, pat themselves on the back because they overwhelmingly attribute the outcome in therapy to a therapist's skills. Since the therapy is most often perceived as beneficial this is a favorable finding. However, therapists attribute the least credit to learning new communication skills and, yet, communication problems was most frequently identified as the greatest source of conflict! Therapy factors, which were scaled from one to four as no influence to great influence, in terms of the therapy outcome are listed in Table 26 in descending order of influence.

Even though therapy was frequently seen as beneficial, 36% indicated that therapy was abruptly or prematurely terminated. The reasons which influenced this termination are listed in Table 27 in descending order of influence on a scale from one to four.

TABLE 25

Average Rating of Benefits from Therapy by Timing of Therapy with Summary of ANOVA

	Somewhat Premature	Appropriate	Somewhat Late	Too Late
Benefits from Therapy	$\bar{x}$ n = 2	$\bar{x}$ n = 164	$\bar{x}$ n = 77	$\bar{x}$ n = 21
Personally	3.50	3.07	2.97	2.99
To the marriage	3.50	2.76	2.40	1.48
To clinical work	3.50	2.87	2.84	2.14
Average of above	3.50	2.90	2.74	1.97

ANOVA Summary Table

Source	df	SS	MS	F
Between Groups	3	17.22	5.74	9.74*
Within Groups	260	153.19	.59	
Total	263	170.41		

*$p<.01$

TABLE 26

Average Rating of Factors Which Influenced the Therapy Outcome

Factors	Influence $\bar{x}$	SD
Therapist's skills	3.291	.873
Gained insight	2.883	.942
Changed behavioral pattern	2.768	.980
Resolving conflict	2.632	.963
Process of going to therapy	2.589	1.034
Learned new communication skills	2.410	1.018

TABLE 27

Average Rating of Reasons for the Premature Termination of Therapy

Reasons	Influence $\bar{x}$	Influence SD
Lack of spouse's motivation	2.195	1.347
Lack of agreement with therapist's methods	2.183	1.248
Spouse's concerns about efficiency	2.175	1.230
Own concerns about efficiency	1.854	1.134
Lack of own motivation	1.731	1.113
Financial concerns	1.721	1.048
Decision to try a different approach	1.712	1.150

Interpreting this table with the previous finding that therapists seldom attribute the initiation of therapy to their spouses, therapists do attribute the abrupt or premature termination of therapy to their spouses' lack of motivation. However, not only do therapists' spouses seem to avoid therapy, therapists (35%) also indicate that they feel more vulnerable in conjoint marital therapy as well. No data were collected on the frequency of initiation for individual therapy for marital distress for therapist's spouses, which would be interesting. When therapists in this study were asked in which modality they've experienced (or would experience) more vulnerability, the findings were: individual therapy (24%); conjoint marital therapy (35%) and family therapy (39%). It would appear that the more family members there are in the therapy room, the greater the vulnerability. This finding may help to explain why some therapists choose individual therapy for marital distress. However, as shown in Table 28, the most highly rated reason for choosing individual therapy instead of, or in addition to conjoint marital therapy, was the desire to gain insight into self more than marriage. The list of reasons are represented in Table 28, with the scores in descending order of influence, based on a scale from no influence to great influence (1-4).

The comments and particularly the interviews provide a richer understanding of why therapists would choose individual therapy instead of (but especially in addition to) conjoint marital therapy for marital distress.

TABLE 28

Average Rating of Reasons that Influenced the Choice of Individual Therapy for Marital Distress

Reasons	Influence $\bar{x}$	SD
Wanted to gain insight into self more than marriage	2.629	1.206
Decision based on training and background	2.210	1.212
Decision based on need for a "different" approach	2.124	1.180
Lack of spouse's motivation to work in marriage	2.071	1.233
Couldn't find a competent marital therapist	1.517	.976
Lack of own motivation to work on marriage	1.421	.848
Feared the vulnerability of conjoint marital therapy	1.371	.738
Had a previously unsatisfactory marital therapy experience	1.187	.611
Felt had already tried self help techniques and therefore nothing could be gained by conjoint marital therapy	1.165	.514

"I've had both individual and conjoint therapy - found individual to be more helpful. A part of my decision to mostly work on marital conflicts individually is my bias that good individual therapists are easy to find and good marital therapists are very rare."

Respondent

"Early in my practice, I would have been too intimidated to seek out conjoint therapy."

"...where the hell does a damn good therapist find a better one...probably not in this town...I can give you a disgustingly horrible honest response... During my marital crisis, which surprised me that I never perceived it as a marital crisis...I did perceive it as a personal crisis and the last thing in the world I wanted was conjoint therapy. In fact, I would have resisted it wholeheartedly probably because my mind was already made up...If I went to see anybody, it would be to go for a little affirmation and support of what I already knew I wanted but probably felt was wrong...But there's another factor too. These are awful things to say, but probably true. One of it may reflect our real ability, or our perceived real ability, that we simply don't want to take a chance on anything that important, in terms of the outcome, so at that particular point our own confidence in our profession is not very high, and that's true...Another factor may be some reluctance to involve one's self into something that's even more painful than what you involve yourself in professionally every day of your life. It would be like taking another dose."

Panelist

"I just couldn't play the client role...so then, I'd also decided I'd have to choose someone whose approach was totally different from mine, so I wouldn't be picking it apart."

Interviewee

"I think it was because I really wanted to do what I did. And if I had taken the initiative to go for marriage therapy, I might have solved my problem and not been able to do what I wanted to do...So that's probably an honest answer. I didn't want my

> problems solved. I wanted to do what I wanted to do about it.
>
> Interviewee

Additionally, therapists were questioned regarding their beliefs about the effectiveness of the choice of therapy modality and whether or not therapists during severe marital distress should seek therapy. The results (from a four point scale of strongly disagree to strongly agree) are presented in Table 29.

These results can be interpreted to reflect the ambivalence regarding the preferred treatment modality for marital problems. Therapists agree but not strongly that most marital problems need to be worked on in conjoint therapy, but they also disagree that individual psychotherapy can be damaging, perhaps this lends some credance to why some therapists choose a combination. There is a striking split as to whether or not the therapist is a "wounded healer" during times of marital distress; however, there is agreement that the therapist should seek supervision and particularly should seek therapy.

Seldom do numbers reveal sincerity or even the agony of honesty, but it's interesting that in the face to face encounter of the interview, as in therapy, the layers unravel and one is confronted with their own human frailties. Frequently, the interviewee would comment: "and that's true" as if admitting their guilt. The cost of marital distress in anyone's life is often profound as witnessed, not only by numbers, but in the pain portrayed in the interviews. Are these costs having any perceived impact on the therapists' clinical work? Therapists were split regarding their beliefs of the therapist as a

TABLE 29

Average Rating of Therapist's Beliefs Regarding the Need for Therapy, Therapy Modality and Supervision

	$\bar{x}$	SD
Individual psychotherapy can be damaging to the marriage?	2.290	.986
Most marital problems need to be addressed in conjoint marital therapy?	3.142	.862
During severe marital distress, the therapist is a "wounded healer"?	2.639	.920
During severe marital distress, the therapist should seek supervision?	3.084	.872
During severe marital distress, the therapist should seek therapy?	3.373	.817

"wounded healer" during times of severe marital distress. One way of beginning to answer the question is to examine what actually does happen in the therapists work. The following section must be interpreted with the constant awareness that the findings are subjective and as one panelist pointed out:

> "It may be that the most significant things that are occurring occur on levels that we are not aware of at the time, such as during the session, that may not appear until sometime afterwards."

Perceived Impact of Marital Distress on Clinical Work

> "...And to whatever degree I'm having a little problem with it, I know my willingness to look at anybody else's problem is less, my energy to be invested in anybody else's situation is less, and I frankly would just like to get the hell out of Dodge, which probably wouldn't be a bad idea."
>
> Panelist

Therapists were asked to rate the frequency to which various concerns, questions or problems occurred in their clinical work during times of personal marital distress. When the entire sample is analyzed as a group, it can readily be discerned from Table 30 that the frequency scores are low. The highest mean (2.142) indicates that during times of personal marital distress work becomes more important as a source of affirmation. Interestingly, when an analysis of variance was applied to each item in the table only this item and the item that discerns if romantic fantasies about patients increased showed any significant differences between men and women. During marital distress women as compared to men are more likely to find their work more important as a source of affirmation ($p < .01$) and men as compared to women are more

TABLE 30

Average Frequency of Perceived Impact on Clinical Work

Impact	Average Frequency $\bar{x}$	SD
Felt your work became more important as a source of affirmation[a]	2.142	.914
Experienced more fatigue with your work	2.050	.829
Found yourself comparing your marriage to your patient's marriages	1.908	.741
Questioned your effectiveness as a marital therapist	1.774	.698
Found yourself easily distracted and thinking about your own situation	1.734	.702
Questioned the validity of doing marital therapy	1.521	.659
Questioned yourself regarding the value of marriage in general	1.492	.711
Felt concern that patients would ask: "If he/she can't help him/herself, how can he/she help anyone else?"	1.491	.753
Felt more desire to save or rescue your patient's distressed marriage	1.443	.702
Sought supervision primarily because of the influence of marital stress or clinical work	1.434	.730
Found yourself having increased romantic fantasies about your patients[b]	1.402	.600
Referred a patient (or couple) who closely mirrored your own distress	1.371	.670

[a]Males: $\bar{x}$ = 2.04, S.D. = .88; Females: $\bar{x}$ = 2.37, S.D. = .97; $F(1,426) = 8.87$, $p<.01$

[b]Males: $\bar{x}$ = 1.57, S.D. = .66; Females: $\bar{x}$ = 1.14, S.D. = .36; $F(1,426) = 58.91$, $p<.001$

likely to have increased romantic fantasies about their patients ($p < .001$).

The results of the questions on therapists' perceived impact of marital distress on their clinical work are presented in descending order of frequency in Table 30. A four point scale from rarely to almost all the time was used.

Furthermore, at least two thirds of this sample reported that during times of marital distress there was no change in their work load, their use of self-disclosure or their advice-giving to patients. When there was an effect it was about evenly divided between the behavior decreasing or increasing. The details of the results are presented in Table 31.

While the questionnaire responses reveal that these changes only rarely or occasionally occur during times of marital distress, the interviews reveal that when they do occur, their occurrence is important.

> "In the middle of it, its extremely difficult... instead of paying attention to what the person was saying, I'd suddenly be back into considering what my own dilemma was. I can remember the pain, I can remember the real agony that I was going through...it became impossible to deal with a situation that was like my situation, but as far as other marital situations, it really didn't have that effect, unless it just came so close to home...I really got into questioning at that point how good a therapist I could really be at all... sometimes I would begin to wonder: 'am I really - as much of a muddle as I'm in right now - am I capable of being a therapist at all?'...I think my level of self-disclosure really did go up at that time and I really questioned if that may have been maybe justification or defensiveness or

TABLE 31

Proportions of Respondent Who Perceived Impact on Clinical Work

Area of Change	No Change	Decrease	Increase
Work load:	n = 357 78%	n = 41 9%	n = 58 13%
Use of self-disclosure:	n = 305 67%	n = 57 13%	n = 93 20%
"Advice giving" to patients:	n = 355 79%	n = 43 10%	n = 54 12%

something. I really don't know. I haven't quite figured it out...I was having reaction in therapy that I don't typically have."

Interviewee

"I noticed that I seemed to have more investment during my time of greater distress in saving marriages, you know, almost having an agenda for: 'I'm going to pull this one out; I didn't succeed at my own' ... possibly I wanted to push a little too fast with some marital work because I felt it was important to save this marriage. One of the things I found myself looking at was comparing my marriage with the marriage of these people and feeling strengths that I wish my marriage had had and for that reason, I wanted to save a marriage. It was something that I had to be very, very, very conscious of and awareness of and hold myself back on...for a long time, I was concerned about: should I be doing marital work? Not so much because my marriage is falling apart but because for a while I was in a lot of distress."

Interviewee

"How much of my own stress am I putting over on this couple? And I really had that question at that time, I remember really struggling with that. I was working on an incest case and I was working with the father while someone else was working with the rest of the family. And I remember he mentioned he was having an affair with another woman and it was at the time I was having an affair too and I said: "Oh, I'm glad to hear that. At least you love to fuck grow-up women too. I think that's much more constructive.' He went home and told his wife what I'd said and she got kind of pissed that I had encouraged him in that I thought it was great he had had an affair. What I mean to say was if he loved to fuck grown-up women too, or liked to fuck grown women, that was much better. I wondered how much of my own projection was going on - that it's good to have an affair. It helps you out...what really used to scare me was when a couple would come in with a problem similar to ours ...one couple in particular was an extreme form of exactly what, well not exactly but something similar to what was going on between (spouse) and I and the guy made me sick! ... I remember looking at him

and saying 'That's the way I am'...It really helped me from that point on because it helped me see myself. I don't know how much I did for the couple, but I learned something...when I was most acutely distressed, I had difficulty concentrating on their problems and would find myself at times generalizing from their problem to our problem or going from theirs into mine and then back again into theirs. I have a difficult time with boundaries sometimes anyway, and I think that was more acute under stress...there was sometimes when I just didn't feel like dealing with marital strife. I think occasionally too I would come across with too much of a simplistic answer to the couple's problem; drawing conclusions too quickly, as if to say: 'let's get this problem over with and get out of here'...I think I did give more direct advice than I usually did in my time of distress...I didn't want to get too deep with the people. I found myself having a hard time becoming really involved with them. It's like I had enough problems myself without getting involved. If there was some simple answer I could give them or some simple advise and they could work it out, then fine, but I wasn't in the mood to get heavily involved emotionally with them. I didn't have energy to do that, I guess...some of my advice giving was probably because I was trying to make it too simple, and to get down to the nitty-gritty might reveal something about me that I didn't want to face, something about my own marriage I didn't want to face."

Interviewee

"I would think it would depend on whether or not the therapist who is the wounded healer has the distress in perspective. That is one can live in a very distressed marriage if there is no other choice and one understands there is distress but says: 'Well, I'm going to live with this' for very rational reasons. If one has that kind of perspective, I don't necessarily think that would have to interfere... I think the primary problem I come up with is that therapists under extreme distress without the kind of perspective I talked about a few minutes ago, that the primary problem would be a projection onto the person of the opposite sex...I think obviously experience helps because I remember very clearly when

> I was first doing therapy it just seemed like I was just one big raw emotion."
>
> Panelist

Beyond descriptively portraying the experience of marital distress and how it may be perceived to impact on therapists' clinical work, other variables were also discovered as being influential: such as the therapist's perspective of the distress and his or her clinical experience. This concludes the descriptive analysis, but the main research question is yet to be fully addressed.

Cluster Analysis

One question addressed by this research is whether or not therapists' own marital distress affects their clinical practice. To investigate this issue, and to further explore the relationships among the indicators of distress, similar respondents were clustered into three groups, each of which represents a unique level of a hierarchical pattern of distress. These subgroups were formed using a cluster hierarchical analysis that employed the squared Euclidean distance calculated on variable z-scores as the distance measure and the average linkage within groups (to create groupings with homogeneous variance). The entire procedure was conducted twice, once for each half of the sample of respondents in order to validate the subgroups that were identified. These two sets of clusters were then combined for the remaining analysis and description.

The concept of similarity in cluster analysis refers to a specific set of attributes and, according to Lorr (1983), it is critical that a

careful definition be given to the attribute domain. The attribute domain here is marital distress as reflected by 26 questionnaire items that call for ratings of the frequency, degree or chronicity of distress and the degree of support felt to be received. Clearly, support is not the same attribute as distress. Yet the overall affect of distress is likely to be modified by the degree of support received, and, as the analysis suggests, support is perceived as a function of distress. That is, support is sought and sometimes found according to a need for it.

When sex and marital status were also entered into the cluster analysis it was impossible to replicate the typology patterns and the analysis was unstable. This may be an indication of the importance (and dissimilarity) of these variables from the other attributes and needed to be considered independently as variables later in the analysis. The cluster procedure failed to produce similar subgroups for the two halves of the respondents until similar proportions of men and women and similar proportions of those married, remarried, or separated/divorced were included in each half. Upon ordering the sample halves by sex and marital status and then selecting every other respondent to form the sample halves, a three-group solution was achieved that was replicable and similar in each sample half. Three clusters were determined to be stable as well as providing for parsimonious description. The interpretation of the cluster analysis is "judgmental, based on theory and pragmatic rather than on statistical determination" (Baker, 1972). It should be noted that to employ cluster analysis only those subjects who answered all the appropriate questions (left no missing values)

could be used in the cluster analysis procedure. This reduced the sample size by approximately one hundred subjects, leaving 364. The recombined sample, when broken down into clusters, included Cluster One (n=149), Cluster Two (n=153) and Cluster Three (n=62). The variables that were selected to be included in the cluster analysis along with the group mean profile of each cluster are provided in Tables 32 and 33.

Upon perusal of the various cluster means it can readily be determined that there are differences between the clusters in terms of levels and frequency of marital distress, as well as differences in support. (Cluster analysis does not test if these differences are significant.) The cluster represents an operational definition of a subgrouping within the data (Lorr, 1983). Given that, the clusters begin to define the various indices of distress in hierarchical levels; for clarity Cluster 1 is being labelled as low (none to mild distress) distress with low support; Cluster Two as moderate distress (mild to moderate distress) and high support; and Cluster Three as high distress (moderate distress but not at severe level) with moderate support.

An examination of the individual items is interesting. Cluster Three members are much more likely than Cluster One or Two to attempt to keep marital distress to themselves. The largest margin of difference for Cluster Three members compared to the others is in communication problems. The only source of conflict category in which Cluster Three members are lower (albeit very small difference) is in family of origin conflict, their mean score (1.85) is slightly lower than Cluster Two (1.89). Cluster One and Two both identified professional colleagues as

TABLE 32

Cluster Profiles: Mean Scores on Frequency and/or Degree of Distress and Support

	Cluster 1 (n = 149)		Cluster 2 (n = 153)		Cluster 3 (n = 62)	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Average distress throughout the past year	1.60	.65	2.09	.62	2.37	.79
Average distress throughout marriage	1.87	.68	2.31	.58	2.87	.64
Duration of distress (Brief or Chronic)	1.05	.21	1.11	.32	1.47	.50
Frequency of behaviors related to distress	1.62	.40	2.07	.47	2.24	.45
Frequency of trying "self help" measures for distress	2.23	.95	3.07	.73	3.03	.81
Frequency of attempting to keep distress to self	2.58	.97	2.80	.86	3.30	.84
Conflict over family of origin	1.64	.77	1.89	.85	1.85	.87
Conflict over finances	1.77	.85	2.11	.85	2.65	1.01
Conflict over children	1.77	.86	2.19	.91	2.60	.97
Conflict over work	1.67	.74	2.01	.81	2.58	.82
Conflict over use of leisure time	1.41	1.25	1.99	1.10	2.31	1.22

TABLE 32 (Continued)

	Cluster 1 (n = 149)		Cluster 2 (n = 153)		Cluster 3 (n = 62)	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Communication problems	1.83	.83	2.44	.83	3.03	.75
Sexual problems	1.64	.80	2.03	.84	2.58	.95

[a] Scales for all items are from one to four, with the exception of Duration of Distress, which was one or two.

TABLE 33

Cluster Profiles: Mean Scores on Support

	Cluster 1 (n = 149)		Cluster 2 (n = 153)		Cluster 3 (n = 62)	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Degree of support from family member	1.71	1.16	2.11	1.10	1.63	.91
Degree of support from lay friend	1.78	1.14	2.86	1.08	2.44	1.22
Degree of support from professional colleague	2.14	1.29	3.07	1.02	2.55	1.22
Degree of support from supervisor	1.18	.64	1.86	1.14	1.26	.64
Degree of support from therapist	1.85	1.25	3.02	1.10	2.79	1.22
Degree of support from minister	1.15	.60	1.66	.98	1.39	.89

n = 364

most helpful in terms of support (2.14 and 3.07); Cluster Three identified a therapist as most supportive (2.79).

Variables that were not used in the cluster analysis were also examined for differences. The pattern of distress when individual items are looked at (as opposed to the averages) continues, as does the difference in support. Interestingly, however, Cluster Three members are less likely to separate (1.129) than Cluster Two (1.178) but as expected are higher than Cluster One (1.081). The average impact scores (averaged over the twelve items on questionnaire number 29) are as follows: Cluster One (1.48), Cluster Two (1.70) and Cluster Three (1.85). An important question with intriguing results that was not used in the analysis is presented in Table 34 for more detailed presentation. Respondents were asked how they felt following the resolution of marital distress, rather than just during it. Table 34 presents the three cluster mean scores (based on a four point frequency scale from rarely to almost all the time).

Cluster Three reports that resolving marital distress did not help them to be quite as empathetic (difference is very small) as Cluster Two, although more so than Cluster One. These results may indicate that cluster one experiences little distress and therefore cannot empathize as much, but what about Cluster Three? Perhaps their distress, being the highest of the three clusters, is at a level where it loses, even following resolution, some of its potential benefits. Its also interesting to speculate if Cluster Two and Three's level of personal support plays a role in that particular finding. Is it harder for

TABLE 34

Cluster Results Following Resolution of Marital Distress

	Cluster 1 n = 113		Cluster 2 n = 121		Cluster 3 n = 51	
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
Helped you to be more empathetic with your patients	2.629	.892	2.941	.783	2.918	.862
Hindered you in working with your patients	1.092	.314	1.129	.347	1.081	.275

therapists to empathize with patients if their own level of personal support during times of marital distress was only moderate? However, the most intriguing and alarming finding is in regards to the frequency to which therapists felt they were hindered in their work following the resolution of marital distress. Again the differences are small between the three clusters, but this time Cluster Three is the lowest. How can it be explained that the cluster with the highest level of marital distress, only moderate support and with the highest impact score report that (of the three clusters) they rarely felt hindered? One possible explanation may relate to the source they identified as most supportive: a therapist rather than a professional colleague. Perhaps the support from a therapist helped to resolve some of the perceived impact on their clinical work during times of marital distress (recall that the average score from the entire sample on the benefits of therapy on clinical work was 2.85, or quite beneficial). Another possible interpretation is that this cluster is denying; they are reporting that regardless of how high their distress, once resolved, it couldn't hinder them, almost a reaction formation. Cluster Three did admit attempting to deny marital distress (2.581) more frequently that Cluster One (1.973) and Cluster Two (2.513). This, together with their tendency to keep distress to themselves is of concern.

In summary, the three subgroups that were eventually selected as clusters began to define the various indices of distress by hierarchical levels from low to high. Differences in support were also found in the three clusters.

While examining the cluster means is the accepted procedure and can be interesting, too many variables are cumbersome and a profile is more efficient and easier to comprehend. Discriminant analysis provides functions or dimensions which provide this profile and also confirms the fact that these three subgroups are significantly distinct.

Discriminant Analysis

The discriminant analysis revealed that all three clusters are significantly different ($p < .001$) from each other (see Table 2 in Appendix K). Two discriminant functions were formed that in essence define the substantive dimensions that divide the cluster membership. Table 35 presents a description by variable list of the functions from the structure matrix (variables are ordered by size of correlation within function).

As can be seen the first function is comprised primarily of the distress variables, with the exception of support from a therapist and lay friend. The second function is comprised primarily of support and a contrasting measure of the duration of distress, whether brief and intermittent or chronic and prolonged. From these data, the first function can be seen to be relatively more important, explaining about 67% of the available variance (eigenvalue 1.257). The second function has an eigenvalue of 0.617. (See Discriminant Function Tables 3 and 4 in Appendix L and M). The canonical correlation squared can be interpreted to reflect the proportion of variance in the discriminant functions explained by the three clusters. The first function has a

TABLE 35

Correlation Description of Functions

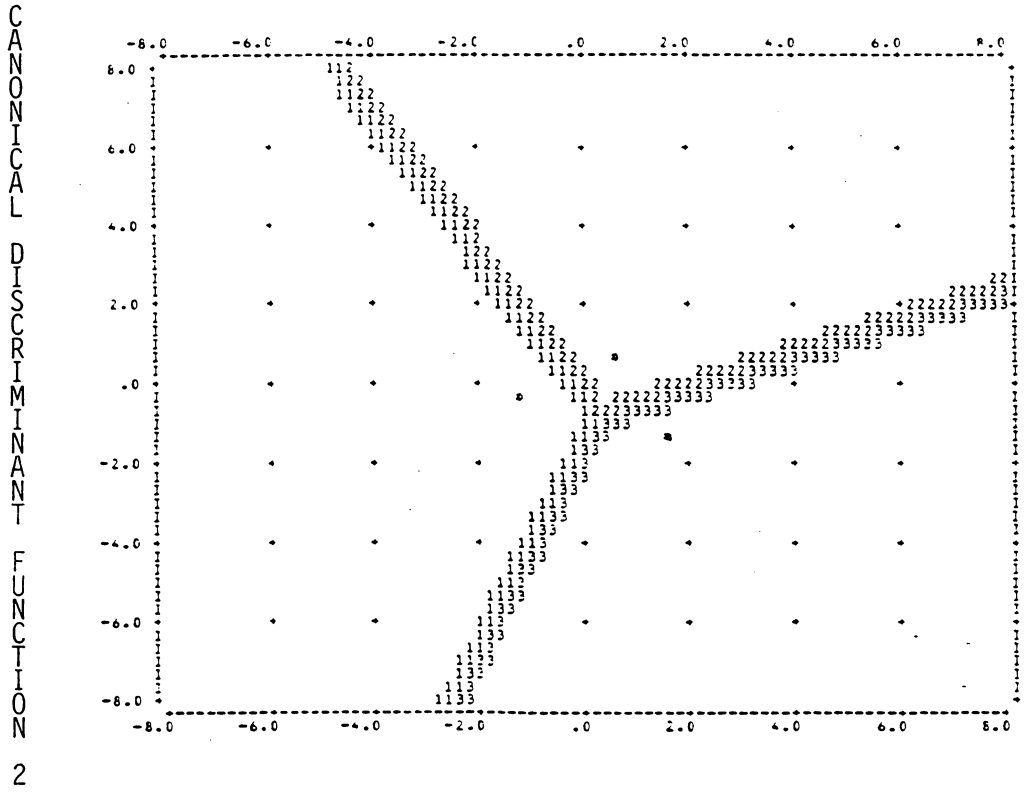
	Function 1*	Function 2*
Frequency of behaviors related to distress	0.505*	0.037
Average distress throughout marriage	0.470*	-0.211
Communication problems	0.471*	-0.144
Frequency of trying "self-help" measures for distress	0.416*	0.193
Conflict over use of leisure time	0.406*	-0.021
Average distress throughout the past year	0.404*	-0.031
Degree of support from therapist	0.377*	0.245
Conflict over work	0.335*	-0.197
Sexual problems	0.334*	-0.164
Degree of support from lay friend	0.326*	0.307
Conflict over children	0.291*	-0.090
Conflict over finances	0.290*	-0.162
Frequency of keeping distress to self	0.218*	-0.113
Conflict over family of origin	0.048*	0.020
Degree of support from supervisor	0.178	0.410*
Duration of distress (Brief or Chronic)	0.316	-0.385*
Degree of support from professional colleague	0.243	0.307*
Degree of support from minister	0.193	0.232*
Degree of support from family member	0.063	0.229*

canonical correlation of 0.746 (56%) and the second function has a canonical correlation of 0.618 (38%). The relative importance of function one is greater which needs to be taken into account when interpreting the location of group centroids on the territorial maps (See Figure 1).

Cluster One has low distress and low support; Cluster Two has more distress and of the three clusters feels the most support, their distress is also likely to be brief and intermittent; Cluster Three members have experienced the most distress in their marriage and while they feel support from lay friends and a therapist (more so as compared to Cluster One and Cluster Two) they are less likely to experience support from a supervisor, professional colleague, minister or family member as compared to cluster one and two. An important distinguishing feature about cluster three membership as compared to one and two is that their stress is more likely to be characterized as chronic and prolonged.

The overlap (See Figure 2) indicates that the groups are not perfectly defined despite the statistically significant separation of the three group centroids. In future research it would be interesting to investigate the highs and lows within each cluster as there are probably interesting differences. Because of the complexity of the variables and interactions it was expected that there would be some overlap, but its reassuring to note that there are not many cases that are far from where one would expect them to be. The method for forming the clusters and for the discriminant analysis is not the same

CANONICAL DISCRIMINANT FUNCTION 1



Canonical Discriminant Functions Evaluated at Group Means (Centroids)

	Function 1	Function 2
Group 1	-1.28860	-0.26022
Group 2	0.63691	0.80282
Group 3	1.52506	-1.35579

Figure 1. Territorial Map

* Indicates a Group Centroid

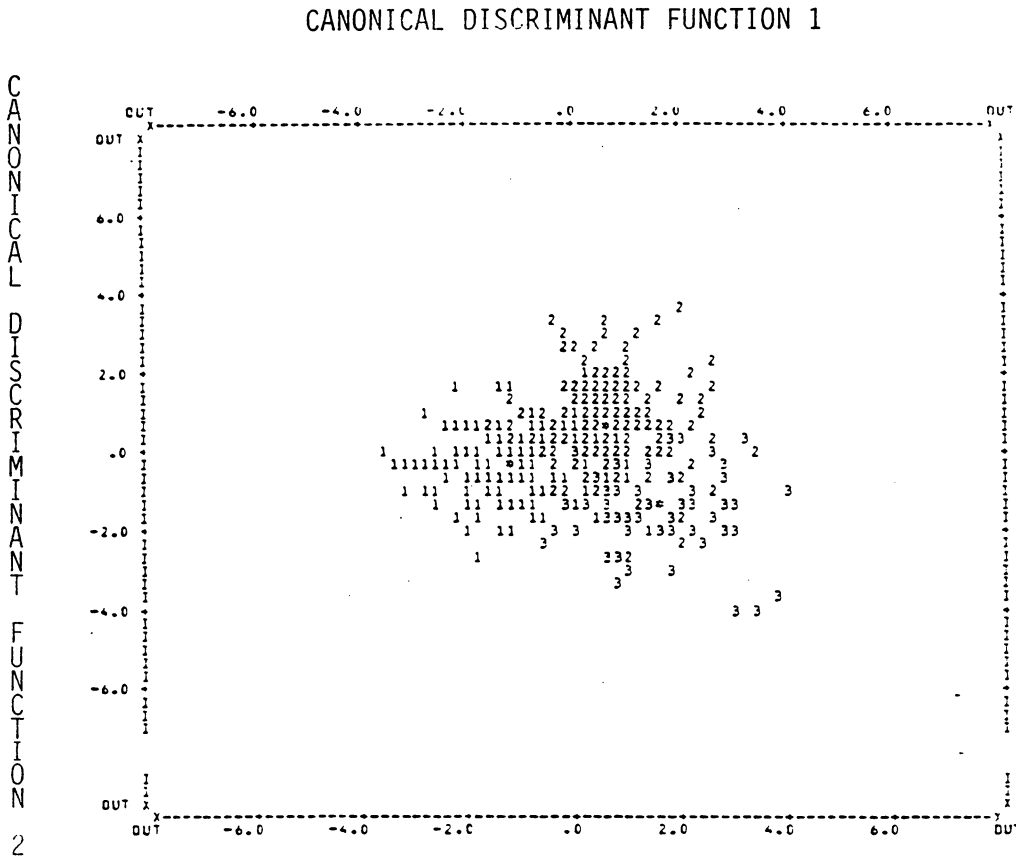


Figure 2. All-Groups Scatterplot

* Indicates a Group Centroid

criterion. For the clusters the within group variance was minimized; for the discriminant analysis the distance between the groups was maximized.

In summary, the discriminant analysis revealed that all three clusters are significantly different from each other. The first function is comprised primarily of the distress variables, with the exception of support from a therapist and lay friend: the remaining function is primarily support and duration of distress. An important distinguishing feature of Cluster Three membership is that they have the highest distress which also tends to be chronic and prolonged. Since the discriminant analysis does separate the three groups it supports the validity of the three clusters.

Analysis of Variance

The next major step in the analysis was to determine if there were any differences between the three clusters, now identified by levels of marital distress and support, on the perceived impact of the distress on their clinical work. Therefore, the dependent variable was the average impact score over 12 aspects of practice each rated on frequency of occurrence on a scale of one to four. The twelve items are listed below:

Questioned the validity of doing marital therapy?
Questioned your effectiveness as a marital therapist?
Questioned yourself regarding the value of marriage in general?
Felt your work became more important as a source of affirmation?
Found yourself having increased romantic fantasies about your patients?

Found yourself easily distracted and thinking about your own situation?
Found yourself comparing your marriage to your patients' marriages?
Experienced more fatigue with your work?
Felt concern that patients would ask: "If he/she can't help him/herself, how can he/she help anyone else?"
Felt more desire to save or rescue your patients' distressed marriages?
Referred a patient (or couple) who closely mirrored your own distress?
Sought supervision primarily because of the influence of marital distress clinical work?

The independent variables were level of distress as measured by the three clusters, sex, marital status and the benefits received, if any, from therapy.[2] The therapist characteristics that are often cited in the literature as effecting the process and outcome of therapy (independent of the treatment setting or the patients treated) are: therapist's personality, mental health, gender and level of experience (Parloff, et al., 1978). To test for level of experience, this study used the number of years the respondents have been in practice. A one way analysis of variance showed that there were no significant differences in work years between the clusters (see Table 36). Parloff, et al. (1978) concluded that regarding the level of therapist work experience as a determinant of outcome the available evidence is weak

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[2]The variable 'benefit from therapy' has been collapsed and recoded: 0 now indicates that therapists did not have therapy; a score of one means low benefit and a score of two means that therapy was perceived as highly beneficial across all categories: to them individually, to their marriages and to their clinical work.

TABLE 36

ANOVA Summary for Clusters Comparing Work Years

Source	SS	D.F.	M.S.	F
Between Groups	297.99	2	148.99	2.62
Within Groups	19815.90	349	56.78	

and not thoroughly investigated.[3] The therapist's theoretical orientation was not included as it was found in one way analysis of variance not to be significant (see Table 37). Sundland (1977) also found that the therapist's orientation was not related to outcome of therapy. Many statisticians recommend that unless a variable is significant in a one way analysis, it is probably wasteful to include it in a multivariate analysis (Huberty, 1975).

The results of the multifactor analysis of variance is presented in Table 38. All of the main effects are significant with the exception of sex, indicating that there is no significant difference between men and women regarding the effect of their own marital distress on their clinical work (the pooled within group correlation matrix is in Appendix N). Parloff, et al. (1968)concluded that the effect of the therapist's sex as a main effect of outcome has not been established. The only significant interaction is between marital status and benefit from therapy. All of the cell means (average impact scores) are presented in Table 39.

While there are significant differences between the levels of distress clusters and the effects of marital status and whether or not one receives benefits from therapy, these differences are small. For

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[3]It must be remembered that Parloff's conclusions are not directly applicable to this study as the measurement of the impact on therapy (while conceivably a therapy process index) is not the same as a measurement of outcome. This lack of clarification regarding process and outcome has plagued research in the past. It is a justifiable criticism made by Parloff, et al. and needs to be rectified in future research.

TABLE 37

ANOVA Summary Comparing Orientations on Impact

Source	S.S.	D.F.	M.S.	F.
Between Groups	.30	4	.07	.45
Within Groups	57.27	349	.16	

TABLE 38

Summary of ANOVA with Effects of Marital Distress, Sex, Marital Status and Benefit from Therapy on Clinical Work

Source of Variation	SS	DF	MS	F
Main Effects	6.61	7	0.94	7.049*
Clusters	2.56	2	1.28	9.567*
Sex	0.04	1	0.04	0.323
Marital Status	2.21	2	1.11	8.251*
Benefit from Therapy	1.56	2	0.78	5.805*
2-Way Interactions	4.59	18	0.26	1.906
Clusters with Sex	0.70	2	0.35	2.622
Clusters with Status	0.23	4	0.06	0.420
Clusters with Benefit from Therapy	0.48	4	0.12	0.898
Sex with Status	0.10	2	0.05	0.378
Sex with Benefit from Therapy	0.37	2	0.19	1.386
Marital Status with Benefit from Therapy	2.02	4	0.51	3.770*
Explained	13.73	25	0.55	
Residual	42.73	319	0.13	
Total	56.45	344	0.16	

n = 364

*p<.01

TABLE 39

Average Impact Cell Means

Total Population		1.64	(n = 345)
Cluster 1		1.48	(n = 136)
Cluster 2		1.70	(n = 149)
Cluster 3		1.85	(n = 60)
Sex - Males		1.64	(n = 221)
Females		1.63	(n = 124)
Marital Status - Married x 1		1.61	(n = 240)
Remarried		1.62	(n = 69)
Currently Separated or Divorced		1.85	(n = 36)
Benefit From Therapy	0	1.52	(n = 146)
	1	1.76	(n = 125)
	2	1.65	(n = 74)

Note: Impact is scored 1 = rarely
2 = occasionally
3 = quite often
4 = almost all the time

TABLE 40

Impact Cell Means: Benefits of Therapy by Sex

	Benefits		
	0	1	2
Sex			
Males (n = 221)	1.56 (n = 107, 48%)	1.77 (n = 73, 33%)	1.60 (n = 41, 19%)
Females (n = 124)	1.41 (n = 39, 31%)	1.74 (n = 52, 42%)	1.72 (N = 33, 27%)

example, the difference between cluster one's impact score and cluster three's impact score is 0.37. Is the difference not only statistically significant, but also of relevance and practical importance? This researcher would argue that it is; anything that influences the therapists personal experience in his or her clinical work merits consideration and further investigation. Again while the differences are very small its interesting and useful to note that those therapists who have had therapy (indicating distress) and if therapy was only minimally beneficial the impact score (1.76) is higher than therapists who report therapy was quite beneficial (1.65). This can be interpreted that when therapy works well it will decrease the impact on one's clinical work and/or decrease one's marital distress which will in turn decrease impact. However, it should be recalled that the benefit of therapy seems to be related to the timing and a third of the entire sample who had therapy said the timing of initiation was somewhat or too late. Parloff et al. (1978) concluded that the importance of personal psychotherapy to enhance the therapists' efficacy remains undemonstrated. This study did not measure therapeutic efficacy; however, the findings suggest that with proper timing and with a beneficial outcome therapy can lower impact on clinical work (as defined by this study). No attempt was made to evaluate this impact as deleterious or conducive. Therefore, the value of marital therapy, for a distressed therapist, to enhance therapeutic effectiveness needs to be further investigated.

Men and women do not differ on their average impact score when the effect of other factors are taken into account. There are differences

as to how men and women report the benefit received from therapy. These results are presented in Table 40.

The other sex difference (again not statistically significant) on impact that is interesting to look at is how sex interacts with cluster membership which approaches statistical significance ($p = 0.074$). The results are presented in Table 41. Women in Cluster One and Two are lower than men on impact but experience a notable increase on impact which is higher than their male counterparts if they are experiencing more marital distress and only moderate support. It would be interesting to know if the marked rise on impact for women is due more to the severity of marital distress or the level of support or some other factor not measured. This trend is not as dramatic when sex differences by marital status are examined in Table 42. When cluster membership is examined with sex and status, there seems to be a slight tendency for females, particularly in Cluster Three, to report higher levels of impact, which is presented in Table 43.

These data suggest that therapists who experienced the most impact on their clinical work from personal marital distress are those who are separated and divorced and who experienced the most marital distress in their last marriage with only moderate support (as determined by cluster membership). Females (however, the n is small) in Cluster Three who are currently separated or divorced report the highest impact score (2.29) thus far cited in this study. This score reflects more than occasional impact.

TABLE 41

Impact Cell Means: Cluster by Sex

	Cluster 1	Cluster 2	Cluster 3
Sex			
Males (n = 221)	1.50 (n = 94)	1.73 (n = 88)	1.78 (n = 39)
Females (n = 124)	1.44 (n = 42)	1.65 (n = 68)	1.97 (n = 21)

TABLE 42

Impact Cell Means: Marital Status by Sex

	Married x 1	Remarried	Separated or Divorced
Sex			
Males (n = 221)	1.63 (n = 164)	1.62 (n = 41)	1.81 (n = 16)
Females (n = 124)	1.57 (n = 76)	1.63 (n = 28)	1.88 (n = 20)

TABLE 43

Impact Cell Means: Marital Status by Cluster by Sex

	Married x 1		Remarried		Currently Separated or Divorced	
	Males	Females	Males	Females	Males	Females
Cluster 1	1.47 (n = 68)	1.42 (n = 25)	1.58 (n = 24)	1.46 (n = 11)	1.50 (n = 2)	1.85 (n = 6)
Cluster 2	1.73 (n = 65)	1.63 (n = 39)	1.65 (n = 13)	1.66 (n = 12)	1.82 (n = 10)	1.74 (n = 10)
Cluster 3	1.77 (n = 31)	1.87 (n = 12)	1.73 (n = 4)	1.93 (n = 5)	1.94 (n = 4)	2.29 (n = 4)

The only two way interaction which was statistically significant was benefit from therapy and marital status. It can be noted that the cell mean under high benefit and separated or divorced status has only an n of one. The interaction reflects the change in the trend or direction of the scores. With a high benefit from therapy, impact scores for those who are currently in their first marriage, as well as for those who are remarried, are lower than if the benefit from therapy was also lower. However, this trend does not hold for those who are currently separated or divorced. If therapy was only somewhat beneficial impact scores were 1.83 but the one reported score by a separated or divorced therapist who found therapy to be quite beneficial was higher (3.08). Except for those who received moderate or low therapy benefits, those who are remarried or in their first marriage reported about the same moderate impact of distress on their clinical work. Those reporting low/moderate benefits who are currently remarried, however, have reported lower impact of distress than those who are currently in their first marriage. No apparent explanation is found in these data for the discrepant trend. These results are presented in Table 44.

In summary, the analysis revealed that there are differences in effects of levels of marital distress (cluster membership), marital status and benefits of therapy on therapists' clinical work. All the effects were significant ($p < .001$) with the exception of sex, indicating that there are no differences between male and female therapists, when other factors are included in an analysis, besides

TABLE 44

Two-Way Interaction Between Marital Status and Benefit from Therapy

Marital Status	Benefit from Therapy 0	1	2
Currently in first marriage	1.52 (n = 124)	1.76 (n = 64)	1.63 (n = 52)
Remarried	1.51 (n = 19)	1.69 (n = 29)	1.63 (n = 21)
Recently separated or divorced	1.64 (n = 3)	1.83 (n = 32)	3.08 (n = 1)

gender. Germane to this study, the data do suggest that various levels of marital distress influence the impact on clinical work differently. This analysis does not indicate which of these factors are most important.

CONCLUSIONS, SUMMARY AND IMPLICATIONS

Divorce rates are of sufficient interest and importance that they are considered to be a "vital statistic" by the U.S. Department of Health and Human Services. Yet many professionals in marriage and family development, as well as many in the public, know that the divorce rate is only one outcome variable in evaluating and understanding marital stability and the quality of married life. Therefore, it is not surprising that therapists would be interested in their own marriages: their marital quality, distress, and even divorce rates. In fact as one respondent in this survey indicated

> "As I look back, I know that much of my motivation to specialize in marriage and family therapy and become an approved supervisor had to do with my own marital and family distress."

What little has been printed on this subject often resembles grocery store tabloid headlines, such as Charney's observation that the majority of senior family therapists, professional leaders, in two major cities had been divorced at least once. It is intriguing to just contemplate the epistomological foundation to the speculation that marital distress and divorce rates are high among marital therapists. And even more importantly, not only would it be useful to know the historical roots of their beliefs, but why they persist. Kennedy once said, "The greatest enemy of truth is very often not the lie...deliberate, contrived, and dishonest, but rather the myth...persistent, persuasive and unrealistic." The purpose of this research was to determine first of all the incidence of marital distress and dissolution

among marital therapists. This information would either substantiate the speculation that marital distress and dissolution among marital therapists is indeed high or it would dispel the myth. The second issue this study addressed was to evaluate the perceived impact that marital therapists' own marital distress may have on their clinical work. If therapist variables are an integral factor of the professional's well being, and given that stress of any kind can influence performance, it is reasonable to infer that marital distress may impact on therapist's clinical work.

There is a void of research on this topic; however, this provides further justification for an exploratory design and unemcumbers the researcher from hypothesis testing. Description, particularly in dispelling myths, can be just as useful as explanation in the early phases of new research. No direct causal effects were tested, but other variables in addition to marital distress that may be related to or influence the impact on clinical work were also looked at: sex, marital status and whether or not therapists who had therapy found it to be beneficial. Marital distress was described through frequency, duration, behaviors associated with the distress, source of conflict and finally if the resolution of distress included therapy and what the outcome was.

A questionnaire, to address the research questions, was designed, pretested and revised. Questions were formulated on a review of the available literature and from in-depth interviewing of therapists who were known to have experienced marital distress and/or recent divorce. One thousand members of the American Association for Marriage and Family

Therapists were selected through systematic procedures. A response rate of fifty-eight percent was achieved; after removing the never married, widows, foreign subjects and those questionnaires which were inappropriately filled out (too many missing values) a total of 478 remained in the sample.

In addition to the questionnaire, in-depth interviews were done to more fully understand the phenomenology of marital therapists' own marital distress and the various ways this may be perceived to impact on their clinical work. The material from these interviews as well as the unexpected wealth of comments on the questionnaire provides the heart and voice of interpretation to the numbers in the questionnaire data. Three experts in the field of marital therapy reviewed the questionnaire for construct validity as well as providing guidance with interpretation and other perspectives based on their experience.

Just as the early explorers in drawing maps would have increased their accuracy if they had drawn what they had seen rather than what they envisioned; researchers, who are doing exploratory studies, should describe what they see rather than what they envision. The marital map of distress is so complex with controversial and diffuse boundaries, it is tempting to define a direction just for some clarification. However, one of the best survival techniques if one is lost is to stay put until you know your territory. This researcher, while often lost in this complex mass of data, stayed with it until it became very familiar ground. However, the familiarity can be deceptively misleading and its important to remember that the questionnaire is really only a crude

device that can be used somewhat like a compass; it can only guide and help lead the researcher to a conclusion. The questionnaire has helped in obtaining needed data but needs refinement. It leads to a destination which must still be defined and interpreted. In fact, conclusions do not seem the most appropriate terminology for exploratory studies, they do not define terminations, but rather new beginnings. All of this is a way of saying that caution is a prerequisite not only in formulating the conclusions, but in reading them.

Descriptive Conclusions

Descriptive statistics were used to define the demographic data and to define the research characteristics of the sample. The sample was comprised of 60% males and 40% females with a mean age of 49. Most identify themselves as marital and family therapists with more than two-thirds of the samples evenly dividing their primary orientation between systemic and psychodynamic theory. The subjects are also primarily well experienced clinicians as over half are in private practice with an average of 14 years in practice.

Since one of the main research questions was to describe the incidence and distribution of marital distress among marital therapists, it's important to clearly portray the marital profiles of the therapists in this sample. Well over two-thirds of the sample are currently in their first marriage, which is of long duration (23.72 years), another twenty percent are now remarried with nine percent being divorced and three percent currently separated. Out of the 45 respondents who are

divorced at the time of this study, 14 are males and 31 are females. Clearly there are considerably more females than males that are divorced and also divorced more frequently. Comparing data on ever-married persons, who at the time of the survey are divorced, to similar information from the U.S. Bureau of the Census indicates that male therapists are not as likely to be divorced at a given time as the male population in general but female therapists are more likely to be than females in the general population. Some of this difference for female therapists can be explained by being well educated female professionals, who tend to have higher divorce rates. It is interesting to contemplate why male therapists in this sample would have lower divorce rates. Wetchler and Piercey (1986) found no gender differences in the stressors or enhancers of marital/family life for family therapists. Do male therapists who enter the field of marriage and family life have more interest and commitment to marriage than the population in general? It would also be of interest to know how male therapists compare to their female colleagues in their commitment to marriage. This is a noteworthy difference that bears further exploring.

Therapists' first marriages which do terminate in divorce tend to last longer to the time of dissolution than the population's average length of duration to divorce. Differences in age, income or education, all may be factors, however, another possibility is that therapists knowing the trauma of divorce from their work may be trying harder and not letting go of a marriage as quickly as the population in general. The next logical step in terms of understanding these differences is to

examine marital distress among marital therapists and what they do about.

The profile that presents in the results was of a cumulative or additive effect to distress. Approximately a third of the samples responded that moderate to severe distress was most characteristic of their marriages throughout. When stress is severe throughout the marriage, it is most often further characterized as chronic and prolonged. In summary, the majority of marital therapists in this sample report mild marital distress for brief and intermittent periods throughout their marriages; if they do experience moderate distress is most likely brief and intermittent, however, when marital distress is severe it will most often be chronic and prolonged. Females are much more likely than males to characterize the distress throughout their marriage as severe, which is reflective of their higher divorce rates. The most frequently cited source of distress was communication problems, with conflict over family of origin as the least cited source.

When distress is evident and the therapist no longer denies its presence, as some attempt to do, many therapists reported in this study that they try to keep the distress to themselves. When they are able to disclose, friends and colleagues (in that order) are the ones they share with but only at little to moderate depths. Colleagues, therapists and friends are reported to be moderately supportive.

As to be expected, as marital distress increases, particularly if it's chronic and prolonged, therapists will obtain therapy for themselves and/or their spouses in conjoint marital therapy. Over 60%

of this sample have been in therapy some time during the current marriage (or last if divorced) for marital distress. Over half in their first marriages have also been in marital therapy, which is a curious finding given the relatively low levels of distress that they reported. A study by Deutsch (1985) which investigated self-reported incidences of various disorders and treatment among psychotherapists found that in their sample (n=264) over three-fourths (82%) reported having "relationship difficulties" and 125 (47%) of all subjects had sought therapy at one time in their lives for relationship problems. There are differences between this study use of marital therapy and Deutsch's use of therapy for relationship problems, but it seems that marital therapists are more likely to have therapy for problems within their marriages than psychotherapists are for problems within their relationships.

Female therapists with brief and intermittent distress sought therapy more frequently than their male colleagues who had similar distress but not quite as often as the males who experienced chronic marital distress. Deutsch found that while female psychotherapists reported equal rates of personal problem occurrence as male therapists, they reported higher frequencies of therapy and medication.

Most therapists state that if their distress were to increase they would choose conjoint marital therapy; in actuality, when they do have therapy for marital distress almost half are in a combination of primarily individual and conjoint therapy. This finding lends some support to Wells and Gianetti's (1986) recent claims that individual

marital therapy needs a critical reappraisal. Many marital therapists are choosing for themselves to have some individual work for marital distress, most in conjunction with conjoint marital therapy. However, it is of concern that in regards to the benefits of therapy, it is least beneficial to the marriage and most beneficial personally. Is this an effect of including individual sessions? This research cannot purport to answer that question, but it does indicate the need for further study.

It was found that the benefits of therapy are related to the timing of therapy. The earlier the timing the more beneficial therapy is. The initiation and timing of therapy is important and therapists in this study take the credit for the initiation with a fourth sharing the initiation with their spouses but only 12 attribute the initiation to their spouse! Possible explanations have been offered but none adequately address this glaring discrepancy. Not only does this need to be explored further it may even indicate the need to address how the profession could provide more support to the spouses of marital therapists, to encourage them to seek or initiate therapy themselves. Indeed, if they did, therapy might not so often be mistimed. Like plumbers' wives who have leaky faucets, the spouses of marital therapists may have leaky marriages and be unable to call the plumber.

When therapy is too late it's most often because therapists tried to solve their own problems and secondly because their spouse delayed. The most common reason for the premature termination of therapy was the perceived lack of spouse's motivation. Clearly, there begins to emerge

in the data a need for the spouse to be heard, not only by the researcher in the future, but by the profession and possibly even by his or her therapist spouse! What are some of the influences that seem to suppress active spousal participation in the therapeutic process? If there were more participation, would the benefits of therapy to the marriage then increase? Most systemic thinkers would probably agree that it would. Therapists in this study agreed that during times of severe marital distress the therapist should seek therapy. Perhaps another question should have been asked: during times of severe marital distress, should the marital therapist's spouse seek therapy?

The second research question this study addressed was an evaluation of the perceived impact marital therapists' own marital distress had on their clinical work. These data are vulnerable to the frequent and often valid criticisms of self-report measures. The credibility of the self-reported impact to actual behavior and practice of these marital therapist is of course unknown. Most importantly, what also remains unknown is whether the impact on clinical work, which results from the therapist's marital distress, is conducive, detrimental or has no effect on the patient/client's progress. The individual impact items were not rated as negative or positive impact. However, it is interesting that the item which many therapists would probably concur has the most potentially negative effect: "found yourself having increased romantic fantasies about your patients" was also one of the lowest scored impact items (only referral of a patient who closely mirrored the therapist's distress was lower). The possible interpretation of the 12 impact items

as negative attitudes or behaviors which might be deleterious to therapeutic effectiveness needs to be considered in light of the relatively low impact scores. It may be that social desirability, in terms of response, is a factor. It's interesting that the highest mean was that during times of marital distress the therapist's work becomes more of an important source of affirmation. A tentative interpretation is that the therapist may be defensively asserting that particularly during times of distress in their marriage their work becomes more valued and thus they must do well to be affirmed (and consequently not allow their distress to impact on their clinical work).

It was anticipated that survey methodology would be inadequate to measure this phenomenological experience of impact, which necessitated the inclusion of the in-depth unstructured interviewing. Qualitative data is often described as productive, fertile, fruitful and other rich terms. These are not inappropriate terms for these data; there is, however, a metaphenomological experience in the interview process itself. This researcher felt during the interviews that marital therapists were stating that the experience of their own marital distress did effect them in various ways that were perceived to have an impact on their clinical work. Most often the therapists shared their concerns about their own efficacy while under stress, their fatigue and lack of energy, which further contributed to distractability. Therapists who were interviewed frequently mentioned the unique difficulties of working with patients/clients who had similar problems

to their own, particularly when the problem in their own lives was unresolved.

The impact scores from the questionnaire merely reflect frequency of various behaviors or attitudes; they do not measure the significance or effect of this on the patient. The meaning and relevancy begin to take form in the words of the therapists. The frequency scores are low, but the interviews seem to support that any occurrence in which therapists because of marital distress question themselves, are distracted, more fatigued, etc., matters. It matters to them and many worry that it may also matter to their patients/clients.

Cluster Analysis Conclusion

Hierarchical cluster analysis was used to provide homogeneous groups of cases on a number of attributes and hence reduce the data. The sample was split in half and the cluster procedure was run on each sample until the typology patterns were stable and similar. The three clusters that were eventually selected began to define the various indices of distress in hierarchical levels. Cluster One was labelled as low distress (none to mild distress) with low support; Cluster Two as moderate distress (mild to moderate distress) and high support; and Cluster Three as high distress (moderate distress, but not at severe level) with moderate support.

While Cluster Three membership is moderate on support, that support is more likely to come from a therapist rather than a colleague. A factor which may prevent them from receiving (or seeking) support from

other sources is that they are the highest on keeping their marital distress to themselves. The most alarming characteristic of cluster membership thus has to do with how the subjects view the effects of marital distress once it is resolved. Cluster Three (which has the highest level of marital distress, only moderate support, and with the highest impact score) report that they felt the least hindered in working with their patients/clients following the resolution of marital distress.

Respondents are ambivalent ($\bar{x}$ = 2.64) as to whether or not during severe marital distress the therapist is a "wounded healer". To characterize a cluster with this label cannot justifiably be done with these data. Nevertheless, Cluster Three's wounds either healed with adhesions that in no one way interferes with their performance or they deny the disfigurement of the wound.

Discriminant Analysis Conclusions

The discriminant analysis revealed that all three clusters are significantly different from each other ($p < .001$). Two functions were formed: the first function is comprised primarily of the distress variables, with the exception of support from a therapist and lay friend; the second function is comprised primarily of support and duration of distress, whether brief and intermittent or chronic and prolonged. An important distinguishing feature of cluster three, other than already described is that their stress is most likely to be characterized as chronic and prolonged. Since the discriminate analysis

does separate three groups (albeit with some overlap) it supports the validity of the three clusters.

Analysis of Variance Conclusions

The factorial analysis of variance tested the effects of 1. cluster membership, that is levels of distress, 2. sex, 3. marital status and 4. benefits of therapy together on therapists' clinical work. Even when all these variable effects were taken into account, the clusters were shown to be significantly different ($p < .001$). All the effects were significant with the exception of sex, indicating that there are no significant differences between male and female therapists regarding the experience of their own marital distress on their clinical work.

The data indicate that various levels of distress and support do influence the impact on clinical work differently. Most importantly it can be stated in brief that the higher the distress, the higher the impact. For marital status, while statistically significant, the differences in impact are small. Those therapists that are separated or divorced are the most vulnerable with the highest impact score. This is particularly evident for females. Therapy, in this study, was statistically significant on impact, but a salient feature of therapy is whether or not it was beneficial; if it was quite beneficial it will tend to lower impact scores (perhaps also related to lowering marital distress). It is possible, of course, for therapy to assist the

therapist in separating the marital distress from his or her professional life without actually lowering or resolving the distress.

Summary

Therapy is a complex process in which reciprocal interactions occur not only between the therapist and the patient/client, but also among their life situations. Marital therapists tend to have longer first marriages than the general population which terminate in divorce. The data seem to suggest that male therapists tend to have lower divorce rates (at a given time) than the population in general but females have a higher rate. The cardiologist who has a heart attack is often portrayed as an example of an ironic twist of fate and consequently a topic of conversation, can be compared to the marital therapist with severe marital distress or who is even divorced. The divorced marital therapist stands out and thus the mythology develops that there is a high level of marital distress and divorce among marital therapists. It really depends on how one defines 'high' and in comparison to what? Just as the cardiologist with a heart attack is interested in reading his electrocardiogram, the therapist is interested in his or her own distress. Furthermore, a heart attack until healing takes place, will impact on the cardiologist's work and marital distress until resolved may also impact on the therapist's clinical work.

This study has shown that the marital life of therapists, notably the experience of marital distress, is perceived by therapists to have an impact on their clinical work. This impact was not evaluated in

terms of its influence (if any) on the patient or therapeutic effectiveness. Other factors which together with distress, have an effect are marital status and whether or not the therapist receives benefit from personal (or conjoint) psychotherapy. In this study the therapists gender, orientation and length of work experience did not seem to have an effect. Impact scores overall were low but the interviews support that any difference is a difference that matters.

Implications

This study, as with most all exploratory research, generates the need for further investigation. An unexpected finding is the role of the marital therapist's spouse in their own therapeutic experience. They were rarely seen as initiating therapy, frequently seen as delaying it if it was somewhat late or not being motivated to maintain it when it was prematurely terminated. These results seem to indicate the need to educate therapists' spouses about the therapy process. This should preferably begin early on while their spouse is in training so that spouses don't feel excluded (or worse, left behind). Before any strong recommendations can be proposed the spouses should be surveyed as these data are self-reported by therapists and, in a sense, the spouses have (once again perhaps) been omitted.

Almost all marriages will experience distress in varying degrees of frequency and intensity for many different reasons over the life cycles; marital therapists are not exempt. On the other hand, it can not be said from these data that just because the subjects are marital

therapists that they are more likely than the general population to have distress and be divorced. Other factors are probably contributing to the findings such as income, education, professional status and even reasons for entering the field of marital therapy. The implications, derived from these findings, do seem to support that female marital therapists, for a variety of reasons, are more vulnerable and should therefore be sensitive to that vulnerability. They need to attend to the distress in their marriages and perhaps even procure preventative measures such as support groups or enrichment seminars.

The support of colleagues and lay friends for both men and women is important in lowering impact scores. A secret, once out in the open, loses some of its power. Marital therapists seemingly have a difficult time disclosing their own marital distress. Perhaps if a network of colleagues could form a support group the secret would be shared and may consequently not have as much an impact on clinical work.

The colleague all therapists should be concerned about is the therapist who is known to be experiencing chronic, high levels of marital distress and is attempting to keep this distress to themself. Since this group of therapists does not frequently approach a colleague for support their colleagues may need to seek the therapist out. If the therapist is not in therapy he or she may need to be, the sooner the better. Furthermore, if possible, it may be preferable for the distressed therapist not to treat patients that closely mirror his or her own problems and to be under supervision. A suggestion of taking a break or time off from work may be appreciated, to alleviate fatigue,

but it should also be recalled that during times of marital distress work becomes more important as a source of affirmation.

The implications of this study regarding the benefits of therapy are that it is more useful in decreasing impact on clinical work when appropriately timed and when the outcome is of high benefit rather than low. An important factor which influences therapy outcome is the therapist's skills; therefore, the choice of therapist is crucial. Unfortunately, many therapists claimed they had difficulty finding a competent therapist within their communities who didn't know them also as colleagues or friends, which can complicate the therapy process. Perhaps it would be helpful to distribute a list of therapists who have developed an expertise in treating other therapists.

Regarding marital status, an easy solution for lowering impact scores for those who are separated or divorced is to simply remarry! What is implied in these findings is that a separated or divorced therapist may have a slight proclivity towards questioning themselves and their efficacy, feeling more fatigue and distractability and needing more affirmation through their work. It is easier to contend with these issues if one's awareness of them is heightened and shared with supportive friends and colleagues or resolved through therapy and/or supervision.

An important implication not readily apparent in these data is that it cannot be inferred that the absence of marital distress has no effect on clinical work or even that a happily married marital therapist makes

a more effective marital therapist. A panelist phrased this caution quite emphatically.

> "Therapists are among the most judgmental of all people, I think, in their private, as well as their public, lives. That's why when you're dealing with this topic as a whole, some caution needs to be put in that having a very fine marriage is not necessarily going to increase your skills as a therapist. And if you start believing that, you start thinking that you're above everyone else and you're in trouble."

Future research endeavors perhaps have more questions than answers generated by this study, but it's hoped that the questions are more well defined. This study has justified the need for continued research. Areas that have been identified are therapists' spouses' role in personal therapy, female therapists' level of marital distress and divorce rates, how to help therapists seek therapy at an earlier stage of marital distress or even for prevention and, most importantly, an investigation of the effect of the impact variables on the patient.

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APPENDICES

APPENDIX A
"MARRIAGE IN CRISIS" CONFERENCE

Survey

The purpose of this survey is to gather information regarding the ways in which psychotherapists' own marital problems are managed in their clinical work.

Please fill out the demographic information requested, rate your response to the questions raised, and make any comments you choose in the space provided.

Marital Status: Are you (please circle one) single, married, separated, divorced. x1 x2 x3 x4

Age _____ Sex _____ Profession: _____

Please rate (by circling the relevant number) the degree to which you have experienced distress in your primary love relationship(s):

1	2	3	4	5	6	7
No distress			Moderate distress			Profound distress

Please indicate how much your distress influenced your therapeutic work:

1	2	3	4	5	6	7
Did not Influence			Moderate influence			Influenced greatly

Please indicate how much your distress hindered or hurt your therapeutic effectiveness:

1	2	3	4	5	6	7
Not harmful			Moderately harmful			Very harmful

Please indicate how much your distress helped your therapeutic effectiveness:

1	2	3	4	5	6	7
Not helpful			Moderately helpful			Very helpful

If you have experienced personal marital distress that influenced your therapeutic effectiveness, did you receive supervision? Yes_____
No _____

Please make any remarks you wish regarding your views on the issue of the therapists' own marital difficulties:

"MARRIAGE IN CRISIS" CONFERENCE SURVEY

Number of Respondents	93
Average Age	34½
Age Range	23-70
Sex	44-47

Marital Status:

Single	13
Married	43
Separated	3
Divorced x 1	17
Divorced x 2	13
Divorced x 3	1
Divorced x 4	2
Widowed	2

Professions:

Medicine	5	Clergy	9
Legal	2	Nursing	10
Psychology	22	Students	9
Counselor	15	Other	3
Social Worker	13	Unclassified	5

	Average Rating
Degree to which respondent experienced distress	4½
Degree to which distress influenced therapeutic work	3½
Degree to which distress hindered or hurt therapeutic effectiveness	2
Degree to which distress helped therapeutic effectiveness	5
Number of respondents seeking supervision	29
Number of respondents who did not seek supervision	41

APPENDIX B

MARITAL THERAPISTS' OWN MARITAL DISTRESS AND EXPLORATION OF PERCEIVED IMPACT ON THEIR CLINICAL WORK

Instructions: The literature reveals a need for an examination of the above issues but a concomitant void of research. This study is an exploratory beginning; the incidence of the marital therapists' own marital distress will be investigated and the therapists' phenomenological experience of marital distress along with the impact on their clinical work will be explored. The literature further implies a relationship between the therapists' own marital health and therapeutic effectiveness. It then behooves us as a profession to critically examine ourselves and our own struggles so as to more effectively treat those who come to us for help. Your participation is greatly appreciated. Since this is a pretest, please feel free to comment on the questionnaire's format, item development and clarity. Your comments at this stage of the research are critical. Thank you once again. Please proceed as directed in the questionnaire. If never married, due to the purpose of the study, you answers would not be appropriate. However, please feel free to make any comments regarding this topic of investigation on the final page of the questionnaire in the space provided. All participation is confidental.

please note number of minutes it took to complete the questionnaire _____.

APPENDIX C

Virginia Highland Health Associates, P.C.

Dear Colleague:

The poet, E. E. Cummings, wrote: "Well, here's looking at ourselves." Apparently this has been difficult for the profession to do as there are no studies reported in the literature on marital therapists' own marital health. It has only been speculated that the divorce rate is high among marital therapists. What is not known is how marital therapists experience marital distress, what they do about it and what the effects are personally, as well as professionally. The literature does imply a relationship between therapists' own marital health and therapeutic effectiveness. The importance of this study is in the contribution that it will make in furthering our understanding of therapists' characteristics, notably therapists' own marital distress and the perceived impact that experience may have on their clinical work. Given this information, it behooves us as a profession to critically examine ourselves and our own struggles as to more effectively treat those who come to us for help.

A random sample of 1000 A.A.M.F.T. members were selected and are being asked to participate in this research. In order for the results to be truly representative, it is crucial that each questionnaire is completed and promptly returned. Please participate in this important endeavor by filling out the questionnaire; it will take you approximately fifteen to twenty minutes. You may be assured of complete confidentiality. The code number on the questionnaire is for mail identification only. This is to facilitate our recordkeeping and to check you off the mailing list when your questionnaire is returned. Your name will never be placed on the questionnaire nor in any way be associated with your answers. Due to the sensitive nature of the study, some of the questions may be anxiety provoking; if the anxiety becomes disturbing, please feel free to discontinue filling out the questionnaire at any point and return it incomplete with an explanation.

I have provided my name, address and phone number on the final page of the questionnaire. Please write or call collect if you have any comments, questions or concerns regarding the questionnaire or research project. Your cooperation and assistance are greatly appreciated. I will be delighted to share the results with you upon completion of the research, which can be indicated in the space provided on the questionnaire. Hopefully the study will be of some interest and help to you personally, as well as for all marital therapists professionally.

Sincerely,

Cheryl Gillespie, R.N.,M.S.
Doctoral Candidate in Marriage
and Family Therapy

CG/sw

Affiliated with St. Alban's Psychiatric Hospital

APPENDIX D

Thank You!

Last week you should have received a questionnaire on marital therapists' own marital distress and the perceived impact that may have on their clinical work. For those of you who have promptly returned it, I am very appreciative. If you have not as yet returned it, please do so today in order that I may begin data analysis.

The questionnaire only requires fifteen minutes of your time, and I need your results to insure representativeness of the sample. Your participation is important. This is not only a study of us as marital therapists and our profession, but a study that is for us, which hopefully will be beneficial personally as well as professionally.

Ms. Cheryl Gillespie, R.N., M.S.
Doctoral Candidate in Marriage
& Family Therapy

APPENDIX E

Virginia Highland Health Associates, P.C.

May 2, 1986

Dear Colleague:

Approximately three weeks ago you were asked to participate in a study on marital therapists' own marital distress and the perceived impact of marital distress on their clinical work. Thus far, out of 1,000 mailed questionnaires, four hundred have been answered and returned. However, I have not as yet received yours; and I wanted to let you know it is not too late to respond. Indeed, I need your participation for the study to be truly representative of the clinical membership of A.A.M.F.T.

An "eyeball analysis" indicates a strong endorsement of the item: how frequently have you attempted to keep marital distress to yourself? Regarding impact, the most frequently endorsed item has been that the therapist's work becomes more important as a source of affirmation. By far, the vast majority of respondents have said that following resolution of marital distress it has helped them to be more empathic with their patients or clients and that it has rarely hindered their clinical work. Respondents have indicated high levels of interest in this topic and have generously shared many personal comments and insights regarding their marriage and work. If this trend continues, I think the study has relevance for us as professionals and for those of us who are married and occasionally experience marital distress. However, your results are important to a further and more complete understanding of the incidence and complexities; so please respond.

If you have misplaced or discarded the questionnaire, you can request a copy by indicating your willingness to participate on the enclosed stamped postcard. As soon as I receive the postcard, I will forward another questionnaire. I sincerely hope this final request will encourage you to participate; if it fails, please let me know why you have not responded by checking your reason on the enclosed postcard. As you know, it is crucial to determine if those who don't participate in a research study differ from those who do participate.

Your cooperation is greatly appreciated.

Very sincerely,

Cheryl Gillespie, R.N.,M.S.
Doctoral Candidate,
Marriage & Family Therapy

CLG/sw

Affiliated with St. Alban's Psychiatric Hospital

Would you be willing to participate in another study if questionnaire was mailed to you? YES____ NO ____
If YES, upon receipt of questionnaire, please respond promptly.

Reasons for nonparticipation (check all that apply):

____ Too busy ____ Questionnaire too lengthy
____ Married and never experienced any marital distress
____ Study does not apply to me personally
____ Study does not apply to me professionally
____ Simply not interested in research
____ Other (Please comment)_____
_____
_____

Marital Status: I.D. _____

____ Never married
____ Married for ____ years
____ Separated & divorced for ____ years
____ Divorced & remarried for ____ years

APPENDIX F

Virginia Highland Health Associates, P.C.

Rt. 2, Box 3
Radford, Virginia 24141
731-1939

HAL G. GILLESPIE, M.D.
General Psychiatry

RONALD L. MYERS, M.D
General Psychiatry

CHERYL L. GILLESPIE, R.N., M.S.
Marital & Sexual Therapy

LINDA S. MYERS, R.N., M.S.N.
Group & Individual Therapy

JOSEPH H. McVOY, Jr., Ph.D.
Marital & Family Therapy

May 13, 1986

Dear Colleague:

Thank you for agreeing to participate if another questionnaire was mailed to you. Data analysis is to begin next week; consequently, it is imperative that you complete the questionnaire and return it as soon as possible. It should only take fifteen minutes of your time.

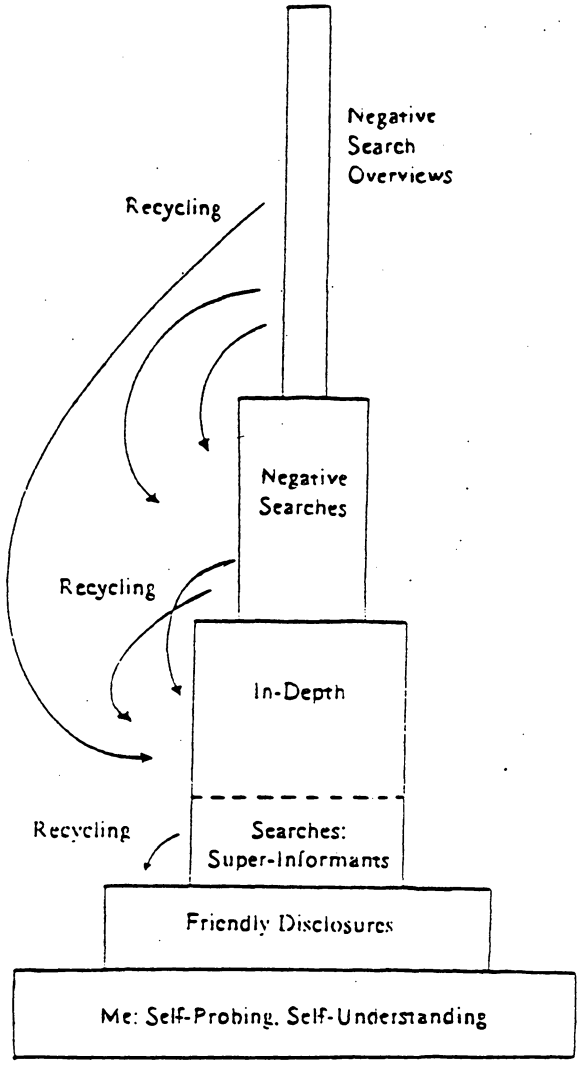
I know how busy therapists tend to be, and therefore your assistance and participation is truly appreciated.

Sincerely,

Cheryl L. Gillespie, R.N.,M.S.

CLG/sw

APPENDIX G


Negative
Search
Overviews
Recycling
Negative
Searches
Recycling
In-Depth
Recycling
Searches:
Super-Informants
Friendly Disclosures
Me: Self-Probing, Self-Understanding

APPENDIX H

ID _____

MARITAL THERAPISTS' OWN MARITAL DISTRESS
AND AN EXPLORATION OF PERCEIVED IMPACT
ON THEIR CLINICAL WORK

Statement of Consent: I have been informed of the nature and purpose of this research. I have been reassured regarding confidentiality. By filling out the questionnaire and returning it, I am consenting to participate.

IF NEVER MARRIED, due to the purpose of this study, your participation would not be appropriate. However, please feel free to make any comments regarding this topic of investigation on the final page of the questionnaire in the space provided. Please return the questionnaire so you may be checked off the mailing list and for accurate record keeping. Thank you.

MARITAL THERAPISTS' OWN MARITAL DISTRESS

AND EXPLORATION OF PERCEIVED IMPACT ON THEIR CLINICAL WORK

DEMOGRAPHIC DATA

1. Sex:
Male _____
Female _____

2. Date of Birth _____

3. Marital Status: (Please check the category that applies to you).

Currently Married in first marriage _____
Currently Married in second marriage _____
Currently Married in third marriage _____
Currently Married in fourth marriage _____
Currently Separated _____
Currently Divorced _____
Currently Widowed _____

4. Marital History (Please fill in the blanks as far as the questions are appropriate to your marital history).

	Length
First marriage (has) lasted number of years	_____ years
Separated and divorced number of years	_____ years
Second marriage (has) lasted number of years	_____ years
Separated and divorced number of years	_____ years
Third marriage (has) lasted number of years	_____ years
Separated and divorced number of years	_____ years
Fourth marriage (has) lasted number of years	_____ years
Separated and divorced number of years	_____ years

If your marital history is different from the above items, please comment:

_____

_____

5. Children:

None _____
1 _____ Age _____
2 _____ Ages _____ _____
3 or more _____ Ages _____ _____ _____ _____ _____ _____

Are children currently living with you? yes _____
no _____
part-time _____

Stepchildren:

None _____
1 _____ Age _____
2 _____ Ages _____ _____
3 or more _____ Ages _____ _____ _____ _____ _____ _____

Are stepchildren currently living with you? yes _____
no _____
part-time

6. Please check your professional identity (if more than one applies, please rank with 1 as your primary identity and 2 as your secondary identity):

Psychologist	____
Social Worker	____
Physician	____
Nurse	____
Minister	____
Marriage & Family Therapist	____
Educator	____
Student	____

7. Please check one of the following theoretical orientations that was the most characteristic of your training?

Psychodynamic	____
Behavioral	____
Systemic	____
Experiential	____
Other	____

8. Primary Work Site:

Academic	____	
Private Practice	____	
Mental Health Agency	____	
Hospital	____	
Other (cite)	____	_____

9. How many years have you been in practice? _____

10. Please check any of the following therapy experiences where involvement as a patient was required of you as part of your training.

Individual Therapy	____
Conjoint Marital Therapy	____
Family Therapy	____
Group Therapy	____

11. Do you believe therapy should be a mandatory requirement of training?

Yes	____
No	____

If YES, what kind:

Individual Therapy	____
Conjoint Marital Therapy	____
Family Therapy	____
Group Therapy	____

THERAPISTS' OWN EXPERIENCE OF MARITAL DISTRESS

Instructions: Please answer the following questions based on your current marriage. If recently separated or divorced (less than a year), please answer all the folllowing questions based on your last marriage. If separated or divorced for more than a year, please answer what applies to you on number 12, then proceed.

12. Please rate, by circling the number, the degree of marital distress you have experienced for each time period:

	No Distress	Mild Distress	Moderate Distress	Severe Distress
This past week	1	2	3	4
This past month	1	2	3	4
This past year	1	2	3	4
Throughout marriage	1	2	3	4

13. Please check the ONE category regarding duration of distress that is (was) most characteristic of your marriage:

Brief periods of intermittent marital distress ____
Chronic and prolonged periods of marital distress ____

14. Please indicate, by circling the number, the frequency of each of the following:

	Never	Rarely	Occasionally	Often
How often have (did) you seriously consider divorce?	1	2	3	4
How often do you think your spouse (has) seriously considered divorce?	1	2	3	4
How often have (did) you and your spouse separate for marital distress?	1	2	3	4
How often has (did) your spouse criticized you for using "psychological nonsense and jargon" on them?	1	2	3	4
How often have (did) you tried "self-help" measures for your own marital distress?	1	2	3	4
How often have (did) you sought (seek) support and understanding for your marital distress from someone other than your spouse?	1	2	3	4
How often have (did) you attempted to deny your marital distress?	1	2	3	4
How often have (did) you attempted to keep marital distress to yourself?	1	2	3	4

15. Please rate, by circling the number, the severity of the following areas of marital distress that you have experienced:

	Not a Source of Distress	Mild Source of Distress	Moderate Source of Distress	Severe Source of Distress
Conflict over family of origin	1	2	3	4
Conflict over finances	1	2	3	4
Conflict over children	1	2	3	4
Conflict over work	1	2	3	4
Conflict over use of leisure time	1	2	3	4
Communications problems	1	2	3	4
Sexual problems	1	2	3	4

16. Please rank the following relationships according to the degree of personal distress you have experienced in them. (Rank from one to four, with one being the least distress and four being the most distress)

Family of Origin _____
Family of Procreation (relation with your children) _____
Work Relationships _____
Marital Relationships _____

17. Please indicate, by circling the number, the degree of support you felt in times of marital distress from each of the following:

	Not Approached	Least Helpful	Moderately Helpful	Most Helpful
Family Member	1	2	3	4
Lay friend	1	2	3	4
Professional colleague	1	2	3	4
Supervisor	1	2	3	4
Therapist	1	2	3	4
Minister	1	2	3	4

18. Please rate, by circling the number, the degree of disclosure you shared with each of the following:

	No Disclosure	Little Shared	Moderate Sharing	In-depth Sharing
Friends	1	2	3	4
Supervisors	1	2	3	4
Colleague peers	1	2	3	4
Male patients	1	2	3	4
Female patients	1	2	3	4
Family members	1	2	3	4
Children	1	2	3	4

19. Have you ever been in therapy because of marital distress (check all that apply)

Yes ____

IF YES, modality chosen:
- Individual therapy ____
- Conjoint marital therapy ____
- Family therapy ____
- Other ____

No ____

If NO,
In the future, if you ever decided to seek therapy for marital distress, which modality would you choose:

- Individual therapy ____
- Conjoint marital therapy ____
- Family therapy ____
- Other ____

Instructions:
IF YOU RELIED NO TO QUESTION 19, PLEASE PROCEED TO ITEM NO. 29.
IF YOU REPLIED YES TO QUESTION 19, PLEASE CONTINUE:

THERAPISTS' OWN EXPERIENCE OF THERAPY

20. Please rate by circling the degree to which you

	None	Slight	Moderate	Severe
Feared too much self-disclosure in therapy?	1	2	3	4
Felt any pressure to be a good, insightful patient?	1	2	3	4
Had difficulty accepting the role of patient?	1	2	3	4
Were concerned with confidentiality during therapy?	1	2	3	4

21. Who initiated treatment?

- Self ____
- Spouse ____
- Joint Decision ____
- Other ____

22. Do you feel the timing (initiation) of therapy was: (circle number)

Too Premature	Somewhat Premature	Appropriate	Somewhat Late	Too Late
1	2	3	4	5

23. If somewhat or too late, please rate by circling the degree to which each of the following were contributing factors:

	Not a Factor	A minor Factor	A moderate Factor	A major Factor
Tried to solve own problems	1	2	3	4
Spouse delayed	1	2	3	4
Financial reasons	1	2	3	4
Denied as long as possible	1	2	3	4
Threat to professional status	1	2	3	4
Couldn't find a trustworthy, competent therapist	1	2	3	4
Other	1	2	3	4

24. Please rate, by circling, the degree to which you felt the following therapy factors influenced the therapy outcome:

	No Influence	Slight	Moderate	Great Influence
Therapist skills	1	2	3	4
Learned new communication skills	1	2	3	4
Gained insight	1	2	3	4
Changed behavioral pattern	1	2	3	4
Process of going to therapy	1	2	3	4
Resolving conflict	1	2	3	4

25. Please rate, by circling the number, the degree to which:

	Not beneficial	Somewhat beneficial	Quite beneficial	Extremely beneficial
You felt therapy was beneficial to you personally?	1	2	3	4
You felt therapy was beneficial to your marriage?	1	2	3	4
You felt therapy was beneficial to you in your clinical work?	1	2	3	4

	Not destructive	Somewhat destructive	Quite destructive	Extremely destructive
You felt therapy was destructive to you personally?	1	2	3	4
You felt therapy was destructive to your marriage?	1	2	3	4
You felt therapy was destructive to you in your clinical work?	1	2	3	4

26. Was therapy ever abruptly or prematurely terminated?

Yes _____
No _____

If YES, please rate the degree to which it was influenced by:

	No Influence	Slight	Moderate	Great Influence
Own concerns about efficacy	1	2	3	4
Spouse's concerns about efficacy	1	2	3	4
Lack of own motivation	1	2	3	4
Lack of spouse's motivation	1	2	3	4
Lack of agreement with therapist's methods	1	2	3	4
Decision to try a different approach	1	2	3	4
Financial concerns	1	2	3	4

Instructions:
QUESTION NO. 27 APPLIES ONLY IF YOU'VE EXPERIENCE CONJOINT MARITAL THERAPY. QUESTION NO. 28 APPLIES ONLY IF YOU'VE EXPERIENCED INDIVIDUAL THERAPY. IF YOU'VE EXPERIENCED BOTH PLEASE ANSWER BOTH. THEN PROCEED TO QUESTION NO. 29.

27. Please rate by circling the extent to which:

	None	Slight	Moderate	Severe
Spouse ever feared your collusion with the therapist?	1	2	3	4
You ever felt humiliated in front of the therapist when spouse became critical of you?	1	2	3	4

28. If you chose individual therapy instead of (or in addition to) conjoint marital therapy for marital distress, please circle all the following reasons that influenced your choice:

	No Influence	Slight	Moderate	Great Influence
Lack of own motivation to work on marriage	1	2	3	4
Lack of spouse's motivation to work on marriage	1	2	3	4
Decision based on training and background	1	2	3	4
Decision based on need for a "different" approach	1	2	3	4
Wanted to gain insight into self more than marriage	1	2	3	4
Couldn't find a competent marital therapist	1	2	3	4
Feared the vulnerability of conjoint marital therapy	1	2	3	4
Felt had already tried self help techniques and therefore nothing could be gained by conjoint marital therapy	1	2	3	4
Had a previously unsatisfactory marital therapy experience	1	2	3	4

If there were other reasons for your choice please elaborate:

_____

_____

_____

PERCEIVED IMPACT ON CLINICAL WORK

29. During times of personal marital distress, indicate by circling the number, the frequency to which you:

	Rarely	Occasionally	Quite Often	Almost all the Time
Questioned the validity of doing marital therapy?	1	2	3	4
Questioned your effective as a marital therapist?	1	2	3	4
Questioned yourself regarding the value of marriage in general?	1	2	3	4
Felt your work became more important as a source of affirmation?	1	2	3	4
Found yourself having increased romantic fantasies about your patients?	1	2	3	4
Found yourself easily distracted and thinking about your own situation?	1	2	3	4
Found yourself comparing your marriage to your patients' marriages?	1	2	3	4
Experienced more fatigue with your work?	1	2	3	4
Felt concern that patients would ask: "If he/she can't help him/herself, how can he/she help anyone else?"	1	2	3	4
Felt more desire to save or rescue your patients' distressed marriages?	1	2	3	4
Referred a patient (or couple) who closely mirrored your own distress?	1	2	3	4
Sought supervision primarily because of the influence of marital distress clinical work?	1	2	3	4

30. During times of marital distress:

	No change	Decrease	Increase
Did your work load:	1	2	3
Did your use of self-discolosure:	1	2	3
Did your "advice-giving" to patients:	1	2	3

31. Following resolution of marital distress, how frequently do you feel:

	Rarely	Occasionally	Quite Often	Almost all the Time
It has helped you to be more empathetic with your patients?	1	2	3	4
It has hindered you in working with your patients?	1	2	3	4

32. If your marital distress increased, would you consider seeking therapy?

Yes ____
No ____

If YES, check all those you would choose:
Individual therapy ____
Conjoint marital therapy ____
Family therapy ____
Other ____

33. As a marital therapist, do you think:

	Strongly Disagree			Strongly Agree
Individual psychotherapy can be damaging to the marriage?	1	2	3	4
Most marital problems need to be addressed in conjoint marital therapy?	1	2	3	4
During severe marital distress, the therapist is a "wounded healer"?	1	2	3	4
During severe marital distress, the therapist should seek supervision?	1	2	3	4
During severe marital distress, the therapist should seek therapy?	1	2	3	4

34. In which therapy do you think as a therapist you've experienced or would experience more vulnerability:

Individual therapy ____
Conjoint marital therapy ____
Family therapy ____

35. Have you ever treated a marital therapist for marital problems?

Yes ____
No ____

If YES, were you more desirous of a "successful" outcome as compared to your other marital therapy caes?
Yes ____
No ____

If YES, please indicate if the therapist was seen in:
Individual therapy ____
Conjoint marital therapy ____
Family therapy ____
Combination ____
Other ____

36. Have you ever pondered the questions in this survey previously and been interested in this topic?

Yes _____
No _____

Thank you for your cooperation, consideration and time in participating in this study. If you have other comments you'd like to make, please feel free to do so in the space provided. If you would like a copy of the results, please indicate this below.

Comments:

Would you like a copy of the study's results sent to you? Yes_____
No _____

If yes, please indicate your address and some pseudonym or identification.

For giving of yourselves so personally, I would like to make myself available to you for any further comments or questions regarding this topic. Please feel free to call collect or to write. Once again, thank you.

I sincerely hope that not only will this study be helpful to me in completing my doctorate in marriage and family therapy, but that it has been or that the results will be of some benefit to you.

Cheryl L. Gillespie, R.N., M.S.
Route 2, Box 3
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(home)
(work)

APPENDIX I

Respondents' Comments

Minister:

Crises can be both beneficial and damaging. It depends on whether you allow it to destroy you and your effectiveness or to be a powerful instrument to help others.

Clinical Psychologist:

Using my own feelings and reactions to my husband (who is sometimes my co-therapist) is a very valuable part of my couples work. Extra effort is needed to separate my issues from the client's issues, but, as my husband and I work on our relationship, it becomes a very sensitive instrument to use with our couples.

R.N.:

I believe the hindrance to therapeutic effectiveness is outweighed by the growth (profound) and consequence in therapeutic effectiveness.

Psychologist:

If a therapist develops personal or interpersonal problems at various short times, I don't feel it would have a great effect. Severe or prolonged problems would need support .....

Psychologist:

Like most crises, my marital problems were resolved in a way which probably enhanced my effectiveness. Early on, however, the distractions made concentration difficult and hence made therapy difficult.

Psychologist:

The more experience the therapist directly has, the more the client is able to identify with you and the greater the influence on therapy.

Psychologist:

Can best help in understanding intense feelings distressed persons experience -- supervision is essential in keeping perspective -- without, disaster!

Actually since I became a marital therapist. After divorce, I have given much thought and introspection to it. For the first 2 or 3 years, I was afraid to treat couples. Then, gradually, I realized that my own experience had enriched my therapy. There is no way of knowing if that therapist has decided to treat us as a couple, instead of me individually, that the marriage might have been saved. Perhaps it is my fantasy. But when I get a call, I refuse to see anyone individually, if they say it is a relationship problem. Once, I wavered and let a woman talk me into seeing her individually - and then later I saw her husband individually. It was a horrible mistake. I will never do it again. I don't mind that you know who I am and, if you want additional details, please call.

Good topic. Think the questionnaire well done. At times in workshops, painfully obvious how presenter's attitudes and talks are influenced by their current life situation. Obvious too that a "happy" therapist more effective than a "stressed", angry one.

Seeing patients' marriages improve with therapy can sometimes increase marital stress. I find myself comparing my marriage to the "ideal" quite often. I also experience less energy to seek solutions to my own marital problems because I give so much to others.

The print is impossible. This is one of the only questionnaires I've completed. Have found it most interesting.

yes, this is an area which I feel requires exploration. The nature of this work is very difficult during times of marital distress. As a therapist, I feel we are vulnerable since our work is not a place to escape problems but to expose ourselves to our own concerns hour after hour. Our ability to make our own marriages work is an expression not only of our personal success, but ourselves as professionals. It's a tough dilemma.

Quest. 16 - ambiguous and confusion - rank the topics 1-4 or rank the 4 topics listed 1 to 4 - I elected to do the 1st. No options given for adoption of children or raising child other than your own.

My personal convictions: We therapists who believe in the effectiveness of therapy should incorporate it ourselves on an as-needed basis. Our relationship counseling was performed by a psychiatrist - who was better suited for individual. The type of therapist should be an important consideration in correlating goals. As a result of therapy, my self-esteem raised sufficiently to get out of the marriage - which was not the intent of the therapy. For most therapists in high level distress a hiatus of practicing should be strongly considered. I happened to be able to have developed the unique trait of setting myself (and my feelings) aside for a certain specified work period -- then return to them when work demand diminished. I operated on a highly

private, nondisclosing basis until my difficulties were resolved. Now I say-disclose marital conflicts only where it is going to be beneficial to the patient. Good luck with your study! I'm curious re your original hypotheses. My husband was a physician also. A most interesting study would be centered on physician families.

Have often been thankful for a happy marriage.

Interesting topic of study. Wording of some of the questions was unclear and ambiguous.

I have had a lot of therapists at different times over the past 14 years. Would have gone for conjoint marital therapy at the start if I'd know it existed. Took a few years to find that.

If one truly denies something, does he or she know it (a14) q19). Both my husband and I have been in therapy for personal issues that affected our marriage, and we did some conjoint work on these issues, but they could not be called marital distress. We have also done family therapy. Please note--my husband is a Ph.D. psychology, MFT in practice with me. q18. After the fact, as an example, I have shared some with clients. I believe it would be seductive (and inappropriate) to share ongoing problems. My husband and I have shared our distress together with our kids at times.

Since my last divorce, I have had intensive and very beneficial therapy; have had many enlightening, peak experiences of great spiritual joy and feel competent (at last!) to have a healthy marital relationship. My help came primarily through Esalin Institute, Big Sur, Ca.

I would be curious if therapists apply the "new epistemologies" to their own marital distress.

A good therapist should be able to put personal problems aside and deal with each case a new challenge. My marital deficits never entered my office.

The stress identified in this survey results from the fact that my wife has a chronic and terminal illness. ALS (Lou Gehrig) disease.

Many of my "marital distress" issues stemmed from the adult child of an alcoholic. I found it difficult to answer these questions without being able to comment on this complicating factor.

I hope it does not bother your research to know that many of my answers are based on distress experienced in a long-term committed relationship that isn't officially a marriage. I think "long-term relationship" should have been another option in #3. Also, in question #15, I think you needed to define "family of origin" which could relate to ethnic and race differences or could mean "in-law" problems.

Questions are very leading and biased. Do not seem to apply at all to me. Serious question this involvement in your study.

I've had both individual and conjoint therapy - found individual to be more helpful. A part of my decision to mostly work on marital conflicts individually is my bias that good individual therapists are easy to find and good marital therapists are very rare.

This is excellent! I believe your questions should be expanded. Wonderful start and I hope you continue - if I can help, let me know.

I am fortunate to have a good marriage. I felt forced to answer, some inaccurately, some questions, such as #13 and #16 because my answers might have suggested more marital discord than I actually perceived.

I use the word "couple or coupling" rather than marriage which has more of a religious connotation.

Why make this so hard to read?

Many surveys take time, but I did it.

"Marital distress" is too strong a term. "Marital stress" is more neutral, if operationally defined. You might also obtain ratings of marital satisfaction, compatibility, commitment, and areas of agreement or communality. You might also obtain measures of impact of a good marriage on the marital therapist's clinical work.

Sounds like a real interesting study - something like "Doctor, Heal Thyself" I feel the concept is less valid in therapy than in medicine.

The greatest help for my spouse and for reducing marital stress came when she was diagnosed as having P.M.S. and put on medication. (Birth control pills for premenstrual stress). Your questionnaire has no provision for pure medical help.

As per my experience, the marital distress which I experienced occurred before (within the initial two years) of my marriage. Hence, there has been little of your querries applicable to me. The time frame was also before I became a therapist. Such a time-frame should have been included in the questionnaire, e.g., when the marital distress occurred?

As you can see from answers, my marital distress was over a long time (4 yrs) but was resolved 10 years ago and was before I entered this field. So some of the questions were confusing as to how to answer.

It's long overdue that somebody study this. Your questions are good but probably don't adequately tap the information that is needed to respond adequately because this is such a complex matter.

Good questionnaire in general, but you don't allow for the therapist's therapy before he/she became a professional. The last part of #4 is very important for Holocaust survivors whose history is unique - I'm glad you added it even if it wasn't for that purpose.

I prefer to work with couples above other forms of therapy. I think the strength of my marriage is a major reason I succeed in my work. I am skilled at what I do partially because: 1) my marriage is extremely well functioning, 2) my first marriage was very difficult and I spent 10 years trying to save it with 5 years of individual, conjoint, and marital group therapy, 3) I've experienced myself almost all the problems my clients have and am happy with my solution.

I appreciate your doing this study.

I notice that a distinction was made in my mind between on-going marital discomfort and severe marital distress. To me, the degree is significant - when elevated to "severe" the circumstances change significantly.

Let me explain that I started out in the field of mental health as a volunteer in 1958 after hospitalization for post-partum depression. I was motivated to become a family counselor after my own full recovery. My marriage was affected adversely by the therapists I endured until I selected my own. My training was undertaken in 1970 after a 3 yr. separation.

Your cover letter and comments are personable and warm. Thank you for your efforts. Good luck.

As long as you were gathering data, you should have asked about marriages prior to current. You need to differentiate between thoughts and feelings a bit more clearly.

I think I'm fairly successful at keeping my marriage problems home and my work at the office. It is difficult to do but can be done!

Question #29, 30 and 31 don't apply as I wasn't a psychologist at the time of my marriage.

Good luck! For my Ph.D. dissertation I, too, did a mailing survey. I'm glad to help.

In #16, there should be room for step-children, a major cause of marital distress in marriages.

I have not been in practice since 1982. I am now a director of a Market Research firm.

I feel that therapy for myself has helped me immeasurably; also my marriage and outcome (divorce) has helped me be a "better" therapist.

Add religious leader instead of minister no. 17. No. 20, add "other reasons" -- and place to write. Very good project!

I have not experienced what I could call marital distress so found it difficult to answer some of the questions. I could not answer #17 it doesn't apply.

Very relevant survey. Would make fine stuff for therapists' group tx.

Since I am not and have never been married, I have not answered the questions as you so directed. However, I found questions in the whole were excellent and particularly 27, 30, 33, 34. To ques 11 I would support ayes within the dual mode of individual and group/family as appropriate. Good luck on your doctorate building on this research!

I understand the need for forced choice questions. However, there were times when I had no opinion (and didn't care) and would have liked to tell you. Questions like #29 seem to indicate the researcher's bias. Rarely is not the same as never. Never would have been an honest response more than once. Clearly you believe all of us experience these things. Perhaps not so.

This type of study is long overdue. Best of luck with it!

#36 poor and vague question. Basically a good questionnaire.

Good beginning in important topic. Should have used larger type and larger envelope.

Interesting and well constructed instrument. I look forward to your findings.

I am a M.A. level marriage and family therapist and my husband is Ph.D. level therapy and I feel our communic. is very good, which helps minimize our distress. We attended marital therapy only w/er my hus. was working on his Ph.D., the most stressful time for us. Good luck! Very interesting topic. A lot of my clients are therapists and physicians so I am interested in your results.

As a feminist therapist, as well as a feminist, many of the questions seem inadequately phrased to me. There seems to be a background assumption about "making marriage work", and "traditional marriage" seems to be assumed.

I have never been married. I have been curious about the subject for a long time and feel a survey of this kind is long overdue. Good luck, future Dr. Gillespie.

No therapy was required. However, I undertook classical analysis in the early '50s for about 3 years. 11. All 4 if possible. This is one of the best ways a therapist can determine what really works. Furthermore, it can serve to protect the therapist - and his/her patients - from trendy, pop-psych.). 28. At the time that I undertook therapy (early '50s) conjoint marital therapy was not available. Psychoanalysts assumed that a "sick" person invariably undertook a "sick" marriage and warned their patients that "getting well" would probably lead to divorce. In consequence, my marriage was almost wrecked. However, I learned a great deal that subsequently proved invaluable to my practice. 34. A professional could not help but feel a degree of vulnerability in any kind of therapy. I think this is an important attempt to achieve self-awareness in the profession, and I congratulate you for looking at these questions. My own situation is so idiosyncratic that it is hard to describe within the confines of a questionnaire. I have tried to be accurate, so if there appears to be some inconsistency, it is due to the uniqueness of my experience.

I've put "0" at those questions I felt were unclear or loosely worded. 5. 23.

Most of my severe marital distress was before beginning private practice.

A key question, I think is - Did romantic/sexual involvement with a patient occur in your practice? ____ Yes _____ No. If "yes" - what was its effect on your marriage at that time? ____ Was not married _____ No effect _____ Some effect, etc. Another question could probe for "religiosity" (I hate that word too). Good study.

I am glad you are doing this study. I look forward to the results. I have learned a lot from my own pain which I can use to help me understand my clients - from the help I have received.

I feel that all persons who do therapy should at some time get into therapy. Also, I feel conjoint therapy to be extremely valuable after experiencing it myself.

Other than therapy, which of the following has been helpful to you during marital distress. 1. Books. 2. Tapes. 3. Journals. 4. Seminars. 5. Sermons. 6. Colleagues. 7 --- 8 --- 9 - etc.

A definition of marital distress would have been helpful. My husband and I teach couples communication classes and attend marriage enrichment often. We do have "normal" arguments but have never thought of our marriage as "distressed" or considered that we needed additional help. We often have reflective conversations about our relationship - expectations, etc. This questionnaire used the term marriage distress often and assumed and forced me to assume this in order to answer certain questions.

In some cases, as I have indicated, a category of "never" would have been more appropriate, I believe.

Only married less than 2 years, am not having severe marital distress - I find many questions difficult to answer. I also am new to a town and have few support systems (friends and supervisors) which changes my willingness to disclose to "friends".

I consider personal therapy an absolute requirement. I believe a distressed therapist must ethically and morally seek supervision and/or therapy. A surgeon with a hangover should postpone surgery. A therapist with a damaged self and sensorium should select his/her cases, postpone "touchy" ones and reduce caseload. It's bad enough to screw up your own life; one has no right to do it to one's patients. You confront one aspect of the problem - the therapist who becomes "damaged". As one who is involved in academic training and clinical supervision of therapists, I am vitally concerned about people who start out incompetent or psychologically damaged.

Excellent questionnaire. Provocative and inciteful.

Some of your questions could be more precise to really give insight.

Worthy topic - very valid and necessary research.

Question 33 A: I believe individual psychotherapy is likely to damage only weak marriages, in the main. In general, I would review it as enriching to healthy marriages - even if expensive.

I learn much from my work that I can apply to personal life with positive outcome. I think my work has contributed to a healthier personal life and marriage.

Many of these questions assumed marital distress. I had a difficult time answering them because our marriage has been unusually stress-free.

My husband and I are fortunate to have a fun marriage and good friendship/partnership. Using our therapy skills as support for each other has been invaluable.

Might have asked about impact of therapy not instigated for marital distress, also particular symptoms (depression, anxiety, withdrawal) which accompany distress. Interesting questionnaire. I feel very strongly that individual therapy can be conducted in a way which strengthens marriage, but it is not often done this way.

Would have liked to see such items as philosophy, values, fundamental differences as reasons listed as friction factors. Another being marrying for all the wrong reasons.

I would like to know your outcome on this survey. It is important. I'm astounded at how seldom therapists utilize therapy!

It was difficult to clarify that the marital distress occurred during one period of my marriage. It was part of a "mid-life crisis," but the primary issues were related to resolving a traumatic childhood. I chose to answer the therapy questions since marital issues were addressed in conjoint sessions.

As I look back, I know that much of my motivation to specialize in MFT and become an approved supervisor had to do with my own marital and family distress. During my 1st marriage for 24 years. 2. The suicide of my son - age 23 - was the focal point that brought about my 2nd divorce. 3. I am currently in a marriage that is for life and works extremely well and is extremely satisfying.

Many of my answers are "composite" answers. I'm surprised and filled this out -- pretty long but I saw you as sincere.

Therapy helped me resolve my hesitance about ending a bad marriage - because I dealt with the dependency issues that had kept me there. If I were to consider marriage again, I would feel it of utmost importance to have some sessions for premarital counselling!

I had difficulty answering many questions due to the development or cycles my relationship has gone through. Example: in the early years, there was some extreme distress. Later on what distress there is seems to be mild.

The questionnaire is confusing because a great deal of material which was applicable was from one's first marriage and at question 12 one is directed away from this and none of my therapy or experience which was learned in marriage one is relevant to the questions asked. Thus, I have answered in terms of my first marriage the questions concerning therapy. Question on children is vague as there are children from first marriage, second marriage and step-children. This is an important area of work, and I'm really interested in your findings. Please send a copy of your results and/or further questions.

Return envelope too small. I could have asked spouses too. Definition of stress is unclear. Everything source of distress at one time or another.

My husband is a recovered alcoholic (23 years sober). My severe marital distress occurred during the 12 years when he was drinking, especially the last 6. I sought marital conjoint therapy which abruptly ended after 4 sessions. We separated for 3 mo. Reconciled after husband agreed to therapy. He had psychiatric sessions 2 years, went to A.A., had spiritual experience and quit drinking. Ten years later, our

son died. The year after my son's death, I returned to school and began my studies for MFCC. Five years after our son's death, I initiated family therapy because of aborted grief process, husband's depression (still sober). Six sessions - very helpful. I was MFCC intern at the time.

Foster children - 5 all grown - male - 2 lived with us 7 years each (age 3-10) (age 6-13). Male - 2 lived with us 12 years each (age (8-20) (age 9-21). Female, 1 lived with us 3 years (age 11-14). All foster care came after my husband was recovered from alcoholism.

My alma mater - The California Family Study Center, Burbank, Ca., encourages married students to participate in a couple's group to acquaint nonstudent spouse with marriage & family lingo and procedures and to prevent higher incidence of divorce among students. My husband and I attended the groups sessions for one year. God idea! Very helpful! Husband very supportive of my work and advanced studies.

I use all my experience with alcoholism, the alcoholic family, and grief in my clinical work. For examples - empathy and credibility - Have flourishing clientele.

I found this a difficult questionnaire. In the 33 years of our marriage, we have experienced very little marital stress since I began my practice. My major problems were around my mother-in-law who died soon after I finished my graduate work. Also, my studies helped me to handle her interventions in our life.

We spend weekends and some weeknights apart to be with friends and families and we do this with some consistence as we struggle with the issues of autonomy and coupling. Of interest to me is when did people come together (age) as it seems to influence the ability to couple and the type of couple you create. I think you need some information about the spouse as mine is the director of a battered women's shelter and also in the field. Would ask you to question more about prior marriage - divorce - prior attitudes as opposed to stressed times - have you dated a client - how long have you practiced and did you have a need for tx without marital stress (in the course of practice. We both believe good tx is a product of good supervision and good personal work and have been committed to ongoing therapy (as needed) as a commitment to ourselves and those we serve. Although we have an exclusive, committed relationship ours varies greatly from many in that we respect and encourage the individual needs/goals and won't sacrifice all for the couple. I believe this is a result of our age/experience/independence throughout life/and the effect upon us of the marriages we have seen and tx'd. Am eager to hear of the results and further studies.

An excellent instrument! I am interested in what was your stated hypothesis for this research. The marital distress I experienced, and

consideration of divorce as about 10 years ago. It was difficult therefore to answer #15 from today's perspective. Good luck in your work!

Most of my marital distress occurred while my children were young and I was a housewife. Since I began my own career, distress has decreased. The communication problems which are part of the dynamics of my marriage (and those of both families of origin) are gradually being worked on.

Question #16 is unclear as to how to answer; i.e. - sequential? (one of each?) - multiple use of same # allowable.

A timely and important study. I'm surprised to learn so little has been done in this area. (Several of the questions in this study, I found to be worded a bit ambiguously).

An interesting study - I wish you well in its completion. (Never married)

In this work, one can either be grateful for one's own good life, or one can magnify one's own dissatisfactions, as we work with others in difficulties. For me, I all the more appreciate my spouse.

Good luck. It's a needed area of study: one of the most helpful supports is being part of a practice. We support each other through our marital issues ranging from 1) single, 2) divorced, divorced and re-married, 3) long-term relationship 4) long-term married in scope. Thus the partnership (5 of us) covers most bases.

Over a 40 yr. marriage, there is room for a wide variety of responses. The responses given most effectively reflect my marital situation at this time.

Excellent questionnaire _ I will be most interested in seeing the results.

I've noted quite a high divorce/sep. and/or troubled-marriage rate in peer group. (I seem to be in the minority!) I would very much like a copy of your results. My husband I feel good about our ever-changing/ growing long-term marriage. Good luck!

My husband died on 12/1/84. We had been married almost 41 years. When we were married during WW II, we were called "the couple on the cake", and really believed in happily ever after. The early years were hard. We had both been spoiled, and marriage counselling was done rarely by trained therapists. When I went to my minister, he made a pass at me (to which--being very young and unable to "talk" to "my husband" -- I succumbed). Later, we went to a prominent psychiatrist who said my husband needed therapy. My husband refused. In time though, we matured

and became closer. The last 15 years of our life together were deeply satisfying. One factor in that was our taking couple communications program training as instructors and teaching other couples. We found it helpful to them, and to us.

My graduate work was done after our two children were grown. My husband too got an MBA, and, on retirement, we opened joint offices in W.N.C. His fatal illness terminated that, but I remain in private practice here.

Glad to see you research this.

Our marriage was characterized by 6 yr. history of communication problems, personality style conflicts, and power struggles. Basic conflict I was growing interpersonally and wanted my wife to do so also. In 7th year we entered business together and have been extremely happy since - because the business success requires personal growth. Therapy was short term by a friend while in graduate school.

After 52 years of marriage and 37 years of marital counseling - very little of this applies.

I like that you are doing this research and am glad I can help you.

Early in my practice, I would have been too intimidated to seek out conjoint therapy. During reflective moments with my spouse, she wonders about being too "inhibited sexually". At these times, I analyze my part in this and together we've considered sexual therapy and would be open to it. Then the moral issue of one of us being sterilized enters and we debate over having another child. This ambivalence seems to play a part in our sexual relationship.

Good luck. Sounds like a great study.

I married late after graduate school and WWII at approximately 27 years. I would not be of the same generation value standards of many in your survey. I never considered divorce ever nor do I believe my wife did. I was-am-somewhat surprised that I believe I'm happily married now to someone who is of similar social background; however my first wife was a M.S.W. also and the present is a non-degree person who holds an L.P.N. and also owned a small business.

These questions reflect a philosophical bias that evolving marital relationships are negative experiences rather than evidences of possible growth for the marital partners. They are irrelevant to my experience.

There are other factors related to this topic: A. age of therapy, B. Training of therapist, C. Family of orientation-ordinal position, D. Family of procreation - what have children done--their marriages - their therapy, etc.

Very interesting - have often wondered re: degree of divorce and/or marital conflict among colleagues - quite extensive! I've been most fortunate in 25 yrs. of marriage. However, husband is an M.S.W. school social worker - we met and spent 2 yrs. together in an M.S.W. program at the University of Denver - married following grad school - so we have similar training and orientation re: communication, etc. I also went on for Ph.D. in psychology and AAMFT approved supervisor status.

I find some of these questions difficult to answer. Individual therapy, I believe, needs to be done from a systems perspective, as mine was, and as I also work with individuals. Otherwise, it can be needlessly destructive to marriages.

You have a good topic, Cheryl. I hope all goes well for you. Thank you for letting me help.

Question 15. Illness of any kind is left out. You certainly stress marital over family therapy. While my family therapy was t------, I do think the potential is there for being more effective than marital and often employed as a first choice.

The questionnaire has too many forced choices and obvious biases in point of view, but I know how it is when you're doing a dissertation - you need something you can quantify. Good luck.

My marital experience is probably quite analytical. After a short, very stressful marriage, I remained single 38 yrs. My current marriage to a partner I'd known for 30 yrs. is going well. We've both worked out so many personal conflicts that afflict younger couples. I reared an adopted son as a single parent which gave me family experience.

With 24 years of marriage and 26 years of practice - these questions often cover a very wide range of personal experience. What was true in 1970 may be very untrue for 1980 and 1986.

If you use this questionnaire again, please make it clearer whether "marital" distress refers to clients or therapists. Another issue to consider is the professional of the partner. My husband is also my associate and colleague, and this definitely impacts on my answers because we are always aware of having to keep our relationship in good shape. We choose to use methods of communication and conflict resolution that we teach our clients and groups on our own relationship. Please note that when you include Canadians in a mail survey, you have to wait for over a month for returns.

This research design may have two problems: 1) does not address that marital therapists tend to be saviours who marry "sick" helpless or

disturbed individuals individuals to "save" them and that results in bad marriages. 2) individuals with "good" marriages are most likely to respond to the survey.

Good luck! You've undertaken quite a venture.

Spouse had premenstrual syndrome, resulting in once a month blow-ups for about four days month. I almost exited the engagement due to it; though at the time I didn't know what it was. Her threats of divorce occurred monthly, beginning after three weeks of marriage. Marital therapy was initiated after 6½ years when I first considered divorce. She got pregnant in therapy (which only lasted about 8-9 hrs.) and her PMS symptoms subsided. Thinking things were wonderful, shortly after therapy, I entered a specialty internship in marital and family therapy.

As a feminist and therapist, I believe every woman experiences marital distress. Male/female socialization creates power conflict that needs to be addressed by men and women.

As a feminist and therapist, I believe every women experiences marital distress. Male/female socialization creates power conflict that needs to be addressed by men and women.

I am admiring of your perseverance in your mailings. Good luck? Yes, results of benefit to me, I shared it with my spouse upon completion.

I found questions 17 and 18 a little confusing. On 17, I consider my wife a family member so I changed the answer. I do not talk with any other family members. In question 18, are you asking about disclosure of marital distress or disclosure in general? I answered for disclosure in general. For marital stress, I disclose to my wife, a therapist, and a professional colleague.

Please share your results with professional journal, such as A.A. Pastoral Counselors, A.A.M.F.T., the A.M.A. especially. As an R.N., please emphasize the value and need for self-disclosure for M.D. types. So many M.D.'s "play God" to own/patient detriment.

In future research, address the issue of a major external crisis preceding marital distress.

Question 15 seriously misses the significant problems in marriages - you have listed the "things" couples focus their conflict around. Yours is a content model, not process.

Very interesting and useful questions. Good luck with it.

During thirty-three years of marriage, it seems I've experienced a great deal of up and down. It's interesting to have become aware of this.

Very useful and timely. My professional choice in the early 50's was analysis. My wife had her therapist. I had mine. We fought it out at home with their support!

Experienced therapists are able to fragment work, play and personal cognitions and behaviors in productive ways. The level of distress could interfere with such compartmentalization but RSA, etc. help.

I genuinely feel I have been more fortunate in marriage than most people. My wife and I actually like each other and enjoy each other's company after 32 years!

I am interested in the perceived degree of importance or lack of importance formal religious practice has on the effectiveness of a therapist's work - i.e., values, etc.

I found some questions hard to relate to as I had marital therapy before I practiced it. However, I found this questionnaire interesting and not stressful (after 40 years, my marriage is better than ever).

I have consistently found some individual sessions with conjoint therapy helpful.

This questionnaire, while admirable in its intent, is flawed in its design. Prior consultation with a psychologist skilled in item construction would have improved it. My experience "falls between the cracks" in several items.

One of the most pertinent issues of our times have developed an affirmation process which has been very powerful.

I am probably in the minority in that I've been married for 38 years, and we've had our ups and downs. I am also a private person - as evidenced by many of my answers.

Being in an older marriage, I had difficulty knowing whether to respond according to earlier conflicted years or according to last decade of very satisfying marriage. Also I assume marital distress meant based on conflict, not based on caring, i.e., my spouse had recently had health problems and that has certainly caused me to feel distress. What you are doing is important, and I look forward to seeing the results in a major journal!

I feel strongly that MFTs should be willing to work as hard on their marital issues as we ask our clients to work, and be accountable for our own personal issues. I also feel strongly that every therapist should be a "patient" to clarify their own issues as well as know how it feels to be "on the other side of the desk." Hurrah for you! This should have been addressed long ago, and should be looked at consistently for MFTs accountability.

My own special interest has been family of origin therapy and impact of history and current relationships with family of origin on the therapy process, therapist's immediate own family, marriage, and even working relationships; as well as dealing with family of origin issues or supervision.

My current marriage is too "new" to be really relevant to your survey. Had I answered in terms of my previous marriage, the data would be significantly different.

My wife and I have been married 42 years with very little interpersonal trauma. It may be that this relationship (longstanding) had influenced, to a great degree, my response.

Due to the length of my own marriage, the periods of experience might apply to the first, second, third, or fourth decade of our relationship, but not throughout. But if it occurred at all, I tried to reflect it.

The scale needed to begin at 0; not at 1. Some of us have managed to have extremely good marriages. Main stress in mine was a child's death.

When I have had individual treatment, it has always been by a family therapist, so I was not sure how to answer #28, and #33. I think individual therapy done by someone who is not trained in systems is hazardous to marriage.

Am intrigued with idea that discreet self-disclosure can encourage model sharing by client.

Any person who has a stressful marriage has obviously not solved his/her problems and has no business trying to remedy in others what he/she cannot remedy in self.

I met my husband when he was beginning medical school and I was a sophomore at the same university. We took a graduate psychiatry course together after dating for two years. He has always been most supportive of my work or my role as mother and homemaker. We both agree that our marriage and family is the most significant event in our lives. It has given us great joy and stimulation to grow as individuals, as well as a couple. I should add that our own parents' marriages were very happy although his mother died when my husband was 2 yrs. old. Later his father remarried very happily. I enjoyed doing marital and family therapy when in active practice and I feel I was successful in many of these efforts. I wish more education concerning marriage would be available to high school students.

Most of my in-depth sharing are with colleagues, who became friends as distinguished from social companions to us as a couple. These "friends" were mine alone - not my spouse's. They were of both sexes. One

question you did not ask was - If you had a need not satisfied in the marriage, and how did you deal with it?

At last! Good luck on collecting results. Have you thought of sending a letter to the editor of AAMFT newspaper to prompt people to respond?

Questionnaire is well constructed and should provide much insight in to the needs of our colleagues. Responding should raise awareness of all who take the time. God's blessing on your endeavor. (Comment from individual who indicated "Never married, Catholic Priest.")

There should have been a "never" category for many answers. This is a good idea - good luck!

Great questionnaire - fits with work and training we are doing here. Soon to be published in Journal of Family and Psychotherapy special edition on Use of Self in Therapy. Our article (Winter & Aponte) on "The Person and Practice of the Therapist: Treatment & Training".

I suspect children would make a high difference in my responses. Good luck. You may be interested in the article in this June's Family Process on the influence of family of origin on family therapists' occupational choice.

I'm very much interested in this topic. While being a "therapist" and a spouse/parent is difficult, being married to one must be equally as difficult. A therapist's spouse must be willing to share her/his spouse with quite a number of vulnerable people.

Thought provoking. Thank you.

Since my husband and I are marital therapists, our life situation is somewhat different than that where a spouse is in a different field.

About fifteen years ago, I attended a workshop by one of the most prominent researchers/writers/clinicians in the mental therapy area. He reported on a study he conducted that he said he would never publish (apparently out of concern that it might unintentionally hurt some marital therapists). He found that those therapists who had themselves been divorced had a significantly higher frequency of divorces among their clients than did therapists who were single or never divorced. In other words, suggesting that the therapists' marital experience and values do affect the treatment process and outcome.

I hope you'll succeed in your doctoral studies, and that you will be able to help many therapists. Tell us why they tend to get into trouble, deeper and more often, than the people they are trained to help?

Interesting questions - good for stimulating a review in me. Some questions confusing - relate to therapy I do, or receive?

I think this is an interesting and important study you are involved in. I was divorced one year ago and pondered each of the questions you ask at some point during the divorce process. I am interested in the results of this study.

I found this to be a carefully worked out questionnaire and commend for your sensitivity and perceptiveness!! Also I am interested in learning from you what inspired or prompted you to do this?

Questions are poorly phrased; too much ambiguity in terms such as "self-help"; use of Rarely rather than Never as a choice. Wording of some questions reflects questioner's bias. Topic has validity but respondent's degree of honesty in answering may be questioned.

Thank you for the opportunity to reflect and to share----and my appreciation to you for tackling a much needed area for study and research.

Great work, Cheryl. Good luck. I am interested in your findings.

The questionnaire doesn't take a stand on, or distinguish between, the anxiety that marriage ingenders which is growth inducing; and that which reflects or leads to dysfunction. I and my wife "agree" that we must work at keeping our marriage alive; and we do not believe crises reflect poorly upon either of us, but rather a need to take care of us.

Appendix J. Table 1. Average Rating of Frequency of Behaviors associated with Marital Distress (Scale 1-4), from never to often)

How often:	Frequency $\bar{X}$	SD
Seriously considered divorce	1.964	.880
Spouse seriously considered divorce	1.810	.798
Separated for marital distress	1.141	.421
Spouse criticized therapist for using "psychological, argon & nonsense on them"	1.970	.890
Tried "self-help" measures for own marital distress	2.723	.931
Sought support and understanding for marital distress from someone other than spouse	2.383	.927
Attempted to deny marital distress	2.293	.882
Attempted to keep marital distress to self	2.731	.945

Appendix K. Table 2. Discriminant Analysis
Significances between Pairs of Groups

	Group 1	2
Group		
2	21.875 0.0000	
3	23.911 0.0000	14.400 0.0000

Each F statistic has 16 and 346 dF

Note: F statistics and significances were computed between pairs of groups after step 16 in analysis.

Appendix L. Table 3. Classification Function Coefficients
(Fisher's Linear Discriminant Functions)

WAVGCE =	1	2	3
AVGDTYR	.7544296	1.372348	1.087447
DTIME4	2.545612	3.326321	4.187368
DT	6.830427	4.987807	9.466767
FREQ5	2.144466	2.972453	2.613761
SOURCE2	1.873245	2.136100	2.756534
SOURCE3	.9579727	1.101251	1.610280
SOURCE4	2.575535	2.724966	3.975546
SOURCE5	1.491092	2.304423	2.448932
SOURCE6	.6391714C-01	.2840781	.8019090
SOURCE7	1.807449	2.040985	2.708245
SUPORT1	.7475013	.8791393	.3674072
SUPORT2	.2893491	.9395112	.4648376
SUPORT3	.7528873	1.121269	.8157010
SUPORT4	.4551563	1.104429	.8284564D-01
SUPORT5	.5721935	1.250251	.9337717
SUPORT6	1.384979	2.108190	1.617875
(CONSTANT)	-20.549407	-33.29928	-42.908985

APPENDIX M TABLE 4

CANONICAL DISCRMINANT FUNCTIONS

Function	Eigenvalue	Percent of Value	Cumulative Percent	Canonical Correction	: After Function	Wilks' Lambda	Chi-Squared	D.F.	Significance
1*	1.25673	67.08	67.08	0.7462445	: 0	0.2740715	457.56	32	0.0000
2*	0.61680	32.92	100.00	0.6176526	: 1	0.6185052	169.84	15	0.0

* Marks the 2 canonical discriminant functions remaining in the analysis

APPENDIX N TABLE 5

POOLED WITHIN-GROUPS CORRELATION MATRIX

POOLED WITHIN-GROUPS CORRELATION MATRIX

	AVGDTYR	CTIME4	DI	XFREQD	FREQ5	FREQ6	SOURCE1	SOURCE2	SOURCE3	SOURCE4
AVGDTYR	1.00000									
CTIME4	0.17387	1.00000								
DI	0.14610	0.30412	1.00000							
XFREQD	0.19684	0.18553	0.35372	1.00000						
FREQ5	0.11306	0.03663	0.13612	0.28511	1.00000					
FREQ6	0.16094	0.09054	0.04649	0.26116	0.16037	1.00000				
SOURCE1	0.10857	-0.03353	-0.07740	-0.01516	-0.10117	0.04645	1.00000			
SOURCE2	0.11181	-0.01248	-0.02942	0.10241	-0.00658	0.11258	0.04362	1.00000		
SOURCE3	0.08161	0.01138	0.01962	0.21610	0.17401	0.13120	0.01976	0.21378	1.00000	
SOURCE4	0.12770	-0.00687	-0.13439	0.00838	-0.03419	0.05165	0.06322	0.13397	0.07830	1.00000
SOURCE5	0.17402	0.03720	0.06001	0.07473	0.05372	0.04803	0.00330	0.01950	-0.03686	0.14695
SOURCE6	0.19556	0.13548	0.27396	0.40143	0.21518	0.23925	-0.05262	0.05544	0.01200	0.01047
SOURCE7	0.16862	0.11530	0.03217	0.18741	0.04621	0.17336	0.05290	-0.09751	0.01185	0.00114
SUPORT1	0.04421	0.10068	0.14073	0.14727	0.00401	0.00790	-0.00626	0.05493	0.09171	-0.00969
SUPORT2	-0.04844	0.12697	0.16333	0.19527	0.12644	-0.04100	0.01948	0.03764	0.07232	-0.03519
SUPORT3	0.05555	0.06582	0.14644	0.27730	0.06296	-0.07277	0.01085	0.00976	0.02998	-0.03913
SUPORT4	0.05762	-0.01226	0.07224	0.17581	0.02547	0.01881	-0.02826	0.01545	0.05774	-0.13986
SUPORT5	-0.03184	0.06131	0.15144	0.30311	0.11491	-0.02054	-0.00150	0.01338	0.01343	-0.04396
SUPORT6	0.04532	0.00643	0.08870	0.01838	-0.04802	0.02639	0.08831	-0.00641	0.03919	0.08093

	SOURCE5	SOURCE6	SOURCE7	SUPORT1	SUPORT2	SUPORT3	SUPORT4	SUPORT5	SUPORT6
SOURCE5	1.00000								
SOURCE6	0.13907	1.00000							
SOURCE7	0.07301	0.19473	1.00000						
SUPORT1	-0.00405	0.00557	-0.03832	1.00000					
SUPORT2	0.06402	0.09352	-0.01724	0.25725	1.00000				
SUPORT3	-0.00290	0.09224	0.04912	0.14972	0.16429	1.00000			
SUPORT4	0.01840	0.06935	-0.00257	0.00059	-0.07492	0.14424	1.00000		
SUPORT5	-0.00604	0.13591	0.10961	-0.00534	0.05644	0.16187	0.06433	1.00000	
SUPORT6	-0.11156	0.06096	-0.02485	-0.05174	0.02057	0.02990	0.16937	0.02062	1.00000

CORRELATIONS WHICH CANNOT BE COMPUTED ARE PRINTED AS 99.0.

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