

TOWARD A SECURE THERAPEUTIC BASE: THE RELATIONSHIP BETWEEN
ADULT ATTACHMENT PATTERN AND THEORETICAL ORIENTATION AMONG
CLINICAL SOCIAL WORKERS

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Dedication

To those who made this journey possible:

To my husband, thank you for the sacrifices you made in support of my dream. When the road was difficult you offered love, encouragement, perspective and levity. I am so grateful you were by my side. Thanks for taking one for the team.

To my parents, it truly takes a village. Thank you for the weekly trips to Philadelphia. Knowing p. was with you allowed me to focus on my work, thank you for that wonderful gift.

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In psychotherapy the relationship between social worker and client, or the working alliance, is thought to be the most robust predictor of therapeutic outcomes. The social worker's attachment pattern impacts his or her ability to form an effective working alliance, utilize countertransference, cope with stress and use social supports. There is insufficient focus on how social worker attachment patterns may inform the social worker's chosen theoretical orientation. Theoretical orientation serves as the foundation for clinical practice and provides a framework with which to view the client, the presenting problems and possible interventions. A theoretical orientation aligned with personal values and beliefs has been linked to job satisfaction, increased therapeutic efficacy, and reduced burnout. This study explored the relationship between adult attachment pattern and theoretical orientation among 170 clinical social workers providing psychotherapy in outpatient settings. The Experience in Close Relationships Scale (ECR-R), the Theoretical Orientation Profile Scale (TOPS-R), and the Theoretical Evaluation Self Test (TEST) were used in the online survey design. Findings highlight the large number of clinical social workers with fearful, or disorganized, attachment patterns. No relationship was found between attachment pattern and theoretical orientation, indicating that perhaps clinical social workers are not actively engaging the use of self when choosing theoretical orientations. Careful assessment of social worker attachment patterns needs to be incorporated into graduate education and ongoing clinical practice. Awareness of the social worker's attachment pattern may serve as a protective factor with regard to career satisfaction, clinical effectiveness, and reduction of burnout.

Keywords: attachment, clinical social worker, theoretical orientation, therapeutic use of self, psychotherapy

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CHAPTER 1 - INTRODUCTION

Statement of the Problem

According to the Bureau of Labor Statistics, in 2014, there were 649,300 practicing social workers in the United States. The field of social work is expected to grow by twelve percent from 2014 to 2024 (Bureau of Labor Statistics, 2014). In the United States, social workers are the largest group of clinically trained mental health professionals; sixty percent of the mental health professionals are clinical social workers, compared to 10% psychiatrists and 23% percent psychologists (NASW, 2000).

In psychotherapy, the relationship between social worker and client is thought to be the most robust predictor of therapeutic outcomes (Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Hubble, Duncan, Miller, & Wampold, 2010; Norcross, 2010; Wampold, 2010). This therapeutic relationship is co-created by the client and the social worker. A social worker's ability to form a positive working alliance, or therapeutic relationship, is directly related to the attachment pattern of the social worker (Black, Hardy, Turpin & Parry, 2005; Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002; Rubino, Barker, Roth & Fearon, 2000; Sauer, Lopez & Gormley, 2003).

Attachment patterns, born out of the infant-caregiver relationship, are thought to guide the ways in which we relate interpersonally in all future relationships throughout life (Bowlby, 1988). These patterns, or relational styles, define our interpersonal stance and comfort level with intimacy and connection (Meyer & Pilkonis, 2001). Despite the large number of clinical social workers engaging in psychotherapy and the significance of the social worker's role in establishing the therapeutic relationship, little attention has

been given to how the social worker's attachment pattern may guide his or her approach to clinical practice. Similarly, there is little attention to how a social worker conceptualizes both the client and the therapeutic relationship.

Purpose of the Study

What is your theoretical orientation? This question is invariably asked throughout a clinician's career. The answer encapsulates our values and approaches to the therapeutic process and may yield insight into how we practice as clinicians. While rigid adherence to one specific treatment modality may not be prominent (Coleman, 2004; Jensen, Bergin, & Greaves, 1990; Poznanski & McLennan, 1995; Worthington & Dillon, 2003), graduate programs in social work emphasize the use of theoretical orientation for case conceptualization and treatment planning. According to the educational policy and accreditation standards published by the Council on Social Work Education (CSWE, 2012), "social workers utilize conceptual frameworks to guide the processes of assessment, intervention, and evaluation and critique and apply knowledge to understand person and environment" (p. 4). Beyond graduate training, for career satisfaction and therapeutic efficacy, identification with one or more theoretical orientations needs to be a thoughtful and deliberate choice by the clinician (Carlson & Erickson, 1999; Cornsweet, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994; Vasco, Garcia-Marques, & Dryden).

While many social workers may identify as "eclectic" or "integrative", most usually note a few primary orientations that influence their practice (Jensen et al., 1990; Worthington & Dillon, 2003). Adoption of a theoretical orientation has been attributed to personal choices predicated on clinical experience, personal values, graduate training,

and personal and professional development experiences (Cornsweet, 1983; Norcross & Prochaska, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994). Recent research indicates that the clinician's attachment pattern predicts theoretical orientation selection (Fleischman & Shorey, 2014).

Research Question

This study explores the following question: what is the relationship between adult attachment pattern and theoretical orientation among clinical social workers providing psychotherapy in outpatient settings?

Implications

Graduate training programs in social work emphasize the importance of self-awareness, managing emotional reactions to clients, or countertransference, and using these factors to inform the therapeutic work. However graduate training programs do not tend to consider the clinician's own attachment style and how that may impact the therapeutic process and the clinician's ability to effectively use the therapeutic relationship. Increased awareness of clinician attachment patterns may highlight the potential challenges inherent in how the clinician relates interpersonally and assist clinicians in delivering competent practice.

Understanding how the clinicians' attachment patterns may impact their approach to treatment, including their selection of theoretical orientation, may enhance clinician self-awareness regarding the impact they have on therapeutic process. This may help to ensure a "goodness of fit", securing career satisfaction and improving therapeutic outcomes for clients. Incorporating awareness of clinician attachment patterns into

graduate education may enhance the clinicians' use of self in the context of the therapeutic work, benefiting the client by providing better quality of care.

CHAPTER 2 – LITERATURE REVIEW

Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler or a schoolchild but throughout his adolescence and his years of maturity as well, and into old age. (Fonagy, 2001, p. 127)

This section provides a summary of the available literature on both attachment theory and theoretical orientation. A brief history of attachment theory, attachment patterns, measures of attachment, and attachment research is included. The section also provides a brief history of theoretical orientation as it relates to the field of social work, an overview of theoretical orientations pertinent to this project, measures of theoretical orientation and theoretical orientation research.

Attachment Theory

A product of the collaborative work of John Bowlby (1907-1990) and Mary Ainsworth (1913-1999), attachment theory has since become an influential theory of human development informing parenting styles and behaviors, child welfare and social work policies and clinical social work practice. Attachment theory is a psychodynamic theory and draws from ethology, developmental psychology and psychoanalysis (Bretherton, 1992). Solidly rooted in empirical support, attachment theory is significant to clinical practice.

John Bowlby, a British psychoanalyst and child psychiatrist, dedicated his career to exploring the significance of the parent-child dyad. From his observations of a group of forty-four maladjusted juvenile boys, Bowlby (1944) posited that these boys displayed

antisocial behaviors as a direct result of maternal deprivation and disruption of the attachment bond. Bowlby (1977) defined attachment theory as the “propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise” (p. 201).

Bowlby’s conceptualization of attachment was a stark departure from the predominant view of the time. Freudians and learning theorists alike postulated that attachment was a secondary dependency drive. According to this predominant view, human bonds developed out of the infants’ motivation to seek connection with others because the reduction of drives depends on others, or in particular, the mother. The infant seeks connection in order to reduce the drive for hunger and then through this connection and satisfaction of the drive, the mother takes on secondary value (Grusec, 1992).

Contrary to this belief, Bowlby (1977) asserted that the infant is biologically motivated to seek and maintain attachments because the infant’s emotional and physical survival depends on the formation of attachment bonds. In fact, the formation of attachments was so critical, that the infant would conform to the needs and desires of his or her caregiver even if this meant adopting a false self (Slade, 2000). In other words, the infant adapts to the attachment style of the caregiver to maintain connection and proximity to the caregiver. This adaptation and accommodation to the caregiver leads to internalized patterns of defense, or internal working models, that guide future relationships and expectations of self-in-relation-to-other. These internal working models,

or attachment styles, are formed in childhood and are thought to guide the ways in which we relate interpersonally in all future relationships throughout life.

Attachment theory posits that humans possess an attachment system, which serves the “biological function of protecting the attachment individual from physical and psychological harm” (Bretherton, 1985, p. 6). The attachment behaviors, manifested as smiling, vocalizing and crying in infants, establish and maintain proximity to the caregiver. Bowlby (1977) notes poetically that, “while especially evident during early childhood, attachment behavior is held to characterize human beings from the cradle to the grave” (p. 203).

In addition to the attachment system, humans possess exploratory and fear systems. The exploratory system allows the child to venture out and explore with world, but without the presence of the caregiver, these exploratory behaviors cease. The fear system activates the attachment system and “the availability of the caregiver reduces the child’s reaction to stimuli that would otherwise be perceived as dangerous” (Fonagy, 2001, p. 9).

According to Bowlby (1977), the role of the caregiver is to “be available and responsive as and when wanted and, secondly, to intervene judiciously should the child or older person who is being cared for be heading for trouble” (p. 204). If the caregiver is able to provide this “secure base”, the child will likely develop confidence and explore his or her environment. This securely attached infant has had a secure base in which “he can return knowing for sure that he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, reassured if frightened” (Bowlby, 1988, p. 11). If, however, there is disruption in these early attachment relationships and a

secure base is not formed, this can lead to difficulty maintaining meaningful interpersonal relationships throughout life.

Ainsworth and Attachment Patterns

Mary Ainsworth began working as Bowlby's research assistant in 1950 and after moving to Uganda in the early 1950s, began her research on attachment. In Uganda, she observed infant–mother relationships of twenty-six families over a period of nine months. Returning to the United States in 1955, Ainsworth continued her observations of infant-mother attachments through her work on the Baltimore Project. As part of the Baltimore Project, Ainsworth designed the “Strange Situation” as a way to observe the interactions between a mother and child in a controlled, laboratory setting (Ainsworth & Bell, 1970).

In the “Strange Situation” the infant is placed in a room for 20 minutes. During this time, the infant undergoes a series of brief separations from his or her caregiver and the infant's behavior upon separation and reunion with the caregiver is observed. Ainsworth's observations from the “Strange Situation” provided empirical evidence to support Bowlby's ideas and led to Ainsworth's classification of three attachment styles: secure, insecure-avoidant and insecure-ambivalent (Ainsworth, Blehar, Waters, & Wall, 1978).

Ainsworth (1970) found that 65% of the infants were securely attached to their caregivers. These infants exhibited distress upon separation but were comforted when reunited with their caregiver. Securely attached infants are thought to be the product of consistent and responsive caregivers. These caregivers are emotionally attuned to the infant and respond warmly to dependency needs. As Bowlby (1988) notes, “this pattern is promoted by a parent, in the early years especially by mother being readily available,

sensitive to her child's signals, and lovingly responsive when he seeks protection and/or comfort" (p. 124).

The remaining infants Ainsworth observed were classified as having either insecure-avoidant (21%) or insecure-ambivalent (16%) attachments. The insecure-avoidant infants exhibited little distress upon separation from their caregiver and were observed to be independent. Upon reuniting with their caregivers, these infants exhibited disinterest and did not immediately seek connection with their caregivers. These infants are thought to have little confidence that their needs will be acknowledged or that they will be comforted by their caregiver, a result of "the individual's mother constantly rebuffing him when he approaches her for comfort or protection" (Bowlby, 1988, p. 125).

The insecure-ambivalent infants showed distress upon separation and, while these infants sought out connection with the caregiver when reunited, they were unable to be comforted by the caregiver. This pattern of attachment was demonstrated by the infant's uncertainty about whether the caregiver will respond to his or her needs. This attachment pattern "is promoted by a parent being available and helpful on some occasions but not on others, and by separations and...by threats of abandonment used as a means of control" (Bowlby, 1988, p. 124).

Later research, conducted by Mary Main, a student of Ainsworth, yielded the classification of a fourth attachment pattern. Through further observation and analysis of the "Strange Situation" protocol, Main and Solomon (1990) classified the fourth attachment style, disorganized attachment. Infants with a disorganized attachment exhibited inconsistent approaches to managing the stress of separation from caregivers

and exhibited fear upon reunion with caregivers. These infants are thought to fear the caregiver and may be victims of physical abuse and/or neglect.

Adult Attachment Patterns

Attachment patterns manifest in the context of our interpersonal relationships in the ways we approach connection and intimacy. The attachment patterns formed in infancy are thought to stay constant throughout life and the attachment patterns of adults “describe people’s comfort and confidence in close relationships, their fear of rejection and yearning for intimacy, and their preference for self-sufficiency or interpersonal distance” (Meyer & Pilkonis, 2001, p. 466). Since these attachment patterns represent a learned pattern of engagement with others, this same attachment pattern will manifest with clients in the context of the therapeutic relationship. The client’s attachment system “may be activated by a close, intimate relationship that evokes the potential for love, security and comfort, including friendship, kinship, romantic partnership, and the therapeutic alliance” (Mallinkckrodt, Gantt, & Coble, 1995, p. 308). In the context of therapy, the client will re-experience his or her primary attachment and through this enactment, or way of relating, the therapist will gain insight into the client’s internal working model (Shilkret, 2005).

Secure attachment in adults. In adults, secure attachment patterns are often characterized by high levels of self-esteem and a capacity for intimate interpersonal relationships. Those with secure attachment patterns display flexibility in interpersonal relationships and tend to be open and comfortable with self-disclosure in the context of relationships. According to Bowlby (1979), the securely attached individual has “built up a representational model of himself as being both able to help himself and as worthy of being helped should difficulties arise” (p. 162). Clients with a secure attachment pattern

tend to feel comfortable interpersonally and can depend on others and have others depend on them. These clients present as emotionally invested and tend to make use of social supports (Bernier & Dozier, 2002). Clients who are securely attached tend to present as open, collaborative, trusting of therapists, proactive in treatment, and able to integrate therapist's comments (Levy, Ellison, Scott, & Bernecker, 2011).

Insecure-ambivalent attachment in adults. Insecure-ambivalent adults tend to be immature and, while they desire closeness in relationships, they tend to be overly dependent on their partners and have a strong need for external validation (Dolan, Arnkoff & Glass, 1993). Despite their strong desire for intimacy, individuals with insecure-ambivalent attachment patterns may reject intimacy and clients with this attachment pattern may “brood over what the therapist really meant and alternate between being angry with the therapist and pleading for help” (Shilkret, 2005, p. 61). Research suggests that these clients are difficult to treat and are likely to develop neurotic symptoms, depression or phobias (Dolan et al., 1993; Levy et al., 2011).

Insecure-avoidant attachment in adults. Adults with insecure-avoidant attachment patterns tend to be compulsively self-reliant and deny need for love and support (Dolan et al., 1993). These individuals may feel uncomfortable with intimacy and self-disclosure in relationships may be challenging. Those with insecure-avoidant attachment patterns may minimize the importance of intimate relationships with others and have difficulty asking for or accepting help when it is offered (Levy et al., 2011). In the context of therapy, adults with avoidant attachment pattern may minimize the importance of the therapeutic relationship, minimize the therapist's comments or “insist they have no feelings about breaks in the therapy” (Shilkret, 2005, p. 58). These clients

are often resistant to treatment, have difficulty asking for help, and tend to retreat from help when it is offered (Levy et al., 2011). Clients with insecure-avoidant attachment patterns are prone to depression and somatic symptoms (Dolan et al., 1993).

Disorganized attachment in adults. Adults with disorganized attachment patterns may mistrust others as their primary relationships were likely based in unpredictability and fear. Adults with this attachment pattern struggle interpersonally and find it difficult to self-soothe. Clients with disorganized attachment patterns “often intensely worry and confuse the therapist as they move between different symptoms, different affective states, and different states of consciousness without any seeming predictability” (Shilkret, 2005, p. 63). These clients are very difficult to treat; research suggests that clients with borderline personality disorder diagnoses are classified as having disorganized attachment patterns (Levy et al., 2011).

Adult Attachment and the Therapeutic Relationship

The therapeutic relationship can be conceptualized as the feelings that clients and therapists have toward one another and how they express these feelings. This relationship between client and therapist is generally considered the most effective component of successful treatment (Norcross, 2010). In fact, when exploring the efficacy of therapy, “there appears to be sufficient evidence to indicate that the psychotherapist is tremendously important to producing the benefits” (Wampold, n.d., para.4) and “available evidence documents that the therapist is the most robust predictor of outcome of any factor ever studied” (Hubble, Duncan, Miller, & Wampold, 2010, p. 23).

Attachment theory posits that any relational dyad can mirror an individual’s attachment bond if the relationship partner becomes a reliable source of protection and support (Mikulincer, Shaver, & Berant, 2013). According to Bowlby (1982), in order for

a relationship partner to become an attachment figure the partner needs to provide a physical and emotional safe haven, a secure base, and be a target of proximity maintenance. From the attachment perspective, the client-therapist dyad involves an attachment bond in that the therapist provides both a safe haven and a secure base for the client.

Awareness of client's attachment style allows the therapist to regulate the approach to intimacy in the way that best suits the client's attachment style and "sensitizes therapists to the kind of attachment the client can tolerate, at least at the beginning of treatment" (Shilkret, 2005, p. 66). For example, a client with an ambivalent or avoidant attachment pattern may not be able to tolerate a therapist who focuses too much on the value of the therapeutic relationship. If a client is dismissing then the therapist may need to be more engaged. Therefore, some of the therapeutic work may be to build space for increased attachment security. Knowledge of the client's attachment pattern can help the therapist anticipate how the client may respond to both the therapist and to the treatment. Research suggests that therapists should "titrate their interpersonal styles so as to not overwhelm dismissing patients or to appear disengaged, aloof, or uninterested to preoccupied patients" (Levy et al., 2011, p. 201).

According to Bowlby (1988), the therapist-client relationship parallels that of the parent-child dyad. The internal working model formed in the client's childhood will be transferred onto the therapist within the therapeutic relationship. In fact, Bowlby (1979) viewed the goal of psychotherapy as a "restructuring of a person's representational models and his re-evaluation of some aspects of human relationships, with a corresponding change in his models of treating people" (p. 181). In other words, the

therapist's task is to help the client recognize and alter his or her insecure or maladaptive internal working model.

Bowlby suggested "that the therapist needs to challenge the client's beliefs about relationships by flexibly adopting a stance that is in contrast (i.e., complementary) to the client's rigid expectations" (Bernier & Dozier, 2002, p. 38). In order to achieve this goal, Bowlby (1988) posited that the therapist has five therapeutic tasks. The first task is to provide the client with a secure base from which the client can explore painful areas of his/her life that he/she has avoided. The second task is to encourage the client to explore her internal working models and the ways he/she relates interpersonally with significant people in her life. The third task is to encourage the client to explore the therapeutic relationship as an example of self-in-relation-to-other as there will be transferences of client's internal working models onto the therapist. The fourth task is to encourage understanding of his/her internal working models and the origin of these models. Finally, the fifth task is to encourage the client to explore how his/her internal working models may not be effective ways of relating in the present, that is, that these internal working models are ways of bringing the past into the present.

In successful cases of therapy, "a secure attachment relationship is eventually formed with the therapist, contributing to a corrective emotional experience for the client" (Mallinckrodt, Gantt, & Coble, 1995, p. 308). A corrective emotional experience, or experiential relearning, allows the client to alter his or her insecure attachment pattern by engaging in secure relational patterns with the therapist (Bernier & Dozier, 2002). In this manner, the client may "internalize and encode a working model of the therapeutic relationship which promotes their own capacity to regulate arousal" (Applegate, 2004, p.

31). In other words, through the use of the supportive therapeutic relationship, the therapist may facilitate this “earned security” allowing a client with a previous insecure attachment pattern from childhood to transition to a secure attachment pattern in adulthood (Saunders, Jacobvitz, Zaccagnino, Beverung, & Hazen, 2011). Thus, awareness of attachment patterns help guide the clinical work and the attuned therapist will temper his or her relational stance to assist with the attachment bond and hopefully, through modeling affect regulation, alter insecure attachment behaviors. The ability to facilitate this “earned security” is likely dependent upon the attachment security of the clinician.

Measures of Adult Attachment

Given the significant impact of client attachment patterns on the therapeutic process, there has been considerable attention given to the measurement of adult attachment patterns. While the attuned clinician may be able to identify the client’s attachment pattern based on how the client engages in the therapeutic relationship, many may rely on concrete measures. There are two approaches to measuring adult attachment: through the narrative interview and through self-report measures.

Mary Main (1985) helped to create the Adult Attachment Interview (AAI), a semi-structured interview in which individuals are asked to describe attachment related experiences during childhood and the impact these experiences have on current functioning (Hesse, 2008). These interviews, about an hour in length, are transcribed and analyzed and yield classifications of attachment states of mind. The scoring is based on the individual’s description of childhood experiences, the language used to describe these experiences and the individual’s ability to provide an integrated and coherent account of

experiences. Thought to be the gold standard of assessing adult attachment patterns, the AAI, based on in-person interviews and subsequent coding, is also considered laborious.

Less cumbersome are the self-report measures of adult attachment. The Adult Attachment Style (AAS) questionnaire, devised by Hazan and Shaver (1987), is a 3-item self-report measure of adolescent and adult romantic attachment patterns based on the Ainsworth's three classifications of attachment: secure, insecure-anxious, and insecure-avoidant. The measure describes the feelings of self in relationships and respondents select which descriptive category best represents their experience. The Relationship Questionnaire (RQ), designed by Bartholomew and Horowitz (1991) is a 4-item questionnaire designed to measure adult attachment patterns in romantic relationships. The RQ is an extension of the AAS and includes the fourth attachment pattern, dismissing. Fraley, Waller and Brennan (2000) devised the Experience in Close Relationship Scale - Revised (ECR-R). This 36-item questionnaire, on a Likert scale, measures adult attachment on two scales: avoidance and anxiety (Fraley, Waller & Brennan, 2000). These measures of adult attachment patterns have contributed to the broad research base of attachment literature.

Attachment Research

Since Bowlby and Ainsworth's pioneering work, attachment theory has changed the landscape of developmental psychology. The empirical findings have provided valuable insight in developmental psychology, clinical social work and other clinical practice. Much of the research has focused on client attachment patterns and the implications for treatment, including the formation of the therapeutic alliance (Dolan, Arnkoff, & Glass, 1993; Eames & Roth, 2000; Gelso, Palma, & Bhatia, 2013; Levy, Ellison, Scott, & Bernecker, 2011; Mallinckrodt, Gantt, & Coble, 1995; Mallinckrodt,

2010; Meyer & Pilkonis, 2001; Mikulincer, Shaver, & Berant, 2013; Parish & Eagle, 2003; Shilkret, 2005). While adequate research has studied the impact of clinician attachment patterns on the formation of the therapeutic alliance (Black, Hardy, Turpin & Parry, 2005; Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002; Rubino, Barker, Roth & Fearon, 2000; Sauer, Lopez & Gormley, 2003), there is insufficient focus on how clinician attachment patterns may direct or guide the therapeutic process (Berry et al., 2008; Dozier, Cue, & Barnett, 1994; Ledwith, 2011; Tyrell, Dozier, Teague, & Fallot, 1999; Yusof & Carpenter, 2012) and inform clinicians' chosen theoretical orientation. This section explores the attachment literature with a lens toward the impact of clinician attachment patterns on the therapeutic alliance, therapeutic process and theoretical orientation.

Clinician Attachment Pattern and the Working Alliance

The working alliance, or relationship between client and clinician, is considered an important indicator of positive therapeutic outcomes (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). Most notably, the “alliance-outcome relationship is robust in that it appears across various therapies, including those that do not emphasize this aspect, such as CBT, and the more relational therapies, such as psychodynamic and humanistic treatments” (Wampold, 2010, p. 68). Given the significance of this working alliance, research has explored the factors that may contribute to the formation and maintenance of this alliance including the personal characteristics and attachment patterns of clinicians (Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002; Sauer et al., 2003; Tyrell et al., 1999).

Dunkle and Friedlander (1996) explored the impact of the personal characteristics of clinicians on the working alliance. They found that “clients whose therapists reported

less hostility, more social support, and greater comfort with closeness were more likely to report a strong emotional bond early in treatment” (Dunkle & Friedlander, 1996, p. 459). The results indicate that the more securely attached the clinician, the more comfortable the clinician is with closeness, the better the working alliance and the stronger the emotional bond in the early phase of treatment. Sauer, Lopez, and Gormley (2003) studied both client and clinician attachment patterns and the relationship to the early working alliance and found that clinician attachment anxiety had a significant positive effect on client early working alliance ratings. Despite this initial benefit, Sauer et al. (2003) found that over time, clinician attachment anxiety negatively impacted the working alliance. The authors posit that clinician attachment anxiety “may be associated with problematic clinical intervention strategies or with particular problems building early work alliances” (Sauer et al., 2003, p. 378). Similarly, Ligiero and Gelso (2002) found that clinician negative countertransference behavior was negatively related to the working alliance but they did not find a relationship between clinician attachment style and working alliance.

Tyrrell, Dozier, Teague and Falot (1999) studied the attachment patterns of both client and case manager and explored how the attachment patterns influenced therapeutic effectiveness and the working alliance. Clients with anxious attachment patterns had stronger working alliances with less anxiously attached case managers while clients who exhibited an anxious-avoidant attachment pattern, worked better with more anxiously attached case managers (Tyrrell et al., 1999). The findings suggest that pairing clients and case managers while considering attachment patterns could impact the outcomes. While

the reviewed literature reveals conflicting results, all of the studies conclude that the clinician's attachment pattern impacts the working alliance and the therapeutic process.

Clinician Attachment Pattern and the Therapeutic Process

According to attachment theory, the client's sense of security depends on the therapist's ability to provide a secure base and function as an attachment figure for the client. In fact, since "sensitive and effective caregiving depends on one's own sense of attachment security, it seems likely that the therapist's contributions to the client's security... can be disrupted by his or her own attachment insecurity" (Mikulincer, Shaver, & Berant, 2013, p. 611). Dozier, Cue and Barnett (1994) explored the relationship between case manager attachment style and his or her ability to respond therapeutically to clients. The Adult Attachment Interview (AAI) was administered to 27 clients and 18 case managers. The case managers were interviewed by telephone and asked to describe their clinical contacts with clients. These interviews were coded and analyzed to assess the depth of clinical work.

Dozier et al. (1994) found that case managers' attachment patterns were significant factors in how the case manager intervened with adults diagnosed with serious and persistent mental illness. The results indicated that securely attached case managers were able to attend to clients' underlying dependency needs, whereas case managers who were more insecure responded to the surface presentation of needs. The securely attached case managers were able to challenge the clients' model of interpersonal relationships whereas the insecurely attached case managers, by failing to challenge clients' internal working models, provided further confirmation of these maladaptive internal working models (Dozier et al., 1994). These findings suggest that attachment insecurity may interfere with the case manager's ability to objectively challenge the client's relationship

patterns. The insecure case manager may respond more readily to his or her own countertransference reactions toward the clients.

While the findings of this study are clinically significant, it is important to note the study limitations. The sample was comprised of case managers, not trained psychotherapists. It is conceivable that the insight gained through psychotherapy training could help to offset the countertransference responses of insecurely attached clinicians. These limitations notwithstanding, the results help to inform clinical practice, perhaps cautioning that an insecurely attached clinician may not be best suited to provide a corrective emotional experience through dynamic work.

The corrective emotional experience may be influenced by the therapeutic alliance. Rubino, Barker, Roth and Fearon (2000) studied the relationship between clinician attachment pattern and clinician empathy and level of interpretation in response to working alliance ruptures. Seventy-seven clinical psychology doctoral students were given the Relationship Style Questionnaire (RSQ; Griffin & Bartholomew, 1994) and were asked to respond to videotaped statements of clients representing four attachment patterns: secure, preoccupied, dismissing and fearful (Rubino et al., 2000). Anxiously attached clinicians tended to respond less empathically to clients, suggesting that clinician attachment patterns may impact their ability to empathize with clients and may “reduce their effectiveness as therapists” (Rubino et al., 2000, p. 416). Clinician attachment pattern did not impact the depth of clinician interpretation. As the authors note, most of the clinicians in the study ascribed to cognitive behavioral or eclectic orientations, both with inherently limited use of deep interpretations. The study underscores the importance of assessing the clinician’s attachment pattern during

graduate training in order to determine the impact of clinician attachment patterns, specifically those with an anxious attachment pattern, on the therapeutic process and therapeutic efficacy.

Mohr, Gelso and Hill (2005) also studied graduate students, focusing on client and trainee counselor attachment patterns as predictors of countertransference in the initial counseling session. The results suggest that countertransference is most likely to occur when the client and clinician have differing patterns of attachment insecurity. Consistent with previous research indicating that dismissing attachment is associated with a distant interpersonal stance (Bartholomew & Horowitz, 1991), the study found that counselors with a dismissing attachment pattern were more likely to engage in hostile countertransference behaviors (Mohr et al., 2005). The results of this study, much like the Rubino et al. (2000) study, highlight the need for investigation of clinician attachment patterns during clinician training. Since counselor attachment pattern and the interaction of counselor and client attachment patterns predicted countertransference behaviors, it may be useful for trainees with insecure attachment patterns to remain aware of how they may respond to clients with a different attachment pattern from their own.

In a move away from the focus on trainees, Berry et al. (2008) assessed the attachment patterns of twenty psychiatric staff members (15 nurses, 5 support staff) working with clients with severe and persistent mental illness in the United Kingdom. The study explored the influence of adult attachment styles on staff psychological mindedness and the therapeutic relationship with clients. Twenty clients were given a self-report questionnaire designed for this study, derived from the Experience in Close Relationships Scale (ECR) (Brennan et al., 1998). Patients completed the Inventory of

Interpersonal Problems (IIP; Barkham, Hardy & Startup, 1996) and the staff members also rated the patients' level of interpersonal problems. To assess psychological mindedness, the staff members listened to brief interviews with the patients and interpreted the issues presented. Staff attachment patterns were measured using an adaptation of the ECR specifically designed for this study. Staff attachment avoidance was positively correlated with discrepancies between the staff and patient ratings of interpersonal problems. Staff psychological mindedness was also negatively correlated with attachment avoidance, which suggests that less psychologically minded staff were more avoidant.

This study is limited by the very small sample size, which did not include any clinical therapists. In fact, as in the Dozier et al. (1994) study, the training a therapist receives may serve to improve psychological mindedness, even in those therapists with an avoidant attachment pattern. Despite these significant limitations, the results could suggest that how therapists approach the clinical process, the extent of psychological depth they are comfortable with, and their choice of clinical orientation, could be directly associated to their attachment style. In that vein, more avoidant therapists, who may be less psychologically minded, may choose and/or be better suited to provide a structured or more scripted approach to treatment.

Ledwith (2011) explored the relationship between the attachment patterns of clinical social workers and their approach to therapeutic termination. Forty-nine clinical social workers were given the Adult Attachment Questionnaire (AAQ) and the Termination Approaches Questionnaire (TAQ), a 36-item self-report questionnaire assessing clinician techniques, perceptions and emotional responses during the

termination process (Ledwith, 2011). The results support a statistically significant relationship between social workers' attachment patterns and their approach to termination. Securely attached social workers were found to be more engaged in the process of termination whereas less securely attached social workers were more likely to exhibit more avoidance with regard to termination. As with any pilot study, the results are limited by the small sample size. Additionally, because one of the self-report measures, the TAQ, was created specifically for this study, there was no previous data on the psychometric properties of the measure.

Despite these limitations, Ledwith's (2011) work highlights the impact of clinician attachment style on therapeutic endings and her study raises questions about therapeutic "beginnings". That is, to what extent does the clinician's attachment style dictate his or her approach to treatment, including the type of treatment he or she chooses to provide? The review of literature uncovered three studies that investigated therapist attachment style and theoretical orientation (Black, Hardy, Turpin & Perry, 2005; Yusof & Carpenter, 2012), one of which aimed to address the potential relationship between therapist attachment style and theoretical orientation (Fleischman & Shorey, 2014).

Clinician Attachment Pattern and Theoretical Orientation

Theoretical orientation refers to a consistent theory of human behavior, psychopathology, psychotherapy and the mechanisms for therapeutic change. Black, Hardy, Turpin and Parry (2005) explored the extent to which therapist self-reported attachment patterns and therapeutic orientations were associated with quality of therapeutic alliance and reported problems in therapy. Self-report questionnaires were mailed to 1400 psychotherapists in the United Kingdom: 146 men and 345 women responded. The Attachment Style Questionnaire (ASQ; Feeney et al., 1994), the Agnew

relationship Measure (ARM; Agnew-Davies et al., 1998), the Therapist problem checklist and the Brief Eysenck Personality Questionnaire (EPQ) were used. The results indicated a significant positive correlation between ASQ and ARM, supporting the study hypothesis that clinician self-reported secure attachment is correlated to clinician self-reported good therapeutic alliance. Thus, therapists who reported higher levels of insecure attachment patterns reported poorer quality of therapeutic alliances. The findings confirm the previous research that therapist attachment insecurity correlates to poorer therapeutic alliance (Dunkle & Friedlander, 1996; Eames & Roth, 2000; Rubino et al., 2000; Sauer et al., 2000).

Interestingly, psychodynamic therapists had the lowest self-reported scores of therapeutic alliance and CBT therapists had the highest self-reported scores of therapeutic alliance. The authors posit that this could be due to the deeper, and more conflict-laden nature of the psychodynamic approach (Black et al., 2005). This study had a very low response rate (39%) and relied solely on self-report measures. The majority of clinicians (54.8%) had over ten years clinical experience. As a result, there is limited generalizability of the findings. While this study examined both therapist theoretical orientation and therapist attachment style, the potential relationship between these two variables was not analyzed.

Yusof and Carpenter (2012) conducted an online survey of eighty-two registered family therapists in the United Kingdom to assess the possible relationship between family therapists' attachment style and their gender, prior profession, and preferred models for therapy. Both the Relationship Questionnaire (RQ) (Bartholomew and Horowitz, 1991) and the Experiences in Close Relationships Questionnaire (ECR)

(Brennan et al., 1998) were administered. Demographic data collected included age, educational qualifications, prior profession and years of experience. Participants were asked to preferentially rank their model of therapeutic approach from the following options: systemic, psychodynamic, cognitive-behavioral, feminist, post-modern, collaborative, narrative, humanistic or integrative (Yusof & Carpenter, 2012).

Of the eighty-two respondents, over half held Master's degrees, half identified as social workers, and most of the sample was female. The findings revealed discrepancies among the results of the RQ and the ECR. The results of the RQ revealed that sixty-one of the eighty-two participants identified as having secure attachment styles, nine identified as preoccupied, six as dismissing and six as fearful. On the ECR, twenty-four of the eighty-two respondents revealed a secure attachment style, sixteen as preoccupied, fifteen as dismissing, and twenty-seven as fearful. The authors suggest that the discrepancies among the measures may be "attributable to the more transparent nature of RQ measures compared to the more subtle ECR" (Yusof & Carpenter, 2012, p. 459). However, due to the study's small sample size and as a result, the small amount of respondents in each category, the potential relationship between attachment style and theoretical preference was not statistically analyzed.

Fleischman and Shorey (2014) explored the relationship between adult attachment pattern, theoretical orientation and therapist-reported alliance quality among licensed psychologists. Two hundred and ninety psychologists from the United States and Canada completed online surveys comprised of the following measures: the Theoretical Orientation Profile Scale-Revised (TOPS-R), the Counselor Theoretical Position Scale (CTPS), the Experiences in Close Relationships Scale (ECRS), and the Working Alliance

Inventory Short Form (WAI-S) (Fleischman & Shorey, 2014). Of the 290 respondents, only 108 were included for statistical analysis, those who identified as psychodynamic (50) and those who identified as cognitive-behavioral (58).

Psychodynamic psychologists endorsed higher levels of attachment anxiety than cognitive-behavioral psychologists and “attachment anxiety correlated positively with endorsement of psychodynamic principles and negatively with endorsement of cognitive-behavioral principles” (Fleischman & Shorey, 2014, p. 8). There was no difference in attachment avoidance or therapist-reported alliance quality between psychodynamic and cognitive-behavioral psychologists. The results support the notion that clinician attachment patterns impact choice of theoretical orientation in clinical practice. The study is limited by the reliance on self-report measures, the limited representation of theoretical orientations, and the sample: mostly securely attached, Caucasian and female. Despite these limitations, the study is noteworthy in that it introduces into the literature the role that attachment patterns have in predicting clinician theoretical orientation (Fleischman & Shorey, 2014).

The literature clearly indicates that the clinician’s attachment pattern impacts his or her ability to form an effective therapeutic alliance (Dunkle & Friedlander, 1996; Rubino et al., 2000; Sauer et al., 2000). Insecurely attached clinicians may offer less therapeutic depth by responding to their own countertransference instead of the clients underlying needs, thus being unable to provide corrective emotional experiences by challenging clients interpersonal representations (Dozier et al., 1994). Research also shows that the therapist’s attachment pattern impacts his or her approach to the process of therapy, including therapeutic endings (Ledwith, 2011). To what extent does the clinician

attachment pattern guide the therapeutic beginnings with regard to the clinician's choice of orientation? Evidence suggests that clinicians largely choose a theoretical orientation based on personal values and experiences (Norcross & Prochaska, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994) and preliminary research supports the assertion that therapist attachment pattern guides preference of theoretical orientation (Fleischman & Shorey, 2014). To build on the previous research both in and outside of clinical social work practice, an exploration of theoretical orientation is indicated.

Theoretical Orientation

A clinical social worker's theoretical orientation serves as the foundation for clinical practice and provides a framework with which to view the client, the presenting problems, possible interventions, and ongoing evaluation of therapeutic process (Poznanski & McLennan, 1995). The use of theory provides the social worker with a systematic way of organizing and understanding complex psychological phenomena. Clinical social workers typically define their practice by citing one or more theoretical orientations that provide a lens from which to view the patient and a rationale for intervention (Cornsweet, 1983). While there are many theoretical orientations, they vary in the extent to which they involve insight or action and focus on the in-session clinician-client dyad. While the therapeutic alliance is an important component regardless of theoretical orientation (Horvarth & Luborksy, 1993; Horvarth & Symonds, 1991; Wampold, 2010), the use of the alliance, or working relationship, varies differently depending on the orientation (Coleman, 2004). This section provides a brief history of theoretical orientation as it relates to the social work profession and an overview of the theoretical orientations relevant to this study.

Diagnostic/Functional Schools and Social Work

Sigmund Freud revolutionized the study of human behavior and emotional illness by developing the first systematic, scientific theory of personality (Dunlap, 2011). In fact, Freud's psychoanalysis, or "talking cure", gave birth to the field of psychotherapy (Bowen, 1976). In the 1920s much of psychology was dominated by psychoanalysis and social workers, striving for professional legitimacy, "became deeply committed to the medical model, which in turn embraced psychoanalytic theory" (Dunlap, 2011, p. 323). Until the 1950s, much of social work theory and practice relied on psychoanalytic principles and was called the "diagnostic school" (Strean, 2011).

The diagnostic school, based on Freudian principles, believed that people are products of their past and that in order for healthy functioning, people needed to bring unconscious thoughts into conscious mind. In this model, the clients were viewed as in need of the professional services of the social worker. Otto Rank, originally a disciple of Freud, adopted a different perspective from the diagnostic school and while most social workers endorsed the Freudian approach, a number endorsed Otto Rank's perspective. Rank's ideas became the foundation for the functional school, endorsed by Jessie Taft and the School of Social Work at the University of Pennsylvania (Dore, 1990; Dunlap, 2011).

The functional approach differentiated from the Freudian diagnostic approach by shifting the focus away from problem etiology and the medical model. Functional theory emphasized client participation, the interaction between social worker and client including the *process* inherent in the helping relationship, and the importance of the client directing the focus of therapy (Dunlap, 2011). Functional theory has had a significant impact on contemporary social work practice and its basic concepts have become integral

to professional social work practice (Dore, 1990; Dunlap, 2011). The functional principles inherent in contemporary social work practice include:

The client's right to self-determination, the understanding of individual difference, starting where the client is, the evolving nature of client assessment, the important role of relationship in the helping process, and a recognition of time as the organizing component of the intervention process. (Dore, 1990, pp. 369-370)

The unique lens of social work profession, which separates social work from other mental health disciplines, is the person-in-environment perspective. The person-in-environment perspective is the understanding of the interplay between the person and the many systems in his or her environment. Social workers are "taught to recognize that all parts of any system are interrelated, interconnected, and interdependent and therefore it is imperative to take into account the influence of various systems and subsystems on client functioning" (Andreae, 2011, p. 601). Social work is known for its strengths based view of clients and the biopsychosocial lens with which the profession conceptualizes the individual.

The strengths perspective is a shift away from pathology and demands that the individual is seen "in the light of their capacities, talents, competencies, possibilities, visions, values and hopes" (Saleebey, 1996, p. 297). Through this lens, the individual is seen as the expert and the focus of the clinical work is on the goals devised by the client. Themes central to the strengths perspective include empowerment, resilience and membership (Saleebey, 1996). While social workers may subscribe to any number of

theoretical orientations, they tend to approach these orientations from the strengths perspective, considering person-in-environment and with a biopsychosocial lens.

Theoretical Orientation Overview

There are a number of theories of human behavior that guide how the social worker conceptualizes the client's problems and strengths. Most theories have a specific set of techniques used for intervention and a specific approach to relating interpersonally with the client. For the purposes of this paper, the theoretical orientations reviewed reflect those represented on the measures used in this study to assess social worker theoretical orientation. This section provides a brief description of each orientation and, when applicable, an investigation into the use of the therapeutic relationship within each orientation.

Psychodynamic. Psychodynamic psychotherapy, which grew out of psychoanalytic theory, posits that unconscious thoughts and feelings, which impact and motivate people, can lead to maladaptive thoughts and behaviors. The goal of therapy is to make the unconscious conscious, helping the client understand how past unresolved conflicts influence them in the present. There are seven features that distinguish psychodynamic therapy from other therapies including: focus on affect and expression of emotion, exploration of attempts to avoid distressing thoughts and feelings, identification of recurring themes and patterns, discussion of past experience, focus on interpersonal relations, focus on the therapy relationship, and the exploration of fantasy life (Shedler, 2010).

The therapeutic relationship in the psychodynamic orientation is viewed as a change agent and unresolved conflicts may be replicated and explored within the therapeutic relationship (Jones & Sulos, 1993). In fact, the therapeutic relationship is

central to psychodynamic psychotherapy as “it not only provides a safe environment in which patients can talk about their problems, but it also allows them to learn about themselves and their relationship to others through their interaction with the therapist” (Cabaniss, Cherry, Douglas, & Schwartz, 2011, p. 7). Through transference and defense interpretations, the social worker uses the here and now aspect of the therapeutic dyad to illuminate client patterns. The use of the therapeutic relationship in psychodynamic work is seen as essential for client growth.

Humanist/existential. Carl Rogers, a founder of the humanist or client-centered approach to therapy, was influenced by the work of Otto Rank and Jessie Taft (Rowe, 2011). In response to the polarized approaches of psychoanalytic and behavioral schools of thought, the humanistic approach became a third school in American psychology (Rowe, 2011). Humanism is predicated on the assumption that people have an innate drive toward growth and self-fulfillment. The goal of client-centered therapy is “to release an already existing capacity for self-actualization in a potentially competent individual” (Rowe, 2011, p. 78).

In order to achieve a positive outcome in therapy the therapist must be genuine, express unconditional positive regard for the client, and express empathic understanding. According to Rogers (1958), “a helping relationship might be defined as one in which one of the participants intends that there should come about, in one or both parties, more appreciation of, more expression of, more functional use of the latent inner resources of the individual” (p. 1). In this vein, humanistic therapists value the therapeutic relationship and use reflective listening and open-ended responses to help their clients develop self-

understanding, acceptance and actualization. Furthermore, Rogers believed in the importance of being “transparently real” and states “if in a given relationship I am reasonably congruent, if no feelings relevant to the relationship are hidden either to me or the other person, then I can be almost sure that the relationship will be a helpful one” (Rogers, 1958, p. 11). Rogers valued open expression and dependable realness in the context of the client-therapist dyad with a focus on the here and now use of the therapeutic relationship.

Family systems. Family systems theory, developed by Murray Bowen, posits that individuals cannot be understood as separate from their family, or emotional unit. This approach utilizes systems thinking to understand human behavior and the dynamic family system. Bowen defined the family as a “system in that a change in one part of the system is followed by compensatory change in other parts of the system” (Bowen, 1966, p. 351). The goal of treatment is alleviation of system dysfunction and improvement of familial relationships. Key concepts of family systems theory include: differentiation of self, triangulation, multigenerational transmission, emotional cutoff, sibling position, societal emotional process, nuclear family emotional system, and family projection process (Bowen, 1976).

In a family systems approach, the therapist may observe patterns of interaction and encourage family members to engage in new behaviors and find new ways of relating. According to Bowen (1966), the therapist becomes a part of the family system and the goal is to stand “alongside [the family] to help them understand and take steps to modify the system” (p. 353). The therapist is action oriented and fills the role of a

“consultant” or coach, providing skill building to the client system. This approach does not utilize the therapeutic relationship as a change agent.

Multicultural. Multicultural social work practice reflects a core value of the social work profession to deliver competent service, specifically, culturally competent service. Multicultural theory does not focus on specific therapeutic techniques, but recognizes the ethnocentric foundation of social work practice. As such, social workers must recognize that “relationships between helping professionals and clients may be strained because of historical or contemporary distrust between various groups...relationships between groups of color and the dominant society” (Weaver, 1999, p. 218). Multicultural theory integrates awareness of ethnicity, race and culture into the clinical work.

The goal of multicultural based social work practice is to help the client identify his or her own ethnic/cultural values and help the client build a stronger sense of self, which “may require resolving cultural conflicts within the family, between it and the community, or in the wider context in which the family is embedded” (McGoldrick & Giordano, 1996, p. 20). The therapist, with a recognition of his or her own social position and inherent power, may use the here and now of the therapeutic relationship in an attempt to resolve cultural conflicts. However, the particular orientation that the social worker utilizes will dictate whether the therapeutic relationship is used as a change agent.

Feminist. Like multicultural theory, feminist theory does not focus on particular techniques but focuses on themes of empowerment of all people, raising consciousness, the importance of unity and diversity, an end to patriarchy (Valentich, 2011). According to Dominelli and Campling (2002), feminist social work “takes women’s experience of

the world as the starting point of its analysis and, by focusing on the links between a woman's position in society and her individual predicament, responds to her specific needs, creates egalitarian relations in 'client'-worker interactions and addresses structural inequalities" (p. 7). The focus in therapy is typically on the present forces or agencies that influence the client's life, with particular attention to socio-political issues. Feminist therapists strive to create an egalitarian relationship with their clients and "rely on the client-worker relationship of partnership" (Valentich, 2011, p. 282). The theoretical orientation that the social worker employs dictates the extent of acknowledgement and use of the therapeutic relationship as a change agent.

Cognitive-behavioral theory. Cognitive behavioral theory emerged in the 1960s and was created by Aaron T. Beck who devised a "structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional thinking and behavior" (Beck, 2011, p. 2). Cognitive behavioral therapy, or CBT, is a psychotherapeutic treatment approach that operates under the assumption that our cognitions affect our behavior, that our cognitions can be changed, and that by changing our cognitions, we can change our feelings and our behaviors. Cognitive behavioral therapy has become "widely adopted as a primary treatment approach...it is one of the most commonly used psychotherapeutic treatments in adults" (Dobson, 2010, p. 39).

In the CBT approach, the therapeutic relationship is "viewed as entailing the service/delivery of technical instruction and guidance; what is imparted is knowledge and information" (Jones & Pulos, 1993, p. 315). Typically, this is an action-oriented approach with emphasis on work outside of the client-therapist dyad. While the

therapeutic alliance is valued, typically CBT does not utilize the therapeutic relationship as a change agent. Instead, the therapy is structured and educative, with the therapist playing an active role in agenda setting and teaching regulation skills.

Ecosystems. The ecosystems perspective, particularly influential in the field of social work, helps the clinician conceptualize clients but does not offer a theory to explain human development or pathology (Coleman, 2004). The perspective emphasizes attention to the reciprocal relationships between the client and the client's physical and social environments and culture (Germain & Gitterman, 1995). The ecosystems approach posits that there is a mutual adaptation between the individual and the environment and as such, stresses the goodness of fit between person and environment.

Utilizing this perspective, the clinician will explore with the client how the client's systems function and explore how change in one area will impact change in another area of the system (Wakefield, 1996). Coleman (2004) notes that for social workers "serving a large proportion of clients who face economic disadvantage and oppression...an ecological theoretical perspective...is essential for directing the clinician to identify systemic influences and client adaptive strengths" (p. 120).

Pragmatic case management. Case management is the method of helping functionally impaired clients develop goals and access and utilize services. By empowering clients to function as independently as possible, case managers promote the clients efforts to improve their well-being through advocacy (Hepworth & Larsen, 1993; Norlin and Chess, 1997). Pragmatic case management takes a more directive approach, advising or guiding the client in the here-and-now to help improve functioning and access

services. As noted by Coleman (2004), while this approach is commonly used in community practice, it has no formal theoretical underpinnings.

Biological. The biological approach to social work posits that mental illness has a biological basis. This approach believes that mental illness is treatable with medication and emphasizes the use of psychiatric medications. From the biological perspective, an important component of therapy is to provide psychoeducation about both mental illness and psychotropic medications (Coleman, 2004). The social worker takes a more directive stance, imparting knowledge to the client.

As evidenced by this brief review, theoretical orientations vary greatly in therapeutic approach and use of the therapeutic relationship. Although there are many different orientations, most clinicians identify two or more theoretical orientations that guide their clinical practice (Jensen, Bergin, & Greaves, 1990). Even as most clinicians may identify as “eclectic” or “integrative”, a majority of clinicians identify with one or more orientation and “graduate training in counseling continues to emphasize theoretical orientation” (Worthington & Dillon, 2003, p. 95). Given that theoretical orientation continues to guide clinical work, and social workers are actively engaged in clinical work, attention to the factors that influence orientation development is imperative.

Theoretical Orientation Research

While it is widely regarded that some clinicians are effective agents of change and have important influences on therapeutic outcomes, relatively few studies have explored the aspects of clinicians’ theoretical orientation development (Cornsweet, 1983; Norcross & Prochaska, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994). In fact, there has been debate about the need to focus on the clinician’s theoretical orientation as research on the efficacy of psychotherapy outcomes has shown that no one approach has

been consistently superior (Luborsky, Singer & Luborsky, 1975) and “differences among models accounted for only 1% of the variance of outcomes” (Hubble et al., 2010, p. 34).

Whether or not all orientations are equally effective, clinicians from varying orientations approach the therapeutic process differently. In fact, “clinicians of different theoretical orientations say different things to clients, ask questions about different features of a problem and even have a different emotional tone” (Coleman, 2004, p. 117). Given these differences and that in the context of therapy, the clinician’s set of values is transferred to the client (Cornsweet, 1983), it is important to adequately understand which factors, especially personal factors, contribute to the selection of theoretical orientation. This section reviews the available literature regarding clinician theoretical orientation development, clinician personality and theoretical orientation selection, and available measures of clinician theoretical orientation. While only a few studies included clinical social workers, as such, studies with mental health professionals (psychologists, family therapists, counselors, and social workers) are included.

Clinician Theoretical Orientation Development

Since the 1950s, researchers have explored therapists’ orientation selection and how it influences therapeutic practice (Poznanski & McLennan, 1995). Originally thought to be “accidental”, research has since indicated that personality and personal and professional experiences influence a clinician’s orientation selection.

Norcross and Prochaska (1983) studied the selection, utilization and efficacy of psychologists’ theoretical orientation. A three-page self-report questionnaire was administered to 479 psychologists assessing their degree of satisfaction with chosen theoretical orientation, the selection of their theoretical orientation, the use of their orientation in practice, and the influence of their orientation on their practice. This

sample was randomly selected from the American Psychological Association database and the psychologists identified their orientation as eclectic (30.89%), psychodynamic (30.05%), behavioral (14.40%), cognitive (6.26%), or systems (4.18%) (Norcross & Prochaska, 1983). The psychologists were asked to rate on a Likert scale from “no influence” to “primary influence”, the extent to which 14 variables influenced their chosen orientation. The 14 variables included: clinical experience, values and personal philosophy, graduate training, postgraduate training, life experiences, internship, its ability to help me understand myself, type of clients I work with, orientations of friends/colleagues, outcome research, family experiences, own therapists’ orientation, undergraduate training, and accidental circumstances (Norcross & Prochaska, 1983).

Adoption of a theoretical orientation “was attributed to personal, deliberate choices primarily predicated on clinical experience, personal values and graduate training” (Norcross & Prochaska, 1983, p. 197). Statistically significant variables included: clinical experience, values and personal philosophy, postgraduate training, internship experiences, life experiences, and the theory’s ability to help me understand myself (Norcross & Prochaska, 1983). The study is limited in that the 14 variables were not all-inclusive and ignored not only therapist personality but also situational and client variables. Additionally, due to the nature of self-report measures, this questionnaire did not tap into the potential unconscious processes involved in theoretical orientation selection.

Similarly, Vasco and Dryden (1994) explored the factors contributing to therapists’ chosen orientation. In this study, Vasco and Dryden (1994) administered self-report questionnaires to 161 Portuguese therapists from varied theoretical backgrounds

including psychodynamic (21.73%), behavioral (8.07%), cognitive (37.88%), eclectic (13.04%), humanistic (9.31%), and systemic (9.93%). The therapists rated the extent to which thirteen variables influenced their chosen orientation. The dimensions included: personal philosophy and values, training, clinical experience, life experiences, ability to help me understand myself, type of patients I work with, research results, orientation of own supervisor, orientation of own therapist, orientation of friends/colleagues, aesthetical appeal, accidental circumstances, and family experiences (Vasco & Dryden, 1994). Results confirmed the findings from the Norcross and Prochaska (1983) study, that “therapists consider the most determinant variable to be personal factors such as clinical experience and personal philosophy and values” (Vasco & Dryden, 1994, p. 328).

Additionally, Vasco and Dryden (1994) found that therapists from different orientations are “differentiable on the weights given to different variables when choosing their respective orientation” (p. 329). Cognitive therapists stressed the importance of research results, while psychodynamic and humanist therapists stressed the orientation of their own therapists (Vasco & Dryden, 1994). The results of this study seem to indicate that when choosing their orientation, a cognitive therapist may involve personal values and experiences to a lesser extent than a psychodynamic or humanist therapist. This variability may indicate a fundamental difference in personality or interpersonal relating styles among therapists of different orientations.

Vasco and Dryden (1994) also found that the degree of dissonance, or difference between the therapists’ personal values and philosophy and the values of their ascribed theoretical orientation was associated with less satisfaction with their orientation and poorer therapeutic performance and efficacy. This finding has profound implications for

training of therapists, that a “more informed process of selection of one’s theoretical orientation may help to prevent possible future mismatches between therapists and theories, which may be reflected negatively in personal well-being and therapeutic performance and efficacy” (Vasco & Dryden, 1994, p. 333). While this study is not without limitations, the findings underscore the importance of increased awareness not only of processes involved in orientation selection but also the need for constant appraisal of “goodness of fit” between therapist values and values of chosen orientation. This echoes Cornsweet’s (1983) directive that “each clinician should choose a theory with a careful and critical eye, and should subject the assumptions, values and empirical results of the application of that to continual evaluation” (p. 312). In order to maintain the harmony between personal values and chosen orientation, the clinician needs to appraise the degree of dissonance not only for goodness of fit, but also for therapeutic efficacy.

Recognizing the importance of accurately assessing clinician values, Carlson and Erickson (1999) developed a training program that would encourage “therapists to explore their own beliefs, values, and commitments, and then to encourage careful exploration of the values that are inherent in the many theories and stances that therapists take” (p. 58). The training program entails a series of questions devised to encourage clinicians to engage in critical self-appraisal in order to examine the values that guide their practice, enabling the clinician to consciously choose to continue acting on those values or to make changes (Carlson & Erickson, 1999).

The research consistently suggests that personal values and experiences are a major determinant of clinician theoretical orientation, yet studies have not explored exactly what these personal values and experiences are and how they contribute to

orientation development. In an attempt to address this gap in research, Bitar, Bean, and Bermudez (2007) conducted a qualitative, grounded theory, pilot study to address the process of theoretical orientation development. Bitar et al. (2007) explored how the variables influenced theoretical orientation development by capturing the clinicians' experiences. Bitar et al. (2007) recruited five licensed marriage and family therapists and conducted qualitative interviews, which confirmed existing research that two factors influence theoretical orientation development: the personal and the professional (Norcross & Prochaska, 1983; Vasco & Dryden, 1994). These two domains included the following variables: personality, personal philosophy, family of origin, own therapy, own marriage, undergraduate courses, graduate training, clients, professional development, and clinical sophistication (Bitar et al., 2007). Bitar et al. (2007) expanded the personal and professional categories to include the clinician's own marriage, the clinician's own theological influences and level of clinical sophistication. Additionally, Bitar et al. (2007) assessed for clinician personality, a variable that has been widely explored and thought to be a main determinant of orientation selection.

Clinician Personality and Theoretical Orientation

In addition to personal values and experiences, research has explored the potential relationship between clinician personality and theoretical orientation selection (Arthur, 2001; Barron, 1978; Tremblay & Herron, 1986; Vasco, Garcia-Marques, & Dryden, 1993; Walton, 1978). Although not an empirical study, Barron (1978) highlighted this potential relationship through his writings published in the journal *Psychotherapy: Theory, Research and Practice*. Barron (1978) believed the relationship between clinician personality and theoretical orientation had great "implications for the factors which affect the course and outcome of psychotherapy, the values which influence direction, the

relationship between science and value systems, and the interaction of values and processes in psychotherapy” (p. 309). He suggested that understanding the value system inherent in both personality and theoretical orientation was the key to understanding the clinical lens of the psychotherapist.

Walton (1978) conducted an empirical study exploring the personality factors and theoretical orientation of 135 male psychologists who self-identified as behavioral, rational-emotive, psychodynamic, humanistic, or eclectic. The participants responded to a mailed questionnaire comprised of a 98-item semantic differential instrument that was created for the study. Statistically significant differences were found in ‘seriousness’, ‘rationality’, and ‘complexity’ between the therapists who ascribed to Rational Emotive Therapy (RET) and those who ascribed to Psychodynamic therapy (Walton, 1978). The psychodynamic therapists perceived “themselves as complex and seriousness, [the] RET practitioners maintain a diametrically opposed position, namely, simple and humorous” (Walton, 1978, p. 392). This study highlighted the differences among therapists who ascribe to different orientations and the potential for therapists to select theoretical orientation based on personality types. This study is limited by the exclusively male sample and limited representation of theoretical orientations.

Tremblay and Herron (1986) investigated the potential relationship among personality and theoretical orientation by targeting clinicians who were strongly committed to one theoretical orientation: humanistic, psychodynamic or behavioral. One hundred and eighty doctoral level psychotherapists (60 humanistic, 60 psychodynamic, 60 behavioral) were administered the Personal Orientation Inventory (POI; Shostrom, 1964) and only minor differences in personality types among different orientations were

found. Humanist orientation was the most loosely defined with therapists having the most unique positive personality traits, while the behaviorists had the most negative personality traits and were the most inflexible (Tremblay & Herron, 1986). The authors suggest that despite these minor differences, there were many more similarities among the therapists, indicating that there is “a therapist personality that spans theoretical orientations and comprises a focus on the present, strong self-acceptance and self-regard, synergy, and a constructive view of the nature of humanity” (Tremblay & Herron, 1986, p. 109). This study is limited by the few theoretical orientations evaluated and the reliance on self-report data.

Vasco, Garcia-Marques, and Dryden (1993) studied the personal characteristics, theoretical orientations, personal philosophy and values of 140 Portuguese therapists who identified as cognitive (43.6%), psychodynamic (25%), systems (11.4%), humanist (10.7%), or behavioral (9.3%). The clinicians’ selection of theoretical orientation was found to be a combination of personal values, worldviews, personal perspectives and philosophical stances. The authors posit that these variables “combine to make a particular orientation more tantalizing than others, contributing to an eventual goodness of fit between a therapist’s personality and a particular orientation” (Vasco et al., 1993, p. 182) and when there is dissonance between therapists’ personal values and the values of their selected orientation, dissatisfaction was present. As a result of this dissonance, the authors assert that since no one orientation has been shown to be more effective than another, “future therapists should be encouraged to give sizeable weight to personal philosophy and values when selecting a theoretical orientation” (Vasco et al., 1993, p. 193) in order to reduce likelihood of clinician dissatisfaction.

Arthur (2001) conducted a study exploring the personality and epistemological traits of 247 psychotherapists from the cognitive behavioral and psychodynamic orientations. While commonalities were found between the two orientations, Arthur (2001) found that cognitive-behavioral therapists tended to be more independent and experience less anxiety, whilst psychodynamic/analytic therapists tended to experience more performance anxiety and neurotic symptoms. The study is limited due to exclusion of other theoretical orientations. Also, it is unclear if these personality differences among the therapists from the psychodynamic and cognitive behavioral orientations were a result of the training the psychotherapists received or if they are in fact true personality differences. Given the interest in understanding the factors that contribute to theoretical orientation development, there has also been interest in accurately assessing clinician theoretical orientation.

Measures of Clinician Theoretical Orientation

As noted, there has been considerable attention given to clinician theoretical orientation and how orientation influences therapeutic practice. As a result, there is a multitude of self-report measures of theoretical orientation. In 1995, Poznanski and McLennan (1995) examined the psychometric properties of the fifteen available self-report measures of clinician theoretical orientation and found that Sundland and Barker's (1962) Therapist Orientation Questionnaire (TOQ) and Coan's (1979) Theoretical Orientation Survey (TOS) were the only two measures determined to be reliable and valid.

The authors revealed the limitations of self-report surveys in capturing and understanding the dimensions of clinician orientation development and suggested that in order to effectively explore the relationship of theoretical orientation to therapeutic

practice a sound measure must be developed (Poznanski & McLennan, 1995). To address this need, Poznanski and McLennan (1999) developed the Counselor Theoretical Position Scale (CTPS) a forty-item Likert scale self-report measure comprised of two sub-scales, the analytical-experiential and the objective-subjective, which highlights theoretical approaches from Cognitive-Behavioral, Psychodynamic, Experiential/Phenomenological and Family-Systems. The scale demonstrated reliability and both construct and criterion validity and showed “promise of providing information additional to that resulting from simply asking counselors to nominate their preferred theoretical perspective” (Poznanski & McLennan, 1999, p. 333).

Worthington and Dillon (2003) designed the Theoretical Orientation Profile Scale - Revised (TOPS-R) to assess theoretical orientation among counselors. The TOPS-R is an 18-item self-report measure on a Likert scale reflecting six schools of psychotherapy: Psychoanalytic/psychodynamic, humanistic/existential, cognitive-behavioral, family systems, multicultural, and feminist (Worthington & Dillon, 2003). The TOPS-R is a face valid measure comprised of three items for each school of psychotherapy assessing identification with the orientation, conceptualization from the perspective of the orientation and utilization of technique reflective of the orientation. The scale, while psychometrically sound, is limited in that the sample was comprised of mainly Caucasian women. Additionally, because the items are transparent, respondents can easily demonstrate consistency among their responses and thus, the scale may not tap into unconscious processes involved in orientation selection.

Coleman (2004) developed the Theoretical Evaluation Self-Test (TEST) which was designed to assess the theoretical orientation of social workers in community settings

who “work with a broad range of cultures and socioeconomic backgrounds, [utilize] theoretical constructs to articulate the environmental influence on clients, and [integrate] psychosocial interventions with biological treatments” (Coleman, 2007, p. 475). This measure was designed to capture the social work perspective of clinical practice. The TEST is a 30-item self-report measure on a Likert scale, assessing the degree to which the respondents agree with descriptors of varying orientations such as psychodynamic, cognitive-behavioral, family therapy, humanistic, ecosystems, cultural, pragmatic case management, and biological (Coleman, 2004). This measure has demonstrated preliminarily sound psychometric properties. Unlike the previous measures of theoretical orientation, the TEST does not use a face-valid approach, but instead was designed to “tap theoretical beliefs that may not be fully formed or articulated” (Coleman, 2007, p. 475).

The TEST is limited due to the small sample size ($n=100$) used to evaluate the scale and the “just adequate reliability” (Coleman, 2004, p. 126). In a replication study, Coleman (2007) found moderate reliability and notes that “a face-valid approach to measuring theoretical orientation such as Worthington and Dillon’s (2003) scale can achieve better reliability if a sample consists of respondents who are well informed and articulate about theoretical orientation” (p. 480). However, if the TEST is used in empirical studies, Coleman (2007) recommends scoring the scale with a simpler factor structure (four-factor vs. six-factor), which “better reflects the multi-theoretical way in which contemporary clinicians think about practice” (p. 479).

The research suggests that a clinician’s theoretical orientation selection is a result of personal and professional development experiences, demonstrates the importance of

harmony between a clinician's chosen theoretical orientation and his or her own personal values, and demonstrates the challenges of assessing the unconscious processes involved in orientation selection (Cornsweet, 1983; Norcross & Prochaska, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994). In fact, in order to avoid mismatching and subsequent dissatisfaction or therapeutic inefficacy, research suggests that the clinician needs to be thoughtful about personal factors involved in orientation selection. One of these personal factors may be the attachment style of the clinician, or the way in which the clinician relates interpersonally. Since the various theoretical orientations approach the therapeutic relationship differently in terms of the depth of interpersonal relating, does the clinician's own personal comfort with relating guide their choice of orientation?

CHAPTER 3: METHODS

The aim of this study was to explore the relationship between adult attachment pattern and theoretical orientation among clinical social workers providing psychotherapy in outpatient settings. It was a quantitative study comprised of an online survey that collected data through the online survey database, PsychData. The Institutional Review Board at the University of Pennsylvania approved the study methodology.

Survey and Measures

The survey was comprised of demographic data and three measures: one measure of attachment style and two measures of theoretical orientation. The following demographic data was collected: age, gender, race, MSW graduate school, years of practice, post-Masters advanced training (yes or no, if yes, what type), theoretical orientation, has theoretical orientation changed since practicing (yes or no), if so, previous orientation, and what contributed to orientation change (click box for options and other).

Adult attachment style was measured by the Experience in Close Relationship Scale – Revised (ECR-R) devised by Fraley, Waller and Brennan (2000). This 36-item questionnaire measures adult attachment on two scales: avoidance and anxiety (Fraley, Waller & Brennan, 2000). The items are answered on a seven-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). Examples of level of anxiety include: “I worry a lot about my relationships”, “My desire to be close sometimes scares people away”. Examples of level of avoidance include: “I prefer not to show a partner how I feel deep down”, and “I find it relatively easy to get close to my partner”. The anxiety subscale has a total of 18 items with possible scores ranging from 1 to 7 with the higher scores

indicating higher levels of anxiety. The avoidance subscale also has a total of 18 items with scores ranging from 1 to 7, with the higher scores indicating higher levels of avoidance. The ECR-R has solid psychometrics with reliability of .94 for the avoidance subscale and .91 for the anxiety subscale (Brennan, Clark, & Shaver, 1998).

Table 1: Categorical Placement of ECR-R items

Category	ECR-R item number
Anxiety Subscale	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Avoidance Subscale	19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36

Theoretical orientation was measured by the use of two scales: the Theoretical Evaluation Self-Test (TEST) and the Theoretical Orientation Profile Scale (TOPS-R). The TOPS-R scale designed by Worthington and Dillon (2003) assesses theoretical orientation among counselors and trainees. Coleman (2004) designed the Theoretical Evaluation Self-Test (TEST) to assess the theoretical orientation of social workers in community settings in order to capture the social work perspective of clinical practice.

The TOPS-R is an 18-item self-report measure on a ten-point Likert scale from 1(not at all) to 10 (completely). The 18 items reflect six schools of psychotherapy: Psychoanalytic/psychodynamic, humanistic/existential, cognitive-behavioral, family systems, multicultural, and feminist (Worthington & Dillon, 2003). For each school of psychotherapy, there are three items assessing identification with the orientation (“I identify myself as psychoanalytic or psychodynamic”), conceptualization from the perspective of the orientation (“I conceptualize my clients from a psychoanalytic or psychodynamic perspective”) and utilization of technique reflective of the orientation (“I

utilize psychoanalytic or psychodynamic methods”). The scale is face valid and psychometrically sound with reliability .93, .69, .88, .89, and .95 from the psychoanalytic/psychodynamic, cognitive-behavioral, humanistic, family systems and eclectic subscales respectively (Worthington & Dillon, 2003).

Table 2: Categorical Placement of TOPS-R items

Category	TOPS-R item number
Psychoanalytic/psychodynamic subscale	1, 2, 3
Humanistic/existential subscale	4, 5, 6
Cognitive/Behavioral subscale	7, 8, 9
Family systems subscale	10, 11, 12
Feminist subscale	13, 14, 15
Multicultural subscale	16, 17, 18

The TEST is a 30-item self-report measure on a seven-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). The items assess the degree to which the respondent agree with descriptors of varying orientations such as psychodynamic, cognitive-behavioral, family therapy, humanistic, ecosystems, cultural, pragmatic case management, and biological (Coleman, 2004). Examples of the items include: “The role of the therapist is to advise and guide the client”, “The therapist’s unconditional positive regard for the client is a crucial therapeutic factor”, “Psychological problems vary with the culture of the client” and “There is evidence that most mental health problems have biological causes”. This measure has demonstrated preliminarily sound psychometric properties with moderate reliability when scored with the four-factor solution. Reliability scores include: .62, .64, .72 and .75 for family therapy, ecocultural, behavioral and

theory-driven psychodynamic scales respectively. Unlike the TOPS-R, the TEST does not use a face-valid approach, but instead is designed to assess theoretical beliefs that may not be fully articulated (Coleman, 2007).

Table 3: Categorical Placement of TEST items

Category	TEST item number
Psychodynamic subscale	1, 9, 20, 27, 30
Biological subscale	8, 17, 23, 29
Family systems subscale	4, 13, 22, 25
Ecosystems subscale	16, 19, 24, 26
Cognitive subscale	2, 6, 15, 21, 28
Pragmatic subscale	5, 10, 11, 14, 18
Humanistic subscale	3, 7, 12

Variables

The independent variable is attachment style and was measured by the ECR-R. The ECR-R measures attachment style on two subscales: anxious and avoidant. Participants with low scores on both the anxious and avoidant scale have a secure attachment pattern. Participants who score high on either of the two scales have an insecure attachment pattern. To further classify participants into attachment categories, the author of this study followed the guidelines outlined by Fraley (2012). Participants will then be assigned to attachment styles based on how they scored against the median scores of the sample. Participants whose anxiety score is less than the median anxiety score and whose avoidance score is less than the median avoidance score will be assigned to the “secure” group; participants whose anxiety score is less than the median anxiety

score but whose avoidance score is greater than or equal to the median avoidance score will be assigned to the “dismissing” group; participants who anxiety score is greater than or equal to the median anxiety score and whose avoidance score is greater than or equal to the median avoidance score will be assigned to the “fearful” group; and participants who anxiety score is greater than or equal to the median anxiety score and whose avoidance score is less than the median avoidance score will be assigned to the “preoccupied” group.

The dependent variable in the study, theoretical orientation, was measured by both the TOPS-R and the TEST. The TOPS-R measures theoretical orientation on six subscales: psychoanalytic/psychodynamic, cognitive-behavioral, humanistic, family systems, feminist, and eclectic. For each participant, the six subscales were scored and the subscale with the highest score indicates the theoretical orientation of the participant. The TEST measures theoretical orientation on seven subscales: psychodynamic, biological, family systems, ecosystems, cognitive, pragmatic, and humanistic. For each participant, the seven subscales were scored and the subscale with the highest score indicates the theoretical orientation of the participant.

Data Analysis

The survey database used, PsychData, aggregated and exported the data to Excel and the STATA 13.0 statistical program. Correlation of the independent variable, adult attachment style, and the dependent variable, theoretical orientation, was analyzed through bivariate analysis. A high correlation between the adult attachment pattern and theoretical orientation would support the hypothesis that there is a relationship between adult attachment style and theoretical orientation among clinical social workers in an outpatient setting.

Hypothesis

This study set out to explore the following hypothesis: there is a relationship between adult attachment style and theoretical orientation among clinical social workers providing psychotherapy in an outpatient setting.

Recruitment Procedures

The study utilized both non-probability convenience sampling and snowball sampling. Recruitment began February 15th, 2015 and continued for 6 weeks with the goal of reaching at least 100 participants. Even though this goal was met prior to the end of 6 weeks, data collection continued for the full 6 weeks.

The survey was emailed to all clinical social workers registered to both the Pennsylvania Society of Clinical Social Work (PSCSW) registered listserv and the New York State Society for Clinical Social Work (NYSSCSW) listservs. As a member of PSCSW, the author of this study had access and ability to email members of PSCSW. The author of this study received permission from the President of the Board of NYSSCSW to access the registered listservs. Additionally, the author of this study contacted clinical social work colleagues and asked that they disseminate the online survey to other clinical social workers appropriate for the study.

Four invitations/outreaches were sent to the PSCSW listserv and the NYSSCSW listservs. An email, with a link to the survey, was sent to the clinical social workers, inviting them to participate in the study. The email included the password needed to log in to the survey. The inclusion criteria for the study were that the participants must be clinical social workers providing psychotherapy in an outpatient setting with a clinical social work license (LCSW or equivalent). Those who received the letter of invitation and identified with the inclusion criteria could choose to participate. If they chose to

participate, the link routed the participants to a password protected website and then to the questionnaire. This procedure allowed for participant confidentiality and anonymity. After the initial invitation, three email outreaches were sent inviting participation.

This project was developed with consideration of the welfare of human subjects and overall ethics of human research standards. The study adhered to standards of both confidentiality and anonymity. Participants were not asked to reveal their identities and they remained anonymous. No identifying information was collected and the researcher was not able to associate any responses with identities of the participants. The collected data was encrypted and kept on a password-protected computer that only the researcher was able to access.

PsychData, the online survey database, included a waiver of consent on the introductory page of the survey. This allowed the participant to check a box after he/she agrees to the terms of the informed consent and continue to the questionnaire. Additionally, any participant could withdraw consent and discontinue participation at any time. Taking part in this study had no direct benefit to the participants but the participants did contribute to the knowledge base of the profession through their participation in the study. The survey posed minimal risks to the participants. Within the field of social work, clinicians are encouraged to remain self-aware and reflective of their use of self in their practice. This survey could be viewed as an exercise in self-awareness and as such, was no different than the standard expectation for clinical social workers.

CHAPTER 4: RESULTS

Sample Descriptive Statistics

Participants were 170 licensed social workers (84.71% female; 15.29% male) from the USA ranging in age from 24 to 87 years ($M = 55.8$ $SD = 14.3$), who completed an online survey after being recruited via e-mail solicitation through professional listservs in New York and Pennsylvania. The sample was predominately white/non-Hispanic (95.81%) with 4.19% “other”. Years of practice ranged from 2 to 50 years ($M = 22.58$; $SD = 12.16$). Terminal degrees included Master’s in social work (93.7%) and Doctorate’s in social work (6.2%). Much of the sample had completed post-Master’s advanced training (76.27%).

Figure 1: Gender

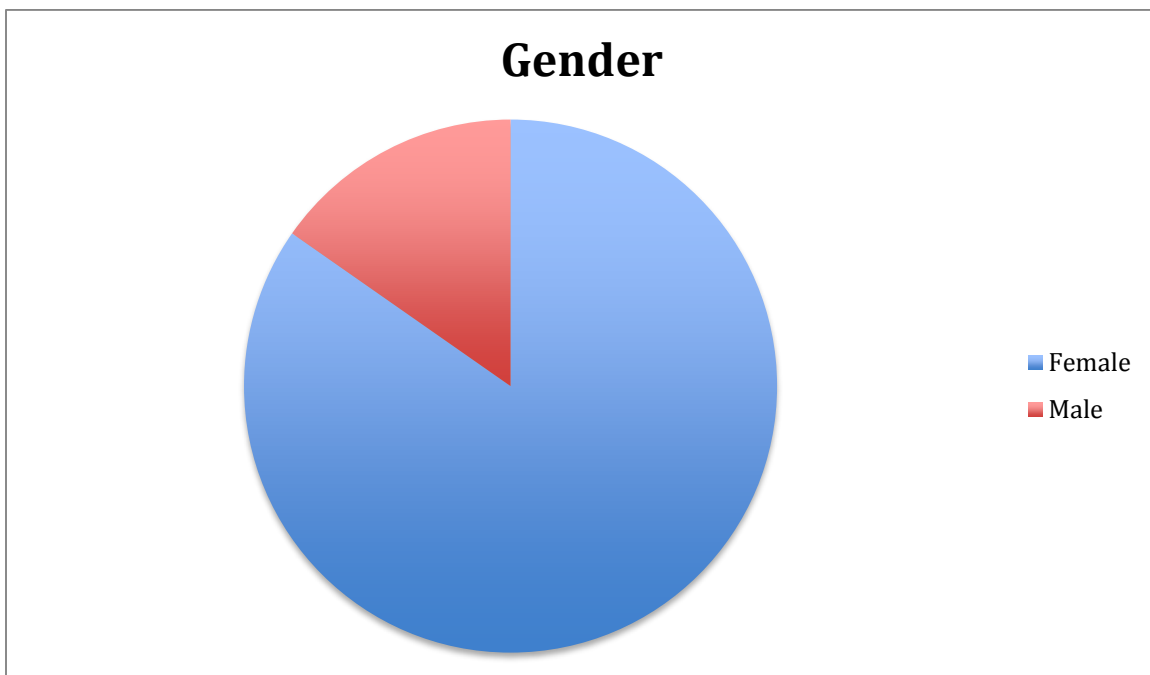


Figure 2: Race

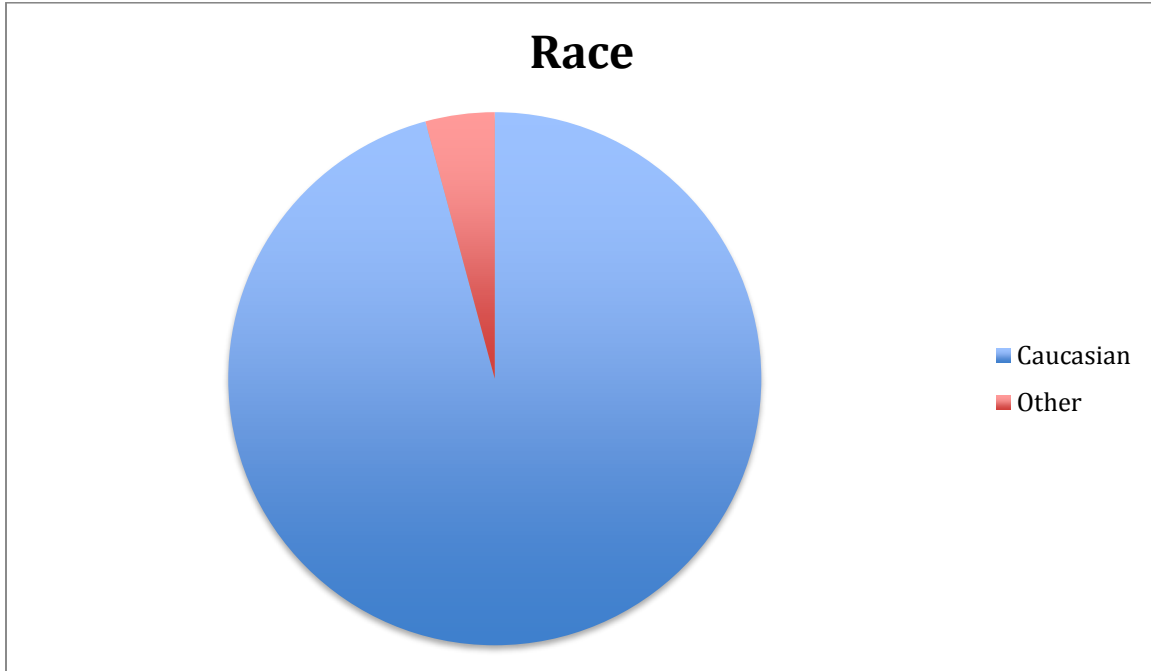


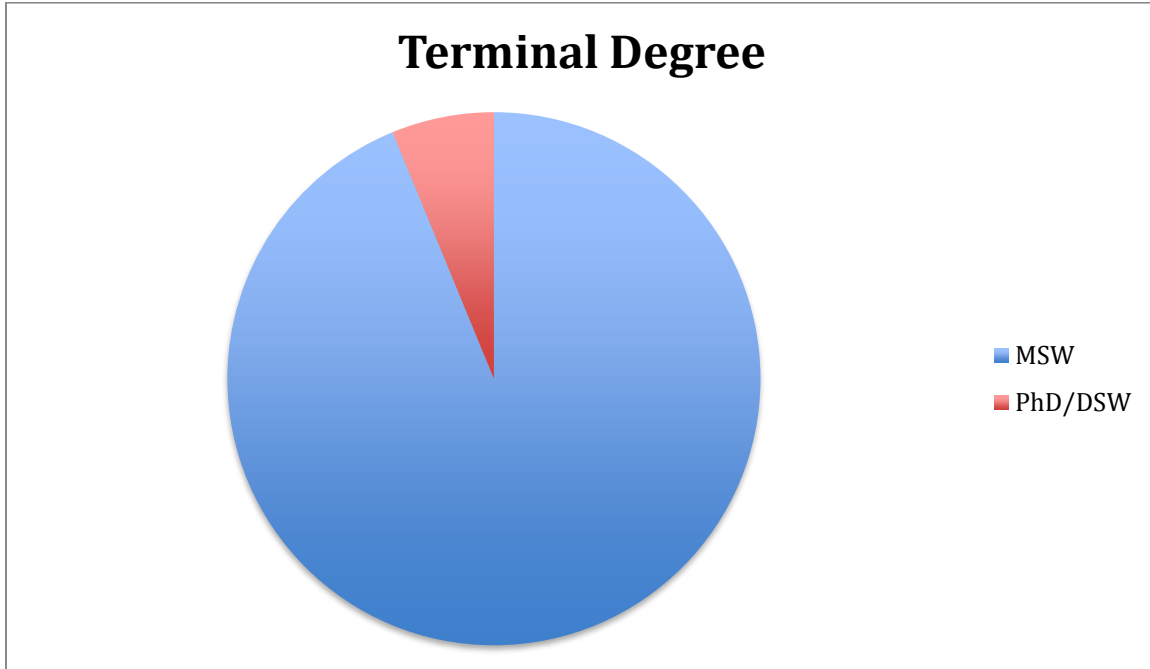
Table 4: Age

	Mean	SD	Range
Age	55.8	14.3	63

Table 5: Years of Practice

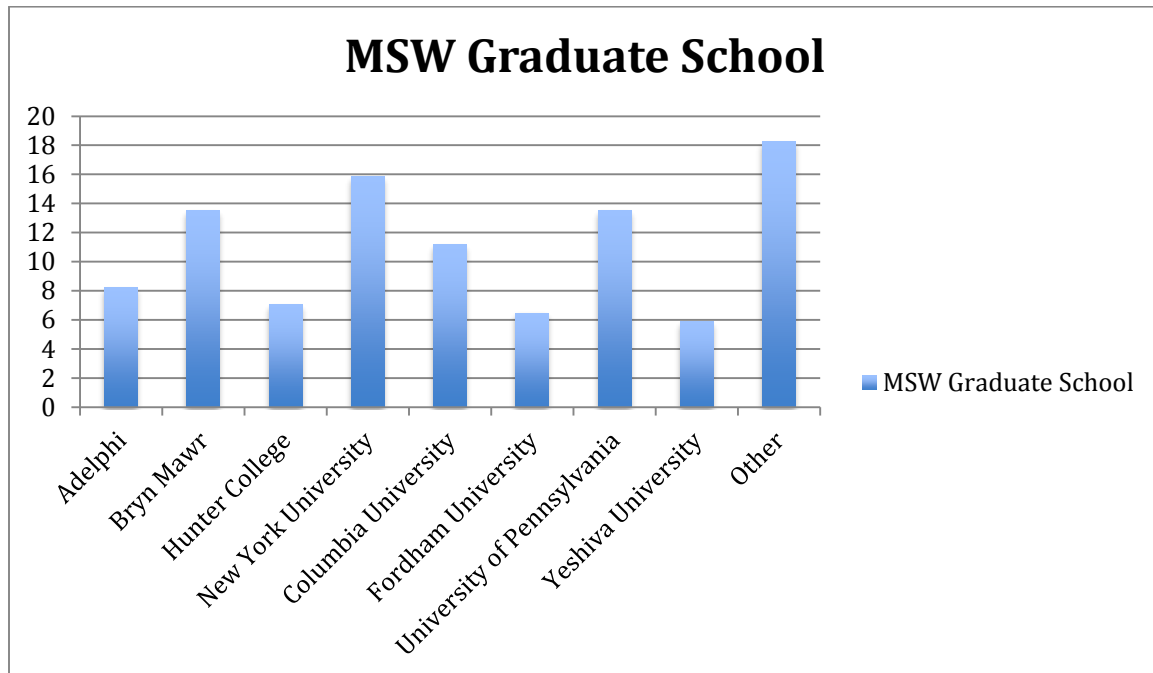
	Mean	SD	Range
Years of Practice	22.58	12.16	50

Figure 3: Terminal Degree



Participants were asked to identify where they received their Master's of Social Work. Of the 170 participants, 170 answered this item. The most represented MSW graduate schools included: Adelphi (8.24%), Bryn Mawr (13.53%), Columbia University (11.18%), Fordham University (6.47%), Hunter College (7.06%), New York University (15.88%), University of Pennsylvania (13.53%), Yeshiva University (5.88%), and "Other" (18.24%). The "other" category is comprised of multiple universities, each endorsed by few participants.

Figure 4: MSW Graduate School



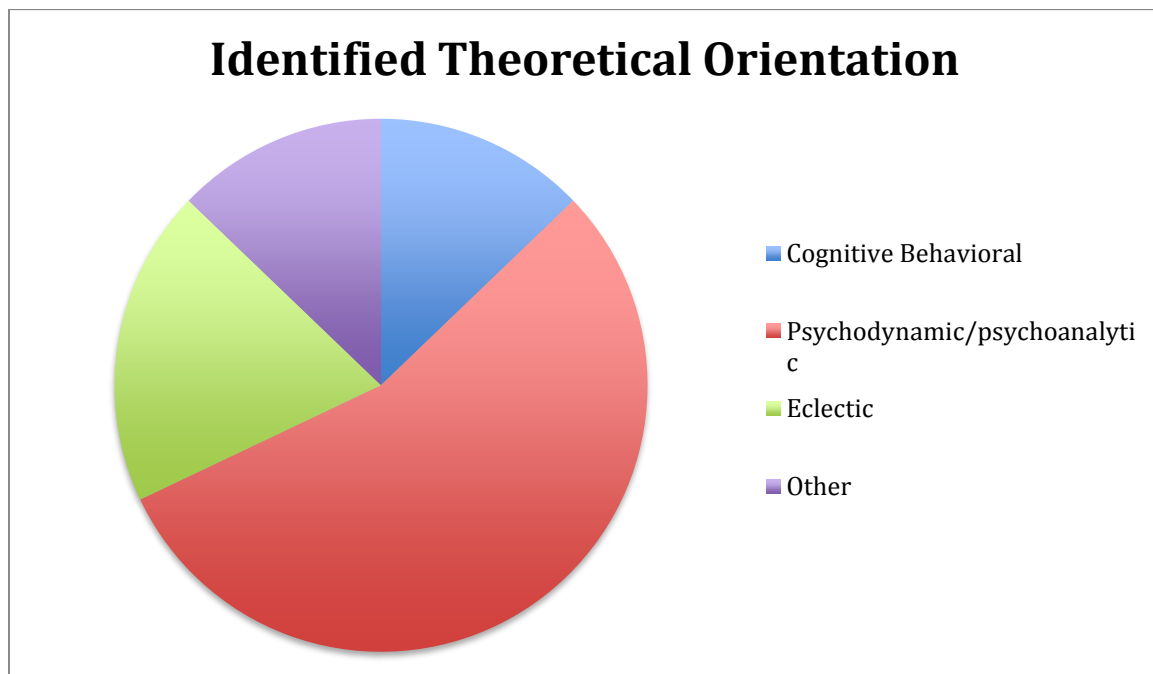
Participants were asked to identify their chosen theoretical orientation. Some participants identified more than one orientation and in this case the first orientation was seen as the primary orientation. If the participants provided multiple orientations (more than 2), these were categorized as having an “eclectic” orientation. If participants identified as “attachment”, “relational”, “object relations”, “relational cultural” or “self psychology”, they were folded into the “psychodynamic/psychoanalytic” category.

Of the 170 participants, 156 provided a theoretical orientation. The initial categorization and cleaning of the data yielded thirteen distinct categories including: 10.8% “cognitive behavioral” (N = 17), 1.9% “behavioral” (N=3), 54.7% “psychodynamic/psychoanalytic” (N=86), 3.1% family systems (N=4), 1.9% “trauma” (N=3), 10.1% “eclectic” (N=16), 1.2% “multicultural” (N=2), 0.6% “feminist” (N=1), 5.0% existential/humanistic (N=8), 0.6% “narrative” (N=1), 0.6% “body psychotherapy”

(N=1), 5.0% cognitive behavioral and psychodynamic/psychoanalytic (N=8), and 3.8% family systems and psychodynamic/psychoanalytic (N=6).

Due to the limited amount of participants representing these broad categories and the subsequent impact on statistical significance, the categories were further collapsed into the following four categories: 12.82 % “cognitive behavioral” (N=20), 55.13% psychodynamic/psychoanalytic (N=86), 19.23% “eclectic” (N=30), and 12.82% “other” (N=20). Within the “eclectic” group were those participants who identified as “cognitive behavioral and psychodynamic/psychoanalytic” or “family systems and psychodynamic/psychoanalytic”. The “other” category included participants who identified as “trauma”, “family systems”, “multicultural”, “feminist”, “humanistic” or “body psychotherapy”.

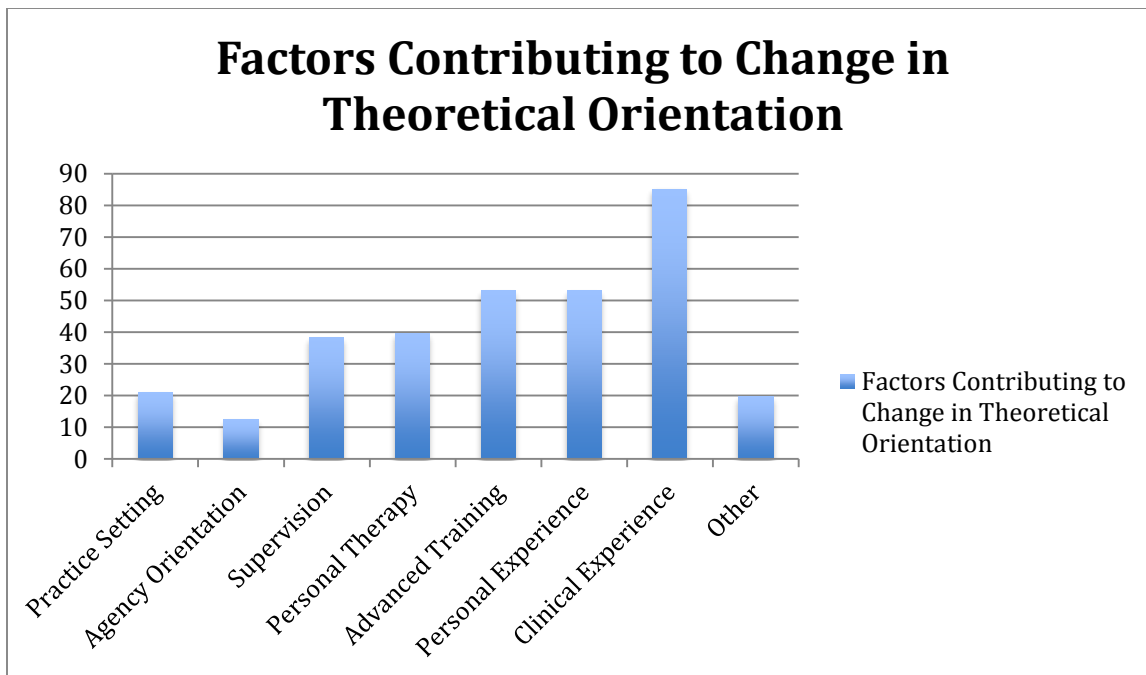
Figure 5: Identified Theoretical Orientation



The participants were asked if their theoretical orientation had changed since they began practicing. Of the 167 participants who responded to this item, 49.09% reported

that their orientation had changed (N=81). Of those 81 participants who reported a change in their theoretical orientation, 78 participants identified factors contributed to the change in theoretical orientation. The participants chose as many of the following items that were applicable in informing their change: practice setting (20.99%), agency orientation (12.35%), supervision (38.27%), own personal therapy (39.51%), advanced training (53.09%), personal experience (53.09%), clinical experience (85.19%) and other (19.75%). The participants filled in any additional factors and of those who identified “other”, some participants wrote in other factors including research (5.19%) and certificate of education (CE)(3.84%).

Figure 6: Factors Contributing to Change in Theoretical Orientation



Reliability of Instruments

Cronbach’s alpha was used to assess the reliability of the measures. The alpha coefficient for the ECR-R was .94; .88 for anxiety subscale and .93 for avoidance subscale. On the TOPS-R measure, Cronbach’s alpha was .87; with the six subscales

yielding alpha's from .89 to .96. Finally, on the TEST measure, Cronbach's alpha was .83; with the seven subscale scales ranging from .57 to .73.

Table 6: Reliability statistics for ECR-R and subscales

	Number of items	Cronbach's alpha
ECR-R Total	36	.94
ECR-R Anxiety	18	.88
ECR-R Avoidance	18	.93

Table 7: Reliability statistics for TOPS-R and subscales

	Number of items	Cronbach's alpha
TOPS-R Total	18	.87
Psychodynamic	3	.94
Humanistic	3	.95
Cognitive-Behavioral	3	.95
Family Systems	3	.96
Feminist	3	.89
Multicultural	3	.92

Table 8: Reliability statistics for TEST and subscales

	Number of Items	Cronbach's alpha
TEST Total	30	.83
Psychodynamic	5	.76
Biological	4	.61
Family	4	.71

Ecosystems	4	.69
Cognitive	5	.62
Pragmatic	5	.57
Humanistic	3	.66

Statistics on Attachment and Theoretical Orientation Measures

The Experiences in Close Relationships Scale – Revised (ECR-R) measures attachment patterns on two subscales: anxiety and avoidance. Of the 170 participants, 112 completed the ECR-R. The mean was 2.35 and the standard deviation was .91. On the anxiety subscale the mean was 2.18 and the standard deviation was .88. On the avoidance subscale the mean was 2.52 and the standard deviation was 1.17.

Table 9: Mean and Standard Deviations of ECR-R total and subscales

	Mean	Standard Deviation
ECR-R Total	2.35	.91
ECR-R Anxiety	2.18	.88
ECR-R Avoidance	2.52	1.17

The Theoretical Orientation Profile Scale – Revised (TOPS-R) was used to measure the theoretical orientation of the participants. Of the 170 participants, 102 completed the TOPS-R scale. On the TOPS-R, it is possible to “tie” categories, or to score the same number in one or more categories. Since the goal of this study was to classify participants into a discrete category, a new category, “mixed”, was created to identify those participants who had a tying score in one or more sub-groups. On the TOPS-R, the total mean was 5.53 and the standard deviation was 1.23. The means and

standard deviations for the six subscales are as follows: psychodynamic $M = 5.53$, $SD = 2.37$; humanistic $M = 5.44$, $SD = 2.45$; cognitive-behavioral $M = 4.73$, $SD = 2.52$; family systems $M = 4.94$, $SD = 2.94$; feminist $M = 5.09$, $SD = 2.42$; and multicultural $M = 6.06$, $SD = 2.44$.

Table 10: Mean and Standard Deviations of TOPS-R total and subscales

	Mean	Standard Deviation
TOPS-R Total	5.53	1.23
Psychodynamic	6.95	2.37
Humanistic	5.44	2.45
Cognitive-Behavioral	4.73	2.52
Family Systems	4.94	2.44
Feminist	5.09	2.42
Multicultural	6.06	2.44

The Theoretical Evaluation Self Test (TEST) was also used to evaluate theoretical orientation. Of the 170 participants, 106 completed the TEST. On the TEST, it is also possible to “tie” categories, or to score the same number in one or more categories. Since the goal of this study was to classify participants into a discrete category, a new category, “mixed”, was created to identify those participants who had the same high score in one or more sub-groups. On the TEST, the total mean was 4.80 and the standard deviation was .57. The means and standard deviations of the seven subscales of the TEST were as follows: psychodynamic $M = 5.75$, $SD = .89$; biological $M = 4.17$, $SD = .99$; family $M = 4.26$, $SD = .98$; ecosystems $M = 5.89$, $SD = .75$; cognitive $M = 4.91$, $SD = .91$; pragmatic $M = 3.43$, $SD = .98$; and humanistic $M = 5.65$, $SD = 1.00$.

Table 11: Means and Standard Deviations of TEST total and subscales

	Mean	Standard Deviation
TEST Total	4.80	.57
Psychodynamic	5.75	.89
Biological	4.17	.99
Family	4.26	.98
Ecosystems	5.89	.75
Cognitive	4.91	.91
Pragmatic	3.43	.98
Humanistic	5.65	1.00

Findings

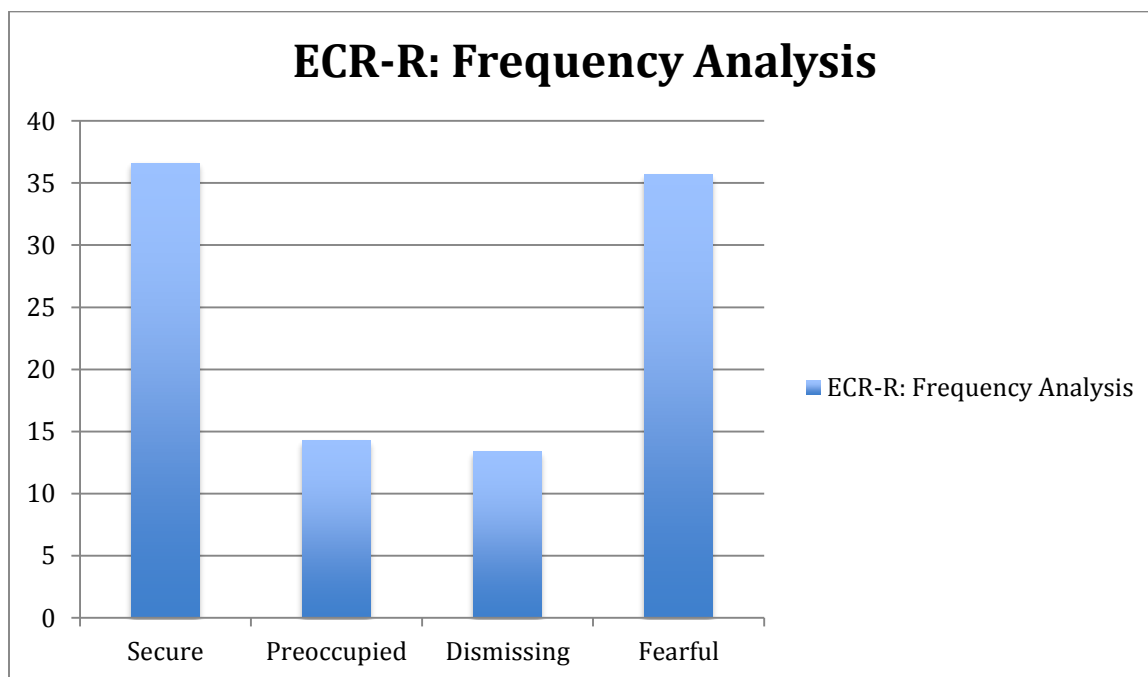
Prior to testing hypothesis, frequency analysis was conducted for all three measures: ECR-R, TOPS-R, and TEST. Of the 170 participants, 112 completed the ECR-R and were included in the frequency analysis. The ECR-R measures attachment on two subscales: anxiety and avoidance. Scores for each of these scales were calculated based on Fraley's (2012) suggested classification method. The medians of both the anxiety and avoidance subscales were calculated and the participants classified into categories as follows:

- 1) If the person's anxiety score is less than the median anxiety score and the person's avoidance score is less than the median score then person is assigned to the secure group.

- 2) If the person's anxiety score is less than the median anxiety score and the person's avoidance score is greater than or equal to the median avoidance score then the person assigned to the dismissing group.
- 3) If the person's anxiety score is greater than or equal to the median anxiety score and the person's avoidance score is greater than or equal to the median avoidance score then the person is assigned to the fearful group.
- 4) If the person's anxiety score is greater than or equal to the median anxiety score and the person's avoidance score is less than the median avoidance score then the person is assigned to the preoccupied group.

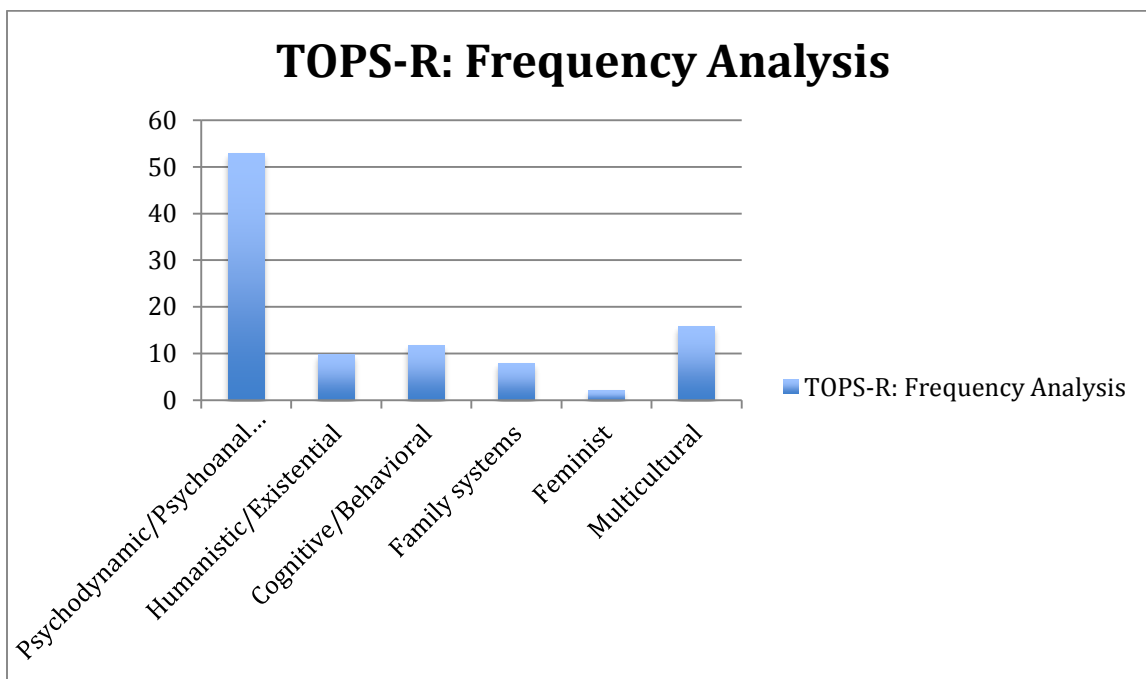
Based on this classification method, the sample included: 41 (36.61%) secure, 16 (14.29%) preoccupied, 15 (13.39%) dismissing, and 40 (35.71%) fearful licensed clinical social workers.

Figure 7. Frequency Analysis of ECR-R



Frequency analysis was conducted for TOPS-R. Of the 170 participants, those who completed the full measure and identified with one primary orientation were included in the analysis. Of the 170 participants, 102 surveys were included in the frequency analysis. Of the 102, the sample included the following: 54 (52.94%) identified as psychodynamic/psychoanalytic, 10 (9.80%) identified as humanistic/existential, 12 (11.76%) identified as cognitive/behavioral, 8 (7.84%) identified as family systems, 2 (1.96%) identified as feminist, and 16 (15.68%) identified as multicultural.

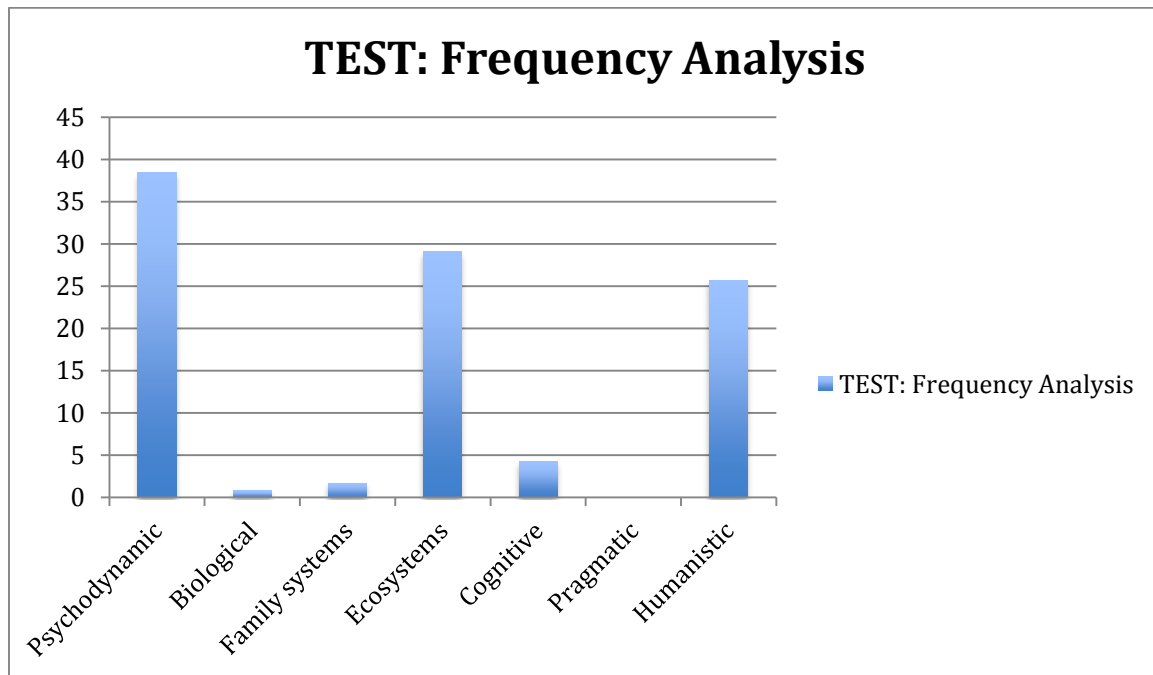
Figure 8. Frequency analysis of TOPS-R



Frequency analysis of TEST was also conducted. Of the 177 participants, those who completed the full measure and identified with one primary orientation were included in the analysis. Of the 177 participants, 117 were included in the analysis. The sample included the following: 45 (38.46%) identified as psychodynamic, 1 (0.85%) identified as biological, 2 (1.70%) identified as family systems, 34 (29.05%) identified as

ecosystems, 5 (4.27%) identified as cognitive, 0 (0%) identified as pragmatic, and 30 (25.64%) identified as humanistic.

Figure 9. Frequency analysis of TEST



Bivariate Analysis

Simple bivariate analysis was used to explore the relationship between the variables. Bivariate analysis explores whether a relationship exists between two variables and explores how the dependent variable may change when the independent variable is varied. Pearson's Chi square was used to examine the relationship between the independent variable, attachment pattern, and the dependent variable, theoretical orientation. Additionally, bivariate analysis was used to explore possible relationships between gender, race, age, years of practice, post-graduate training, graduate program and theoretical orientation.

The relationships found to be statistically significant are as follows: the relationship between TOPS-R and TEST, identified orientation and TOPS-R, identified

orientation and TEST, MSW graduate school and if theoretical orientation changed, and age and identified theoretical orientation. The following relationships were explored and no statistical relationship was found: the relationship between TOPS-R and ECR-R, the relationship between TEST and ECR-R, the relationship between identified orientation and ECR-R, the relationship between MSW graduate school and identified theoretical orientation, the relationship between MSW graduate school and TEST, and the relationship between MSW graduate school and TOPS-R.

Of the 170 participants, 163 disclosed their age. The relationship between age and self-identified theoretical orientation was found to be statistically significant at $p < .05$. The mean age for those who categorized as “CBT/Behavioral” was 46.89 with a standard deviation of 14.41. For those categorized as “psychodynamic” the mean age was 58.16 with a standard deviation of 14.18. For those categorized as “eclectic”, the mean age was 53.73 with a standard deviation of 11.31, and those categorized as “other” the mean age was 54.85 with a standard deviation of 14.79.

Table 12: Average Age by Self-Identified Theoretical Orientation

Average Age by Self-Identified Theoretical Orientation (N=163)**		
	Mean	SD
CBT/Behavioral	46.89	14.41
Psychodynamic	58.16	14.18
Eclectic	53.73	11.31
Other	54.85	14.79

* $p < .10$ ** $p < .05$ *** $p < .01$

Of the 170 participants, 163 identified both MSW graduate school and whether there was a change in their theoretical orientation. This relationship between MSW graduate school and whether theoretical orientation had changed was found to be

statistically significant at $p < .01$. Of the 163 respondents, 48.47% reported a change in their theoretical orientation while 51.53% reported no change in their theoretical orientation.

Of the 18 respondents who attended Columbia University, 66.6% reported a change in their orientation. Of the 12 respondents who attended Hunter College, 75% reported a change in their orientation. Of the 22 respondents who attended University of Pennsylvania, 59% reported a change in their orientation. Of the 7 who attended Yeshiva University, 71.4% reported a change in their theoretical orientation. Of the 23 respondents who attended Bryn Mawr, 60.8% reported no change in their orientation. Of the 26 respondents who attended New York University, 76.9% reported no change in their orientation.

Table 13: MSW Program and Change in Theoretical Orientation

MSW Program and Change in Self-Identified Theoretical Orientation*** (N=163)

		Change in Theoretical Orientation		
		Yes	No	Total
MSW Program	Adelphi	N 8	6	14
		% 10.13%	7.14%	8.59%
	Bryn Mawr	N 9	14	23
		% 11.39%	16.67%	14.11%
	Columbia	N 12	6	18
		% 15.19%	7.14%	11.04%
	Fordham	N 4	6	10
		% 5.06%	7.14%	6.13%
	Hunter	N 9	3	12
		% 11.39%	3.57%	7.36%
NYU	N 6	20	26	
	% 7.59%	23.81%	15.95%	
University of Pennsylvania	N 13	9	22	
	% 16.46%	10.71%	13.50%	
Yeshiva	N 5	2	7	

	%	6.33%	2.38%	4.29%
Other	N	13	18	31
	%	16.46%	21.43%	19.02%
Total	N	79	84	163
	%	48.47%	51.53%	100%

*p<.10 ** p<.05 *** p<.01

Of the 170 respondents, 97 provided theoretical orientation and completed the TOPS-R. This relationship was found to be a statistically significant relationship at $p < .01$. Those who identified as CBT, $N = 9$, also identified as cognitive on the TOPS-R. Those who identified as psychodynamic, $N = 38$, also identified as psychodynamic on the TOPS-R.

Table 14: TOPS-R and Self-Identified Theoretical Orientation

TOPS-R Type and Self-Identified Theoretical Orientation*** (N=97)

		TOPS-R Type								
		Cogniti ve	Femini st	Humanis tic	Mixe d	Multicultu ral	Family Systems	Psychodyna mic	Tot al	
Theoreti cal Orientati on	CBT/Behavioral	N	9	0	1	3	0	0	0	13
		%	9%	0%	1%	3%	0%	0%	0%	13%
	Psychodynamic	N	0	0	4	6	3	2	38	53
		%	0%	0%	4%	6%	3%	2%	39%	55%
	Eclectic	N	3	1	1	6	3	2	1	17
		%	3%	1%	1%	6%	3%	2%	1%	18%
	Other	N	0	0	2	4	5	2	1	14
		%	0%	0%	2%	4%	5%	2%	1%	14%
	Total	N	12	1	8	19	11	6	40	97
		%	12%	1%	8%	20%	11%	6%	41%	100%

*p<.10 ** p<.05 *** p<.01

Of the 170 participants, 102 completed the TEST and provided a theoretical orientation. This relationship was found to be statistically significant at $p < .01$. Of those

who identified as psychodynamic, N= 58, 51.7% also identified as psychodynamic on the TEST.

Table 15: TEST and Self-Identified Theoretical Orientation

Test Type and Self-Identified Theoretical Orientation*** (N=102)

		TEST Type								Total
		Biologic al	Cogniti ve	Ecosyste m	Famil y	Humanist ic	Mixe d	Psychodyna mic		
Theoretic al Orientati on	CBT/Behavioral	N	0	2	4	0	3	2	1	12
		%	0%	2%	4%	0%	3%	2%	1%	12%
	Psychodynamic	N	0	1	14	0	10	3	30	58
		%	0%	1%	14%	0%	10%	3%	29%	57%
	Eclectic	N	0	0	7	0	6	1	3	17
		%	0%	0%	7%	0%	6%	1%	3%	17%
	Other	N	1	0	7	1	4	0	2	15
		%	1%	0%	7%	1%	4%	0%	2%	15%
	Total	N	1	3	32	1	23	6	36	102
		%	1%	3%	31%	1%	23%	6%	35%	100%

*p<.10 ** p<.05 *** p<.01

Of the 170 participants, 84 were included in the analysis of the relationship between TOPS-R and the TEST. This relationship was found to be statistically significant at $p < .01$. Of those who identified as psychodynamic on the TEST, N = 29, 62% identified as psychodynamic on the TOPS-R.

Table 16: TOPS-R and TEST

TOPS-R Type and TEST Type*** (N=84)

		TOPS-R Type							Total	
		Cogniti ve	Femini st	Humanis tic	Mixe d	Multicultu ral	Family Systems	Psychodyna mic		
TEST Type	Cognitive	N	1	0	0	1	0	0	0	2
		%	1.2%	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	2.4%
Ecosystem	Ecosystem	N	3	1	1	10	6	0	6	27

	%	3.6%	1.2%	1.2%	11.9%	7.1%	0.0%	7.1%	32.1%
Family System	N	0	0	0	0	0	1	0	1
	%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	1.2%
Humanistic	N	6	0	3	3	3	0	7	22
	%	7.1%	0.0%	3.6%	3.6%	3.6%	0.0%	8.3%	26.2%
Mixed	N	1	0	0	0	0	1	1	3
	%	1.2%	0.0%	0.0%	0.0%	0.0%	1.2%	1.2%	3.6%
Psychodynamic	N	0	0	3	3	0	5	18	29
	%	0.0%	0.0%	3.6%	3.6%	0.0%	6.0%	21.4%	34.5%
Total	N	11	1	7	17	9	7	32	84
	%	13.1%	1.2%	8.3%	20.2%	10.7%	8.3%	38.1%	100.0%

*p<.10 ** p<.05 ***
p<.01

CHAPTER 5: DISCUSSION

This section summarizes and interprets the results of the study, reviews the limitations, addresses implications for clinical practice, and highlights areas for further research. The goal of this study was to explore the relationship between attachment pattern and theoretical orientation among clinical social workers practicing psychotherapy in outpatient settings. While this relationship was not found to be statistically significant, there were several noteworthy findings.

Findings

A statistically significant relationship was found between identified theoretical orientation and TOPS-R, identified theoretical orientation and TEST, and between TOPS-R and TEST. The relationship between these variables indicates consistency among the respondents; there was continuity among how the participants scored on the measures and how they self-identified.

TOPS-R and TEST.

The TOPS-R and the TEST are both measures of theoretical orientation. There is overlap of the subgroups on both measures with the exception of ecosystem, biological, and pragmatic, which are only included on the TEST. The TOPS-R is a face value measure and the TEST is designed to capture the tenets or ideology of the theoretical orientations. The relationship between the TOPS-R and the TEST may indicate that participants who scored in one category on the TOPS-R tended to score in the same category on the TEST measure. In fact, this significant correlation between these measures could in part be due to the psychodynamic subgroup. Of the 29 participants who identified as psychodynamic on the TEST, 18 identified as psychodynamic on the TOPS-R.

Of the 22 participants who identified as humanistic on the TEST, 6 identified as cognitive on the TOPS-R and 7 identified as psychodynamic on the TOPS-R. On the face valid measure, these participants identified as both cognitive and psychodynamic but identified more with humanistic principles on the TEST. Examples of humanistic items on the TEST include: “the therapist’s unconditional positive regard for the client is a crucial therapeutic factor”, “change occurs in therapy because of the therapist’s empathic, non-judgmental, positive attitude towards the client”, and “it is important for the therapist to respond to the client with spontaneous, genuine affect.” These “humanistic” items are similar to therapeutic common factors, or the ingredients of effective therapy shared by all theoretical orientations and approaches (Hubble, Duncan, Miller, & Wampold, 2010). One of these common factors is ‘therapist characteristics’ and includes: warmth/positive regard, empathic understanding and acceptance (Grencavage & Norcross, 1990). It is possible that participants identified with these “humanistic items” on the TEST because the items are reflective of therapeutic common factors, or therapist qualities.

Age and identified theoretical orientation.

Age and identified theoretical orientation was established as a statistically significant relationship. Not surprisingly, younger participants tended to identify as CBT/Behavioral and older participants tended to identify as psychodynamic. Research has shown that therapists in practice the longest tend to adopt psychodynamic or psychoanalytic orientations while younger therapists tend to identify as eclectic (Steiner, 1978). Anecdotally, it does seem that newer therapists, or therapists in training, seem to gravitate toward orientations or interventions that are more concrete and prescriptive, such as CBT. Also, whereas psychodynamic theory emerged in the 1920’s, CBT materialized in the 1960’s and could be appealing to younger social workers because it is

a newer theoretical orientation. Additionally, given the recent push for evidence-based practice both in training and in the field, younger social workers recently graduated from MSW programs may be more likely to ascribe to evidenced based approaches, such as CBT.

MSW program and change in theoretical orientation.

A statistically significant relationship was found between MSW graduate school and whether clinician theoretical orientation had changed. The analysis of this relationship did not control for other variables, including clinician age. Additionally, the survey did not inquire whether the MSW program identified with a particular theoretical orientation. Nonetheless, we can speculate that perhaps those respondents who attended New York University and Bryn Mawr, who reported no change in their theoretical orientation, found a goodness of fit between their own orientation and that of the MSW program they attended. Likewise, for those who attended Columbia University and the University of Pennsylvania and reported that their orientation had changed, perhaps they did not find a goodness of fit between the MSW program and their own personal orientation. This relationship could also be reflective of the phase of clinician career. Perhaps those social workers who reported that their orientation had not changed are in the early stages of their career while those who reported their orientation had changed are further on in their career. This relationship represents a gap in the research and is an area for future social work research.

Attachment pattern and theoretical orientation.

The hypothesis of the study asserted that there was a relationship between attachment pattern and theoretical orientation. The fact that no statistically significant relationship was found between attachment pattern and theoretical orientation could be an

indication that clinical social workers are not actively engaging in the therapeutic use of self when choosing a theoretical orientation. A powerful tool for promoting growth in clients, the therapeutic use of self can be defined as use of personality, use of belief system, use of relational dynamics, use of anxiety, and use of self-disclosure (Dewane, 2006). These relational dynamics may involve the social worker's attachment pattern, the unconscious processes involved in relating to others. It is possible that no relationship was found between theoretical orientation and attachment pattern because clinical social workers may not engage the "self" when choosing a theoretical orientation.

The relationship between client and social worker is thought to be more important than the specific orientation or technique a therapist utilizes (Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Hubble, Duncan, Miller & Wampold, 2010; Norcross, 2010; Wampold, 2010). Yet there is a strong push in the mental health field to employ evidenced-based practice. Evidence-based practice involves using specific approaches and interventions that have evidence to support efficacy. Certain treatment modalities, including manualized treatment protocols, tend to be designed to gather evidence about efficacy. The danger is that adherence to a specific approach or technique can strip away therapeutic authenticity, devalue the role of social worker in the two-person therapeutic dyad, thus disregarding the evidence that the most effective change agent is the therapeutic relationship. This may teach graduate students and clinicians alike that who they are in the room does not matter as much as what they do in the room, resulting in missed therapeutic opportunities.

In fact, as a clinical social worker, who you are in the room with the client (your personality traits, personal values, beliefs and relational approach) is more important than

what you know (techniques and theories) as a social worker (Edwards & Bess, 1998). The social worker's "self" is often considered the most significant therapeutic tool (Dewane, 2006; McTighe, 2010; Reupert, 2007). This means the social worker *must* engage the self and integrate his or her personal and professional values. In order to do so, social workers must take an inventory of self and develop deeper self-knowledge (Edwards & Bess, 1998). To fully understand self in relation to other, the social worker should "engage in a systematic inventory of their personal traits and characteristic behaviors which come to them as naturally as breathing" (Edwards & Bess, 1998, p. 97).

This notion of self-knowledge, or self-awareness, is often touted as an integral component to clinical practice as a social worker and yet it is often only addressed superficially in graduate training. Graduate programs may engage in cursory exercises such as writing an autobiography, reflecting on personal biases, or exploring potential challenging clients, but it seems that there is a fear of probing too deeply into the personal. It does a great disservice to the social worker and client alike to ignore the myriad ways a social worker's personal self will impact the clinical work.

According to Edwards & Bess (1998) "the development of a therapist's self-awareness must carry at least as much weight in his or her professional education and training as the accumulation of knowledge about theories and methodologies" (p. 98). Engaging in therapy as the *client* is not structured into graduate training programs for MSW students as it is for some mental health disciplines. Engaging in personal psychotherapy as a client is by no means the only avenue to improved self-awareness, but it is perhaps the most effective. Learning about the therapeutic use of self is usually left to the relationship between supervisor and supervisee in graduate field placements and

post-graduate job placements. While this is an appropriate use of the supervisor-supervisee relationship, this relationship is typically taxed by the many demands of field placements. Leaving this relationship as the only means for the beginner social worker to learn of therapeutic use of self, means that this critical lesson may in fact get missed. The use of self, if absent in education and training, may then be absent in the practice.

Social work education today is more focused on cognitive-behavioral theories and other time-limited treatments that emphasize outcomes over process (Urdang, 2010). By glossing over the “process” of psychotherapy, social work education may in fact be diminishing the importance of self-reflection and self-awareness in the context of psychotherapy. In fact, Applegate (2004) noted that

Knowledge for practice increasingly has become skill-based and performance-oriented, to the relative neglect of meaning, emotion, and dynamics of inner-life...So-called competency-based training, focused on the behavior rather than the person behaving, does little to equip social work students with the critical analytic skills they need to address the multilayered complexity of their clients’ problems. (pp. 33-34)

Urdang (2010) posits that these “critical analytic skills” include self-analytical skills, or self-awareness and insight. These self-analytical skills are necessary to help prevent boundary violations and clinician burnout and likely, increase therapeutic efficacy.

The Council on Social Work Education (CSWE), the accrediting board for all undergraduate and graduate academic programs in the United States, provides guidelines that shape the curriculum of social work education. In the Educational Policy and Accreditation Standards, the CSWE states that social workers practice “self-reflection

and self-correction to assure continual professional development” (2012, p. 3) and “recognize and manage personal values in a way that allows professional values to guide practice” (2012, p. 4). These standards do not address the complex critical analytic skills required for effective psychotherapy and also seem to direct social workers away from their inner world in order to allow their professional values to guide clinical work. The separation of personal and professional values may discourage the use of therapeutic self in the context of therapy and direct trainees away from using themselves as a therapeutic tool.

Findings of this study suggest that by fragmenting the personal and professional, the social worker is unable to find a “goodness of fit” between self and orientation. Edwards and Bess (1998) believe that the whole person should be a filter for choosing a theoretical orientation. They assert that “no technique...should ever be applied to a therapist’s own work if it feels in the slightest incompatible with the therapist’s sense of self” (p.99). Research supports this position indicating that for increased job satisfaction and for therapeutic efficacy, theoretical orientation should be congruent with the personal values of the therapist (Carlson & Erickson, 1999; Cornsweet, 1983; Vasco & Dryden, 1994). The successful integration of personal and professional self would allow the social worker to authentically engage in therapeutic process.

Additional Findings

TOPS-R and TEST frequency analysis.

For complete frequency data, refer to Chapter 4, figures 8 and 9. On the TOPS-R, the overwhelming majority of the participants identified as psychodynamic/psychoanalytic and utilized psychodynamic or psychoanalytic principles in their practice. The next most endorsed theoretical orientation was multicultural,

followed by cognitive/behavioral and humanistic/existential. Like the TOPS-R, the most endorsed category on the TEST was psychodynamic, followed by ecosystems and humanistic. A smaller amount of participants identified as psychodynamic on the TEST versus the TOPS-R. This may indicate that while participants identify on the face value measure as psychodynamic, they are identifying with the subtle items of humanistic and ecosystems.

The majority of participants were recruited through two listservs: the New York State Society for Clinical Social Work and the Pennsylvania Society of Clinical Social Work. Given that the majority of participants on both measures who endorsed the psychodynamic orientation, it is probable that these two organizations attract those with a psychodynamic or psychoanalytic orientation.

ECR-R frequency analysis.

An interesting and noteworthy finding emerged when computing the frequency analysis of the ECR-R. Of the 170 participants, 112 completed the measure and were included in the frequency analysis. The sample included: 41 (36.61%) secure, 16 (14.29%) preoccupied, 15 (13.39%) dismissing, and 40 (35.71%) fearful licensed clinical social workers. This breakdown varies greatly from both the general population and studies including psychologists, but is quite similar to a United Kingdom study including family therapists. There were no studies found reporting the attachment pattern frequencies of clinical social workers.

Several studies have conducted frequency analyses of the attachment patterns of the general population. Hazan and Shaver (1987), in their study of 620 adults, found that 56% identified as secure, 35% as avoidant and 19% as anxious. Similarly, the 1997 study of 8,000 adults found that 59% identified as secure, 25% as avoidant and 11% as anxious

(Mickelson, Kessler & Shaver). Rates of attachment patterns among psychologists have been found to be different than in the general population. Leiper and Casares (2000) found that of 196 British psychologists, 70% were securely attached, 9% were preoccupied, 18% were dismissing and 3% were fearful. Fleischman and Shorey (2014) found that of 290 psychologists from the United States and Canada 72% fell into the secure category with 14% preoccupied, 8% dismissing and 6% fearful.

These discrepancies between the attachment patterns of the general population and psychologists could be explained by the social desirability bias in that presumably, psychologists are savvy to the measures and can anticipate which items will lead to a secure attachment pattern. It is also conceivable that the population of psychologists may be more secure in attachment patterns, that people with secure attachment patterns may be drawn to the mental health field.

However, the sample in this study varies greatly from both the general population and the previous studies of psychologists. As noted, of the 112 participants who completed the ECR-R, 35.71% of this sample fell into the fearful attachment pattern, with 36.6% secure, 14.29% preoccupied, and 13.39% dismissing. This is a surprising result given both how the general population and psychologists have scored. However, the attachment patterns in this study are similar to a study of family therapists in the United Kingdom. Yusof and Carpenter (2012) found that of 82 family therapists, 29% fell into the secure category with 19% preoccupied, 18% dismissing, and 33% fearful. Over half of the 82 respondents in Yusof and Carpenter's (2012) study had a prior professional qualification as a social worker.

The disorganized, or fearful, attachment pattern is “usually preceded by a serious relationship disruption, perhaps abuse, neglect, or other early traumatic events that impinge on the child’s emotional and relational development” (Brandell & Ringel, 2007, p. 166). Individuals with disorganized attachment patterns desire social connection but this desire is countered by the fear of rejection. These individuals view themselves as undeserving of love and support from others (Bartholomew, 1990) and as such, tend to avoid relationships in which they could be vulnerable to rejection. Those with disorganized attachment patterns “are caught in an approach-avoidance conflict: both lack of social intimacy and the prospect of vulnerability in intimate relations are anxiety-inducing” (Bartholomew, 1990, p.167). These individuals may present as needy and dependent, desperately seeking care and connection, or they may present as compulsive caregivers (Blatt & Levy, 2003 as cited by Brandell & Ringel, 2007).

Perhaps individuals with a disorganized attachment pattern may then be drawn to clinical social work as a way to meet the need for social connection without risking the vulnerability of rejection present in most mutually reciprocated relationships. Embodying the role of clinician may serve as a surrogate for connection, sublimating the clinicians’ needs for connection through the role of caregiver. In the mental health field, there is an archetype of the wounded healer, therapists drawn to the work as a result of their own personal trauma or attachment injuries which may have bestowed upon them certain healing powers (Guggenbuhl-Craig, 1971; Nouwen, 1972; Sedgwich, 1994). While a background of problematic experiences may provide a level of attunement and empathy to the distress of clients, it also may prove to be a barrier to effective therapeutic intervention and process. Those who choose “social work for self-reparation and the

working through of old injuries or conflicts, there is potential for growth, but also greater likelihood that conflicted care will be part of the caretaker's response" (Lackie, 1982, p. 198). Failure to resolve his or her own distress may leave the therapist unable to respond to countertransference and thus, could be potentially harmful to the client (Dozier, Cue, & Barnett, 1994).

Research has shown that one predictor of entering the mental health field is traumatic childhood experiences in the family of origin (Chudnof, 1988; Elliot & Guy, 1993; Lackie, 1983). Studies also show that social work students have a high frequency of family of origin trauma (Black, Jeffreys, & Hartley, 1993). Lackie (1983) found that social workers with more profound family dysfunction were more likely to be in private practice than those social workers with less family dysfunction. Elliot & Guy (1993) found a high prevalence of trauma and family dysfunction in the childhoods of mental health professionals. Guy (1987) indicated "the needy therapist may unwittingly or even intentionally exploit therapeutic relationships in an attempt to meet his or her own needs to the detriment of the patient" (p. 14). This supports Dozier, Cue, & Barnett (1994) research suggesting that attachment insecurity may interfere with the therapists ability to challenge the client's relationship patterns and may respond more readily to his or her own countertransference.

The high frequency of fearful attachment pattern in this study could be reflective of the number of wounded healers drawn to the field of social work. However, it is also conceivable that the work itself may have altered the attachment pattern of the clinician through vicarious traumatization or compassion fatigue. Compassion fatigue refers to negative psychological outcomes associated with the stress of helping or wanting to help

traumatized individuals (Figley, 2002). Compassion fatigue is thought to involve two processes: burnout and vicarious trauma (Adams, Boscarino, & Figley, 2006). Burnout refers to the emotional exhaustion from caring and vicarious trauma refers to the symptoms associated with secondary exposure to traumatic client material. This includes: difficulty separating work life and personal life, intrusive imagery, increased negative arousal, cognitive changes, loss of hope, functional impairment, and destructive attempts at self-care (Adams, Boscarino, & Figley, 2006).

In a 1999 study, Brandon examined the relationship between adult attachment pattern and vicarious traumatization. The aim of the study was to explore whether the clinician's attachment pattern was disrupted by vicarious traumatization. Securely attached clinicians reported fewer disruptions in their attachment patterns than clinicians with insecure attachment patterns.

West (2015), in a systematic review, examined the association between adult attachment pattern and burnout or compassion fatigue across 10 studies of diverse disciplines, including social work. West (2015) found consistent findings for secure and anxious attachment patterns: secure attachment pattern was associated with lower levels of burnout and/or compassion fatigue and attachment anxiety was associated with higher levels of burnout and/or compassion fatigue. This review found “compelling evidence of a link between insecure adult attachment style and negative psychological outcomes associated with emotionally challenging work in health and human services occupations” (West, 2015, p. 585).

These studies highlight that a secure attachment pattern is seen as a protective factor for clinicians. Secure attachment patterns may help mitigate the impact of

vicarious traumatization and reduce the likelihood of therapeutic burnout. However, it is also conceivable that prolonged exposure to traumatic client material may alter the clinician's attachment pattern. In fact, this could be an explanation for the large percentage of social workers with a fearful attachment pattern in this current study. It is possible that the clinicians' own attachment pattern may have been altered from engaging in the therapeutic process. Clinical social workers work with clients who often have complicated pathologies and long histories of trauma. It is possible that by engaging in psychotherapy with clients who have been traumatized, they themselves may suffer from secondary trauma, which given chronic exposure, may disrupt or even alter the clinician's attachment pattern.

Implications for Practice

This study highlights the need to pay careful attention to the attachment patterns of social workers throughout graduate school, training, and clinical practice. Social worker attachment patterns inform all aspects of clinical work including theoretical orientation. This section addresses the implications for social work education and both the micro and macro levels of clinical practice.

Social work education.

Graduate programs in social work are uniquely positioned to mold future clinical social workers. These programs have the ability to shape the social worker's clinical perspective, to provide social work students with the proper tools to engage in self-care and to teach social workers about the use of therapeutic self. The social worker's self and therapeutic use of self is considered a primary therapeutic tool (Dewane, 2006; McTighe, 2010; Reupert, 2007) and as such, it is imperative that social workers learn about the concept early on in clinical training. This use of self includes the social worker's

attachment pattern, or view of self-in-relation-to-other. Understanding how to effectively engage the self and integrate personal and professional values needs to be incorporated into the foundation of graduate curriculum. This would help equip future social workers with some of the necessary critical analytical skills required to navigate the conscious and unconscious clinical material.

As gatekeepers of the profession, schools of social work are responsible for recognizing the potential impact of personal trauma on the helping process and addressing these growth spots in the early stages of training. Identifying the social worker's attachment pattern early in training may prove to be significant protective factor throughout the social worker's career. Learning early on about the impact our attachment pattern has on the ability to withstand the clinical work will allow social work students to form reasonable expectations about the type of work that suits them best, setting social work students up for a healthier career path.

Graduate school is often a social workers first exposure to the various theoretical orientations. Using the lens of the social worker's own attachment pattern to understand the orientations may help the social worker choose an orientation which is personalized, better suited to his or her approach to intimacy. Awareness of interpersonal relational capacities, or attachment patterns, could help the social worker find a theoretical orientation that is aligned with personal values, which research has shown reduces burnout and improve therapeutic efficacy (Carlson & Erickson, 1999; Cornsweet, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994; Vasco, Garcia-Marques, & Dryden, 1993).

Practice and continuing education.

In the field, awareness of the social worker's attachment pattern may serve as a protective factor with regard to career satisfaction, clinical effectiveness, and reduction of burnout. Research shows that insecure attachment patterns reduce clinicians' ability to effectively utilize countertransference, impact ability to develop working alliance, cope with stress and effectively use social supports (Bowlby, 1969/1982; Mikulincer & Shaver, 2007). As such, additional supervision may be needed for social workers with an insecure attachment pattern in order to identify and explore reactions to clients. Awareness of attachment patterns would also allow the clinical social worker to make arrangements for deepened social supports when dealing with challenging clients or clients with a history of trauma.

Given that who the social worker is in the room is more important than what they know, ongoing training is needed around the personal world of the social worker. Deepening the understanding of self would improve clinical encounters, but also serve as a means to protect the social worker. Staying attuned to his or her inner world may help the social worker know when to engage in self-care and harness their resources to protect themselves. As a social worker, self-care is a critical skill required to help manage stress of clinical work and guard against burnout and secondary trauma. Social workers who enter the field with a history of trauma are more susceptible to the vulnerabilities of chronic exposure to traumatic clinical material.

Awareness of self-care has been incorporated into graduate education but is not usually embedded in the culture of mental health agencies. While social workers are encouraged to engage in self-care, "they are provided minimal guidance in conceptualizing this critical process that promises both self-preservation and professional

goal attainment... suggestions offered for promoting personal care are often found to be of limited use or effectiveness” (Cox & Steiner, 2013, p. 2). There are often agency barriers to practicing self-care. For example, a social worker may need to take a break after a challenging client but is unable to do so given a full clinical schedule. Or, if the social worker did take a needed break, he or she may fall further behind on work, thereby creating more stress. Often times agencies have requirements on the number of clinical hours a social worker has available, making “time” at work to engage in self-care unavailable.

Research shows that work environment has much to do with social worker burnout (Maslach & Leiter, 2008). Six domains of the work environment have been associated with burnout including: workload, control, reward, community, fairness, and values (Maslach & Leiter, 2008). Common in mental health agencies, social workers are often overworked and underpaid, asked to do a significant amount of work with little resources, reward or control. Often there is confusion about the exact role of the social worker, the scope of the job and the expectations of others, which can lead to role conflict. In fact, role conflict and role ambiguity are associated with greater burnout (Cordes & Dougherty, 1993; Maslach, Jackson, & Leiter, 1996). Training for both social workers and agencies is needed to find practical solutions to ensure the social workers have the ability to engage in self-care without negative consequences. With an awareness of the impact of burnout on social workers in general and specifically the vulnerabilities of social workers with insecure attachment patterns, agencies may need to work to make adjustments to workload, reward and level of control, while building a sense of community and managing with a spirit of fairness.

The push for evidenced based practice, and treatments that third party payors will cover, has reduced the importance of the selection of an orientation that “fits” with the social worker’s personality and relationship style and with the needs of the client. Uniformly applying one treatment with all clients ignores the complicated intricacies of our client’s lives. Agencies may have policies around the type of intervention that the clinicians may provide and yet research has shown that for reduction of clinician burnout and for increased therapeutic efficacy, the interventions need to be aligned with clinicians’ personal values (Carlson & Erickson, 1999; Cornsweet, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994; Vasco, Garcia-Marques, & Dryden, 1993). To protect their employees, improve overall quality of care and effectiveness of interventions, agencies may want to allow the social worker to dictate the type of treatment or intervention to utilize with clients.

Limitations

Inherent in the research design are limitations. This design relied on an online survey, which limited the sample to those social workers with access to the internet, had private use of the internet and who were comfortable with internet technology. Additionally, the design relied on the clarity of the survey items. If the participants had questions regarding the items on the questionnaire, they were not able to seek clarification and as such, participants may have interpreted the questions differently, impacting the validity of the study.

The study relied on self-report measures, which introduce additional limitations including social desirability bias. Social workers who know what a secure attachment looks like may be inclined to endorse items on the self-report measure that reflect secure

attachment styles instead of answering truthfully. Self-report measures rely on honesty of the respondents and may not tap into the unconscious processes of respondents.

Limitations specific to this study include the small sample size and the amount of missing data among the participants. Although the overall sample size was 170, for much of the analysis, only 84 of the participants completed all of the measures. This small sample size could have contributed to the lack of a relationship found between ECR-R and theoretical orientation. The missing data could have been due to the length of the questionnaire and possible response fatigue.

Another major limitation is the lack of diversity among the sample. The sample was predominantly Caucasian (95.81%) and female (84.71%) limiting the generalizability of the findings beyond this specific group. The sample in this study does not vary too greatly from the population of social workers in the United States. According to the NASW Center for Workforce Studies, of the social workers in the United States, 81% are women and 86% are Caucasian (NASW Center for Workforce Studies, 2006).

With regard to sampling procedures, this study relied on clinical social workers affiliated with the Pennsylvania Society of Clinical Social Work, the New York State Society for Clinical Social Work and those in the professional network of the researcher. Pennsylvania and New York are northeastern states and there may be a regional bias. As such, the sample may not be generalizable beyond the northeastern area.

There was also a lack of diversity among the theoretical orientations. Most of the sample identified as psychodynamic, other orientations were underrepresented. The results of the study are not generalizable past the population of clinical social workers

who practice in outpatient settings and have such affiliations. This study may also demonstrate a lack of diversity among clinical social work practitioners in psychotherapy settings, perhaps highlighting a gap in service provision.

Another limitation of the study is the use of a moderately reliable instrument, the TEST. This measure was used because it was designed specifically for social workers and was designed to capture the multi-theoretical way in which the social worker may conceptualize his/her practice. Due to the moderate reliability of the TEST, the TOPS-R was also used. The TOPS-R has solid psychometrics and is designed to assess the same construct, theoretical orientation.

Lastly, use of the ECR-R is not without limitations. The instructions on the ECR-R read, "The statements below concern how you feel in emotionally intimate relationships. We are interested in how you *generally* experience relationships, not just in what is happening in a current relationship" (Brennan et al., 1998, p. 69). Although the scale is designed to capture a general pattern of adult attachment, most of the questions are geared toward experience in romantic relationships. Even though the instructions allow respondents who are not currently in romantic relationships to provide accurate answers, the items may be problematic for some who do not interpret the items in general terms.

Areas for Future Research

More research is needed that explores the relationship between attachment pattern and theoretical orientation of clinical social workers. This section highlights the areas for future social work research that emerged from this study. Future research is indicated in both graduate education and clinical practice.

Graduate education.

Graduate programs in social work are the primary point of exposure to clinical concepts and frameworks. As such, it is necessary to explore in greater detail the curriculum of graduate programs in social work. Exploring the MSW curriculum would provide insight into the extent to which clinical concepts such as attachment patterns and therapeutic use of self are addressed.

This study highlights the lack of attention to personality characteristics of the clinician in regard to selection of theoretical orientation. Further research is needed to explore the intricacies of theoretical orientation selection including the extent to which the MSW curriculum impacts selection of social workers' theoretical orientation. The deliberate choice of theoretical orientation is associated with job satisfaction and therapeutic efficacy and more work is needed to understand how the social worker chooses an orientation so the process is personalized rather than prescriptive.

Clinical practice.

Selection of theoretical orientation has been attributed to personal choices predicated on clinical experience, personal values, graduate training, and personal and professional development experiences (Cornsweet, 1983; Norcross & Prochaska, 1983; Poznanski & McLennan, 1995; Vasco & Dryden, 1994). Engaging clinical social workers in semi-structured interviews would help understand the role of personal beliefs, values, and relational dynamics in choosing a theoretical orientation. This could shed further light on the process of choosing an orientation that engages the personal self of the social worker.

The self, and the therapeutic use of self is thought to be the most effective tool a clinical social worker possesses (Dewane, 2006; McTighe, 2010) and the primary tool to

facilitate change (Reupert, 2007). A social worker's attachment pattern could be considered a domain of therapeutic use of self. More research is needed to determine the extent to which clinical social workers are using the domains of therapeutic use of self including: use of personality, use of belief system, use of relational dynamics, use of anxiety, and use of self-disclosure.

This study highlighted the relationship between vicarious trauma and attachment patterns of clinicians. The social worker's attachment pattern serves as a protective factor against burnout and compassion fatigue. Further research is needed to explore if the social worker's attachment pattern is altered through the therapeutic work, both in a corrective manner and also in response to chronic exposure to vicarious trauma.

Replication of this study with a larger sample could be done to validate the ECR-R frequencies among clinical social workers found in this study. It may be beneficial to use the Adult Attachment Interview (AAI) in an attempt to reduce social desirability bias and the limitations of self-report measures. Perhaps targeting clinicians who are deeply affiliated with psychodynamic, cognitive, humanistic, family systems orientations would help to determine if there is a relationship with orientation and attachment style.

Conclusion

This study explored the relationship between the attachment pattern and theoretical orientation of clinical social workers providing psychotherapy in outpatient settings. Although that particular relationship was not found to be significant, there were many noteworthy findings. The study underscores that careful assessment of social worker attachment patterns needs to be a fundamental component of graduate education and clinical training. All social workers in ongoing clinical practice, regardless of

attachment pattern, need to engage in self-care to minimize the impact of vicarious trauma from client material.

The absence of a relationship between theoretical orientation and attachment pattern could indicate that social workers are not actively engaging the use of self when choosing an orientation. This depersonalization of orientation selection may be due to the push for evidence-based practice and treatment, minimizing the importance of an orientation that “fits” with the social worker. Choosing an orientation that is not aligned with the “self”, may lead to career dissatisfaction, ineffective clinical interventions, and burnout.

This study identified a significant number of social workers with a disorganized, or fearful, attachment pattern. While this may be reflective of the number of wounded healers drawn to the field, it also could be a result of the impact of clinical work. The attachment patterns of clinical social workers may in fact be altered by prolonged exposure to traumatic client material. This highlights the possible vulnerabilities of a great number of social workers. Awareness of attachment patterns would allow the social worker to approach clinical work with better care, approach countertransference with a keener lens, and engage in deeper self-awareness. This would help to protect the social worker and it would improve clinical encounters and client care.

While there has been a wealth of research on the attachment patterns of clients, there remains a gap in the literature with regard to the myriad ways in which the social worker’s attachment pattern impacts clinical work. This study provides insight into the significance of the personal world of the social worker. These insights can be incorporated into graduate education, clinical training, and clinical practice. Social

workers in all stages of practice need to be thoughtful about how their attachment pattern impacts clinical process including the potential challenges of clinical work. In addition to the requisite question ‘what is your theoretical orientation?’ social workers need to start asking ‘what is my attachment orientation?’

CHAPTER 6 – REFERENCES

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Appendix A (Letter of Invitation)

Dear Colleague,

My name is Marisa Miller Nero and I am a clinical social worker and doctoral candidate at the University of Pennsylvania School of Social Policy and Practice. I invite you to participate in my dissertation research on the adult attachment patterns and theoretical orientations of clinical social workers. Findings will help to inform the theoretical orientation selection process for clinical social workers and contribute to the current knowledge base of the profession.

In order to participate you need to have an LICSW/LCSW, or equivalent, and need to be providing psychotherapy in an outpatient setting. Participation involves consenting to participate, completion of demographic information, and completion of three short instruments. **This survey will take about 20 minutes to complete.**

Your participation in this study is voluntary, confidential and anonymous. You may choose not to answer all of the questions and you may discontinue the survey at any time. There are no known risks to participating.

If you have questions about your participation in this study or about your rights as a research participant, you may contact me anytime at 347-421-0846. You may also call the Office of Regulatory Affairs at the University of Pennsylvania at (215) 573-2540.

If you believe you meet the criteria and are willing to participate in the study, please click on the following link that will direct you to the online survey.

[Insert link & password here]

Thank you in advance for your participation.

Sincerely,

Marisa Miller Nero MSW, LCSW

Doctorate of Clinical Social Work Candidate
School of Social Policy and Practice
University of Pennsylvania

Appendix B (Informed Consent)

Informed Consent

Purpose/Procedure: You are being asked to participate in this study because you are a clinical social worker. The purpose of this study is to explore the relationship between adult attachment style and theoretical orientation among clinical social workers providing psychotherapy in outpatient settings. The study is being conducted as a requirement for a dissertation in social work. Participation in this study involves completion of an online survey that should take about 20 minutes to complete.

Risks: There are no known risks involved. However, if you find some of the questions to be upsetting, you may discontinue the survey at any time.

Benefits: There are no direct benefits to you. Participation in the study will contribute to the advanced knowledge base within the field of social work.

Confidentiality: Your answers will be confidential. You will not be asked to reveal your identity and you will remain anonymous. No identifying information will be collected and the researcher will not be able to associate any responses with identities of the participants. The collected data will be encrypted and kept on a password-protected computer that only the researcher can access.

Voluntary Participation and Withdrawal: Taking part in this study is completely voluntary. If you decide to take part, you are free to withdraw at any time.

Compensation: There will be no compensation for participation in this study.

If you have questions: The researcher conducting this study is Marisa Nero, LCSW. If you have questions later, you may contact Marisa Nero at marisamnero@gmail.com or at 1-347-421-0846. If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Office of Regulatory Affairs at 215-573-2540 or access their website at <http://www.upenn.edu/regulatoryaffairs>.

By checking this box, I am agreeing to the terms of the informed consent and study requirements.

Appendix C (Survey)

Thank you for your participation in this study. Your participation is anonymous and your answers will be kept confidential.

Gender: _____ **Age:** _____ **Race:** _____

MSW Graduate School: _____ **Years of Practice:** _____

Post-Masters Advanced Training: **yes** **or** **no**

If yes, what type? _____

Theoretical Orientation: _____

Has Theoretical Orientation Changed Since Practicing? **yes** **or** **no**

If yes, what was previous theoretical orientation? _____

If yes, what contributed to change in theoretical orientation?

practice setting **agency orientation** **supervision**
own therapy **advanced training** **personal experience**
clinical experience **other** _____

Experience In Close Relationships Scale – Revised

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by circling a number to indicate how much you agree or disagree with the statement.

QUESTION	1=Strongly
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		Disagree.....7=Strong Agree						
1.	I'm afraid that I will lose my partner's love.	1	2	3	4	5	6	7
2.	I often worry that my partner will not want to stay with me.	1	2	3	4	5	6	7
3.	I often worry that my partner doesn't really love me.	1	2	3	4	5	6	7
4.	I worry that romantic partners won't care about me as much as I care about them.	1	2	3	4	5	6	7
5.	I often wish that my partner's feelings for me were as strong as my feelings for him or her.	1	2	3	4	5	6	7
6.	I worry a lot about my relationships.	1	2	3	4	5	6	7
7.	When my partner is out of sight, I worry that he or she might become interested in someone else.	1	2	3	4	5	6	7
8.	When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.	1	2	3	4	5	6	7
9.	I rarely worry about my partner leaving me.	1	2	3	4	5	6	7
10.	My romantic partner makes me doubt myself.	1	2	3	4	5	6	7
11.	I do not often worry about being abandoned.	1	2	3	4	5	6	7
12.	I find that my partner(s) don't want to get as close as I would like.	1	2	3	4	5	6	7
13.	Sometimes romantic partners change their feelings about me for no apparent reason.	1	2	3	4	5	6	7
14.	My desire to be very close sometimes scares people away.	1	2	3	4	5	6	7
15.	I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.	1	2	3	4	5	6	7
16.	It makes me mad that I don't get the affection and support I need from my partner.	1	2	3	4	5	6	7
17.	I worry that I won't measure up to other people.	1	2	3	4	5	6	7
18.	My partner only seems to notice me when I'm angry.	1	2	3	4	5	6	7
19.	I prefer not to show a partner how I feel deep down.	1	2	3	4	5	6	7
20.	I feel comfortable sharing my private thoughts and feelings with my partner	1	2	3	4	5	6	7
21.	I find it difficult to allow myself to depend on romantic partners.	1	2	3	4	5	6	7
22.	I am very comfortable being close to romantic partners.	1	2	3	4	5	6	7
23.	I don't feel comfortable opening up to romantic partners.	1	2	3	4	5	6	7
24.	I prefer not to be too close to romantic partners.	1	2	3	4	5	6	7
25.	I get uncomfortable when a romantic partner wants to be very close.	1	2	3	4	5	6	7

26.	I find it relatively easy to get close to my partner.	1	2	3	4	5	6	7
27.	It's not difficult for me to get close to my partner.	1	2	3	4	5	6	7
28.	I usually discuss my problems and concerns with my partner.	1	2	3	4	5	6	7
29.	It helps to turn to my romantic partner in times of need.	1	2	3	4	5	6	7
30.	I tell my partner just about everything.	1	2	3	4	5	6	7
31.	I talk things over with my partner.	1	2	3	4	5	6	7
32.	I am nervous when partners get too close to me.	1	2	3	4	5	6	7
33.	I feel comfortable depending on romantic partners.	1	2	3	4	5	6	7
34.	I find it easy to depend on romantic partners.	1	2	3	4	5	6	7
35.	It's easy for me to be affectionate with my partner.	1	2	3	4	5	6	7
36.	My partner really understands me and my needs.	1	2	3	4	5	6	7

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Theoretical Orientation Profile Scale Revised (TOPS-R)

Please identify the extent to which you identify with the following statements from 1 = not at all to 10 = completely or from 1= never to 10= always.

1) I identify myself as psychoanalytic or psychodynamic in orientation.

1 = not at all	2	3	4	5	6	7	8	9	10 = completely
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2) I conceptualize my clients from a psychoanalytic or psychodynamic perspective.

1 = never	2	3	4	5	6	7	8	9	10= always
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3) I utilize psychoanalytic or psychodynamic methods.

1 = never	2	3	4	5	6	7	8	9	10= always
--------------	---	---	---	---	---	---	---	---	---------------

4) I identify myself as humanistic or existential in orientation.

1 = not at all	2	3	4	5	6	7	8	9	10 = completely
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5) I conceptualize my clients from a humanistic or existential perspective.

1 = never	2	3	4	5	6	7	8	9	10= always
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6) I utilize humanistic or existential methods.

1 = never	2	3	4	5	6	7	8	9	10= always
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7) I identify myself as cognitive or behavioral in orientation.

1 = not at all	2	3	4	5	6	7	8	9	10 = completely
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8) I conceptualize my clients from a cognitive or behavioral perspective.

1 = never	2	3	4	5	6	7	8	9	10= always
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9) I utilize cognitive or behavioral methods.

1 = never	2	3	4	5	6	7	8	9	10= always
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10) I identify myself as family systems in orientation.

1 = not at all	2	3	4	5	6	7	8	9	10 = completely
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11) I conceptualize my clients from a family systems perspective.

1 = never	2	3	4	5	6	7	8	9	10= always
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12) I utilize family systems methods.

1 = never	2	3	4	5	6	7	8	9	10= always
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13) I identify myself as feminist in orientation.

1 = not at all	2	3	4	5	6	7	8	9	10 = completely
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14) I conceptualize my clients from a feminist perspective.

1 = never	2	3	4	5	6	7	8	9	10= always
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15) I utilize feminist therapy techniques.

1 = never	2	3	4	5	6	7	8	9	10= always
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16) I identify myself as multicultural in orientation.

1 = not at all	2	3	4	5	6	7	8	9	10 = completely
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17) I conceptualize my clients from a multicultural perspective.

1 = never	2	3	4	5	6	7	8	9	10= always
--------------	---	---	---	---	---	---	---	---	---------------

18) I utilize multicultural therapy techniques.

1 = never	2	3	4	5	6	7	8	9	10= always
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Worthington, R. L., & Dillon, F. R. (2003). The Theoretical Orientation Profile Scale-Revised: A Validation Study. *Measurement and Evaluation in Counseling and Development*, 36(2), 95-105.

Theoretical Evaluation Self-Test

Circle the number which best reflects your agreement or disagreement with the item.

- 1. One central therapeutic factor is the symbolic recreation of a nurturing caretaker relationship with the therapist.**

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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- 2. The therapist should educate the client about the relationship of patterns of cognition and many mental health problems.**

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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- 3. The therapist's unconditional positive regard for the client is a crucial therapeutic factor.**

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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- 4. It is important for therapists to see clients together with their families.**

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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- 5. The therapeutic alliance is important primarily to provide a foundation for collaborative case management.**

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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- 6. Human behavior is shaped by patterns of reinforcements and punishments in the environment.**

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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7. Change occurs in therapy because of the therapist's empathic, non-judgmental, positive attitude towards the client.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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8. Psychoeducation about the benefits and side effects of medications is an important part of treatment.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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9. Dreams discussed in therapy can uncover significant unconscious wishes, conflicts and feelings.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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10. Most psychotherapy theories are distractions from the central task of solving the client's problems.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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11. Advocacy with other providers on behalf of clients is a central role of the therapist.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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12. It is important for the therapist to respond to clients with spontaneous, genuine affect.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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13. Primary emphasis should be placed on the client's interactions with his or her family.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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14. The role of the therapist is to advise and guide the client.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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15. Client's problems are often caused by negative patterns of thinking.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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16. Psychological problems vary with the culture of the client.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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17. Many mental health problems are effectively treated with medication.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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18. The therapist should be active, directive and goal-oriented.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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19. Client's problems are often contributed to by social problems and gaps in the social service system.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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20. It is important to attend to what the client is projecting onto the therapist.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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21. The therapist should teach clients techniques to address problem areas.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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22. When one person in a family is experiencing problems, it is usually the expression of family communication and relationship problems.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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23. Many clients can benefit from psychiatric medication.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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24. It is important to assess not only the person seeking services, but his or her environment as well.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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25. Change occurs in therapy through restoring healthy family structures.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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26. It is essential for therapists to be aware of the values and worldview of their own culture and how they might affect clients.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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27. Change occurs in therapy because of the client's insight into characteristic ways of relating with others set in early childhood.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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28. It is helpful to ask questions to lead the client to realize their mistakes or misperceptions.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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29. There is evidence that most mental health problems have biological causes.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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30. Denial, repression, intellectualization and other defense mechanisms are important to understanding psychology.

1=strongly disagree	2=disagree	3= mildly disagree	4= neutral	5=mildly agree	6=agree	7=strongly agree
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