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Lindsey Calder
Personality Development in
Clinical Social Workers: The
Significance of the
Introjective Personality Type
in Therapists

ABSTRACT

This study explored the relationship between clinical social workers who were identified as having strong self-definitional personality characteristics and self-definitional attributes within the social worker's clinical work. Self-definitional characteristics of clinical social work study participants were identified through Self-Criticism scores within the Depressive Experiences Questionnaire (Blatt, D'Afflitti, & Quinlan, 1976). Motivation for this study grew out of the apparent dearth of research on introjective and anaclitic personality characteristics among psychotherapy providers and the researcher's subsequent desire to bring a more Relational perspective to research regarding personality development and characteristics as measured by the Depressive Experiences Questionnaire. Quantitative data for this study was obtained through an internet-based survey, which included demographic questions, the standard Depressive Experiences Questionnaire, and questions related to clinical characteristics. Sample size of this study and the lack of valid and reliable instruments to measure introjective characteristics of therapy providers within the therapeutic setting were influentially limiting factors to data analysis and significant findings within this study. The researcher's hope is that this study will open up the opportunity for future study on introjective and anaclitic personality characteristics in clinical social workers and other psychotherapy providers, thereby increasing the amount of research guided by the Relational tradition.

PERSONALITY DEVELOPMENT IN CLINICAL SOCIAL WORKERS:
THE SIGNIFICANCE OF THE INTROJECTIVE PERSONALITY TYPE IN
THERAPISTS

A project based upon an independent
investigation submitted in partial fulfillment
of the requirements for the degree of Master
of Social Work.

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2015

ACKNOWLEDGEMENTS

Thank you to my family and friends who encouraged and supported me throughout this entire process, who continuously asked (and at times, appropriately and graciously did not ask) about the progress of this project.

Thank you to Marjorie Postal, who went above and beyond to help me with the completion of the data analysis and Findings chapter.

Thank you also to my thesis advisor, Alexandra Starr, who supported me in the completion of this project.

Thank you to David Zuroff, who graciously volunteered to analyze a portion of my data and welcomed all of my many questions.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

ii

TABLE OF
CONTENTS

iii

LIST OF
TABLES

iv

LIST OF
FIGURES

v

CHAPTER

I INTRODUCTION

6

II LITERATURE
REVIEW

9

III METHODOLOGY

30

IV FINDINGS

38

V DISCUSSION

45

REFERENCES

53

APPENDICES

Appendix A: Smith College Human Subjects Committee Approval
Letter

60

Appendix B: Smith College Human Subjects Committee Protocol Change Approval
Letter

.....
61

Appendix C: Assurance of Research Confidentiality Signed
Form

62

Appendix D: Instrument
Guide

63

Appendix E: Informed Consent
Form

69

LIST OF TABLES

Table

1. DEQ Self-Criticism
Scores
40

2. Responses to Clinical Introjective
Questions
42

LIST OF FIGURES

Figures

1. Personality Development through Interpersonal Relatedness and Self-Definitional Development Stages
15

CHAPTER I

Introduction

The way in which an individual's personality develops and functions dictates their underlying experience of the world. In the work of psychotherapy, a better understanding of one's personality development is crucial in understanding how the individual perceives their world, the way in which they relate to others, and the manner in which they see and define themselves. Within the therapeutic relationship, this type of conceptualization of an individual's experience can provide a richer understanding of one's behaviors, feelings, and thoughts.

World-renown psychoanalyst, author, and researcher, S.J. Blatt, has, along with colleagues, both theoretically and empirically supported a way to conceptualize personality development with their theory and research of introjective and anaclitic personality configurations (Blatt, 1990, 2008; Blatt & Shichman, 1983; Blatt & Blass, 1996). This model is an extrapolation of Blatt's (1974) theory of depressive types based on these differing developmental lines. According to this theory, an individual's personality develops and evolves in a "dialectical" fashion within the anaclitic and self-definition lines. "Anaclitic," or interpersonal relatedness, personality development involves "the development of the capacity to establish mature, mutually satisfying interpersonal relationships," whereas the "introjective," or self-definitional, developmental line focuses on "the development of a consolidated, realistic, essentially

positive, differentiated, and integrated self-identity” (Blatt, S. J., Shahar, G., Zuroff, D. 2001 p. 449).

When personality development includes an overemphasis of either of these developmental lines, anaclitic or introjective personality styles develop as a result. Anaclitic issues include a preoccupation with interpersonal issues of trust, mutual relatedness, and intimacy; introjective issues involve a preoccupation with self worth, autonomy and control, and establishing and maintaining a sense of self. There has been much research around these developmental types in order to better conceptualize the underlying experience of the client and subsequently better inform treatment interventions. However, there has been minimal research to date of anaclitic or introjective personality issues among therapists.

The ideology of psychotherapy has evolved beyond Freud’s “blank screen” therapist. Per the relational model, the therapist is not an objective outsider whose perspective is more “real” than that of the client’s. Rather, the therapist is continually part of the transference-countertransference configurations, with the aim being “to broaden the analytic relationship, and by extension the analysand's other relationships as well, into richer, more dialectical exchanges” (Mitchell, 1988, p. 300). Therefore, the way in which the therapist relates to others and perceives themselves is directly influential to the way in which the therapist will relate to the client, which is paramount to the therapeutic relationship and thus the therapeutic work and treatment in accordance to the relational model.

Thus, in light of the importance of the therapist (or in this case, clinical social worker) within the therapeutic relationship as a multidimensional relational being, the

goal of this study is as follows: How do clinical social workers who are characterized with high introjective scores on the Depressive Experiences Questionnaire (Blatt, D’Afflitti, & Quinlan, 1976) define their competence as therapists?

One of the potential benefits to social work from this research is the increase in information regarding introjective and anaclitic personality traits among clinical social workers, thereby increasing the amount of research guided by relational model focus. In addition to this, information from this study could lead to an increased awareness of the impact a clinical social worker’s personality traits has on his or her professional sense of self. This greater mindfulness of self can lead to a greater awareness of a therapist’s relational needs, which may subsequently allow the clinical social worker to employ their use-of-self more effectively in their clinical practice (and better attune to the client or patient).

CHAPTER II

Literature Review

The literature review is divided into 5 sections. The first section examines both the westernized cultural context and historical psychoanalytic framework within and upon which this study and S. J. Blatt and colleague's theory of personality development is written (Geertz, 1973; Abraham, 1949; Klein, 1952; Freud, 1914/1957, 1926/1959). The second section examines this theory of personality development, consisting of two interdependent lineages of interpersonal relatedness and self-definitional development (Erikson, 1950, 1959; Sullivan, 1953; Blatt, 1990, 2008; Blatt & Shichman, 1983; Blatt & Blass, 1996). The third section reviews the possible results of unbalanced development of interconnected relatedness and self-definitional stages within the individual (Blatt, 1974, 2001, 2004, 2008; Desmet, M., Coemans, L., Vanheule, S., & Meganck, R., 2008; Besser, Guez, & Priel, 2008; Besser & Priel, 2003; Campos, Besser, & Blatt, 2011; Blatt, Shahar, & Zuroff, 2001). The fourth section examines the Depressive Experiences Questionnaire in regards to scoring procedures, demographic factors, and its use among clinical and non-clinical populations (Blatt, et al. 1976; Zuroff, Quinlan, & Blatt, 1990; Blatt et al., 1982; Desmet, Verhaeghe, Van Hoorde, Meganck, Vanheule, & Murphy, 2009; Santor, Zuroff, & Fielding, 1997; Kopala-Sibley, Mongrain, & Zuroff, 2013; Rosenkrantz and Morrison, 1992). Finally, the fifth section examines the Relational tradition in light of the available research on introjective and anaclitic

personality measured by the Depressive Experiences Questionnaire (Aron & Lechich, 2012; Mitchell, 1988, p. 299).

Cultural and Psychoanalytic Context of Personality Development

Western culture, generally speaking, tends to prioritize self-definitional values over those of interconnected relatedness. Despite this bias in western thought, many (Western) psychoanalytic theorists identify both self-definition and interrelatedness with others and fundamental to personality development. There has been a predominant focus on self-definition and individualism in Western civilization, more so than in non-Western cultures, which are often more communal. Non-Western cultures, in general, often tend to be more communal and less individualistic, valuing group communion and interpersonal relatedness, as opposed to individual autonomy. Thus, the very idea of differentiating between individualism and interpersonal connectedness is saturated in the Westernized assumption that these are two distinct concepts (e.g. Geertz, 1973). In other words, individualistic (Western) cultures assume a tension between individual autonomy and interpersonal relatedness that other cultures (such as those that are non-Western, or more collectivist) do not acknowledge.¹ Nevertheless, there are many voices that have challenged this individualistic view of human personality development, including feminist and object relations theorists (Blatt, 2008, p. 23).

Within this cultural predominance on individual autonomy, psychoanalytic theorists have still identified both interconnectedness and self-definition as two

¹ In light of the Western leanings toward both the differentiation of self-identity from interconnectedness and the overarching prioritization of self-definition over interrelatedness, the following literary review (and study, as a whole) should be seen as working with and within the bias of Westernized theory and research.

developmental systems that are fundamental to an individual's personality development. Freud emphasized the fundamental polarity between self-definition and relatedness, or in his words, attachment and individuation, in many of his writings (Freud, 1930/1961, 1914/1957, 1926/1959). Freud's early works discuss his belief that an individual's development is the result of the unique interaction between two "urges," a rivalry between the urge for self-gratification and the urge toward union with others (Freud, 1914/1957, 1926/1959). With respect to object relations, Freud again speaks to the existence and polarity of these two personality lineages, relatedness and self-definition, when identifying two distinguished types of object choice: the use of other individuals to enhance one's own self (self-definitional) and developing mutual, affectionate relationships with other individuals (relatedness) (Freud, 1914/1957, 1926/1959). Other psychoanalytic theorists who discussed these two developmental processes include Karl Abraham (1949), who envisioned the attachment to the caregiver (relatedness or anaclitic object choice) as a necessary foundation to allow one to establish close, mature relationships as an adult, and viewed narcissistic (self-definitional or introjective) object choices as leading to autonomy and self-definition and also necessary for establishing mature relationships in adulthood. Furthermore, Melanie Klein (1952) theorized that the development of object relations (or interconnected relatedness) and self-definition "depends on the degree to which the individual is able to achieve and maintain an optimal balance between projection and introjection, between the discovery of others and the discovery of the self" (as cited in Blatt, 2008, p. 27).

Many psychoanalytic theorists have identified relatedness and self-definition as important processes of personality development. Nevertheless, these theorists prioritize

one process over the other: Some of these theorists emphasize interpersonal relatedness as the most fundamental process in personality development, with self-definition as an important (though necessarily secondary) byproduct (e.g. H. S. Sullivan, 1953; Bowlby, 1969, 1973), while others identify self-definition as the primary component and the ability to interpersonally relate to others as a subsequent result (e.g. Erikson, 1950, 1959). Nevertheless, while most theorists prioritize one of these fundamental processes over the other, Sidney Blatt emphasizes the interdependent, parallel process of these two fundamental dimensions the development of an individual's personality using Erikson's (1950) epigenetic model of psychosocial development.

Theory of Personality Development: The Anaclitic/Introjection Double Helix

Within the context Western psychoanalytic theory regarding personality development, S. J. Blatt conceptualizes personality development as pertaining to two equally fundamental developmental processes – self-definition and relatedness – which evolve in a dialectical, “double helix”-like facilitation throughout an individual's formative years. While most theorists prioritize one of these fundamental processes over the other, S. J. Blatt and colleagues emphasize the interdependent, parallel processes of these two fundamental dimensions the development of an individual's personality, demonstrated in a modification of Erikson's epigenetic model of psychosocial development (Blatt, 1974; Blatt, 2008; Blatt & Shichman, 1983; Erikson, 1950).

Erikson's epigenetic stages, as a near mirror to Freud's conceptualization of psychosexual development stages, denote the stages of trust-distrust (oral), autonomy-shame (anal), initiative-guilt (phallic), and industry-inferiority (latency) (1950, 1959). During this first stage, the infant individual first experiences intimate relationships in the

quality of attachment that the infant shares with its primary caregiver. It is this beginning developmental experience of relational interconnectedness (whatever the level of attachment may be) that denotes its position in the interrelatedness lineage (Blatt, 2008). Erikson's later stages, autonomy-shame, initiative-guilt, and industry-inferiority develop the individual's personality (identity, as Erikson would say) associated with their definition of self by means of "an early sense of separation and autonomy from the control of another" (autonomy-shame); the ability to initiate internally determined, proactive activity (initiative-guilt); and the capacity for sustained, goal-directed activity (industry-inferiority) (Blatt, 2008; Erikson, 1950, 1959). The last and most developmentally mature stages that Erikson delineates are Identity-Role Diffusion, Generativity-Stagnation, and Integrity-Despair (Erikson, 1950, 1959).

Erikson has been critiqued for the heavy emphasis he places on individual autonomy in his developmental model (e.g. Carson, 1972; Gilligan, 1982). For Erikson, an individual's identity involves their development as separate and autonomous from others (Erikson, 1959): "attachment and interpersonal relatedness appear to play secondary roles in identity development, either facilitating or serving as by-products of identity formation" (Blatt, 2008, p. 100). On the other side of the spectrum, H. S. Sullivan's (1953) psychoanalytic theories emphasize the importance of interpersonal relationships on personality development. Sullivan's interpersonal theory posits that an individual's personality develops through one's increased ability to connect and relate with others. The first stage in which this develops is Trust-Mistrust, the initial relationship between the infant and caretaker in which the first level of trust is laid in shared affect (or lack thereof) between infant and primary caretaker. The second stage of

Sullivan's interpersonal relatedness development, Cooperation-Alienation, takes place as the preschool aged child begins to progressively recognize relationships with others and is increasingly able to collaborate with family members and then with peers. The third and most developmentally mature stage, Intimacy-Isolation, occurs as the individual is able to establish and sustain mutual, reciprocal relationships with others.

Blatt (2008) illustrates the combination of Erikson (1950, 1959) and Sullivan's (1953) theories (which emphasize self-definition and interpersonal relatedness, respectively) that results in a modified version of Erikson's epigenetic stages of development. In this modified model, personality development begins with the Trust-Mistrust stage within the relatedness line, and then moves onto Autonomy-Shame and Initiative-Guilt, both of which pertain to the self-definitional developmental line. These self-definitional stages are then followed by Sullivan's Cooperation-Alienation stage, within the interpersonal relatedness line. Personality development then continues through the more mature self-definitional stages of Industry-Inferiority and Identity-Role Diffusion, which is then followed by the more mature expression of interpersonal relatedness, Intimacy-Isolation. Lastly in the personality development process are Erikson's final stages within the self-definition line, Generativity-Stagnation and Integrity-Despair.

Figure 1. Personality Development through Interpersonal Relatedness and Self-Definitional Development Stages.



In this modified conceptualization of personality development (Figure 1), the experience of each stage deeply affects the next, so that each stage in its self-definitional or relatedness lineage intertwines and evolves interdependently. For example, an individual's mastery of Cooperation is dependent upon their sense of self-differentiation from others (Autonomy) and their ability to act from their own desires and needs (Initiative) (Blatt, 2008, p. 104). Thus, interconnected relatedness and self-definition develop in a dialectical fashion: "An increasingly differentiated, integrated, and mature sense of self is contingent on establishing satisfying interpersonal relationships; and conversely, the development of mature and satisfying interpersonal relationships is contingent on the development of a mature self-identity" (Blatt et al., 2001, p. 449).

Possible Results of Unbalanced Development within the Introjective/Anaclitic

Double Helix

When personality development includes an overemphasis of either self-definition or relatedness, anaclitic or introjective personality organizations develop as a result.

Further imbalance of these developmental lines may also lend itself to a greater vulnerability for more symptomatic mental health issues and related diagnoses. Due to the dialectical developmental process of these self-definitional and relatedness lineages, differences in the relative emphasis in either self-definition or relatedness developmental experiences are expressed as introjective or anaclitic personality styles, respectively. The term “anaclitic” comes from the Greek word *anaclitas*, meaning “to lean upon or depend on” (Blatt, 2004 p. 29). Freud first coined this term when describing the experience of an oral-like object choice in which the individual seeks to be soothed, comforted, and cared for by the object. The term “introjective” originates from E. Jacobson’s (1954) description of “introjective identification,” the establishment of a punitive, destructive, and aggressive superego as a bad object within the individual. Blatt uses the term “introjective” in this context to explicate the formation of a “harsh, punitive, unrelentingly critical superego” that results from predominant emphasis on self-definitional personality processes (Blatt, 2004, p. 29).

S. J. Blatt and David Zuroff’s article, “Interpersonal Relatedness and Self-definition: Two Prototypes for Depression,” indicates that an “adequate coordination” between the relatedness and self-definitional developmental lineages denotes “optimal development” and assumed physical and psychological wellbeing and reduced stress (1992). Nevertheless, the focus of the research that this article reviews is subtypes of

depression (based on introjective and anaclitic experiences, briefly discussed later in this section), not the process of personality development involving relatedness and self-definition. Therefore, Blatt and Zuroff's (1992) suppositions on what constitutes "adequate coordination" to produce an ideal personality development is based on clinical symptoms due to extreme overemphasis and does not then necessarily show evidence of what constitutes an ideal coordination between the relatedness and self-definitional lineages. It is important to note that S. J. Blatt's proposed model of personality development—the symbiotic, double-helix-like developmental evolution of relatedness and self-definition—is a conceptual model that aims to better understand personality development and characteristics, and does not prescribe an "ideal" personality development or particular expression, *per se*.

Introjective and anaclitic personality styles are distinguished by distinct cognitive patterns, defenses, and coping strategies, which are more vibrantly expressed when an individual is under stress (Besser, Guez, & Priel, 2008; Besser & Priel 2003; Blatt, 2008). The more emphasis that is placed within the development of one of these two lineages, the more pronounced these personality styles become: exaggerated emphasis on either self-definitional or relatedness developmental experiences may lead to more entrenched personality traits of dependency or self-criticism and can make one more susceptible to related psychopathologies, including depression (e.g. Blatt et al., 1974; Coyne & Whiffen, 1995; Hokanson & Butler, 1992; Nietzel & Harris, 1990). Research conducted by S. K. Fuhr and G. Shean (1992) does not support the Dependency and Self-Criticism factors, measured within the Depressive Experiences Questionnaire (Blatt et al., 1976), as adequate representations of introjective and anaclitic depression. As the introjective

personality process is concerned with forming a “differentiated, integrated, realistic, essentially positive sense” of self-identity, exaggerated emphasis on this developmental line lead to a susceptibility to clinical issues focused on “establishing and maintaining a viable sense of self, ranging from a basic separateness, through concerns about autonomy and control, to more complex internalized issues of self-worth” (Blatt, 2008, p. 15; Blatt et al., 2001, p. 450). Introjective psychopathology is “triggered when excessively self-critical and autonomous subjects are confronted with stressors pertaining to achievement (e.g. failure to graduate)” (Desmet, M., Coemans, L., Vanheule, S., & Meganck, R., 2008). Diagnoses that relate to these introjective clinical issues include over-ideational borderline personality disorder, paranoia, obsessive-compulsive personality disorders, (introjective) depression, and types of narcissism (Blatt et al., 2001, p. 450). On the other side, the relatedness line of personality development involves the ability to establish and sustain mature, mutually beneficial relationships with others. Subsequently, extreme overemphasis of this developmental process can lead to “preoccupation with interpersonal issues of trust, caring, intimacy, and sexuality,” and may include DSM diagnoses of dependent personality disorder, borderline personality disorder, (anaclitic) Major Depressive Disorder, etc. (Ibid.).

In addition to these related mental health diagnoses, a greater amount of emphasis on either self-definition or relatedness during one’s personality development may also increase the individual’s vulnerability for specific types of depression. In fact, there is a great amount of empirical research that suggests that high levels of self-criticism or dependency are vulnerability dimensions for depression (Campos, Besser, & Blatt, 2011). Individuals with a dependent personality style may experience depressive states in

response to disruptive interpersonal events and their experience an “anaclitic” form of depression, centered on feelings of loneliness, abandonment, and being unloved. On the other side of the personality dialectic, individuals with a self-critical personality style may be more vulnerable to depressive states in response to disruptions in self-definition and personal achievement. These individuals may experience “introjective” depressive states around feelings of failure and guilt centered on self-worth. (Campos et al., 2011, p. 197). In “Levels of Object Representation in Anaclitic and Introjective Depression,” Sidney Blatt (1974) reviews Fenichel and Bibring’s theories of development and extrapolates that introjective depression is considered more developmentally advanced than anaclitic depression. This conclusion is supported by both Bibring and Fenichel’s discussions that one source of depression (anaclitic) is primarily oral in nature, originating from unmet needs from an omnipotent caretaker; while another source is related to the (more developmentally advanced) formation of the superego and involves the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage.

Blatt, Shahar, & Zuroff’s (2001) article describes anaclitic and introjective personality configurations and reviews their relationships to psychotherapy process and outcome with participating patients. Their findings indicated that anaclitic patients improved more in long-term supportive expressive therapy than in psychoanalysis, whereas introjective patients improved more in psychoanalysis than in long-term supportive expressive therapy or brief manualized treatment for depression. There are many strengths in this research review, including large sample sizes in a variety of treatment levels (90 inpatient, 33 long-term outpatient, and 125 short-term outpatient,

respectively). Despite the variety in treatment level and modalities, the article says little about the specific characteristics of the participants of each study: with the exception of gender, anaclitic and introjective scores, and treatment modalities, the research review mentions no other variables that could have contributed (and in other studies, have been shown to contribute) to either a participant's introjective or anaclitic status (including nationality, ethnicity, or age) or their amenability to treatment (including their relationship to their treatment provider, level of outside support, or efficacy scales) (Kopala-Sibley et al., 2013; Levander & Webart, 2012; Fuhr & Shean, 1992).

The Depressive Experiences Questionnaire

Since its 1976 origin, the DEQ has been broadly used to measure dependency and self-criticism, two personality dispositions that may lead individuals to be more vulnerable to depressive experiences (Blatt, et al. 1976; Zuroff, Quinlan, & Blatt, 1990; Blatt et al., 1982). Studies have shown that the Depressive Experiences Questionnaire is a valid measurement of introjective and anaclitic personality characteristics (labeled “self-criticism” and “dependency”) as two stable, continuous, and nearly orthogonal (or statistically independent) personality characteristics (Zuroff, Mongrain, & Santor 2004). Many studies have also supported the validity of the DEQ's measurements of these two personality development lineages (Blatt & Zuroff, 1992; Blatt, 2004; Zuroff et al., 2004). In addition to the validity of the psychometric factors within the DEQ, these factors, Dependency and Self-Criticism, have also been empirically validated by research studies with the DEQ and several other instruments, including the Dysfunctional Attitudes Scale (Wessman & Beck, 1978), Sociotropy-Autonomy Scale (Beck, 1983), and the Personal Styles Inventory (Robins et al., 1994) (Campos et al., 2011). Within the DEQ,

Dependency includes preoccupation with a need for closeness and dependent interpersonal relationships, as well as concerns regarding abandonment, helplessness, and loneliness (Blatt et al., 1976). The 2nd DEQ factor, Self-Criticism, measures preoccupation with intense and persistent self-criticism and feelings of failure and ambivalence towards oneself (Ibid.). Further research has identified and empirically validated two subscales, Neediness and Connectedness, within the Dependency factor of the DEQ² (McBride, Zuroff, Bacchiochi, & Bagby, 2006). In addition to these two factors, the DEQ also measure a third value, labeled “Efficacy,” which measures “goal-oriented strivings” without excessive competition with others (Campos et al. 2011, p. 200).

DEQ was developed by Blatt et al. (1976) for the purposes of measuring anaclitic and introjective personality styles, as an indicator of vulnerability to different subtypes of depression (namely, anaclitic and introjective depression). Coyne, Thompson, and Whiffen’s (2004) research study expresses skepticism regarding the empirical validity of the DEQ as a measurement of anaclitic and introjective personality styles. In direct response to this criticism, the 2009 study, “The Depressive Experiences Questionnaire as a Measure of Psychoanalytic Constructs Reported to be Measured,” the researchers found

² As explicated by Blatt (2008), although some theorists use the term “dependency” to identify entire developmental lineage of “relatedness,” (e.g. Gilligan, 1982), Blatt uses Erikson’s developmental stages to suggest that, within the relatedness developmental line, dependency is distinguished as an early form of relatedness (since in the more mature development of relatedness comes the emergence of an individualized sense of self, which “enables one to participate in mature, reciprocal, mutually satisfying relationships with others” (Blatt, 2008, p. 103). Thus, within the parallel processes of the two developmental lines, the emergence of a more individualized, articulated sense of self allows the individual to progress from dependency to more mature interpersonal relatedness) (Ibid).

“adequate convergence” (i.e. “0.45”) between DEQ Dependency and Self-Criticism scales and anaclitic and introjective types (Desmet, Verhaeghe, Van Hoorde, Meganck, Vanheule, & Murphy, 2009). Nevertheless, recommendations for this study call for more research to be done on the sex-specific (i.e. male-female) validity of the DEQ (specifically the Self-Criticism scale) (Ibid.).

DEQ scoring procedures. In the original, standard scoring procedures, Self-Criticism and Dependency scores are the product of factor-derived scale scores (rather than unit-weighted composite scale scores) by the use of means, standard deviations, and item-loadings from the original 1976 student sample (Blatt, 1976). According to Santor, Zuroff, & Fielding (1997), one of the most prevalently expressed critiques of the DEQ is the use of factor-derived scale scores rather than unit-weighted composite scores (p. 146). Indeed, the convoluted original scoring process has been regarded as a limitation by many studies, which has led to the production of modified scoring systems that use unit weighting of a small number of items selected on the basis of factor loadings (Bagby, Parker, Joffe, & Buis, 1994; Welkowitz, Lish, & Bond, 1985). Although a strength of these modified scoring systems is a simplified manner of scoring DEQ results, a 2004 study by Zuroff et al. reports that the resulting high correlation of Dependency and Self-Criticism scales are due to scoring system properties (as opposed to factor redundancies) (p. 492).

Demographic factors and the DEQ. Despite the DEQ’s broad use, issues regarding the DEQ’s psychometric properties of the original measure have been raised in several studies (ref. in Santor et al., 1997, p. 146). One of the most prominent critiques of the standard scoring method is that it necessitates a reliance on scoring coefficients from

validation samples that are based exclusively on women (Blatt, 1976). Based on the standard scoring procedures of the DEQ, most research with the DEQ has applied the “female” scoring parameters (factor scoring coefficients from the original 1976 sample) to both men and women, since the “female” parameters were based on a larger sample) (Zuroff, Quinlan, & Blatt, 1990, p. 67). Despite expressed issues with gender-specific validity of DEQ Dependency and Self-Criticism factors (e.g. Desmet et al., 2009), Zuroff et al. (1990) recommends continued use of standard scoring procedures for both men and women due to high similarities factor loadings of their men-women 1990 sample to the original 1976 female factor loadings.

Research studies using the DEQ have seen changes in anaclitic and introjective personality traits in relation to age. Results from a 2013 research study on aging women ages 60 to 89 living in Lisbon, Portugal found that Dependency and Connectedness (2 anaclitic factors) were negatively related to age (Henriques-Calado, Duarte-Silva, Campos, Sacoto, Keong, & Junqueira, 2013). Another 2013 study, conducted by Kopala-Sibley et al. found that both self-criticism and dependency decreased in a linear fashion across the lifespan of the individuals. The aim of this longitudinal study, however, was not to study depressive experiences in an aging population (as it was for Henriques-Calado et al., 2013), but to explore developmental trends in multicultural samples of anaclitic and introjective factors across an individual’s lifespan and across the moderating impact of important life experiences (Kopala-Sibley et al., 2013). The study’s sample included approximately 3500 Canadians, and analyses were replicated in multicultural sample of approximately 600 Canadians and approximately 650 individuals born and currently living in East Asia, Middle-East Asia, or South Asia. This is the first study to

examine the developmental trends of Dependency and Self-Criticism personality traits in a longitudinal study across significant life events, age, and “culture”. One limitation to this study is that although some cultural demographic information was obtained (such as geographic location, ethnicity, and nationality), this data – with the exception current continental residence (i.e. North America or Asia) – was not analyzed as separate variables. Thus, as the researchers indeed note, there is no way to generalize results or differentiate among different cultural demographics (Kopala-Sibley et al., 2013, p. 138). Furthermore, all participants of this study, regardless of continent of origin, had to have the ability to read and comprehend English, an ability that may be demonstrative of westernized ideals, manners, and/or values (Ibid.) Nevertheless, a strength of this study was that the cross-cultural comparison may have helped to offset the limitations of cross-sectional studies (e.g. different birth cohorts showing differing personality profiles even when there were no age-related changes in personality) (Kopala-Sibley et al., 2013).

Use of DEQ among therapy-provider populations. Despite the broad use of the DEQ on clinical and non-clinical populations (discussed in this and the previous chapter within this literature review), there seems to be a dearth of studies – one, to be specific – that use the DEQ on a therapist population. This lone study conducted by Judith Rosenkrantz and Thomas Morrison in 1992 assessed the influence of specific personality characteristics (such as tendency to depressive experiences and personal boundary preferences) on psychotherapist reactions to patients diagnosed with borderline personality disorder. The researchers used the DEQ to measure personality characteristics of the therapists in the study. Although Rosenkrantz and Morrison interpreted the DEQ scores as depressive experience types, rather than introjective and anaclitic personality

characteristics, the personality types that the DEQ results indicate in this study do not change. The researchers hypothesized that certain dimensions of therapist personality (as measured by the DEQ) would influence therapists' perceptions of themselves and patients depending on specific patient behaviors (Rosenkrantz & Morrison, 1992). In conjunction with one of their hypotheses, the results of the study suggested that therapists with high anaclitic characteristics evaluated themselves less favorably when faced with "withdrawing" behavior from a client. In light of what is understood as more triggering behavior for those with anaclitic tendencies (i.e. relational separation, fear of abandonment, or feeling devalued or helpless), it would make sense that when the anaclitic-type therapist perceives a distant and self-sufficient client, this behavior would likely trigger the therapist's anaclitic characteristics (Blatt et al., 2001).

Contrary to their hypotheses specifically to therapists with high introjective scores, the results of the study indicated that therapists with higher levels of introjective characteristics evaluated both themselves and patients more positively, regardless of patient behavior (i.e. withdrawing or rewarding object relations toward participating therapist). What the authors gave as a possible explanation was that adaptive functions of self-criticism is an important part of self-discipline and may demonstrate a learned trait of maintaining high levels of regard for patients and themselves within the therapeutic process (Rosenkrantz & Morrison, 1992, p. 551). The study results of the introjective therapists could also be understood, in part, as an exemplification of how introjective tendencies may be more developmentally advanced, in that therapists with these characteristics would be better able to adaptively cope to developmental triggers (which may also be easier to do since triggers are supposedly rooted in higher developmental

stages) (Blatt, 1974). Another possible explanation of these results could be that both variables, the “withdrawing” and “rewarding” object relations with clients) are both other-relational in nature, which is where anaclitic triggers, not necessarily introjective triggers, originate. In this vein, if “trigger” variables were developed in other manners, specifically those that touch on self inadequacies and guilt in therapists with introjective characteristics, therapist perceptions of themselves within the psychotherapeutic setting may produce different results.

The Rosenkrantz and Morrison (1992) study indicates that developmental personality types (as measured by the DEQ) may influence therapist’s perceptions of themselves and of their clients. Nevertheless, despite the broad research conducted with the DEQ, the majority of studies have focused on clinical and non-therapy providing populations. This gap in literature and research seems to reflect a traditional, one-person psychology framework of psychotherapy.

The Relational Tradition

The dearth in literature and research regarding introjective and anaclitic characteristics and therapy providers seems to reflect a traditional, one-person psychology model, as opposed to a two-person psychology relational model. The one-person psychology model has strong roots within the history of psychoanalytic thought. According to the traditional psychoanalytic definition of transference, the individual receiving therapy (hereafter referred to as “client” or “patient”) displaces an old object onto the therapist, as the new object. The therapist is then left to determine which parts of the psychotherapeutic interactions are part of the “real” relationship, and which parts were the results of distorted object relations, or transference (Aron & Lechich, 2012).

Within this traditional view of transference, the client “misresponds” or “misperceives” while the therapist provides a more “objective” perspective (Mitchell, 1988, p. 299). In this same vein, the therapist’s emotional and behavioral response within the therapeutic encounter is thought to originate, countertransferentially, from the client. In this one-person psychology model of the psychotherapeutic interaction, there is “one subject and one observer, both studying the mind of the patient, and the analytic relationship is structured in hierarchical fashion” (Mitchell, 1988, p. 299).

In contrast to this traditional model of psychoanalytic thought, the relational tradition consists of a more mutually interactive, two-person psychology framework. Relational psychoanalysis is not a unified theory, but a “big tent” paradigm that encompasses overlapping approaches, ideas, and concerns held together by shared core concepts and clinical strategies (Aron & Lechich, p. 211). According to the relational model, transference and countertransference, rather than originating from the client with the therapist as and separated observer, are co-created by client and therapist in every two-person interaction they have together (Aron & Lechich, 2012). In this way, rather than the viewing the therapist as a more objective outsider of the transference and countertransference, “As constricting transferential constraints are clarified through interpretive activity, the newly won relational positions themselves take on new transferential meanings which carry with them their own constraints” (Mitchell, 1988, p. 297). This is not to say, however, that previous ways of relating, with old objects, are not used, but they are seen in a different light according to the relational tradition: viewed as a fundamentally interactive encounter between two persons, “Familiar timeworn

strategies are employed, to be sure, but as pathways to connect with what the [client] has experienced about this particular analyst as a person” (Mitchell, 1988, p. 300).

Using this perspective of the relational model, the thoughts, feelings, expressions of the therapist are not only incapable of being neutral, but become imperative to the therapeutic relationship and therapeutic work itself. Therefore, in accordance with the relational tradition, increased awareness and understanding into the way in which a therapist relates to themselves and to others, especially within the therapeutic relationship, would increase the therapist’s opportunity to broaden and strengthen the therapeutic relationship to the benefit of the client or patient.

Summary

Within the framework of western psychoanalytic thought, Sidney Blatt and colleagues adapted a model of personality development that establishes introjective (or self-definitional) and anaclitic developmental processes that mature in a dialectical manner in which their development is contingent upon one another. Many previous and on-going studies on introjective and anaclitic characteristics use the Depressive Experiences Questionnaire and focus on clients or patients (i.e. effectiveness of treatment modalities, related psychopathological issues, etc.). Furthermore, there has been only 1 research study to date, done by Rosenkrantz and Morrison (1992), that focuses on therapy *providers*, and uses the DEQ to measure therapists introjective and anaclitic characteristics. This unbalanced leaning in research and literary focus parallels a traditional, one-person psychology model, which is in contrast to the relational tradition. In accordance with a relational, two-person psychology perspective, the therapist's actions, words, and non-verbals are imperative in the therapeutic process.

In a logical extension of the relational framework, there is a need for more DEQ research that acknowledges the integral part the individual therapy provider plays within the therapeutic relationship regarding the influence of the therapist's personality characteristics. Thus, this study aims to identify introjective clinical social workers (those who are identified as having high introjective scores) via the Depressive Experiences Questionnaire (Blatt et al., 1976) and explore the relationship between their introjective characteristics and the way in which they define their competence as therapists.

CHAPTER III

Methodology

The aim of this exploratory quantitative study is to identify clinical social workers who have a particular personality trait, as identified through the Depressive Experiences Questionnaire (Blatt, D'Afflitti, & Quinlan, 1976), and then explore how this personality style may influence the way that the clinical social worker sees themselves as a therapist. An internet-based survey, Survey Monkey, was used and included three separate sections: Demographic Questions (5 items), the DEQ (66 items on 7-point Likert scale), and Questions Regarding Clinical Therapy (15 items on 7-point Likert scale). Using Survey Monkey allowed for the security of the anonymity and confidentiality of each participants (see “Ethics and Safeguards” section within this chapter for more details).

Sample

This study used snowball-sampling method in order to reach a larger number of eligible participants in diverse professional and educational environments and geographical locations. The researcher’s goal was to have at least 50 participants involved in the study. Nevertheless, due to time limitations in recruiting participants, the minimum number of participants was set at 15.

Inclusion Criteria. Eligible participants for this study must have received or had been currently enrolled as a student working to obtain a Masters or PhD in social work and had been currently working (or interning) in a clinical setting. For the purposes of this study, the term “clinical setting” referred to the work environment in which the

interventions of the social worker (or social work student) included those “directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues” that are focused around a “person-in-situation” perspective (National Association of Social Workers [NASW], 1989, Standards for the Practice of Clinical Social Work). For this study, this researcher decided to focus on individuals who self-reported to have received (or were currently enrolled in school to obtain) a master degree in social work, or individuals who were currently working to obtain a master’s degree in social work. This researcher has chosen to narrow the focus of this study to self-identified masters-level social workers (as opposed to individuals who had received or were in the process of receiving a bachelor’s degree in social work; or individuals who had not received a bachelors or master’s degree in social work but reported to work in the general field of social work). This researcher made this decision based on the assumption that master-level social workers have, in general, put forth greater time, experience, and thought into their identity and increasing their competency as a social work professional. Based on this assumption, this researcher believes that narrowing the focus to individuals with a master degree in social work would result in more thoughtful responses, specifically to survey questions regarding the clinical self-identity and competency of the participants. Whether or not participants had, in fact, received a master’s degree in social work was not able to be verified since the identities of the participants were anonymous and confidential, and was thus self-reported by participants.

Exclusion Criteria. The Internet survey and recruitment social media postings and emails were written in English due to the fact that this researcher is only fluent in the

English language. Therefore, participants who were not able to understand written English were not able to participate in the study.

Recruitment Procedures. Recruitment for this study involved reaching out to students and colleagues who were not members of the Smith College School for Social Work community through email, networking (via email) with friends and also students and colleagues within the Smith College School for Social Work community to help recruit eligible participants for the study, and reaching out to colleagues and other potential participants using the professional social media website, LinkedIn. Participants were drawn from volunteers who accepted the request to complete the Internet survey. In the recruitment emails and posts, this researcher also encouraged recipients to forward the email or LinkedIn post to other individuals who may meet eligibility criteria for this study.

Ethics and Safeguards

All participants voluntarily gave their informed consent to participate in the study. Survey Monkey encrypted the survey responses in this study in order to secure the privacy and confidentiality of the data. The survey in this study did not collect any names, email addresses, IP addresses, or any other identifying data. Non-personal identification numbers were assigned to each participant's set of responses. There is no way for the researcher to determine who completed surveys. The data gathered will be kept confidential, accessible only by the researcher, her research advisor, and the data analysts. All research materials including consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then

destroyed. All electronically stored data will be password protected during the storage period.

Because the researcher used an Internet-based survey that ensured anonymity and confidentiality of participants, there was no way of knowing which individuals had (or had not) completed the survey (thus leading to no appearances of coercion). Nevertheless, the researcher did not knowingly recruit for this study any individual who was a past or current patient or client through any measure (LinkedIn or email).

This study poses a low risk for participants. Nevertheless, it is possible that some participants may feel uncomfortable or distressed when reflecting on their personality tendencies, especially when followed up with reflecting on their personality tendencies as a therapist. In order to provide participants some protection and mitigate these risks, Participants were made aware prior to beginning the survey that although all responses are voluntary, anonymous, and confidential, they have the right to refuse to answer any question on the survey without repercussions or exit the survey at any time.

Participation in this study will provide participants, as social work students and professionals the opportunity of reflecting on their own personality tendencies, which hopefully will allow for more self-awareness as a practicing clinician. Participation in this survey will give participants the opportunity to reflect on the way in which they see themselves as therapists. Participants did not receive any compensation besides the potential benefits just described.

The researcher provided an opportunity to ask questions by providing her email address within the recruitment email, LinkedIn recruitment post, networking email to recruit participants, and her email and telephone number in the Informed Consent Form.

Data Collection

This research study used an internet-based survey, Survey Monkey, which secured the anonymity and confidentiality of the participants. Because of the personal and professional nature of the survey questions, the researcher opted to use Survey Monkey as a means of maintaining the anonymity and confidentiality of the participants. This researcher believed that this would increase likelihood of honesty in participant responses: since all participants will either be practicing professionals or preparing to become practicing professionals, securing participant anonymity and confidentiality would help participants answer the study questions more without feeling at risk of negative professional or personal perception by others.

Once individuals were found to be eligible participants of the study via the two self-report screening questions (see “Inclusion Criteria” in this chapter), they were directed to the Informed Consent form, which participants were asked to read and then select whether or not they agree to participate (see Appendix A for Informed Consent Form). Participants (who necessarily give their informed consent) will then move onto to the demographic questions. Participants were then asked to respond to 5 demographic questions, which included questions about how long the participant has been practicing clinical social work, the environment in which they practice clinical social work, racial identity, ethnic identity, and gender identity.

Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti, & Quinlan, 1976). The second portion of the survey consisted of the 66-item DEQ, the use of which was granted by one of the original authors (S.J. Blatt) for clinicians and researchers through David Zuroff (a professor at McGill University who has co-authored multiple

research studies with S.J. Blatt). Responses will be given on a 7-point Likert Scale, ranging from 1 (“Strongly Disagree”) to 7 (“Strongly Agree”), with 4 being “undecided or neutral”. The DEQ was originally developed for the purposes of differentiating between various types of experiences associated with depression (i.e. anaclitic and introjective). Nevertheless, the DEQ is not a measure of depressive symptoms but a measure of stable personality traits, namely Self-Criticism and Dependency (i.e. Introjective and Anaclitic), with test-retest reliabilities of .75 and .80 at 3 and 12 months, respectively (Kopala-Sibley, D., Mongrain, M., & Zuroff, D., 2013). The Dependency factor within the DEQ comprises anaclitic themes of dependency, hopelessness, loneliness, abandonment, and rejection (e.g. item 32, “I constantly try, and very often go out of my way, to please or help people I am close to.” Or item 20, “I would feel like I’d be losing an important part of myself if I lost a very close friend”). The Self-Criticism factor within the DEQ comprises introjective themes of guilt, inferiority, self-blame, and inadequacy (e.g. item 13, “There is a considerable difference between how I am now and how I would like to be.” Or item 7, “I often find that I don’t live up to my own standards or ideals”). The third primary factor of the DEQ is labeled “Efficacy,” which measures goal-oriented strivings without excessive competition with others. Efficacy measures a participant’s well being, indicating independence, self-acceptance, and normal affect (Blatt et al., 1982). High Efficacy scores have been shown to have negative correlations with depression and other mental health issues (and positive and significant correlation with hypomania) (Blatt et al. 1982) Nevertheless, this study did not focus on participants’ efficacy scores due to the fact that Efficacy is not related to a developmental personality process as is Self-Criticism and Relatedness. In addition to this, Efficacy is not an

operationalization of a factor in Blatt's personality development theory (Blatt et al., 1976).

Study Focus of DEQ: Self-Criticism/Introjection. This study focused only on participants' Self-Criticism measures of the DEQ due to time limitations of the study and the nature of study participants. Participants of this study were higher functioning: all participants of this study had obtained, or were currently in the process of obtaining, a Master's or PhD (which also necessitates the previous attainment of higher education); and they were currently functioning at a level that allowed them to be currently practicing clinical social work. In light of Blatt's 1974 article that describes introjective characteristics (specifically depression) as a developmentally more advanced than those of anaclitic (see section titled "Depressive Experiences Questionnaire" of this project's Literature Review), in addition to the time restrictions for this study, the researcher made the decision to narrow the focus of the study as it is.

The third portion of the survey consisted of 15 questions developed by the researcher for the purposes of determining introjective and anaclitic characteristics within the participant's clinical work. The number of questions (15) was decided with idea of wanting to keep the number of questions short, with the assumption being that the shorter the total number of survey questions, the stronger likelihood of every participant completing the survey in its entirety. Within these 15 questions, 11 were designed to comprise introjective themes of independent goal attainment, sensitivity to others' control, and preference for solitude (e.g. item 8, "When I achieve something I've been striving for in my work with a client or patient, I get more satisfaction from reaching that goal than from any appreciation I might get from the client or patient." Or item 13, "If I

think I am right in my clinical judgment about something, I feel comfortable expressing myself even if my client or patient does not like it.”). A strong majority of questions in this portion of the survey, 11 of the 15, were designed to consist of introjective themes due to the fact that the focus of the study was introjective, as opposed to anaclitic or introjective and anaclitic, characteristics within the clinical work of social workers who were characterized as introjective by their DEQ scores. The remaining 4 questions within this portion of the survey were developed with the intention of consisting of anaclitic themes, including the desire to please others and fear of criticism or rejection (e.g. item 2, “I censor what I say to my client or patient because I’m worried that they may disapprove of or disagree with me.” Or item 6, “I feel uncomfortable when I cannot tell whether or not my client or patient likes me”). All responses to the 15 questions of this section were on a 7-point Likert Scale, ranging from 1 (“Strongly Disagree”) to 7 (“Strongly Agree”), with 4 being “undecided or neutral”. This design was implemented in order to aid with scoring consistencies among the DEQ section and third (clinical characteristics) portion of the study.

CHAPTER IV

Findings

This was an exploratory study that employed a quantitative methods design. The purpose of the study was to identify clinical social workers with introjective characteristics and explore the relationship between these characteristics and self-identified introjective characteristics within their clinical work.

Demographic Characteristics

The sample consisted of 18 participants who met eligibility criteria and completed the entire survey. Nine additional individuals attempted to take the study survey, but were either found to be ineligible (n=5) or were found eligible but did not complete the survey (n=4). The average number of years the participants had been a social worker ranged from one to 23 years, with a mean of 4.5 years, and a median of 2 years. Within this study sample, 11 participants practiced at outpatient community mental health organizations, 1 practiced in an outpatient private practice, 5 practiced in school settings, 1 practiced in a court setting, 1 practiced in partial hospitalization programs, 1 practiced in private inpatient hospitals, 4 practiced in public inpatient hospitals, 2 practiced in a non-mental health hospital setting, and 1 participant practiced in a public human services setting. In regards to self-reported participant ethnicities, the majority of participants (n=10) identified themselves as North American, Eastern European (n=4), and Western European (n=7). Other ethnicities that were reported were African, Jewish, Central American, South Asian, and Mexican-American. The majority of participants in this

study racially self-identified themselves as “White” (n=15), while other racial identifications included Latino(a) and Southeast Asian, and “Mixed”. The questions on work setting, race and ethnicity allowed participants to check more than one answer, and thus do not sum to 18. The overwhelming majority of participants were self-identified women (n=15), with other participants’ genders including men (n=2), and “gender fluid” (n=1) individuals.

Introjective Characteristics as Measured by the DEQ

The researcher’s original intent was to distinguish participants within the archetypal group, “introjective,” in accordance with their relatively high Self-Criticism (SC) scores within the DEQ (and relative to their Dependency and Efficacy scores) (Kemmerer, 2006). However, upon further research and discussion with researcher and analyst David Zuroff, this researcher found that these scores are continuous and not types, and thus, should be described as such. The relevant responses within the DEQ portion used for this study were the Self-Criticism (SC) scores. DEQ data analysis is completed through factor-derived scale scores. DEQ researcher, David Zuroff, completed the DEQ data analysis in this study. SC scores are presented in Table 1. These are continuous scores that are not meant to create or be divided into archetypal groups, meaning that participants cannot be characterized as “introjective” or “not introjective” (Zuroff et al., 2004, p. 491). Table 1 shows minimum and maximum mean and median scores for the sample. Higher scores indicate more self-criticism and lower scores indicate lower self-criticism scores.

Table 1. DEQ Self-Criticism Scores.

Minimum	-1.76
Maximum	1.18
Mean (std dev)	-0.1857(.930)
Median	-0.3395

In regards to the DEQ data analysis, the original goal of the researcher was to divide the highest and lowest scores to create different groups, which is done by grouping the DEQ scores (which, in this case, would be the standard DEQ scores for Self-Criticism) above and below the median (Kemmerer, 2007). However, though some studies using the DEQ have employed the use of median splits in their data analysis, Zuroff et al. (2004) suggests that the scores be used as a continuous variable, as the use of median splits have low statistical power and are sample dependent. Given the limitations in sample size in this study and research of Zuroff et al. (2004), the DEQ Self Criticism scores was used as a continuous variable.

Clinical Characteristics

A summary of the responses to the Clinical Characteristic (Clinical) questions and mean responses to each question are presented in Table 2. Table 2 shows the responses to the 15 clinical questions, which ranged from strongly agree (7) to strongly disagree (1). Clinical questions are divided into the two groups, introjective and anaclitic. The responses to the introjective Clinical questions, which are the focus of the study (relative to the anaclitic Clinical questions), demonstrated the most agreement and disagreement among participant responses. The mean score for each Clinical question where on the 1-7 scale the responses fell. Lower means scores on this 1 to 7 scale indicate more disagreement with certain questions, while higher means indicate more agreement with

certain questions. The means showed the most disagreement with Clinical question 7 (mean=2.11), which stated, “When I have a client- or patient-related problem, I prefer to think through it on my own, by myself, rather than being influenced by other colleagues;” Clinical question 11 (mean = 2.72), (“Sometimes it is more important for me to meet my own clinical objectives in my client or patient’s treatment than to meet my client or patient’s objectives,” and Clinical question 15 (mean = 2.89), which stated, (For me, as a clinical social worker, accomplishing a clinical goal is more important than worrying about the reactions of my client or patients”. The questions that participants agreed with the most were Clinical question 5 (mean = 5.39), “I enjoy meeting the clinical goals I have for my client or patient more than I enjoy being given credit for them by clients or patients;” Clinical question 10 (mean = 5.11), “The possibility of being rejected by my client or patient for standing up for what I believe is right would not stop me from doing what I believe is right;” and Clinical question 14 (mean = 5.78), “It is very important that I be in control of my emotions when working with a client or patient”.

Table 2. Frequency scale of responses to Clinical Characteristic Questions. Scale scores range from 1 = “strongly disagree” to 7 = “strongly agree”. Clinical questions measuring introjective characteristics are highlighted.

Question	Response (N)							Mean
	1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree	
Clinical 1	0	1	6	3	4	4	0	4.22
Clinical2	4	2	6	0	6	0	0	3.11
Clinical3	0	2	2	4	7	0	3	4.56
Clinical4	1	2	2	1	6	4	2	4.61
Clinical5	0	0	1	2	6	7	2	5.39
Clinical6	0	1	3	3	9	2	0	4.44
Clinical7	4	8	6	0	0	0	0	2.11
Clinical8	0	2	3	2	7	2	2	4.56
Clinical9	3	2	8	0	5	0	0	3.11
Clinical10	1	0	0	4	7	2	4	5.11
Clinical11	4	5	4	2	3	0	0	2.72
Clinical12	4	3	3	1	5	2	0	3.33
Clinical13	1	1	2	4	6	2	2	4.50
Clinical14	0	0	0	1	6	7	4	5.78
Clinical15	4	3	5	3	3	0	0	2.89

The full text of all 15 Clinical Characteristic questions is located in Appendix C.

For Clinical question 7, "If I think I am right in my clinical judgment about something I feel comfortable expressing myself even if my client or patient does not like it," all responses were in the low range (1-3), with no one agreeing strongly with this statement. For Clinical question 14, “It is very important that I be in control of my

emotions when working with a client or patient,” all responses were in the high range (4-7), with no one disagreeing with this statement.

Correlation Results

To determine if there was a relationship between each of the Clinical Introjective questions (4, 5, 7-15) and SC, Spearman rho correlations were run. There was a significant negative correlation between responses to Clinical question 10 (“The possibility of being rejected by my client or patient for standing up for what I believe is right would not stop me from doing what I believe is right”) and SC scores ($\rho = -.585$, $p = .011$, two tailed). A negative correlation suggests that as a participant’s SC increases, their agreement with Clinical Introjective 10 decreases, and vice versa. However, referring to table 2 and the responses to Clinical question 10, we see that all but one response was in the neutral to strongly agreement range. This suggests that, while SC increases as agreement with Clinical question 10 decreases, this movement downward is minimal, within the range of “strong agree” toward “neutral”. There were no significant correlations found between SC and any of the other Clinical Characteristic questions.

A Spearman rho analysis was completed to explore the relationship between years a participant had been working as a social worker and their SC scores. A Spearman rho analysis was also completed to explore the relationship between years working as a social worker and Clinical Introjection scores. There were no significant correlations found in either of these tests.

The researcher would have been interested in looking at the relationship of the other various demographic data obtained (i.e. location of clinical practice, ethnicity, race,

and gender) and the DEQ and clinical characteristics. However, this study does not look at any of these demographic factors given the sample size.

CHAPTER V

Discussion

The aim of this study was to examine the relationship between introjective characteristics of clinical social workers – as measured by Self-Criticism scores of the Depressive Experiences Questionnaire – and their introjective tendencies within their clinical work. Because of the extremely minimal research to date on introjective (and/or anaclitic) personality characteristics within psychotherapists in relation to their clinical work, the researcher chose to conduct an exploratory study to explore this relationship using a quantitative method to obtain data. The following chapter will present the key findings of this study and relate them to the related literature. Furthermore, the chapter will also review the major strengths and limitations of this study and make related recommendations for future studies. Lastly, this chapter will discuss the implications of this study within the larger sphere of social work treatment and research.

Introjective Characteristics as Measured by the DEQ

A strength of this study was the use of the DEQ as valid and reliable measurement of introjective (and anaclitic) characteristics. An additional strength was the ability to have David Zuroff complete the DEQ data analysis for this study, since the scoring procedures of the DEQ are complex and have been cited as a primary limitation in numerous studies (as referenced in Bagby et al., 1994).

As Blatt and colleagues indicate in their original 1976 study, the Self-Criticism value within the DEQ identifies an individual's preoccupation with intense and persistent

self-criticism and feelings of failure and ambivalence towards themselves. Previous research by Zuroff et al. (1990), found DEQ Self-Criticism (SC) scores ranging from -1.63 (for women, -1.47 for men) to 1.29 (for women, 1.41 for men). However, results from this study demonstrated a minimum SC score of -1.76. The -1.6 SC score from the Zuroff et al. (1990) study reflects the 5th percentile scores for women on the Self-Criticism scale within the sample, so individual SC results may have reflected lower scores than -1.63. The maximum SC score found in this study (n=1.18) is within the 95th percentile SC scores for women and within the 90th percentile SC scores for men reflected in the Zuroff et al. (1990) study. Due to the limitations of sample size and gender diversity, groupings of SC scores based on participant gender are not available. Nevertheless, the mean SC score for this study were synonymous with the mean SC score found in the female SC responses of Zuroff et al.'s (1990) study. This suggests that although this study was limited by its small sample size, DEQ SC responses were very similar to those of Zuroff et al.'s (1990) study (with a sample size of 779 women) despite large differences in sample size. This similarity in mean scores may indicate that the extent and range of introjective characteristics among clinical social workers were congruent with those of non-clinical social workers (Ibid.). Due to this study's sampling method (e.g. snowball sampling) limits the capacity of generalizing the results of this study to a wider scope of the population. Therefore, more studies with larger and more generalizable samples are needed to increase the probability and statistical confidence of the similarities of SC score averages among non-clinical and therapy-provider populations.

Clinical Characteristics

The responses to the introjective Clinical questions, which are the focus of the study (relative to the anaclitic Clinical questions), demonstrated the most agreement and disagreement among participant responses. Means showed most disagreement with questions 7, 11, and 15, independent of SC scores. These results suggest that these questions may not be valid, in that they may not actually measure introjective clinical characteristics. For example, the wording and/or nature of Clinical question 11, “Sometimes it is more important for me to meet my own clinical objectives in my client or patient’s treatment than to meet my client or patient’s objectives,” may not get at introjective characteristics but rather, speak to clinician’s desires to prioritize and honor their patients’ or clients’ expressed needs within treatment. In addition to invalidity, trends of disagreement on Clinical question 7, “When I have a client- or patient-related problem, I prefer to think through it on my own, by myself, rather than being influenced by other colleagues,” may be reflective of this study’s sample: as the majority of participants had relatively minimal experience within the field of clinical social work, it makes sense that they would be more inclined to ask others for support, alternative perspectives, etc. In this way, the study’s small sample size and lack of diversity in years of experience may have allowed for more information/interpretation as to the validity of certain Clinical questions.

Clinical questions that demonstrated overall agreement, independent of other variables (including SC scores), may also reflect validity limitations. For example, the wording of Clinical question 10, “The possibility of being rejected by my client or patient for standing up for what I believe is right would not stop me from doing what I believe is right,” may have been convoluted and may have conflicted with participants’ self-

perceptions of being able to stand up for what they believe is “right”. In this case, more neutral wording of this question may have allowed for a wider range of responses, and thus may have not measured introjective therapeutic characteristics per se. Responses to Clinical question 14, “It is very important that I be in control of my emotions when working with a client or patient,” also reflected a high range of agreement, with no answers that disagreed with this statement. In the case of this question, participants may have been agreeing to mindfulness and management of the therapist’s emotionality, as opposed to speaking to their preference for solitude, which is an introjective characteristic. Due to lack of peer-reviewed research on this issue, this researcher did not have access to valid and reliable measurements to test for introjective and anaclitic personality characteristics with clinical social workers or other psychotherapy providers. Thus, recommendations for future research include efforts to establish valid and reliable measurements of introjective and anaclitic characteristics of clinical social workers within the therapeutic setting.

Correlation Results

The primary focus of this study was to explore the relationship between therapists with high introjective scores and their perception of competency (i.e. their introjective characteristics) within the therapeutic setting. This relationship was measured by running a correlation test between SC scores and the results from the Clinical introjective questions (4, 5, 7-15). There were no significant correlations found between SC and Clinical Characteristic questions, with the exception of one question (Clinical question 10). One possible reason for the lack of significant findings includes the limitations in the study’s sample size. Given a larger sample size, greater data analysis could have been

completed (i.e. multiple regression) with increased statistical confidence. Another possible factor could be the aforementioned concerns with the validity of the Clinical questions that were created by the researcher to measure introjective clinical characteristics. Another possible reason for the lack of significant findings is the possibility that there is no significant correlation between SC scores of therapists in this study and introjective clinical characteristics. These results are similar to those of the Rosenkrantz & Morrison (1992) study in that results for introjective therapists were contrary to the study's hypotheses. What the authors gave as a possible explanation – which could possibly be true in this case – was that adaptive functions of self-criticism is an important part of self-discipline and may demonstrate a learned trait of maintaining high levels of regard for patients and themselves within the therapeutic process (Rosenkrantz & Morrison, 1992, p. 551).

There was a significant negative correlation found with SC scores and responses to Clinical question 10 (“The possibility of being rejected by my client or patient for standing up for what I believe is right would not stop me from doing what I believe is right”). This correlation is opposite to what the researcher would expect the findings to be (i.e. positive correlation between SC scores and introjective clinical characteristics). Nevertheless, differentiation of responses relative to SC scores was quite minimal, which suggests that results may not reflect strong correlation. Furthermore, as was discussed in the previous section, issues of wording and validity with this question further challenge the significance of this finding.

Two correlation tests were also done to explore the relationship between 1) SC scores and 2) Clinical Introjective characteristics, and years a participant had been

working as a social worker and their SC scores. There were no significant correlations found in either of these tests. Research conducted by Kopala-Sibley et al. (2013) found that both self-criticism and dependency decreased in a linear fashion across the lifespan of the individuals. Because of this, the researcher expected this study to reflect similar results, in that self-criticism would decrease with increased experience of clinical social work. Nevertheless, limitations in sample size decrease the confidence in statistical analysis. Therefore, a greater sample size is recommended in future studies to explore, with more statistical confidence, the correlation between self-criticism and years of experience as a clinical social worker.

The researcher would have been interested in looking at the relationship of the other various demographic data obtained (i.e. location of clinical practice, ethnicity, race, and gender) and the DEQ and clinical characteristics. However, this study does not look at any of these demographic factors given the sample size. Given the westernized assumed distinction between individual autonomy and interpersonal relatedness that other cultures (such as those that are non-Western, or more collectivist) do not acknowledge (e.g. Geertz, 1973), the researcher would have liked to have analyzed the correlation between specified ethnicities and SC scores to explore the possible correlation between SC scores and “western” and “non-western” ethnicities. However, one of the limitations for the Kopala-Sibley et al.’s (2013) longitudinal multicultural study was that all participants of this study, regardless of continent of origin, had to have the ability to read and comprehend English. As was discussed in the study, the ability to read and understand English that may be demonstrative of westernized ideals, manners, and/or

values. Thus, recommendations for future studies include the use of DEQ surveys in the participant's original language in order to allow for less westernized responses.

Demographics

The sample size of this study was an influential limiting factor for a variety of reasons, which will be continuously discussed throughout this chapter. One factor that may have led to this small sample size include the time limited nature of this study, which limited the amount of time available to recruit participants. Another possible contributing factor to the small sample size is the manner in which the researcher recruited participants: attempting to recruit participants through additional means other than snowball sampling (i.e. recruitment letters to NASW members, all therapy providers within selected agencies, etc.) would have most likely increased the sample size of the study. The length of the survey, which consisted of 89 questions in total, could have also contributed to the small sample size, especially given that multiple eligible individuals did not complete the entire survey.

The majority of participants racially self-identified as white. The majority of participants also ethnically self-identified as being from Western ethnicities (e.g. North America and Western Europe). A more racially and diverse sample size is recommended for future research in order to allow for more generalized results. The aforementioned possible ways to increase sample size (e.g. broader means of recruitment) may have also contributed to a more diverse sample, in terms of years in clinical social work, race, ethnicity, and gender. Gender diversity within this sample may also reflect the gender makeup of clinical social work as a profession. Recommendations for future research

include obtaining a larger and more diverse sample size, regarding participant ethnicity, race, years as a social worker, and gender.

Summary

The researcher recommends that future studies focus on establishing a valid instrument to measure introjective characteristics of therapy providers within the therapeutic setting. Further recommendations include using a valid measurement of clinical introjective characteristics in studies that continue to explore the relationship between introjective (and anaclitic) DEQ scores and introjective and anaclitic therapeutic characteristics of clinicians. In order to increase statistical confidence and opportunity for further data analysis, these studies should look to obtain large sample sizes with diversity among ethnicity, race, language, gender, and years of experience. The researcher's hope is that this research project will open up the opportunity for future research regarding introjective and anaclitic personality characteristics in clinical social workers and other psychotherapy providers, thereby increasing the amount of research guided by relational model focus. Further study in the field could lead to an increased awareness of the impact a clinical social worker's personality traits has on his or her professional sense of self, which may subsequently allow the clinical social worker to employ their use-of-self more effectively in their clinical practice (and better attune to the client or patient). Thus, practicing clinician owe it to themselves and the individuals they serve to promote further research to this issue.

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Appendix A

Smith College Human Subjects Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-
7994

April 11, 2015

Lindsey Calder

Dear Lindsey,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee
CC: Alexandra Starr, Research Advisor

Appendix B

Smith College Human Subjects Committee Protocol Change Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

May 6, 2015

Lindsey Calder

Dear Lindsey,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Alexandra Starr, Research Advisor

Appendix C

Assurance of Research Confidentiality Signed Form

Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- Non SSW person(s) who will have access to this data for data analysis purposes shall sign this assurance of confidentiality.
- This data analyst should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also confidential until they have been published or presented in public.
- The researcher for this project, Lindsey Calder, shall be responsible for ensuring that the data analyst who works with the data is instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that s/he has signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Lindsey Calder, for this project. I understand that, according to Federal Regulations, violation of this pledge is sufficient grounds for disciplinary action, including termination of data analysis services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

David Zurhoff

Signature

May 9, 2015

Date

Lindsey Calder

Lindsey Calder, Researcher

May 8, 2015

Date

Appendix D

Instrument Guide

3. How many years have you been working as a clinical social worker? (Please round to the nearest year)

—

4. Where do you currently practice clinical social work? (as an employee, student intern, fellow, or volunteer). Please click all that apply:

Outpatient – Community mental health organization

Outpatient – Private practice

School setting

Court setting

Partial Hospitalization Program

Inpatient – Private clinic or hospital

Inpatient – public hospital

Hospital setting (not mental health)

Other (please specify)_____

6. How do you identify ethnically? (Please select all that apply):

African

South Asian

East Asian

Pacific Islander

Middle Eastern

South American

Central American

Native American

North American

Eastern European

Western European

If your ethnicity is not summed up by these responses, please describe: _____

5. How do you identify yourself racially? (Please select all that apply):

Black / African American

South Asian

East Asian

Pacific Islander

Middle Eastern

White

Latino

If your race is not summed up by these responses, please describe: _____

7. Please select the gender you most identify with:

Woman

Man

Transgender

If you gender is not summed up here, please describe: _____

The following section in the Depressive Experiences Questionnaire (DEQ), Copyrighted Sidney J. Blatt, Ph.D., Joseph P. D'Afflitti, Ph.D., Donald M. Quinlan, Ph.D., 1979.

Listed below are a number of statements concerning personal characteristics and traits. Please read each item and decide whether you agree or disagree and to what extent. If you strongly agree, enter 7; if you strongly disagree, enter 1; The midpoint, if you are neutral or undecided, is 4.

[Answer choices for each of the 66 questions that comprise this section of the survey are given on a 7-point Likert scale, 1 being "strongly disagree," 4 being "neutral or undecided," and 7 being "strongly agree"]

1. I set my personal goals and standards as high as possible.
2. Without support from others who are close to me, I would be helpless.
3. I tend to be satisfied with my current plans and goals, rather than striving for higher goals.
4. Sometimes I feel very big, and other times I feel very small.
5. When I am closely involved with someone, I never feel jealous.
6. I urgently need things that only other people can provide.
7. I often find that I don't live up to my own standards or ideals.
8. I feel I am always making full use of my potential abilities.
9. The lack of permanence in human relationships doesn't bother me.

10. If I fail to live up to expectations, I feel unworthy.
11. Many times I feel helpless.
12. I seldom worry about being criticized for things I have said or done.
13. There is a considerable difference between how I am now and how I would like to be.
14. I enjoy sharp competition with others.
15. I feel I have many responsibilities that I must meet.
16. There are times when I feel "empty" inside.
17. I tend not to be satisfied with what I have.
18. I don't care whether or not I live up to what other people expect of me.
19. I become frightened when I feel alone.
20. I would feel like I'd be losing an important part of myself if I lost a very close friend.
21. People will accept me no matter how many mistakes I have made.
22. I have difficulty breaking off a relationship that is making me unhappy.
23. I often think about the danger of losing someone who is close to me.
24. Other people have high expectations of me.
25. When I am with others, I tend to devalue or "undersell" myself.
26. I am not very concerned with how other people respond to me.
27. No matter how close a relationship between two people is, there is always a large amount of uncertainty and conflict.
28. I am very sensitive to others for signs of rejection.
29. It's important for my family that I succeed.
30. Often, I feel I have disappointed others.
31. If someone makes me angry, I let him (her) know how I feel.
32. I constantly try, and very often go out of my way, to please or help people I am close to.
33. I have many inner resources (abilities, strengths).
34. I find it very difficult to say "No" to the requests of friends.
35. I never really feel secure in a close relationship.
36. The way I feel about myself frequently varies: there are times when I feel extremely good about myself and other times when I see only the bad in me and feel like a total failure
37. Often, I feel threatened by change.

38. Even if the person who is closest to me were to leave, I could still "go it alone."
39. One must continually work to gain love from another person: that is, love has to be earned.
40. I am very sensitive to the effects my words or actions have on the feelings of other people.
41. I often blame myself for things I have done or said to someone.
42. I am a very independent person.
43. I often feel guilty.
44. I think of myself as a very complex person, one who has "many sides."
45. I worry a lot about offending or hurting someone who is close to me.
46. Anger frightens me.
47. It is not "who you are," but "what you have accomplished" that counts.
48. I feel good about myself whether I succeed or fail.
49. I can easily put my own feelings and problems aside, and devote my complete attention to the feelings and problems of someone else.
50. If someone I cared about became angry with me, I would feel threatened that he (she) might leave me.
51. I feel comfortable when I am given important responsibilities.
52. After a fight with a friend, I must make amends as soon as possible.
53. I have a difficult time accepting weaknesses in myself.
54. It is more important that I enjoy my work than it is for me to have my work approved.
55. After an argument, I feel very lonely.
56. In my relationships with others, I am very concerned about what they can give to me.
57. I rarely think about my family.
58. Very frequently, my feelings toward someone close to me vary: there are times when I feel completely angry and other times when I feel all-loving towards that person.
59. What I do and say has a very strong impact on those around me.
60. I sometimes feel that I am "special."
61. I grew up in an extremely close family.
62. I am very satisfied with myself and my accomplishments.
63. I want many things from someone I am close to.
64. I tend to be very critical of myself.

65. Being alone doesn't bother me at all.
 66. I very frequently compare myself to standards or goals.
-

Listed below are a number of statements concerning your own clinical characteristics and traits **as they relate to your work as a clinical social worker**. Please answer each question honestly, as it relates to you and your clinical practice.

If you strongly agree, enter 7; if you strongly disagree, enter 1; The midpoint, if you are neutral or undecided, is 4.

[Answer choices for each of the 15 questions that comprise this section of the survey are given on a 7-point Likert scale, 1 being “strongly disagree,” 4 being “neutral or undecided,” and 7 being “strongly agree”]

1. I pride myself on being a unique clinical social worker more than being a member of a group in my clinical work.
2. I censor what I say to my client or patient because I'm worried that they may disapprove of or disagree with me.
3. It is important to me to be liked and approved by my client or patient.
4. It is more important to me that I know I've done a good job in my clinical work and less important to me that my client or patient knows that I've done a good job.
5. I enjoy meeting the clinical goals I have for my client or patient more than I enjoy being given credit for them by clients or patients.
6. I feel uncomfortable when I cannot tell whether or not my client or patient likes me.
7. When I have a client- or patient-related problem, I prefer to think through it on my own, by myself, rather than being influenced by other colleagues.
8. When I achieve something I've been striving for in my work with a client or patient, I get more satisfaction from reaching that goal than from any appreciation I might get from the client or patient.
9. When clients or patients ask me personal questions, I don't like it because it feels like an invasion of my privacy.
10. The possibility of being rejected by my client or patient for standing up for what I believe is right would not stop me from doing what I believe is right.
11. Sometimes it is more important for me to meet my own clinical objectives in my client or patient's treatment than to meet my client or patient's objectives.

12. If I believe a treatment goal is important, I will pursue it even if it may make my client or patient uncomfortable or upset.
13. If I think I am right in my clinical judgment about something, I feel comfortable expressing myself even if my client or patient does not like it.
14. It is very important that I be in control of my emotions when working with a client or patient
15. For me, as a clinical social worker, accomplishing a clinical goal is more important than worrying about the reactions of my client or patients.

Appendix E

Informed Consent Form



SMITH COLLEGE

Smith College School for Social Work • Northampton, MA

.....
Title of Study: “Personality Development in Clinical Social Workers: The Significance of the Introjective Personality Type in Therapists”

Investigator: Lindsey Calder, Smith College School for Social Work,
LCalder@Smith.edu

.....
Introduction

- You are being asked to be in a research study that explores the relationship between specific personality styles and the way in which clinical social workers see and define themselves as clinicians.
- You were selected as a possible participant because you have either received a Master’s or PhD degree in Social Work, or are currently enrolled as a student in a Masters or PhD social work program, and currently practice (as an employee, intern, fellow, or volunteer) in a clinical setting.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to identify clinical social workers who have a particular personality trait (as identified through the Depressive Experiences Questionnaire), and then explore how this personality style may influence the way that the clinical social worker sees themselves as a therapist.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: You will first be asked a series of demographic question (such as age and current geographic location). The second section is the Depressive Experiences Questionnaire (which, despite its name, measures stable personality traits, not depressive symptoms). In the third and last section, you will be asked a series of questions regarding the perception and definition of yourself as a therapist in

relation to your clients or patients. This online questionnaire will take about 20-25 minutes to complete in its entirety.

Risks/Discomforts of Being in this Study

- The study has the following risks. There is a small risk that participating in this study will bring up negative emotions in the participant, due to the fact that this questionnaire will ask you to reflect upon your personal tendencies and perceptions of yourself as a therapist.

Benefits of Being in the Study

- The benefit of participation is the opportunity to reflect on your personality tendencies and the way in which you see yourself as a clinical social worker.
- The benefits to social work/society are: possible contribution to furthering the development of knowledge around the relationship between personality styles and self-definition and self-perception of therapists.

Confidentiality

- This study is anonymous. I will not be collecting or retaining any information about your identity.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time while taking the survey* without affecting your relationship with the researcher of this study or Smith College. However, once you complete the full questionnaire and submit your answers, or exit the survey, it will not be possible for you to then withdraw your responses because there will be no way to identify your answers (due to the confidentiality and anonymity measures in place). Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw from the survey by clicking on the “Exit Survey” button located on each page of the survey. If you choose to do this, any answers that you provided to any previous questions will be permanently deleted. **Nevertheless, any responses you give in the survey, if not retracted by going backwards through the survey and withdrawing each answer, will be collected whether or not you withdraw from the survey by clicking “Exit Survey”.**

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Lindsey Calder, at LCalder@smith.edu or by telephone at (***) ***-****. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research

participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (***) ***-****.

Consent

- By checking the box below marked “I Agree,” you are indicating that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

I Agree

I Do Not Agree