Examining Counselors Level of Professional Experience With Adult Attachment Style and Comfort with Emotional Intimacy

By

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EXAMINING COUNSELORS LEVEL OF PROFESSIONAL EXPERIENCE WITH ADULT ATTACHMENT STYLE AND COMFORT WITH EMOTIONAL INTIMACY

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DEDICATION
This dissertation is dedicated in memory of my grandmother, Ruth Cheeks, who instilled in me the value of education;

To my father who started this journey with his baby girl, but became a guardian angel and has supported me from above;

To my mother whose love and support is ineffable-you’ll never know how you encouraged me each time I called, and you said, “Hey Doc!”.

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ABSTRACT

KENIKA S. HOLLOWAY
EXAMINING COUNSELORS’ LEVEL OF PROFESSIONAL EXPERIENCE WITH ADULT ATTACHMENT STYLE AND COMFORT WITH EMOTIONAL INTIMACY
Under the direction of Dr. Donald Redmond, Associate Professor

The purpose of this study is to determine if professional experience influences discussing emotional intimacy with clients as well as counselors’ adult attachment style and comfort with intimacy. This study recruited licensed and unlicensed professional counselors and marriage and family therapists including associate-level, master’s-level, and student/interns in both disciplines. A MANOVA was conducted to analyze the data collected from the Revised Adult Attachment Scale and Fear of Intimacy Scale. This study bridges the gap in the counseling literature in regard to counselors’ susceptibility to countertransference regarding emotional intimacy, due to their own personal adult attachment style and comfort with emotional intimacy. This study highlights the importance of counselors being more self-aware of the influence of their attachment and intimacy history.
CHAPTER 1

INTRODUCTION

Counseling is a profession in which the counselor serves as an agent of change to assist clients reach their therapeutic goals (Hazier, Kottler, Lawson, & Venart, 2007). Counselors are trained to experience clients’ feelings through empathy, see the world through their clients’ eyes, and to connect to the pain that clients experience when vulnerable (Hazier et al., 2007). The American Counseling Association (2014) explains that counselors are to facilitate client development and growth in ways that foster the welfare and interest of clients and promote the formation of healthy relationships. Comparatively, marriage and family therapists are trained in psychotherapy and use a family systems approach to attend to the nature and role of individuals in primary relationship networks such as marriage and the family (American Association for Marriage and Family Therapy, AAMFT, 2017). Both disciplines expect professionals to have awareness of their own personal issues including the possible influence of personal issues on the helping process and seek appropriate professional assistance if necessary (ACA, 2014; AAMFT, 2015, Russell, Peplau, & Cutrona, 1980).

Since counselors experience the same trials as everyone else, through the process of their work it is inevitable that counselors may have to confront unexplored personal blocks such as power, loneliness, death and intimate relationships (Corey, 2013). The unfinished business of a counselor’s own family of origin, memories, psychological associations, fantasies and his or her own emotional responses may become unsettled
in intensified sessions with clients (Kaslow & Schulman, 1987). Counselors are not immune against family and personal problems (Deacon, Kirkpatrick, Wetchler & Niedner, 1999), thus a critical topic is how counselors manage these life events and the influence on therapeutic outcomes (Gladding, 2000).

Statement of the Problem

Many adult clients seek help to resolve the crises in their lives, most which are problems related to aspects of intimacy which can be multifaceted (Spooner, 1982). Couples experiencing problems in their romantic relationship often live in a private world where their partner is emotionally detached or unavailable (Stephens, 2014). Stephens (2014) states that the emotionally detached partner characteristically lacks friendship, commitment to family, communication, and faith which can lead to distress and the dissolution of the relationship. Couples facing dissolution express that there is a lack of attentiveness and feel as though their partner has detached both emotionally and verbally (Stephens, 2014). Ellis (2003) stated if couples do not pursue professional help to manage the crisis in their relationship, then it is possible to sabotage the relationship by allowing the challenges to defeat the union.

Since counseling is viewed as an intimate form of learning, it is the appropriate environment that clients can experience growth from the context of a person-to-person relationship (Corey, 2013). Pistole (1999) believes addressing core interpersonal relations in counseling can be advantageous for clients. However, counselors should be cognizant of their internal conflicts and how likely their problems are to affect their professional role (Corey, 2013). Corey (2013) warns if counselors hide behind the safety of their professional role, then clients are likely to keep themselves hidden as well.
Emotional Intimacy

Human beings have a natural desire to form relationships (Baumeister & Leary, 1995) and the pursuit of intimacy is just as persistent and profound (Storkey, 1995). This can be observed throughout the lifespan as infants and primary caregivers bond (Bowlby, 1973), adolescents begin their attempts to bond through dating (Rathus, 2012) and as many adults marry then divorce only to remarry or find a life partner (McGoldrick & Carter, 2010). Spooner (1982) explains if one accepts the basic principle of existential theory, that people are attempting to make meaning of their lives, then in doing so, humans are constantly testing perceptions of their reality. Spooner (1982) posits intimacy is a facet of that endeavor. Intimate interactions with another person is a powerful mediating factor of both confirming and disconfirming who one is (Spooner, 1982). According to Spooner (1982), “Rejection is equated with death and the possibility of rejection is as fundamental to the fear of intimate contact as the fear of loss of identity” (p. 168). Therefore intimacy, as confirmation and connection, poses a serious issue in adulthood as individuals may approach it with both desire and fear (Spooner, 1982).

Emotional intimacy has several definitions. These include “feelings of closeness, connectedness, and bondedness in loving relationships” (Sternberg, 1997, p. 315); “an interpersonal process that involves communication of personal feelings and information to another person who responds warmly and sympathetically” (Reis & Shaver, 1988, p. 375); “a product of eye contact, distance, smiling and other behaviors” (Patterson, 1976, p. 235); “a subjective appraisal, based upon interactive behaviors, that leads to certain relational expectations” (Chelune, Robinson & Krommor, 1984, p.13); and “emotional bonding including intensity of liking, moral support and ability to tolerate flaws in the
significant other” (Tolstedt & Stokes, 1983, p. 574). Additionally, Prager (1995) defined intimacy as existing over time, involving verbal and nonverbal exchanges which leaves both partners feeling positive about the relationship and themselves; and partners have a perception of knowing or understanding one another and anticipate having continuous interactions in the future. Intimacy, then, involves the sharing of closeness, acceptance, trust, disclosing private feelings and thoughts, warmth, care and the expected reciprocation from another partner (Storkey, 1995).

Although these definitions exist, the term intimacy can still be confusing because it is often used as a euphemism for sexual activity (Storkey, 1995; Spooner, 1982). Sex is an important part of how couples connect and bond (Berman & Wohlsifer, 2010), however, Freud (1959) clarified that “sexual intimacies do not always wait for the ability to develop a true and mutual psychological intimacy with the other person” (p. 101). In fact, Spooner (1982) explained that sexual activity has become a substitute for intimacy to avoid being in touch with another individual and removing oneself out of the anxious process and risk of developing true intimacy.

One of the most important sources of delight and purpose in life is having satisfying intimate relationships (Thelen, Vander Wal, Thomas, & Harmon, 2000). Emotional intimacy is an important condition to romantic relationships (Ferber, 2016) and theoreticians have long proposed that this type of intimacy is vital to psychosocial adjustment, mental health, and basic human needs (Erikson, 1963, Maslow, 1970; Sullivan, 1953). For example, intimacy has been linked to psychological health of both parties in a relationship (Murray, 2009). High levels of comfort with intimacy is related to both partners’ ability to provide and receive support in their relationship (Davila &
Kashy, 2009). The capability to receive support suggests that individuals that are comfortable with intimacy can communicate pertinent information about their needs to their romantic partner (Davila & Kashy, 2009). On the other hand, individuals who fear intimacy are less likely to engage in supportive and healthy interactions with another individual (Emmons & Colby, 1995).

Although interpersonal relationships can produce happiness, these relationships can also be the source of misery and emotional pain (Firestone & Catlett, 2004). Individuals seem to experience the most turmoil and distress regarding the difficulties encountered in personal relations (Firestone & Catlett, 2004). Dissatisfaction or rejection in a relationship is perhaps the most common reason individuals seek psychotherapy (Firestone & Catlett, 2004). Since intimacy represents an essential factor of human functioning, an impaired ability to form intimate bonds may have negative consequences (Thelen, et al, 2000). Several researchers found those individuals who lack intimate relationships are likely to develop symptoms of psychological disturbance (Chamberlaine, Barnes, Waring & Wood, 1989; Peterson 1993; Reisman, 1985; Steil & Turetsky, 1987) and experience loneliness (Wheeler, Reis & Nezlek, 1983).

Fear of Intimacy

The fear of intimacy is defined as an anxious reaction to sharing personal feelings and thoughts with a highly valued significant other (Descutner & Thelen, 1991). In the last decade, the fear of intimacy has grown in interest (Sorbal & Costa, 2015) and recently was associated with alexithymia (Karakis & Levant, 2012), attachment (Rotella, 2010; Neuenschwander, 2010; Wood, 2007), body image (Sklar, 2008), childhood trauma (Repic, 2007; Wells, 2012), commitment phobia (Diaz, 2012), emotional restrictiveness
(Ferber, 2016), impediments to intimacy (Alperin, 2006), intimate partner violence (Gage, 2013), and substance abuse (Thorberg & Lyvers, 2006). Previous research found that the fear of intimacy interferes with having satisfying marriages (Fields, 1983), hinder progress in dating (King & Christensen, 1983) and can trigger the onset and development of neurotic disorders (Wilhelm & Parker, 1988). Theory supports intimacy as an essential component of human relating, therefore an impaired capacity to develop intimate bonds may have deleterious consequences (Prager, 1995; Thelen, et al., 2000).

Counselor as a person

The notion that the counselor as an individual is significant for therapeutic outcomes is based in part from familiar and commonly cited finding of meta-analyses that therapy outcome appears to be less related to the use of different therapy methods linked to established schools of therapy, and significantly related to variances between the individual counselors providing the therapy (Nissen-Lie, Havik, Høglend, Monsen, Rønnestad, 2013). Nissen-Lie and colleagues (2013) pointed out that studies to date suggest that theoretical orientation, experience level and type of training have limited value in distinguishing between successful and unsuccessful therapists. Instead, counselors’ interpersonal qualities are more related to successful outcomes, such as their facilitative interpersonal skills; their ability to be empathic, affirmative and responsive; their capability to resist counter-aggression when provoked with rejection and devaluation by clients; and their interpersonal functioning in their private lives (Nissen-Lie, et al, 2013).

Limited research exists on the personal lives of counselors and how their lives impact the therapeutic relationship. One study assessed client and therapist psychological
health with four Minnesota Multiphasic Personality Inventory (MMPI) scales and proved that therapists’ personal adjustment is positively connected to positive changes on the MMPI in clients (Garfield & Bergin, 1971). Deutsch (1985) collected basic self-report information on personal problems and treatment among 264 psychotherapists. The results showed that over half of these therapists had experienced depression or relationship difficulties. Similarly, a sequence of studies by Guy and colleagues (Guy & Liaboe, 1986; Guy, Poelstra & Stark, 1989) investigated the relationship between counselors’ personal and professional lives. Guy and colleagues (1989) asked 749 practicing psychologists to evaluate, by self-report, the influence of their personal distress on the quality of client care. A total of 74.3% therapists stated they had experienced personal distress throughout the preceding 3 years. Of those therapists, 36.7% reported that it had negatively affected their work quality, and 4.6% acknowledged that it had caused inadequate treatment for their clients (Guy et al., 1989).

Previous research focused on other aspects of counselors. Several researchers investigated counselors’ motivation underlying career choice such as the desire to resolve personal psychological distress (Guy, 1987), the desire to fulfill need for intimacy and closeness not encountered in childhood (Dryden & Spurling, 1989; Liaboe & Guy, 1987), and the need to continue with the caretaking role which started in the family of origin (DiCaccavo, 2002). Other research explored factors that contribute to the counseling relationship was limited to attachment style, personality traits, technical skill and ability (Barber, Muran, McCarthy, & Keefe, 2013) and burnout (Barnett, 2015; Pace, & Rosenberg 2006; Thompson, Amatea, & Thompson, 2014). However, Knott, Wetterneck, Derr, and Tolentino (2015) found that limited research has explored therapist intimacy
behaviors by comparing differences in therapists’ personal relationships and therapeutic relationships. Knot and colleagues (2015) proposed that an investigation in this area may not only further research and an understanding of exactly how the therapeutic relationship evokes change, but also address whether training in specific therapies may contribute to the use of intimacy promoting behaviors.

In the therapeutic process, therapists inevitably experience emotional arousal in the therapeutic alliance (Billow, 2001). Freud (1959) coined this concept as countertransference which is defined as counselors’ own resistances, emotions and complexes that hinders their work. When counselors are triggered in session and are unable to manage their emotions, the likelihood of successful outcomes are compromised (Freud, 1959; Shamoon, Lappan, & Blow, 2016). A counselor that is stirred up may avoid clients’ content or over-respond to content in a way that alienates the client (Shamoon, et. al, 2016). Ackerman and Hilsenroth (2001) found when counselors are not in control of their emotions, they are likely to contribute to the erosion of the therapeutic relation by behaving with rigidity, distance, uncertainty, distractibility and criticism.

Shamoon and colleagues (2016) stated who the counselor is and how she or he practices therapy is centrally important to the change process as well as how she or he manages anxiety in session. Counselors that are in-tune with their anxiety and can manage it are more helpful than those counselors that are unable to manage their anxiety in session (Shamoon, et. al, 2016). The researchers clarified the anxiety they were referring to is the discomfort and instinctive reaction that happens in response to a stimulus and not the clinical manifestations of anxiety that are diagnosable. For therapists, it is the anxiety that is provoked in stressful or emotional laden situations
encountered in session such as when clients are hostile to one another, challenge the therapist, discuss extreme political positions to the therapist or when clients trigger unresolved issues in the history of the counselor (Shamoon, et. al, 2016).

Purpose of the Study

Since counselors are raised in the same culture as their clients it is likely that they may experience similar problems as the general population. The purpose of this study is to examine whether counselors’ level of professional experience, adult attachment style and comfort with intimacy assists or interferes with counselors’ ability to broach the topic of emotional intimacy with their clients.

Conceptual Underpinnings for the Study

Erickson’s Psychosocial Development

Erikson (1968) explains that intimacy can only occur when identity formation is well developed. The adolescent who is unsure of his or her identity tends to shy away from interpersonal intimacy or resort to behaviors which are promiscuous and without true fusion (Erikson, 1968). This fusion may be expressed through marriage or abiding friendships (Rathus, 2012). Not having a secure sense of identity is a warning that the individual is not ready to commit to a relationship and is likely connected to the high divorce rates in teen marriages (Rathus, 2012). Erikson (1968) explained if the youth is unable to establish intimate relationships with others by late adolescence or early adulthood, then he or she may settle for a deep sense of isolation (Erikson, 1968).

Erikson (1963) proposed an eight-stage life-span theory of development that has unique crisis in each stage to assist with identity development. A basic strength arises from the successful resolution of one stage that is needed to be successful in the next
stage (Fleming, 2004). If a successful resolution does not occur, then the opposite of basic strength will occur which is called core pathology (Fleming, 2004). Erikson’s (1963) eight stages include trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity versus role confusion, intimacy versus isolation, generativity versus stagnation and ego integrity versus despair. He believed that growth is triggered by crises or turning points which are crucial periods of increased vulnerability and heightened potential. Trust versus mistrust, identity versus role confusion and intimacy versus isolation will be discussed further as they are most related to this study.

Trust versus Mistrust

The first stage of Erikson’s (1963) psychosocial stages of development is trust versus mistrust. The crucial social interaction at this stage is between the infant and the mother or primary caregiver (Fleming, 2004). These exchanges are the first demonstration of social trust that the infant learns of comfort and people associated with it (Erikson, 1963). The consistency, continuity and sameness from caregivers provides a rudimentary sense of ego identity which depends “on the recognition that there is an inner population of remembered and anticipated sensations and images which are firmly correlated with the outer population of familiar and predictable things and people” (Erikson, 1963, p. 247). This sense of trust implies that the infant has learned to rely on the sameness and continuity of the caregivers as well as to trust oneself to self-regulate (Erikson, 1963, Fleming, 2004). Thus, mothers create a sense of trust in their child by being sensitive and trustworthy which forms the basis for the child’s identity which will later combine a sense of being satisfied of being oneself and becoming what other people
trust that he or she will become (Erikson, 1963). Mistrust then is absence of trust and the infant socially withdraws and lacks hope (Fleming, 2004).

Identity versus Role Confusion

Erikson’s (1963) fifth stage of development, identity versus role confusion, proposes that youth begin to question their physiological revolution within themselves as well as their future adult tasks. Life can be stressful in adolescence as it is a period of great change due to youth body changes, with sexual organs maturing and social and academic adjustments to middle school (Fleming, 2004). Many youth become concerned about how others perceive them as compared to what they feel about themselves (Erikson, 1963). Preoccupation with how to integrate the roles and skills cultivated earlier within the occupational prototypes in society are of added concern with adolescents (Erikson, 1963). Teens basic task during this stage is to separate oneself from their parents and assume their own identity (Fleming, 2004). They must learn who they are, define who they are and invent themselves (Fleming, 2004). Their identities are tried out and are reflections of their role models which may be parents, coaches, teachers, athletes, celebrities or outlaws (Fleming, 2004). Role confusion is the danger if an adolescent’s identity is unclear (Erikson, 1963). Erikson (1963) posits the lack of career identity is what disturbs most youth and to keep themselves together they briefly overidentify with cliques and crowds to the point of complete loss of identity.

Intimacy versus Isolation

Erikson (1950) emphasized the social context of development and viewed the formation of one’s identity in adolescence as critical to having intimacy in adulthood.
Intimacy is the ability to talk things over endlessly, confess what one feels like and what the other seems like and by discussing wishes, expectations, and plans (Erickson, 1959). Erickson (1959) also theorizes if an individual does not accomplish the task of intimate relations with another, then the individual will isolate or seek relationships, but have repeated failures (Erickson, 1959). The achievement of intimacy is an important developmental task of adulthood and possible only after the individual has passed successfully through the first five stages, the last of which is the achievement of self-identity (Erikson, 1963). True engagement of another is possible only after both individuals have developed a strong sense of self-delineation (Fleming, 2004).

Attachment Theory

The attachment system established in childhood has significant influence on adult relationships (Mallinckrodt, Gantt, Coble, 1995). Feeney found that adults have attachment needs comparable to children’s needs which are met through adult attachment relationships with romantic partners, peers and family members (as cited in Bettman, 2006). Marris stated that emotionally important relationships represent the meaning of people’s lives (as cited in Pistole, 1999), and research shows that addressing core interpersonal relations in counseling can be valuable to clients (Pistole, 1999). Accordingly, confronting emotional issues with a significant individual from childhood can help resolve negative experiences in adulthood (Bowlby, 1977). Couples that are distressed from lacking intimacy within their marriage may be helped by resolving attachment issues (Stephens, 2014). Additionally, attachment theory is particularly relevant to counselors’ work because of the central position that interpersonal relating has in the therapeutic relationship (Pistole, 1999).
This study will utilize Hazan and Shaver (1987) research on adult attachment styles which stems from Bowlby’s (1969) foundational work on attachment theory with infants and mothers and Ainsworth and colleagues (1978) theory on attachment styles. Bowlby (1969) posited that infants are pre-programmed of behavioral patterns towards establishing a relationship with their mothers. He proposed that the attachment system served the evolutionary purpose of protection, with attachment reflecting the motivation to maintain proximity to a primary caregiver who provides a sense of security by being a safe base (Pistole, 1999). Bowlby (1969) observed that an infant will become distressed when separated from his or her mother and goes through predictable emotional reactions which are protest, despair and detachment. In his later work, Bowlby (1988), added that attachment behavior is not confined to children, but can be observed in the behaviors of adults. He explained that romantic relationships create a reciprocal dynamic in which the adults can be the attachment figure and the caregiver for each other.

Bowlby’s attachment theory was expanded by Ainsworth and her colleagues in their study of the Strange Situation with 106 one-year-olds (Ainsworth, Blehar, Waters & Wall, 1978). The researchers introduced one-year-olds who were with their mothers to an unfamiliar playroom with a large variety of toys. The researchers observed the exploratory behaviors of the infant in their mother’s presence and absence and to a stranger with the mother present and absent. The infant’s response to his mother’s absence was observed both when he was alone and when he was left with the stranger. The way the infant responded to his mother’s return after an absence was compared to the response of the stranger’s return after an absence.
Ainsworth et. al. (1978) research revealed that a mother’s accessibility and responsiveness to her infant’s needs develops into three styles of attachment which are secure, anxious/ambivalent and avoidant. Behaviors of secure infants included active exploration in their mother’s presence with some anxiety when separated and were easily comforted when their mother returned. Anxious/ambivalent infants were unreasonably anxious, angry and clingy which interfered with their ability to explore the room. These infants became distressed during separation and were difficult to comfort upon reunification with their mothers. Avoidant infants demonstrated little interest in their mothers.

In 1987, Hazan and Shaver conceptualized adult romantic love as an attachment process. The researchers drew a parallel from the literature on infant-mother interactions to explain that the development of bonds in infancy translate to adult romantic love. The translation focused on the three styles of infant attachment discovered by Ainsworth and her colleagues; secure, anxious and avoidant. Hazan and Shaver (1987) found that there is a comparative prevalence of the three attachment styles in adulthood as in infancy, the three attachment styles in adulthood are expressed predictably in the way romantic love is experienced, attachment styles is related to mental models of self and social relationships, and to early parental relationship experiences.

Research question and hypothesis
This study seeks to address the following questions:

**Question 1:** Is there a difference in fear of intimacy scores and reported adult attachment scores between licensed and unlicensed professional counselors and marriage and family therapists?
Null Hypothesis 1: There is no difference in fear of intimacy scores and reported adult attachment scores between licensed and unlicensed professional counselors and marriage and family therapists.

Significance of Study

Researchers have explored counselors' comfort with discussing physical intimacy with clients (LoFrisco, 2013; Cupit, 2010), yet limited research exists that investigates counselors’ comfort with discussing emotional intimacy with clients. Although, therapists are trained to explore all aspects of a person’s life; some may neglect to discuss emotional intimacy with clients or become anxious when the topic is broached due to countertransference or lack of training. Thus, intimacy problems may not be consistently resolved in counseling. There is also a gap in the literature that investigates counselors’ emotional intimacy in their own romantic relationships and their comfort with broaching clients’ emotional intimacy issues. This study aims to add to the literature on whether counselors’ level of professional experience influences comfort in exploring emotional intimacy issues with clients and investigate counselors’ personal comfort with intimacy and counselors’ adult attachment style.

Definition of Terms

The subsequent explanation of terms is provided to warrant consistency and understanding of these concepts throughout the study. The researcher developed the definitions not accompanied by a citation.

Attachment: An intense bond associated with an enduring relationship characterized by the yearning to maintain contact with both strong positive and negative emotions (Twardosz & Nordquist, 1983).
Counselor: The term counselor will be used interchangeably with therapist and include the collective levels of training and experience within both the counseling and marriage and family disciplines.

Counselor-in-Training: A student who is engaged in a complex, intentional progression of reflective educational and experiential activities to promote the development of knowledge and skills (Mullen, Uwamahoro, Blount, Lambie, 2015).

Countertransference: A paradigm in the counseling relationship when counselors’ unresolved issues are believed to be triggered by clients’ disclosure which then elicits counselors’ affective, cognitive, and/or behavioral reactions (Fauth & Hayes, 2006).

Emotional Intimacy: This study will use the term intimacy to refer to emotional intimacy which is the collaboration of partners revealing themselves by being vulnerable and self-disclosing and seeking and expressing validation of each other’s world-views and attributes (Reis & Shaver, 1988).

Fear of Intimacy: The fear of intimacy is defined by the “inhibited capacity of an individual, because of anxiety, to exchange thoughts and feelings of personal significance with another individual who is highly valued” (Descutner & Thelen, 1991).

Licensed Professional Counselor (LPC): An individual in the United States that has acquired a state license to practice counseling independently (Baggs, Kim, Lee, Mixon, Park, & Puig, 2012) to facilitate clients’ growth.
and development in ways that fosters the interest and welfare of clients and promote healthy relationships (ACA, 2014).

Marriage and Family Therapist (MFT): A licensed mental health professional trained in psychotherapy and family systems that can diagnose and treat mental and emotional disorders within the context of marriage, family and couples systems (AAMFT, 2017).

Master’s Level Counselor: An individual who has attained a master’s degree from a program related to counseling, but has not earned full licensure from the state.

Romantic relationships: A complex, ongoing, erotic, dyadic relationship that is grounded in the likelihood of shared exchanges of loving experiences between individuals whom perceive themselves as a couple either through marriage or outside of the legal arrangements of marriage (Logan, 2000).

Organization of the Remainder of This Study

This chapter has presented the introduction, statement of the problem, conceptual underpinning, research questions, significance of the study, and definition of terms. Chapter two contains the review of related literature related to intimacy, fear of intimacy, attachment and counselors’ personal lives. The methodology, procedures used to gather data, limitations, and delimitations of this study are presented in chapter three. Chapter four will present the data analysis of the study. Lastly, chapter five will discuss the study findings, implications for practice and recommendations for future research.
CHAPTER 2
REVIEW OF THE LITERATURE

This chapter will review and discuss relevant past and current literature as it relates to intimacy and the target population of counselors. The investigation included EBSCOhost, PsycINFO, and ProQuest, Eric and Wilson found in Mercer University’s library database. Articles, dissertations and books in print were included in the search. Relevant scholarly peer reviewed articles found in Google Scholar became a part of this study as well. Although sexual intimacy is an important factor in relationships, it will not be the primary factor in addressing intimacy in romantic relationships for this study. While a great deal of the selected dissertations, books and articles were creditable and appropriate for the literature review, many of the studies neglected to consider therapist own interpersonal relationships and their efficacy with clients with issues that mirror the professional helper, specifically around emotional intimacy.

Emotional Intimacy

The initial and most critical task facing a researcher investigating intimacy and intimate behavior is to properly define the term (Brigham, 1989). While the layperson’s use of the word “intimacy” may not create confusion in conversation, understanding the specifics of what academics mean when they mention intimacy is critical for understanding and interpreting their results (Edwards, 2014). Depending on the research,
intimacy could be used to describe sexual encounters, feelings of closeness in either platonic or romantic relationships or even the ambience of a surrounding environment (Edwards, 2014). In fact, Moss & Schwebel (1993) found sixty-one unique definitions of intimacy in the close relationships literature. Thus, without a clear definition of intimacy, researchers can misconstrue study findings and draw misguided conclusions (Edwards, 2014).

Sexton and Sexton (1982) found the origins of the term intimacy and stated “the word intimacy is derived from the Latin word *intimus*, meaning inner or inmost. To be intimate with another is to have access to, and to comprehend, his/her inmost character” (p. 1). Emotional intimacy is commonly associated with an exchange of affection (Stephens, 2014). Emotional intimacy is reputed to be the pinnacle of mutual social sharing and feeling (Sherman, 1993). According to Waring (1988), “the behavioral aspect of intimacy is predictability; the emotional aspect is a feeling of closeness; the cognitive aspect is understanding through self-disclosure; and the attitudinal aspect is commitment” (p. 38-39). Intimacy involves a process of being interested in paying attention to one another, trusting one another, caring what the other is experiencing and the willingness to entrust oneself to the other individual (Sherman, 1993). Cordova and Scott (2001) also believe intimacy is behavioral. The researchers suggest that intimacy will make an individual vulnerable to interpersonal closeness or punishment because on one hand individuals can be subjected to criticism, or verbal, emotional or physical abuse and then there can be love and affection (Cordova & Scott, 2001).

Dahms (1972) describes intimacy as “the overlooked requirement for survival” (subtitle). Brigham (1989) suggests that intimate relationships in our human experience
cannot be overemphasize. Researchers have evidenced protective effects of intimate relationships when one has heart disease, (Brummett, Barefoot, Siegler, Clapp-Channing, Lytle, Bosworth, Williams, & Mark, 2001; Coyne & Smith, 1991; Waltz, Bandura, Pfaff & Schott, 1988); and pregnancy related stress (Dimitrovsky, Perz-Hirshberg & Itskowitz, 1987). Intimacy is often affiliated with affectionate exchanges (Stephen, 2014). Thus, to achieve intimacy, a person must be willing to put forth the self and care about another person (Sherman, 1993). Additionally, a safe atmosphere to share is necessary to develop an ongoing pattern of intimate behavior with the expectation that the intimate sharing is reciprocated (Sherman, 1993).

Additionally, Olson (as cited in Schaefer and Olson) identified seven types of intimacy. These included emotional intimacy, social intimacy, intellectual intimacy, sexual intimacy, recreational intimacy, spiritual intimacy, and aesthetic intimacy. Emotional intimacy is described as the experience of having a closeness of feelings. Social intimacy is the involvement of having common friends and likenesses in social networks. Intellectual intimacy is defined as the experience of sharing ideas. Sexual intimacy includes the experience of sharing overall fondness and/or sexual activity. Recreational intimacy is the shared experiences of interest in hobbies, reciprocated participation in sporting events. Spiritual intimacy relates to the experience of having ultimate concerns for the other, a comparable sense of meaning in life and/or religious faith. Aesthetic intimacy is described as the closeness that results from the experience of sharing beauty.

Prager (1995) argues that intimacy is too broad of a term because it is a multitiered concept. She points out that scholars’ lack agreement about how to define intimacy
because it is difficult to specify the features of a natural concept. For example, Prager (1995) demonstrates the following instances as intimacy:

- When Jorge looks at Mariano, he feels a rush of warmth and love (intimacy seems to be an emotion).
- Jerry holds an infant close and strokes his skin (intimacy seems to describe tender physical contact).
- Yan Chang tells Alice a secret, and Alice promises not to reveal it to anyone (intimacy seems to involve sharing private information).
- Kareem is married to Aretha (intimacy seems to describe a kind of relationship).
- Martha knows that when Dwight purses his lips and looks away, he’s feeling nervous (intimacy describes how well two people know each other).
- Wilma and Betty reminisce about their many shared experiences (intimacy seems to describe a kind of interaction).
- Felicia caresses Alex (intimacy seems to describe sexual contact).
- Mark feels close to Greg while they are fishing in silence (intimacy requires no communication).
- Marion stands close enough to Edward for him to feel her breath on his face (intimacy describes how two people occupy space together). (p.18).

Prager (1995) proposed that intimacy includes two basic concepts which are intimate interaction and intimate relationship. Intimate interactions include both intimate behaviors and intimate experiences. Intimate behavior is when partners share anything personal or private with one another. Intimate experience is the positive affect and perceived understanding that partners experience because of or along with intimate behavior. Her definition of intimate relationships begins with relational intimacy which is the existence of ongoing, frequently occurring intimate interactions between partners. The sharing of personal information about the self, occupies a pivotal position in theory and research concerning relational intimacy (Prager, 1995) and the development of personal relationships (Derlega, Metts, Petronio, & Margulis, 1993).

Intimacy in Romantic Relationships
Although divorce happens in the realization of low levels of satisfaction, highly satisfying marriages are vulnerable to dissolution as well (Lavner & Bradbury, 2012); however Americans are still romantics at heart (Abowitz, Knox, Zusman, & McNeely, 2009). Most Americans marry and remarry and look forward to it, in spite of the corrosion of the traditional supports and institutions for courtship and mate selection observed in recent decades (Abowitz et. al., 2009). Although, individuals in romantic relationships behave in extremely individualized and complex ways (Rotella, 2009); the desire for close relationships is one of the most basic human motivations, and research suggests that we truly need these relationships to function normally (Baumeister & Leary, 1995). In fact, not only are romantic relationships needed for well-being and health (Cohen, 1988), but important since the most significant personal relationship in one’s life is usually with a committed sexual partner (Popovic, 2005).

Moss and Schwebel (1993) proposed the following definition of intimacy: “the level of commitment and positive affective, cognitive and physical closeness one experiences with a partner in a reciprocal (although not necessarily symmetrical) relationship.” (p.33). The researchers then explained the terminology used in the definition. The term level in this definition emphasizes the amount of intimacy an individual experience while in a relationship. Commitment is the base that allows the opportunity for the other intimacy dimensions to cultivate due to the desire to permanently remain with the partner. The term positive is used to imply valence rather than pleasantness and refers to feelings, thoughts and physical encounters that attract as opposed to repel a partner to his/her significant other. Affective closeness is related to both the affective domain an individual has in common with one’s partner as well as the
depth of awareness of the partner’s emotional world. It involves having emotions of love, caring deeply for one another and being attracted to or liking the other partner (Moss & Schwebel, 1993). *Cognitive closeness* is what an individual has in common with one’s significant other as well as the depth of awareness of his/her partner’s cognitive world. The development of deep cognitive understanding of each other is fostered by sharing personal information of hopes, fears, idiosyncrasies, strengths weaknesses and values (Moss & Schwebel, 1993). The amount of information disclosed is related to the level of perceived intimacy and the discovery of shared attitudes, beliefs, and values helps to validate each partner’s ability to interpret the each other’s world (Moss & Schwebel, 1993). *Physical closeness* refers to the depth of physical encounters, ranging from sexuality to proximity, that one shares with one’s partner as well as the physiological arousal states that an individual experience at the various levels of physical encounter. Those involved in romantic relationships have been found to be comfortable with close physical proximity, exhibit extended periods of gazing, and engage in deeper stages of tactile involvement (Moss & Schwebel, 1993). Researchers found that physiological changes in the automatic nervous system and neurochemical transmitters have been associated with attraction (Liebowitz, 1983; Zillman, 1984). Other researchers found couples that revealed information to someone they considered highly intimate has been found to effect physiological changes associated with increased blood pressure, palm sweating, and heart rate (Ashworth, Furman, Chaikin & Derlega, 1976).

Failure to develop intimacy in romantic relationships has been cited as the most frequent reason given by divorcees whose marriages dissolved (Waring, 1988). There is substantial literature indicating that couples whether married or in married-like
relationships receive great mental health benefits from having good quality or supportive relationship and that marital dissatisfaction is linked to a higher likelihood of psychiatric disorder (Leach, Butterworth, Olesen, & Mackinnon, 2013). A close, satisfying relationship is frequently considered as the crucial factor to adults’ health, happiness, adaptability, and it provides a sense of meaning in life (Popovic, 2005). Sarason (as cited in Popovic, 2005) found that adults in loving relationships with open communication were less lonely and depressed and more content with their relationships.

Recently, romantic relationships have been the focus of research (Hampel & Vangelisti, 2008; Koenig, Jody, Bean, Cunningham & Ka Yun, 2008). DeLucia-Waack and colleagues (2001) found that gender socialization and consequential gender ideology create different scripts that define understanding and expectations of romantic relationships. Cultural variations and dimensions shape how romantic relationships are developed and expressed (Stephens, 2014). Individuals involved in a romantic relationship have been found to have a lower rate of mental health issues, are involved in fewer automobile accidents and are more resistant to several diseases and physically disabling conditions (Holt-Lunstad, Birmingham, Jones, 2008; Kershaw, Murphy, Divney, Magriples, Niccolai, Gordon, 2013; Soller, 2014).

Couples’ Intimacy Issues

Sherman (1993) explains once a couple is established, “the two individuals must learn to accept another’s languages of love and intimacy and expand their personal vocabularies to understand and practice both languages for love and intimacy to be expressed and received as intended (p. 319). Sherman (1993) theorizes that the languages are developed from personal needs, private logic and priorities of a person based on what
was missing or most negative while growing up as well as what was rewarding and most favorable while growing up. Sherman (1993) includes habits, myths, traditions, beliefs, customs, expectations, rules and values as components within understanding one’s partner’s love and intimacy language.

Sherman (1993) pointed out the way couples love each other will inevitably be different. Due to these differences, it is likely that conflict will emerge and impact the level of intimacy enjoyed within relationships (Sherman, 1993). Sherman (1993) outlined the ten of the most common marital issues around intimacy to assist with treating couples in therapy. These issues include 1) being versus doing and other gender differences 2) wanting to change the other 3) territoriality 4) intensity 5) differences in styles 6) differences in rules, customs and traditions 7) being of several minds 8) symbiotic attunement 9) common blocks to intimacy and 10) sexual intimacy.

First, Sherman (1993) explained that couples deal with gender differences within their relationship due to how women and men are reared in our society. According to Sherman (1993) women define intimacy as having in depth personalized talks and connecting by being together, thus learning to socialize through relationships that are emotionally expressive. On the other hand, men are socialized towards achievement and competition and express intimacy by having a physical presence, sexual intercourse and doing things together (Sherman, 1993). The second source of martial conflict is wanting to change one’s partner. He describes how women tend to marry men in hopes of changing them and men marry women with hopes of keeping them the same. This dynamic stifle growth by making an environment of attack and defensiveness and goes against the desire to be respected and accepted by their chosen partner (Sherman, 1993).
Territoriality is the third type of conflict. This concept deals with boundaries around physical and emotional space which can vary between people and between cultures (Sherman, 1993). He explains that one partner’s perception of comfortable closeness may be too smothering or too detached. The outcome is a cycle in which the individual demanding more space adopts the role of pursuer/victim who is neglected by the partner. The other partner adopts the role of distancer/victim who is criticized and not allowed to have time away from the partner. Sherman (1993) explained, “the more the spouse pulls away, the more needy and rejected the pursuer feels and pushes harder, triggering further distance” (p. 321). Intensity is the fourth identified common marital issue. Sherman (1993) shared that some individuals are very intense and emotional in their expressions while others are very controlled. Due to these two extremes, the first type is perceived as overdramatic, crazy and out of control to their partner and the second type is perceived as passive, cold, withdrawn and out of touch with their emotions (Sherman, 1993). The fifth common issue deals with differences in styles. Examples for these issues are being comfortable when the temperature is warmer versus cooler, degrees of order and cleanliness, concepts of time and timeliness, and selection of metaphors to explain life experiences (Sherman, 1993). When a partner is not understood, a gap is created in intimacy and communication by provoking the belief that the other partner does not care. (Sherman, 1993). The sixth issue comprises of differences in rules, customs and traditions. This conflict is common for couples that do not share the same background or have different values. Couples must negotiate what will be normal and acceptable for them. This category differs from those in the difference in styles because of the strong moral component of advocating what is right, and it requires criticism of the person and
the deed (Sherman, 1993). Being of several minds is intimacy issue number seven. According to Sherman (1993) there are two types of individuals in this category. The first type has a desire to be close but becomes frighten and pushes people away once it is offered. They often vacillate between the fear of being abandoned, taken over or robbed of their selfhood. The other type maintains clear aloofness yet welcomes a close partner but pushes them off for fear of rejection or losing the closeness (Sherman, 1993).

Symbiotic attunement is the eighth marital issue. Sherman (1993) explains in its healthiest form partners can discern what is going on with one another without being informed due to paying exquisite empathic attention. Symbiotic attunement in a more distorted form is likely to be demanded by a narcissistic person that cannot express what he or she is feeling or wanting. The individual believes if they disclose their desire to their partner this will ruin it because having to express their needs will be proof that their partner does not care enough to fully attend to him or her (Sherman, 1993).

Nine covers common blocks to intimacy in four subcategories. The first one is fear. These fears include becoming dependent, loss of face, control of self, integrity or having to take responsibility of oneself. The second is misunderstanding and miscommunication. Behaviors such as giving incomplete information, double messages, lying, and projecting one’s own ideas and meaning unto another will fall under this category. Negative interactions are the third category which is playing the victim, helpless one or assuming the role of pessimist. The fourth block to intimacy are controlling interactions (Sherman, 1993).

Lastly, sexual intimacy is the tenth marital issue. Sherman (1993) explains that sexual intercourse can occur with or without sexual intimacy. However, he explains that
sexual interactions that provide the couple a mutual sense of closeness, warmth, and unity may be described as intimate (Sherman, 1993). He also identified blocks to sexual intimacy. These included the fear of inadequate performance, feelings attached to previous physical, sexual, or emotional abuse, beliefs that sex is dirty or members of the opposite sex are bad or hurtful in some way, differences in sexual appetites and styles of satisfaction, and fear of loss of control, self or power, anger towards or distrust of the partner (Sherman, 1993).

Although conflict is inevitable and a natural occurrence in intimate relationships (Stephens, 2014), the need for intimacy is the reason most individuals marry (Greeff & Malherbe, 2001). Gottman and Silver (1999) found couples not in distress have a level of friendship and can resolve marital conflicts respectfully. Sullivan, Pasch, Johnson, and Bradbury (2010) conducted a study and their results implied validation, care, and empathy were essential elements in developing intimacy within a marital relationship. Stephens (2014) suggests if crucial components are missing from a relationship, then it may foreshadow future struggles in managing conflict and solving problems.

Harley (2001) defined the ten most common emotional needs among women and men in marriage as affection, sexual relations, intimate conversation, recreational companionship, financial support, physical attractiveness of spouse, honesty and openness, domestic support, family commitment, and admiration. In 1986, Harley developed the Emotional Needs Questionnaire; however, it was updated in 2017. He suggested the variables of intimacy or varying emotional needs are detailed as follows:

Affection: The non-sexual expression of care through words, cards, gifts, hugs, kisses and courtesies; creating an environment that clearly and repeatedly expresses care. Sexual
fulfillment: A sexual experience that is predictably enjoyable and frequent enough for you. Intimate Conversation: Talking about feelings, topics of personal interest/opinions, and plans. Recreational companionship: Leisure activities with at least one other person. Honesty and openness: Truthful and frank expression of positive and negative feelings, events of the past, daily events and schedule, and plans for the future; not leaving a false impression. Physical attractiveness: Viewing physical traits of the opposite sex that are aesthetically and/or sexually pleasing. Financial support: Provision of the financial resources to house, feed, and clothe your family at a standard of living acceptable to you. Domestic support: Management of the household tasks and care of the children, if any are at home, that create a home environment that offers you a refuge from stress. Family commitment: Provision for the moral and educational development of your children within the family unit. Admiration: Being shown respect, value, and appreciation.

Horowitz (1979) found the importance of intimacy to individuals’ general well-being through noting that issues with intimacy include the largest single cluster of problem behaviors which motivates couples to seek counseling. When marriages endure stonewalling behaviors or prolonged distress then the chances of divorce or separation is increased (Gottman & Silver, 1999). Howe (2012) found when couples perceive the synergy with their partner is off balanced or they need restoration of their emotional wellness they seek help. Some of the universal reasons why married couples divorce is due to insecure attachments, repeated unresolved conflicts, intense disputes, financial strain, and lack of communication, which contributed to low levels of emotional intimacy (Howe, 2012).

Secure and Insecure Attachments
One of the central concepts underlying many theories of personality is that the primary social experiences one has in early life leaves an indelible imprint on individuals, including how they interact with others in later relationships (Simpson, Collins & Salvatore, 2011). This foundation is the basis of several key philosophies, including those of Freud (1940), Erikson (1963), Bowlby (1969/1977). Emotional intimacy can best be understood by knowing one’s emotional needs for a secure attachment within a romantic relationship (Stephens, 2014). Bowlby (1977) explained attachment theory as follows:

…Attachment theory is a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise (p.201).

Attachment theory suggests that bonding with a caregiver in early life is necessary for the development of internal working models for interpersonal behaviors, communication and regulation of emotions (Bowlby, 1973). A recent study of attachment found that parent-child attachment security at twenty-four months significantly predicts social competence during adolescence (Alviso, 2013). Thus, the meaning a person make of these early attachment experiences are later related to their adult attachment styles (Thorberg & Lyvers, 2013).

In her work with couples, Johnson (2003) explained Emotional Focus Therapy (EFT) usefulness with understanding how adult intimacy and love is perceived. EFT has a foundation of attachment theory and is based on the 10 central tenets of attachment theory. The 10 central tenets of attachment are: (1) “Attachment Is an Innate Motivating
Force” or to seek and maintain contact with another person is a primitive motivating
principle across the life span (p. 5); (2) “Secure Dependence Complements Autonomy”
or if we are securely connected, then the more different and connect we are free to be
(p.5); (3) “Attachment Offers a Safe Haven” which means proximity to a loved one
provides comfort and security and the perceived in inaccessibility of such figure induces
distress(p.5); (4) “Attachment Offers a Secure Base” is the presence of a secure base
encourages exploration, openness to new information promotes confidence and self-
reflection (p.5). In relationships, a secure base offers a sense of security and individuals
are able to deal with stress and conflict positively and provide support for others; (5)
“Accessibility and Responsiveness Build Bonds” is defined as the emotional engagement
is central to attachment because it tells us and communicate to others what our needs and
motivations are (p.6); (6) “Fear and Uncertainty Activate Attachment Needs” means in
times of crises a sense of reassurance is activated which is an innate emotional regulation
that evokes a need for comfort, connection and proximity (p.6); (7) “The Process of
Separation Distress Is Predictable” because if attachment behaviors do not evoke
comforting responsiveness and contact from attachment figures, then a predictable
process of angry protesting, clinging, depression and despair ensues, ending eventually in
detachment(p.6); (8) “A Finite Number of Insecure Forms of Engagement Can Be
Identified” (p.7) – how individuals cope with the unresponsiveness of attachment figures
is limited. For example, anxiety is triggered when threat of dissolution of a relationship is
anticipated, avoidant behaviors are used to deactivate the attachment system and suppress
needs when there is a lack of safe emotional engagement and when chaotic or traumatic
attachments are the source of and the solution of fear children use a disorganized strategy
whereas adults use fearful-avoidant strategies; (9) “Attachment Involves Working Models of Self and Other” means attachment strategies reflect ways of dealing with and processing emotions (p. 8). Models of self and others are developed after thousands of interactions and these become expectations and biases that are carried forward into new relationships; and (10) “Isolation and Loss Are Inherently Traumatizing” means attachment theory defines and explains the trauma of loss, deprivation, abandonment and rejection by those we need the most and immense impact it has on us (Johnson, 2003, p.9). One way to assist couples that are distressed and lacking intimacy is to resolve attachment issues (Stephens, 2014).

Fear of Intimacy

Theoreticians have long considered intimacy important to basic human needs, psychosocial development and mental health (Erickson, 1963; Maslow, 1954/1970; Sullivan, 1953). Healthy relationships have been linked to happiness and crucial to one’s emotional well-being (Beihl, 2012). Studies have also documented the significance for intimacy for relationships’ longevity and satisfaction (Hassebrauck & Fehr, 2002; Hill, Rubin, & Peplau, 1976; Hendrick, 1981; Sprecher, 1987). However, when there is an absence of close relationships, one may feel powerless, worthless, and alienated (Baumeister & Leary, 1995). A significant impediment to the development of intimacy in close relationships may be the fear of intimacy (Thelen, et al., 2000). The fear of intimacy must be clearly theorized as an explicit variable that effects intimacy, and while existing self-report measures are valuable for determining significant features of intimacy, these measures have limited efficacy for assessing the inner disposition to avoid and fear intimacy (Descutner & Thelen, 1991). Thus, these researchers developed
the Fear of Intimacy Scale to assess the fear of intimacy which they defined as “the inhibited capacity of an individual, because of anxiety, to exchange thoughts and feelings of personal significance with another individual who is highly valued” (p. 219).

Fear and love are central theories to the fear of intimacy and these two major emotions drive human beings (Brunn, 2001). These two emotions can build upon each other and coexist (Brunn, 2001). Wolpe (1988) emphasizes that fears act as signals, forcing individuals to acknowledge the presence of a dangerous situation to which the individual needs to respond. Thus, when an individual is faced with the fear of intimacy, arising from an awareness of the risks involved in being intimate, he or she may impair the relationship by avoiding taking these risks (Brunn, 2001). In this instance, the avoidance response, produced by the fear of intimacy, becomes stronger than the longing to seek pleasure in the form of love (Brunn, 2001). Villalobos (2016) describes ten fear of intimacy signs and symptoms. These include poor relationship history, inability to express emotions, infidelity, distancing oneself, thoughts of a serious relationship is scary, equate serious relationship to identity loss, fear of rejection or getting hurt, appear strong and positive to others, testing partner loyalty, and deliberately selecting the wrong person. Brunn (2001) believes this avoidance response or the fear of intimacy may be related to marital difficulties and may contribute to dissatisfaction in marriages.

Previous research on the fear of intimacy in adulthood had various concepts of how to conceptualize this issue. Hazan and Shaver (1987) which adopted Bowlby’s (1977) proposition that a continuity exists of individuals’ early attachment process and their ability to form intimate relationships in adulthood. Erikson (1968) posits intimacy cannot exist without first resolving the crisis of self-identify in adolescence. Storkey
(1995) suggests that the fear of intimacy is social since patriarchal power structure limits men’s ability to be intimate because emotional responsiveness is reserved for women. Firestone and Catlett (1999) propose that existential fears such as losing the intimate relationship in death that hinders individuals from being close to another person. Firestone and Catlett (1991) posits that the fear of intimacy is a defense mechanism to protect the individual from pain and harm. Empirical evidence has shown links between fear of intimacy, insecure adult attachment, and emotion regulation difficulties (Hazan and Shaver 1987; Bekker, Bachrach & Croon, 2007) and between higher capacity for intimacy and secure adult attachment, empathy and emotional awareness (Feeney 1996; Laible 2007).

Mental Health and Lack of Emotional Intimacy

When a child is born, it depends on his or her primary caregiver for warmth, nurturing, sustenance, protection from danger and hygiene (Izard, 1991). Izard (1991) states that the infant is also reliant on parental affection for psychological well-being and for health. Aligned with this concept, is that adults who feel they are unloved have a difficult time dealing with life challenges and may develop depression (Izard, 1991). According to Izard (1991), many psychiatrists and psychologists believe emotional problems is the culprit to types of psychopathology and problems of adjustment. Such as depression which is linked to loss including loss to a companion or a love relationship (Izard, 1991). Greenfield (1984) agrees and asserts that loneliness is undoubtedly an influence to some of the behavioral problems and mental illness in society. He affirms that human beings need one another. Greenfield provides an illustrative example when he wrote:
The worst form of punishment in prison is solitary confinement. Administrator of the space-exploration program recognized early that they did not dare send a lone man into space for long. Suicides tend to be people who felt isolated or had broken ties with significant others. Note the high suicide rates among college youth who are away from home and friends, and the elderly whose mate has died or whose work associates and friends have retired.

Intimacy has been generally recognized as a human necessity that is vital to psychosocial adjustment and mental health (Descutner & Thelen, 1991). Thus, it is adequate to state that the fear of intimacy or the lack of intimacy in one’s life can cause mental health problems and substance use issues (Descutner and Thelen 1991). Izard (1991) explains that “emotions are fundamental motivators and that some emotion is always present and influencing behavior” (p.210). Izard (1991) asserts that addiction is developed because the bond with the substance is the only way some individuals can experience joy and prevent negative emotions. Hofler and Kooyman (1996) found that many individuals use drugs and alcohol to ease anger, pain, and ambivalence and to avoid intimacy or rejection. Moreover, Flores (2001) posited that addiction is an attachment disorder; and research suggests that insecure attachment is associated with alcohol consumption, harmful drinking patterns and substance use disorders (Cooper, Shaver & Collins, 1998; Finzi-Dottan. Cohen, Iwaniec, Sapir & Weizman, 2003; McNally, Palfai, Levine, & Moore, 2003; Vungkhanching, Sher, Jackson & Parra, 2004; Thorberg and Lyvers 2006).

also discussed messages in American society of not getting too close to anyone. He believes people who are critical, unhappy, judgmental and complain suffer from relational deficiency (Greenfield, 1984). Lowenthal & Haven (1968) found a link between intimacy deficiencies to low morale and depression and Waltz (1986) discovered that poor physical health, loneliness, ineffective adaptation to stress, and emotional isolation were related to intimacy problems and that anorexia and bulimia are caused by depressive symptoms (Izard, 1991).

The Counseling Profession

Counseling as a profession is 100 years or so old, but helping those who are troubled with everyday life problems is much older (Pope, 2015). The foundation of counseling lies in the traditional practices of indigenous healers around the world such as qigong, acupuncture, shamanism, animism and others (Pope, 2015). Another tier to the foundation of counseling is that the field of counseling utilized influences from established mental health professions, such as social work, psychiatry, and psychology, in addition to political and social events (Barnett, 2015). More specifically, social workers found that they do more than case management and in the process of helping it also meant helping individuals look at themselves through a process called vocational guidance which is now termed career counseling (Pope, 2015).

At the end of the 1800s and the beginning of the 1900s, career counseling developed from the need to assist individuals who were having personal, financial and employment problems due to the major societal transition of being an agrarian society to an industrial society (Pope, 2015). This transition propelled a new profession of professional counseling, but it took “the support of the progressive social reform
movement, the rise of psychological testing as a scientific endeavor, and the emergence of laws that were supportive of vocational guidance” (Pope, 2015, p. 28) that were receiving much societal support to strengthen the development of professional counseling and make it relevant in the military, colleges and schools (Pope, 2015).

Over ten years ago, the American Counseling Association (ACA), the main association in the United States representing professional counselors, defined professional counseling as the application of mental health, psychological, or human development principles through affective, behavioral, cognitive or systemic interventions, strategies that address personal growth, wellness, or career development, including pathology (Sangganjanavanich, 2015). More recently, ACA developed a task force, “20/20: A Vision for the Future of Counseling,” to update the definition of professional counseling (Sangganjanavanich, 2015, p. 3). Presently, a professional counselor refers to “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (ACA, 2017).

To become a professional counselor, counselors must adhere to a credentialing process that is governed by state counseling boards (Paylo, Protivnak & Kress, 2015). In order to receive a license, state governments mandate counselors to have completed specific coursework, completed a supervised residency and pass a standardized examination all of which vary with some similarities (Paylo, Protivnak, Kress, 2015). The educational component for most state boards require an individual to graduate from an accredited master’s program with at least a minimum of 48 semester credit hours, while some states require 60 semester hours before licensure consideration (Paylo, Protivnak, Kress, 2015). Course work must include the core competency areas which
may include counseling theories and techniques, career development, ethics, assessment, group counseling, life-span development, the diagnosing and treatment of mental illness (Paylo, Protivnak, Kress, 2015). Moreover, some states require coursework that aligns with the Council for Accreditation of Counseling and Related Educational Programs (CACREP) educational expectations and standards.

In addition to the educational state requirements, professional counselors are to complete a supervised clinical experience or residency post-graduation (Paylo, Protivnak, Kress, 2015). This process involves the prospective licensee to accumulate postgraduate clinical experience which can vary by state from 2,500 to 4,500 hours at an approved site (Paylo, Protivnak, Kress, 2015). CACREP internships require at least 40% of a student’s time is spent in direct service of clients such as providing individual or group counseling and the remainder of the supervised time may consist of record keeping, staff meetings, supervision, and other counseling-related activities (Paylo, Protivnak, Kress, 2015). Also while at the site, counselors are to have supervision from a professional counselor and some state allow supervision to be conducted by other licensed practitioners such as psychologist, social workers or marriage and family therapists (Paylo, Protivnak, Kress, 2015).

Lastly, each state requires an applicant for licensure to pass a comprehensive examination to assess the prospective licensee’s knowledge and/or application of counseling practices (Paylo, Protivnak, Kress, 2015). All the examinations that are used by state regulatory boards are developed and managed by the National Board for Certified Counselors (NBCC). The National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE) are the two most
used by NBCC (Paylo, Protivnak, Kress, 2015). The NCE assess general counseling abilities, knowledge and skills and the NCMHCE evaluates the ability to diagnose and treat a range of clinical issues (Paylo, Protivnak, Kress, 2015).

Marriage and Family Therapy

Professional marital counseling developed between the 1920s and 1930s (Sholevar, 2003). In 1929, the Marriage Consultation Center was founded in New York City, the Marriage Council of Philadelphia was established in 1932, and in 1939 the American Institute of Family Relations was created in California to offer counseling for marital problems (Sholevar, 2003). In the past 40 to 50 years, marriage, family and couple counseling and therapy has garnered the full attention of practitioners in the helping profession (Capuzzi & Stauffer, 2015). It is relatively a new profession and only recently accepted in all fifty states in the United States (Rambo, Boyd, Gonzalez Marquez, 2016).

According to the American Association for Marriage and Family Therapy (AAMFT, 2017), there are approximately 48,000 marriage and family therapists in the United States and Canada. The number of states regulating marriage and family therapy has grown rapidly from 11 in 1986 to 50 in 2009, including the District of Columbia. Marriage and Family Therapists (MFTs) are highly experienced, with an average of 13 years of clinical practice (2017). Those who obtain the MFT license or certificate have met high educational and clinical experience criteria. All states require a Master's or Doctoral degree and at least 2 years of clinical experience (AAMFT, 2017). MFTs are recognized as an essential mental health profession, along with psychology, psychiatry, psychiatric nursing and social work (AAMFT, 2017).
Marriage and Family Therapists broaden the traditional emphasis on the individual to include the nature and role of individuals in their primary relationship network (AAMFT, 2017). MTFs believe a person’s problems cannot be assessed or treated separate from the “context” in which they occur and the “functions” that they serve (Sholevar, G., 2003 p. 4). They are trained to evaluate and treat emotional and mental disorders along with other behavioral and health problems, and address a myriad of relationship issues within the context of the family system (AAMFT, 2017).

The function of marital therapists has changed over the last three decades (Sholevar, 2003). Initially, couples therapy was designed to preserve marriages at all costs, today couples therapy has become a highly effective tool to assist spouses achieve higher levels of personal development and maturity, whether the outcome is continuing with the marriage or filing for divorce (Sholevar, 2003). Treatment refers to a broad range of treatment modalities that strives to modify the marital relationship with the goal of enhancing satisfaction or correcting dysfunction (Sholevar, 2003). Another goal can include the treatment of any underlying emotional disorders in one or both spouses.

Counselor as a Person

Corey (2013) explained that the type of person the counselor is remains the most critical influence affecting the client and promotion of change. He stated that therapy is an intimate form of learning and demands a counselor who is willing to be authentic in the therapeutic relationship. When counselors hide behind the protection of their professional roles, their clients will likely hide as well (Corey, 2013). He discussed if counselors are inauthentic, then clients will probably sense it and become discouraged by the detected behavior (Corey, 2013). Thus, if clients’ experience growth within the
context of a person-to-person connection, then counselors’ personal and interpersonal components are essential to effective therapy (Corey, 2013). Satir (1987) explained that “Therapy is a deeply intimate and vulnerable experience, requiring sensitivity to one’s own state of being as well as to that of the other. It is the meeting of the deepest self of the therapist with the deepest self of the patient or client” (p. 17).

Since the self of the therapist is believed to be a significant part of encouraging the client’s optimal development and growth (Sangkanjanavanich, 2015), Rogers (1995) posits that for therapy to be effective, three conditions must be exhibited by the counselor: congruence, unconditional positive regard and empathy. Congruence implies that the basic counselor to client encounter is a person-to-person exchange without defensiveness or retreat into false roles (DeBoer, 1970). Unconditional positive regard is demonstrated by the counselor expressing an accepting, positive, nonjudgmental stance towards the feelings, demeanor or expression of the client (Tilliman, 2016). Lastly, empathy is the ability to sense the internal world of the client, can communicate their understanding to the client and to express warmth, respect and love for the client (DeBoer, 1970).

Alperin (2006) presumes clinicians agree that intimacy is good and that most individuals want it and consider it a necessity to well-being. Piercy and Wetchler (1987) questioned how providing therapy impacts the counselor’s own life and family, how an individual’s family of origin influences the choice of one’s profession and how a counselor’s work is impacted by his or her own family and marital problems. The key factor that affects counseling outcomes, excluding the client, is the counselor (Bugental, 1964). Although counselors support clients as they work through personal problems,
counselors experience their own personal problems as well (Watkins & Watts, 1995). Personal problems can be anything from relationship problems to financial problems to emotional problems to health problems (Mathers, 1998). A study by Mahoney (1997) explored the experiences of 155 nonrandom psychotherapists about their approaches of managing their life stresses and personal problems. Emotional exhaustion and fatigue were the most common personal problems reported by the sample of mental health practitioners. Problems with interpersonal relationships and feelings of isolation, disillusionment about the profession, depression, and anxiety were also reported.

Personal problems can distort a counselor’s responsibilities or priorities, perhaps by causing a counselor to utilize the counseling relationship for their own gain and not for the benefit for the client (Mathers, 1998). Therapists who are dealing with personal problems may use the client’s idealization, unconsciously or consciously, as a means of narcissistic repair (Simon, 1995). This may cause the counselor to lose sight of the responsibility inherent in the profession and practice not for the welfare of the client, but for selfish reasons (Mathers, 1998). Thus, Wicks (2012) explains it is sensible to strengthen the interior life of counselor as it becomes an act of generosity for the population they serve. Likewise, Deacon and colleagues (1999) posits it is important for counselors to not only be skilled, but psychologically healthy to be of assistance to their clients and Knott and colleagues (2015) believes that increased intimacy behaviors may contribute to a stronger therapeutic alliance (Knott, et. al, 2015).

Counselors with healthy attitudes and beliefs about sensitive topics can create an environment that is safe for clients grow (Corey, 2005). If clients become aware of their counselor’s discomfort with a topic, then they may decide not to introduce the topic a
second time (Cupit, 2010). Beihl (2012) discusses in his article the significance of attunement and ruptures of attunement in the therapeutic relationship. Attunement are the concepts that refer to therapist’s sensitivity, attentiveness, and responsiveness to the client’s fluctuating emotional needs and mental state in the dynamic moments of client-therapist interactions (Beihl, 2012). Whereas a rupture in attunement is described as a failure to be sensitive to the client’s anxieties, needs and negative reactions to counselor’s non-verbal and verbal behaviors (Beihl, 2012). He believes a turn of phrase, a wisp of insensitivity, a passing comment may be enough to cause a breach in the therapeutic relationship. Failures in attunement or ruptures are a possible threat to successful treatment outcomes, as the client feels unheard, withdraws emotionally, minimized, misunderstood or manipulated (Beihl, 2012). If this occurs, then Beihl (2012) posits clients may only disclose what she or he thinks the therapist would like to hear. He also states:

When a rupture occurs, the client’s sense of emotional connection from the therapist may be masked or hidden due to underlying feelings of shame-shame born out of exposure in early life to parental challenges that resulted in feelings of humiliation, rejection or negation. If the therapist is not vigilant, such ruptures may fester below the surface, while on the surface the client goes through the motions of maintaining a false bond.

The multifaceted interrelationship between the elements of the therapeutic process, the transactions and transitions of the families with whom one works, and the therapists whom one supervises, and one’s own personal life and significant others are regularly interacting and influencing their respective outcomes (Kaslow & Schulman, 1987).
Countertransference

When Rosenberger and Haynes (2002) reviewed the literature on countertransference, they discovered that over two decades had elapsed since the last major review was published in 1977. Theorists and researchers have described countertransference in several different ways (Cruz, 2007). The notion of countertransference has experienced considerable transformation from the time of its inception in 1910 (Cruz, 2007). The meaning of this concept continues to vary significantly between theoretical schools of thought and therapists (Cruz, 2007). The psychoanalytic literature on countertransference addresses three components of this concept which are as affect, cognition, and play, which is a state of being somewhere between primary and secondary process (Cruz, 2007). The classical definition on countertransference from the early Freudian perspective describes countertransference reactions as originating from the analyst’s own pathology in response to the client, which is similar to the way transference is referred to the client’s unconscious pathological expressions aimed toward the therapist (Cruz, 2007). In contrast, object relation theorists recognized countertransference as an affective response on the part of the therapist (Cruz, 2007). Lastly, Gelso and Carter (1985) defined countertransference as an integrative approach to due to the “inevitable therapist reactions to clients that result from his or her own conflicts and needs rather than from reality-based reactions to clients” (Friedman & Gelso, 2000, p. 1222). The integrative approach focuses on the counselor’s struggle to manage conflictual feelings resurrected in therapy with clients (Cruz, 2007). Because this study focuses on the counselors’ ability to manage personal feelings about their fear
of intimacy that may manifest in counseling sessions, the integrative definition of countertransference will be utilized.
CHAPTER 3

METHODOLOGY

The purpose of this study is to determine if there is a difference between licensed and unlicensed professional counselors and marriage and family therapists fear of intimacy and adult attachment styles. The present study seeks to answer the following research question related to the connections among counselor’s personal fear of intimacy, adult attachment styles and comfort with discussing intimacy issues with clients among the five therapist levels:

**Question:** Is there a difference in fear of intimacy scores and adult attachment scores between licensed and unlicensed professional counselors and marriage and family therapists?

**Null Hypothesis:** There is no difference in fear of intimacy scores and reported adult attachment scores between licensed and unlicensed professional counselors and marriage and family therapists.

This chapter presents the methodology used in this study. The chapter will begin with a discussion of the participants. This will be followed by an explanation of the demographic questionnaire, the instruments that includes the Fear of Intimacy Scale and the Revised Adult Attachment Scale. The remainder of the study is divided into the following sections: procedures, limitations and delimitations. The participants section clarifies the inclusion requirement for those surveyed and the rationale for number of participants. The instrumentation section explains each instrument, including a justification for its use. The procedures section outlines how data will be collected and provide details regarding the
survey package. This chapter will conclude with an explanation of the limitations and delimitations of this study.

This study will consist of quantitative questions to assess counselors’ personal fear of intimacy and their adult attachment style. Additionally, a question will be developed by the researcher to gain awareness about the participants’ manner of discussing intimacy issues with clients.

Participants

Participants in this study were categorized into two groups licensed and unlicensed counselors. This study describes each counseling type as the following: (a) licensed therapists are individuals in the United States that have acquired a state license to practice counseling independently in order to facilitate clients’ growth and development in ways that fosters the interest and welfare of clients and promote healthy relationships; (b) master’s-level therapists are individuals who has attained a master’s degree from a program related to counseling, but has not earned full licensure from the state; (c) associate level therapists are individuals in the United States who hold a provisional state license, or associate license, to practice counseling only under direct supervision of a professional counselor; and (d) student/intern are students who are engaged in a complex, intentional progression of reflective educational and experiential activities to promote the development of knowledge and skills (Baggs et al., 2012). The participants will be recruited by convenience sampling. This is a sampling technique in which participants are identified from a readily available source and which characteristically involves acquiring volunteer participants (Manyam & Stalnaker-Shofner, 2014). All racial and ethnic groups will be recruited for this study. Each participant must be in a romantic relationship of a minimum of least 6 months.
The researcher facilitated the recruitment process by sending an invitation to participate in three ways: (1) email, (2) post to online listservs, and (3) post on social media websites. Invitation to participate emails were sent to counseling-related program faculty members, marriage and family program faculty members, community mental health agencies, and individuals in private practice throughout the United States. Invitations to participate was posted to counseling-related online listservs sponsored by national, regional and state counseling-related organizations. Invitations to participate were posted to Facebook pages dedicated to therapy and to individual therapists on LinkedIn.

In total, three variables will be examined in this study: fear of intimacy, adult attachment styles, licensure status. These variables will be used to determine the minimum number of participants. Fear of intimacy and adult attachment styles were the dependent variables and licensure status was the independent variable.

Instrumentation

Instruments were chosen to ascertain the potential relationship between counselors’ fear of intimacy and adult attachment styles in licensed and unlicensed professional counselors and marriage and family therapists. The instruments used in this study included a demographic questionnaire, the Fear of Intimacy Scale (FIS) developed by Descutner and Thelen in 1991 and the Revised Adult Attachment Scale (RAAS) created by Collins and Read in 1990.

Demographic Questionnaire

A questionnaire was used to gather demographic information for data analysis. The researcher collected information related to age, nationality or ethnic background, gender, marital status, number of months in current relationship, number of years in the profession
and primary work setting. The questionnaire also asked participated to state comfort level with discussing emotional intimacy, how would they feel if they had to initiate a discussion on emotional intimacy and if discussing emotional intimacy was common practice.

Fear of Intimacy

The Fear of Intimacy Scale (FIS) was used to determine the participants’ level of fear of intimacy. The results from this assessment were used as one of the dependent variables. The FIS measures an individual’s anxiety about being in a close relationship or the probability of being in a close relationship (Descutner & Thelen, 1991). The FIS is intended to measure three features Descutner and Thelen (1991) defined as being central for intimacy; content, emotional valence, and vulnerability. The FIS is a self-report measure that has 35 items. The individual is asked to imagine that he or she is in a “close, dating relationship” (p. 225) and then to respond as if he or she is in that close, dating relationship. Using a Likert Scale, the individual rates how characteristic each statement is of his or her self. The rating options are: 1 - not at all characteristic of me; 2 - slightly characteristic of me; 3 - moderately characteristic of me; 4 - very characteristic of me; and 5 - extremely characteristic of me. The FIS scores range from 35 to 175, with a high score demonstrating a higher fear of intimacy. The mean score is 75.78 (men = 77.65, women = 75.27) and a standard deviation of 22.13 (men = 23.77, women = 21.80) (Descutner & Thelen, 1991). The FIS has an alpha coefficient of .93 and demonstrates having a high internal consistency as demonstrated by (Descutner & Thelen, 1991).

Revised Adult Attachment Scale (RAAS)

Collins’ (1996) RAAS is a slightly modified version of the Adult Attachment Scale initially created by Collins and Read (1990) for the assessment of Hazan and Shaver’s (1987)
three attachment styles (secure, avoidant, and anxious–ambivalent) in the context of romantic relationships. Collins and Read’s factor analysis of their scale in an undergraduate sample revealed three dimensions. The Close dimension refers to the degree to which an individual is comfortable with closeness and intimacy (e.g., “I am comfortable developing close relationships with others.”). The Depend dimension refers to the degree to which an individual feels he or she can trust and depend on others (e.g., “I know that people will be there when I need them.”). The Anxiety dimension refers to the degree to which an individual is fearful about being abandoned or unloved in relationships (e.g., “I often worry that romantic partners don’t really love me”). Each of the 18 statements is rated on a 5-point scale from 1 (Not at all characteristic of me) to 5 (Very characteristic of me). Scores for each six-item dimension of adult attachment also range from 1 to 5 after averaging across items. The scales have been shown to have adequate internal consistency (alphas ranging from .69 to .75) and temporal stability over a 2-month period (rs ranging from .52 to .71). Validity of the scales was shown in the initial sample through association with Hazan and Shaver’s measure of attachment and theoretically predicted relations with attitudes toward the self and others and characteristics of current romantic relationships. In the current study sample, Cronbach’s alpha for Close, Depend, and Anxiety was .84, .76, and .90, respectively.

Procedures

After receiving Institutional Review Board (IRB) approval, the researcher conducted recruitment in three ways: (1) an invitation-to-participate posted to online listservs, (2) an invitation-to-participate by email, (3) invitation-to-participate posts through a social media site. Invitation to participate posts were submitted to counseling-related online listservs sponsored by national counseling-related organizations, including the following: Counselor
Education and Supervision Network Listserv, the Georgia Therapy Network, and the Licensed Professional Counselor Association of Georgia Listserv. Invitations were sent to counseling-related program faculty members at colleges and universities; and community mental health agencies in the United States. Invitation to participate posts will be made to counseling related Facebook pages and LinkedIn professional profiles.

Participation was voluntary. Each participant was at least 21 years old and agreed to complete an online survey investigating therapists’ comfort with broaching intimacy topics with clients, fear of intimacy and adult attachment style. The informed consent and the study surveys was converted into an online web-based format which will be accessible via an active web-link embedded within the invitation to participate email or post. Individuals interested in partaking in the study clicked the link which will direct them to Survey Monkey, the study survey site. Once the consent to participate form was completed, participants proceeded to the study survey within Survey Monkey. The survey took approximately 20-30 minutes to complete. There was no compensation for completing the survey.

Participants data was protected throughout the study. The data collected from Survey Monkey was entered onto an Excel data file on Mercer University Technology database. Databases are protected behind security firewalls which require login and password security to avert confidentiality breaches. After a designated period of time, the research data will be destroyed.

Data Analysis

The primary means of evaluating participant responses required the researcher to compute the data into SPSS 21 as the analysis instrument. Descriptive statistics such as the measures of central tendency (e.g., mean, median, and mode), dispersion (e.g., range and
standard deviation) and distribution were used to analyze demographic data. To answer the research question regarding whether there is a significant difference in fear of intimacy scores and adult attachment scores between licensed and unlicensed professional counselors and marriage and family therapists, a one-way multivariance analysis was used.
CHAPTER 4

RESULTS

The purpose of this study is two-fold. First, this study attempts to determine if a relationship exists between the fear of intimacy and adult attachment styles among licensed and unlicensed practitioners. Second, this study explores whether the fear of intimacy and adult attachment styles influences whether a counselor broaches emotional intimacy in counseling sessions. Ultimately, this study seeks to investigate the connections among the fear of intimacy, adult attachment style, and counselor’s comfort with discussing emotional intimacy among the counseling professionals surveyed.

This chapter presents a summary of the results of this study. This chapter is divided into two sections: descriptive statistics and inferential statistics. The descriptive statistics will review the demographic variables of the surveyed population and describe the data outcomes of the study survey (Caldwell, 2010). The inferential statistics will discuss the applicable statistical analyses used and the results, which address both of the tested null hypotheses. This chapter will conclude with a summary.

Part I: Descriptive Statistics

Upon receiving research approval from the Institutional Review Board (IRB), the researcher recruited participants utilizing convenience sampling in one of the three following ways: (1) an invitation-to-participate posted to online listservs, (2) an invitation-to-participate email, and (3) invitation-to-participate posted through social media sites. These participants received an electronic participation request that included a
link to the online questionnaire hosted by Survey Monkey (Appendix A). Data was collected between October 2017 and January 2018.

From these requests, a total of 124 individuals attempted the study’s online survey; however 90 individuals completed the survey, which comprised of an informed consent document, demographic questionnaire that collected information on insurance status, age, sex, region of residence, sexual orientation, relationship status, number of years in relationship, race or ethnic background, years of counseling experience, primary work setting, comfort with discussing emotional intimacy, personal feelings of discussing intimacy; and Fear of Intimacy Scale (FIS) and Revised Adult Attachment Scale (RAAS).

Age Groupings

Of the participants whose surveys were collected, 34 (37.7%) were 25 to 34 years old, 35 (38.8%) were 35 to 44 years old, 12 (13.3%) were 45 to 54 years old, 9 (1%) were 55 and older. The ages of these participants ranged from 26 to 67 years with a mean age of 39.25 years and a standard deviation of 10.54 years. See Figure 1 for a comparison of the age groups.

Figure 1. Age Groupings
Nationality or Ethnic Background

Of the 90 participants whose surveys were collected, 45 (50%) were African American, 3 (3.3%) were Asian American, 4 (4.4%) were Caribbean, 31 (34.4%) were Caucasian, and 7 (7.8%) were multi/biracial. See Figure 2 for a comparison of nationalities/ethnic backgrounds.

![Nationality or Ethnic Background](image)

*Figure 2. Nationality or Ethnic Background*

Years of Counseling Experience

Of the 90 participants whose surveys were collected, 26 (28.8%) had 0 to 3 years of experience, 17 (18.8%) had 4 to 7 years of experience, 23 (25.5%) had 8 to 11 years of experience, 13 (14.4%) had 12 to 15 years of experience, 5 (5.5%) had 16 to 19 years of experience, 2 (2.2%) had 20 to 23 years of experience, 1 (1.1%) had 24 to 27 years of experience, 2 (2.2%) had 28 to 31 years of experience, and 1 (1.1%) had 32 years of experience or more. The mean years of experience is 8.91. See Figure 3 for a comparison of the years of experience of the participants.
Gender

Of the 90 participants whose surveys were collected, 78 (86.7%) were women, 11 (12.2%) were men, and 1 participant (1.1%) chose not to respond to this question. The gender breakdown is displayed in Figure 4.

Marital Status

Of the participants whose surveys were collected, 24 (27%) were single, 4 (4.5%) were engaged, 51 (57.3%) were married, 5 (5.6%) were divorced, 4 (4.5%) were
remarried, 1 participant (1.1%) was widowed and 1 participant (1.1%) chose not to respond to this question. The marital breakdown is displayed in Figure 5.

![Marital Status Diagram](image)

*Figure 5. Marital Status*

Length of Time with Partner

Of the participants whose surveys were collected, 10 (11.6%) have been with their significant other 6 to 12 months, 17 (19.8%) have been with their significant other 1 to 3 years, 11 (12.8%) have been with their significant other 4-6 years, 10 (11.6%) have been with their significant other 7 to 9 years, 18 (20.9%) have been with their significant other for 10 to 15 years, and 20 (23.3%) have been with their significant other over 16 years. The length of time participants have been with their significant other is displayed in Figure 6.
Counselor Level

The sample groups for this study were individuals in either the Professional Counselor discipline or Marriage and Family discipline who were either fully licensed or were unlicensed. The licensed counselor is described as an individual in the United States who holds a state license to practice counseling independently (Baggs et al., 2012). The unlicensed participants included individuals who have acquired a provisional associate license, have completed a master’s degree program in professional counseling or MFT program or a student/intern actively engaged in a master’s degree counseling or MFT program. Thus, the counselor levels included in this study were collapsed into two categories; licensed and unlicensed. Of the 90 participants whose surveys were collected, 49 (54.4%) were licensed professional counselors, 12 (13.3%) were licensed marriage and family therapist, 8 (8.9%) were associate-level counselors, 5 (5.6%) were associate-level marriage and family therapists, 7 (7.8%) were master’s-level counselors, 3 (3.3%) were master’s-level marriage and family therapist, 2 (2.2%) were counselors-in-training.
and 4(4.4%) were marriage and family therapists-in-training. See Figures 7, 8 and 9 for a comparison of the counselor levels.

Figure 7. Licensed Status of Professional Counselors

Figure 8. Licensed Status of Marriage & Family Therapists
Primary Work Setting

Of the 90 participants whose surveys were collected, 23 (25.6%) primarily worked at community-based agencies, 1 (1.1%) primarily worked at a correctional facility, 11 (12.2%) primarily worked in college/university setting, 39 (43.3%) primarily were in private practice, 10 (11.1%) primarily worked in outpatient, and 6 (6.7%) selected other. Participants who selected Other listed the following as their primary work setting: high school, hospital, public charter school or not providing services at the time of the survey. See Figure 9 for a comparison of primary work settings.

![Primary Work Setting Diagram](image)

*Figure 9. Primary Work Setting*

Comfort Discussing Emotional Intimacy (EI)

Of the 90 participants whose surveys were collected, 52 (57.8%) self-reported being very comfortable discussing EI, 30 (33.3%) self-reported being comfortable
discussing EI, 6 (6.7%) self-reported being neutral in discussing EI, and 2 (2.2%) self-reported being uncomfortable discussing EI. See Figure 10 for a comparison of comfort with discussing EI.

![Pie chart showing comfort levels discussing EI]

*Figure 10. Comfort Discussing Emotional Intimacy*

**In-Session Feeling If Broaching EI**

Of the 90 participants whose surveys were collected, 74 (82.2%) would feel confident towards broaching EI in session, 6 (6.7%) would feel uneasy towards broaching EI in session, 8 (8.9%) would feel indifferent towards broaching EI, and 2 (2.2%) selected Other for feelings towards broaching EI. Participants who selected Other included the following statements: “Alert for client's comfort/discomfort” and “I would over-rehearse the phrasing so I would feel confident enough”. See Figure 11 for a comparison of in-session feelings towards broaching EI.
Common Practice to Discuss EI

Of the 90 participants whose surveys were collected, 66 (73.3%) reported EI is common to discuss in practice and 24 (26.7%) reported EI is not common to discuss in practice. See Figure 12 to see a comparison of how common it is for counselors to discuss emotional intimacy.

Figure 11. In-Session Feeling if Broaching EI

Figure 12. Common Practice to Discuss Emotional Intimacy
Part II: Inferential Statistic

Research Question One-Way MANOVA

A one-way between-group multivariate analysis of variance was performed to investigate differences between licensed and unlicensed counselors’ adult attachment styles and fear of intimacy. The dependent variables were adult attachment style and fear of intimacy. The independent variable was licensed status of the participants, either licensed as a professional counselor or marriage and family therapist or unlicensed. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity, with no serious violations noted. There was no statistically significant difference on the combined depended variables, $F (1, 90) = 2.16, p = .022$; Wilks’ Lambda = .98; partial eta squared = .051. The researcher therefore rejected the null hypothesis. See Figure 13 for the results of the research question using a one-way MANOVA.

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This chapter presented the results of the descriptive and inferential statistics of this study. The results revealed that there is no difference between adult attachment style and fear of intimacy among the study participants. A complete discussion of these findings, along with recommendations for future research and practice implications, will be provided in chapter five.

Table 1. Research Question One-Way MANOVA

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a. Design: Intercept + ExpLicensestatus

b. Exact statistic
CHAPTER FIVE
DISCUSSION

This final chapter presents a discussion of the major findings and inferences of this study. This study sought to evaluate if there was a difference in fear of intimacy scores and reported adult attachment scores between licensed and unlicensed professional counselors and marriage and family therapists. The researcher evaluated the quantitative results in consideration of the original research question. This leads to a discussion of probable implications for licensed and unlicensed professional counselors and marriage and family therapists. The researcher then identifies directions for future research. The chapter concludes with a summation of the study and its significance.

Part I: Study Results

This study explored adult attachment styles and fear of intimacy between licensed professional counselors and marriage and family therapists and unlicensed professional counselors and marriage and family therapists which included associate-level, master’s-level, and counselors-in-training. The purpose of this study was to gain an understanding of whether counselor’s adult attachment style and comfort with intimacy were significant when scored together. Understanding more about counselors’ adult attachment style and comfort with intimacy is important due to the heavy emphasis on the therapeutic relationship. One’s attachment style reveals the early experiences an individual had with early caregivers and are internalized as a working model of relationships (Poston, 2013). This internal working model, which is basically a cognitive-affective schema, is then
used as the prototypical model in subsequent relationships, thereby allowing individuals to predict the result of attachment behaviors (Poston, 2013). Counselors attachment style can benefit or hinder therapeutic outcomes. Obegi and Berant (2008) argued in a review of attachment informed psychotherapy research that securely-attached therapists ‘are likely to possess alliance-enhancing characteristics and sensitivity (e.g. warmth, sensitivity) and therefore better able to create the atmosphere of security that Bowlby (1980) viewed as a prerequisite for productive therapeutic work’ (p. 466). Since, the counselor’s attachment style enters each session with the counselor and influences how the counselor engages with clients, the question becomes are counselors with anxious/ambivalent or anxious/avoidant type attachment style aware of this possible barrier to explore topics such as emotional intimacy objectively.

Intimacy again is the inhibited capacity to share feelings and thoughts of personal meaning with another individual who is highly valued (Thelen et al., 1991). Intimacy includes three vital components: (1) the communication is of personal information (2) there are strong feelings about the information being shared between the two individuals and (3) vulnerability is present due to the high regard for the individual receiving the information. Investigating counselors’ comfort with intimacy is needed due to the high likelihood of working individuals or couples with emotional intimacy issues. Those counselors with a fear of intimacy maybe able to compartmentalize their issues and focus on the client without mental distractions. However, will they truly be able to fully explore barriers to intimacy if they have not processed their own fears. For example, can a counselor who uses work to avoid dating be able to navigate a client with the identical
issue objectively without first acknowledging their own behaviors and seek out their own
counselor to address this issue.

The research question sought to test whether there is a difference in fear of
intimacy scores and reported adult attachment scores between licensed and unlicensed
professional counselors and marriage and family therapists. A one-way multivariate
analysis test was used to test the difference in the fear of intimacy scores and adult
attachment scores among the counselor levels. The result of the one-way multivariate of
analysis revealed that there is no difference in the fear of intimacy and adult attachment
between licensed and unlicensed professional counselors and marriage and family
therapists.

Although the results were not significant between the measures in this study, there
are some assumptions that can be drawn from the results. The results for the Revised
Adult Attachment Style could be reflective of the high number of married participants
57.3% and the length of time the participants have been with their significant other which
was between 10 to 15 years (20.9%) and 16 or more years (23.3%). Given the length of
time participants have been in a committed relationship, it is likely that they have a
secure adult attachment style, and this may create comfortability outside of their personal
relationship thus the ability of broaching intimacy with their clients with confidence.

Contrarily, the Fear of Intimacy scores may indicate that it is easier to discuss
intimacy issues in counseling, than deal with intimacy issues in personal relationships.
More than half of the participants (57.8%) indicated they were very comfortable and
33.3% indicated they were comfortable discussing emotional intimacy. Additionally,
82.2% indicated they were confident in session if they had to bring up emotional intimacy and 73.3% stated that it is common practice to discuss emotional intimacy.

Additionally, counselors’ age and level of professional experience are factors that may interplay with both adult attachment style and comfort with intimacy. The mean age of the participants was 39.25 and the mean of years in practice was 8.9. If the average counselor is approximately forty, then the assumption is that they have had more life experiences and opportunities to explore romantic relationships. However, the application of counseling theories, gaining self-awareness and managing possible anxiety while in session is likely to still be in development.

Part II: Recommendations for Practice

This study hopes to initiate an open dialogue in the counseling and marriage and family profession regarding how adult attachment styles and comfort with intimacy influence how counselors broach emotional intimacy with clients. The American Counseling Association’s Taskforce on Counselor Wellness and Impairment (2002) established the following working definition of counselor impairment.

"Therapeutic impairment occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to:

- Substance abuse or chemical dependency
- Mental illness
- Personal crisis (traumatic events or vicarious trauma, burnout, life crisis)
- Physical illness or debilitation
Impairment in and of itself does not imply unethical behavior. Such behavior may occur as a symptom of impairment or may occur in counselors who are not impaired.

Counselors who are impaired are distinguished from stressed or distressed counselors who are experiencing significant stressors, but whose work is not significantly impacted. Similarly, it is assumed that an impaired counselor has at some point had a sufficient level of clinical competence, which has become diminished as described above" (ACA, 2002).

Impairment from this working definition does not specifically address countertransference due to the counselors’ intimacy and attachment issues which could interfere with therapeutic outcomes. Since counselors are not immune to unexplored personal issues, unfinished business from their family of origin or lack of secure attachments from childhood; the likelihood of being triggered in session is high. Counselors need to be skillfully neutral to prevent harming the client or therapeutic relationship (Connery, 2006) when triggered. Yet, there is a paucity of research on the counselor as a person and how their personal lives impact their ability to navigate emotional intimacy with clients.

Gelso and Hayes (2007) extrapolated from Freud’s explanation of countertransference that not only are counselors required to recognize their own unconscious workings, but also expect counselors to somehow eradicate these responses to be effective in working with others. Counselors can develop awareness of their unconscious workings and aim to manage them, however those counselors who are not successful in eliminating their response should consider another profession (Connery, 2006). This controversy has directed some theorists to propose that this unyielding view
held by Freud might have been a projection of his own countertransference (Gelso & Hayes, 2007). Over the years, many theorists have debated that it is impossible to eliminate with all countertransference because it is part of being human (Gabbard, 2001). Also, other definitional disagreement regarding countertransference have also arisen; specifically, whether countertransference should include only counselor behavioral reactions or if it should include the counselors’ cognitive reactions and internal affective state too (Connery, 2006). Further, some theorists posit that the term countertransference should only be used to describe unconscious counselor reactions, whereas others maintain countertransference includes conscious reactions as well (Connery, 2006). Another point of debate has centered on whether countertransference must arise out of an unresolved area of conflict or if countertransference can simply arise out of any area of conflict within the counselor (Connery, 2006).

Counselors, educators and supervisors all have enormous influence on either exacerbating or mitigating self-awareness of emotional intimacy and countertransference. The following are three practice recommendations that professional counselors and marriage and family therapists, supervisors, and educators can implement.

The first practice set of recommendations for professional counselors and marriage and family therapists include promoting continuous education courses for post-graduate counselors on awareness of self on the therapeutic process and how to manage in-session anxiety. Post-graduate education, such as continuous education courses, can communicate the risks associated with not being self-aware and treatment outcomes, define and review countertransference and outline strategies for the management of counselor anxiety when triggered in session. Additionally, increase discussions on
counselors’ challenges of discussing topics that mirror their own can normalize countertransference and encourage counseling for the counselor. This can improve therapeutic outcomes and prevent harm to the client.

The second recommendation is to prepare counselor supervisors to handle counselors-in-training that experience a client that has an issue that is similar to their own and to equip supervisees with positive coping mechanisms for professional development (Gladding & Newsome, 2014). A practice recommendation for counselor supervisors is to include attachment education and discuss comfort with discussing emotional intimacy within the clinical supervision experience for counselors-in-training. This can be infused with having the supervisees take the RAAS and the FIS and discuss the results within the context of supervision. A proactive approach to being self-aware can improve supervisees’ confidence and teach them how to manage thoughts, behaviors and feelings related to personal challenges while in session and be more efficient.

The final practice recommendation is for counselor educators to (1) provide a lecture on countertransference and (2) develop a one hour course that highlights the influence of the counselor as a person. The lecture on countertransference could include guest speakers with topics to include the progression of becoming more comfortable managing anxiety in session, behaviors: overactive, avoidance, withdrawal and nonverbal ques, and when anxiety is not managed well. Also, when students are preparing for practicum, they can be provided role plays and if necessary highlight when additional support is needed and encourage students to seek counseling.

The one-hour requirement will ensure that every student is exposed to the importance of realizing that they enter the therapy session not only as the professional,
but also a person with triggers. One objective would be to recognize the potential harm associated with clients by counselors not seeking personal counseling. Research shows that many people seek counseling because of relationship issues, thus it is very probable that students will have a client with relationship issues. Ethically, counselors are to do no harm, thus not addressing past negative experiences can jeopardize treatment outcomes. Another objective would be for students to identify their adult attachment style and comfort level with emotional intimacy. Students should be more aware of who they are and how who they are as a person can impact treatment. Like clients, counselors and student are either in a relationship, want to be in a relationship or seek to dissolve a current relationship. Thus, students receiving didactic and experiential learning on how attachment and intimacy influences personal romantic relationship will have a stronger foundation and comfort with discussing similar concept with clients.

Part III: Recommendations for Future Research

The purpose of most scholarly research is to generate a recurring pattern of research results leading to new research questions to be tested. This study conducted statistical analyses of adult attachment styles and fear of intimacy and tested the fear of intimacy scores on counselors’ fortitude in discussing emotional intimacy with clients. The following are five recommendations for future research in the field of counseling to gain further insight into how the counselor as a person influences the therapeutic outcomes specifically related to counselors’ fear of intimacy, adult attachment style and addressing emotional intimacy with clients.

Emotional Intimacy and Fear of Intimacy Scale
The first research recommendation is to replicate this study using the revised Fear-of-Intimacy Scale (Thelen, 1993). The original Fear of Intimacy Scale was a validated using college students and explored the dimensions of adult attachment as potential correlates of fear of intimacy. The 1993 version of FIS was replicated and extended using many of the same measure of the original version; however, it was validated with a middle-aged sample. The revised FIS may serve to yield clearer results since participants mean age from this study was approximately forty.

Countertransference and Emotional Intimacy

The second research recommendation is to conduct a mixed-method study investigating countertransference when intimacy in discussed in-session among licensed and unlicensed professional counselors and marriage and family therapists. Since clinical and empirical literature show that countertransference reactions can assume numerous forms, both externally and internally (Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998), an improvement of the study would be to investigate specific behaviors, thoughts, or feelings that result from discussing emotional. The focus would be on the response to countertransference triggers which can either provoke underinvolvement, overinvolvement or appropriate behaviors in session, thus a construct of clarity of both positive and negative reactions would be a fruitful endeavor to further uncover if adult attachment styles and fear of intimacy are a mediating factor to counselors’ comfort with discussing emotional intimacy.

Clients’ Perception of Counselors Comfort with EI

The third research recommendation is to compare clients’ perceptions of counselors’ comfort with broaching emotional intimacy to their counselors’ self-report.
Since this study was self-report it would help to determine if clients are perceptive of counselors’ comfort level on the topic and how this impacts therapy. The participants could be asked to rate counselor’s behaviors as appropriate or as underinvolvement or overinvolvement. Since, counselors are not immune to intimacy or attachment problems that may mirror their clients, it is imperative for counselors to have feedback regarding how they are managing possible anxiety in session. A well devised study could also assist counselors to observe/reflect on countertransference. Counselors may think they are managing thoughts and feelings, but verbal and nonverbal behavioral reactions could reveal a different truth.

Gender and Broaching EI

The forth recommendation for further research is to replicate this study focusing on male professional counselors and marriage and family therapists. This study had a total of 90 participants and only 11 participants identified themselves as men. A study that primarily investigated men responses could serve to yield clearer results regarding gender differences in adult attachment style and fear of intimacy as mediating factors to broaching emotional intimacy.

Culture and Broaching EI

The fifth recommendation is to investigate the extent to which culture influences adult attachment style and the fear of intimacy among counselors and their comfort with broaching emotional intimacy with clients. The current study had underrepresentation of Asian Americans and Caribbean descendants and no representation of Hispanics, Hawaiian and other Pacific Islanders, Native Americans or East Indian Americans. Additional consideration should include the dynamics when the client’s culture is
different from the counselor’s culture and whether this contributes to approaching or avoiding the topic of emotional intimacy with clients.

Limitations

As with any study, there were a few limitations that were identified. Each of the limitations became apparent for the researcher. The first limitation to this study is that the recruitment of participants for both disciplines, professional counselors and marriage and family therapists, of licensed and unlicensed counselors was more difficult than imagined. The initial goal was to seek out an equivalent or nearly equivalent number of participants in each level of experience (i.e. students, associate level, master’s level, etc.) to compare. Several emails, social media postings and postings to listservs were used to acquire the number of participants desired. Although there were a number of participants, the number of participants across levels were not adequate for comparison.

Another potential problem of online data collection is attrition rate and differential rate of drop out due to the constructs under investigation. In this study, it was difficult to determine whether potential participants who feared intimacy or who lacked secure adult attachment decline to participate in the study because of the nature of the study details. The study explored licensed and unlicensed therapists’ experience of broaching the topic of intimacy problems when working with individuals or couples and the impact of therapists’ own level of intimacy and attachment on the provision of therapeutic services. The likelihood of those participants deterring to complete the survey could reflect attitudes of not being competent in the area of emotional intimacy or self-awareness of personal issues that relates to the topic of this study and lacking readiness to
acknowledge. Furthermore, this study was limited to participants who had access to the internet and could complete the online survey.

Additionally, the research design raises concern with the level of honesty of the participants with a self-reported, online questionnaire. The utilization of parametric statistical analyses in this study is a limitation because Likert-type scales provide ordinal data. Ordinal data is ranked by general options such as on a five-point scale of strongly disagree, disagree, neutral, agree, and strongly agree (Robertson, 2012). One cannot assume the measure between strongly agree and agree would be the same as the measure between neutral to disagree (Robertson, 2012).

The setting in which services are provided is a limitation to this study. The therapist in private practice may have less restrictions in regard to time than those therapists in a community-based programming. Thus, the private practice therapist may be able to explore in greater depth an individual or a couples’ distress compared to a therapist providing substance abuse counseling that may focus on stabilization and preventing relapse with limited ability to focus on exploring interpersonal relationships.

Lastly, the lack of racial diversity both among professional counselors and marriage and family therapists is also a strong limitation in this study. Thus, the generalizability of the findings may not extend to licensed and unlicensed counselors and therapists representative of various cultural backgrounds. Another limitation is that this study was written in English. Therefore, it cannot be generalized to other populations whose primary language is not English.

Delimitation
Factors that may be related to and/or influence therapists’ comfort with discussing intimacy, fear of intimacy and adult attachment styles, but are beyond the scope of this study include individual life events, counselors not in a current romantic relationship, and supervision and training.

Life events can be defined as a generic term that signifies major individual experiences (e.g., death of a close person, an accident, personally relevant important success), meaningful changes (e.g., birth of own child, relocation, lay-off by employer), and normative transitions in life (e.g., starting a family, retirement) (Kandler, Bleidorn, Riemann, Angleitner, & Spinath, 2012). Although it seems common that life events reflect external influences on individuals, behavioral genetic research shows heritability for many measures of life events which suggests individual differences in experiencing life events can at least partly be explained by genetics (Kendler, Neale, Kessler, Heath, & Eaves, 1993). Similarly, personality is strongly influenced by genetics and personality traits may not only affect how individuals perceive and understand their environments but also influence which experience individuals choose (Kandler et al, 2012). Since counselors are diverse in their life experience this variable was not included in this study because the focus of this investigation is on the comfort with intimacy and adult attachment style to discussing emotional intimacy, not on possible life events and genetic make-up that may hinder or influence counselors ability to discuss emotional intimacy.

An important delimitation to note was that the research criteria stipulated participants were to have been in a romantic relationship for at least 6 months.

What remains to be studied is the experiences of those counselors who are not involved in a romantic relationship and their adult attachment style, fear of intimacy and broaching
emotional intimacy with clients. This would be an important population to study since over half of the participants in the current study were married and approximately 44% of the participants have been in a relationship over 10 years. Another delimitation of this study is the influence of supervision and training of counselors’ ability to discuss emotional intimacy with clients. These concepts were not a part of this research but could influence counselor’s comfort and confidence with broaching emotional intimacy.

Final Conclusion

The ultimate goal of this research study is to increase awareness of how counselors enter counseling sessions as a person with unique histories related to attachment and intimacy. It is imperative that counselors are self-aware of how they respond or do not respond when triggered by client topics. Although the quantitative approach used in this study did not reveal a significant between licensed and unlicensed counselors’ adult attachment style and fear of intimacy, these internal processes can be overlooked as an impairment if not discussed consistently and be a barrier to helping clients achieve emotional intimacy.
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APPENDICES
APPENDIX B
INVITATION TO PARTICIPATE STATEMENT
Dear Respondent,

My name is Kenika Holloway. I am a doctoral candidate in Penfield College’s Counselor Education and Supervision program at Mercer University. I am conducting a research study about the relationship between the fear of intimacy and attachment in therapists’ personal lives. The study is called: Examining Counselors Level of Professional Experience With Adult Attachment Style and Comfort With Emotional Intimacy. I am emailing to ask if you would like to participate by completing a survey for this research project. Mercer University’s IRB requires investigators to provide informed consent to the research participants.

Mercer University’s IRB requires investigators to provide informed consent to the research participants. If you would be interested in taking this survey, please click the following link for more information on how to participate: https://www.surveymonkey.com/r/7XHXYDW.

If you have any questions about the study contact the investigator Kenika Holloway at (404) 645-9292 or 10425256@live.mercer.edu.

Mercer University’s Institutional Review Board (IRB) reviewed study #H1709250_01 and approved it on 10/20/2017.

Questions about your rights as a research participant:
If you have questions about your rights as a research participant of if you are at any time dissatisfied with any part of this study, you may contact, anonymously if you wish, the Mercer University Institutional Review Board (IRB) by phone at (478) 301-4101 or by email at ORC_Research@Mercer.Edu.

Thank you in advance for your time and participation!
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
Please respond to all questions:

1. Were you born and raised in the United States?
   - [ ] Yes (1)
   - [ ] No (2)

2. Which region of the United States do you reside?
   - [ ] South
   - [ ] North
   - [ ] Midwest
   - [ ] East
   - [ ] West

3. How old are you? _____

4. What is your gender?
   - [ ] Male (1)
   - [ ] Female (2)
   - [ ] Transexual (3)
   - [ ] Other (4)

5. Do you consider yourself heterosexual?
   - [ ] Yes (1)
   - [ ] No (2)
   - [ ] Other (3)

6. What is your relationship status?
   - [ ] Single, never married (1)
   - [ ] Engaged (2)
   - [ ] Married (3)
   - [ ] Divorced (4)
   - [ ] Re-married (5)
   - [ ] Widowed (6)

7. How long have you been with your significant other/spouse?
   - [ ] 6 months to 12 months (1)
   - [ ] 1 to 3 years (2)
   - [ ] 4 to 6 years (3)
   - [ ] 7 to 9 years (4)
   - [ ] 10 to 15 years (5)
   - [ ] 16 to 20+ (6)
8. Please indicate your race/ethnicity.
   □ African American or Black (1)
   □ Alaskan Native (2)
   □ American Indian (3)
   □ Asian (4)
   □ Caribbean (5)
   □ Caucasian (6)
   □ East Indian (7)
   □ Hispanic or Latino (8)
   □ Native Hawaiian or Other Pacific Islander (9)
   □ Two or More Races (10)
   □ Other (11)

9. Which of the following best describes your professional title? Select one

   □ Licensed Professional Counselor
   □ Licensed Associate Professional Counselor
   □ Master’s degree from PC Program
   □ Master’s level student/Intern PC Program

   □ Licensed Marriage Family Therapist
   □ Licensed Associate Marriage Family Therapist
   □ Master’s degree from MFT
   □ Master’s level student/Intern MFT

10. How many years have you been in the field working with clients? ________

11. Which environment best describes where you provide services now?
   □ Community Based Agency
   □ Correctional Facility/Prison
   □ College/University
   □ Inpatient Treatment Program
   □ Outpatient Treatment Program
   □ Private Practice
   □ Other _____________________________

For this study, emotional intimacy is described as the collaboration of partners revealing themselves by being vulnerable and self-disclosing, and seeking and expressing validation of each other’s world-views and qualities. Please answer the following questions regarding emotional intimacy.
1) How comfortable are you with discussing emotional intimacy with clients in romantic relationships?
   a. Very Comfortable
   b. Comfortable
   c. Neutral
   d. Uncomfortable
   e. Very Uncomfortable

2) If you had to bring up emotional intimacy while in a session you would feel _______ while discussing the topic:
   a. Confident
   b. Uneasy
   c. Indifferent
   d. Fearful
   e. __________

3) Is it common practice for you to discuss emotional intimacy with clients?
   a. Yes
   b. No
APPENDIX D

WEB-BASED INFORMED CONSENT
Title of Project: Examining Counselors’ Level of Professional Experience With Adult Attachment Style
and Comfort with Emotional Intimacy
Investigator Name: Kenika Holloway
E-Mail Contact Information: 10425256@live.mercer.edu

You are invited to participate in an online survey for a research project conducted through Mercer
University. Mercer University’s IRB requires investigators to provide informed consent to the research
participants.

The purpose of this online research study is to examine both counselors and marriage and family therapists
from students to fully licensed professionals comfort with emotional intimacy. Participants will be asked
questions about how they are in their personal relationships and their comfort with discussing emotional
intimacy with clients. Your participation in the study will contribute to a better understanding of therapists
personal lives and its influence on the therapeutic process. Participants must be involved a romantic
relationship for at least 6 months.

If you agree to participate
The survey will take approximately 25-35 minutes of your time. You will complete a survey regarding yo
adult attachment style and personal comfort with intimacy and your ability to discuss emotional intimacy with
clients. You will not be compensated.

Risks/Benefits/Confidentiality of Data
There are no known risks to participation in this research. There will be no costs for participating. Although
your participation in this research may not benefit you personally, it will help us understand the “counselor
as a person” and how our personal experiences influence therapeutic outcomes regarding intimacy. Your name
and email address will not be kept during the data collection phase. A limited number of research team
members will have access to the data during data collection. No identifying information will be stored.

Participation or Withdrawal
Your decision to participate or decline participation in this study is voluntary. You may decline to answer a
question and you have the right to withdraw from participation at any time. Withdrawal will not affect your
relationship with Mercer University in anyway. If you do not want to participate, click on the “stop survey
arrow or close the browser window.

If you do not want to receive any more reminders, you may email us at 10425256@live.mercer.edu

Contacts
If you have any questions about the study contact the investigator Kenika Holloway at 404-645-9292 or send
an email to 10425256@live.mercer.edu. Mercer University’s Institutional Review Board (IRB) reviewed study
#H1709250_01 and approved it on 10/20/2018.

Questions about your rights as a research participant
If you have questions about your rights or are dissatisfied at any time with any part of this study, you can
contact, anonymously if you wish, the Institutional Review Board by phone at (478) 301-4101 or email at
ORC_Research@Mercer.edu.