My Family Made Me Do It: The Influence of Family Therapists' Families of Origin on Their Occupational Choice

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This study is an empirical test and exploration of the folklore about family life correlates of family therapists' occupational choice. The folklore is translated into systems concepts, including role complementarity and the mutually determining effect of process and roles. Fifty-nine family therapists, 49 siblings of the therapists, and 51 undifferentiated, non-helping professionals were compared on FACES (29), The Complementary Role Questionnaire, and on demographic data. Inconsistencies in the results led to a critique of the clinical faithfulness of current systems measures. Family therapists did not differ on FACES, but did differ in aspects of roles from their siblings and from the control professionals.

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WHY DO PEOPLE BECOME FAMILY THERAPISTS? Folklore has it that therapists emerge from disturbed families. This implies that their vocational choice is a result of early exposure to emotional distress. The autobiographies of individually oriented therapists reinforce the myth of wounded healers, that is, the sufferers who differentiated themselves from other sufferers by their attempts to master their wounds through their profession (18, 27, 38, 40).

Family Therapists' Myth of Enmeshment

Family therapists have a similar and more specific myth about their families of origin. They name enmeshment as their particular family dysfunction (see 28, 41). By enmeshment they seem to mean overreactivity (16), blurred subsystem boundaries, and cross-generational coalitions (23). They also, however, seem to be including a style of rigid adherence to the enmeshed structure even when family life stages require change. Current systems literature separates degree and kind of relationship characteristics from adaptiveness to life-cycle stage components (9). Olson, Sprenkle, and Russell call these two dimensions "Cohesion" and "Adaptability" (31).

Cohesion and the Myth

Family therapists tend to say that members of their families of origin were overly involved in others' thoughts, feelings, and behaviors. They correlate the heat generated in such an overly reactive system with the active style of their form of therapy. The high reactivity may also have height-

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ened the therapists' vigilance for observing patterns of nonverbal behavior, an important skill in treating family groups. In addition, these therapists' past experience with blurred subsystem boundaries may have contributed to their capacity for empathy and transient identifications, necessary attributes for success in their work.

Adaptability and the Myth

As a family meets its developmental milestones, it must be able to enrich its rules or appropriately adhere to old rules (11, 37). Family therapist folklore suggests that their families' enmeshed structures militated against members' altering their rules about role relationships. This in turn inhibited differentiation wishes and separation behaviors. Research on individual therapists supports the idea that therapists have more difficulty than the norm in leaving home (14). The present study's systems explanation of this separation difficulty would be impaired Adaptability in the family. That is, the family fails to enrich its repertoire of rules and roles (31) enough to facilitate a member's separation.

More Folklore: Roles

Another well-entrenched belief among therapists is about their role in their family of origin. Therapists all nod in agreement when they are cited as the overresponsible members in their family. Family therapists see themselves as particularly busy children, vibrating with the moves of each family member, advising, mediating, and fighting for objectivity. Their name for this role is the "parental child" (25, p.98). We call this role the parentified child (see 4) to keep the process aspect of role assumption and assignment in focus.

Family Systems and Roles

There are important systems descriptions of roles (1, 36, 39), but roles more often connote individual personality dynamics. The role of the overresponsible child, for example, typically describes particular personality organization. Family systems literature, however, rarely convey family process. The role of parentified child, for instance, describes a child who inappropriately holds executive functions, thereby implying impaired hierarchy in the family. Differing from what we call the appropriately parental child, who is authorized to perform parental duties in the executive's absence, the parentified child takes the place of a parent, a peer to, caretaker of (4), or pseudo-spouse to a parent.

Roles and Structure

Families with a parentified child often see this child as an asset (7) who picks up the spousal slack left by a distant or absent adult. The structural function of this "Golden Child" (35), however, is more complex (see 6). Roles and structure are mutually determined. Parentified children perpetuate dysfunctional family process. They do this by shielding the parent from appropriate partners and by maintaining blurred generational boundaries. These structural dysfunctions in turn support the role. Parentified children, the incipient family therapists of this study, appear to the family as admired caretakers. Seen objectively, they are structural culprits as well.

Role Complementarity

If family therapists were the overresponsible, parentified members of their family, another member was the underresponsible one. Roles coexist with their complements. Complementarity describes the way that family members are partners in their context (24). What we refer to as role complementarity takes into account the link both between members' roles as individual cop-

ing response styles and between family structures and roles.

Complementary roles seem to be similar to structural function. The underresponsible child is often called the Identified Patient (IP). IP children, like their parentified child complements, have been linked to conflict-detouring (39), triangulation into spousal conflict (15), and cross-generational coalitions (12, 23). Complementary roles seem to differ, however, in family esteem and behavioral style. Parentified children are often overtly, highly esteemed. Their behavioral styles do not seem to elicit increased executive functioning from the executives. In contrast, the IPs carry overt low esteem. Their style does induce increased attempts at executive functioning by the executives. These role dimensions, family esteem and behavioral style, are thus important discriminators between roles overlapping in function.

Previous Research

Our systems translation of the folklore around family therapist origins has suggested several hypotheses. There is little empirical research about therapist origins (9, 10, 13, 14, 17, 20, 32, 33) and none from a structural systems point of view. Recently, Henry, Sims, and Spray attacked the romance that therapists are formed by exposure to family trauma (13, 14). They propose instead the decisive influence of specific religio-cultural features. Demographic features are influential in occupational choice (5, 22, 34) and are considered in the present study. They may, however, be misleading when they are about systems issues and are not analyzed by systems concepts. Henry et al., for example, examined the relationship of their subjects' parents from the sociological perspective (14). They noted that there was a low divorce rate and concluded that the marriages were satisfactory. Stable marriages, however, may not be satisfactory marriages, particularly if a child is serving a conflict-detouring role.

Summary

This study examined the folklore among family therapists about themselves and tested this mythology empirically. It suggested that family therapist families of origin have dysfunctional levels of Cohesion and Adaptability, and that the family therapists enacted roles which differed from those their siblings played.

This raises the issue that even if the study detects systems dysfunction in the families of family therapists, this says nothing about why only some dysfunctional families produce therapists. Certainly not all dysfunctional families produce therapists. Moreover, a family stresses all its members, but not all its members become therapists. The question which must first be answered is whether or not there is pathology in family therapists' families that differentiates them from other nonhelping professionals' families. Once this is answered, the question of how they differ from nontherapist-producing families with pathology may be addressed.

HYPOTHESES

The hypotheses for this study were as follows:

1. Family therapists perceive their families of origin as having either high or low Cohesion, and either high or low Adaptability compared to undifferentiated nonmental health professionals who perceive their families as having Cohesion and Adaptability in the medium range.

2. Family therapists and their siblings' descriptions of their families' Cohesion and Adaptability are significantly associated with one another.

3. Family therapists enacted roles in their families of origin in which they crossed the generational boundary, as compared to the control group who enacted

roles that did not cross the generational boundary.

4. Family therapists and their siblings enacted roles in their families of origin with clearly discernible features:

a. The therapists enacted roles in their family of origin which were parentified and did not elicit increased executive functioning as compared to siblings' roles which elicited increased executive functioning from others.

b. Therapists enacted roles in their family of origin of high family esteem as compared to the siblings who did not.

METHOD

One hundred and fifty-nine men and women were recruited from 3 groups: 59 family therapists, 49 siblings of the therapists, and 51 architects, C.P.A.s, biochemists, engineers, and physicists. In 11 therapist/sibling pairs, only the therapist returned the finished protocol, while in one other pair, only the sibling did.

The participating family therapists were faculty or practitioners at New York, Philadelphia, and New Jersey institutes. They included psychiatrists, psychologists, and social workers. Their inclusion in this study required the sibling closest in age to each therapist to agree to participate as well. Control group professionals were recruited through professional societies, labs, and chemical companies in New York, Connecticut, and New Jersey. They held Ph.D.s or were licensed at the highest level of their discipline.

Measures

Family Adaptability and Cohesion Evaluation Scale (FACES)

Olson, Sprenkle, and Russell (31) developed the Circumplex Model of Family Functioning after their systems literature review revealed two salient dimensions along which to type families. FACES, developed by Olson, Bell, and Portner (29), measures these dimensions—Cohesion Adaptability. Cohesion describes the gree of family entanglements from tremely under- to extremely over- including disengaged, separated, nected, and enmeshed regions of the tinuum. Adaptability describes a fa capacity to negotiate situational and opmental changes. The Adaptability includes rigid, structured, flexible, chaotic regions on a continuum extreme stasis to extreme changeabilit

Combining the Cohesion and Adapta ity data yields the total family functio score. Olson et al. describe three categori or three Circumplex Types of total family functioning: Balanced (either of the two non-extreme regions from one dimension paired with either non-extreme region from the second dimension), Mid-range (either extreme end of one dimension paired with either non-extreme region of the second), and Extreme, (either extreme region of one dimension paired with either extreme of the other).

For the present study, subjects were to respond to FACES items with regard to their family of origin up until their own age 17.

Complementary Role Questionnaire (CRQ)

The author developed the CRQ to explore the dimensions Generational Boundary Crossing (GBX) and Esteem. She found, however, that the GBX dimension actually elicited information not just about boundary clarity, but also about whether the subjects' coalitions seemed to elicit increased and united executive functioning from the executives. The CRQ asks the subject to choose three roles from among a series of role behaviors. It then requests brief essays describing the situations which evoked the three roles and the effect the role behaviors had on the situations. The interaction of the role behavior with executive functions, and the esteem

accorded the subject, were the scored variables.[1]

Demographic Data Questionnaire (DDQ)

The DDQ elicited data pertaining to subjects and their families for the period of time when the subjects were 1-17 years old. The variables were: Age, Birth Order, SES, Religion, and Religious Apostasy.

RESULTS

Hypothesis 1: Cohesion

For statistical analyses, the 4 categories of the FACES Cohesion dimension (Disengaged, Separated, Connected, and Enmeshed) were collapsed into 2 categories: Extreme (Disengaged plus Enmeshed) and Non-Extreme (Separated plus Connected). The results indicated no significant differences between the two professional groups' families, with scores predominantly in the normal range. Seventy percent of family therapists (N = 59) and 68% of other professionals' ratings of their families (N = 51) were classified Non-Extreme. Notably, no family therapists rated their families in the Enmeshed range of the scale.

Although Hypothesis One described only differences between types of families with professionals, differences between matched pairs of siblings and family therapists were also investigated (N = 48). Again there were no significant differences. The majority of scores—65% of family therapists and 73% of siblings—were classified Non-Extreme.

Hypothesis 1: Adaptability

The 4 categories of the Adaptability scale (Rigid, Structured, Flexible and Chaotic) were collapsed into 2: Extreme (Rigid plus Chaotic) and Non-Extreme (Structured plus Flexible). The differences between the two professional groups were not significant. The family therapists' scores for their families were predominantly in the Extreme range (59%, N = 59) as was a substantial proportion of the other professionals' scores for their families (48%, N = 51). The greatest number of subjects in each group, 56% of the family therapists and 41% of the other professionals, rated their families in the Rigid region of the scale.

In addition to investigating between-family types, intrafamilial differences in Adaptability were analyzed. There was no significant difference between pairs of siblings and family therapists. In each group, the greatest number of subjects—48% of the family therapists and 56% of the siblings (N = 48)—rated their families in the Rigid range of the Extreme category.

Hypothesis 2: Sibling Agreement

The Pearson Product Moment correlation was not significant for the Cohesion dimension (N = 48, $r = .07$). The correlation was statistically significant for the Adaptability scale, but at only a moderate level of strength (N = 48, $r = .31$).

Additional Analyses for Circumplex Types

Pairs of siblings and family therapists evidenced no significant differences between their Circumplex Types. Forty-four percent of each group (N = 48) scored in

[1] In generating the CRQ, the author asked 19 family therapists, who had between 8-20 years experience in the field, for a list of ten roles siblings may play in families. They defined the roles with attention to boundary clarity and esteem dimensions. Because roles themselves are neither necessarily healthy nor pathological, the essay question was included to clarify the context and the effect of the role behaviors. Two raters scored the responses for boundary clarity, interaction with executive functioning, and esteem, then compared definitions in the role manual to the three role statements the subjects checked and to the essays they wrote. The definition manual suggested scores for the three variables but no score could be interpreted without taking into account the subject's explanatory essays. While content scoring has disadvantages, raters for the present study agreed 89% of the time.

the Mid-Range category in describing their families.

Comparing family therapists with other professionals' Circumplex Types also revealed no significant differences. Forty-four percent of the family therapists (N = 59) and 45% of the other professionals (N = 51) scored their families in the Mid-Range category.

Hypothesis 3 and 4a: Boundary Clarity and Executive Functioning

Family therapists and other professionals appeared to differ significantly ($\chi^2 = 12.99$, $p < .01$) in this more exploratory aspect of the protocol, as did family therapists and their paired siblings (Wilcoxon $z = -3.37$, $p < .001$). In selecting their three role statements, family therapists most often chose three out of three executive styles, while siblings and other professionals chose three out of three such roles least often (see Tables 1 and 2).

Hypothesis 4b: Esteem

The paired scores of siblings and family therapists differed significantly (Wilcoxon $z = -1.71$, $p < .05$) on the CRQ Esteem dimension. While both family therapists and sibling subjects chose three out of three average to high esteem roles more often than other arrangements, significantly more family therapists did so (see Table 3).

An additional analysis of the two professional groups revealed that family therapists and other professionals did not differ significantly in their childhood esteem levels. Seventy-seven percent of the family therapists (N = 59) and 76% of the other professionals (N = 51) chose high esteem roles.

TABLE 2

Comparison of Executive Functioning in Matched Pairs of Family Therapists vs. Siblings

	NUMBER OF EXECUTIVE ROLES				
	0	1	2	3	TOTAL
Family Therapists	11	6	13	18	48
Siblings	18	16	11	3	48
Total	29	22	24	21	96
	Wilcoxon $z = -3.37$				$p <$

Sociodemographic Data

There were no significant effects of gender in any analysis of FACES, CRQ, or SDD data. Nor were Age, SES, Religion, or Religious Apostasy significantly different among subject types. Birth Order did not differ between family therapists and other professionals. These two professional groups did differ, however, from the sibling group, with more professionals being eldest ($\chi^2 = 9.87$ for siblings and controls, $p <$ .01; McNemars $\chi^2 = 4.37$ for paired siblings and family therapists, $p < .05$).

DISCUSSION

Sociodemographic data were investigated both to insure homogeneity in the

TABLE 1

Comparison of Executive Functioning in Family Therapists vs. Other Professionals

	NUMBER OF EXECUTIVE ROLES				
	0	1	2	3	TOTAL
Family Therapists	13	8	15	23	59
Other Professionals	19	12	15	5	51
Total	32	20	30	28	110
	df = 3		$\chi^2 = 12.99$		$p < .01$

TABLE 3

Comparison of Esteem in Matched Pairs of Family Therapists vs. Siblings

	NUMBER OF HIGH ESTEEM ROLES				
	0	1	2	3	TOTAL
Family Therapists	1	7	4	36	48
Siblings	5	6	11	26	48
Total	6	13	15	62	96
	Wilcoxon $z = -1.71$				$p <$ .05

sample and to rule out Henry, Sims, and Spray's proposition that religio-cultural variables are the decisive factors in mental health professionals' occupational choice (13, 14). The stereotype of the upwardly mobile, urban, Jewish apostate received these authors' empirical support. They found no evidence that therapists assumed a caretaking role in their families of origin (13, p. 9). The present study confirmed Henry et al.'s demographic findings, but not their conclusions about therapists' roles. Instead, this research demonstrated that when family therapists did not differ from nonmental health professionals on cultural variables, they did differ on a measure of boundary clarity and family roles. Significantly more family therapists played just that caretaking role for which Henry et al. found no support. The one difference found in the sociodemographic data, that is, the difference in Birth Order between the two professional groups and the sibling group, is consistent with previous research (21, 34) that suggests eldests are preeminent in the professions.

Systems Data

Contrary to family therapist folklore, none of their families were described as Enmeshed (66% were either Disengaged or Separated). They did rate their families, however, predominantly in the Rigid region of Extreme Adaptability. Neither Non-Extreme Cohesion nor Rigid Adaptability distinguishes their families from those of other professionals.

The combination of Non-Extreme Cohesion and Extreme Adaptability is a mild inconsistency which Olson et al. consider theoretically possible but clinically unlikely (31). There is a second inconsistency, that is, family therapists describing predominantly Disengaged and Separated Cohesion along with boundary blurring coalition roles. These inconsistencies highlight a problem with certain systems measures (26, 29, 30). In order to calculate the level of cohesion in the family, systems measures seem to elicit levels of behavioral unity rather than levels of reactivity or differentiation.

Measures such as FACES require the subject to respond to questions about family behavior as though family behaviors were unitary. An Enmeshed score on FACES is obtained, for example, by a subject responding that all members are close and do the same as one another nearly all the time. Clinicians, however, frequently see families where there are overinvolved coalitions and an underinvolved third member. These families in practice are considered enmeshed. Literature on violent families, for example, cites three different formats for overinvolved, violent families (19). All three structures contain both overinvolved coalitions and underinvolved members. If subjects from any one of these three formats were responding to FACES, they would be confronted with a question such as, "Our family does things together" (29). In order to answer this question, subjects may either be forced to "average" the behavior of both allied and distant members, obscuring their differences, or may respond "never," obscuring the enmeshment. The first test response strategy would result in an average score leading to an apparently balanced diagnosis that was inaccurate for the family. The second strategy would diagnose an enmeshed family as disengaged.

A family with mixed over- and underinvolved members may, however, all share an equal level of undifferentiation or reactivity. For example, an overinvolved mother and child fight at home; the reactive father stays longer at his job. He is only apparently uninvolved and differs from the father who stays at his job so long that he doesn't know what the home situation is. If reactivity or differentiation could be assessed, an "averaging together" response set would be clinically faithful. Since the time of the present study, the authors of

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FACES have incorporated criticisms about their Cohesion scale (2, 3) into FACES II (30). Just as with FACES, however, FACES II also does not have the sensitivity to subsystems and coalitions necessary to accurately measure levels of differentiation or reactivity in a family.

EXPLORATION OF FAMILY ROLES

Therapists and Other Professionals

The exploration of role behaviors revealed dramatic differences between family therapists and nonhelping professionals. Family therapists most often chose three out of three roles that coexist with blurred generational boundaries. Other professionals most often chose three roles indicating age-appropriate roles.

Family therapists experienced themselves as having held executive or expressive functions in their families much as a parent would. Their actions did *not* seem to induce increased executive functioning from parents. They were frequently dominant siblings who perceived themselves as advisors and important regulators of their parents self-esteem as well. Following is a typical family therapist description. (The distance noted between parents was common in therapists' descriptions.)

> Tension between my parents—usually mother angry at criticisms and restriction placed by my father. My clowning, joking, etc., was always a way of bringing the attention to me, decreasing tension. Also, I'm sure it was also a way to cheer up depressed parents. During periods of great distress and distance between parents, my mother used me as confidante.

Control subjects typically described age-appropriate roles, for example, this statement by a biochemist.

> I lived in a patriarchal family in which my father was clearly boss and where male/female roles were very clearly different. Father made the rules and mother r... the rules to my sister and myself. We did... participate in family decisions, and we ... sheltered from family problems.

Another typical role, that of mediat... appears to be a crucial addition in ... therapist repertoire. Not only were f... therapist subjects more often in coaliti... with a parent, but they moved in and ou... coalitions linking family members.

> The overall role was that of linker—a ... which persists to some smaller degree tod... If my father were angry at one of my broth... I would become anxious and try to think ... something one or another of them could do ... get back together . . . I made a point of keep... ing as open contact as possible with each ... my brothers and my father. I failed to keep a direct open channel with mother but was very aware of her moods and sometimes interpreted these for others. Very frequently father or brother would ask me what was *really* going on with one of the others.

The role of linker who moves in and out of being a partner to a parent seems to describe an experience of both centrality and difference. There may be a sense both of grandiosity and uniqueness conferred by a linking role, which mediates across the generational boundary and yet pulls back from the conflict. To temper their grandiosity, linkers would need to remain aware that roles can be reassigned, or that they could assume a variety of roles for themselves.

The subjects in the present study offered evidence that being treated as a precocious, pseudo-mature adult who can keep the family linked together is early grooming for therapist attunement. So it is not just the coalition with the parent that seems to be a precondition for therapist empathy. If the therapists were only parentified, in the sense of massive accommodation to the parents' needs, they might not have the capacity for objectivity. Indeed, if 59% of

family therapists evidence impaired family Adaptability on their FACES scale and 49% cite three out of three blurred boundary roles, one may ask why they are not more seriously impaired? Why not *only* patients instead of healers? A critical difference may lie in the built-in flexibility of the mediating role and its possible relation to the Non-Extreme level of Cohesion in these families.

Family Therapists and Siblings

The siblings of family therapists also chose roles that differed significantly from the linking and parentified therapists. They tended to choose either secure, "just-kids" roles or scapegoat/rescuer roles. Usually the sibling closest in age to the family therapist was neither parentified nor a problem. When a subject did choose a scapegoat/rescuer role on the CRQ, however, that subject was significantly more often a sibling than a family therapist.

> As an adolescent I was very rebellious—dating older men my parents disapproved of, becoming involved in drugs, etc. I was the "problem child." I acted out any anger [at] my parents and their overprotectiveness, by doing these things. I ended up in serious trouble.

While the scapegoats/rescuers may be coalition participants, their style of participation would more likely elicit increased executive functioning rather than their acting as overt parental caretakers like their therapist siblings.

Esteem

The exploration of differences in Esteem for the roles of sibling and family therapist subjects also elicited significant differences, with family therapists more often choosing three out of three high-esteem roles.

The difference seemed to hinge on those siblings who described themselves as the problem and who could not live up to the favored therapist sibling's achievements, and the family therapists who described themselves as the golden child in the family. Following are excerpts of pairs of siblings to demonstrate this finding:

> (Sibling) Both parents developed a drinking problem and were often drunk by 8:00 p.m. with slurred speech.... I was melancholy, crying all the time... mother thought I was mean ... [family therapist sibling] was father's and mother's favorite—bright, seemed self-confident.

The therapist sibling of the above subject wrote as follows:

> When my brother or sisters misbehaved or fought with parents, my staying out of it made me look good. Also, my confidential relationship with my father, who had many pet names for me....

Again:

> (Sibling) I was treated like I was retarded. I was thought of as mean and bad.

The therapist sibling's descriptions:

> I was characteristically involved in mediating conflicts between my parents and my sibs, between my parents and between others in my extended family. Lots of rewards, brownie points and reinforcements of my role as mediator and *good one*. Great difficulty in showing my bad side [etc.].

The fact that so many subjects chose three out of three of the same role choices for themselves—75% of the therapists, 54% of the siblings (N = 48)—indicated a certain rigidity in the role apportionment consonant with their Rigid Adaptability. Had there been more flexibility in the role apportionment, the families may have been even less dysfunctional. The good one, however, may have feared improvement in

the bad one, a fear that they would exchange roles. Once the lack of flexibility settled in, the developmental correlates of later role choices may have settled in. The therapists were rewarded for their empathic or vigilant attention to the moods of others; the siblings were rewarded with family unity for sacrificing esteem.

CONCLUSION

Myths are strong, perhaps stronger than facts, and surely stronger than memory. If myths are so powerful, this study may not have been a fair test of the hypotheses because the study relied on subjects' self-report. Subjects may be influenced by the power of the myth themselves. Family therapists may want to identify themselves with the stereotype of what a family therapist is supposed to be. Thus, if folklore has it that they were parentified children, they may describe themselves as such for the sake of identifying with their stereotype of their profession. Part of the power of the results of this study, however, lay in the capacity of the design to check the view of the family therapist against that of the paired sibling. These siblings often confirmed the differing roles and esteem in the family, referring to one another in role descriptions.

The evidence of this research supports the demographic description of therapists from previous research (13, 14) and adds family systems determinants that correlate with the family therapist's occupational choice. A more discriminating model has emerged than the simple, individual role theory and folklore about the developmental correlates of the profession. Some of the romanticism of folklore has been lost, but the realities are more complex than the stereotypes and quite respectable in themselves.

REFERENCES

1. Ackerman, N. W. Group dynamics 1. Social role and total personality. *American Journal of Orthopsychiatry 21:* 1-17, 1951.
2. Bilbro, T., & Dreyer, A. A methodological study of a measure of family cohesion. *Family Process 20:* 419-427, 1981.
3. Beavers, W. R., & Voeller, M. N. Comparing and contrasting the Olson Circumplex Model with the Beavers Systems Model. *Family Process 22:* 85-97, 1983.
4. Boszormenyi-Nagy, I. Intensive family therapy as process. In I. Boszormenyi-Nagy & J. L. Framo (eds.), *Intensive family therapy: Theoretical and practical perspectives.* New York: Harper & Row, 1965.
5. Clausen, J. Family structure, socialization and personality. In M. Hoffman & L. Hoffman (eds.), *Review of child development research.* New York: Russell Sage Foundation, 1964.
6. Cleveland, M. Families and adolescent drug abuse: Structural analysis of children's roles. *Family Process 20:* 295-304, 1981.
7. Ferber, A. We became family therapists. In A. Ferber, M. Mendelsohn, & A. Napier (eds.), *The book of family therapy.* New York: Science House, 1972, pp. 89-93.
8. Galinsky, M. D. Personality development and vocational choice: A study of physicists and clinical psychologists. *Journal of Counseling Psychology 9:* 299-305, 1962.
9. Goldner, V. Diagnosis technique in family therapy with children. In A. Earheart, L. Greenhill, & D. Schaffer (eds.), *Diagnosis in treatment in pediatric psychiatry.* New York: Macmillan & Sons, 1984.
10. Grigg, A. E. Childhood experiences with parental attitudes: A test of Roe's hypothesis. *Journal of Counseling Psychology 6:* 153-156, 1959.
11. Haley, J. *Uncommon therapy: The psychiatric techniques of Milton H. Erickson, M.D.* New York: W. W. Norton, 1973.
12. ———. *Leaving home: The therapy of disturbed young people.* New York: McGraw-Hill, 1980.
13. Henry, W. E., Sims, J. H., & Spray, S. L. *The fifth profession.* San Francisco: Jossey-Bass, 1971.
14. ———, Sims, J. H., & Spray, S. L. *Public*

and private lives of psychotherapists. San Francisco: Jossey-Bass, 1973.

15. Hoffman, L. Deviation-amplifying processes in natural groups. In J. Haley (ed.), *Changing families: A family therapy reader.* New York: Grune & Stratton, 1971.
16. ———. "Enmeshment" and the too richly cross-joined system. *Family Process 14:* 457-468, 1975.
17. Holt, J., & Luborsky, L. *Personality patterns of psychiatrists.* New York: Basic Books, 1958.
18. Jung, C. G. *Memories, dreams and reflections.* New York: Random House, 1965.
19. Justice, R., & Justice, B. *The abusing family.* New York: Human Services Press, 1976.
20. Lackie, B. *60th anniversary alumni study.* North Hampton: Smith College School for Social Work, 1980.
21. McArthur, C. Personalities of first and second children. *Psychiatry 19:* 47-54, 1956.
22. McClendon, M. J. The occupational status attainment processes of males and females. *American Sociological Review 41:* 52-64, 1976.
23. Minuchin, S. *Families and family therapy.* Cambridge: Harvard University Press, 1974.
24. ———, & Fishman, H. C. *Family therapy techniques.* Cambridge: Harvard University Press, 1981.
25. ———, Montalvo, B. G., Guerney, B., Rosman, B. L., & Schumer, F. *Families of the slums: An exploration of their structure and treatment.* New York: Basic Books, 1967.
26. Moos, R. H. *Family Environment Scale, Form R.* Palo Alto: Consulting Psychologists Press, 1974.
27. Mowrer, O. H. An autobiographical sketch. In G. Lindzey (ed.), *A history of psychology in autobiography, Vol. 6.* Englewood Cliffs NJ: Prentice-Hall, 1974.
28. Napier, A. We became family therapists. In A. Ferber, M. Mendelsohn, & A. Napier (eds.), *The book of family therapy.* New York: Science House, 1972, pp. 93-96.
29. Olson, D. H., Bell, R., & Portner, J. *FACES: Family Adaptability and Cohesion Evaluation Scales.* St. Paul: University of Minnesota Press, 1978.
30. ———, Portner, J., & Bell, R. *FACES II, Family Adaptability and Cohesion Scales.* St. Paul: University of Minnesota Press, 1982.
31. ———, Sprenkle, D. H., & Russell, C. Circumplex Model of Marital and Family Systems: I. Cohesion and adaptability dimensions, family types, and clinical applications. *Family Process 18:* 3-28, 1979.
32. Roe, A. *The making of a scientist.* New York: Dodd & Mead, 1953.
33. ———. Early determinants of vocational choice. *Journal of Counseling Psychology 4:* 212-217, 1957.
34. Schacter, S. Birth order, eminence and higher education. *American Sociological Review 28:* 757-767, 1963.
35. Schecter, N. Therapists typology and their developmental and motivational correlates. Unpublished doctoral dissertation, University of Michigan, 1978.
36. Spiegel, J. P. The resolution of role conflict within the family. In N. W. Bell, & E. F. Vogel (eds.), *A modern introduction to the family* (revised ed.). New York: Free Press, 1968.
37. Terkelsen, K. G. Toward a theory of the family life cycle. In E. A. Carter & M. McGoldrick (eds.), *The family life cycle: A framework for family therapy.* New York: Gardner Press, 1980.
38. Viscott, D. S. *The making of a psychiatrist.* Greenwich CT: Fawcett Publications, 1972.
39. Vogel, E. F., & Bell, N. W. The emotionally disturbed child as the family scapegoat. In N. W. Bell, & E. F. Vogel (eds.), *A modern introduction to the family* (revised ed.). New York: Free Press, 1968.
40. Wheelis, A. *Vocational hazards of psychoanalysis in the quest for identity.* New York: W. W. Norton, 1958.
41. Whitaker, C. We became family therapists. In A. Ferber, M. Mendelsohn, & A. Napier (eds.), *The book of family therapy.* New York: Science House, 1972, pp. 96-101.

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