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Shoshanna Dearborn Brady
Questioning Neutrality: An Inquiry
into Contemporary Therapists'
Attitudes towards Neutrality in the
Clinical Encounter

ABSTRACT

This study was undertaken to explore the possible relationship between clinicians' training in neutrality at Smith College School for Social Work and their enduring practice ideals with respect to neutrality. Grounded in the theoretical literature regarding models of psychodynamic therapeutic change, this research project sought to describe the role of neutrality in contemporary clinical practice, addressing a gap in comprehensive empirical research on this topic.

Research data was collected from 224 alumni who graduated from Smith College School for Social Work (SCSSW) during the past 30 years and are currently practicing in the field of mental health. Participants completed an online survey designed to assess their training in neutrality at SCSSW, factors that have contributed to adaptation of participants' practice stance since graduation, and the role of neutrality in participants' current clinical work. The survey incorporated questions from an established survey measure, as well as questions designed by the researcher. The survey was comprised of demographic questions, 26 Likert-scaled items, and two opportunities for narrative response.

The major findings of the research indicate that emphasis on neutrality in the SCSSW curriculum has slightly decreased over the past 30 years. Despite this change, the research indicates that there is no significant correlation between participants' era of graduation and their current attitudes towards neutrality in their work.

**QUESTIONING NEUTRALITY:
AN INQUIRY INTO CONTEMPORARY THERAPISTS' ATTITUDES
TOWARDS NEUTRALITY IN THE CLINICAL ENCOUNTER**

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

Shoshanna Dearborn Brady

Smith College School for Social Work
Northampton, Massachusetts 01063

2012

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CHAPTER I

Introduction

A central tenet of psychodynamic theory since the time of Freud and the beginnings of the profession, neutrality has long been promoted in clinical training programs. Clinicians' unbiased, non-directive attitude and guarded, non-revealing behavior have been upheld as ideals in order to allow transference to develop in the relationship and to facilitate the clinician's capacity to observe the client without contamination of the therapist's own material (Ceroni, 1993; Freud, 1915.) Neutrality has been seen as a means of mediating clinicians' tendency to influence clients to be more like them, enabling clients' capacities to direct the course of treatment. In this classical model, the locus of therapeutic action resides within the client; the therapist facilitates change by acting as an objective, neutral observer, offering interpretations about unresolved issues from the client's past. As the client's unconscious conflict becomes conscious, he gains internal control and equilibrium. (Stark, 2000).

Since the development of object relations and self-psychology theories in the 1960s, however, the ideal of clinical neutrality has been increasingly called into question. In these developmental/ relational models, psychopathology is conceived as resulting from early caregiving deficits, not structural conflict, the product of nurture rather than nature, if you will. Therapeutic change is understood to occur through the therapist's provision of a corrective-emotional experience or holding environment, the therapist's role changing with the client's

development, much as a parent's role changes over time. The locus of therapeutic action resides in the connection between therapist and client, as the client gradually internalizes the care-giving functions provided by the attuned therapist (Greenberg & Mitchell, 1983). Offering a simplification of the two models, Stark suggests that in the classical model, the client essentially seeks understanding; while in the developmental/ relational models, the client seeks to be understood (2000). Debate regarding neutrality and the ideal therapeutic stance continues.

While much theory has been written regarding the role of neutrality in both classical and developmental/ relational models of therapy, empirical research on the subject is scant. Case studies have been used to illustrate the range of perspectives on neutrality, but this researcher found only one study of neutrality that incorporated quantitative data. Motivated by an interest in clinicians' theories of therapeutic change and how they inform clinicians' practice stance with respect to neutrality, this study hopes to begin to address the dearth of empirical research on the subject. The decision was made to explore this topic by collecting data from alumni from a single psychodynamically-oriented school, where curriculum was expected to be relatively consistent, providing a baseline for participants' training in neutrality. This study seeks to answer the following questions: Is there a relationship between clinicians' training in neutrality and their current practice ideals? And to what extent do contemporary psychodynamically-trained therapists aim for neutrality in their work with clients?

An online quantitative survey of Smith College School for Social Work (SCSSW) alumni was conducted to collect the data for this study. The study sample was limited to alumni who graduated between 1981 and 2011 and included only those who are currently practicing mental health professionals. All SCSSW alumni with email addresses on file with the school were sent an email recruitment announcement which included a link to the survey on SurveyMonkey. Two

hundred seventy-five participants began the survey and 224 completed it. Please refer to Chapter Three for further elaboration on the methodology employed.

Because the ideal of neutrality has direct implications for controversial clinical concerns such as self-disclosure and use of countertransference, the findings of this research will be particularly useful for improving social work education. Specifically, my proposed research will elucidate the impact of the SCSSW curriculum on clinicians' long-term practice ideals regarding neutrality. This inquiry attempts to address the lack of empirical research on neutrality by expanding the knowledge base regarding the relationship between clinical theory as experienced in the SCSSW curriculum and clinicians' current conceptions of their practices. Reflection on and improvement of social work education may in turn facilitate the enhancement of services offered to clients.

CHAPTER II

Literature Review

Since the inception of clinical work and Freud's original texts, the question of clinicians' ideal therapeutic stance, or use-of-self, has been a central theoretical and practical concern. Blank, reflective, and impersonal, the metaphors of "mirror" and "blank screen" have often been employed to describe the classical Freudian therapeutic stance (Ceroni, 1993). As Freud's followers have adapted his theories of pathology and cure over the past century, so too, have conceptions of use-of-self evolved and diversified. Psychoanalytic literature of the past several decades is replete with arguments for and against clinical neutrality, with many contemporary theorists offering revisions of its definition and role in clinical work (Cooper, 1996; Franklin, 1990). Serving a more diverse population than Freud's clientele and incorporating recent advances in developmental theory, contemporary psychodynamic clinicians increasingly locate their work in developmental and relational contexts. Instead of discovering patients' innate internal truths through neutral observation, many contemporary clinicians engage in therapeutic work as a collaborative and creative process, understanding that it may be mutually transformative (Schamess, 2011; Summers, 1999). Few analysts currently aim toward the rigidly neutral, impersonal stance originally advocated by Freud, yet the tradition of clinical neutrality continues to influence and shape contemporary practice (R. Miller, personal communication, November 11, 2011). This chapter offers a review of the existing psychodynamic literature regarding neutrality. It first presents the origins of neutrality in the

drive/ structure model, and then offers a discussion of the critique and reconception of neutrality in the *relational/ structure models*. A discussion of the limited empirical research on the subject of neutrality follows, and the chapter concludes with a brief note regarding the relationship between psychodynamic theory and practice.

In their text, *Object Relations in Psychoanalytic Theory*, noted theorists Greenberg and Mitchell delineate two models that have dominated psychoanalytic thinking: the *drive/ structure model* and the *relationship/ structure model* (1983). The classical Freudian, or *drive/ structure model*, understands pathology as rooted in the patient's unconscious conflicted drives, and emphasizes analytic neutrality in order to draw the conflict into consciousness; conversely, the more recent *relational/ structure model*, conceives of both personality and therapeutic change as consequences of adaptive interaction (i.e. the products of nurture, rather than nature). Freud's neutral stance is rejected or thoroughly redefined by the *relational/ structure model*, as relational clinicians seek to provide their patients with a lived experience of empathic attunement or authentic interaction, rather than detached objective insight (Greenberg & Mitchell, 1983; Summers, 1999; Winnicott, 1965). Using Greenberg and Mitchell's models, this review will describe the varied role of neutrality in psychoanalytic literature in its historical and theoretical contexts.

The Tradition of Neutrality and the Drive/ Structure Model

The Freudian psychoanalytic tradition finds its origins in the hypnotism of hysterical female patients in late 19th century Europe. Developing a theory of mind for the first time, Freud posited that his hysterical patients suffered as a result of repressed conflicted ideas (Berzoff, 2008). In Freud's conceptualization of the human mind, the id, a repository of individuals' unrestrained sexual and aggressive instincts (drives) exists in constant conflict with the superego,

the moral conscience and voice of social conformity. The ego mediates ongoing conflict between id and superego, keeping the tension out of conscious awareness through the use of defenses such as symptom formation, mental compromises designed to enable continued functioning in the social world (Schamess, 2008). Recognizing his hysterical patients' symptoms as manifestations of unconscious, undigested internal conflict, Freud devised psychoanalysis as a method for eliciting patients' unconscious material (Mitchell & Black, 1995).

In psychoanalysis and the *drive/ structure* model, a neutral analyst mirrors the patient's internal life back to the patient through interpretation. The patient is healed by increasing understanding of his internal motivations, gradually setting him free of internal constriction and defensiveness (Mitchell & Black, 1995). "The patient is cured once the patient has come to know all that the therapist knows—which is what the patient had (unconsciously) known all along" (Lacan cited in Stark, 2000, p. 10). Central to Freud's hypotheses is the assumption that individual personality and pathology stem from inherent instinctual drives, rather than environmental influences; accordingly, the curative process also occurs primarily within the individual, facilitated by the analyst as external observer (Stark, 2000).

Neutrality protects the therapeutic frame

Given Freud's understanding of pathology and cure as processes occurring within the individual patient, the analyst's neutral stance follows logically: only a "blank" clinician can serve well as a mirror. Wachtel explains that "The stance of neutrality is designed to ensure that we do not muddy the waters of transference or, to use another commonly used and related metaphor, that we do not contaminate the field" (1986, p. 61) Contrary to most contemporary clinical methods, traditional psychoanalysis did not employ the use of questions, as any input from the analyst was thought to impede the process of eliciting the patient's unconscious

material (Mitchell & Black, 1995). Clinicians who espouse the *drive/ structure* model generally aim to keep their own opinions and personal life circumstances completely outside of their clinical work and refrain from supporting or directing patient behavior (Stark, 2000).

Neutrality and objectivity

Drive/ structure theory regards neutrality as a means of protecting patients' right to autonomy and self-direction (Leider, 1983; Ceroni, 1993). Wanting patients' internal capacities to dictate the course of treatment, Freudian theory instructs clinicians to reserve judgment and personal opinion in order to safeguard against their natural inclination to influence clients to be like them (Greenberg, 1986). The neutral clinician is thought of as an objective observer, lending clinical work the dignity of scientific inquiry (Renik, 1996). Greenberg describes the analyst's neutrality as "objectivity borne of externality, the rationality leading to enlightenment, the impartiality of the reasonable observer" (1986, p. 91). In the Modern Era, psychology has been legitimized by the belief that neutral, objective clinicians observe and treat clients' subjective problems (Arnd-Caddican & Pozzuto, 2008; Loewald, 1960). Training and emotional maturity render the analyst an expert observer, and it is this same capacity for observation and understanding that the patient seeks to develop, in order to discover objective internal truths (Eagle, Wolitzky, & Wakefield, 2001; Loewald, 1960; Shill 2004).

In addition to preserving the analyst's objectivity, Freud proposed that clinical neutrality functioned as an incentive to patients to strive for transformation; if the analyst were to gratify patients' wishes, he would be accommodating and enabling dysfunction. In his "Observations on Transference Love," Freud writes that "the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes" (1915, p. 165). In the same text, he warns that the analyst's "tender feelings" would be

difficult to control and monitor if allowed any expression, and were therefore best kept entirely in check (1915, p. 164). In summary, the *drive/ structure* model locates pathology and change in the individual patient and upholds clinical neutrality as the basis of the therapeutic frame. The neutral analyst is objective, seeing and interpreting the patient's internal life without contamination of the analyst's own material; the analyst motivates change by maintaining a dispassionate stance.

The Birth of the Relational/ Structure Model and Rejection of Classical Neutrality

Building on Freud's writings and ongoing clinical observation, his colleagues and followers over the past century have enriched and expanded his contributions to the field of psychology, examining territories he had noted but did not fully explicate during his lifetime. Beginning as early as the 1930s, the expansion of psychodynamic theory into the realm of relational developmental processes has led to a theoretical rift between *drive/structure model* loyalists and *relational/ structure* theorists. Drawing on observation of patterns of normal and pathological human development, *relational/ structure* theorists understand clients' personality and behavior as adaptive responses to their relational environment, particularly the early caregiving relationship (Fonagy & Target, 2003). Although the concept of internal conflict has not been entirely abandoned, contemporary psychodynamic clinicians tend to understand individual mental life as shaped by social interaction and existing in a relational context (Gergen, 1991; Greenberg & Mitchell, 1983). Developmentally-appropriate relational experience, not insight, becomes the mode of therapeutic action, and clinicians increasingly abandon the ideals of guarded behavior and anonymity.

Dubbed the "father of ego psychology" Heinz Hartmann is credited with first shifting focus away from the ego's role in mediating internal conflict to look at its role in social

processes (Siskind, 1992, p. 6). Hartmann's interest in early development led to hypotheses about the reciprocal interchange between mother and infant and his theory of the "average expectable environment," a term used to denote the conditions necessary for normal psychological development. Hartmann proposed that children can only cultivate autonomous ego functions if genetic endowment is adequate and development is supported by caregivers' fulfillment of early needs such as nurturance and protection. If the caregiver is adequately attuned to the infant's needs and meets them responsively through a mutually adaptive process, the infant's development can be expected to proceed within the normal range of physical and psychological health; however, where the child's genetic predisposition or social environment are compromised, psychological development is also disturbed (Hartmann, 1939; Schames & Shilkret, 2008).

Drawing on the work of Hartmann and other Ego Psychologists, Object Relations theorists further explore and elucidate the significance of the early care giving relationship as a foundation for psychological health. Winnicott describes the "good enough mother" as initially consumed with her role in meeting the needs of her child almost instantly but also explains the importance of the mother's small and gradual failures in empathic attunement (1965b). Building on a base of adequately responsive early care-giving from which the infant has developed a sense of omnipotence, the secure infant can tolerate increasing periods of frustration before the gratifying breast arrives. These brief lapses in the continuity of connection between mother and child are critical in order for the child to develop not only the capacity for self-soothing, but also an emerging sense of self as an independent agent. Normal psychological development occurs in the context of relationship, as moments of parental misattunement and repair offer children

opportunities for increasing distress tolerance, self-control, and self-responsibility (Winnicott, 1965b).

Adequate early care-giving instills an underlying sense of trust that endures throughout the process of later gradual parental failures; the holding environment of “good enough mothering” provides a setting for the integration of aggression and love, and with integration, a developing sense of internal continuity. *Relational/ structure* models suggest that small parental failures are inevitable and motivate growth, while serious care-giving failures in early life force the child to negotiate questions of identify too early, causing impaired capacity for internal regulation, henceforth referred to as “structural deficit” (Stark, 2000). Structural deficit refers to the pathology that results when the child lacks “good enough mothering” and fails to internalize a sense of trust and goodness, and the associated capacity for affect-regulation, from the parental environment.

Because *relational/ structure* models see humans as essentially seeking connection, a child who experiences parental failure naturally fears retraumatization in relationship, and tends to develop a “false self” as an adaptive strategy to secure needed parental care (Mitchell & Black, 1995; Fonagy & Target, 2003). Lacking adequately attuned care-giving, the spontaneous and original gestures of the individual’s “true self” cannot emerge and evolve, and the individual fails to develop the capacity to feel good about himself without external regulation of self-esteem (Burke & Tansey, 1991). *Relational/ structure* models conceive of personality and pathology as patterned in early life, yet also bear significant hope for change if the individual can engage in relationships, particularly with therapists, that attend to unmet developmental needs later in life.

Accordingly, in *relational/ structure* models of therapy, the therapist serves as a holding environment for regression and growth, joining the client through empathic attunement and

offering a corrective experience of reliable and consistent care-giving that the client likely lacked in early life. Stark explains that “What is curative for the patient with structural deficit is the experience not of the truth (which is thought to be the curative agent in the drive/ conflict model of therapeutic action) but of being provided for in the way that a good mother provides for her young child” (2000, p. 11). Rather than addressing the patient’s unconscious from an external and objective standpoint and drawing attention to new insight, the empathic *relational/ structure* therapist responds to the patient’s conscious experience with gentle inquiry, and accepts the patient’s current understanding of the truth. In fact, Tansey and Burke suggest that in *relational/ structure* models, “The patient’s longings ought not to be viewed from Freud’s archaeological model as requiring the light of consciousness to allow for their renunciation. In stark contrast, the patient’s longings require acceptance, understanding, and responsiveness” (1991, p. 362). At first, the patient is likely to experience the inevitably imperfect therapist as similar to her old bad objects, yet as the therapist continues to show up and care, and the patient finds his needs are accepted and responded to, the patient can gradually let go of pathogenic relational patterns from childhood and learn to feel held, allowing the “true self” to emerge (Summers, 1999; Winnicott, 1965a).

The new meaning of neutrality in the relational/ structure model

Feeling that traditional analytic neutrality idealizes an inexpressive position too cold and aloof for most patients, who might experience an interpretive therapist as similar to a traumatically neglectful parent, *relational/ structure* therapists reject the “blank slate” neutrality of the *drive/ structure* model and favor a more active and affirmative stance. The term ‘neutrality’ is retained by *relational/ structure* theorists, but takes on a new meaning. Jay Greenberg writes that relational neutrality “embodies the goal of establishing an optimal tension

between the patient's tendency to see the analyst as an old object and his capacity to experience him as a new one" (1986, p. 97). In this model, neutrality is not a static set of behaviors, but depends on the quality of the patient's relationships and needs. The "relationally neutral" therapist may use selective self-disclosure and even give advice with one client, but may be more guarded and withholding with another client. Greenberg elaborates:

Generally speaking, the silence and anonymity which constitute unmodified classical technique enable the patient to include the analyst in his internal object world, while a more active or self-revealing posture establishes the analyst as a new object. Thus, with a patient who is firmly encased in a closed world of internal objects, the analyst will have to assert his newness more affirmatively to achieve an optimal level of tension, while with a more open patient just such assertiveness would constitute an impediment to the development of transference and to insight about it. Neutrality is thus not to be measured by the analyst's behaviors at any moment, but by the particular patient's ability to become aware of and to tolerate his transference. (1986, p. 97)

The neutral position Greenberg describes is essential to therapeutic change in the *relational/structure* model. Stark (2000) points to the same process of therapeutic change that Greenberg describes, explaining that the "relationally neutral" therapist is experienced as first old bad object and then new good object, facilitating the patient's experience of "bad-become-good" (p. 79). Through here-and-now engagements between patient and therapist, the "patient's internal bad objects can be gradually reworked, modified, and detoxified—the therapist lending herself as a container for and psychological processor of the patient's disavowed psychic contents" (2000, p. 79). This conception of neutrality, in which the therapist's use-of-self is shaped and reshaped by the developing patient's needs, differs starkly from the neutrality of the *drive/conflict* model.

Changing conceptions of countertransference and self-disclosure

Because neutrality is redefined, and *relational/ structure* therapists do not seek the guarded, non-revealing stance endorsed by *drive/ structure* theory, many of the practice behaviors and attitudes once seen as essential to therapeutic work have also been modified and reshaped, particularly clinicians' conceptions of countertransference and self-disclosure. Understanding psychology through the *drive/ structure* model, Freud and his colleagues envisioned the demeanor of the therapist as calm and objective, an "evenly-suspended attention" (Freud, 1912, p. 111). Because the clinician was seen as neutral, transference material that seemed to be about the analyst was understood to be displaced from the client's past; while, countertransference was seen as a regrettable displacement of the clinician's unresolved feelings from the past, which should be processed in the clinician's analysis in order to be resolved (Mitchell & Black, 1995). Because the *drive/ conflict* therapist aims to keep her personal material outside of the therapeutic sphere so that the patient's intrapsychic conflicts can emerge through the transference neurosis, "disclosure of what the therapist is experiencing with the patient can only represent a dramatic interruption of this process, foreclosing the patient's opportunity to see us as he needs to see us" (Burke & Tansey, 1991, p. 358).

Over the past several decades, as theory has shifted from a one-person psychology model to a two-person framework, clinicians have increasingly recognized that they contribute to and exist within the interactional field that both patient and clinician seek to understand (Benjamin, 2004; Mitchell & Black, 1995). Wachtel makes this image vivid: "One cannot stay outside the field, one cannot avoid influencing what one is observing. We are always observing something that occurs in relation to us, and not just to us as screens or phantoms, but to us as specific flesh and blood human beings sitting in the consulting room" (1986, p. 61). The patient's repetitive

patterns of interpersonal difficulties inevitably impact the clinician, and the patterns that develop between clinician and patient echo the patterns of the patient's family (Fonagy & Target, 2003; Wachtel, 1986). Countertransference is now understood to combine remnant feelings from the clinician's past experience with emotional content related to the here-and-now interaction. With this new understanding, countertransference becomes a tool for advancing therapeutic understanding rather than an obstacle (Arnd- Caddigan & Pozzuto, 2008; Edwards & Bess, 1998). Clearly, *relational/ structure* therapists must still use judgment to determine which parts of their countertransference may be appropriate to verbalize to clients and when, but countertransference disclosure is no longer seen as inherently contraindicated by the goal of neutrality.

Rather than prescribing a fixed stance on self-disclosure, *relational/ structure* theorists suggest that decisions about disclosure of both personal and emotional material must be made on a case-by-case basis, oriented by patients' needs as well as the therapist's personal style (Edwards & Bess, 1998; Levine, 2007). Abundant articles advocate judicious use of self-disclosure and feature clear clinical examples of its utility; however, their authors often seem to organize their statements as counterarguments against classical neutrality, as if the stance of guarded anonymity continues to be embraced by most in the psychodynamic community (Edwards & Bess, 1998; Levine, 2007; Renik, 1995; Siebold, 2011). Citing recent developments in feminist and postmodern theory, several of these authors argue against attempts at clinical anonymity due to its impact on power dynamics inherent in the clinical dyad (Renik, 1995; Renik, 1996; Siegenthaler & Boss, 1998). Renik asserts that the clinician's decision to withhold his viewpoint from the patient gives the clinician false authority and encourages idealization (1995; 1996). Judicious self-disclosure can facilitate an atmosphere of authentic candor and

reflection on the therapeutic process, as well as making it possible to address the existing power dynamics (Edwards & Bess, 1998). While selective self-disclosure seems fairly among *relational/ structure* theorists at this point, Levine reminds clinicians: “No matter how much we reveal or disclose about ourselves, we also retain aspects of the classical neutral- anonymous position” (2007, p. 103). Regardless of theoretical orientation, clinicians remain responsible for monitoring self-disclosure to ensure it benefits the patient, as well as protecting the boundaries of the therapeutic frame.

Postmodernism and the Deconstruction of Neutrality

The shifting role and meaning of neutrality in the psychodynamic community over the past several decades can be located in the larger conversation of Postmodern and constructivist theories, which have increasingly questioned and rejected classical neutrality and objectivity as human impossibilities (Arnd- Caddigan & Pozzuto, 2008; Renik, 2006; Gergen, 1991). Scientists across the disciplines increasingly recognize that it is impossible to stand outside the field of observation, and that our perceptions are inherently colored by the lenses we see through (Gergen, 1991). Clinicians, of course, are human, and we bring our histories into the room with us—through our patterns of speech, our style of dress, our viewpoints, the questions we choose to ask, and those questions which do not come to mind for a myriad reasons. Expressing a widely-held belief among *relational/ structure* theorists, Wachtel declares that our “reactions cannot really be eliminated or hidden” (1986, p. 67). Agreeing with Wachtel, Raines asserts that “the idea that we can be blank screens is impossible; our personality exudes from everything we do or do not do” (1996, p. 364). Particularly in the past 30 years, relational and intersubjective theories have replaced the image of therapist as anonymous external observer with the conception of therapist as participant-observer; clinician and patient are understood to co-

construct the therapeutic experience, and both may be transformed by the relationship (Greenberg, 1986; Hoffman, 1983; Schamess, 2011). Instead of framing the therapist's subjectivity as an obstacle, *relational* models assert that the therapist's "realness" enhances her ability to form an attachment with the humanness of the client in service of therapeutic change (Edwards & Bess, 1996; Goldstein, Miehl, & Ringel, 2009; Schamess, 2011). Relational theorist Alvarez rejects the traditional metaphor of therapist as mirror, suggesting that Bion's image of the container may more aptly characterize the ideal therapeutic stance; mirrors are not modified by what they reflect, whereas therapists are (quoted in Ceroni, 1993).

In summary, *relational/ structure* models locate the etiology of pathology in early caregiving relationships and the locus of therapeutic action in the corrective experience of the caregiving relationship between clinician and patient. The guarded and anonymous analyst of the *drive/ structure* model is replaced by the image of therapist as holding container, who responds to the patient's developmental needs and offers validation of the patient's conscious experience. Rather than implying a set of practice behaviors, neutrality is redefined as the balance or tension between the patient's tendency to experience the clinician as an old object, and his growing capacity to experience him as a new object. *Relational/ structure* therapists aim to recognize their contribution to the relational field and use countertransference and selective self-disclosure as clinical tools. Incorporating constructivist and postmodern theories, contemporary relational theories reject the possibility of the therapist as neutral observer, instead emphasizing the therapeutic relationship as an evolving mutual construction by clinician and patient.

Empirical Investigation of Neutrality

Interestingly, although the psychoanalytic community has written prolifically on the subject of neutrality in the past twenty-five years, there appears to be little empirical data

supporting theorists' assertions. Theorists often reference single case examples of neutrality in their practice with a particular client, yet my research has revealed only one larger-scale empirical study on analytic neutrality, a quantitative study which explores the correlation between therapists' attitudes and client outcomes in terms of symptom distress. Using a sample size of 167 therapists, and reviewing 327 cases, Sandell, Lazar, Grant, Carlsson, Schubert, and Broberg explored the outcomes of psychodynamically trained Swedish therapists (2006). Like my proposed study, this study used an attitudinal and behavioral definition of neutrality. Neutrality was assessed using therapists' agreement with statements such as, "I do not express my own feelings in the sessions," and "I keep my personal opinions and circumstances completely outside the therapy" (Sandell et al., 2006, p. 646). The study found that therapists with good treatment results were those who placed a high value on both kindness and neutrality in the clinical encounter. Given the results of this study and the extensive research suggesting that the therapeutic alliance is the major determinant of clinical outcomes, Sandell et al. propose that the therapist's kindness and neutrality are components of a solid working alliance; however, they also offer an alternative explanation, that therapist kindness and neutrality are engendered by the clients' offer of a positive alliance (2006). This study is limited in that its sample population is entirely Swedish, and specifically because the Swedish population is relatively homogenous racially and culturally, making the practice of a neutral stance different than it would be in the U.S. (Rowe & Fudge, 2003). It is likely that neutrality plays a dissimilar role in the therapeutic alliance formed between a therapist and client who come from different racial and cultural perspectives, as is often the case in this country, highlighting the need for further research in this area. Despite the limitations of this study, I have found its research inspiring and

have incorporated elements of the testing instrument into my own research (See Chapter III: Methodology).

The Relationship between Clinical Theory and Practice

While I have observed that quantitative research regarding the practices of neutrality is notably lacking, it must also be acknowledged that the accumulation of single-case examples, “enumerative inductivism,” is the predominant theory-building strategy of the psychodynamic work (Fonagy & Target, 2003, p. 287). When one phenomenon follows another in every known example, such as a decrease in client distress after a particular intervention, enumerative induction leads us to conclude that the phenomena will always occur together; however, such conclusions may be flawed because instances in which the phenomena do not occur together may not be thoroughly studied and documented.

We consider theories to lend support to inductive observations because we assume that theories imply that the number of observations on which an inductive inference is based is very considerable, and this somehow lends weight to the conclusions. In so doing, however, we are merely applying inductive arguments for induction. (Fonagy, 1999, p. 514)

Inductions are necessarily shaped by past theory, not simply observation of the particular individual, and thus theory is inherently contaminated by the technique used to generate it. Instead of practice being dictated by theories of mind and therapeutic action, as one might assume, Fonagy suggests that practice is shaped by “what has been found clinically helpful” and is inherently personalized by practitioners (Fonagy & Target, 2003, p. 288). Theories provide an organizing framework for clinical work yet cannot predict outcomes nor justify particular methods. Clearly, theory informs clinical treatment methods, but it is impossible to achieve a

one-to-one mapping between theory and technique. One of the purposes of this study is to illuminate the relationship between theoretical training in neutrality and ongoing practice ideals and to explore what factors have contributed to changes in clinicians' practice with respect to neutrality.

Conclusion

While guarded anonymity was once promoted uniformly as the ideal therapeutic stance, classical neutrality has become a contentious clinical ideal whose role and meaning in psychodynamic work varies depending on clinicians' theories of therapeutic change. Abundant single case examples evidencing the range of viewpoints about neutrality can be found, yet little quantitative research has been conducted regarding the practices of neutrality from the perspective of practitioners. The methodology that follows is designed to address the gap in the research by employing quantitative methods to describe clinicians' practice ideals with respect to neutrality and elucidate the relationship between psychodynamic training in neutrality and ongoing practice ideals.

CHAPTER III

Methodology

This study is an investigation into psychodynamic training with respect to neutrality and clinicians' current practice ideals. With this purpose in mind, the questions guiding my research are: Is there a relationship between clinicians' training in neutrality and their current practice ideals? And to what extent do contemporary psychodynamically-trained therapists aim for neutrality in their work with clients? The decision was made to explore this topic by collecting data from alumni from a single psychodynamically-oriented school, Smith College School for Social Work (SCSSW), where curriculum was expected to be relatively consistent, providing a baseline for participants' training in neutrality. Because the ideal of neutrality was more prevalent in historical psychodynamic theory and has been increasingly questioned and even rejected more recently, I hypothesized that alumni's era of graduation would be correlated with adherence to the ideals of neutrality, with earlier graduation indicating greater adherence to neutrality.

Characteristics of Participation

Criteria for inclusion in the study required that participants were currently working in the field of mental health at the time of completing the survey and had graduated from SCSSW between the years 1981 and 2011. Individuals who were not currently working within the field of mental health, as well as individuals who have not already graduated from the SCSSW program, those who graduated before 1981, and those without an active (non-confidential) email address

on file with the SCSSW alumni office were excluded. The SCSSW alumni population was chosen as the sample frame for convenience purposes and in order to explore the possible impact of curriculum changes on therapists' enduring attitudes about neutrality. The SCSSW alumni population was particularly well-suited for this research because of the school's singular clinical focus. SCSSW maintains an internally-consistent systematic educational focus on psychodynamic theory, thus alumni from a given time period are expected to have received relatively consistent training. I limited my sample frame to alumni of the past 30 years because these individuals are likely to be in current practice, and because I am particularly interested in investigating the shift in psychodynamic attitudes about neutrality that has occurred over the course of the past three decades. The survey link was sent to all alumni with active email addresses on file with the SCSSW alumni office, a list of 2,592. Of the alumni with active email addresses, 2,503 graduated between 1981- 2011.

Recruitment Process

This research project employed non-probability convenience/ availability sampling; currently practicing psychodynamically-trained therapists made up the sample universe, but only those who graduated from Smith were included in the study sample because they are a resource available to me, and a population which was likely to give a good response rate. In order to gain access to the alumni population, I contacted Pat Graham at the SCSSW alumni office. After my study and recruitment materials were approved by the HSR committee, Pat emailed the alumni my recruitment announcement to the alumni list (See Appendix B: Recruitment Announcement). The recruitment announcement contained a link to my survey, and interested alumni were able to access the survey by clicking on this link. When prospective participants arrived at the survey, the first page involved screening questions; participants were asked if they are alumni of SCSSW

from 1981 to 2011, and then were asked if they are currently working in the field of mental health. If the answer to either of these questions was “no,” they were sent a disqualification page, which thanked them for their interest and explained the boundaries of the sample frame. Those who answered both questions affirmatively were directed to the informed consent page (See Appendix C: Letter of Consent).

Nature of Participation and Data Collection

After giving informed consent, participants were invited to complete an anonymous self-administered online survey, expected to require less than 15 minutes. The method of an online survey was chosen because it was expected to yield the largest number of alumni participants, being easy for participants to access and complete at their convenience. The survey asked participants for both demographic and quantitative data, with two requests for narrative response. Quantitative data collected through the survey took the form of Likert scales (See Appendix D: Questioning Neutrality Survey). A primarily quantitative study was best suited to this project because neutrality has been discussed in depth in the literature, and the range of attitudes towards neutrality has been well documented (Renik, 1996; Ceroni, 1993; Franklin, 1990; Leider, 1983). This prior research was used to formulate survey questions that span the range of theoretical stances and practices, and the quantitative methods employed allowed the researcher to synthesize data from a large number of participants.

The Questioning Neutrality Survey includes questions designed by the researcher, as well as several questions borrowed from a pre-existing instrument, the Therapist Attitude Scales (TASC 2). Specifically, my survey takes items 16, 19, 23, 27, 31-33, and 35- 37 directly from the TASC 2, while items 14, 26, and 28 are adapted versions of items from the TASC 2; all remaining questions were developed by this researcher. The TASC 2 was developed by Swedish

psychology researcher and professor Rolf Sandell and colleagues and is designed “to predict the self-designated theoretical orientations of therapists and to discriminate reliably between therapists with different levels of professional experience and different varieties of training” (Sandell et al, 2006, p. 630). The TASC 2 has also been used to study the efficacy of psychological treatment from different theoretical orientations (Sandell et al, 2006). Sandell and colleagues’ 2006 article “Therapist attitudes and patient outcomes. III. A latent class analysis of therapists” presents the only empirical data regarding neutrality that I have been able to locate, and their items have been pre-tested and used repeatedly with meaningful results, recommending their inclusion in my research. I contacted Dr. Sandell by email to request his permission to use items from the TASC 2, and he wrote back with enthusiastic approval (See Appendix E: Letter of Permission to Use TASC 2).

Data Analysis

Quantitative survey data was processed through statistical analysis, using both descriptive and inferential statistical measures, with the help of SCSSW’s statistician Marjorie Postal. Descriptive statistics were used to portray characteristics of the study sample, such as the race and gender composition of the study sample. Inferential statistics were used to test possible correlations between participants’ era of graduation and their reported adherence to neutrality in their practice. A total cumulative neutrality scoring tool was designed in order to synthesize data from the survey, allowing the researcher to compare participants’ adherence to the principles of neutrality by discrete categories (e.g. difference by graduation era). The total cumulative neutrality score was determined by averaging the scores from items 14- 22, 24-30, and 33. Items 14, 17- 19, 22, 25, and 27- 30 were reverse scored (i.e. a score of “1” on these items was equivalent to a “5” on other items, and vice versa). Sub-scores were also created for each

thematic page of the survey, the mean of scores from all items on each given topic: self-disclosure, transference and countertransference, bias, directiveness, and supportiveness. Cronbach's alpha was used to test the internal reliability of cumulative neutrality score. Spearman's rho was used to test correlation between graduation era and experience of neutrality in SCSSW curriculum. Spearman's rho was also used to test correlation between participants' graduation era and their cumulative neutrality scores and sub-scores. A Oneway Anova was run to determine if there was a difference in participants' neutrality scores by the era they graduated. Finally, a Bonferoni post hoc test was run to determine which eras of graduation showed significant differences in neutrality scores. Additionally, qualitative data from items 13 and 38 was coded to determine patterns and significant themes in participants' narrative responses.

CHAPTER IV

Findings

Motivated by an interest in psychodynamic theories of therapeutic change, and seeking to address a gap in empirical research regarding neutrality in clinical practice, this study aims to answer the following questions: Is there a relationship between clinicians' training in neutrality and their current practice ideals? And to what extent do contemporary psychodynamically-trained therapists aim for neutrality in their work with clients? The decision was made to explore this topic by collecting data from alumni from a single psychodynamically-oriented school, Smith College School for Social Work (SCSSW), providing a baseline for participants' training in neutrality. Because the practice stance of guarded anonymity was more prevalent in historical psychodynamic theory and has been increasingly questioned and rejected in recent decades, I hypothesized that alumni's era of graduation would be correlated with adherence to the ideals of neutrality, with earlier graduation indicating greater adherence to neutrality. The major findings of this research failed to support my hypothesis, suggesting that while training in neutrality has waned, and guarded anonymity is less promoted within the SCSSW curriculum over time, there is no significant correlation between era of graduation and adherence to principles of neutrality. Participants cited many experiences outside of the curriculum that have contributed to changes in practice ideals since graduation, and participants' current degree of adherence to neutrality spans a wide range, although none reported strict faithfulness to all of the practices of neutrality examined. This chapter will first present descriptive statistics regarding the demographics of the

study sample and then present inferential correlations and qualitative data to address the research questions outlined above.

Characteristics of the Study Sample Population

Two hundred seventy-five participants began the Questioning Neutrality Survey, and 224 completed it. The 224 participants who completed the survey represent 11.17% response rate from the 2,592 individuals who received the recruitment announcement and whose era of graduation made them eligible.

Graduation era

Participants were grouped into 5-year eras of graduation in order to enable the researcher to investigate changes in curriculum and to identify trends in participants' responses by era. The largest group, comprising 40% of the study sample, was made up of graduates from the past 5 years (2005-2011). Graduates from 2001- 2005 made up the second largest group, totaling 17.27% of the sample. The third group of participants consisted of graduates from 1996- 2000, comprising 11.82% of the sample. The fourth group, comprised of graduates from the preceding period (1991-1996), made up 14.09% of the sample. The earliest graduates included in the sample, those from 1981- 1985, totaled 9.54% of the sample, while the final 7.27% were those from 1986-1990 (See Appendix L: Figure 1: Participants' Era of Graduation). Noticing that participation rates decline among earlier alumni cohorts, and more than half of the sample consists of alumni from the past decade, I hypothesize that recent graduates likely make up a greater proportion of the email list, and may be more familiar and comfortable with online surveying technology, making them more likely to respond to the recruitment notice.

Gender

The gender composition of the study sample consists of 84.8% females, 14.8% males, and 0.4% transgender (See Appendix M: Figure 2: Gender of Participants). Although the SCSSW alumni office told me they do not keep composite records of the gender composition of the entire alumni body, and exact figures are therefore unknown, the gender composition of the sample was roughly as expected given the high proportion of females in the social work profession and at SCSSW today.

Race/ ethnicity

Racial/ ethnic categories employed in the Questioning Neutrality Survey were described according to the major racial and ethnic populations currently residing in the United States. A heavy majority of the participants, 94.5%, identified as being White. All other racial/ ethnic categories were far less represented among the sample, a finding which was unfortunately expected due to the racial/ ethnic composition of SCSSW alumni population in general. Participants who identified as Black or African American make up 3.8% of the sample. American Indian and Alaska Native participants comprise 2.1% of the sample. Hispanic or Latina/ Latino participants make up 1.7% of the sample, and 1.3% identified as Asian. None of the participants identified as Native Hawaiian or Other Pacific Islander. Thirteen participants responded in the “Other” category, 9 identifying themselves as Jewish, 3 identifying as Biracial or Mixed Race, and one identifying herself as the White parent of an African-American child (See Appendix N: Figure 3: Race/ Ethnicity of Participants).

Practice setting

Participants’ primary practice setting comprised the next demographic characteristic. In the sample 42.6% participants worked in an outpatient clinic, 35.1% worked in a private practice

setting, 9.4% worked in a school setting, 5% worked in a residential program, 2.5% were working in a hospital, and 2.5% worked in an inpatient unit. Forty-four participants responded in the “Other” category, including those who worked in college counseling, emergency services, hospice, in-home therapy, community health clinics, and other community agencies such as an adoption, a methadone clinic, and an LGBTQ youth center (See Appendix O: Figure 4: Practice Setting of Participants).

Practice modality

Participants were asked to identify the distribution of individual, couple, family, and group cases in their current case load. As SCSSW’s clinical training is predominantly oriented towards individual work, it is not surprising that individual clients made up the majority of participants’ case loads (74.95%). Work in multi-person modalities was far less represented. Participants reported an average of 23.95% of their case load consisted of family work, while 12.12% was made up of groups, and an average of 10.16% of participants’ work was with couples (See Appendix P: Figure 5: Practice Modalities of Participants).

Age of participants’ patients

The Questioning Neutrality Survey also inquired about the distribution of participants’ patients by age. An average of 46.26% of participants’ case loads consists of adult patients aged 31-61. Young adults aged 19-30 made up an average of 29.26% of participants’ case loads, while adolescents 13-18 were almost equally represented, making up 28.92%. Children 0-12 comprised an average of 21.6% of participants’ case loads, and older adult patients, aged 65 and above, were least represented, totaling an average of 11.35% (See Appendix Q: Figure 6: Age of Participants’ Patients).

Internal Reliability of the Cumulative Neutrality Scoring Procedure

After depicting the study sample using descriptive statistics and formatting quantitative data to reflect reverse-scoring of some test items (as described in Chapter III's methodology), my next task was to ascertain whether cumulative scoring of the Questioning Neutrality Survey would generate meaningful results. Cronbach's alpha, a test of internal reliability and consistency, was used for this purpose, yielding a score of .71. This score indicates that the survey questions fit well together; because test items are interconnected, measuring similar traits, participants' responses across the survey are relatively consistent (e.g. participants who believe in less self-disclosure probably also believe in giving less concrete advice). Cronbach's alpha is measured on a scale of 0 to 1, with scores above .6 being considered acceptable (Marjorie Postal, personal communication, April 30, 2012). Cumulative scoring of the Questioning Neutrality Survey enables the researcher to describe participants' degree of adherence to the principles of neutrality, as well as to test correlations between participants' total neutrality scores and era of graduation, the results of which may be found below.

Participants' Degree of Adherence to Neutrality

Participants' degree of adherence to the principles of neutrality was examined by calculating cumulative scores from the Questioning Neutrality Survey, as well as by looking at sub-scores from survey categories: self-disclosure, transference and countertransference, directiveness, and supportiveness. Participants' cumulative scores ranged from 2.12 to 5, with a score of "1" indicating strict faithfulness to the position of guarded anonymity, and "5" indicating loyalty to relational practices. The mean score was 3.57, and standard deviation was .34. The researcher was not surprised to find that 13.6% of participants scored "4" or above, as I had expected that relational practices were particularly embraced by recent graduates (and

graduates from the past decade comprise more than half of the sample). Less than half as many participants (6.3%) scored “3” or below, suggesting that the classically neutral position promoted within *drive/ structure* theory remains a central influence to a select few (See Appendix F: Table 1: Frequencies of Cumulative Neutrality Scores and Appendix G: Table 2: Descriptive Statistics of Neutrality Subcategories).

Directiveness sub-scores

Comparing mean sub-scores from survey categories, it was found that participants were most likely to endorse neutrality in the area of directiveness ($m=2.37$). Directiveness scores ranged from 1 to 5, with a standard deviation from the mean of .85. This was the only category in which the sample’s mean fell below 3, indicating that, as a group, participants generally aim not to direct patient behavior, whether or not they embrace other facets of neutrality. Participants’ responses to item 25 (“When clients seek answers about what they should do in a particular dilemma, I tell them how I might handle the situation”) were particularly dramatic; 74.1% of the sample scored indicated disagreement with this statement. This finding suggests that even those who endorse relational principles are wary of overly influencing patients and therefore see the value in maintaining neutrality in this respect.

Self-disclosure sub-scores

In contrast to the low scores found in the directiveness category, the sample was more supportive of a relational stance with respect to questions of self-disclosure ($m=3.37$). Self-disclosure scores ranged from 1.25 to 5, with a standard deviation from the mean of .72. When asked if they had used self- disclosure as an effective intervention (item 17), a striking 84% of participants agreed, but responses were much more divided on the issue of whether therapists should answer clients’ questions about the therapist’s personal life (item 15), only 34.7%

agreeing in this case. Apparently the sample is much more comfortable with the therapist's elective self-disclosure, perhaps including revelation of emotional responses to the patient, than they are with responding to patients' direct inquiry about the therapist's life beyond the therapy room.

Transference and countertransference sub-scores

Scoring of questions related to transference and countertransference yielded a mean of 3.88 and ranged from 2.5 to 5, with standard deviation of .37. An overwhelming majority of the sample (93.7%) agreed that countertransference is an important instrument in their work, suggesting that most participants do not find the *drive/ structure* model's conception of countertransference as an obstacle relevant or helpful to their current practice. At the same time, many therapists reported that they do aim to be "blank screens"—less to elicit clients' projections than to minimize the impact of their personal material on the therapeutic relationship (items 20 and 21; $m= 1.43$ and $m= 3.01$, respectively). This data suggests that clinicians are aware of countertransference and likely use this awareness to guide treatment decisions, but they do not necessarily share their emotional reactions overtly. Given the data, it is likely that most participants share the contemporary *relational/ structure* understanding of countertransference as a product of both therapist's and client's material; however this definition was not made explicit in the research.

Supportiveness sub-scores

In contrast to the wider range of opinions reported by participants on questions of directiveness, self-disclosure, and countertransference, the sample was mostly in agreement regarding the value of the therapist's active supportiveness ($m=4.37$). Supportiveness scores ranged from 2.25 to 5, and showed the smallest standard deviation (.57). Reflecting the

therapeutic approach of *relational/ structure* models, which emphasize acceptance of the patient's conscious experience, 83.9% of the sample agreed that they "aim to offer clients validation" (item 30). The most controversial item in this set, asked participants if they agreed that "the client should feel an underlying sense of being liked by the therapist" (item 29). Although 78.6% of the sample agreed with this statement, several participants commented in the survey's narrative response section that it had been important to their own growth to have therapists who did not reveal their affections.

The Relationship between Era of Graduation and Training in Neutrality

Seeking to identify the relationship between curricular training in neutrality and clinicians' ongoing practice ideals, my first task was to investigate the position of neutrality in the SCSSW curriculum to determine whether the curriculum has changed over time. Spearman's rho was used to test the correlation between clinicians' era of graduation and responses to item 10 on the Questioning Neutrality Survey: "I was taught at Smith SSW that I should strive for an impartial attitude with regard to clients." A very weak positive correlation was found ($\rho=.211$, $p=.002$, two-tailed). A positive correlation suggests that recent graduates are more likely to disagree, or disagree more heavily, with item 10. This finding indicates that "impartial attitude" was historically promoted in the SCSSW curriculum, and emphasis on this practice stance has diminished.

Similar to the previous test, Spearman's rho was used to determine the correlation between clinician's era of graduation and responses to item 11: "I was taught at Smith SSW that I should aim for anonymous behavior with clients." Again, a very weak positive correlation was found ($\rho=.180$, $p=.007$, two-tailed). This positive correlation suggests that recent graduates disagree more with item 11, indicating that curricular emphasis on "anonymous behavior" has

declined in recent decades (See Appendix H: Table 3: Correlations between Graduation Era and Neutrality Training). These findings were expected, as it was assumed that the SCSSW curriculum would be modified over time to reflect changes in the field of psychodynamic theory. It must be noted, however, that the accuracy of these findings is dependent on participants' memory of their experience of the SCSSW curriculum, some more recent than others; the cross-sectional nature of this study means that participants' memory of the curriculum is captured, and may not fully reflect the data that would have been reported if the survey was administered at the time of graduation.

With approximately 11% of the study population participating in this research (items 10 and 11 obtained 220 and 235 responses, respectively) the statistically-weak correlation between participants' era of graduation and neutrality training seems to have minor social significance, meaning that there has been some notable qualitative change in the curriculum; however, the large sample size may create a false impression of the importance of these findings. Curricular changes in the past 30 years regarding the issue neutrality do not appear to be dramatic, and the results may not have been statistically significant with a different sample or sample size.

Correlation between Era of Graduation and Adherence to Neutrality

Next, I wanted to identify whether there is a relationship between neutrality training and participants' current practice ideals. Spearman's rho was used to test the correlation between era of graduation and cumulative neutrality scores. Spearman's rho was also used to test correlation between era of graduation and sub-scores from each survey category: self-disclosure, transference, bias, directiveness, and supportiveness. No significant correlation was found in any of these tests, suggesting that era of graduation does not predict ongoing practice ideals with

respect to neutrality (See Appendix I: Table 4: Correlations between Graduation Era and Adherence to Neutrality).

Looking at the data in an alternate manner, a Oneway Anova was run to determine if there was a difference in neutrality scores by era of graduation. A significant difference was found in directiveness scores ($F(5,214)=2.983, p=.013$) (See Appendix J: Table 5: Directiveness Sub-scores by Graduation Era). A Bonferoni post hoc test indicated that the significant difference was between those who graduated in 1986- 1990 ($m=2.97$) and those who graduated in 1991-1995 ($m=2.18$), as well as between those who graduated in 1986- 1990 ($m=2.97$) and those who graduated in 2001- 2005 ($m=2.09$). In both cases the earlier group had a higher mean, indicating lesser adherence to neutrality; specifically, in this case it suggests that alumni from 1986- 1990 give more direct advice (See Appendix K: Table 6: Bonferoni Posthoc Tests of Directiveness by Era). While it was hypothesized that alumni's training in neutrality would predict a comprehensive and noticeable long-term impact, this data suggests the opposite; the only significant differences in practice ideals identified by the tests indicate that graduates from the earliest cohorts studied, 1981-1985 and 1986- 1990 are actually most comfortable offering clients advice ($m=2.45$ and $m=2.97$, respectively). In considering factors which may explain the divergence of the findings from the researcher's hypothesis, the Research Advisor, Roger Miller, noted that participants who graduated in the 1980s have not only received different training, but have also engaged in more years of practice experience. Graduates from the 1980s may have developed a sense of authority founded on accumulated experience over the years, and as real veterans of the field with significant wisdom, it may seem natural to extend advice to clients (personal communication, May 22, 2012). Participants who graduated in the 1980s are also likely to be older than graduates from more recent decades, and thus more likely to be older than their

clients; the difference in age between clinician and client may additionally encourage the dynamic of advice-giving.

In summary, the data does not suggest a meaningful correlation between participants' era of graduation and their degree of adherence to the ideals of neutrality. Only 7% of participants reported that the role of neutrality in their work has remained unchanged since graduation, and 63% offered brief narratives regarding formative experiences that have inspired modification of their practice ideals since graduation, themes from which are presented below.

Factors Contributing to Changes in Participants' Practice Stance

Participants were given two opportunities to provide narrative responses within the Questioning Neutrality Survey: first, item 13 inquired about experiences that had contributed to changes in the role of neutrality in participants' work since graduation, and secondly, item 38 invited participants to share any further reflections on the content or process of the survey, as they completed it. Item 13 yielded 174 responses, while 84 participants chose to comment on item 38. The following analysis of the qualitative data incorporates responses from both narrative survey items, and additional discussion of the qualitative data may be found in the subsequent Discussion chapter. Participants cited a wide range of influences contributing to adaptation of their practice stance, as will be described.

The clinician's growth in relationship

Clinicians' personal and professional growth in the context of relationship was widely cited as a major factor affecting changes in use-of-self. Eight participants referred to their own experiences in therapy, and nine spoke about the influence of supervision. Thirty-four referenced growth inspired by engagement with clients, particularly long-term treatment relationships. Although expressed in a variety of ways, many participants shared the perspective that with the

accumulation of treatment experience comes increasing capacity for flexibility in therapeutic technique. As one example of this position, a participant writes: “Years of experience doing psychotherapy has broadened my view of how I can be most effective with clients.” Five participants suggested that it was natural and important for novice clinicians to have strong boundaries; anxiety can cause rigidity when new to practice, leading new clinicians towards more manualized treatments. One participant writes, “I think impartiality, etc. is a good place to start, an important one, but over time I think we can bring more of ourselves into the work.” Experience yields increasing capacity for discernment of appropriate techniques, comfort with one’s intuition and with bringing more of one’s authentic self into the treatment relationship, all leading to greater modification and flexibility based on the individual client and client population’s needs. A participant reflects, “Lived experience has deepened my respect for the relationship between helper and client, when and what to disclose. I am more judicious now than when I started.”

Needs of the client population

In addition to factors related to the clinician’s accumulation of experience, participants referred to the distinct needs of their client populations as central to decisions about neutrality. Seventeen clinicians who work with children, adolescents, and families in their homes spoke about needing to be more “real” with these populations than their training in individual adult therapy dictated. One participant writes, “Working with kids you have to give all of you and sometimes that [involves] giving of who and what you believe.” Another states, “In working with teenagers, I feel like it's impossible and not helpful to be "neutral," because I feel like the teenagers I work with need to get a sense of a clinician's personality in order to connect and trust.” A third spoke about her desire to provide clients with a corrective experience of parenting

in therapy: “Sometimes, the adolescents I work with have had really poor role models and do not know different... it is important to help them make healthier choices, to be the guide in identifying healthier choices.” Although *relational/ structure* models that emphasize supportive and directive techniques are typically framed as remedies to inadequate parenting in early life, it makes sense that the same methods would be particularly important and useful for child and adolescent clients currently navigating developmental tasks, as well as for parents who are serving as holding environments for their children’s development and need modeling.

Like those who worked with children and families, participants felt that a non-neutral position was often required when working with populations with poor capacity for judgment and those who pose safety risks. Three clinicians who work with lower-functioning or severely and persistently mentally ill clients reported needing to give more guidance to their clients than allowed by the classically neutral position, and two referred to the need to direct clients when their behavior is harmful. One participant explains, “My work in a hospital setting is at times crisis driven in which directive intervention is essential to the safety of patients’ and their families.” When safety is a concern, participants felt that the need for directive interventions to reduce risk outweighed the value of neutrality.

Developments in theory across the field

Beyond the specifics of therapists’ experience and client populations’ needs, participants’ decisions about neutrality and use-of-self are located in the context of changes and developments in the broader field of clinical theory. Participants report keeping up with changes in the field through continuing education courses, reading books about theory, and attending workshops and conferences— all experiences which expose participants to new and expanding models of theory and practice, inviting them to engage in ongoing reflection on possible adaptations to their work.

As theories of therapeutic change have multiplied and diversified over the past decades, and scientific research has been employed in support of a wide range of treatment modalities, it is no surprise that clinicians who trained in Smith's psychodynamic model have come to embrace a diverse set of practice ideals.

CBT and DBT

Four clinicians referred to the influence of cognitive behavioral theory (CBT) and its corollary dialectical behavioral theory (DBT) on their practice stance, both models which lack the psychodynamic emphasis on the treatment relationship and do not particularly promote clinical neutrality. One participant explained that, "Within those frameworks, there is value in having genuine reactions and also helping people learn through examples you can give of using certain skills in your life." While branching away from his psychodynamic training base, this same participant incorporated an appreciation for the value of neutrality in CBT/ DBT practice: "The examples that are used by a clinician, however, should share only enough information to convey what is to be learned and should also be appropriate in nature." I would imagine that the opinion expressed by this participant is the kind SCSSW professors hope of their graduates; he is able to incorporate useful elements of his training into new methods, adapting both models to create a sophisticated hybrid. As the research has demonstrated thus far, the SCSSW curriculum is not the only formative influence in participants' ongoing practice ideals, but it seems to have been an important and long-lasting factor for many.

Trauma and attachment theories

More than they referenced the influence of the CBT and DBT models, participants referred to developments within the psychodynamic field that have impacted and strengthened their practice, particularly the expansion of trauma and attachment theories, including research

about affect regulation. Multiple participants specifically referred to the influential research of Bessel Van der Kolk, Dan Hughes, and Judith Herman; these researchers expand on and support *developmental/ relational* theories through research addressing the brain's development in a relational context, as well as the devastating impact of trauma on relational and regulatory mental structures. Because relationship is emphasized by these theorists as a protective and curative factor, classical neutrality is not held as an ideal.

Intersubjectivity and relational theories

Citing the work of Stolorow and Atwood, participants also referred to the influence of relational and intersubjective theories on decisions about practice stance. Building on the *relational/ structure* models described in Chapter II, relational and intersubjective theories offer a contemporary theoretical framework for psychodynamic work based on genuine, personalized clinical relationships, rather than fixed practice techniques. In these models, the ideal of clinical neutrality is replaced by the goal of authenticity and mutual reflection on the co-constructed clinical relationship. One participant explains: "Learning more about relational principles and intersubjectivity has enlightened me to the healing power of the authentic relationship." Another adds, "As people, clinicians have personalities, identities, values and histories that interact with those of the clients, and I've found it to be more useful to process the factors that are impacting impartiality and neutrality in our relationships, rather than striving for it." Because relational theories posit that it is not possible for clinicians to be divorced from their circumstances in order to be objective, their inherent subjectivity is acknowledged framed as an asset toward building connection.

Feminist and anti-oppression theories

In addition to the psychodynamic and behavioral theories that have shaped participants' practice, they also referred to the influence of feminist and anti-oppression theory on their work. The field of social work has long aimed to ameliorate inequalities in the social environment, and SCSSW has a specific mission to intervene against the deleterious effects of racism and promote the value of diversity in our society. Although the school's anti-racism mission was adopted since the earliest participants graduated, both recent and longer-practicing graduates reported a commitment to clinical practice as anti-oppression work. Participants aspired toward reflection with clients on the power dynamics inherent in the therapy relationship and larger social structure, seeking to actively empower clients and create change in the environment, rather than simply addressing symptoms in the individual. Clinical neutrality may inadvertently imply agreement with the status quo and give the clinician false authority, while advocacy often requires that clinicians take a more active stance. One participant writes, "I tend to work with the disadvantaged (socio-economic, race, etc) therefore rather than be neutral I feel I am more of an advocate at times." A second participant echoes, "I have found that supporting the teenagers I work with, in a school setting, has involved my "siding" with the students sometimes -as their advocate." A third speaks more generally about her intention to address oppression through her work: "I... work in a practice that is very open and direct about being a feminist practice that takes political and overt positions around issues of oppression of all people." As the above quotes evidence, many participants share the awareness that clinical practice occurs in a social context built upon institutional oppression; anti-oppression theories ask clinicians to address the power dynamics inherent in clinical work, and to use their power responsibly to advocate for

clients. From a feminist and anti-oppression perspective, clinical neutrality reinforces the client's disadvantaged position, making it an antiquated ideal.

Postmodernism and the rejection of objectivity

While participants cite a wide range of theoretical frameworks supporting their arguments against the value of clinical neutrality, some go so far as to reject the possibility of neutrality altogether, asserting that an objective, unbiased perspective cannot be attained. Participants did not particularly elaborate on their reasons for rejecting the possibility of neutrality, but several shared this position: "I learned at Smith and elsewhere that neutrality is a myth." Another declares, "I have come to believe that neutrality is a somewhat unrealistic construct." While a third contends, "I have come to believe that neutrality and abstinence are neither desirable nor possible." It is likely that these participants have been influenced by contemporary postmodern theories that emphasize the intrinsically subjective nature of observation and interpretation; these theories propose that clinical interactions cannot exist in a vacuum because clinicians' perspectives are inherently shaped by their own histories and social locations. From a postmodern perspective, one cannot hope for neutrality, yet from a relational perspective, the therapist's subjectivity is seen as an asset in building human connection, rather than an obstacle to treatment. One participant emphasizes this viewpoint, stating strongly that "No healing can take place if you aren't very genuine, authentic, and sharing of your real life." Another affirms that "'impartiality' and 'neutrality' are less useful concepts than how the therapist's own self, connectedness to the other, and helping clients become more real and true to themselves impact the therapy." These quotes from participants evidence a dramatic shift from the clinical ideals advanced by Freud. Few clinicians seek the strictly neutral position Freud envisioned as therapeutic, while most have incorporated recent developments in clinical theory

into their practice, coming to value a more authentic, relational model of therapy that contextualizes clinical work in a social context.

Conclusion

In conclusion, the reader will note that this study has emphasized the diversity of perspectives on neutrality presently held by participants. Despite the fact that a primarily quantitative study was conducted, some of the most meaningful data surfaced from participants' narrative responses, offering context and clarification of their numerical scores. The research conducted for this study has revealed both expected and unexpected findings. As anticipated, participants reported that SCSSW's curricular emphasis on neutrality has waned over the past 30 years. The researcher was surprised to find, however, that there is no significant correlation between participants' era of graduation and their current adherence to neutrality. The only significant difference in participants' neutrality scores by era was found in the subcategory of directiveness, but the data distribution suggested that this was likely an incidental difference. Participants' level of adherence to neutrality spanned a wide range, yet none of the participants reported strict adherence to the original Freudian neutral position. Factors contributing to participants' decisions about use-of-self included clinicians' personal growth in relationship, the particular needs of the client population and individual client, and developments in and diversification of clinical theory. The high rate of participation among the pool of recruitment, as well as participants' passionate and thoughtful narrative responses, suggest that clinical neutrality remains an important and controversial issue in the psychodynamic field, worthy of further investigation. Strengths and limitations of the study, as well as the researcher's recommendations for further study, will be presented in the following chapter.

CHAPTER IV

Discussion

Overview of the Study

This study was designed as a quantitative exploration of psychodynamic therapists' attitudes regarding the ideal of neutrality in clinical practice and the relationship between current practice ideals and clinicians' curricular training in neutrality. Neutrality has historically been promoted as a clinical ideal in order to protect against intrusion of the therapist's personal material, enabling the patient's capacities to guide treatment; however, recent developments in theory have led to dramatic shifts and diversification in therapists' use-of-self. As established in Chapter II, psychodynamic theories of change can generally be divided into two groups: *drive/structure* models that emphasize intrapsychic conflict and the utility of clinical neutrality, and *relational/structure* models that emphasize interpersonal deficits and the healing properties of the care-giving clinical relationship. As contemporary clinicians continue to practice from both theoretical standpoints, and many have combined elements of both frameworks, the role of neutrality remains an important and controversial issue in psychodynamic practice. Theoretical discussion and single-case examples supporting *drive/structure* and *relational/structure* approaches are abundant, yet this researcher could find only one larger-scale empirical study of neutrality, evidencing a need for further research. Motivated by my interest in psychodynamic theories of therapeutic change, grounded in questions about why clinicians choose particular practice methods, this study sought to address the gap in the literature. This chapter will present

implications of the findings for psychodynamic practice and education, discuss strengths and limitations of the study, and conclude with recommendations for further research.

Implications of the Study Findings and Importance of the Topic

The major questions addressed by this research were: Is there a relationship between clinicians' training in neutrality and their current practice ideals? And to what extent do contemporary psychodynamically-trained therapists aim for neutrality in their work with clients? The decision was made to explore this topic by collecting data from alumni from a single psychodynamically-oriented school, Smith College School for Social Work (SCSSW), where curriculum was expected to be relatively consistent, providing a baseline for participants' training in neutrality. This research is important because it provides a description of the role of neutrality in clinical work from the perspective of contemporary practitioners; looking at a sample who were exposed to a particular set of psychodynamic theories and habits of self-reflection and dialogue, this study offers a snapshot of the long-term effects of SCSSW students' induction into the realm of psychodynamic thinking. Essentially, this study explores the connection between developments in theory (as portrayed in the curriculum) and how they play out in practice, describing the fate of ideas transmitted through SCSSW education, and how they endure or are revised over time.

Because the ideal of neutrality was prevalent in historical psychodynamic theory and has been increasingly questioned and even rejected more recently, the researcher hypothesized that alumni's era of graduation would be correlated with degree of adherence to the ideals of neutrality, with earlier graduation indicating stronger loyalty to classical neutrality. The study data, however, failed to support this hypothesis, suggesting that although curricular emphasis on neutrality has waned somewhat over the past 30 years, there is no significant relationship

between era of graduation and participants' current adherence to neutrality in their practice. In considering the significance of this finding, the researcher was struck by an observation proposed by the research advisor, Roger Miller: the assumption that the SCSSW curriculum might have a significant impact on participants' practice up to 30 years after graduation may be relatively unique to the Smith community. Whereas other training programs often offer a variety of tracks and curricular foci, all SCSSW students can be expected to receive fairly consistent clinical training. In a program with individualized courses of study, it would be difficult to study the impact of the overall curriculum on later practice, yet the internally consistent SCSSW curriculum provides an exceptional opportunity to investigate how the process of psychodynamic indoctrination endures over time. The internal consistency of the SCSSW curriculum makes the alumni from this program an ideal choice of study population, and this can be considered a strength of the study.

Research Advisor Roger Miller asserts that to the extent that the SCSSW curriculum does have a lasting impact on graduates, this may be the result of the school's induction of students into the psychodynamic community, rather than merely being a consequence of the explicit curriculum (personal communication, May 8, 2012). Graduates of the SCSSW program have not only been exposed to the contents of the curriculum, but have also had an opportunity to engage in significant psychological growth, and this transformative process lays a foundation for ongoing habits of reflection and growth after graduation. Given the above conception of these factors, which has evolved during the research process, the researcher would revise her original hypothesis; it now seems logical that that the practice ideals of SSW graduates would not remain static after graduation, as SSW students and graduates pride themselves on their engagement in self-reflection, dialogue, and adaptation. Psychodynamic theory appears to serve as a rough

guide to SSW graduates in their practice, but participants in this study, like many contemporary Relational and Intersubjective theorists, assert that real decisions about practice with particular clients must be contextualized and individualized. Theoretical constructs presented within the SCSSW curriculum, including the concept of neutrality, seem to be fated for ongoing reflection, revision, and individualization; this study has captured some of this complexity.

In considering the importance of this study to the field, the researcher is struck by a parallel between clinicians' individual professional development and the development of theory across the field. Chapter IV presents participants' assertion that novice clinicians are likely to hold more strictly to a uniform set of orthodox practice traditions (e.g. aiming for neutrality with all clients), while experienced clinicians can refer to diverse sets of theory and accumulated practice wisdom in order to individualize practice decisions on a case-by-case basis. Theoretical knowledge is not rejected by the experienced clinician, but it may inform and inspire individualized treatment decisions, rather than dictating unvarying rules. Similarly, the field of psychodynamic theory began with a uniform acceptance of Freudian *drive/structure* ideals, but has since expanded and diversified to include Object Relations, Self Psychology, Relational theory models, and others. Like an experienced clinician, the "matured" field of psychodynamic practice no longer suggests a rigid set of practice behaviors, as much as a way of thinking and approaching human problems. The research advisor, Roger Miller, asserts that the utility of psychodynamic theories lies not in their reflection of objective reality, but rather in their ability to guide the practitioner and allay her anxieties. Clinical work is, as Roger says, "hazardous to one's health," and psychodynamic theory serves as a compass for clinicians, giving them an organizing framework with which to process and understand complex clients and the nuances of treatment relationship. The development of clinical relationships and insight, and consequential

therapeutic change, seems to require that clinicians have some point of mooring and organization from which to make sense of the quagmire of human life, regardless of the specifics of the theory. While neutrality may have been over-valued in early psychodynamic work, and for many clinicians and theorists its meaning and role have shifted away from the classical Freudian definition, the researcher sees the value of studying neutrality as a cornerstone of theory, as one foundation of an organizing framework.

Strengths of the Study Methodology

Pleased with the number of participants who responded to recruitment efforts, the researcher feels that the online surveying methodology employed by this study was well-suited to the aims of the project. The decision to use a primarily quantitative internet survey, rather than direct interviews, facilitated the participation of a large number of SCSSW graduates in the research, making it possible to conduct a systematic analysis of cohort changes. It would not have been possible to collect data from a large enough sample to investigate differences in cohorts through interviewing, given the timeframe and scope of this project; however, given the challenges of condensing theoretical and practical matters into a meaningful quantitative form, the researcher does see that there would be value in conducting interviews on this topic. Interviews would yield more sophisticated and nuanced data, and this research has suggested that practitioners' decisions about neutrality require contextualization. Future qualitative research regarding the role of neutrality in SCSSW graduates' training and current practice is indicated.

The high response rate from the recruitment pool (11.17%) and enthusiastic responses of participants suggest that the issue of neutrality is relevant and meaningful to practicing clinicians, and that participants found the survey thought-provoking. When participants were asked for any further comments on the survey's content and process as they completed it, one

wrote, "I enjoyed the questions. It is nice to talk about how the work gets done." Another responded, "I love the intermingling of essentially philosophical questions with 'how we practice' questions -- thanks for the mental exercise!" And a third reported, "The survey has helped me to think more about my views on the subject of neutrality." The researcher had hoped that the survey would benefit participants by inspiring reflection on their practice, and the comments above suggest that the study was successful in that endeavor.

Limitations of the Study

The ambiguity of language

Inherent in any empirical study of clinical work, the vagueness and individual interpretation of language presents a complication. Fonagy describes this problem:

Perhaps in order to accommodate proliferating ideas, the definition of theoretical terms has been left vague... This is neither unusual nor easily avoided. It is the way that human language and all human conceptual systems deal with the complexity of the phenomena we require them to signify... However, the absence of operational definitions can encourage fragmentation, and can also obscure important differences between theoretical approaches. (2003, p.289)

The problem of the ambiguity of language is particularly pronounced in the case of the word "neutrality," a term which is redefined by a variety of theorists and can imply a set of attitudes, or behaviors, or both. The classically neutral *drive/ structure* clinician aims for guarded, anonymous behavior and unbiased, nonjudgmental attitude. The neutral position promoted by *relational/ structure* theorists contradicts the earlier definition, instead requiring the clinician to strike a balance between the client's tendency to see the clinician as an old bad object, and the client's growing capacity to experience the clinician as a new good object. For the purpose of

this survey, the classical definition of neutrality was employed because it was assumed that this was the definition most participants would be familiar with. The survey's working definition of neutrality was clarified for participants in the letter of consent, yet the definition seems not to have been sufficiently clear or visible, as multiple participants expressed uncertainty about the term. For example, one participant commented on the survey that she was, "not sure what your definition of 'neutrality' and 'impartial' are here. Blank slate-ness? Allowing [the] client to decide their own fate?" Because the ambiguity of survey terminology likely resulted in participants inserting their own subjective understandings of neutrality and its components, and participants' personalized definitions are unknown, the results of the study may be skewed. Further research might ask participants for their own definitions of neutrality, as well as aiming to be clearer and more precise about the researcher's operational definition of the term.

The cross-sectional nature of the study

In addition to the complication of the vagueness of language, another potential limitation of this study's methodology results from its cross-sectional study of changes over time. Because of the time frame available for conducting this study, participants were only asked to complete one online survey, which covered questions about their education at SCSSW as well as questions regarding their current practice. The sample included participants who had graduated up to 30 years ago, and as human memories are imperfect, it is likely that those reporting on their education in the distant past do not remember it as clearly, or as accurately, as recent graduates. It must also be noted that graduates from the earlier eras not only received a qualitatively different education at SCSSW than more recent cohorts, but they have also had significantly more time and experience practicing in the field, and are, on average, older-- all factors which likely impact their use-of-self.

Participants' subjective interpretation of their practice

In considering the accuracy of participants' reporting, the researcher is aware that participants' statements about their clinical practice are subject to their interpretation. If data for this study had been collected through the researcher's direct observation of participants' sessions (which would have significantly reduced the possible number of participants), the researcher might have recorded different responses than participants expressed. For example, item 16 asks whether participants keep their "personal opinions and circumstances completely outside the therapy," and 38.2% of the sample responded that they do. From the researcher's post-modern perspective, participants cannot really stand outside their own circumstances in order to answer this question, nor does the researcher believe it is possible for clinicians to eliminate the impact of their opinions and circumstances on their interactions with clients; however, had the research been conducted by someone else, clinical practices would have been observed through different lenses and recorded in an alternative manner. The inherent subjectivity of clinical observation means that data are necessarily influenced by those who participate, and therefore do not reflect any kind of objective description.

The problems of the quantitative scale

Although the research methodology was designed to gather quantitative data from participants for the purpose of synthesizing responses from a large number of participants, the quantitative Likert scales employed by the survey also dictated and limited the kinds of information that could be expressed by participants. Participants were asked to report on their practice in a generalized way, and several stated that this was a challenge, potentially leading to oversimplification. Many participants reported that their practice stance fluctuates case-by-case, as well as over time with the particular client, as the client's needs change; numerical responses

were not able to capture the nuances and context of treatment decisions. One participant commented at the end of the survey, “I will say that it was very difficult to put numbers to these questions. I adapt my work to each client and so some of these answers might vary situationally. But I tried to answer by averaging it all out.” Another participant agreed, “I would like to have answered most of these questions, ‘It depends.’” A third participant suggested that the study might have been better conducted using qualitative measures and indicated that the topic was interesting enough that she would have been willing to volunteer the additional time that qualitative interviewing would have required. While I understand that a qualitative study would have allowed for greater subtlety in the data collection, some generalization is required for larger scale research; one of the purposes of research is to identify patterns, and this cannot be done with exclusive focus on variation on a case-by-case basis. Abundant single case examples regarding the context for clinicians’ decisions about neutrality and use-of self can already be found in the psychodynamic literature, and the dearth of larger-scale, more generalized research informed the decision to employ a quantitative scale for this project.

The quantitative scale posed a different set of problems on questions related to treatment theories, such as item 33, which asked participants to identify whether therapeutic change is made possible by new insight or new relational experience. Because the survey format forced participants to condense multifaceted beliefs into numerical form on the 1 to 5 Likert scale, when participants wanted to endorse both ends of the scale, they reported resorting to selecting the “neutral” answer of “3.” One participant explained, “So many of the questions cannot be answered as either/or, such as our work being governed by intuition or systematic thinking. I hope my choice of the number "3" in this and similar questions conveys my belief that both are operational factors.” Another wrote, “By putting my beliefs squarely in the middle, that does not

minimize my strong beliefs in both the intuitive processes of therapy and the need to rely on science, especially brain research, in therapy as well... Lots of paradoxes..." While the researcher had expected that some participants would want to contextualize their quantitative responses and therefore provided the opportunity for narrative response at the end of the survey, I had not anticipated participants' frustration with the dichotomous choices presented. One wrote, "It seems many of these ideas are set up as though it is an either/or but I disagree with that." The most extreme example of displeasure with the survey format was expressed by a participant who stated, "Some of the ways that these questions are structured is disturbing and supposes that important aspects of psychotherapy are mutually exclusive." As I reflect on participants' comments, I agree that the Likert scale suggests falsely that ends of the spectrum are mutually exclusive rather than complementary choices. As one participant explains, "insight is typically unhelpful without an (emotional) relational experience. I see both as necessary and related." Intersubjective theorist Robert Stolorow upholds the same belief, suggesting that interpretation is most likely to lead to therapeutic change when it is experienced as developmentally-appropriate attunement in the context of an authentic affective relationship (2004). Contemporary intersubjective theorists posit that the intrapsychic focus of the *drive/structure* model is not negated, but rather contextualized, by the interpersonal emphasis of the *relational/structure* models. Stolorow explains:

Once the psychoanalytic situation is recognized as an intersubjective system, the dichotomy between insight through interpretation and affective bonding with the analyst is revealed to be a false one... The analyst's transference interpretation, in other words, are not disembodied transmissions of insight *about* the analytic relationship; they are an inherent, inseparable component *of* that very bond. (2004, p. 11)

In future investigation of neutrality, the researcher would not use the Likert scale format for questions about psychodynamic philosophy or about factors that contribute to therapeutic change. The researcher sees that the current format of the Questioning Neutrality Survey reinforces dichotomous thinking, whereas she would prefer that her research promote integrative thinking. With the intention to advance integrative thinking, further research in this vein might ask participants, “How do you use insight and interpretation as part of the client’s corrective experience?”

The limitations of sample diversity

As was noted in the Findings chapter, racial/ ethnic diversity of the sample was unfortunately limited, reflective of the larger SSW alumni population. Gender distribution of the sample also reflected the heavily female composition of the SSW alumni population and social work profession. The researcher could have made greater effort to recruit People of Color, males, and transgender individuals into the study, leading to a more diverse sample, but such efforts may have rendered the sample less representative of the study population. A further limitation of sample diversity resulted from the high representation of recent graduates; fifty-seven percent of the sample graduated during the past decade, while class size has remained fairly stable throughout the time period studied. Efforts to recruit more early graduates would have made for a more representative sample and may have required phone contact, as the researcher hypothesizes that earlier graduates may be less familiar with internet surveying.

Recommendations for Further Research

This research project was undertaken as a quantitative study in part because the literature was notably lacking in comprehensive empirical research regarding generalized trends in the practice of neutrality in psychodynamic clinical work. Even the single example of quantitative

research regarding neutrality located by the researcher, Sandell and colleagues' article, investigated the relationships between therapist attitudes and outcomes of particular clients' cases, rather than probing the "generalized case" (2006). This research process has revealed that there are significant reasons for other researchers' decisions to employ qualitative methods and single-case study examples when studying neutrality-- reasons which this researcher did not fully consider while planning the project. Qualitative interviewing and case studies enable researchers to convey the individualized context of their practice decisions; many participants of this study have indicated the importance of context in their decisions about neutrality. Because of the quantitative scales employed by this study, the research was only able to capture anecdotal data regarding the context and nuance of practice decision. Much of the interesting and meaningful data was yielded by the survey's two qualitative items. For example, several participants noted the relevance of their clients' age in determining clinicians' use-of-self. Participants observed that work with children, teens, and families often requires clinicians to be more personal and direct, and it would be useful to explore the role of neutrality in working with these populations more systematically.

In order to build on the cohort-specific research of neutrality training and ongoing practice ideals conducted in this study, this researcher would like to conduct qualitative interviews of several alumni from each graduation era, as defined in this project (e.g. 3 participants from 1980- 1985, 3 more from 1986-1990, etc.). In conducting a qualitative study of neutrality in the future, this researcher would be particularly interested in inquiring about which aspects of the SSW curriculum were formative in participants' thinking about neutrality and use-of-self (e.g. the role of supervision). I am also curious about which elements of neutrality participants have struggled with.

In summary, future research on the topic of neutrality should consider and address the following concerns which emerged from this project:

1. Terminology should be clear to participants; define the term neutrality and ask for participants' definitions.
2. Quantitative scales cannot capture the nuance of practice decisions regarding neutrality, which may make qualitative interviewing and case study examples more meaningful and germane.
3. The Likert scale format promotes thinking in terms of dichotomous choices, making this method inappropriate for questions about factors that contribute to therapeutic change.
4. Further research is indicated regarding experiences that have been formative in clinicians' thinking about neutrality (e.g. how a supervisor's use-of-self is internalized), as well as factors that impact particular practice decisions with respect to neutrality (e.g. a client's age and developmental needs).

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APPENDIX A

Human Subjects Review Committee Approval Letter



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

January 29, 2012

Shoshanna Brady

Dear Shoshanna,

You did a very nice and thoughtful job of responding to the requirements and suggestions. On your one remaining question, I think your response is fine, but you do realize that you cannot answer an underlying question as to where neutrality comes from if you do not make that link directly between practice and education in your questions as there are other forms of education and supervision and learning since graduation. Most of what I learned as a clinician did not come from school - that was only the beginning.

If you do not want to make any additional changes, your revisions are accepted and you are ready to get started. If you want to make revisions, please send those in for approval before you begin.

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:

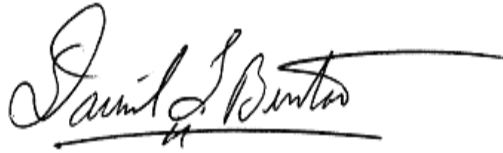
Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

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.

Best of luck with a very interesting study!

Sincerely,

A handwritten signature in black ink, reading "David L. Burton". The signature is written in a cursive style with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Roger Miller, Research Advisor

APPENDIX B

Recruitment Announcement

Neutrality in the contemporary clinical encounter: Where do you stand?

If you graduated between and 1981 and 2011 and currently work in a mental health setting, you may be eligible to participate in a research study that explores clinicians' attitudes about the role of neutrality in clinical work. If you choose to participate, you will have the opportunity to reflect on the role of neutrality in your work, including your use of self-disclosure and countertransference. Participants will complete a quantitative survey online, which is completely anonymous and is expected to take less than 15 minutes. In addition to helping me fulfill the thesis requirement, this study will contribute to the body of knowledge on contemporary clinical ideals, hoping to improve social work education at Smith and thereby enhance clinicians' ability to best serve clients.

Please click on the following link to access the survey:

<https://www.surveymonkey.com/s/QZZDJJJ>

If you have any questions or would like more information, please contact me at



Thank you,

Shoshanna Brady, M.S.W. Candidate, SCSSW

APPENDIX C

Letter of Consent

Dear Participant,

I am a second-year student in the Smith School of Social Work program working on the research for my Master's thesis project. My study investigates therapists' attitudes about clinical neutrality. For the purpose of this study, I am defining neutrality in terms of clinicians' impersonal, unbiased attitude and guarded, non-revealing behavior. I want to find out whether currently practicing clinicians hold neutrality as a clinical ideal and whether attitudes about neutrality originate in participants' educational experience at Smith SSW. The data I collect will be used for my MSW thesis, as well as for possible later publication and presentation.

If you are interested in being part of the study, participation will involve taking an anonymous online survey, which is expected to take less than 15 minutes. I am looking for participants who graduated from Smith SSW between the years of 1981 and 2011 and are currently working in the field of mental health.

A potential benefit of participation in this study is the possibility of gaining a new perspective on neutrality. Participation might inspire you to reflect on the implications of neutrality in your clinical practice; however, participants are encouraged to consult relevant literature and/ or supervision before adopting new practices. An additional benefit of participation is the opportunity to contribute to the development of knowledge about contemporary psychodynamic practice. This knowledge, in turn, can facilitate improvements in clinical education and enhance our ability to serve clients.

I want you to know that I value your privacy and that you will remain completely anonymous throughout the process of participation. SurveyMonkey technology will record your responses online, and identifying information will not be collected. I will analyze the data in its anonymous form, and this data will also be accessible to my research advisor and statistics consultant, both members of the Smith staff. When data is presented for public presentation or publication, information about groups of study participants will be revealed, without identifying individual responses. As required by federal guidelines, all data will be kept securely for 3 years, using a password on my computer and my SurveyMonkey account; at that point the data will be destroyed or, if I still need it, I will continue to keep it securely until it is destroyed.

Please be assured that participation in this study of clinical neutrality is completely voluntary.

You may refuse to answer any question(s) included in the survey for any reason. You may also choose to discontinue the survey entirely; however, once the survey has been completed and submitted, I will not be able to remove any individual's contribution to the data set because records will be kept anonymously. If you have questions or concerns about the nature of participation or withdrawal, your rights as a participant, or any other aspect of the study, please

do not hesitate to contact me by email at [REDACTED] or phone at [REDACTED].

Questions and concerns can also be directed to the Chair of the Human Subjects Review Committee at Smith College School for Social Work at 413-585-7974.

Feel free to print this page if you would like to keep a copy of the terms of participation for your records.

By clicking "I agree" below, you are indicating that you have read and understand the above information and that you have had the opportunity to ask questions about the study, your participation, and your rights and that you agree to participate in the study.

APPENDIX D

Questioning Neutrality Survey

Screening Questions

1. Did you graduate from Smith College School for Social Work between the years of 1981 and 2011?
2. Are you currently working in the field of mental health?
3. Letter of consent (see Appendix C: Letter of Consent)

Demographic Questions

4. Year of graduation _____
5. Gender Male, Female, Transgender
6. Race/ Ethnicity

Check all categories with which you identify:

American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Hispanic or Latina/ Latino, Other

7. Practice setting

Choose one primary practice setting:

Day Treatment Facility, Inpatient Unit, Medical Social Worker at Hospital, Outpatient Clinic, Private Practice, Residential Program, School, Other _____

8. Practice Modality

Thinking of your current caseload, what percentage of your work is with:

Individuals, Couples, Families, Groups

9. Age of clients

Again, thinking of your current caseload, what percentage of your work is with:

Children (0-12), Adolescents (13-18), Young adults (19-30), Adults (31-64), Older adults (65+)

Quantitative Questions

(Respondents scored items 10- 12 and 14- 30 below using a 5 point Likert scale of degree of agreement; a score of 1 indicated “Agreement,” and 5 indicated “Disagreement,” as demonstrated for Item 1. Items 31-37 were scored on their own 5 point scales, the end points of which are given for each question, as demonstrated for Item 31. Items 13 and 38 asked for a narrative response. All questions were optional.)

Origin of Beliefs

10. I was taught at Smith SSW that I should strive for an impartial attitude with regard to clients.

| | | | | |
|-------|---|---|---|----------|
| 1 | 2 | 3 | 4 | 5 |
| Agree | | | | Disagree |

11. I was taught at Smith SSW that I should aim for anonymous behavior with clients.

12. The role of neutrality in my work has changed since my time at Smith.

13. If so, please explain what changes have occurred and what experiences have contributed to the change (e.g. an influential book you read, participation in continuing education, lived experience working with clients, etc.).

Self-disclosure

14. I express my own feelings in sessions.

| | | | | |
|-------|---|---|---|----------|
| 1 | 2 | 3 | 4 | 5 |
| Agree | | | | Disagree |

15. Therapists should not answer clients’ questions about the therapist’s personal life.

16. I keep my personal opinions and circumstances completely outside the therapy.

17. I have used self-disclosure as an effective intervention.

Transference/ Countertransference

18. When clients develop an attachment to me, this generally advances our therapeutic work.

- 19. My countertransference is an important instrument in my work.
- 20. I aim to be a “blank screen” in order to elicit clients’ projections.
- 21. I aim to be a “blank screen” in order to minimize the impact of my personal material on the therapeutic relationship.

Bias

- 22. I believe that my personal opinions inevitably influence my interactions with clients, even when I don’t intend them to.
- 23. I do best with clients who are similar to myself.
- 24. With practice, I become a more objective clinician.

Directiveness

- 25. When clients seek answers about what they should do in a particular dilemma, I tell them how I might handle the situation.
- 26. It is generally not appropriate to give concrete advice to clients.

Supportiveness/ expressed care

- 27. It is important to convey hope to the client.
- 28. I am eager for the client to achieve his/ her life goals.
- 29. The client should feel an underlying sense of being liked by the therapist.
- 30. I aim to offer clients validation.

Belief in the character of human behavior

- 31. Human behavior is governed by ... free will/ uncontrollable factors.

1 2 3 4 5

Free will

Uncontrollable factors

- 32. Human behavior is governed by... external, objective factors/ internal, subjective factors.

Belief in the nature of therapeutic change

33. Psychotherapeutic change is made possible by... new insight/ new relational experience.
34. Psychotherapeutic work is governed by ... conscious processes/ unconscious processes.
35. Psychotherapy may be described as... a form of art/ a science.
36. Psychotherapeutic work is governed by... intuition/ systematic thinking.
37. Psychotherapeutic work is governed by... relativistic views/ absolute convictions.
38. Would you like to share any comments about the content or process of this survey, or any further thoughts that have come up during the process?

APPENDIX E

Letter of Permission to Use TASC 2

9/13/11

Dear Shoshanna,

Thanks for your interest in the TASC scales. Your idea sounds interesting - although you no doubt realize that the alumnis in the 80s and 90s have changed in the meantime because of the relational development. Do you plan to ask them to retrospect?

Anyway, feel free to use whatever parts of the attached questionnaire you feel relevant.

Good luck and keep me informed, please!

Kind regards,

Rolf

Rolf Sandell

Professor

Sandhamnsgatan 39

115 28 Stockholm

Sweden

APPENDIX F

Table 1: Frequencies of Cumulative Neutrality Scores

| | | Frequency | Percent | Cumulative Percent |
|-------|------|-----------|---------|-----------------------|
| Valid | 2.12 | 1 | .4 | .4 |
| | 2.47 | 1 | .4 | .9 |
| | 2.59 | 1 | .4 | 1.3 |
| | 2.65 | 1 | .4 | 1.8 |
| | 2.71 | 1 | .4 | 2.2 |
| | 2.76 | 1 | .4 | 2.7 |
| | 2.81 | 2 | .8 | 3.6 |
| | 2.88 | 3 | 1.1 | 4.9 |
| | 2.94 | 3 | 1.1 | 6.3 |
| | 3.00 | 1 | .4 | 6.7 |
| | 3.06 | 8 | 3.0 | 10.3 |
| | 3.06 | 1 | .4 | 10.7 |
| | 3.12 | 5 | 1.9 | 12.9 |
| | 3.18 | 12 | 4.5 | 18.3 |
| | 3.24 | 9 | 3.4 | 22.3 |
| | 3.25 | 1 | .4 | 22.8 |
| | 3.29 | 8 | 3.0 | 26.3 |
| | 3.35 | 4 | 1.5 | 28.1 |
| | 3.38 | 2 | .8 | 29.0 |
| | 3.41 | 13 | 4.9 | 34.8 |
| | 3.47 | 19 | 7.2 | 43.3 |
| | 3.50 | 1 | .4 | 43.8 |
| | 3.53 | 7 | 2.7 | 46.9 |
| | 3.59 | 14 | 5.3 | 53.1 |
| | 3.65 | 14 | 5.3 | 59.4 |
| | 3.71 | 13 | 4.9 | 65.2 |
| | 3.76 | 13 | 4.9 | 71.0 |
| | 3.82 | 16 | 6.1 | 78.1 |
| | 3.88 | 14 | 5.3 | 84.4 |
| | 3.94 | 4 | 1.5 | 86.2 |
| | 4.00 | 6 | 2.3 | 88.8 |
| | 4.06 | 5 | 1.9 | 91.1 |
| | 4.12 | 5 | 1.9 | 93.3 |
| | 4.18 | 4 | 1.5 | 95.1 |
| | 4.24 | 1 | .4 | 95.5 |
| | 4.29 | 3 | 1.1 | 96.9 |
| | 4.35 | 3 | 1.1 | 98.2 |
| | 4.41 | 2 | .8 | 99.1 |
| | 4.47 | 1 | .4 | 99.6 |
| | 5.00 | 1 | .4 | 100.0 |

| | | | | |
|-------|--------------|--------------|------|--|
| Total | Total 264 | 224 100.0 | 84.8 | |
| | | | | |

Participants' cumulative neutrality scores were measured on a scale of 1 to 5, with "1" indicating strict adherence to classical neutrality, and "5" indicating loyalty to relational practices.

Cumulative neutrality scores were determined by averaging the scores from survey items 14- 22, 24-30, and 33. Items 14, 17- 19, 22, 25, and 27- 30 were reverse scored (i.e. a score of "1" on these items was equivalent to a "5" on other items, and vice versa).

APPENDIX G

Table 2: Descriptive Statistics of Neutrality Subcategories

| | | Self-disclosure | Transference | Directiveness | Supportiveness |
|----------------|---------|-----------------|--------------|---------------|----------------|
| N | Valid | 224 | 224 | 223 | 223 |
| | Missing | 40 | 40 | 41 | 41 |
| Mean | | 3.3672 | 3.8765 | 2.3744 | 4.3733 |
| Median | | 3.5000 | 3.7500 | 2.5000 | 4.5000 |
| Std. Deviation | | .72236 | .60660 | .85552 | .57337 |
| Variance | | .522 | .368 | .732 | .329 |
| Minimum | | 1.25 | 2.50 | 1.00 | 2.25 |
| Maximum | | 5.00 | 5.00 | 5.00 | 5.00 |

Neutrality subcategory scores were measured on a scale of 1 to 5, with “1” indicating strict adherence to classical neutrality, and “5” indicating loyalty to relational practices. Subcategory scores were determined by averaging participants’ responses to all items within the given survey section. Items 14-17 referred to self-disclosure, while items 18-21 referenced issues transference. Items 25 and 26 referred to directiveness, and finally, items 27- 30 referred to supportiveness. Items 14, 17- 19, 22, 25, and 27- 30 were reverse scored (i.e. a score of “1” on these items was equivalent to a “5” on other items, and vice versa).

APPENDIX H

Table 3: Correlations between Graduation Era and Neutrality Training

| | | grad year in categories | taught at SSW should aim for anonymous behavior (1 agree to 5 disagree) |
|-------------------|----------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------|
| Spearman's rho | grad year in categories | Correlation Coefficient | 1.000 |
| | | Sig. (2-tailed) | .007 |
| | | N | 222 |
| | taught at SSW should strive for impartial attitude (1 agree to 5 disagree) | Correlation Coefficient | .211** |
| | | Sig. (2-tailed) | .002 |
| | | N | 223 |
| | taught at SSW should aim for anonymous behavior (1 agree to 5 disagree) | Correlation Coefficient | .180** |
| | | Sig. (2-tailed) | .007 |
| | | N | 222 |

** . Correlation is significant at the 0.01 level (2-tailed).

Spearman's rho was used to test the relationship between era of graduation and training in neutrality (items 10 and 11). A very weak positive correlation was found between era of graduation and item 10: "I was taught at Smith SSW that I should strive for an impartial attitude with regard to clients." (rho=.211, p=.002, two-tailed). A positive correlation suggests that graduates from more recent eras disagree more with item 10. Again, a very weak positive correlation was found between era of graduation and item 11: "I was taught at Smith SSW that I should aim for anonymous behavior with clients." (rho=.180, p=.007, two-tailed). A positive correlation suggests that graduates from more recent eras disagree more with item 11. Both of these findings suggest that training in classical neutrality has waned over the past 30 years, but the changes have not been dramatic in their social significance.

APPENDIX I

Table 4: Correlations between Graduation Era and Adherence to Neutrality

Spearman's Rho

| | | | Grad year by era | Self-disclosure | Transference | Directiveness | Supportiveness |
|------------------|------------------|-------------------------|------------------|-----------------|--------------|---------------|----------------|
| Spearman's rho | Grad year by era | Correlation Coefficient | 1.000 | .033 | .053 | -.015 | .087 |
| | | Sig. (2-tailed) | . | .631 | .434 | .823 | .199 |
| | | N | 235 | 221 | 221 | 220 | 220 |
| Neutrality score | Neutrality score | Correlation Coefficient | .051 | .712** | .615** | .530** | .492** |
| | | Sig. (2-tailed) | .453 | .000 | .000 | .000 | .000 |
| | | N | 221 | 224 | 224 | 223 | 223 |
| Self-disclosure | Self-disclosure | Correlation Coefficient | .033 | 1.000 | .263** | .280** | .127 |
| | | Sig. (2-tailed) | .631 | . | .000 | .000 | .059 |
| | | N | 221 | 224 | 224 | 223 | 223 |
| Transference | Transference | Correlation Coefficient | .053 | .263** | 1.000 | .147* | .143* |
| | | Sig. (2-tailed) | .434 | .000 | . | .028 | .032 |
| | | N | 221 | 224 | 224 | 223 | 223 |
| Directiveness | Directiveness | Correlation Coefficient | -.015 | .280** | .147* | 1.000 | .190** |
| | | Sig. (2-tailed) | .823 | .000 | .028 | . | .004 |
| | | N | 220 | 223 | 223 | 223 | 223 |
| Supportiveness | Supportiveness | Correlation Coefficient | .087 | .127 | .143* | .190** | 1.000 |
| | | Sig. (2-tailed) | .199 | .059 | .032 | .004 | . |
| | | N | 220 | 223 | 223 | 223 | 223 |

** . Correlation is significant at the 0.01 level (2-tailed).

No significant correlation was found when Spearman's rho was used to test the relationship between participants' era of graduation and their cumulative neutrality scores or any of the subscores.

Oneway Anova

| | | Sum of Squares | Df | F | Sig. |
|------------------|----------------|----------------|-----|-------|------|
| Neutrality score | Between Groups | 1.564 | 5 | 2.081 | .069 |
| | Within Groups | 32.332 | 215 | | |
| | Total | 33.896 | 220 | | |
| Self-disclosure | Between Groups | 3.344 | 5 | 1.335 | .251 |
| | Within Groups | 107.718 | 215 | | |
| | Total | 111.062 | 220 | | |
| Transference | Between Groups | 1.319 | 5 | .718 | .610 |
| | Within Groups | 78.935 | 215 | | |
| | Total | 80.254 | 220 | | |
| Directiveness | Between Groups | 10.240 | 5 | 2.983 | .013 |
| | Within Groups | 146.937 | 214 | | |
| | Total | 157.177 | 219 | | |
| Supportiveness | Between Groups | 2.376 | 5 | 1.457 | .205 |
| | Within Groups | 69.811 | 214 | | |
| | Total | 72.187 | 219 | | |

A Oneway Anova was also used to determine if there was a difference in neutrality scores by era of graduation. A significant difference was found in the category of Directiveness ($F(5,214)=2.983, p=.013$).

APPENDIX J

Table 5: Directiveness Sub-scores by Graduation Era

Descriptive Statistics

| | N | Mean | Std. Deviation | 95% Confidence Interval for Mean | |
|-----------|-----|--------|----------------|----------------------------------|-------------|
| | | | | Lower Bound | Upper Bound |
| 1981-1985 | 21 | 2.4524 | .92066 | 2.0333 | 2.8715 |
| 1986-1990 | 16 | 2.9688 | .99111 | 2.4406 | 3.4969 |
| 1991-1995 | 31 | 2.1774 | .78047 | 1.8911 | 2.4637 |
| 1996-2000 | 26 | 2.3654 | .85508 | 2.0200 | 2.7108 |
| 2001-2005 | 38 | 2.0921 | .83711 | 1.8170 | 2.3673 |
| 2006-2011 | 88 | 2.4261 | .77881 | 2.2611 | 2.5912 |
| Total | 220 | 2.3682 | .84717 | 2.2556 | 2.4808 |

Oneway Anova

| | Sum of Squares | Df | Mean Square | Sig. |
|----------------|----------------|-----|-------------|------|
| Between Groups | 10.240 | 5 | 2.048 | .013 |
| Within Groups | 146.937 | 214 | .687 | |
| Total | 157.177 | 219 | | |

Graduates from 2001 to 2005 showed the lowest mean score in the area of directiveness (m=2.09), suggesting they give the least direct advice. Next, graduates from 1991-1995 displayed a mean score of 2.17, while graduates from the next era, 1996- 2000, showed a mean of 2.36. The most recent graduates, from 2006 to 2011, displayed a mean score of 2.43, while the earliest graduates included in the study displayed a mean score of 2.45. Graduates from 1986 to 1990 showed the highest mean score, 2.97, suggesting these participants are most comfortable giving direct advice.

APPENDIX K

Table 6: Bonferoni Posthoc Tests of Directiveness by Era

| (I) grad year in categories | (J) grad year in categories | Mean Difference (I-J) | Std. Error | 95% Confidence Interval | |
|-----------------------------|-----------------------------|-----------------------|------------|-------------------------|-------------|
| | | | | Lower Bound | Upper Bound |
| 1981-1985 | 1986-1990 | -.51637 | .27497 | -1.3326 | .2999 |
| | 1991-1995 | .27496 | .23419 | -.4202 | .9702 |
| | 1996-2000 | .08700 | .24312 | -.6347 | .8087 |
| | 2001-2005 | .36028 | .22531 | -.3086 | 1.0291 |
| | 2006-2011 | .02624 | .20124 | -.5711 | .6236 |
| 1986-1990 | 1981-1985 | .51637 | .27497 | -.2999 | 1.3326 |
| | 1991-1995 | .79133* | .25507 | .0341 | 1.5485 |
| | 1996-2000 | .60337 | .26329 | -.1782 | 1.3850 |
| | 2001-2005 | .87664* | .24695 | .1436 | 1.6097 |
| | 2006-2011 | .54261 | .22520 | -.1259 | 1.2111 |
| 1991-1995 | 1981-1985 | -.27496 | .23419 | -.9702 | .4202 |
| | 1986-1990 | -.79133* | .25507 | -1.5485 | -.0341 |
| | 1996-2000 | -.18797 | .22036 | -.8421 | .4662 |
| | 2001-2005 | .08531 | .20054 | -.5100 | .6806 |
| | 2006-2011 | -.24872 | .17307 | -.7625 | .2650 |
| 1996-2000 | 1981-1985 | -.08700 | .24312 | -.8087 | .6347 |
| | 1986-1990 | -.60337 | .26329 | -1.3850 | .1782 |
| | 1991-1995 | .18797 | .22036 | -.4662 | .8421 |
| | 2001-2005 | .27328 | .21090 | -.3528 | .8993 |
| | 2006-2011 | -.06075 | .18496 | -.6098 | .4883 |
| 2001-2005 | 1981-1985 | -.36028 | .22531 | -1.0291 | .3086 |
| | 1986-1990 | -.87664* | .24695 | -1.6097 | -.1436 |
| | 1991-1995 | -.08531 | .20054 | -.6806 | .5100 |
| | 1996-2000 | -.27328 | .21090 | -.8993 | .3528 |
| | 2006-2011 | -.33403 | .16085 | -.8115 | .1434 |
| 2006-2011 | 1981-1985 | -.02624 | .20124 | -.6236 | .5711 |
| | 1986-1990 | -.54261 | .22520 | -1.2111 | .1259 |
| | 1991-1995 | .24872 | .17307 | -.2650 | .7625 |
| | 1996-2000 | .06075 | .18496 | -.4883 | .6098 |
| | 2001-2005 | .33403 | .16085 | -.1434 | .8115 |

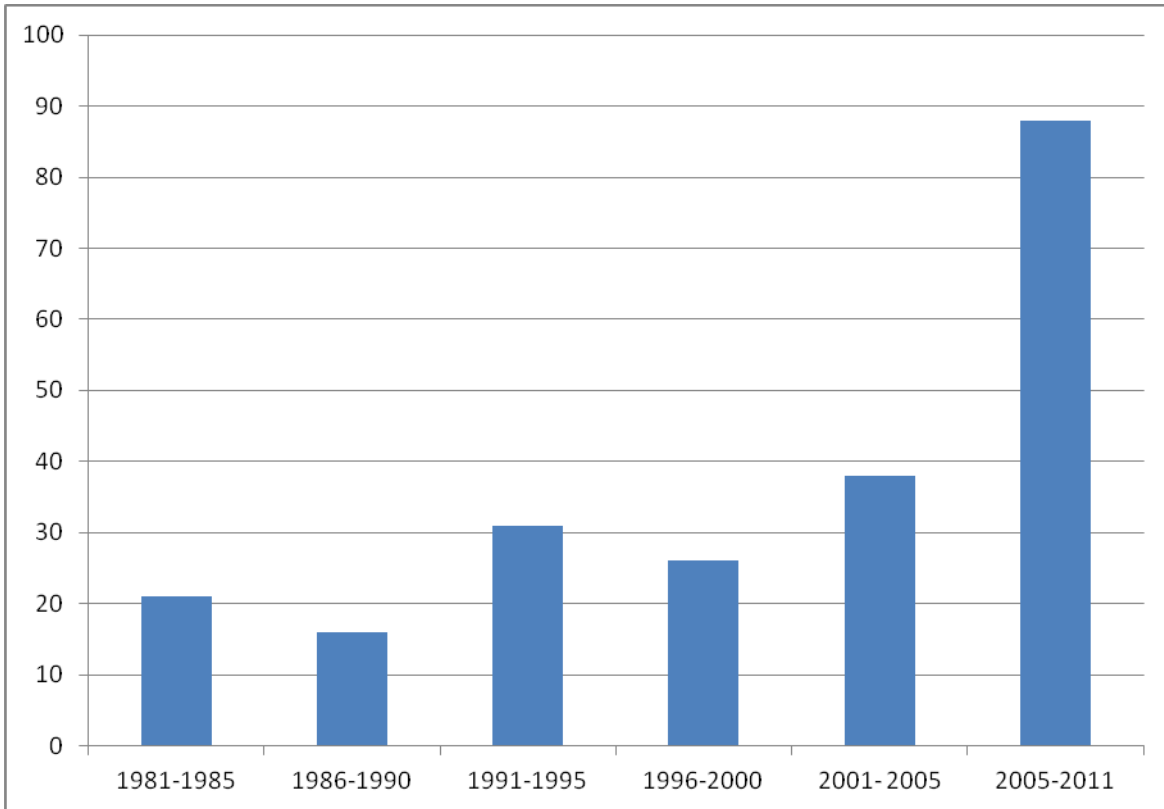
*. The mean difference is significant at the 0.05 level.

The Bonferoni post hoc test shown above indicated that the significant difference was between those who graduated in 1986 to 1990 (m=2.97) and those who graduated in 1991-1995 (m=2.18),

as well as between those who graduated in 1986 to 1990 ($m=2.97$) and those who graduated in 2001=2005 ($m=2.09$). In both cases the earlier group had a higher mean, indicating lesser adherence to neutrality (in this case it suggests they gave more direct advice).

APPENDIX L

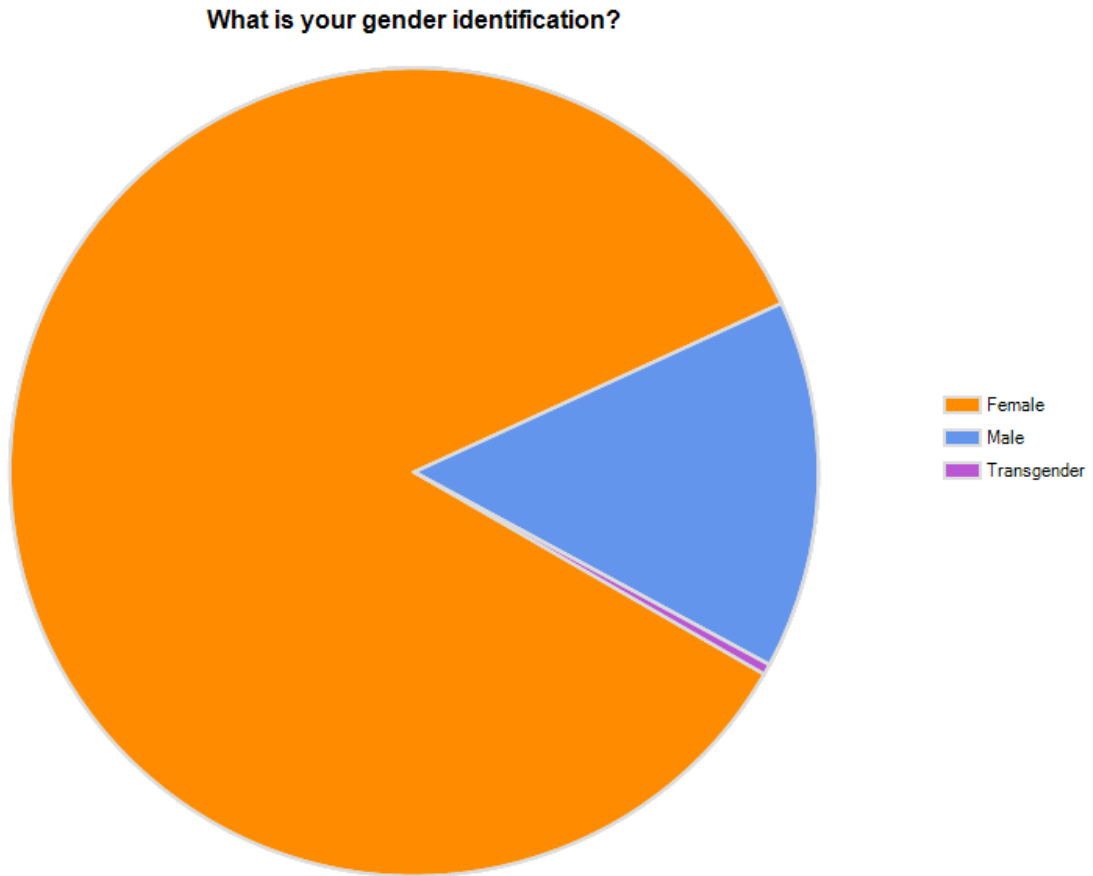
Figure 1: Participants' Era of Graduation



The composition of participants by graduation era is as follows: 1981-1985 (n= 21, 9.54%), 1986-1990 (n= 16, 7.27%), 1991- 1995 (n=31, 14.09%), 1996- 2000 (n=26, 11.82%), 2001-2005 (n=38, 17.27%), 2005-2011 (n=88, 40%).

APPENDIX M

Figure 2: Gender of Participants

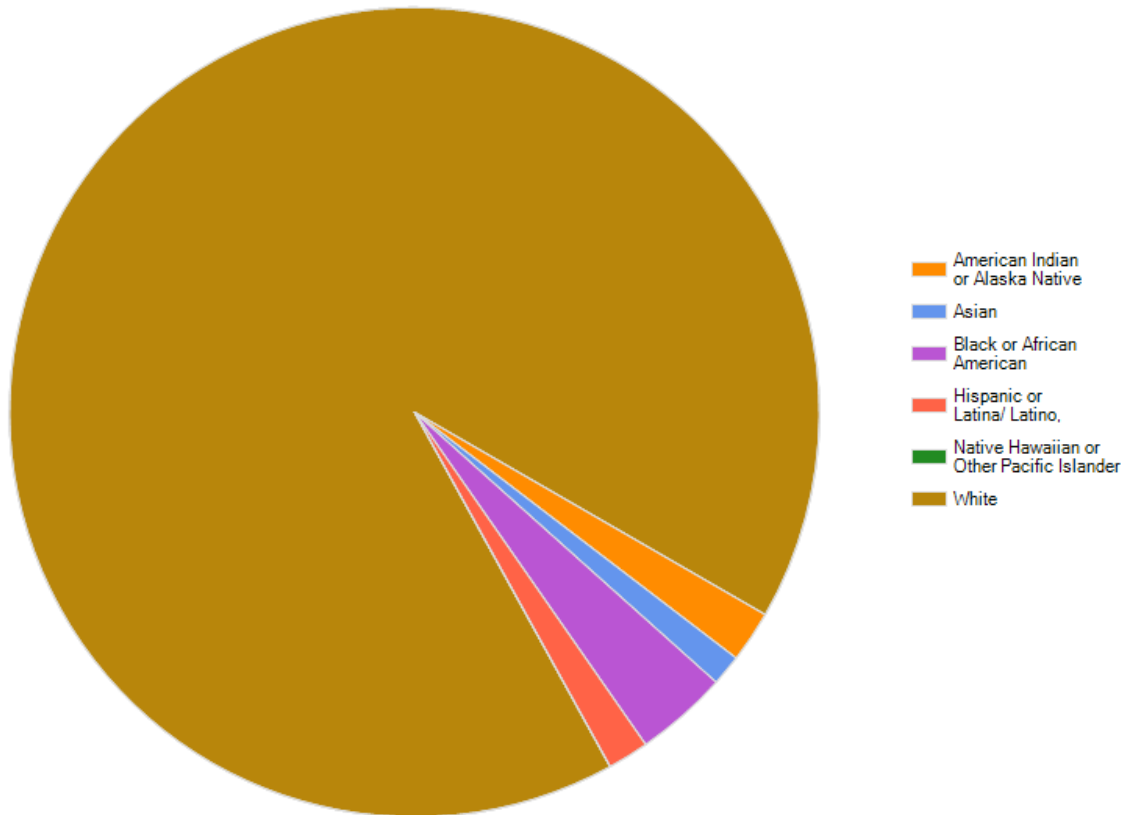


The gender of participants was as follows: Female (n=201, 84.8%), Male (n=35, 14.8%), and Transgender (n=1, 0.4%).

APPENDIX N

Figure 3: Race/ Ethnicity of Participants

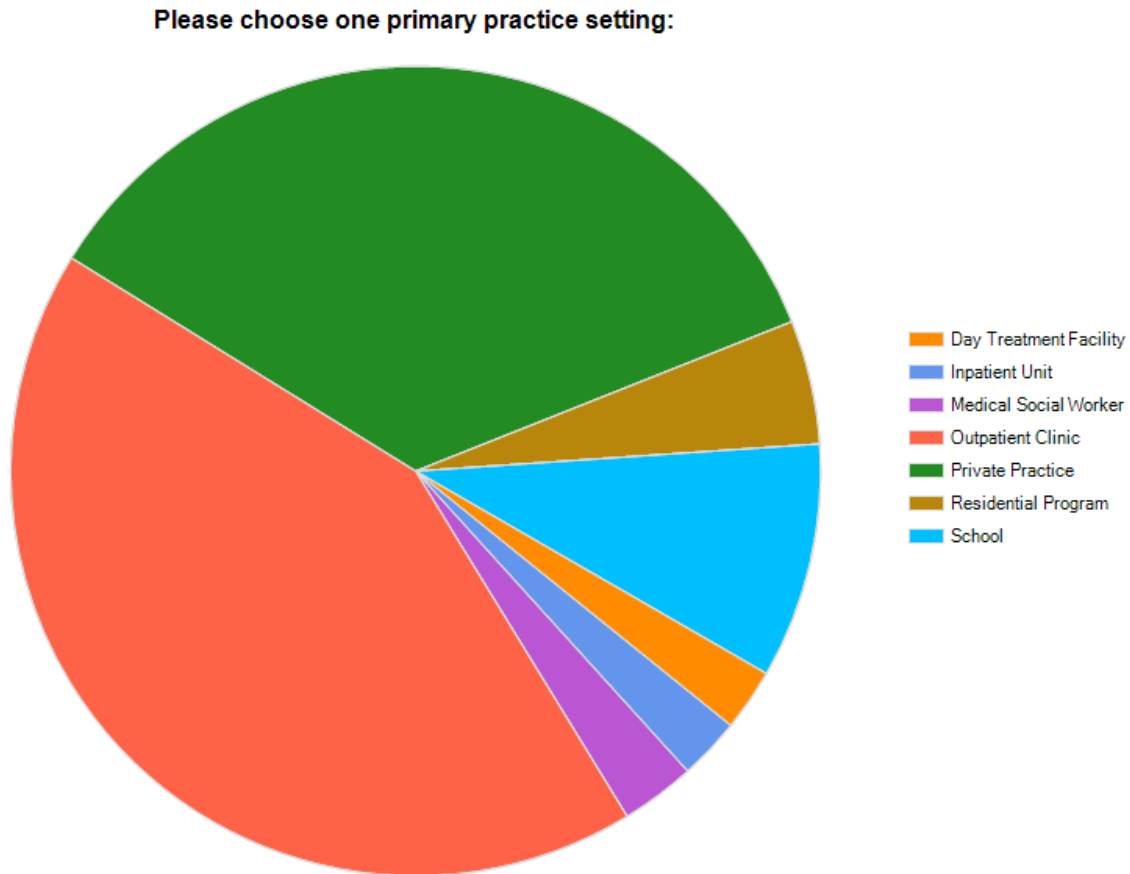
Please check all race/ ethnicity categories with which you identify:



The race and ethnicity of the sample was: American Indian or Alaska Native (n=5, 2.1%), Asian (n=3, 1.3%), Black or African American (n=9, 3.8%), Hispanic or Latino/ Latina (n=4, 1.7%), Native Hawaiian or Other Pacific Islander (n=0, 0%), and White (n=222, 94.5%). Thirteen participants responded in the Other category, 9 identifying themselves as Jewish, 3 identifying as Biracial or Mixed Race, and 1 identifying herself as the White parent of an African-American child.

APPENDIX O

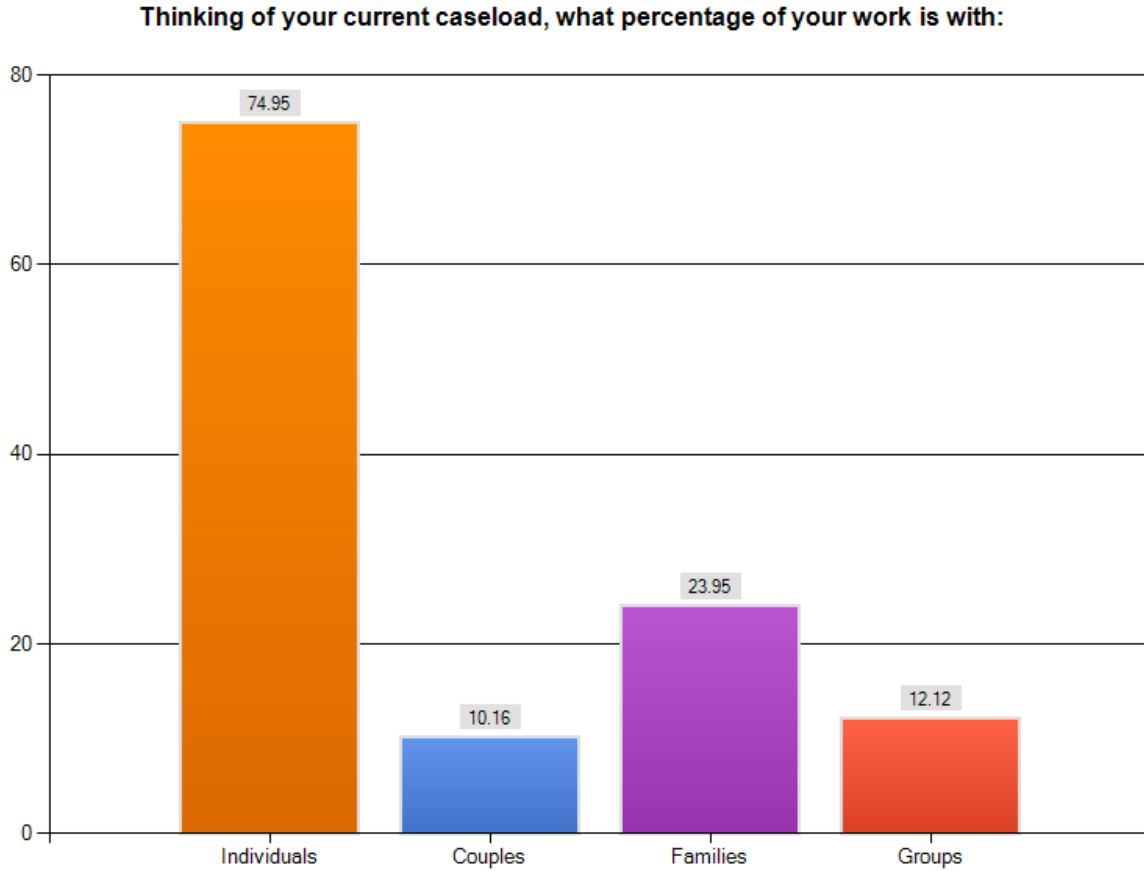
Figure 4: Practice Setting of Participants



Participants' primary practice settings were as follows: Day Treatment Facility (n=5, 2.5%), Inpatient Unit (n=5, 2.5%), Medical Social Worker (n=6, 3.0%), Outpatient Clinic (n=86, 42.6%), Private Practice (n=71, 35.1%), Residential Program (n=10, 5.0%), and School (n=19, 9.4%). Forty-four participants responded in the Other category, including those who worked in college counseling, emergency services, hospice, in-home therapy, community health clinics, and other community agencies such as an adoption, a methadone clinic, and an LGBTQ youth center.

APPENDIX P

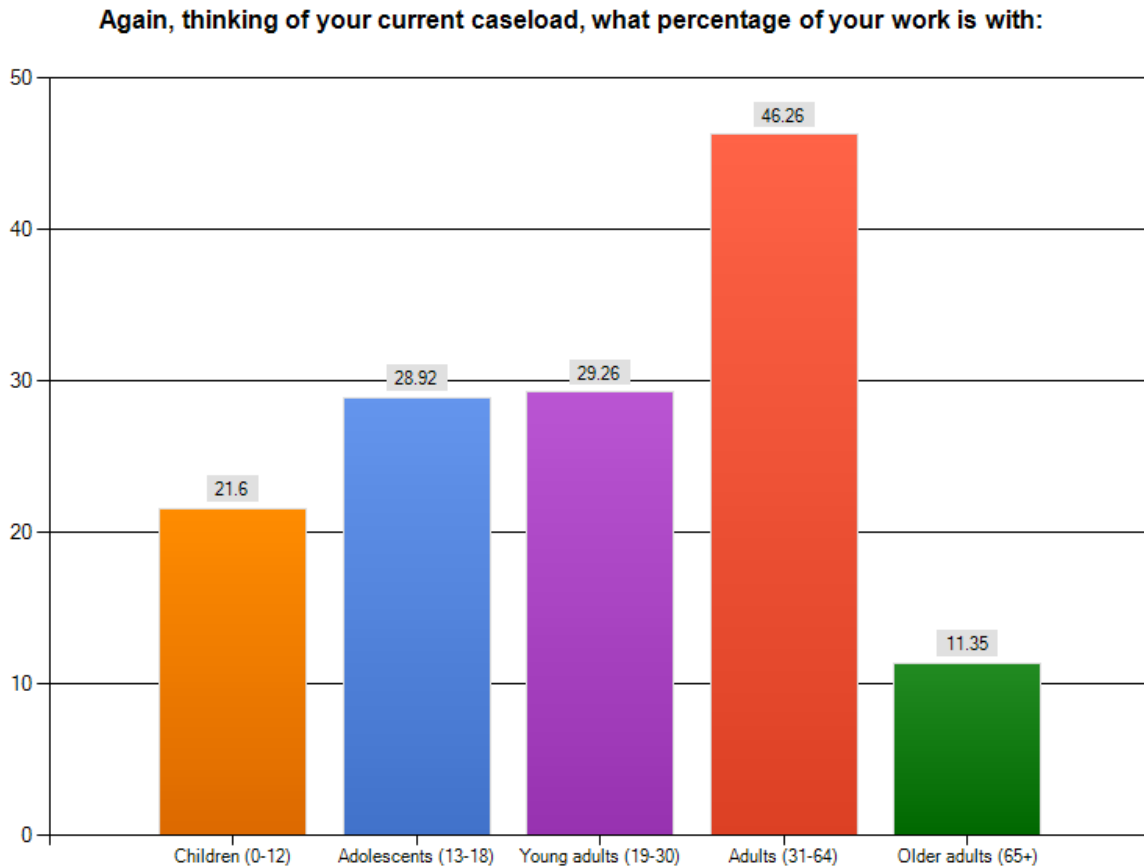
Figure 5: Practice Modalities of Participants



The following data reflects the mean scores in each category: 74.95% of participants' work is with individuals; 10.16% of participants' work is with couples, 23.95% of participants' work is with families, and 12.12% of their work is with groups.

APPENDIX Q

Figure 6: Age of Participants' Patients



The following data reflects the mean scores in each category: 21.6% of participants' work is with children aged 0-12; 28.92% of participants' work is with adolescents aged 13-18; 29.26% of participants work is with young adults aged 19-30; 46.26% of participants' work is with adults aged 31-61; and 11.35% of their work is with older adults, aged 65 and above.