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**FACTORS AFFECTING MOTHERS' AND ADOLESCENT SONS'
PREFERENCE FOR FAMILY COUNSELING APPROACHES**

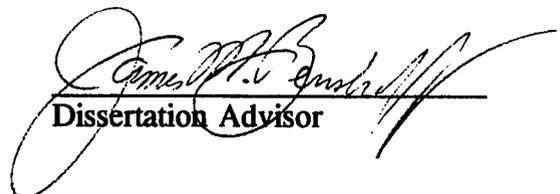
by

James Alan Wachsmuth

**A Dissertation Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy**

**Greensboro
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Approved by


Dissertation Advisor

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This study investigated whether the preferences of mothers' and adolescent sons' for three different counseling categories were affected by participant's (a) race, (b) socioeconomic status, (c) client status, (d) previous counseling experience, (e) total number of concerns, (f) most important concern, and (g) mother's level of depression. The three family counseling categories were the historical, structural, and experiential outlined by Levant (1980), and presented to the mothers and sons in a vignette format created by the researcher. The Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erlbaugh, 1961) was used to assess mothers' level of depression. A researcher-developed survey of presenting issues was used to identify mothers' and sons' concerns as well as the concern they identified as most important. Responses were received from 153 mother/adolescent son dyads, with 133 used in the final data analysis.

Two discriminant analyses were performed on the mother and adolescent son data to determine which client characteristics influence preference for the three family counseling categories. In addition, a Chi-Square analysis was performed to determine the difference in preference between mothers and adolescent sons.

Results of the discriminant analysis on the mother data indicated that the factors of race, and socioeconomic status were the best predictors for distinguishing preference between the historical family counseling category and the structural and experiential family counseling categories. The discriminant analysis on the adolescent son data indicated that none of the independent variables accounted for the preferences of adolescent sons for the three family counseling categories. Results from the Chi-Square analysis indicated a significant difference between the preferences of mothers and adolescent sons for the three family counseling categories. These findings suggest that preferences for family counseling categories are different for mothers and adolescent sons, and that for mothers these preferences can, to a certain degree, be predicted by race and socioeconomic status. The results have implications for the counselor/family relationship in treatment of mothers and adolescent sons.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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TABLE OF CONTENTS

	Page
APPROVAL PAGE	ii
ACKNOWLEDGEMENTS	iii
LIST OF TABLES	vii
LIST OF FIGURES	viii
CHAPTER	
I. INTRODUCTION	1
Need for the Study	7
Levant's Family Categorization System	12
Purpose of the Study	13
Research Questions	14
Definition of Terms	14
Organization of the Study	16
II. REVIEW OF RELATED LITERATURE	18
Family Structure	19
Rationale for Studying Mothers	21
Rationale for Studying Adolescent Sons	23
Family Counseling Approaches	24
Rationale for Family Counseling with Adolescents	25
Growth/Use of Family Counseling as a Treatment Modality	27
Levant's Classification of Family Counseling Approaches	28
Historical Model	29
Structure/Process Model	30
Experiential Model	31
Extensions of Levant's System	32

TABLE OF CONTENTS (continued)

	Page
II. (continued)	
Factors Influencing Participants in Counseling	34
Race	34
Socioeconomic Status (SES)	38
Previous Counseling Experience and Client Status	39
Number and Type of Presenting Concerns	41
Depression	43
Summary	45
III. METHODOLOGY	46
Research Hypotheses	46
Participants	48
Instrumentation	50
Beck Depression Inventory (BDI)	50
Problem Survey (PS)	52
Historical Experiential Structural Indicator (HESI)	53
Procedures	55
Analysis of Data	56
Discriminant Analysis	56
Chi-Square Analysis	57
Descriptive Statistics	57
Results of the Pilot Study	57
IV. RESULTS AND DISCUSSION	60
Results	60
Hypothesis 1: Comparing Preferences of Mothers and Adolescent Sons	64
Hypothesis 2a: Race as a Predictor of Preference	64

TABLE OF CONTENTS (continued)

	Page
IV. (continued)	
Hypothesis 2b: Socioeconomic status as a Predictor of Preference	65
Hypothesis 2c: Previous Counseling Experience as a Predictor of Preference	67
Hypothesis 3: Client Status as a Predictor of Preference	67
Hypothesis 4: Maternal Level of Depression as a Predictor of Preference	68
Hypothesis 5a: Number of Concerns as a Predictor of Preference	70
Hypothesis 5b: Most Important Concern as a Predictor of Preference	71
Summary	73
V. SUMMARY, CONCLUSIONS, AND IMPLICATIONS	76
Summary	76
Limitations	77
Conclusions	80
Recommendations for Future Research	84
Implications	87
BIBLIOGRAPHY	90
APPENDICES	100
Appendix A: Beck Depression Inventory (BDI)	100
Appendix B: Problem Survey (PS)	103
Appendix C: Historical Experiential Structural Indicator (HESI)	105
Appendix D: Consent to Act as a Human Subject	109
Appendix E: Demographic Data Questionnaire (DDQ)	110

LIST OF TABLES

	Page
Table 1. Living Arrangements of Children Under 18	20
Table 2. Demographic Information on Mother/Adolescent Son Dyads	50
Table 3. Group Centroids of the Discriminant Functions for Mother and Son Data	61
Table 4. Results of Discriminant Function Analysis of Predictor Variables - Mother Data	66
Table 5. Mothers Level of Depression	69
Table 6. Frequency of Mothers and Adolescent Sons With 1, 2, 3, and 4 Presenting Concerns	71
Table 7. Frequency of Mothers' and Adolescent Sons' Concerns Identified on the PS	72

LIST OF FIGURES

	Page
Figure 1. Canonical Discriminant Functions Evaluated at Group Means (Group Centroids) - Mother Data	62
Figure 2. Canonical Discriminant Functions Evaluated at Group Means (Centroids) - Adolescent Son Data	63

CHAPTER I

INTRODUCTION

One of the most difficult periods for a family can be when one of its members is going through adolescence. Adolescence is a period of rapid physiological, emotional, and behavioral change (Piaget & Inhelder, 1969). It is not surprising that during this time of change adolescents engage in many forms of problem behavior (Carlson & Lewis, 1993), and some families are faced with transitions that are potentially tumultuous. Often, these transitions cause the family to seek out counseling.

The tendency for adolescents to engage in problem behaviors has increased dramatically in the past decade (Carlson & Lewis, 1993). More adolescents today are engaging in gang activities (Ingersoll & Orr, 1993), substance abuse (Robinson, 1993), suicidal behavior (Capuzzi, 1993), and sexual activity (Hayes & Cryer, 1993). Parents are finding it increasingly difficult to handle their concerns regarding the adolescent's tendency toward at risk behavior and frequently are turning to counselors for assistance (Carlson & Lewis, 1993).

Many counselors believe that in treating adolescent issues such as delinquency, anorexia, and suicidal behavior, attention should be focused on the social context within which problem behaviors occur. Of the many areas that

affect an adolescent's life (e.g., family, peers, school, culture, and role models), the family is one of the most influential (Fishman, 1988). The foundation of the adolescent's growth comes from the family's history, and the support for that growth occurs in the family's interactions. While younger children need more guidance and protection, a new, more egalitarian relationship must develop between adolescents and their parents. With this change in relationship, problems often occur in the family in such areas as communication, problem-solving, effective parenting, and behavior management (Worden, 1991).

In the last three decades, counselors have acknowledged the family's continuing power to influence the course of treatment (e.g., Haley, 1976; Minuchin, 1974). Helping professionals recognize that counseling adolescents without considering and frequently including other family members decreases the likelihood of lasting change. An adolescent's problem that has its "roots" in the family is difficult to treat without the participation of principal family members. If the adolescent is treated outside of the family, change may occur; however, when adolescents return to the family without the support of counseling, they may revert back to former patterns of dysfunctional behavior (Fishman, 1988). In essence, while the client has changed, the rest of the family has not.

In examining parent-adolescent problems in the family, relationships and interactions between mother and adolescent have been shown to be critically important. Findings in the area of parent-adolescent issues indicate the pivotal

role of both the mother (Montemayor, 1983; Montemayor & Hanson, 1985) and adolescent male (Carlson & Lewis, 1991; Norman & Harris, 1981). The adolescent male is involved in more problematic behavior (Carlson & Lewis). Adolescent males engage in more tobacco, alcohol, and drug use and abuse than female adolescents (Norman & Harris). Antisocial behavior, juvenile crime, and aggressive behavior are more prominent in adolescent boys than girls (Winbush). More violent crimes like murder, rape, assault, robbery, and auto theft are committed by adolescent males (Winbush, 1993). In addition, Patterson (1982, 1986, 1990) consistently has reported on the incidence of the aggressive male child within coercive family processes.

Montemayor (1983) and Montemayor and Hanson (1985) found the highest level of conflict to be in the mother-adolescent relationship. The lowest conflict level was reported in the father-adolescent relationship. The greater frequency of conflict with mothers may be a result of different parental role definitions and different levels of involvement by mothers and fathers (Demo, 1992; Hawkins & Roberts, 1992). Thus, when issues arise, it is the mother who typically presents with the child or adolescent in counseling. Even with intact families that seek counseling, less than 30% of fathers participate in the actual family counseling process (Goldenberg & Goldenberg, 1985).

Patterson (1981) offers further evidence that it is often the mother that occupies the most focal position in the family. The role of mother can be more

stressful than that of the father since she is often the one responsible for responding to the children and adolescents in terms of discipline and related family matters. At times there can be little to no positive support for the mother from other family members. Although mothers may seek this positive reinforcement from their husbands, fathers often are unavailable due to work, other obligations, or emotional or physical separation (Lamb, 1981). Younger children frequently are unable to give the type of reinforcement the mother needs (e.g., words of affirmation, gifts), and adolescents are preoccupied as they struggle with their own individuation. Without this positive reinforcement, interactions between mother and child or mother and adolescent can be conflictual, leading to antisocial behavior in the youth or depression in the mother (Patterson, 1990).

The changing structure of families also suggests the need to focus on the mother-adolescent relationship. With 50% to 60% of all marriages resulting in divorce, more and more families are headed by a single parent for some period of time. These families are often mother-headed households (Carlson & Lewis, 1991).

A single mother can be faced with several problems including the high stress of single parenting, financial issues, and loss of social supports. Any of these pressures can contribute to depression in the mother (Sholevar & Schwoeri, 1994). This depressed mood of the mother can result in uninvolved parenting, poor monitoring of the adolescent's behavior, and/or periodic harsh discipline.

This in turn can result in coercive exchanges or conflictual behavior between the mother and adolescent son, increasing the likelihood that the family will seek counseling (Patterson, 1990).

The depressed mood of the mother also can result in poor decision-making about family and counseling-related issues (Patterson, 1990). Robbins (1993) suggests that depressed individuals are less likely to cope with a situation because of their inability to make decisions. The ability to make decisions is inherent in an individual being able to choose among options to indicate a preference (Gelatt, 1962; Gelatt & Clarke, 1967). Therefore it appears that maternal depression could be a factor in a mother's preference for a particular counseling approach.

Relatedly, the amount or type of psychosocial stressors may have an affect on preference. Again, in a cyclical explanation of the literature, the high stress of single-motherhood can increase risk factors associated with the mother's mental health (Patterson & Forgatch, 1990). The more stress a mother is under, the more likely she will have mental health concerns (Bank, Dishion, Skinner, & Patterson, 1990). The amount of stressors or concerns that an individual has affects decision-making (Rutter, 1992), and decision-making is a major component of preference (Gelatt, 1962; Gelatt & Clarke, 1967).

Maternal depression also can affect a mother's motivation for seeking help from a counselor. Cunningham, Shaffer, Reed, and Barbee (1990) reported that depression is negatively related to an individual's desire to help or to seek help.

In addition, mothers may not acknowledge their role in the adolescent's problematic behavior, preferring to blame other sources (e.g., peers, environment).

Adolescents also can be unmotivated in counseling. Adolescents entering counseling characteristically are impatient, intolerant, and uncommunicative (Kazdin, 1988). They often fail to elaborate on any issues or difficulties presented. They may deny any responsibility for the presenting issue, preferring to place the blame on something or someone else. Many times adolescents may have limited insight into the reasons why they have been referred for counseling (Brown & Prout, 1986). The application of various interventions such as "talking about one's concerns" may be more difficult than it would be with adults (Worden, 1991). Consequently, the value of counseling may not be apparent to adolescents.

Special efforts are needed to better understand mothers' and adolescents' views of counseling in order to enhance their motivation for counseling and perhaps increase the positive effects of treatment. These efforts include assessing preferences for family counseling approaches in agencies outside the school environment (Kazdin, 1988).

Determining clients' preferences can be important in the counseling relationship based on the client attrition rates in counseling. Thirty percent of all clients who seek counseling fail to return after the initial interview. Fifty percent of all minority clients who seek counseling do not return after the initial session.

Moreover, only eight percent of early dropouts from counseling seek alternative services (Lorion, 1978). These percentages reflect a waste of professional time and money; more importantly, however, they represent troubled individuals and families who do not receive help. Goldstein (1962a, 1962b) suggested that preference for a counseling approach is associated with clients' continuance in and profit from the counseling process. Devine and Fernald (1973) suggested that receiving a preferred rather than randomly assigned therapy has a significant positive effect on outcome.

The decision to include the client when making decisions about treatment goals varies among counselors. O'Donahue, Fisher, Plaud, and Curtis (1992) examined counselors' rationale for treatment choices. In only 29% of cases did the client's preferences influence the selection of treatment methods. When asked to describe the decision process that leads to the selection of treatment methods, 92% of the therapists responded either "That is what I always do," or "It seemed to make sense." O'Donahue et al. (1992) found that the therapist's own preferences were the most important influence in determining treatment methods.

Need for the Study

A family's preference for an approach to family counseling is an important factor for the counselor to consider when a family comes in seeking family counseling. Yet, clients' preferences for different theoretical approaches to individual counseling or family counseling have received minimal attention in the

literature. Most research conducted in the early to mid-1970s has produced inconclusive results. For example, Fancher and Gutkin (1971) found that college students, after reading a description of two behavioral theories and two insightful theories, preferred the insightful approach. Contradictory results were obtained by Holen and Kinsey (1975), however, who found that college students exposed to different counseling approaches preferred the behavioral counseling approach over both client-centered and psychoanalytic models.

A larger number of studies have investigated factors present in the client that may contribute to a preference for different theoretical approaches. For example, Stuehm, Cashen, and Johnson (1977) looked at the relationship between locus of control and preference for counseling. Marshall (1985) studied client learning style and preference. Other individual characteristics that have been explored in the preference literature include: cognitive characteristics (Neufeldt, 1978); gender (Cashen, 1979); race and social class (Anderson, 1983; Exum & Lau, 1988); previous experience in counseling (Hensley, Cashen, & Lewis, 1985); social intimacy (Mindingall, 1985); and personal epistemology (Lyddon, 1989). In addition to yielding inconsistent results, this research is not inclusive, with, in many cases, one study being done per factor.

Research has found that a high value is placed on family in the Black household (Foley, 1975). Black families are more likely to turn to their families, neighbors, friends, or ministers in times of crisis (Hines & Boyd-Franklin, 1982).

They have strong feelings about trust and opening up to "outsiders." The literature suggests (Hines & Boyd-Franklin, 1982; Sue & Sue, 1990) that Black families are likely to be most responsive to time-limited, problem-solving, child-focused, family counseling approaches. These findings suggest the need for further investigation of race as a variable in preference for counseling approaches.

Acosta, Yamamoto, and Evans (1982) suggested that SES has a significant impact on the type of counseling approach an individual prefers and/or needs. For example, low-income families live on such a limited income that setbacks can more easily become crises. They may prefer a counseling approach that will resolve their problems in a straightforward and short-term manner. Low-income clients may also show a reluctance to express or disclose their feelings, attitudes, or problems in the counseling process (Lorion, 1974). One study was found which examined socioeconomic status (SES) and counseling preference (Proctor & Rosen, 1981). No significant interaction effects were found between SES and client preference. The researchers suggested that their inconclusive results may have been due to disproportionate sample sizes or the lack of a significant difference between what is considered medium and low SES statuses. This literature suggests a need for further investigation examining the exact nature of SES as a variable in counseling preference.

Inconclusive results have also been found related to the effect that previous counseling experience has on differences among subjects in their preferences for

counseling approaches. Hensley, Cashen, and Lewis (1985) found that students with prior counseling experience preferred a behavioral approach while students with no experience in therapy did not exhibit a preference. The researchers suggested that the students with no counseling experience may have been unable to differentiate between the two approaches. They contend that some experience may be necessary in order to judge counseling techniques. This issue warrants further investigation.

Most research in the area of preference has been conducted on non-client populations such as undergraduate and graduate college students (e.g., Bernstein, Hofmann, & Wade, 1987; Lopez, Lopez, & Fong, 1991; Mau & Jepsen, 1988; Rich, Brooks, & Yechieli, 1989). Even those studies that included both clients and non-clients typically have had a heavier non-client population (e.g., Hensley et al., 1985). Other studies have produced contradictory results. Marshall (1985) determined that there was a difference in preference of counseling approach between clients and non-clients, while Dreman (1977) found that both clients and non-clients preferred the same type of approach to counseling. The inconclusive findings of these studies may be due in part to the subject pool being examined. To obtain a more accurate picture of client preference, studies need to compare preferences of actual client populations (e.g., families) with those of non-clients.

Only counseling approaches that treat the individual client have been explored in the preference literature (Anderson, 1983; Fancher & Gutkin, 1971;

Hensley et al., 1985; Holen & Kinsey, 1975; Lyddon, 1989; Stuehm et al., 1977).

These include counseling approaches that are behavioral, cognitive, psychoanalytic, and/or client-centered in their theoretical orientations. Literature on families' preferences for family counseling approaches is virtually nonexistent. Researchers have not explored families' preferences for approaches such as strategic, structural, or communications. Even approaches to family counseling that are behavioral or dynamic in their orientation and practice have not received attention. The paucity of information on preferences for family counseling approaches suggests a critical need for descriptive research in this area.

Accordingly, this study will examine the preferences of mothers and adolescent sons for three different categories of family counseling approaches.

In the research conducted on differences in preference of individuals for counseling orientation, researchers primarily have examined three approaches: behavioral/cognitive, psychoanalytic, and/or client-centered. Fancher and Gutkin (1971), Anderson (1983), and Hensley et al. (1985) examined the differences in preferences between two of the approaches. Holen and Kinsey (1975), Stuehm et al. (1977), and Lyddon (1989) examined differences in preferences among all three approaches. Levant's Family Categorization System (1980) categorizes family counseling approaches into these three common theoretical foundations.

Levant's Family Categorization System

A number of different family counseling approaches are being utilized in the field today. These include, but are not limited to: communications, strategic, structural, behavioral, Bowenian, experiential, rational emotive, Adlerian, and transgenerational. Many of these approaches share similar theoretical bases and primarily differ according to the techniques used (Goldenberg & Goldenberg, 1985; Gurman & Kniskern, 1981).

A model developed by Levant (1980) categorizes different family counseling approaches according to time perspective (focus on the past or present), focus of therapeutic change, role of the therapist, expected duration of counseling, and theoretical background of the approach. The three categories of family counseling approaches, as defined by Levant, are the historical, the structure/process, and the experiential.

The historical category includes the psychodynamic, multigenerational, and intergenerational-contextual schools of family counseling. Counselors who use approaches in this category believe that issues result from an over-attachment to individuals in previous generations. Issues are solved as clients gain insight into these attachments through interpretation by the counselor (Levant, 1980).

The structure/process model includes the family counseling schools of communication, structural, strategic, behavioral, functional, and problem-solving. These approaches share a common concern with current relationships within the

family. Past history is not considered to be particularly relevant and the role of feelings receives little to no emphasis (Levant, 1980).

The final category is the experiential which includes Gestalt, experiential, symbolic-interactional, and client-centered schools of family counseling. These approaches also are concerned with the here-and-now interactions of the family. However, they are more concerned with enhancing the quality of life of individual family members rather than changing the family system or reducing specific problem behaviors (Levant, 1980).

Purpose of this Study

Because families who seek counseling are not alike, families' preferences for counseling approaches are likely to vary considerably depending on the family, participant characteristics, and the type of problem faced. The primary purpose of this study was to determine and compare the preferences of mothers and adolescent sons for different family counseling categories. A second purpose of this study was to determine the degree to which race, socioeconomic status, and previous counseling experience of mothers and adolescent sons can be used in predicting preference for family counseling categories. Third, this study investigated the degree to which client and nonclient status can be used in predicting mothers, and adolescent sons' preferences for family counseling categories. A fourth purpose of the study was to determine the degree to which maternal depression can be used as a predictor of mothers' preference for family

counseling categories. Finally, the number of issues that mothers and adolescent sons identified as problematic, and their most important concern were examined to determine the degree to which they can be used as predictors of preference for family counseling categories.

Research Questions

This study focused on five questions:

- (1) What is the preference for type of family counseling categories for mothers and their adolescent sons?
- (2) To what degree do race, socioeconomic status, and previous counseling experience account for preference for family counseling categories?
- (3) To what degree does client and nonclient status account for preference for family counseling categories?
- (4) To what degree does maternal depression account for preference for family counseling categories?
- (5) To what degree does the number of identified concerns and type of concern that mothers and adolescent sons rate as most important account for preference for family counseling categories?

Definitions of Terms

Key terms are defined below to aid in the clarity of this study. Some terms refer to the dependent and independent variables used in this study.

Preferences: In the literature, there has been an inability to differentiate between preference and expectation. Grantham and Gordon (1986) and Cheatham and Patrick (1987) defined preference not as the process of arriving at a decision or the elements included in that choice, but as the actual choice one makes. For purposes of this study, preference was defined as the likelihood that a mother or adolescent son would go to see a family counselor who practices family counseling according to the description supplied. In addition, preference among family counseling approaches also was determined by a rank ordering of the three family counseling categories.

Families: Given the current high rate of divorce, resulting single-parent families (most of which are headed by single mothers), lack of paternal participation in counseling, and the high incidence of mothers and sons presenting for counseling, this study used mother and adolescent son dyads to represent families.

Adolescence: Adolescence usually is considered a time of both biological growth and critical developmental challenges. Developmental tasks for adolescents include individuation, identity formation, sex-role development, career choice, and moral development. Havighurst (1972) defines adolescent development in terms of tasks accomplished by the individual between 12 and 18 years of age. Adolescents between the age of 12 and 18 were used in this study.

Levant's Family Counseling Categorization System: The three categories proposed by Levant (1980) include the historical, structure/process, and experiential. Two major tenets of the family counseling approaches included in the historical category are that problems result from attachments to past generations, and problems are solved by clients gaining insight into these attachments. The structure/process category includes family counseling approaches that stress current patterns of interaction that exist within the family, and how these cause presenting concerns. The experiential category consists of family counseling approaches that are more concerned with enhancing the quality of life of each individual family member through the expression of feelings.

Previous Experience in Counseling: Previous experience in counseling refers to an individual's prior experience with individual, group, or family counseling.

Organization of the Study

This proposal is presented in three chapters. Chapter I is a brief introduction to the literature and empirical research associated with preference for different counseling approaches. The statement of the problem, need for the study, purpose of the study, research questions, definitions, and organization of the study are described. Chapter II presents a review of related literature, including a rationale for studying mothers and adolescent sons. Chapter II also elaborates on Levant's model and supporting models of family counseling categorization, and

explores factors that influence preference for counseling approaches. Chapter III describes the methodology used in the study, including research hypotheses, subjects, procedures and method of data analysis. Chapter IV presents the results of the data analyses. Chapter V includes a summary of the results, discussion of conclusions and limitations, and implications for the profession.

CHAPTER II

REVIEW OF RELATED LITERATURE

The escalation of adolescent problem behavior (Carlson & Lewis; Winbush, 1993) has increased the need for counseling services that often involve different family members. The mother and adolescent son can be integral figures in the family system and in family counseling. However, acquiring and maintaining the active involvement of adolescents often is a difficult task in any type of counseling. Determining an adolescent's preference for type of family counseling approach may be a way of resolving this issue. However, in the context of family counseling, counselors must concern themselves not only with the adolescent's preference, but also with the preferences of the parents involved. Parents are sometimes unwilling, reluctant, or unavailable to become involved in family sessions. For example, parents may initially deny any responsibility for the adolescent's "problem" and may not see the need for family sessions. Ascertaining the parent's preference for type of family counseling approach may be one effective way to engage them in the counseling process.

The supportive research and literature review for this proposal is divided into three main sections. The first section focuses on family structure and the rationale behind examining the mother-adolescent son relationship. The second

section looks at family counseling approaches in regard to counseling adolescents. This section also reviews Levant's (1980) classification system of family counseling and examines the main assumptions, goals, and techniques of each of Levant's three categories. The final section explores the literature on preferences for different aspects of counseling and the counseling relationship as well as individual characteristics that have been shown to influence participation in counseling.

Family Structure

"Typical American families" do not exist in today's society. Rather, it is more accurate to refer to types of families that have different organizational patterns, lifestyles, and living arrangements. Fewer than one in four American families fits the traditional description of the nuclear family consisting of a homemaking mother, wage-earning father, and dependent children all living under the same roof (Goldenberg & Goldenberg, 1985). There are extended families (nuclear family plus grandparents, aunts, uncles, or other relatives); blended families (husband, wife, plus children from previous marriages); single-parent families (household is led by one parent due to death, desertion, divorce, or never having married); gay couples; and cohabitation (Demo, 1992). Changes in living arrangements of black and white children under the age of 18 in the past three decades are illustrated in Table 1.

Table 1

Living Arrangements of Children Under 18

Living Arrangement	1960	1970	1980	1989
White				
Percentage living with:				
Two parents	90.9	89.5	82.7	79.6
Mother only	6.1	7.8	13.5	16.1
Father only	1.0	0.9	1.6	2.7
Other	1.9	1.8	2.2	1.6
Black				
Percentage living with:				
Two parents	67.0	58.5	42.2	38.0
Mother only	19.9	29.5	43.9	51.1
Father only	2.0	2.3	1.9	3.4
Other	11.1	9.7	12.0	7.5

Note. From U.S. Bureau of the Census, Marital Status and Living Arrangements, Current Population Reports, Series p.20. March 1988, No. 433, Table A-4; and March 1989, No. 445, Table 4.

Diversity in the structure of the family often can lead to difficulties. There can be strain on single-parent households where the primary care-giver attempts to provide for the entire families' needs, balancing family needs (emotional, physical, financial) with his or her own. Members of reconstituted families often struggle to learn the different behaviors of new members coming from homes affected by divorce, desertion, or death. Extended families that include grandparents, aunts, uncles or other relatives contend with such issues as lack of space or privacy and role issues (Goldenberg & Goldenberg, 1985). These families often turn to counselors as a resource for dealing with these kinds of problematic issues.

Rationale for Studying Mothers

Fifty to sixty percent of all marriages result in divorce (LaRossa, 1988), resulting in more families headed by a single parent. Ninety percent of single-parent families are mother-headed households consisting of single mothers and their children (Goldenberg & Goldenberg, 1985). In addition, most research conducted on parent-adolescent dyads has focused on mothers and sons (e.g., Bank, Patterson, & Reid, 1987; Hall, 1987; Patterson, 1982). This is due to the rising number of single-parent female-headed households created by death, divorce, and separation, as well as the traditional role of mother as primary caregiver (Carlson & Lewis, 1991). The resulting increase of responsibility for mothers in households of this nature can potentially lead to relational strains between the mother and adolescent son (Patterson, 1981).

Patterson (1981) has suggested that the mother is the pivotal person in a system of mutually aversive family interaction. The role of the mother often is structured in such a manner as to be more stressful than that of the father. Her role typically requires high rates of responding with very low levels of positive reinforcement. She seeks this positive reinforcement from the husband. However, given that the husband may be available for less than 50% of the family's waking hours, mothers often do not receive support in areas such as discipline. Most younger children seem to provide little direct reinforcement for mothers, and adolescents are primarily learning to deal with their own individuation (Patterson,

1990). The mother's interactions with children and adolescents then becomes a major source of aversive events.

Montemayor (1983) and Montemayor and Hanson (1985) found the highest levels of family conflict to be in the mother-adolescent relationship. The lowest level was reported in the father-adolescent relationship. Wierson, Armistead, Forehand, McCombs, and Fauber (1990) examined the differences between mothers and fathers regarding perceived parent-adolescent conflict. One hundred and twenty-two adolescents and their parents participated in the study. Wierson et al. found that mothers generally reported a less positive relationship, greater number of conflicts, and more intense discussions of conflicts with their adolescents.

Results of these studies have suggested that the greater frequency of conflict with mothers may be a result of different parental role definitions and different levels of parental involvement. Mothers frequently are involved more than fathers in enforcing family rules and confronting inappropriate interpersonal behavior (Demo, 1992). One reason that disciplinary interventions do not happen as frequently with fathers is because adolescents tend to spend less time with them (Lamb, 1981). Thus, when incidents of adolescent acting-out or at-risk behavior occur, it is most often the mother who is involved in the conflict and who goes for counseling with the adolescent (Barber, 1992).

Rationale for Studying Adolescent Sons

Recent social science research (Barber, 1992; Elliot, Huizinga, & Menard, 1989; Gecas & Seff, 1990) indicates an increased emphasis on adolescence as an important phase in the life course and the family as a context for understanding adolescent development and behavior. The rationale for examining adolescent sons in this study is two-fold. The rationale stems from the high incidence of at-risk behavior among adolescents (Carlson & Lewis, 1991) as well as the high occurrence of the male child being one of the primary participants in coercive family processes (Patterson, 1982).

Despite recent increases in female adolescent at-risk behaviors, it is still primarily the adolescent male who engages in more problematic behavior (Carlson & Lewis, 1991). In a survey of 160,000 adolescents, Norman and Harris (1981) found that boys engage in more tobacco, alcohol, and drug use and abuse than their female counterparts. Similar results were found by Newcomb, Chou, Bentler, and Huba (1988) in a survey of over 1,000 high school students regarding alcohol and marijuana use. Social deviance (antisocial behavior, juvenile crime, aggressive behavior) also continues to be more prominent in adolescent boys than girls. For example, most violent crimes (murder, rape, assault, robbery, and auto theft) are committed by adolescent males (Winbush, 1993).

Hetherington, Cox, and Cox (1978), Patterson (1986), and Hetherington (1987) consistently have reported on the incidence of the aggressive male child

within divorced and separated families. Known as the *Hetherington Effect*, studies by Hetherington et al. (1978, 1987) have shown that during the first year of separation, boys were significantly more aggressive and antisocial. Six years after the divorce, a significant number of the mothers were still having difficulty with aggressive behavior in their sons. Patterson (1986) has demonstrated that a pattern of maternal stress and depression and antisocial behavior in boys is cyclical and that deviancy in sons significantly contributed to the continuation of stress and depression in the mother. This increase in stress and depression results in poor maternal discipline, which in turn leads back to antisocial or acting out behavior in the adolescent (Patterson, 1986).

These statistics and studies clearly indicate the need for adolescent males to receive help from mental health professionals such as counselors. Because there is no single cause or defined pattern of adolescent problem behavior, there is no single type of intervention that is appropriate to every adolescent. Help can come in many forms such as individual, group, or family counseling. As stated previously, mental health care professionals identify the family as an integral component in counseling adolescents. The next section reviews some of the literature regarding the use of family counseling in the treatment of adolescents.

Family Counseling Approaches

The family frequently has the most resources with which to make changes (Fishman, 1988). It is for this reason that many counselors use family counseling

when working with adolescents. The family also is the social environment from which the adolescent emerges. It is the source of the most enduring relationships and the adolescent's primary source of financial support.

Rationale for Family Counseling with Adolescents

The family is a complex system composed of many smaller subsystems. The family is not a group of individual members, but rather a system that has an organization and structure. Various subsystems within the family (e.g., mother-father, father-son, mother-daughter-father, etc.) interact to form this system. When an individual within the system evidences disturbed behavior, the focus should be on the relationships between system parts (Bertalanffy, 1968).

Counselors acknowledge that counseling adolescents without considering the family system and its relationships can make it difficult to effect a change in the adolescent. An adolescent's problem that originates in the family can be unaffected by counseling when there is no participation by family members. If the adolescent is treated independently of the family, change may occur; however, when the adolescent returns to the family without the support of counseling, he or she may revert back to former patterns of dysfunctional behavior (Fishman, 1988).

There are several advantages to including family members in the process of counseling adolescents. First, by involving the entire family, the counselor moves the focus of the problem away from the adolescent, thereby freeing the adolescent from a position of blame as the "symptom carrier." Second, family members also

offer their own unique perspectives that may prove helpful in assisting with the concern. Third, family changes tend to have an immediate impact on all involved, and act to prevent development of problems in younger siblings. Finally, adding family members to the process may facilitate movement at various points of impasse (Worden, 1991).

Although different methods of treatment are used in counseling adolescents, family counseling appears to be at least as effective as individual, group, or other treatment approaches. Gurman and Kniskern (1981) examined 14 studies comparing non-behavioral family therapy with other modalities. Family counseling proved more effective in 10 of these and equally effective in the remainder. In a separate analysis, these authors also estimated the overall improvement rate for cases seen in family therapy to be 73%.

Although the debate continues as to whether individual or family counseling is the treatment of choice with adolescents (Offer & Vanderstoep, 1986), many authors (e.g., Clarkin, Frances, & Glick, 1981; Meeks, 1975; Sherman, 1972) agree that there are certain indications when family counseling should be considered. According to the above authors, any of the following criteria can indicate a need for family counseling with adolescents: (a) family interaction is influenced by the course of the symptom; (b) the adolescent's pathology is required to maintain a neurotic family homeostasis; (c) recent stress is affecting the whole family; (d) the adolescent controls or manipulates the parents; (e)

adolescent acting out behavior is the chief complaint; (f) symbiotic parent-adolescent relationship prevents individuation and adolescent symptoms result from problems in separating from parents; and (g) improvement of one family member has led to symptoms in another (Clarkin, Frances, & Glick, 1981; Meeks, 1975; Sherman, 1972).

Worden (1991) suggested the following additional indicators for family counseling with adolescents: (a) family patterns are clearly seen as inhibiting individual development; (b) siblings are close in age (family patterns may impact all adolescent children in similar ways); (c) parent-child or parent-adolescent coalitions are formed with other siblings; (d) there is psychological intrusion from extended family members (e.g., grandparents, aunts, uncles); and, (e) environmental demands (e.g., death, divorce, separation, unemployment, physical illness) are overloading the family's adaptive capacity.

Growth/Use of Family Counseling as a Treatment Modality

Family counseling has become a major approach and popular choice in the counseling field. Training programs are developing rapidly, and professional associations are setting standards for accrediting such programs (Goldenberg & Goldenberg, 1985). One of the first professional organizations for family counselors was the American Association of Marriage Counselors (AAMC). This organization, which is currently known as the American Association for Marriage and Family Therapy (AAMFT), credentials counselors, psychologists, and social

workers as marriage and family therapists. Currently, AAMFT has over 12,000 members and more than 45 regional, state, and provincial divisions in the United States and Canada. As of September 1, 1995, the International Association for Marriage and Family Counselors, the family counseling division of the American Counseling Association, has 7,626 members. Clearly, family counseling is a treatment approach that is widely used by a variety of mental health practitioners.

In addition, there are a variety of settings in which family counselors practice. Family counseling is currently practiced in schools, hospitals, mental health agencies, private practice settings, welfare agencies, and churches (Brown & Christiansen, 1986). A variety of family counseling approaches can be used in these settings to affect family functioning and enhance individual development (Carlson & Lewis, 1991). These approaches range from behavioral models (strategic, structural, problem-solving) to analytic models (Bowenian, intergenerational, psychodynamic) to humanistic models (experiential, communications, client-centered) (Goldenberg & Goldenberg, 1985). In order to better understand what counselors are offering their clients, it is necessary to classify the many types of family counseling approaches.

Levant's Classification of Family Counseling Approaches

Levant (1980, 1984) undertook the task of categorizing the many family counseling approaches based on their similarities. Through examining prevalent family counseling approaches, Levant (1980, 1984) classified family counseling

approaches into three categories, Historical, Structure/Process, and Experiential, based on several distinguishable characteristics, including:

1. The time perspective that is taken in viewing the family, whether oriented towards the generational history of the family, the broadly conceived present (that is, including the recent past in terms of the development of the presenting problem, and the immediate future in terms of therapeutic efforts to solve the problem), or the present moment (that is, the present in its most immediate here-and-now sense);
2. The focus of therapeutic change, whether it is to free individuals from their unresolved attachments to their family of origin, or to change the structure or process of the family as a social organization, or to create an intense affective experience for the members of the family;
3. The role of the therapist, including the degree and nature of the therapist's activity and the kinds of interventions used;
4. The expected duration of therapy, from short to long term;
5. The principal theoretical background from which the various schools have developed.

Historical Model

The historical model includes the psychodynamic, multigenerational, and intergenerational-contextual schools of family counseling. These approaches are concerned with the individuals within the system, with particular attention to those

elements of their interpersonal functioning that represent attachments to figures in the past and that will be transmitted to future generations. Basic to these approaches is a fundamental commitment to psychodynamic theory. Yet, through the integration of systemic concepts, this perspective has been broadened to include interactional patterns of a family of individuals (in particular, the transmission of interactional patterns over generations).

In general, the approach to counseling in the historical cluster of therapies involves freeing individuals from their excessive attachments to the previous generation. This occurs through a process of uncovering these attachments, gaining insight into their inappropriateness, and gradually giving them up. The counselor's role involves facilitation of this process, either through the interpretation of the relationship between past attachments and present behavior, or through "coaching" clients as they attempt to form more appropriate, present-oriented, adult relationships with members of their family of origin (Levant, 1980, 1984).

Structure/Process Model

Approaches associated with the structure/process model include communication systems family therapy, structural family therapy, strategic family therapy, and behavioral family therapy. In general, these approaches are concerned with current patterns of interaction within the family, and with the relationship of these patterns to the symptoms or presenting problem of the

identified patient. Some variation exists among these schools in whether the interactional patterns are viewed from a structural or process perspective, whether the primary goal is broad (change the structure) or more narrow (remove the symptom), and whether the orientation is drawn from systems theory or learning theory. As a group, however, they differ from historical approaches in dismissing history taking, uncovering, interpretation, and insight as irrelevant to the treatment process. In focusing at the system level, structure/process approaches give little or no consideration to the psychology of the individual. They also contrast with the experiential therapists in playing down the importance of feelings or affect in the treatment process (Levant, 1980, 1984).

Structure/process approaches to therapy involve reordering the family system in order to remove the dysfunctional elements that produced or maintain the symptom. The counselor's role is to diagnose the dysfunctional elements of the system and plan a series of interventions that will alleviate them. Directives, sometimes paradoxical, are used as a means towards this goal (Levant, 1980; 1984).

Experiential Model

The experiential model includes Gestalt, experiential, and client-centered schools of family counseling, as well as the humanistic-communicational approach of Satir. Experiential approaches are concerned with enhancing the quality of life of the individuals in the family rather than alleviating symptoms or changing the

family system. These approaches are based primarily on phenomenological theoretical orientations and emphasize providing an intensified affective experience for family members, so that their own self-actualizing processes will take hold. The counselor's role is facilitative, following and reflecting the process of family interaction and joining the family process as a genuine person (Levant, 1980, 1984).

Extensions of Levant's System

Levant's (1980, 1984) classification system has been supported by a similar classification system developed by L'Abate and Frey (1981). L'Abate and Frey suggested that there are three domains of human existence - emotionality, rationality, and activity (ERA). The E school, represented by Satir, Napier, and Whitaker, is similar to Levant's experiential category. L'Abate (1981) and L'Abate and Frey, like Levant (1980), described these therapies as prioritizing how feelings are experienced, expressed, and interpreted within family transactions. The R or rationality school is represented by the work of Boszormenyi-Nagy, Sparks, Steirlin, Bowen, and Framo. This categorization corresponds with the historical paradigm of Levant. The R school is distinguished by its psychoanalytic and cognitive prioritization of the role of thinking in overall family and individual functioning. Finally, the A or activity-oriented schools correspond to Levant's (1980) structure/process paradigm. Representative theorists include Jackson, Haley, Minuchin, Patterson, and Rabkin. These

theorists are systems and/or behaviorally oriented, and all emphasize changes in relationships and actual change outside the therapy office.

Further support of Levant's model is found in work by Foster and Hoier (1982) and Stanton (1981). In their review of systems and behavioral family counseling approaches, Foster and Hoier found that these two approaches exhibit many similarities. Both systems and behavioral family counseling approaches: (a) monitor behaviors and interpersonal interactions, (b) view family problems as a result of nonproductive interactions rather than individual pathology, (c) emphasize the present rather than past history, (d) view the goal of counseling as restructuring interactions, and (e) utilize techniques such as restructuring, reframing, coaching, and training. Stanton (1981) compared structural and strategic therapies and found that both emphasize the present, are concerned with process more than content, view family problems as stemming from faulty interactions, and see change as restructuring these interactions through behavioral assignments.

Levant's (1980) model allows the researcher to categorize a variety of types of family counseling approaches. Use of a classification system is important in the research examining preferences for family counseling approaches because of the time it can take for subjects to complete lengthy surveys, especially if a researcher is examining a multitude of family counseling approaches that may have as many similarities as differences.

Factors Influencing Participation in Counseling

The literature on preferences for counseling approaches has focused on individual approaches rather than family counseling. Research has been conducted on preferences that individuals have for different aspects of the counseling relationship such as counselor race and gender. In addition, research has focused on different subject characteristics. Inconclusive results have been found regarding the effect that factors such as race, socioeconomic status, previous experience in counseling, type of concern, and gender have on preferences in counseling. In this section, research findings related to preference on each of these variables will be reviewed.

Race

Race has been considered to be a factor in counseling preference. For example, Black families are more likely to turn to their families, neighbors, friends, or ministers in times of crisis (Hines & Boyd-Franklin, 1982). They have strong feelings about trust and opening up to "outsiders." Exploration of feelings may be uncomfortable for Black family members. Black families are likely to be most responsive to time-limited, problem-solving, child-focused, family counseling approaches (Hines & Boyd-Franklin, 1982; Sue & Sue, 1990). They expect a family counselor who is active and directive. Moreover, these characteristics could influence their preference for one type of family counseling approach over another.

A number of studies have examined differences in preference by race.

Anderson (1983) examined the preferences of three different cultural groups for two different counseling methods. Twenty four Black, 24 White, and 18 Mexican-American students were studied to determine their preference for either a directive (low facilitative techniques and high action-oriented techniques) or a nondirective (high facilitative techniques and low action-oriented techniques) counseling approach. Anderson found significant preference differences between the Black group and the combined group of Whites and Mexican-Americans. Whites and Mexican-Americans preferred the nondirective approach, while the Black group preferred the directive approach. Anderson also found a significant three-way interaction of cultural group by social class by counseling method. Lower class Black males rated the counseling methods like the Black females.

Exum and Lau (1988) conducted a study to determine the counseling approach preference of 50 Chinese students attending a large midwestern university. Students were asked to rate two videotapes, one exhibiting a directive counseling approach and one showing a nondirective approach. Preference was determined by a positive rating on the Counselor Effectiveness Rating Scale (CERS) developed by Atkinson and Carskaddon (1975). The respondents rate counselors on 5 dimensions: (a) counselor's knowledge of psychology, (b) counselor's ability to help the client, (c) counselor's willingness to help the client, (d) counselor's comprehension of the client's problem, and (e) respondent's

perception of the counselor as someone he or she would go to see to discuss a problem. Participants rated each item on a 7-point Likert scale ranging from good (1) to bad (7). Results indicated that Chinese students had a strong preference for a directive counseling approach rather than a nondirective approach (Exum & Lau, 1988).

Bernstein, Wade, and Hofmann (1987) examined the preferences of 169 students (freshman through graduate) at a large midwestern, urban university. Of the total sample, 51 Black and 49 White females and 23 Black and 46 White males completed the Counselor Preference Scale developed by Parham and Helms (1981). The CPS measures preference for race, sex, age, and level of experience of a counselor. Both Black and White subjects tended to prefer Black counselors. Only 19% of White subjects expressed a preference for a White counselor. These findings may reflect race relations in the particular community surveyed, or the fact that the study was conducted in a large, urban university where a substantial proportion of students and staff is Black. It is possible that more White students would expect to see Black counselors. Social desirability may have had an effect on suppressing White students' expression of no preference or of preferences for White counselors, particularly because the data was collected by a Black researcher (Bernstein, Wade, & Hofmann, 1987).

Mau and Jepsen (1988) surveyed 148 American and 102 native Chinese graduate students at a United States University on their preferences for counselor

characteristics, images of counselors, and attitudes toward counseling services.

They found that, although both groups agreed that counselor characteristics were not of great importance, the Chinese subjects expressed a preference for older counselors with the same racial background.

Proctor and Rosen (1981) compared the preferences and expectations of 34 male (26 White and eight Black) veterans seeking counseling at a Veterans Administration outpatient mental health clinic. Results showed that although about half of the White clients and half of the Black clients indicated that they had no preferences, White clients did not express preferences for Black counselors and Black clients did not express preferences for White counselors. The significant association between race and client preference for counselor race suggested that clients having definite preferences prefer counselors of their same race.

Research in the area of race and its relation to preference of counseling approaches has produced varied results. Findings suggest that a relationship may exist between race and the counseling preference of individuals. Studies also suggest differences in preferences of individuals for aspects of the counseling relationship other than approach (like race and gender). However, all of the studies that were conducted in the area of race, focused on individual counseling approaches. No research was conducted in the area of family counseling.

Socioeconomic Status (SES)

Socioeconomic Status (SES) also has been examined as a factor in counseling preference. Acosta, Yamamoto, and Evans (1982) suggested that SES has a significant impact on the type of counseling approach an individual prefers and/or needs. Low SES clients are less obsessional about how they relate to life. In addition, they live on such a limited income that setbacks can more easily become crises. They are less likely to accept a plan of counseling that will take several months or even years. They may prefer a counseling approach that will resolve their problems in a straightforward and short-term manner (Acosta et al., 1982). Low-income clients may also show a reluctance to express or disclose their feelings, attitudes, or problems in the counseling process (Lorion, 1974).

Proctor and Rosen's (1981) study also examined SES as a variable in counseling preference. No significant interaction effects were found between SES and client preference. These inconclusive results may be due to disproportionate sample sizes or the lack of a significant difference between what is considered medium and low SES statuses. The literature suggests a need for further investigation examining the exact nature of SES as a variable in counseling preference.

Of the studies outlined above, only Proctor and Rosen's (1981) utilized an actual client population, and their sample size was relatively small (N= 34). Using a nonclient population raises serious questions as to applicability of research

findings to actual clients. Counseling clients may give more careful consideration to their responses about counseling issues because they are more personally involved. Research also indicates that prior experience in counseling (which an actual client population usually has) allows an individual to better evaluate preferences (Hensley et al., 1985; Marshall, 1985).

Previous Counseling Experience and Client Status

Marshall (1985) explored the relationship between client learning style and preference for counseling approach. She hypothesized that clients would prefer counselors whose counseling approaches corresponded to their own learning styles. Specifically, concrete experience learners would prefer an experiential or Gestalt approach; abstract conceptualization learners would prefer a rational or cognitive approach; active experimentation learners would prefer a behavioral approach; and reflective observation learners would prefer a client-centered approach. Her participants were 205 counseling clients from urban areas and 75 nonclient university students. Although results of the study did not provide support for the four-way counselor-client matching model, a difference in preferences was found between clients and nonclients. Clients preferred the rational or cognitive approach, while nonclients preferred the client-centered approach. These results indicate that the preferences of actual clients may differ from those of nonclients.

Hensley et al. (1985) compared the preferences of 100 university students (46 with prior experience in counseling and 54 with no prior counseling

experience) for a behavioral approach to counseling and a client-centered approach. The students viewed videotapes of the two approaches utilizing the same client and counselor, and then were asked to rate which approach they thought would be more effective in helping a client. Results showed that students with prior counseling experience preferred a behavioral approach while students with no experience in therapy did not exhibit a preference. Those with no counseling experience may have been unable to differentiate between the two approaches, believing that since the tapes represented two ways of doing the same thing both approaches were acceptable. As in other areas of life, it may well be that some experience is necessary in order to be an adequate judge of effective techniques.

Dreman (1977) found contradictory results in examining the preferences and expectations of clients versus nonclients at Hebrew University in Jerusalem. The sample consisted of 100 nonclients and 100 students who had approached the University's counseling center for counseling services. A questionnaire was administered to subjects regarding preferences and expectations about the counseling service. In particular, the questionnaire assessed preferences about counselor activity. Dreman found that both clients and nonclients preferred a more directive approach to counseling.

These studies are inconclusive as to the effect that previous counseling experience or client/nonclient status has on differences among subjects in their

preferences for counseling approaches. The current study addressed this void in the literature by examining differences in preferences between clients and nonclients. It also used previous experience in counseling as an independent variable in looking at mother and adolescent son preference.

Number and Type of Presenting Concerns

By pulling together related research, a relationship can be said to exist between number of psychosocial stressors and preference. High stress, especially that associated with single-motherhood, can increase risk factors associated with the mother's psychological status (Patterson & Forgatch, 1990). The more stress that a mother is under, the more likely she will have mental health concerns. Stress in single-mothers can lead to social-interactional concerns, discipline-related problems that can translate into acting out behavior by the adolescent at home or in school (Bank et al., 1990). High stress in single-mothers can also cause emotional concerns like depression, or concerns related to finance (Patterson, 1990).

Rutter (1992) suggests that the amount of psychosocial stressors can affect an individual's decision-making capabilities. Individual differences in decision-making can be explained by the amount of psychosocial stressors or concerns that a person has, as well as the social context within which the stressor occurs. In turn, decision-making is a major element in making a choice as they relate to preference (Gelatt, 1962; Gelatt & Clarke, 1967). Given these findings, it may be

reasonably hypothesized that the number of concerns may have an affect on preference for family counseling approaches. The current study investigated this hypothesis.

Preference for counseling modalities has been found to differ according to the type of concerns that clients bring to the counseling situation. Bertocci, Hirsch, Sommer and Williams (1992) conducted a mental health needs assessment survey of 344 students at Columbia University. The survey was intended to assess the mental health concerns of students as well as their preferences for treatment. Bertocci et al. (1992) found that treatment preferences varied significantly depending on the type of mental health concern that was addressed. Those students who identified drug use, eating problems, self esteem, anxiety, depression, suicidal/homicidal thoughts, sexual assault/harassment, and academic problems as the most troublesome preferred individual counseling over other treatment options. Students that were troubled by their physical health, love relationships, and separation difficulties preferred peer counseling. Students dealing with alcohol use preferred small group sessions. Finally, those students concerned about sexually transmitted diseases and AIDS preferred educational presentations.

Bertocci et al. (1992) did not suggest reasons for the significant difference in preference of treatment according to mental health concern. It appears that when matters of a more personal nature arose (e.g., eating problems or

depression), individual counseling was preferred. Peer counseling was preferred for issues that adolescents often speak about with friends (e.g., relationship concerns). The results of this study are inconclusive. Questions still remain as to the relationship between presenting concerns of clients and their preference for a certain type of counseling.

Depression

The role of a single mother can be highly stressful due to financial issues, loss of social supports, and increased responsibility. Maternal depression can result (Sholevar & Schwoeri, 1994) and lead to uninvolved parenting, poor monitoring of the adolescent's behavior, periodic harsh discipline, and/or poor decision making (Patterson, 1990). Coercive exchanges can occur between mother and adolescent son that are circular in nature. As the level of stress increases in the mother, so too may her level of depression. If the adolescent decides to act out, the depressed mother's reaction is frequently one of inaction. Antisocial behaviors become reinforced and over time contribute to the maintenance of the mother's stress and depression, thus creating a cyclical pattern.

All of the above may in turn cause the family to seek counseling. Depression can affect an individual's decision-making processes, from whether or not to seek counseling (Cunningham, Shaffer, Reed, & Barbee, 1990; Halgin, Weaver, Edell, & Spencer, 1987) to what preferences they have (Gelatt, 1962; Gelatt & Clarke, 1967). Cunningham et al. (1990) reported that depression is

negatively related to an individuals' desire to help or to seek help. As an individuals' level of depression increases, their desire to seek help decreases. Halgin et al. (1987) examined 429 college students to determine if level of depression affected their attitudes toward seeking professional psychological help. They found that depressed college students were less likely to seek help than those who were not depressed. Previous experience in counseling was found to be a mediating factor.

Level of depression can be a factor that affects preference. The ability to make decisions is inherent in an individual being able to choose among options to indicate a preference (Gelatt, 1962; Gelatt & Clarke, 1967). Mechanic (1975) suggested that the factor that most influences counseling approach decisions is level of subjective distress. Depressive symptomatology appears to be a common manifestation of stress or distress. Pietromonaco and Rook (1987) investigated the contribution of cognitive factors to the decision style of depressed individuals. In examining 89 college students with varying levels of depression, they found that depressed individual's cognitive analyses of common life situations leads them to make decisions that promote their social isolation and, thereby, perpetuate their depression. Robbins (1993) suggests that depressed individuals evidence poorer coping skills when it comes to problematic situations because of their inability to make decisions.

A direct relationship between level of maternal depression and preference for family counseling approaches has not been examined in the literature. However, researchers have shown that maternal depression can have an affect on the family system (Patterson, 1990; Sholevar & Schwoeri, 1994). They have shown that depression influences an individual's decision-making (Cunningham et al., 1990; Halgin et al., 1987; Pietromonaco & Rook, 1987; Robbins, 1993). And they have shown that decision-making is a major component in preference. Given these findings, it may be reasonably hypothesized that depression may have an affect on preference for family counseling services. The current study investigated this hypothesis.

Summary

In summary, studies in the area of preference exhibit limitations in: 1) their use of non-clients as opposed to clients, 2) their focus on individual counseling approaches as opposed to family counseling approaches, and 3) their inconclusiveness regarding how different subject characteristics, like race, SES, and previous counseling experience, affect preference. Although research has not been able to draw any conclusive results, it does appear that many of these variables warrant further investigation.

CHAPTER III

METHODOLOGY

A review of the literature provides evidence that factors such as race, socioeconomic status (SES), previous experience in counseling, and client/nonclient status may affect the preferences that individuals have regarding various aspects of the counseling process, including the type of counseling approach that they prefer. In this chapter, the methodology for the study is presented. This includes research hypotheses, descriptions of participants and procedures, and data analysis procedures.

Research Hypotheses

From the research questions outlined in chapter one, five hypotheses were examined.

- (1) There will be a significant difference in mothers' and adolescent sons' preferences for particular family counseling categories.
- (2) There will be a difference in preference for family counseling categories for mothers and adolescent sons by three different variables:
 - (2a) There will be a difference in preference for family counseling categories for mothers and adolescent sons according to their race.

- (2b) There will be a difference in preference for family counseling categories for mothers and adolescent sons according to their socioeconomic status.
- (2c) There will be a difference in preference for family counseling categories for mothers and adolescent sons according to their previous experience in counseling.
- (3) There will be a difference in preference for family counseling categories between mothers and adolescent sons who seek counseling and those who do not.
- (4) There will be a difference in preference for family counseling categories between depressed and non-depressed mothers.
- (5) There will be a difference in preference for family counseling categories depending on two factors related to presenting concerns:

 - (5a) There will be a difference in preference for family counseling categories for mothers and adolescent sons according to the number of concerns they present with.
 - (5b) There will be a difference in preference for family counseling categories for mothers and adolescent sons according to the concern that they identify as most important.

Participants

This study focused on families with adolescent sons between the ages of 12 and 18 years. Two populations were used for this study. The first population was mothers and adolescent sons who seek counseling or were referred for counseling at Family and Children Services in High Point, North Carolina, Family and Children Services in Winston-Salem, North Carolina, and Youth Focus in Greensboro, North Carolina. The issues that these families typically bring to the agency include interfamilial conflict, adolescent acting out behavior, and school related problems. The second population consisted of mothers and adolescent sons who have not presented for or who are not currently in counseling. These participants were selected from area churches and non-counseling youth organizations (YMCA and YWCA) in Greensboro, High Point, and Winston-Salem, North Carolina.

Participants consisted of 138 mother and adolescent son dyads from divorced families. There were 72 (52.2%) White, 61 (44.2%) Black, and 5 (3.6%) Hispanic mother-son dyads. The 5 Hispanic dyads were not included in the analyses because they were underrepresented as compared to Black and White dyads. This left a total of 133 mother and adolescent son dyads for analysis. Mothers' age ranged from 28-50 ($M=36.6$, $SD=4.1$), while sons' age ranged from 13-17 ($M=14.1$, $SD=1.1$). Within the household, 21 (15.8%) of the adolescent sons had no other siblings, 48 (36.1%) had one sibling, 41 (30.8%) had

two siblings, and 23 (17.3%) had three siblings. In addition, 104 (78.2%) households had no adult besides the mother residing there, 28 (21.1%) had one other adult living in the household, and only 1 (0.8%) had 2 other adults living in the household. Out of the 133 mother and adolescent son dyads, 63 (47.4%) were seeking counseling while 70 (52.6%) were non-client dyads. Fifty two (39.1%) of the mother-son dyads reported having some kind of previous experience in counseling. Eighty one (60.9%) of the dyads reported having no previous counseling experience.

Socioeconomic status was determined using Duncan's Socioeconomic Index (1961). Factors used to calculate SES in this model are occupation and education. Using Duncan's occupational prestige ratings and subsequent updates by Stevens and Cho (1985) and Stevens and Hoisington (1987), the dyads were classified into upper, middle, and lower socioeconomic (SES) groups. Twenty-five dyads were classified as "upper" SES (Prestige score between 40.00 and 99.99). Eighty one dyads were classified as "middle" SES (Prestige score between 21.00 and 39.99). Twenty-seven dyads were classified as "lower" SES (Prestige score between 14.53 and 20.99). Table 2 summarizes the data on race, previous counseling experience, client/non-client status, and socioeconomic state (SES).

Instrumentation

Beck Depression Inventory

The Beck Depression Inventory (BDI) is probably the most frequently used self-report method of assessing depressive symptoms. Originally developed by

Table 2

Demographic Information on Mother/Adolescent Son Dyads

Variable	Frequency	Percent
<u>Race</u>		
Black	61	44.2
White	72	52.2
Hispanic	5	3.6
<u>Counseling Experience</u>		
Previous counseling	52	39.1
No previous counseling	81	60.9
<u>Client Status</u>		
Client	63	47.4
Non-client	70	52.6
<u>Socioeconomic Status (SES)</u>		
Upper	25	18.8
Middle	81	60.9
Lower	27	20.3
<u>Number of Siblings in the Household</u>		
No Siblings	21	15.8
One Sibling	48	36.1
Two Siblings	41	30.8
Three Siblings	23	17.3
<u>Number of Other Adults in the Household</u>		
No Other Adults	104	78.2
One Other Adult	28	21.1
Two Other Adults	1	0.8

Beck, Ward, Mendelson, Mock, and Erlbaugh (1961) as an interviewer-assisted procedure, it consists of 84 self-evaluative statements grouped into 21 categories. The categories assess the affective, cognitive, motivational, and physiological symptoms of depression. For each of these categories of symptoms, there is a numbered series of four alternative statements, ranging from neutral (e.g., "I don't feel sad") to a maximum level of severity (e.g., "I am so sad that I can't stand it"). The items are scored from 0 to 3, so that the total BDI score can range from 0 to 63. Generally, a total BDI score of 0-9 indicates a nondepressed state, 10-15 reflects a mild level of depression, 16-23 reflects a moderate level of depression, and 24-63 indicates severe depression (Shaw, Vallis, & McCabe, 1985).

The BDI has good to excellent reliability and validity. Split-half reliability coefficients average .86 indicating high levels of internal consistency (Beck & Beamesderfer, 1974; Strober, Green, & Carlson, 1981). With respect to convergent validity, the BDI correlates well with other self-report measures of depression and with clinician's ratings of severity of depression (Davies, Burrows, & Poynton, 1975).

In this study mothers completed the BDI. Four levels of depression were assessed based on generally accepted BDI levels (Shaw, Vallis, & McCabe, 1985). A score of 0-9 for mothers indicated no depression; 10-15 indicated a mild level of depression; 16-23 indicated moderate depression; and 24-63 indicated severe depression (see Appendix A).

Problem Survey

Oster, Caro, Eagen, and Lillo (1988) suggest that assessment devices that are particularly long may cause the adolescent to adopt a more negative orientation to completing the assessment process. Given the large number of specific problem areas ($n=208$) on the Personal Problems Checklist developed by Schinka (PPC; 1984) and the time it would take both mother and son to complete the checklist, an alternate method to assess presenting concerns was used. The Problem Survey (PS; see Appendix B) was a researcher-developed survey of presenting issues based on the 13 factors identified by Schinka in the Personal Problem Checklist (PPC; 1984). The PPC is a self-report measure that allows an individual to indicate problem areas. The instrument provides written documentation of presenting problems from the client's perspective and is broken into 13 general problem areas (social, appearance, work, family or home, school, financial, religious, emotional, sexual, legal, health, attitude, and crisis problems). Subsumed under each general problem category are specific areas that the individual checks. In examining the reliability and validity of the PPC, Hinkle, Sampson, and Radonsky (1991) found a one week test-retest correlation of .91. The same authors examined the convergent validity of the PPC with the Mooney Problem Check List (MPCL). They found significant validity between the paper-and-pencil version of the PPC and the MPCL ($r=.91$, $p<.001$), as well as the computer assisted PPC and the MPCL ($r=.83$, $p<.001$). This suggests that the

PPC accounts for a significant amount of the variance in measuring personal problems.

Historical Experiential Structural Indicator (HESI)

The HESI was developed by the researcher to assess participant preferences for each of Levant's (1980) three categories of family counseling (Historical, Experiential, Structural). Brief family counseling vignettes were developed by the researcher to represent each of Levant's categories.

Concise descriptions of Levant's (1980) three categories of family counseling (historical, structure/process, and experiential) were given to ten independent expert raters. Raters also were given three untitled vignettes representing Levant's (1980) three categories, and asked to determine how closely they matched the descriptions by assigning each a number that represented each of the categories. Raters included two doctoral level students in counselor education at the University of North Carolina at Greensboro and four professors from counseling programs in the United States. Four family counselors from family counseling agencies in various parts of the United States also acted as raters. Raters had a minimum of two years of experience doing family counseling, with family counseling experience ranging from 2 - 25 years ($M=8.7$). One hundred percent agreement was obtained among raters that the vignettes accurately reflected Levant's three classification categories. Vignettes were constructed on a fifth grade reading level using the Fog Index (Gunning, 1952, 1956)

Following each vignette, mother and adolescent son were asked to circle the answer to the following question:

Would you go see the family counselor described above?

Answer choices were as follows:

- (1) I **definitely would** go to see this family counselor.
- (2) I **probably would** go to see this family counselor.
- (3) I **am not sure** whether or not I would go to see this family counselor.
- (4) I **probably would not** go to see this counselor.
- (5) I **definitely would not** go to see this counselor.

At the end of the three vignettes, subjects were asked to rank order the three descriptions according to which they preferred. A "1" represented the most preferred family counseling category, while a "3" represented the least preferred (see Appendix C).

Thus, preference, as used in this study, was assessed on two different levels. On one level, preference was assessed by determining the appeal of a certain category of approaches (e.g., "Would you go to see the family counselor described above?") on a Likert-type scale. On another level, preference among categories was determined by having participants rank order the three categories of family therapy in order of preference.

Procedures

All mother and adolescent son dyads were given a packet consisting of a consent form, Demographic Data Questionnaire, the Historical Structural Experiential Indicator (HESI), the Problem Survey (PS), and the Beck Depression Inventory (BDI). Only the mother was to complete the BDI. Clients seen at Family and Children Services in the Triad area are often instructed to arrive about 10-15 minutes early in order to fill out appropriate paperwork (billing, insurance forms, etc.). In this study, mothers and adolescent sons from the client group were given the packet upon entering the agency for the initial intake interview. They were instructed to arrive about 20-30 minutes early to allow additional time to complete the packet. So the mother and adolescent son would not be influenced by the particular approach of their initial counselor, they were instructed to complete the packet in the waiting area prior to entering the initial session. Counselors at these agencies were amenable to allowing mother and son time to complete the packet. Mothers and adolescent sons from the nonclient group were given the packet during initial contact by the researcher or staff at the YWCA/YMCA.

Participants were given a consent form (see Appendix D) which briefly described the study, terms of confidentiality, and dissemination of results. Mothers and adolescent sons then determined if they wished to participate in the study. Mothers and adolescent sons who agreed to participate signed the consent

form and began by filling out the Demographic Data Questionnaire - DDQ (see Appendix E). The DDQ was used to collect relevant demographic information to examine if relationships exist between subject characteristics and their preference for the types of family counseling approaches. Once mothers and sons completed the DDQ, they were instructed to individually complete the modified PS and the HESI. Mothers were instructed to complete the BDI. A total of 389 packets were distributed to both the client and nonclient dyads who met the requirements of the study. Mother and adolescent son dyads who were seeking counseling services returned 71 surveys, while nonclient mother/son dyads returned 82 surveys for a total of 153.

Analysis of Data

Discriminant Analysis

Discriminant analysis is used to determine which combinations of independent variables are helpful in predicting a dependent variable most accurately (Kleinbaum & Kupper, 1978). In this study, discriminant analysis was used to determine the ability of independent variables (race, SES, previous experience in counseling, client/non-client status, number of presenting concerns, most important concern, mother's level of depression) or combination of these variables to predict mothers' and adolescent sons' preference for a family counseling category.

Chi-Square Analysis

Chi-square analysis is used when a large number of random samples of the same size are drawn from a normally distributed population to be compared (Kleinbaum & Kupper, 1978). In this study, chi-square analysis was used to determine differences in preferences between mothers and their adolescent sons.

Descriptive Statistics

Descriptive statistics were used to make the information from large sample sizes more manageable. Means were calculated to determine preference scores for two racial groups (Black, and White); three socioeconomic levels (high, medium, and low); two levels to indicate participation in previous counseling (yes and no); and two subject classifications (client and nonclient). Percentages were examined to determine which of Levant's (1980) categories is rated as most, middle, and least preferred.

Results of Pilot Study

A pilot study was conducted from May - August 1994 in order to investigate the first three research questions contained in the final study. The population in the pilot study consisted of 42 mother-adolescent son dyads. Of these dyads, 47.6% ($n=20$) were seeking counseling services. The remainder ($n=22$) were nonclients. Approximately 59.5% ($n=25$) of the mothers liked the structural category most, with 38.1% ($n=16$) preferring the experiential, and 2.4% ($n=1$) preferring the historical. The sons showed similar results with 52.4%

($n=22$) preferring the structural category, 38.1% ($n=16$) preferring the experiential, and 9.5% ($n=4$) preferring the historical category.

Results from the discriminant analysis on the pilot study data indicated slightly different results for mothers and adolescent sons. Socioeconomic status and race were the best predictors of mothers' preference for the different counseling categories. More Black mothers preferred the structural family counseling category (66.7%) than did White mothers, who preferred the experiential family counseling category better (68.8%). All lower SES mothers liked the structural category over the other two, and a larger percentage of upper SES mothers preferred the experiential approach (69.2%).

Socioeconomic status was found to be the best predictor of adolescent sons' preference for the counseling categories with 93.3% of the lower SES group preferring the structural approach. Those classified in the upper and middle SES groups preferred the experiential approach (61%). Therefore the hypothesis that race and socioeconomic status are factors that influence preference was supported in the pilot study results.

Based on results of the pilot study, two additional independent variables were considered appropriate for the final study. Maternal depression and mothers' and adolescent sons' most important concern were added to the study. The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erlbaugh, 1961) was used to assess mothers' level of depression, while a researcher-developed

survey based on the 13 factors identified by Schinka in the Personal Problem Checklist (PPC; Schinka, 1984) was used to determine mothers' and adolescent sons' most important concerns.

Incorporating refinements based on the pilot study, this study was implemented. The purpose of the current study was to determine preferences for family counseling categories and to identify factors that may influence preference for a type of family counseling approach. Determining these factors may aid mental health practitioners in providing more appropriate family counseling services to a wide range of clientele.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents findings from the current study. The chapter is divided into two sections. The first section will describe the Chi Square results on the combined mother/adolescent son data. The first section will also describe the discriminant analysis results on both mother and adolescent son data. All analyses will be reported in relation to the five research hypotheses. The final section of the chapter will summarize the results of the data analysis.

Results

A direct discriminant function analysis was performed on mother data using seven variables as predictors of preference for three different family counseling categories. A second discriminant function analysis was conducted on adolescent son data using six variables as predictors of preference for three different family counseling categories. Predictor variables for both mothers and adolescent sons were socioeconomic status, race, number of presenting concerns, most important concern, client status, and previous counseling experience. Level of depression was the additional discriminator variable for mothers. The three family counseling categories were structural, historical, and experiential. In addition, a

Chi-Square analysis was conducted to determine if there was a difference in preference for family counseling categories between mothers and adolescent sons.

Of the original 153 mother son dyads, 9 were dropped from analysis because of missing data. Missing data appeared to be randomly scattered throughout groups and predictors. An additional 6 dyads were dropped because they did not satisfy the "divorced" condition of the study. Finally, 5 Hispanic mother-son dyads were dropped from analysis because they represented less than 5% of the subject pool.

Two discriminant functions were calculated for mothers, with a combined $X^2(14) = 48.34, p < .00001$. After removal of the first function, there was still strong association between family counseling categories and predictors ($X^2(6) = 13.31, p < .0384$). The two discriminant functions accounted for 74% and 26%, respectively, of the between-group variability. The group centroids (means) of the two discriminant functions for both mother and son data are listed in Table 3.

Table 3

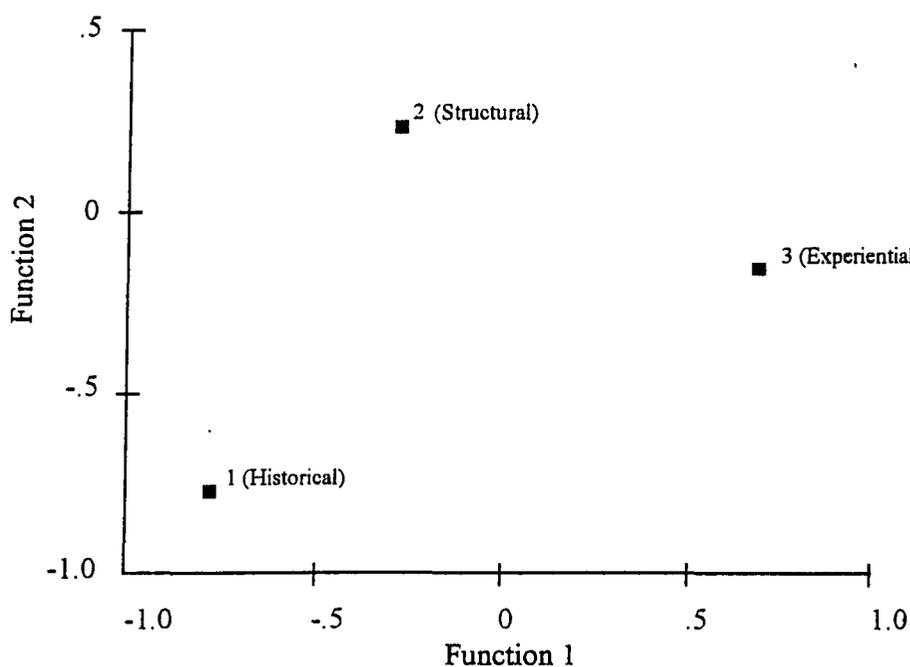
Group Centroids of the Discriminant Functions for Mother and Son Data

Group	Mother Discriminant Functions		Son Discriminant Functions	
	Function 1	Function 2	Function 1	Function 2
Historical	-.696	-.638	.420	-.155
Structural	-.345	.300	.258	.171
Experiential	.679	-.088	-.206	-.015

To obtain an illustration on how the preferences between the three groups differ, the group centroids can be plotted. Figure 1 shows that both the first and second discriminant function separates preference of the historical group from both structural and experiential group preferences. The plot suggests that all three groups (historical, structural, and experiential) are separate.

Figure 1

Canonical Discriminant Functions Evaluated at Group Means (Group Centroids) - Mother Data

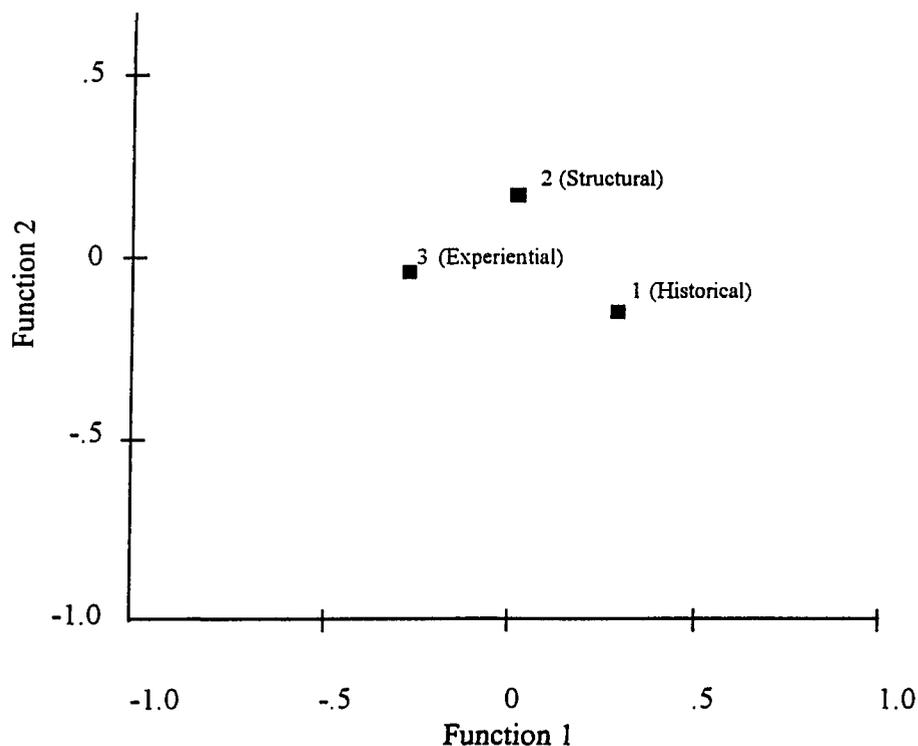


Additionally, two discriminant functions were calculated for sons, with a combined $X^2(12) = 10.36$, $p < .5849$. These results suggest a poor association between the family counseling categories and the six predictors, or independent

variables. The two discriminant functions accounted for 87% and 13%, respectively, of the between-group variability. As shown in Figure 2, neither the first nor the second discriminant function separates preference of the three groups (historical, structural, and experiential). Therefore, none of the predictor variables proved to be significant in regards to predicting preference for family counseling categories for adolescent sons in this sample. The lack of significant results may be due to adolescents' possible disinterest in completing the packet.

Figure 2

Canonical Discriminant Functions Evaluated at Group Means (Centroids) - Adolescent Son Data



Hypothesis 1: Comparing Preferences of Mothers and Adolescent Sons

To look at the first hypothesis regarding the difference in preferences between mothers and adolescent sons, a Chi-Square analysis was performed. Results showed that there was a significant difference between mothers' and adolescent sons' preferences for the three family counseling categories, with a $X^2(2) = 18.44, p < .0001$. Most mothers preferred the structural category (45.1%, $n=60$), while adolescent sons overwhelmingly preferred the experiential category (61.7%, $n=82$). Therefore the first hypothesis which stated that there would be differences in mothers' and adolescent sons' preference for family counseling categories was supported. In examining each mother and adolescent son dyad individually it was found that in only 36 (27%) dyads did the mother and adolescent son prefer the same family counseling category. This finding has significant implications for family counselors who are seeing mothers and sons in counseling and using one type of family counseling approach.

Hypothesis 2a: Race as a Predictor of Preference

The discriminant function weight for race, as seen in Table 4, suggests that race is a reliable predictor for distinguishing preference of mothers among the three family counseling categories ($r=.635$). Thus, Hypothesis 2a was supported for the data on mothers. Correlations were completed for all existing independent variables to determine whether variables were related to one another. As shown in the pooled within-group correlation matrix in Table 4, no significant correlations

existed between variables. This suggests each variable could be considered independent of the others in assessing whether it is a good predictor of preference.

In examining race, some trends were noted. In regards to race, more Black mothers ($n=18$, 85.7%) preferred the historical family counseling category than did White mothers ($n=3$, 14.3%). More White mothers ($n=37$, 71.2%) preferred the experiential family counseling category than did Black mothers ($n=15$, 28.8%). An approximately equal percentage of Black ($n=28$, 46.7%) and White ($n=32$, 53.3%) mothers preferred the structural family counseling category.

Hypothesis 2b: Socioeconomic status as a Predictor of Preference

The discriminant function weight for SES, as seen in Table 4, also indicated that it is a significant predictor of mothers' preference for family counseling category ($r=-.525$). Therefore, Hypothesis 2b was supported for the mother data. However, results related to socioeconomic status (SES) should be interpreted with caution because the sample did not have an equal distribution of mothers classified into all three classes as determined by Duncan's Occupational Prestige Scale (1961). Approximately 61% ($n=81$) of the sample was middle class. There were 25 (18.8%) mothers classified as upper class, and 27 (20.3%) mothers in the lower class.

Table 4

Results of Discriminant Function Analysis of Predictor Variables - Mother Data

Predictor Variables	Discriminate Function Weights		Pooled Within Group Correlations Among Predictors					
	1	2	RACE	CLIENT	PREV COUN	BECK	CONCERN	NUMCON
Socioeconomic Status (SES)	-.525	.452	.01	-.21	.11	.04	.07	-.01
Race (RACE)	.635	.786		.05	.24	.17	-.11	.14
Client Status (CLIENT)	.011	.414			.25	-.04	-.00	-.06
Previous Counseling (PREVCOUN)	.113	-.451				.06	-.02	.00
Depression (DEPRESS)	.277	-.397					.36	.09
Most Important Concern (CONCERN)	.380	-.122						-.13
Number of Concerns (NUMCON)	-.252	.067						
Eigenvalues	.317	.110						

Those mothers who were classified into the lower socioeconomic status were more likely to choose the structural category as the most preferred family counseling category ($n=17$, 63%). Mothers who were classified in the "upper" socioeconomic status preferred the experiential family counseling category ($n=14$, 56%). In the "middle" socioeconomic status, an approximately equal percentage preferred either the structural ($n=36$, 44.4%) or experiential ($n=34$, 42.0%) family counseling categories.

Hypothesis 2c: Previous Counseling Experience as a Predictor of Preference

Significant results were not found in examining previous counseling experience as a predictor of preference. The discriminant function weight in Table 4 indicates a nonsignificant correlation ($r=.113$) between previous counseling experience and the discriminant function. This may be due to the larger percentage of dyads that did not have previous counseling experience ($n=81$, 61%). It could also be a reflection of the type of previous counseling that mothers had (e.g., family, individual, group, marriage, etc.).

Due to the nonsignificance of the discriminant function for the data on adolescent sons, the hypothesis that race, SES, and previous counseling experience affected their preference for family counseling categories was not supported.

Hypothesis 3: Client Status as a Predictor of Preference

According to the discriminant analysis on the mother data, client status was not a significant predictor of mothers' preference for family counseling category

($r=.011$, from Table 4). Due to the nonsignificant results of the discriminant analysis conducted on adolescent son data, client status also could not be determined to be a significant predictor of preference for family counseling category. The hypothesis that stated that differences in preferences were affected by whether or not the mother or adolescent son were seeking counseling (client/nonclient status) was not supported. However, in examining the results from the Likert scale rating for each vignette, it appears that more clients chose the extremes of the scale (1 or 5). When mothers and adolescent sons were asked on the HESI if they would go see the family counselor described in the vignette they just read, more client mothers and adolescent sons chose "I definitely would go to see this family counselor" or "I definitely would not go to see this family counselor." Of the moms who chose 1 (definitely would), 68% ($n=37$) were clients. Of the adolescent sons who chose 1 (definitely would), 87.5% ($n=7$) were clients. All of the mothers and adolescent sons who chose 5 (definitely would not) were clients. This suggests that individuals seeking counseling (clients) may have a more defined idea of what they like and what they do not like. This also has implications for including actual clients in research conducted in the counseling profession.

Hypothesis 4: Maternal Level of Depression as a Predictor of Preference

In this study mothers completed the Beck Depression Inventory. Four levels of depression were assessed using generally accepted BDI levels (Shaw,

Vallis, & McCabe, 1985). A score of 0-9 for mothers indicated no depression; 10-15 indicated a mild level of depression; 16-23 indicated moderate depression; and 24-63 indicated severe depression.

The subjects in the study were not equally represented on each level of the BDI. The largest percentage of mothers fell into the nondepressed ($n=106$, 79.7%) group. Fifteen percent ($n=20$) of the moms were classified as having a mild level of depression, and 5.3% ($n=7$) scored in the moderate level. No mothers in the sample scored between 24-63 to indicate a severe level of depression. Table 5 summarizes the mothers' scores on the BDI.

Table 5

Mothers Level of Depression

Level of Depression	Frequency	Percent
None	106	79.7
Mild	20	15.0
Moderate	7	5.3
Severe	0	0.0

According to the discriminant analysis, level of depression was not a significant predictor of mothers' preference for family counseling category ($r=.277$, from Table 4). Therefore, the research hypothesis that stated maternal depression affected preference for family counseling categories was not supported. The lack of significant results for this variable may have been due to the small

number of mothers who scored at a mild, moderate, or severe level of depression on the BDI.

Hypothesis 5a: Number of Concerns as a Predictor of Preference

Mothers in the study were not equally represented across a varying range of number of concerns as identified on the Problem Survey (PS). Most mothers identified 1, 2, or 3 presenting concerns. Twenty-four percent ($n=7$) of the moms indicated having only 1 presenting issue. Forty three percent ($n=58$) of the mothers indicated 2 presenting concerns, and approximately thirty percent ($n=40$) of the moms indicated having 3 problems. Only three mothers indicated having four concerns (2.3%). Most of the adolescent sons indicated 1 presenting concern ($n=62$, 46.6%). Fifty one (38.3%) identified 2 presenting concerns on the PS, 19 (14.3%) identified 3 presenting concerns, and only 1 identified 4 presenting concerns. Table 6 summarizes the data for mothers and sons regarding the number of presenting concerns. Mothers and adolescent sons were allowed to identify all the problem areas on the PS, but also were instructed to identify their most important concern.

According to the discriminant analysis, number of concerns was not a significant predictor of mothers' preference for family counseling category ($r=-.252$ from Table 4). Therefore, research hypothesis 5a which stated that number of concerns would affect preference for family counseling categories was not supported. The lack of significant results for this variable may have been due

to the small range of number of concerns. A wider range of frequencies may have produced significant results. Because of the nonsignificance of the discriminant

Table 6

Frequency of Mothers and Adolescent Sons with 1, 2, 3, and 4 Presenting Concerns

No. of Concerns	Mother's Concerns		Son's Concerns	
	Frequency	Percentage	Frequency	Percentage
One	32	24.1	62	46.6
Two	58	43.6	51	38.3
Three	40	30.1	19	14.3
Four	3	2.3	1	.8

analysis on adolescent son data, this hypothesis also was not supported for adolescent sons.

Hypothesis 5b: Most Important Concern as a Predictor of Preference

Mothers and adolescent sons showed some similarities in their choice of most important problem. Mothers (48.1%) and adolescent sons (43.6%) most frequently chose family/home problems as their most important concern. School problems was the second most frequently chosen concern by both mothers (24.8%) and sons (34.6%). After these two problem areas there were some differences in chosen concerns between mothers and sons. Emotional problems ranked next for

mothers (12.8%), while sons chose social problems (13%). Frequencies on other areas (appearance, vocational, financial, religious, emotional, sexual, legal, health, attitude, and crisis) identified by adolescent sons on the PS were too small for interpretable analysis. Table 7 summarizes the data on mothers' and adolescent sons' most important concerns. This table also includes frequencies and percentages of all identified concerns on the PS.

Table 7

Frequency of Mothers' and Adolescent Sons' Concerns Identified on the PS

	All Identified Concerns		Most Important Concern	
	Mothers	Sons	Mothers	Sons
Social	10 (3.6%)	21 (10.4%)	1 (0.8%)	13 (9.8%)
Appearance	6 (2.1%)	11 (5.5%)	0 (0.0%)	8 (6.0%)
Vocational	8 (2.9%)	2 (1.0%)	3 (2.3%)	1 (0.8%)
Family/Home	98 (35.0%)	77 (38.3%)	64 (48.1%)	58 (43.6%)
School	85 (30.0%)	59 (29.4%)	33 (24.8%)	46 (34.6%)
Financial	13 (4.6%)	3 (1.5%)	4 (3.0%)	0 (0.0%)
Religious	2 (0.7%)	4 (2.0%)	0 (0.0%)	2 (1.5%)
Emotional	32 (11.4%)	8 (4.0%)	17 (12.8%)	3 (2.3%)
Sexual	2 (0.7%)	1 (0.5%)	0 (0.0%)	0 (0.0%)
Legal	3 (1.1%)	2 (1.0%)	0 (0.0%)	0 (0.0%)
Health	4 (1.4%)	3 (1.5%)	2 (1.5%)	1 (0.8%)
Attitude	14 (5.0%)	6 (3.0%)	6 (4.5%)	0 (0.0%)
Crisis	3 (1.1%)	4 (2.0%)	3 (2.3%)	1 (0.8%)

According to the discriminant analysis, most important concern was not a significant predictor of mothers' preference for family counseling category

($r = .380$ from Table 4). The lack of significant results for this variable may have been due to the fact that only three concerns were predominantly identified by mothers to be most important. Family/home, school, and to a lesser extent, emotional concerns were identified by mothers as most important. Frequencies on other areas (social, appearance, vocational, financial, religious, sexual, legal, health, attitude, and crisis) were each less than 5% of the sample. A wider spectrum of most important concerns may have produced significant results. The hypothesis that stated that mothers' preference for family counseling category is affected by their most important concern was not supported. Because of the nonsignificance of the discriminant analysis on adolescent son data, this hypothesis was not supported for adolescent sons as well.

Summary

Overall, results of discriminant analyses conducted on both mother and adolescent son data suggests that there are characteristics that influence mothers' preference for family counseling categories. Mothers' race and socioeconomic status were the most significantly factors related to preference for family counseling category. The other factors (client status, previous counseling experience, depression, and number of concerns) were not highly significant. In looking at family counseling category composition, the following can be said:

1. Mothers who prefer the historical family counseling category are more likely to be black, low SES clients with previous counseling

experience, low levels of depression, and a higher number of presenting concerns.

2. Mothers who prefer the experiential family counseling category are more likely to be white, high SES nonclients with no previous counseling experience, higher levels of depression, and a lower number of presenting concerns.
3. Mothers who prefer the structural family counseling category are more likely to be black, middle SES clients with previous counseling experience, moderate levels of depression, and a higher number of presenting concerns.

The discriminant analysis on adolescent son data proved to be nonsignificant. It may be difficult for adolescents to distinguish a preference for counseling approaches. They may not like any of the counseling categories, they may be indifferent to counseling (preferring not to be there at all), or they may assume that all approaches should work equally well. Oster et al., (1988) suggest that lengthy assessment devices may cause an adolescent to be more resistive when filling out the question. Oster et al., (1988) also state that adolescents may be more responsive to computer-based tests, rather than paper-and-pencil devices.

Mothers' and adolescent sons' preferences for family counseling categories were found to be significantly different using a Chi-Square analysis. This raises important issues for family counselors who are seeing mothers and adolescent sons

together. These issues as they relate to the counseling profession will be discussed in the following chapter.

CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary

Keeping families invested in the counseling process is a difficult task for family counselors, especially when working with adolescent family members. Determining the families' preferences for counseling approaches may be one way to actively engage both adolescent sons and mothers in the counseling process.

The primary purpose of this study was to determine the preferences of mothers and adolescent sons for different family counseling categories. The second purpose of this study was to determine the relationship between race, socioeconomic status, previous counseling experience, and client status of mothers and adolescent sons and their preferred family counseling category. Third, this study examined the relationship between mothers' level of depression and their preferences for family counseling categories. Lastly, the frequency of concerns and type of concern that mothers and adolescent sons identify as most important were examined as variables affecting preference for family counseling category.

Participants in this study consisted of mother and adolescent son dyads. Adolescent sons in this sample were between the ages of 13 and 16 years of age. Because prior research on counseling preference have primarily utilized only

nonclient populations, this study examined both client and non-client mother/adolescent son dyads.

Participants were given a packet of material to complete independently. Mothers were instructed to complete a Demographic Data Questionnaire that collected data such as race, level of education, income, and past counseling experience. To assess level of depression, mothers completed the Beck Depression Inventory. Both mothers and sons completed the Problems Survey (PS) developed by the researcher and based on the 13 factors identified by Schinka in the Personal Problems Checklist (PPC). The Historical Experiential Structural Indicator (HESI), developed by the researcher, was used to assess preference for family counseling categories. The HESI consisted of three descriptive vignettes of Levant's (1980) family counseling categories. Both mothers and sons independently completed the HESI as part of their information packet.

Limitations

Some data analysis was restricted given the limited representation across levels of the independent variables. As noted previously, all levels of depression assessed by the Beck Depression Inventory (BDI) were not represented in the sample of mothers. This is inconsistent with current findings in clinical research (Pietromonaco & Rook, 1987; Robbins, 1993) that suggest a large percentage of the population seeking counseling services is clinically depressed. The small percentage of clinically depressed mothers also may be accounted for by the fact

that they were presenting with their sons for counseling to work on issues that were unrelated to their own possible depression, such as school-related or discipline problems. In addition, the literature suggests that the incidence of depression can decrease the longer the mother has been divorced (Patterson & Forgatch, 1990). The study did not examine the length of time since divorce.

A second limitation is that the results of this study cannot be generalized to populations other than Black and White. Although this study included participants from three racial groups (Black, Hispanic, and White), Hispanic dyads were dropped from the final analysis because they were not equally represented ($n=5$). Given the literature (Stevens & Hoisington, 1987) that indicates that Hispanics are growing as a minority group, it is somewhat surprising that they were underrepresented in this sample. However, the U.S. Bureau of the Census' (1989) report on marital status, living arrangements, and current population, indicated that even though the Hispanic population is increasing in the United States, they are still primarily residing in large cities and the southwest. Because of the small number of Hispanic dyads and subsequent exclusion from analyses, the results of the study cannot be generalized to other cultural groups.

There are several types of family counseling approaches in the literature. The rationale for using Levant's (1980) categories was based on the similar fashion in which individual counseling approaches have been looked at in the preference literature. The nuances in each specific approach may account for different results

in regards to preference. There may be approaches that are preferred based on the fact that they have appealing parts of two or more of Levant's categories. For example there are characteristics of Virginia Satir's Communication Family Therapy that can classify it as fitting into both Levant's structural and experiential category.

A fourth limitation to the study involves the exclusion of participation of significant others in the household. Even though the study examined only divorced families, it did not examine the level of participation of fathers, grandparents, other relatives, or siblings. Many fathers often play an integral part in parenting, even after the divorce. Fathers can be involved in many decisions concerning the family including treatment issues. There were some families in the sample who had extended family members living in the household (grandparents, aunts or uncles). These members may also have an influence in important family issues/decisions. Lastly, the level of parenting of older siblings was not assessed. Older siblings in single-mother headed households can often be responsible for the parenting of younger adolescent siblings. More information about family composition and the role that each member takes in the family may help to explain the lack of variability in the results.

A final limitation to the study is the use of the Problems Survey (PS) developed by the researcher. As indicated before, the PS was developed because of the concept that lengthy assessment packets may cause the adolescent to fill out

the forms in a negative manner. However, even though the PS is based on the 13 factors identified by Schinka's Personal Problem Checklist (PPC), the reliability and validity of this instrument may differ from that of the entire PPC, causing some variation in the results.

Conclusions

In this study, factors of race, socioeconomic status, previous counseling experience, client status, and most important concern, were not found to have an affect on adolescent sons' preferences for family counseling categories. However, two of the original five research hypotheses were supported to some degree. Results of the study suggests that there is a difference in preference for family counseling approaches based on mothers' race and socioeconomic status. These findings can assist family counselors to determine with some degree of accuracy what type of family counseling approach mothers might prefer given information on these three variables.

Results showed that there was a significant difference between mothers, and adolescent sons' preferences for the three family counseling categories. Mothers preferred the structural approach, while adolescent sons preferred the experiential approach. In only a small percentage of dyads did the mother and adolescent son share preference for the same family counseling category. This finding suggests that family counselors may find that one or more family members are not content with the counseling process.

The second hypothesis was partially supported. The study found that race and socioeconomic status (SES) are reliable predictors for distinguishing preference of mothers between the historical, structural, and experiential family counseling categories. More Black mothers preferred the historical family counseling category than did White mothers. A major concept in family counseling approaches from Levant's (1980) historical category is the inclusion of extended family members in counseling (e.g. grandparents). Thus, this finding makes sense in light of the fact that a high value is placed on family in the Black household (Foley, 1975), and grandparents, aunts, and uncles are usually available to help with the parenting and can often be found residing in the same household (Vacc, Witmer, & DeVaney, 1988). Family counselors should assess who should be included in the family counseling process.

The study also found that more White mothers than Black mothers preferred the experiential category. This finding may be explained by the willingness of Black families to trust counselors. Black families are more likely to turn to their families, neighbors, friends, or ministers in times of crisis (Hines & Boyd-Franklin, 1982). They have strong feelings about trust and opening up to "outsiders." A major component of Levant's (1980) experiential counseling category is the exploration of feelings. This may be uncomfortable for Black family members. As previously stated in chapters I and II, the literature suggests (Hines & Boyd-Franklin, 1982; Sue & Sue, 1990) that Black families are likely to

be most responsive to time-limited, problem-solving, child-focused, family counseling approaches. Black families expect a family counselor who is active and directive. This may explain why a large majority of the Black mothers preferred the structural category.

It is suggested in the literature that SES has a significant impact on the type of counseling approach an individual prefers and/or needs (Acosta et al., 1982). Low-income families may prefer a counseling approach that will resolve their problems in a direct manner since they have other concerns (e.g., financial) to worry about. Low-income clients may also show a reluctance to express or disclose their feelings or attitudes in the counseling process (Lorion, 1974). The literature also suggests that female-headed, lower class families have more counseling concerns such as behavioral and discipline problems with children and adolescents (Fishman, 1988; Worden, 1991). It appears that these theories were supported in the study. Mothers classified as lower socioeconomic status were more likely to choose the structural approach as the most preferred family counseling category. Mothers who were classified in the "upper" socioeconomic status preferred the experiential family counseling category. For "middle" SES mothers, preference was for either the structural or experiential family counseling categories.

However, as suggested before, the results for this variable should be interpreted with caution given that the sample had a disproportionate number of

mothers who were classified as middle class. Sixty one percent of the sample was classified as middle class. Previous counseling experience was not found to be a significant predictor of mothers' preference for family counseling category.

Client status was not a significant predictor of mothers' preference for family counseling category. However, closer inspection of the responses on the HESI to the Likert scale rating for each vignette showed that a larger proportion of the client population chose the extremes. Mothers and adolescents who were seeking counseling had a more definite opinion about what family counselors they would and would not go see. This suggests that researchers should attempt to include actual clients whenever possible to perhaps gain a more accurate picture of preference.

This study did not find level of depression to be a significant predictor of mothers' preference for family counseling category. The lack of significant results for this variable may have been due to the small number of mothers who scored at a mild, moderate, or severe level of depression on the BDI. As suggested previously, mothers in the client group presented with their sons for family counseling. The issues that mothers identified as presenting concerns were usually family/home and school problems. None of the mothers participating in this study presented for counseling with issues of depression. The other half of the sample were nonclients, thus explaining for the possible lack of depression.

Results from the study did not support the hypotheses that mothers' most important concerns and mothers' amount of concerns can predict their preference for family counseling categories. The nonsignificant results for most important concern can perhaps be explained by the lack of representation across all areas of concerns. Family/home, school, and emotional concerns were the three most chosen concerns (48%, 25%, and 13% respectively) on the Problem Survey (PS). All other concerns (social, appearance, vocational, finance, health, sexual, religious, attitude, legal, and crisis) were under 5%.

In addition, the number of concerns that mothers identified on the PS was not a significant factor in accounting for mothers' preference for family counseling category. Most of the mothers identified either having 1, 2, or 3 presenting concerns. This may not have been a wide enough range of number of concerns for significant variance. Over half of the mothers in the study were non-clients, suggesting that presently they may not have a large number of concerns. However, the fact that a majority of mothers in the client population did not have over 3 concerns is surprising, given that the literature suggests that a clinical population usually presents with several concerns (Rutter, 1992).

Recommendations for Future Research

Some recommendations for future research center around the limitations of the current study. Future research should control for confounding variables such as participation of fathers, siblings, and other family members residing and not

residing in the household. Given the amount of influence that estranged fathers, siblings, and extended family members have on the family unit, level of participation would be a variable to examine in regards to preference for family counseling approaches. In addition, it is important to consider preferences for these other family members.

Findings indicated that race was a significant predictor of mothers' preference for family counseling categories. Unfortunately there were only 5 Hispanic dyads in the sample, an insufficient number to include in data analyses. Multicultural issues, however, have come to the forefront of the counseling profession within the last 10 years and family counselors increasingly are counseling families from diverse racial backgrounds (Vacc et al., 1988). Future research should examine other races and their preferences for family counseling approaches.

As suggested by Halgin et al. (1987), Cunningham et al. (1990), and Patterson (1990), maternal depression is an important issue in families. Maternal depression can lead to lack of motivation to seek professional help, inability to make decisions and solve problems, and poor parenting. Although, this study did not find significant results regarding level of depression in mothers and its' affect on preference, all levels of depression were not equally represented in this sample of mothers. Future research should examine larger samples of clinically depressed mothers to determine if their preferences are different from a nondepressed

population. The role and participation of various family members may also account for levels of depression in the mother and the amount of concerns she brings to counseling. As Patterson (1990) suggests, a mother who has a better support system will be less depressed and have more resources to help cope with day to day stressors. Future research should examine support systems and their relationship to preference.

In addition, adolescent depression is an issue that continues to grow in importance for counselors (Carlson & Lewis, 1991). Adolescent depression may also affect preferences for family counseling approaches. Although this study did not examine levels of depression of adolescent sons, future studies should consider examining this variable and its potential influence on preference for counseling approach.

Future research needs to take a closer look at the relationship between decision-making and preference. Rutter (1992) suggests that amount of stressors can affect decision-making. Bertocci et al. (1992) found that treatment preferences varied significantly depending on the type of mental health concern that was addressed. The current study did not support the hypotheses that number of and most important concerns are significant predictors of mothers' or adolescent sons' preference for family counseling categories. Future research should examine a wider range of number of concerns as well as type of concern.

The counseling profession has always been concerned with outcome research. Goldstein (1962) suggested that clients can benefit more from receiving a preferred therapy over one that is assigned. Other literature suggests that clients can still benefit from counseling even when their preferences are not taken into consideration (O'Donohue et al., 1990). This study found that the preference of mothers for different family counseling categories could be predicted with some reliability by the mothers' race, SES, and most important counseling concern. Research should be conducted comparing outcomes of being given a preferred versus prescribed family counseling approach. Does a good match on preferred approach actually yield better results in counseling?

In addition, researchers should examine a family's preference throughout the course of family counseling. The question being, does preference for the current approach change during the course of counseling? One or more family members may become dissatisfied with the approach. Assessing preference on an ongoing basis in conjunction with assessment of goals and progress, addresses the issue of counselor accountability.

Implications

The results of the study have implications for three areas of the counseling profession. First, it has implications for family counselors in regards to the potential for differing preferences of family members in the counseling process. Second, it has implications for family counseling agencies in regards to staffing

and attrition rates. Lastly, and to a smaller extent, the study has implications for researchers in the area of family counseling regarding the use of clients as subjects.

The results of the study showed that mothers and adolescent sons have different preferences for the type of family counseling they prefer. When working with the mother-adolescent son dyad, it is often difficult for the family counselor to have the active participation of both parties (Fishman, 1988). The counselor can find him or herself dealing with a disgruntled adolescent, or even a parent who feels that the counselor may be taking the sides (not hers). O'Donahue, Fisher, Plaud, and Curtis (1992) found that in less than one-third of the cases examined, did the client's preferences influence the selection of treatment methods. Most often it is the therapist's own preferences that are the most important influence in determining treatment methods. By including the client in treatment decisions the family counselor may be able to motivate otherwise difficult adolescents or parents. Attempting to come to mutually agreed upon topics of discussion, goals, and methods, may be one way for the family counselor to make headway with the family. Differences in preference that cannot be resolved, may also be an indication that individual counseling is needed for one or more of the family members. Perhaps leading back to family counseling with all members involved.

Determining clients' preferences can be important for mental health counseling agencies especially in light of the attrition rates. Roughly one-third of

all clients who seek counseling fail to return after the initial interview. Family counseling with low income Black families has not been very successful either. Gwyn and Kilpatrick (1981) reported that in one particular family treatment center, 81% of the Black families dropped out of counseling as opposed to 50% of the White families. Individuals and families who dropout of counseling early, rarely seek alternative services (Lorion, 1978). It is suggested in the literature (Devine and Fernald, 1973) that receiving a preferred counseling approach has a significant effect on counseling outcome and attrition rates.

This study has important implications for mental health professionals and agencies. Agencies may be able to best serve the needs of their clientele by assessing their preference for different family counseling approaches. By determining the characteristics that are the best predictors of preference, agencies can assign families to counselors that may best agree with their preference. Thus decreasing the possibility of early dropout, or wasted time with family counselors who practice an approach that is not satisfying to the family.

Finally, this study has implications for family counseling researchers, and perhaps other researchers in the counseling profession. Results from the study suggest that clients have more definitive preferences for family counseling approaches that they like and dislike. Researchers may wish to utilize actual client samples when doing research on mental health counseling issues, to gain a better understanding of the salient issues for clients.

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**Appenndix A
Beck Depression Inv.
Pages 100-102**

UMI

Appendix B**Problem Survey (PS)**

ID# _____

Please indicate in which areas you are having problems. Check all that apply but circle the most important.

_____ **Social problems**

For example: not getting along with other people, feeling inferior, or being let down by friends

_____ **Appearance problems**

For example: being too thin or too fat, or not being clean or well groomed

_____ **Work problems**

For example: not having a job, boss being critical or unfair, or working too many hours

_____ **Family or Home problems**

For example: children misbehaving, living in dangerous neighborhood, or having problems with parents

_____ **School problems**

For example: children getting bad grades, or children not getting along with other students

_____ **Financial problems**

For example: budgeting money, not having a steady income, or dealing with bill collectors

_____ **Religious problems**

For example: not having any religious beliefs, or failing in religious beliefs

_____ **Emotional problems**

For example: feeling anxious or uptight, feeling depressed or sad, or not being able to relax

_____ **Sexual problems**

For example: being uncomfortable with the opposite sex, worrying about sexual performance, or disliking sex

_____ **Legal problems**

For example: needing legal advice, being on parole, or facing criminal charges

_____ **Health problems**

For example: being physically hurt or abused, using drugs or alcohol, or having recurring health problems

_____ **Attitude problems**

For example: having a poor attitude about everything, not understanding the attitudes of others, or having a poor attitude about work, family, or self

_____ **Crisis problems**

For example: friend or family member committing suicide, friend or family member getting a divorce, friend or family member dying, or child running away from home

Appendix C

Historical Experiential Structural Indicator (HESI)

ID# _____

DESCRIPTION #1

You and your family are having problems such as arguments and conflicts, so you go to see a family counselor. This counselor is concerned with what is happening in the session right now. This counselor is also concerned with how family members express their feelings and how other family members respond to them. This counselor believes that your family's problems come from different members of your family not feeling good about themselves.

The primary goal would be to get everyone to feel good about themselves. As family members start to feel good about themselves they become more aware and sensitive to the other family member's feelings, which in turn leads to better communication with each other.

This counselor becomes close to your family and shares his or her own feelings and personal stories as a model for good communication. This counselor teaches family members how to respond to each others feelings. The counselor gets your family to talk to one another.

Please circle the answer below to the following question:

Imagine that you are allowed to choose the counselor you wish to see. Would you go see the family counselor described above?

1. I **definitely would** go to see this family counselor.
2. I **probably would** go to see this family counselor.
3. I **am not sure** whether or not I would go to see this family counselor.

4. **I probably would not go to see this family counselor.**
5. **I definitely would not go to see this family counselor.**

DESCRIPTION #2

You and your family are having problems such as arguments and conflicts, so you go to see a family counselor. This counselor is concerned with events that occurred in your past and how they relate to what is happening now. This counselor is also concerned with how you relate or related to your parents and grandparents. This counselor believes that your family's problems come from different personality traits or different relationships that were passed down over generations.

The primary goal would be to uncover past relationships and look at personality traits. As family members talk about past relationships that caused problems they learn how to correct them and learn new ways to interact.

This counselor frequently includes grandparents in the family counseling session. The counselor lets family members talk about past relationships and shares with the family what he or she thinks the problem is and how to correct it.

Please circle the answer below to the following question:

Imagine that you are allowed to choose the counselor you wish to see. Would you go see the family counselor described above?

1. I definitely would go to see this family counselor.
2. I probably would go to see this family counselor.
3. I am not sure whether or not I would go to see this family counselor.
4. I probably would not go to see this family counselor.
5. I definitely would not go to see this family counselor.

DESCRIPTION #3

You and your family are having problems such as arguments and conflicts, so you go to see a family counselor. This counselor is concerned with the present and only a brief history of the family's problems. This counselor is also concerned with the way your family interacts. The counselor believes that problems in your family come from interactions that are not productive.

The primary goal would be to replace interactions that are not productive with ones that are. As family members learn new ways to interact their problems decrease.

During counseling this counselor becomes like a part of the family and is able to identify the interactions that are not productive. This counselor teaches new ways of interacting by having family members go home and practice.

Please circle the answer below to the following question:

Imagine that you are allowed to choose the counselor you wish to see. Would you go see the family counselor described above?

1. I **definitely would** go to see this family counselor.
2. I **probably would** go to see this family counselor.
3. I **am not sure** whether or not I would go to see this family counselor.
4. I **probably would not** go to see this family counselor.
5. I **definitely would not** go to see this family counselor.

List in order the family counseling approach you liked the most, the one you liked next, and the one you liked least (in other words #1, #2, or #3).

Most favorite _____

Middle favorite _____

Least favorite _____

Appendix D

THE UNIVERSITY OF NORTH CAROLINA AT GREENSBORO**Consent to Act as a Human Subject**

Subjects' Names: _____

Date of Consent: _____

NAME OF THE STUDY: "Factors affecting mothers' and adolescent sons' likelihood to participate in family counseling approaches."

PURPOSE OF THE STUDY: To determine the factors that affect mothers' and adolescent sons' preferences for different family counseling approaches.

WHAT TO DO: Mothers need to fill out the enclosed information form on page 3. Mothers will then read the three descriptions on the pink form and answer all questions. At the same time, adolescent sons will read the descriptions on the blue form and answer all questions. It should take about 20 minutes to fill out the entire packet.

QUESTIONS: This project and this consent form has been approved by the University Institutional Review Board which ensures that research projects involving human subjects follow federal regulations. If you have any questions you can call the Office of Research Services at (910)334-5878 or Jim Wachsmuth at (910)275-1216.

CONFIDENTIALITY & RISKS: All responses will be kept confidential with every mother and son receiving a code number (upper right hand corner of all material). There are no apparent risks in this study. If at any point, you or your son wish to stop you may do so. Participants can receive a copy of the results by contacting Jim Wachsmuth at the above number, or indicating on page 3 where they would like the results sent. All information completed on these forms will be destroyed at the end of this study.

We hereby consent to participate in the research project described above.

Mother's Signature

Witness

Son's Signature

Appendix E

Demographic Data Questionnaire (DDQ)

Family # _____

DEMOGRAPHIC DATA QUESTIONNAIRE (DDQ)

Mother: Age _____ Occupation _____

Adolescent son: Age _____ Occupation (if they have job) _____

Father (if living in household): Age _____ Occupation _____

How many family members are in the household? _____

Age and relation of other adults in the household: _____

Age and sex of others sons and daughters: _____

Marital status of parents (circle): single married divorced separated widowed

Race

Mother: _____

Adolescent son: _____

Last grade completed in school

Mother: _____

Adolescent son: _____

Have you or any member of your family been in counseling before? (circle) Yes No

If so, has it been with this agency? (circle) Yes No

Previous counseling/therapy (indicate how long, and what type of counseling if known - family, individual, group)

Mother: _____

Adolescent: _____

Other Family Members: _____

Presenting problem (What concerns are your family experiencing now that have caused you or might cause you to seek counseling?)

If you would like the results of the study sent to you, please include your name and address below. Or you may contact Jim Wachsmuth at 910-275-1216.

Name: _____

Address: _____
