AN EXPLORATION OF THE INFLUENCE OF RELATIONAL AND CONTEMPORARY FREUDIAN PARADIGMS ON THE THINKING AND PRACTICE OF BEGINNING CLINICIANS: A Q-METHODOLOGICAL STUDY

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy,
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Abstract

AN EXPLORATION OF THE INFLUENCE OF RELATIONAL AND CONTEMPORARY FREUDIAN PARADIGMS ON THE THINKING AND PRACTICE OF BEGINNING CLINICIANS: A Q-METHODOLOGICAL STUDY

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Deborah A. Gillman

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This study used Q-methodology and a qualitative interview to explore the ideas and practices that guide beginning clinicians in the practice of psychodynamic psychotherapy with adults. The psychoanalytic literature variably suggests that beginners are drawn to newer relational approaches or that they are among the most conservative of clinicians. Lacking is empirical research on how trainees actually make sense of the challenges to theory and practice posed by relational paradigms or the degree to which contemporary Freudian paradigms continue to resonate. This study aimed to fill that gap.

Fifty-four Q-sort statements reflecting diverse theoretical paradigms were developed in consultation with experienced clinicians. Thirty doctoral students in clinical psychology completed the Q-sort, expressing their affinity for classically- or relationally-oriented approaches as well as for ideas and practices not easily categorized as either classical or relational.

The data revealed that the majority of participants gives relatively low priority to classically-oriented ideas and practices but does not wholly embrace a relational approach. The Q-sort statements with the broadest appeal were those that bridge

orientations. Factor analysis yielded seven groupings of students according to the following views: 1) those committed to an egalitarian, collaborative approach to treatment, 2) those who consider their approach to be eclectic; 3) those influenced by object relations theory, who emphasize intra-psychic processes; 4) those who are pre-occupied with therapist disclosure; 5) those with a classically-oriented view of the therapist's participation in the treatment dyad; 6) those most clearly allied with a relational approach, who prioritize therapist subjectivity; and 7) a final group of trainees who are difficult to categorize.

In interviews, participants discussed their Q-sort selections in light of their training. While trainees embrace concepts such as flexibility and the inevitable impact of countertransference, many are struggling to reconcile conflicting messages and contradictory impulses on the matters of therapist disclosure and neutrality. Also apparent in this sample was confusion about the parameters that distinguish orientations and the labels used to define them.

Results of this study are of special relevance for clinical supervisors and educators aiming to influence and support the next generation of psychodynamic clinicians.

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For the daughter whose mother is a psychotherapist and whose father is a rabbi and professor of Jewish philosophy, my choice of career represented a homecoming of sorts. Indeed, the psychological-mindedness and reflectiveness honed at my family's dinner table found its forum for expression in graduate school classes and in the consultation room. I credit my parents, who both identify as educators, with my own interest in pedagogy and professional training. They modeled for me the importance of finding work that one loves and taking pride in the work one produces. Crucially, my mother also emphasized the special importance for women of cultivating one's professional identity. This document represents the fulfillment of all these values and more. I acknowledge Sarah and Neil Gillman for helping to make this doctorate possible.

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Introduction

In recent decades, relational models of psychoanalysis have challenged classical analytic notions of the role of the therapist and the nature of the patient-therapist relationship (Ehrenberg, 1992; Frank, 1999; Greenberg & Mitchell, 1983; Hoffman, 1998; Levenson, 1993; Maroda, 1991; Stolorow, Atwood, & Brandchaft, 1987; Wachtel, 1987). From the relational vantage point, the therapist-patient relationship—and not simply the intrapsychic life of the patient—is the focus of investigation in treatment. The term "relational" was first used by Greenberg and Mitchell (1983) to encompass the diverse theories which had emerged as alternatives to classical drive and structural theories. Prominent among these alternatives were the British object relations and American interpersonal traditions and Kohut's self psychology. Other influences included American feminist psychology and psychoanalytic theory (Benjamin, 1988; Chodorow, 1978; and Gilligan, 1983), social constructivist and post-modernist trends in psychology and philosophy, and advances in research on the mother-infant dyad (Beebe & Lachmann, 1988). Broadly, these models and theories "placed relationships at the center of their theoretical systems" (Mitchell & Aron, 1999, pp.xvii). As the patient-therapist dyad has been thus re-conceptualized, the field as a whole has grappled with the notion that the therapist, not only the patient, is a person in the room whose individuality and subjective experience are critical features of the treatment.

I come to this discourse on the therapist's participation in the treatment dyad as a beginning clinician. Moreover, my interest in this topic is both shaped by and a function of my being new in the field. In learning to become a therapist, I have struggled with the nature of my participation in my conduct of psychotherapy with adult patients. The

question of how I am or how I may be as a clinician is a crucial one *because* my professional identity is still in formation.

Nearly a century ago, Freud (1912/1960) recognized that new therapists, in particular, grapple with how to participate in the therapeutic dyad. He wrote:

> Young and eager psychoanalysts will no doubt be tempted to bring their own individuality freely into the discussion, in order to carry the patient along with them and lift him over the barriers of his own narrow personality. It might be expected that it would be quite allowable and indeed useful, with a view to overcoming the patient's existing resistances, for the doctor to afford him a glimpse of his own mental defects and conflicts and, by giving him intimate information about his own life, enable him to put himself on equal footing. One confidence deserves another, and anyone who demands intimacy from someone else must be prepared to give it in return. But in psycho-analytic relations things often happen differently from what the psychology of consciousness might lead us to expect. Experience does not speak in favour of an affective technique of this kind...The doctor should be opaque to his patients and, like a mirror, show them nothing but what is shown to him. (pp.117-118)

Freud acknowledges the desire for mutuality and the pull for shared intimacy with a patient but briskly concludes that the analyst will be most useful to the patient if he remains anonymous and if the relationship remains asymmetrical. Thus, whereas the pull for mutuality may lead a therapist to self-disclose, Freud contends that such behavior would ultimately distract the patient, increase the patient's desire to know more about the

analyst, and create obstacles to the management of resistance and resolution of the transference. Freud concludes[1] that the clinician must resist the pull for mutuality and assume position behind an opaque mirror of professionalism.

Many elements of the relational critique of the classical analytic stance are present in this citation by Freud (Frank, 1999).[2] What is the value of therapist anonymity? Is it possible to be neutral? Is there a place for the analyst's personality and subjective experience in treatment? How might therapists increase their affective engagement with patients? When Freud (1912/1960) declared that the analyst was to remain anonymous, he biased generations of clinicians against the open exploration of what it means to sit with a patient in the practice of psychotherapy, effectively suppressing the very challenge which has become the domain of relational critics. Relationalists, building on the work of select others before them, reopened for candid debate questions about the nature and value of therapist anonymity and neutrality, how one works with transference and countertransference, and the pull for mutuality in the therapeutic dyad, challenging long-standing assumptions about the therapeutic dyad and practice of psychoanalysis and psychoanalytic psychotherapy.

Freud's (1912/1960) therapist-as-mirror metaphor has had an unshakeable hold on the field despite explorations of its limits even among his contemporaries (e.g. Balint &

[1]According to Greenberg's (1995) reading of this passage: "Freud's words and tone are those of a clinician who has tried something many times and lived to regret the consequences" (p.194).

[2]Frank (1999) charges "American orthodox analysts" with selectively advancing the one-person aspects of Freudian theory and ignoring the "relational seeds" which existed in Freud's ideas (p.12).

Balint, 1939;[3] Fenichel, 1941; Ferenczi, 1932). In addition, it is widely acknowledged that in practice, Freud used his personality a great deal and behaved in a manner that was far from opaque or mirror-like (Balint & Balint, 1939; Greenberg 1986; Lohser & Newton, 1996; Racker, 1968). The therapist-as-mirror has also been held up, unfairly at times, for the purpose of critique by those who advocate a relational approach, leading classical analysts to complain that they are being caricatured. What, then, prompted Freud to coin this now infamous mirror metaphor? His perceived need to admonish beginning therapists.

The "young and eager" clinician, by virtue of some combination of inexperience and earnestness, is characterized by Freud (1912/1960) as "tempted" to bring his individuality into the room and disclose personal information to the point of sharing his own difficulties. Desiring a balanced or co-equal relationship with patients, the beginning clinician is tempted to throw off the mantle of authority which his position demands. It seems that Freud overstated his case in order to discourage new clinicians, unable to discern and navigate the subtle nuances of their contributions in the treatment setting, from expressing any aspect of their individuality or personality, let alone disclosing their personal problems (Spezzano, 1995a). Freud must have thought this necessary based upon his experience with psychotherapy trainees. As a psychotherapist-in-training, Freud's depiction rings somewhat true to me, but it is also an unfortunate oversimplification of the experience and conduct of new clinicians. Indeed, we are

[3] The Balints wrote in 1939: "Formerly belief in the absolute validity of the mirror-like attitude was so firm that contesting it was liable to be regarded as a sign of desertion. And now...the very possibility of such an attitude is challenged" (p.228). Abundant clinical data on the interplay of transference and countertransference on the analytic situation, and evidence of positive outcomes with analysts whose practices and personalities differed widely provided the justification for this challenge.

"tempted" to do many things, from joining with our patients in their struggles to excessively distancing ourselves from them (Davis, 2002). Aron (1996) and Hoffman (1998) have discussed at length how therapists naturally experience a tension between the desire to be known and not known by their patients, to engage with patients in the spirit of mutuality and to assert authority over them. Surely new clinicians experience these dual pressures as well.

Nearly a century has passed since Freud diagnosed new therapists as susceptible to wanting to put themselves on "equal footing" with their patients. His prescription for this and related problems was clear. But as revised ideas about the nature of the therapeutic dyad and technique have emerged over time, clinicians of all levels of experience have rethought their positions on therapist neutrality, the pull for mutuality, therapist subjectivity, and other aspects of clinical work. What, then, are the implications of these revisions for the training of new clinicians? Put differently, what has been the impact of the relational challenge–with the ideas and technical implications it encompasses–for the training of new clinicians? How do new clinicians *themselves* understand the challenges posed by relational paradigms, and to what degree have relational ideas been integrated into their thinking and practice? Importantly, to what degree do more classically oriented ideas and guidelines continue to resonate with today's trainees and influence their practice? This study undertook to explore whether beginning clinicians are drawn to newer or more traditional paradigms and whether and how these are being combined.

Below, I will review a range of positions on the nature of therapist participation as they have developed over time with attention to those that have most strongly influenced

the development of relational theory. I will then examine the relational-classical debate and the issues that have perpetuated it. The views of this writer that form the underlying premise of this study will also be presented. Returning to the issue of training, I will profile the psychotherapist trainee who is learning to conduct psychotherapy in an era in which diverse positions about therapist participation abound and are accepted. I will review the guidelines that have been suggested for the training of clinicians in the current poly-theoretical climate. Variations on Freud's argument that new clinicians should be prevented from expressing their subjective experience or personalities persist, and the durability of this viewpoint will be challenged.

Literature Review

The evolution of therapist participation

Freud was not alone among early analysts in wondering about the role of the therapist[4] in treatment. During the 1920's and 1930's Sandor Ferenczi conducted 'mutual analyses' in which he innovatively worked with countertransference disclosures and championed mutuality and egalitarianism in the therapeutic dyad. For Ferenczi, the analyst-patient relationship was "the heart of the analytic situation" (Aron, 1996, p.162). Ferenczi (1932, 1949) grappled throughout his career with the tension between the wish to be known to his patients and concern about the impact of being known by them. But his experiments with mutuality "gave the notion of self-disclosure a bad name" (Jacobs, 1999, p.161). Among classically-trained analysts, self-disclosure came to be associated with acting out or the poor management of transference. In view of the recent developments in relational thinking, however, Ferenczi has been reclaimed as a heroic innovator (Aron, 1996).

Another early step away from the Freudian view of the patient's mind as a closed system was Melanie Klein's concept of projective identification. The patient projects a part of himself or herself into the analyst and yet tries to maintain a connection to or control over that expelled aspect of self. The therapist must then contend with a therapeutic framework in which the boundaries of experience between patient and therapist are fluid in this way. While for Freud the analyst remained relatively

[4]Much of the discourse on relational psychoanalysis is by psychoanalysts who are typically–but not exclusively–writing about a clinician who is an analyst, conducting psychoanalysis. For the purpose of this paper, the perspectives of these writers will be considered applicable to the work of psychodynamic psychotherapists as well, and the terms 'analyst', 'clinician,' and 'therapist' will be used interchangeably.

detached—and Klein herself did not diverge from this model of an analyst—projective identification led neo-Kleinian's such as Bion to regard

> the analyst's affective experience as much more centrally involved in the patient's struggles...In the contemporary Kleinian perspective, psychoanalysis is an arena in which two persons struggle to organize and make meaningful the affective life of the patient into which the analyst is inevitably and usefully drawn. (Mitchell & Black, 1995, p.107)

Bion's "interpersonalizing" (p.106) of projective identification was influential for analysts such as Racker (1968) who argued that the notion that the analytic relationship was "an interaction between a sick person and a healthy one" (Racker, p.132) was a myth. Challenging the asymmetry inherent in the classical model of the therapeutic dyad, Racker wrote that therapy is an interaction between "two personalities" (p.132), each of whom responds to every aspect of the analysis.

Frank (1997) has cited Fairbairn, a figure of the British object relations school, as having described the analytic dyad as one with 'two-person' qualities. For Fairbairn (1958), it was through the therapeutic relationship that a patient had the opportunity to develop newly positive object relations. Significantly for Fairbairn, this relationship was an "actual" (p.377) and "total relationship" (p.379). If the relationship is real, then there are two people in the room and the work of therapy takes place between the two of them, not simply in the psyche of the patient.

The American interpersonal school developed in the United States during the 1930s and 1940s with its foundation in the writings of Harry Stack Sullivan and his efforts to develop new therapeutic techniques for schizophrenic patients. For Sullivan,

the analyst is a participant-observer whose task is to elicit the patient's history and sort out the patient's real and illusory personifications of others, to sort out past relationships from the present (Mitchell, 1997). Sullivan recognized that the personality of the analyst would impact upon this process and influence patients. However, he believed that if the patient were to have too strong an impact on the analyst, the analyst's work might be derailed (Sullivan, 1954, as cited in Mitchell,1997, p.75). Mutual influence is inevitable, but Sullivan believed the analyst should be able to recognize, control, and factor out his or her participation. In contrast, contemporary interpersonal theorists acknowledge that self-reflective observation cannot be separated from participation in the treatment dyad (p.87).

Kohut's self psychology, as it developed in the early 1970s, offered another alternative to the classical definition of the role of the analyst. From his work with narcissistic patients, Kohut came to believe that patients treat analysts not as separate people but as "extensions of themselves, as intensely needed, functional aspects of their own subjective experience" (Mitchell & Black, 1995, p.160). Kohut argued that analysts ought to refrain initially from interpretations other than those regarding how the patient views the therapist in the transference. Patients must be permitted to immerse themselves in a 'mirroring transference' until they develop an increased sense of well-being or a sense of themselves as wonderful or strong by virtue of their connection with the analyst in an 'idealizing transference.' Kohut urged empathy towards patients, encouraging a therapeutic process by which archaic selfobjects are replaced by the empathic response of the therapist while the patient develops the capacity to seek out more appropriate selfobjects (Tropp, 1994).

Further elaborations on Kohut's work were theoretical developments on the intersubjective aspects of the patient-therapist relationship by Stolorow, Atwood and their colleagues (Stolorow & Atwood, 1984; Stolorow, Atwood, & Brandschaft, 1987). In self psychology terms, "not only does the patient turn to the analyst for selfobject functions but the analyst also turns to the patient for such functions" (Stolorow, 1994, p.37).[5] Moreover, the analyst's experience interacts with the patient's even when his or her function as a selfobject has been disrupted. The patient's understanding of this disruption must be explored. Patients must be helped to develop a capacity for reflective self-awareness of the unconscious organizing principles that shape their reality (Tropp, 1994). Crucially, psychoanalysis from an intersubjective framework focuses on "the interplay between the differently organized subjective worlds of the observer and the observed" (Stolorow & Atwood, 1984, p.41), of the analyst and the patient. Stolorow and Atwood (1984) have argued the following:

> We suggest that rules of abstinence, neutrality, and anonymity can be subordinated to a more general and inclusive therapeutic principle that the analyst's actions...should as much as possible be determined by his understanding of the nature, origins, and functions of the configurations currently structuring the patient's subjective experience. (p.45)

From an intersubjective perspective, neutrality and anonymity are not the route to patients' improved self-understanding. No longer completely anonymous or neutral, the therapist enters the therapeutic dyad as a real presence.

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[5]The concept of the therapeutic dyad as a field of reciprocal influence also drew upon research on the mother-infant dyad (see Beebe & Lachmann, 1988).

In concert with the above theoretical developments of the second half of the twentieth century, select classically-trained psychoanalysts began to articulate the view that the patient-therapist relationship is not characterized only by transference. As early as 1946, Alexander and French wrote in favor of a "modern" analytic attitude, suggesting that the analyst discard the "blank screen" persona or the "ideal of impersonal behavior" to make therapy understandable and to "put the patient at ease by behaving in the way the patient would normally expect from one to whom he has come for help and counsel" (p.87). The patient is better served, they argue, by having his behavior projected against a background of normal behavior as opposed to a mysterious blank screen.

Zetzel (1956, 1970) argued that a successful analysis requires a therapeutic alliance, a "consistent, stable relationship which will enable the patient to maintain an essentially positive attitude towards the analytic task" (1970, p.182) in the face of revived conflict. This alliance, formed with patient's mature, observing ego, is the pre-requisite for later analysis of the transference. Psychoanalysis' pioneers, needing to assert the merits of their methodology, emphasized the rules of practice and the unwavering posture of the surgeon-like analyst. However the growth and wider recognition of the field, including the development of psychoanalytic psychotherapy, had allowed for recognition of this "real" aspect of the therapeutic relationship (Zetzel, 1970). Greenson (1967), similarly, described the "working alliance" as a feature of the patient's reaction to the therapist that is on par in importance with the transference neurosis. Moreover, the working alliance is fundamentally incompatible with Freud's therapist-as-opaque mirror. Freud was misunderstood, argued Greenson. A therapist ought not to intrude his values

or standards upon a patient, but the therapist should not be inanimate, cold, or unresponsive (p.212).

Stone (1961), in his examination of the "essential nature" of the psychoanalytic situation, challenged the classical analytic stance of neutrality and abstinence, favoring a view of the analyst as a more genuine and naturally engaged presence. He also observed that the caricature of the rigid and mirror-like analyst had exerted an enduring influence over the field. Recognizing the impact of this portrayal on students of psychoanalysis, Stone noted that otherwise "intelligent and naturally friendly young colleagues" (p.29), when in the analytic situation, feel constrained against offering their patients simple, socially-appropriate well-wishes or concerns. Curiously, these young analysts had come to fear interpersonal niceties far more than expressions of aggression (the latter of which may fit more easily into a scientific schema of the therapeutic relationship, suggested Stone). Stone observed that the field has historically responded to the challenges of analysts such as Ferenczi or Alexander, who emphasized the analyst as a genuine presence, with an over-intellectualization of the analytic process and renewed emphasis on classical methods and models of the analyst. The effect of this backlash is most powerfully observed in newer clinicians. Says Stone:

> These formalistic emphases (a sort of psychoanalytic neo-classicism) have been reflected in certain overliteral attitudes of younger (sometimes older) analysts. In my observation, the rigidities of younger colleagues far exceed in most instances the constraints of practice of most older analysts (of conservative conviction). (p.30)

Stone cited the appeal of this classical (or neo-classical) analytic posture to new clinicians despite many challenges to and revisions of this model. Unlike Freud, who believed that beginning therapists would be drawn to an intersubjective construal of the therapeutic dyad, Stone found that decades later, many were still trying, literally, to function as mirrors.

Historically, a tension has persisted between classical analytic guidelines for the therapist's participation, as originally influenced by Freud, and periodic challenges to these guidelines. New therapists must sort through diverse theories and models of the patient-therapist relationship to arrive at the one which best fits the way they wish to work. Determining one's orientation is arguably one of the essential tasks of developing a professional identity and is an ongoing process. En route to resolving the question of orientation or model of treatment, many influential voices come to trainees through readings, professors, supervisors, and trainees' own therapists. As with any clinician, beginners may be exposed to and come to draw from different traditions or opt to work in disparate ways with different patients. The present study explored the views of students with a range of orientations or emerging ideas about their orientations and the extent to which the students have been influenced by traditional models of therapist participation and/or the relational critique of these models.

The relational vs. classical debate

Sugarman and Wilson (1995), editors of a special section of the journal *Psychoanalytic Psychology*, introduce the section as a forum for critical dialogue on the theories and practices of modern structural and relational analysts. The stated goal is clarification and, if desired, synthesis of these views. Because many relational theorists

have developed their ideas in response to the classical or structuralist paradigm, relationalists have made more of an attempt to address the differences between the two paradigms than have classical analysts. The editors thus organized the special section first to provide the structuralists an opportunity to critique various "object relational models" (p.3) and techniques and then for the relational theorists to respond. Despite these intentions, the ensuing exchange proved to be a disappointing contribution to the relational vs. classical debate, raising more questions than it answered (Christiansen, 1995).

Several authors (Bachant, Lynch & Richards, 1995a; Sugarman, 1995; Wilson, 1995) critique the dissent of relationalists from the classical psychoanalytic tradition. Bachant, et al. argue that "relational considerations" (p.73) have always been a part of the psychoanalytic tradition and that it was not necessary to dichotomize relational and structural perspectives or to force clinicians to choose between one or the other. Wilson outlines how, despite their claims (Greenberg & Mitchell, 1983; Mitchell, 1988), relationalists have wrought, not a true paradigm shift in the field, in the Kuhnian sense, but rather a "regression away from progress" (p.15). Wilson argues that Mitchell and his relationalist colleagues should have worked *within* the classical paradigm on the model of theorists such as Kernberg and Gedo. Sugarman, similarly, cites Kernberg, Loewald, and Sandler as examples of theorists who have been able to bridge "the shift from internal issues of conflict to external interpersonal interactions" (p.57) represented by contemporary relational theorists, while remaining loyal to analytic tradition. The source of Sugarman's distress is twofold: Recognizing that a major ideological shift has taken place, he harbors the wish that the field was not so polarized and also regrets that those

working within a relational paradigm will inevitably come to practice differently, eschewing techniques refined by classical analysts over the years.

Bachant, et al. (1995a) and Busch (1995) argue that the premises of the relational critique are flawed since it relies upon outmoded elements of classical theory as the basis for a relational alternative. According to Busch, Greenberg and Mitchell (1983) erroneously lump resistance with Freud's pre-1915 view of repression, ignoring Freud's later conceptualization of resistance as the ego's response to anxiety. More broadly, Bachant, et al. argue that Greenberg and Mitchell misrepresent and oversimplify Freud's drive theory as something static and bound by the body. According to Bachant, et al., contemporary structural analysts view drives and drive derivatives as unfolding from an underlying and organizing "dynamic unconscious" (p.74).

Bachant, et al. and the other contemporary structuralists writing in this section argue further that relationalists have forsaken intrapsychic conflict or "conflict between mental elements" (Wilson, 1995, p.18) for interpersonal conflict in patients' external environment. Transference, too, is newly construed in the relational model as precipitated by an interaction with the analyst and not by unconscious factors (Bachant, et al., 1995a). Murray (1995) argues that relational analysts confuse interpersonal interaction with transference, confuse changes in behavior towards the therapist with changes in the transference or in underlying structures and motivations, and erroneously intervene in the transference by manipulating the quality of relatedness in the dyad; relationalists rely upon interventions as opposed to interpretations, says Murray (pp.38-39). According to Wilson (1995), transference is something the relational analyst "strives to be within rather than out of" (p.19). Hoping to establish some common ground,

Sugarman (1995) asserts that while modern-day classical analysts do "consider the role of their personality and their interaction with the patient in dealing with transference material" (p.65), they nevertheless believe that interpretation of the transference neurosis and the working through of intrapsychic conflict are what are mutative.

From this point on, the debate deteriorates. Declaring it a failure, Marshall (1995) cites the misguided efforts of the contributors to "pull relational ideas through the filter of structural psychoanalysis" (p.591); the judgmental stance of at least two contributors; another contributor's oversimplification of relational terms and concepts; and the editors' premature rush to theoretical synthesis or integration, foreclosing full exploration. Moreover, Marshall suggests, if the editors had established a uniform terminology for this section, a good deal of semantic confusion might have been avoided. Spezzano (1995b), responding, complains that the special section contributors cited only a very narrow selection of relational writings. Benjamin (1995), too, criticizes the contributors for treating Stephen Mitchell's work as the sum total of relational thinking and the editors' failure to reflect upon the wealth of other relational voices that exists. Mitchell (1995) himself dismisses their poorly-informed, "shallow disparagement" (p.575) of relational theory.

Although the spirit of dialogue is, by the conclusion of the debate, overshadowed by sparring and criticism, the relational analysts do respond (despite Murray's, 1996, and Wilson's, 1996, laments that the relationalists' contributions lacked substance). Mitchell (1995) affirms that he and Greenberg used the term "relational" to bridge distinct but compatible American interpersonal and British object relations theories. Differences exist within these traditions, as well, so Murray (1995) and Busch (1995) were misguided

in referring to all relational theories by the uniform term of "object relations theory." Mitchell flatly rejects the idea that relational theories disfavor the unconscious. Stolorow (1995) affirms that he and his collaborators have worked to bridge the dichotomies of the intrapsychic and the interpersonal in their theory of intersubjectivity. Benjamin (1995), similarly, responds that it is the structuralists who have, with their critique and clinical vignettes, polarized the different paradigms and the issues that divide them, such as transference. While relational analysts may be united by their interest in the intersubjective meaning of the transference, "in articulating the emotional experience of being in the room with the other person" (p.597), this in no way excludes a commitment to unconscious processes. Benjamin suggests that where relational and structural analysts differ is in their relative views of what is mutative. As an example, structural analysts are more committed than relational analysts to the interpretation of internal conflict. Moreover, says Benjamin, relationalists tend to be more open to a heterogeneity of opinions.

In such a debate, it seems inevitable that one side will eventually contend that they value a given element or construct (the importance of the body, of the unconscious, of the patient-therapist interaction) as much as the other side. The debate is practically destined to fail because of the difficulties inherent in this comparison. One enduringly problematic aspect of the relational vs. classical debate is that of terminology. (Indeed, the very terms selected for the previous sentence—e.g. 'relational' and 'classical'—may be disagreeable to some readers.) The terrain for this dialogue is so muddy that it is a struggle even to initiate discussion on the subject. While there is consensus on the use of the term 'relational' among theorists from within that paradigm, some scholars continue

to write as “interpersonalists” or as “object-relationalists.” As an example, Gill (1995) responds to the structuralist critique of relational psychoanalysis in the special section by stating, first, that in his view relational theory is an “offshoot of interpersonal theory” (p.89). Spezzano (1995a, in a separate article not connected to this debate), seeking to outline a middle ground between classical and relational theory, juxtaposes classical with what he terms “contemporary” theory. The term “classical” requires clarification as well: For Spezzano, “classical” denotes theories of classical ego analysis while Bachant, et al. (1995a) participate in the *Psychoanalytic Psychology* debate as “modern-day structuralists.”

The problem of terminology plagues this debate on many levels. I have already alluded to the contentions and ambiguities regarding the names for different paradigms, such as one-person vs. two-person, relational, interpersonal, intersubjective, etc. vs. classical, traditional, structural, modern-day structural, etc… The problem of language also plagues the terminology used to further articulate these viewpoints. For example, although there is some consensus that one factor distinguishing relational from structuralist views concerns the relative emphasis on “drive,” Bachant, et al. (1995a) argue that Greenberg and Mitchell’s relational theory targets an outmoded classical Freudian drive theory that ultimately “eschew[s] any drive component” (p.73) in its formulation. As described above, Bachant et al. articulate their contemporary view of drive as a component of a developing dynamic unconscious (a view which de-emphasizes the bodily aspects of drive, notes Gill, 1995). Gill (1995), for his part, attempts to reframe the controversy by discussing the place of the “innate” in each paradigm (and is later accused by Bachant, Lynch and Richards, 1995b, of insufficiently defining

"innate"). Mitchell (1995) both clarifies and complicates matters in his response to Bachant et al. (1995a) by asserting the relational paradigm's belief in the "importance of the body and constitutional factors" (p.577). The clarification comes from his attempt to highlight the shared concerns of the divergent paradigms; the complication comes from the shift in terminology from drive to body.

Gill (1995) notes that "relationalists are chary of using classical terms, because so often any one of them connotes the whole classical theory" (p.96). But Mitchell (1995) responds to the structuralist critique in the special section saying that a shift in paradigms necessitates a shift in terminology and usage.

> From a relational-constructivist perspective, it is wrong-headed to first separate the body from social interaction...Rather it makes more sense to approach the body (as experienced and represented in the mind) as derivative of relational processes. (pp.578-579)

For Mitchell, a hallmark of the shift to a relational paradigm is the reconceptualization of "classical concepts of the body or drive" that are "no longer utilizable in their original form" (p.579).

Greenberg (1986) has described a similar negotiation of the 'language problem' in the evolving reconceptualization of the analytic principle of neutrality. For Freud, neutrality implied keeping any sign of one's personality, affective response, or countertransference in check. Anna Freud (1936), however, defined neutrality as the analyst's position of equidistance from a patient's id, ego, and superego. Under the relational paradigm, in which attention is predominately directed toward the patient's internal object world and the patient-therapist interaction, the goal of analytic neutrality,

which Greenberg opts (and works) to *maintain* as a part of his analytic lexicon, is defined as follows:

> Neutrality embodies the goal of establishing an optimal tension between the patient's tendency to see the analyst as an old object and his capacity to experience him as a new one. (p.97)

Just as Anna Freud refined psychoanalytic terminology to accommodate her theoretical contribution, so too have contemporary writers undertaken to do the same. Loyalty toward traditional terminology despite changes in theory might be construed as a marker of the durability of psychoanalytic terms and concepts. Others, as part of their relational critique, argue that since the ideas of analytic objectivity or neutrality are illusory, these concepts and descriptors have no place in a theory of psychoanalytic psychotherapy. A term such as neutrality, therefore, becomes problematic when it must be stretched beyond recognition in order to be employed in a relational conceptualization (See Wachtel, 1987).

Already, here, we have begun to talk about more than language. Part and parcel of the debate over the suitability of certain terms to describe theoretical constructs is the question of the overall compatibility of the competing constructs themselves. Greenberg and Mitchell (1983) faced this challenge when they sought to unite diverse but compatible alternatives to classical drive theory. What they viewed as common to these alternatives was the effort to find a greater role for the importance of object relations in theory construction. The term "relational" was selected to refer to these multiple alternatives.

Mitchell (1988) outlines three approaches to reconciling drive and relational models. The first is grounded in the assumption that the theories inherently overlap and that the idea of a relational matrix has always been implicit in the drive model, that "object relations are merely vicissitudes of drives" (p.55). (This was the view espoused by some of the special section contributors.) The second strategy assumes that both positions are distinct but compatible, with relational models a natural extension of the precursor drive theory. The third strategy assumes the two positions are fundamentally incompatible. Freud rejected the mixing of models, "eschewing any role for primary relatedness in his theory and relying instead solely on drive economics" (Mitchell, p.54). Mitchell, too, argues for a "purely relational" perspective "un-mixed with drive-model premises" (p.54).

Mitchell and other relational writers believe that the development of the relational paradigm marks a transition to a new way of thinking or world view (Aron, 1996; Hoffman, 1998) and has implications for a new approach to practice (Frank, 1999; Jacobs, 1999; Maroda, 2002). But, as we saw above, it is far from obvious how to organize a discussion about these changes let alone agree upon them. Language is one complicating factor. But even if the editors above had established a uniform terminology for the debate, disagreement would have likely prevailed. How does one discuss meaningful differences between two paradigms when participants in the debate cannot agree that two distinct paradigms exist? Yet another complicating factor is the multiplicity of voices representing each viewpoint and the recognition that differences of opinion exist even among proponents of a given paradigm. In view of such diversity of opinion, it is important that the assumptions underlying the present study be stated.

The first assumption is that the relational critique does represent a fundamental shift in the analytic tradition, in its re-conceptualization of the patient-therapist relationship and of the therapist's participation in treatment. The differences between the classical or structural paradigm may be viewed on three levels: underlying epistemology, the development of theory, and the implications for clinical practice.[6] Epistemologically, relational psychoanalysis has been associated with a post-modern, constructivist view of the therapeutic situation, according to which the patient-therapist dynamic is co-constructed in each interaction by both participants (Stolorow & Atwood, 1984); one participant (the therapist) cannot assume to know another's (the patient's) experience with absolute certainty (Hoffman, 1998). According to Aron (1996), a relational view emphasizes that the mind is a "relational construct" that "can be studied only in the relational context of interaction with other 'minds'" (p.51). This epistemological shift, in turn, challenges one's theories about psychoanalysis and psychoanalytic psychotherapy practice.

If the therapist accepts that her subjectivity is always in interaction with the patient's subjectivity, can she legitimately value neutrality or anonymity as a therapeutic ideal? This reconceptualization impacts the therapist's thinking or theory about psychodynamic work, for example, in terms of how she construes the therapeutic dyad or understands the function of transference and countertransference. It may affect her practice as well. The relational approach has been associated with greater participation on the part of the therapist, which translates into more active intervention in patients'

[6]Spezzano (1996) organizes the one-person vs. two-person debate into three separate debates regarding each paradigm's theory of development, ontology, and epistemology.

lives in addition to or in place of interpretation (Wachtel, 1997); increased use of therapist self-disclosure, including countertransference disclosures (Bollas, 1983; Renik,1999); and the recognition that even the most inadvertent aspects of a therapist's participation have an impact (Frank, 1997). There is no one well-articulated guide to relational practice, and it has been argued that there should not be one (Aron, 1996). However, any clinician who *thinks* 'relationally' must decide for herself the implications of these views for her own practice.

The second assumption of the present study is that a persistent dialectical tension exists between the relational and classical paradigms and their implications. The difficulty encountered in a comparison of models arises when an attempt is made to present the ideas embraced by each paradigm in absolute opposition to each other. As Mitchell and Aron (1999) have written,

> ...each model actually *does* provide understandings of *all* the phenomena in question...The relational tradition has generated new understandings of precisely the phenomena that drive theorists have traditionally regarded as foundational: the body, sexuality, pleasure, aggression, constitutionality, the patient's free associations. (p.xiv)

Hence, the need for the structuralists to claim that they have long-valued relational considerations and for the relationalists to vehemently reject the suggestion that they have abandoned everything intrapsychic or unconscious.

In his contribution to the *Psychoanalytic Psychology* debate, Merton Gill (1995)[7] frames the relational vs. classical comparison in terms of each paradigm's hierarchy of priorities. In conceptualizing the individual, the relational view emphasizes the experiential over the innate aspects of the individual. The classical view emphasizes the innate over the experiential. Furthermore, in the relational view, the "experiential is explanatorily superordinate to the innate" (pp.92-93), while the innate is explanatorily superordinate to the experiential in the classical view. The classical point of view "emphasizes how the past determines the present" (p.93), since the present is a *repetition* of the past, "whereas the relational point of view emphasized (sic) how the present can be illuminated by the past" (p.93). Finally, in bridging theory and practice, Gill argues that "the relational view stresses new interpersonal experience over insight as mutative, whereas the reverse is true in the classical view" (p.93).

Gill's approach to understanding the differences between the relational and classical paradigms is particularly useful given the aims of the present study. The goal here is not to focus on absolute differences of opinion. Rather, this study aims to explicate the relative priority given to relational vs. classical views of treatment, as well as to explore the degree to which the views associated with these paradigms are either dichotomized or integrated. The question at hand is: What are the ways in which beginning psychodynamic therapists construct their understanding of and approach to clinical work in view of the fact that their training may have exposed them to both relationally- *and* classically-allied theories and practices? Mitchell (1988) rejects model-

[7]As a testimony to the soundness of Gill's contribution to this debate, it is difficult to discern whether his contribution to the special section was intended to be part of the structuralist critique or the relationalist response.

mixing in favor of a "purely relational" (p.54) perspective. In assessing the views of practitioners, however, rather than theory builders, we must be open to the possibility that the blending of theories or model-mixing is the norm (Frank, 1999). This may be especially true for beginning clinicians for whom ideas about theory and practice are still in formation.

The endless flow of decision-making and the beginning therapist

Faced with the decision about whether to prioritize relational or classical views, how does one decide? On the one hand, the current abundance of views on therapist participation offers beginners broad leeway in their search for the "correct" stance. But it also creates confusion, at times, about how to proceed—a confusion, I confess, that I have experienced profoundly. Experienced clinicians have voiced this confusion as well. Schafer (1995) has said that the "chronic and inevitable conflict" between objectivist and intersubjectivist positions creates an "ongoing tension" (p.229) with which we must struggle. Spezzano (1996) has noted that it is "troublesome...to think, write, and work clinically during a period of tension between multiple robust paradigms" (p.604).

It has also been argued that the shift to a relational epistemology makes the practice of psychotherapy more difficult. For Burke (1992), an interpersonal analyst, the willingness to share one's subjectivity with a patient in the form of a countertransference disclosure, for example, requires the therapist to tolerate a considerable amount of uncertainty and ambiguity. Mitchell (1997) concurs that "the demise of the classical theory of technique has left us with profound doubts about how we know what we are supposed to be doing" (p.145). Levenson (1993) says further that relinquishing the classical paradigm of the patient-analyst relationship invites the clinician to engage with a

range of existential questions including: “If I am not the arbiter of the patient’s reality, what am I? What is it to be an analyst? What defines a patient if the patient may be the arbiter of my experience” (p.385)? What are the consequences of this discourse? What are the consequences of providing clinicians with a greater range of choices, with an “endless flow of decisions” (Greenberg, 1995, p.197) to make about their participation?

The tension between paradigms, the debates which ensue in the literature, and the potential challenges of practicing from within a relational paradigm have been described. But is this tension always problematic? Irwin Hoffman (1998) has suggested that the dialectical tension between often-dichotomized aspects of clinical theory and practice (such as the pull for mutuality vs. authority, the ritualized aspects of the treatment and the therapeutic role vs. the spontaneous aspects of interpersonal exchange) creates an optimal therapeutic stance. In the literature, those with differences of opinion have been slow to reconcile. However, in practice, according to Hoffman, a dialectical tension between models enables clinicians to evaluate each clinical interaction in its context and respond to each patient in the most authentic way possible. This study examined how beginning therapists understand this dialectical tension, whether they experience it—*if* they experience it at all—as a source of *real* tension or confusion, or whether it informs and energizes their thinking and practice in a positive way.

The data offered by this study also reveal how the next generation of psychodynamic clinicians is being trained to understand relational theories and employ relationally-influenced practices. Recall that Freud (1912/1960) rejected implicitly relational notions in order to keep inexperienced clinicians from translating these ideas into practice. Presently, the discourse on relational theory and related practices is in full

swing. How, then, should new clinicians be instructed? A range of positions on this question has been articulated.

In a curious echo of Freud circa 1912, Berzoff and de Lourdes Mattei (1999) are concerned that beginning therapists are tempted by relational models such as intersubjectivity because, relative to the classical paradigm, these models are "new and exciting" or "fashionable" (p.381).[8] They write: "Trainees struggle with their own legitimacy, power, knowledge and authority" (p. 385). Trainees should therefore not work within a deconstructed paradigm that teaches them to understand their patients as co-constructors of an intersubjective field *before* they have learned to understand their patients as separate people. Techniques grounded in relational theories may, in some instances, be used effectively, but inexperienced therapists are at risk for *mis*using them and endangering their patients. Berzoff and de Lourdes Mattei argue that trainees require grounding in drive theory, ego psychology, and object relations, the modeling of "therapeutic restraint" (p.383), and time to accumulate greater self-understanding.

Berzoff and de Lourdes Mattei (1999) believe that there is an appropriate amount of knowledge that a therapist must have before he or she can work from a relational (they specify intersubjective) model. Until this knowledge is acquired, trainees must bracket the influence of relational paradigms. But how can a therapist, even a therapist-in-training, essentially tune out what the field has come to understand about the nature of the patient-therapist relationship? How can one tune-out an epistemological framework? I also question the authors' conclusion (identical to Freud's) that new therapists will

[8]Ironically, Freud (1912/1960) was concerned that new clinicians would be subject to temptations from within themselves. Berzoff and de Lourdes Mattei (1999) locate the source of temptation as external, in the field. (See also Davis, 2002).

automatically be drawn toward practices implicitly favored by a relational paradigm, such as self-disclosure.[9] While I concur that new clinicians struggle with their legitimacy, power, knowledge, and authority, I disagree that this *necessarily* leads them to self-disclose excessively or inappropriately or to want to do so. In fact, research on self-disclosure has found that less-experienced therapists disclose far less than their more experienced colleagues (Andersen & Anderson, 1989; Basson, 1997; Berg-Cross, 1984; Simon, 1988).

Davis (2002) offers a more balanced depiction of the beginning clinician struggling with the decision to disclose or not and also suggests how new clinicians might make sense of a relational perspective. Citing two case examples from his own training, Davis experienced both the urge to disclose *and* the strong urge to withhold personal information in the face of direct questions from patients. His inexperience was manifest not in the act of disclosure or non-disclosure but in his failure (later recognized) to reflect upon the motivations behind each of his decisions. New clinicians lack finesse with certain therapeutic techniques, to be sure. What is critical is how one learns to think through the implications of different choices regarding one's participation in a treatment. Says Davis:

> Perhaps the most important line of development in practicing psychoanalytic psychotherapy is learning to be open to patients' intense transferences and to work non-defensively with these feelings. (p.442)

[9]The eager-to-disclose beginning therapist has been depicted elsewhere. See Therapists redraw line on self-disclosure, by E. Goode, in *The New York Times*. (January 1, 2002).

For Davis, learning to work with the transference-countertransference dynamic is one of many developmental lines for the new clinician. New clinicians do not necessarily encounter these issues *less* by virtue of being *less* experienced, although they may be less sensitive to them and less clear about how to manage them. Beginning therapists ideally develop along a trajectory of self-understanding that enables them to make the best possible decisions. This is a process that can only move forward with the benefit of experience and supervision.

What Davis (2002) makes clear, in addition, is how Berzoff and de Lourdes Mattei's call for the bracketing of subjectivity is frankly untenable. New clinicians make choices regarding their participation in the therapeutic dyad from their earliest hours on the job. Under the influence of supervisors, literature, didactic courses on psychotherapy practice, and their own treatment beginners are, from the start, making small and large decisions about how authoritative or neutral to be, about how much subjectivity to express. Advising new clinicians not to use their subjectivity and removing ideas about relational theory and practice from the curriculum (so to speak) is akin to the hope that teaching abstinence will prevent teenagers from engaging in sexual activity prematurely.

Others are less worried about exposing new clinicians to relationally-influenced ideas or practices. Writing about the use of transference interpretations in psychodynamic psychotherapy, Gill (1984) doubts that new clinicians will find themselves in over their heads, saying "there is an automatic safeguard in that the therapist is likely to see only that which he is capable of dealing with" (p.175) in a patient's transference expressions. Gill would not teach beginners to avoid making transference interpretations due to inexperience. In fact, he believes it is easier to teach

beginners to learn to work with transference than to studiously avoid it. Says Gill: "Therapists use the technique to whatever degree their skill and comfort in exposing the transferential significance of the patient's experience of the relationship permits" (p.175). Some trainees will be drawn to reckoning with the transference and countertransference dynamic while others less so; but the dynamic will always be a feature of clinical work.

Interpersonal theorist Edgar Levenson (1991) makes use of relationally-influenced techniques in supervision depending upon the trainee's level of experience. The more experienced the trainee, the more deeply Levenson invites the therapist to attend to his or her subjectivity and participation in the treatment. With beginning clinicians, Levenson first works on "structuring the therapy, delineating it, helping the therapist to pace and control the flow of material, helping him to learn how to do an inquiry" (p.121). At the same time, he introduces the therapist to the notion that he is both examining *and* interacting with a patient, encouraging him to notice "the extent to which parallel or isomorphic interactions seem to take place in the patient and in himself, in the process of therapy" (p.121). At the second level of supervision, trainees are encouraged to examine more closely the impact of their subjective experience on their interpretations and on patient-therapist interactions. But it is only at the third level of supervision, reserved for more experienced clinicians and the termination phase of a treatment, that the treatment relationship can truly be construed as an intersubjective one in which the "the distinction between doctor and patient becomes blurred" (p.121-122), and trainees are encouraged to examine their "realistic participation" with the patient.

Levenson describes a hierarchy of subjectivity that can be regulated, to some degree; but is such precision possible? How does one mete out subjectivity? Granted, a

myriad of factors may lead a therapist to express her subjectivity with one patient but not with another. Furthermore, a hint of therapist subjectivity may go a long way toward furthering one treatment while creating obstacles in another. Once one construes the psychotherapeutic dyad according to a two-person model, the door is open to *the possibility* of a wider range of therapeutic interactions. If we accept that being known to our patients is inevitable then how can we 'pretend' to be anonymous? Clearly it is impossible to work as a clinician and not even think about the nature of one's subjectivity. But that does not necessarily mean that explicit disclosure of one's subjective experience with the patient is inevitable.

According to Mitchell (1997), in a culture influenced by relational concepts, "there is now widespread consensus that the analyst…cannot successfully operate in this way [according to many precepts of the classical paradigm], that it simply cannot be done" (p.178). Factors which cannot be ignored or unlearned include altered notions of objectivity as expounded in philosophies of science and epistemology; the wide acceptance across orientations of the centrality of countertransference in treatment; and the recognition that therapists are never truly anonymous.

Psychoanalytic theory has evolved, in part, out of clinicians' own need to reevaluate their stance vis a vis their patients and the theoretical models driving their technique (Frank, 1997; Maroda, 1991; Renik, 1999; Wachtel, 1997). More simply put, many clinicians came to find classical models of treatment untenable, even unethical (P. Fraenkel, personal communication, October 2001). Beginning clinicians, too, may find that a relational or post-modern paradigm poses particular challenges. For others, this

paradigm shift may be what makes it possible for them to enter this field in the first place (Bader, 1998; Dunn, 1995).

It has also been suggested that the epistemological shift encompassed by contemporary relational theory actually facilitates the training of new clinicians, that trainees have an advantage over more experienced clinicians when it comes to integrating relational principles into practice. Safran and Muran (2000) train therapists to conduct short-term, dynamic psychotherapy in which the therapist reflects upon the minute interactions and enactments occurring in the therapeutic relationship and then shares these impressions with the patient, encouraging joint reflection. Therapists are trained to develop a mindfulness or moment-to-moment awareness of their experience, a skill which, in Buddhist terms, amounts to cultivating a "beginner's mind" (p.36) or an openness to many possibilities. While new and experienced clinicians alike struggle to feel competent in this work, experienced therapists' ideas of therapeutic phenomena tend to be even more reified and they are more likely to fall into habitual interpretations of therapeutic interactions. Jeremy Safran (personal communication, January 2002) has found that newer therapists are typically more open to and have an easier time working in this model of treatment.

In a similar vein, Barry Farber (personal communication, July 2002) notes that the relational paradigm implicitly values the kinds of skills that new clinicians tend to possess. Farber (1985) has noted that the quality of psychological-mindedness that has drawn many a new clinician into the practice of psychotherapy consists of both intellectual and experiential components of knowing. Too often, clinical training emphasizes the former, producing clinicians less inclined to utilize their capacity for

expressiveness, spontaneity, and affect. Trainees are also poorly served by didactic models of supervision in which they learn that "openness and flexibility with patients constitute countertransferential difficulties that must be understood and mastered, and that technical expertise is the *sine qua non* for professional acceptance" (Farber, 1985, p.175), a position that can be traced back to Freud and a classical attitude towards technique. Technical ability will come with time, practice, study, and supervision, says Farber. But beginning therapists—and their patients—may be well served by models of training in which therapists' affective engagement and spontaneous participation in the dyad are prioritized (See Ehrenberg, 1992; Fosha, 1995).

How does one practice according to a relational paradigm? There remains the sense, even among self-declared relationalists, that new clinicians need instruction in something more tangible than the deconstruction of a classical approach (Frank, 1999). However, as Frank (1999) has noted, the actualization of a relational technique has not emerged (p.xii). Maroda (2002), too, argues that relational advocates have thus far failed to develop techniques that are "reliable and teachable" (p.104). Reluctant to set in print a theory of technique that would become as reified as the classically-oriented practices of the field's forefather(s), relational theorists have de-emphasized structure in favor of creativity. The result is a void of technique felt especially by therapists in training. Both authors take steps towards rectifying this problem.

At this time, clinicians learning to conduct psychodynamic psychotherapy are exposed to diverse models of accepted practice, from contemporary classical or structural views to those articulated by relationalists. The training literature prescribes different timetables for how beginners' practice should reflect the influence of relational

paradigms: A relational sensibility should be avoided or bracketed (Berzoff & de Lourdes Mattei, 1999); integrated gradually (Levenson, 1991); or embraced from the start (Safran & Muran, 2000). What is not known is how new clinicians *themselves* actually understand relational ideas, juxtaposed with more traditional psychoanalytic guidelines, and how these ideas affect their practice. This study provides data on how contemporary relational and classical views fit within the practice spectrum of the field's newest practitioners. It reports on how current trainees of psychodynamic psychotherapy experience and reconcile the tensions that exist in the field at-large between and among different orientations, revealing the choices they are making in the face of multiple models.

Methodology

The methodology used for this exploration of the thinking and practice of beginning clinicians included a Q-sort and qualitative interview.

A Q-sort is an exercise in which participants are presented with a series of statements about the subject of interest, typically printed on cards, although computer-based measures have recently been developed (Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997). Participants are first instructed to sort the statements according to whether they agree, disagree, or feel neutrally towards them. They are then asked to sort the statements into a quasi-normal distribution, with the categories 'most agree' and 'most disagree' at the tapered ends of the curve and the neutral statements sorted into the middle columns (See distribution grid, Appendix A). Each participant orders the statements along the prescribed distribution according to his or her subjective viewpoint, constructing a personalized profile of his or her beliefs.

Participants' distributions are then collected and factor-analyzed and the dominant factors or groupings of statements, determined. The particular procedure for the factor analysis of Q-sort data forms the basis of what is known as Q-methodology.[10] Q-methodology was developed by William Stephenson (1953) as a psychometric alternative to the dominant correlational or 'R' methodology of his day. Q-methodology goes beyond correlations among test responses to reveal correlations among the respondents themselves, to reveal clusters of like-minded participants (See also Kerlinger, 1966; Kitzinger, 1999; Rogers, 1995; and Snelling, 1999). In Q-methodology, the outcome of the factor analysis reflects groupings of participant-sorters, derived from how they

[10] Results of a Q-sort or any card-sorting task may be analyzed by traditional factor analytic procedures. Q-methodology, by comparison, involves a variation on these procedures that will be described below.

conducted the Q-sort. The Q-sort elicits "a wide diversity of different subjective experiences, perspectives, and beliefs, none of which are defined a priori by the researcher" (Kitzinger, 1999, p.269). Participants are not required to identify with a particular preexisting viewpoint. Instead, it is they who demonstrate the range of views that exists among them. Results reveal how participants apply their subjectivity to the pool of Q-sort items at hand (Rogers, 1995).

For the purpose of this study, Q-sort statements reflected both relational and contemporary Freudian analytic views on therapist participation in the psychotherapeutic dyad as well as those that bridge these paradigms. Q-methodology was deemed uniquely well suited for an exploration of new clinicians' views since beginners are often not well informed about the labels for different paradigms or theories and may utilize aspects of each in varying combinations. As discussed, there has been a great deal of debate and confusion in the field at-large about the appropriateness of a given label—such as relational or classical—for a particular paradigm and the concepts behind these labels (Bachant, Lynch, & Richards, 1995a; Gill, 1995; Mitchell, 1995). The Q-sort had the advantage of enabling trainees to indicate their *implicit* identification with either paradigm (or some other organizing configuration) by stating their relative agreement or disagreement not with an orientation as a whole but with particular ideas or practices. Whether these choices cohered into "relational" and "classical" configurations could be approached as an *empirical* question: Which items tended to be endorsed together? Were there just two groups of therapists or multiple groups? Participants were not expected or required to state explicitly their overall model of practice. This choice of

methodology derived, rather, from the premise that an orientation label is frequently less meaningful than an elaboration of the beliefs behind it.

The sorting process was additionally well-suited for this topic because clinicians of all levels of experience often identify with some elements of relational or classical models but not others (Frank, 1999). Many clinicians are trained to utilize techniques associated with different paradigms. While some clinicians come to identify as purely relational or classical, others, in practice, choose to emphasize or prioritize only certain features associated with a given model. Therefore, the process of sorting specific statements according to what one feels is most or least meaningful to them as a therapist is parallel in certain respects with how one comes to formulate and implement a clinical orientation.

Development of the Q-sort

The Q-sort was developed by the PI in collaboration with Professor Paul Wachtel. As other researchers have described (Jones, Cummings, & Horowitz, 1988; Westen, et al. 1997), the development of Q-sort statements typically involves a review of the literature or other media sources relevant to the subject of interest, including other assessment instruments and consultation with experts or representatives of the target population. For this project, an initial pool of nearly 100 items was developed from a sampling of the psychoanalytic literature on the stance of the therapist and the nature of the psychotherapeutic dyad. Sources representing a range of views, from classical to neo-classical to contemporary relational, were consulted, yielding quotes or modified quotes from authors writing from the period 1946-2002.

Upon review, these quotes were found to represent seven distinct if overlapping domains of therapeutic practice or a theoretical position: 1) the constructivist-positivist debate, or matters of therapeutic epistemology; 2) the role of countertransference; 3) the merits of an interpretive vs. interventional approach; 4) the role of therapist neutrality; 5) the overall role of therapist; 6) therapist self-disclosure; and 7) the management of transference. To ensure the representativeness and comprehensiveness of the final pool of items, it was determined that the statements ought to reflect the range of views on these seven domains. The statements in each domain were reviewed and their ideas summarized. Utilizing these domain summaries, the researchers then drafted and edited a set of 53 statements.

As an example, following are two original quotes selected from the literature:

> The effort to remain neutral should not lead the therapist to avoid looking at things honestly and, when appropriate, taking them up with the patient. It is not a departure from neutrality to call a spade a spade. (Schafer, 1983, p.6)

> To achieve neutrality requires a high degree of subordination of the therapist's personality, not to be misunderstood as elimination of personality, as in total non-expressiveness. (Schafer, 1983, p.6)

Based on a review of these and 15 other quotes representing the fourth 'therapist neutrality' domain, seven original Q-sort statements reflecting different views from this domain were drafted. The following statement aimed to express the view of the original quotes by Schafer, becoming Q-sort statement #10:

> Neutral does not equal total non-expressiveness. Therapists may be neutral and still have a personality, be genuine and present, in essence, be themselves.

In the creation of a Q-sort, the initial "universe of propositions" (Rogers, 1995, p.183) is typically larger than the final set of statements. The process of item reduction ensures a balance of ideas, the appropriateness and applicability of the statements, intelligibility, simplicity, and comprehensiveness. Enrico Jones and colleagues (1988) have also cautioned that items must be edited for the elimination of jargon. In this case, the decision was made to use the quotes from the literature as a basis for a final pool of original statements for the above reasons, as well as to ensure evenness and appropriateness of tone and to better control the nuanced expression of the full range of ideas expressed in the literature-based statements, minimizing overlap.

Pilot study

The initial Q-sort statements were administered to three doctoral students from different clinical psychology doctoral training programs. The goal of the pilot study was to ensure the clarity of the statements; the relevance of the statements and of the overall exercise for the target population of therapist trainees; and to practice administration of the Q-sort. Students reported that they found the statements to be clear, comprehensive, and relevant to their work. Moreover, they found the exercise to be both interesting and enjoyable, and they welcomed the opportunity to reflect upon their values and assumptions as clinicians. No edits or additional items, nor any adjustments to the administration of the measure were recommended.

Review and validation of the Q-sort statements

The Q-sort statements were then reviewed by a panel of senior clinicians to ensure that the items chosen to represent classical and relational positions in fact did so. Four relational and four classical clinicians ("experts") were selected via word-of-mouth,

based upon their training at and affiliation with a relationally or classically-oriented institution, or based upon recognition of them as clearly allied with one or the other orientation given their contributions to relevant journals and/or affiliation with relevant professional associations. The experts were asked to review and score each Q-sort statement according to a Validation Scale (See Appendix B). Statements were to be rated as either: Primarily Classical (1), Relatively Classical (2), Difficult to Classify (3), Relatively Relational (4), or Primarily Relational (5). The Likert-scale format was deemed appropriate for this exercise in recognition of the fact that 'relational' and 'classical' are not absolute, black or white categories.

Some of the Q-sort items were drafted to fit with either a relational or a classical orientation while others were intended to be less classifiable, in recognition that an item may be hard to classify but still reflect a key clinical idea or value. The format of this scale was thus compatible with the nature of ideas in the field and the intention behind the construction of the items.

This review of items by expert clinicians revealed that some items were consensually viewed as relational or primarily relational; some items were consensually viewed as classical or primarily classical; and some items were found to be not aligned with either orientation.

The Q-sort items were then divided into three categories (described below) according to the expert ratings they received. Each category revealed the degree of consensus among the experts achieved by each item. Given that some items were deliberately drafted to bridge orientations—e.g. *not* to fall firmly into a relational or classical category—utilizing the three categories described below was believed to be

more relevant than eliminating items achieving low consensus. Low consensus about an item among the experts did not imply than an item is a poor item or that the expressed idea is not clinically relevant. It merely meant that the idea is not consensually viewed as relational or classical. Each of the three categories of items also represented a particular take on the relational vs. classical debate that has been articulated in the literature.

Category one: Anchor items

Out of an initial 53 items, 20 achieved broad consensus among both the relational and classical clinicians as to which orientation the items belonged. They were thus labeled as either Anchor Classical or Anchor Relational items. These items received scores of either 1 and 2 (primarily or relatively classical) or 4 and 5 (relatively or primarily relational), and no more than one score of 3 (difficult to classify). Anchor items were thus found to be essentially relational or essentially classical by 7 out of the 8 experts.

These scores reflect agreement across orientations about a set of ideas which do distinguish the orientations from each other. In an analysis of the final Q-sort factors, the prominence of one or more of these items in a factor would thus be said to represent the prioritization by new therapists of a recognized relational or classical viewpoint.

One underlying premise of this study was that, despite the cross-fertilization of ideas in the field, distinguishable viewpoints do exist and the relational critique does represent a fundamental shift in the analytic tradition via its re-conceptualization of the patient-therapist relationship and the therapist's participation in the treatment. This view is supported by authors (Aron, 1996; Mitchell, 1988; Wachtel, 1997) who have argued

that the relational paradigm is distinct from a classical or structural paradigm. Anchor items reflect this distinction.

Category two: Split Consensus items

Out of an initial 53 items, 10 received scores reflecting a split among the experts about whether the item reflected a relational or classical viewpoint. These items received at least one score of 1 or 2 *and* one score or 4 or 5. This reflected a disagreement over which 'side' claims the idea for itself (in the case where members of each orientation endorse the item as their own), or to which side the idea 'belongs' (where disagreement occurs *within* groups about where an item belongs).

Split Consensus items divided the experts. Should one of these items be found to define a final Q-sort factor, it would be important to consider what other items it has been grouped with. This would raise the question of whether beginning clinicians are making the case for the item's affiliation with either Anchor Relational or Anchor Classical items—with a relational or classical orientation—or whether the item has been endorsed for the construction of an original viewpoint.

This disagreement about the ownership of a particular idea or practice reflects an aspect of disagreement that surely exists in the field. As discussed above, Bachant, Lynch and Richards (1995a) argue that relationalists have appropriated ideas which already existed in the classical framework. Others have cited the seeds of relational ideas in classical writings as far back as Freud's. Similarly, relationalists, who are seen by classical proponents as ignoring the body or intrapsychic conflict, for example, do not necessarily agree that these concerns "belong to" the classical tradition. Given these views and disagreements, it is not surprising that clinicians of relational and classical

orientations may be unable to achieve consensus about the ownership of a particular idea. Split Consensus items reflect this reality.

Category three: Bridging items

Out of an initial 53 items, 23 were rated by two or more experts as "difficult to classify." These items received two or more scores of 3.

As was noted above, a selection of the Q-sort items were deliberately drafted to be endorsable by both relational and classical therapists. Despite their status as "unclassifiable," it was argued, these items reflect clinically meaningful ideas. They were retained in the Q-sort to enable it to represent the range of key ideas that guide most psychodynamic clinicians' work. Moreover, were an item from this category to be found to define one of the final Q-sort factors, the study will have yielded original data about the kinds of ideas that truly distinguish groups of clinicians—ideas that do not replicate groups delineated in the literature.

There are several reasons for the apparent 'messiness' inherent in the debate between orientations. The waters of debate are muddied by problems of language and disagreement regarding the use of certain terms and labels to define diverse viewpoints. It is sometimes difficult to know whether authors disagree about terminology alone or the concepts behind the words. Related to this, disagreement may exist on the level of theory but not in practice; clinicians of diverse orientations may think and write differently about their clinical work but in practice might not look so different from each other. Recall, also, that a diversity of viewpoints exists even among colleagues from within a particular orientation. And finally, Gill's (1995) expressed view that differences between orientations may reflect differences in the *prioritization* of certain values, although not absolute differences of values themselves,

also explains why an idea might be hard to classify. Bridging items may have been scored as unclassifiable for any of the above reasons, none of which diminishes their relevance to clinical practice or their rightful place in the Q-sort.

Through completion of the validation scale, the items were additionally screened by experts for clarity, soundness, coherence, and relevance to clinical work. Only in several cases were items found to be misleading, confusing and/or conceptually flawed. Minor edits were suggested. It was noteworthy that clinicians of both orientations tended to critique the same items. For example, the following item was thought to depict a stereotyped therapist:

> Therapist neutrality is required in the interest of scientific objectivity and to guarantee a *tabula rasa* for the patient's transferences.

With this feedback the item was revised and re-rated by experts as an Anchor Classical item #12:

> Therapist neutrality is required in the interest of maintaining as much objectivity as possible and to enable patients to recognize transference reactions as coming from within themselves, not simply as responses to the actual behavior or characteristics of the therapist.

This review process led to the revision of 12 items, the elimination of 1 item, and the addition of 2 new items, for a total of 54 final Q-sort items. The 14 new and revised items were then re-reviewed and re-scored by the panel of experts,[11] each of whom indicated that the revisions had improved the items.

Of 54 items, 14 were rated as 'AC' or Anchor Classical items; 9 were rated as 'AR' or Anchor Relational items; 23 were rated as 'B' or Bridging items; and 8 as 'S' or Split Consensus items.

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[11]One of the classical experts was unable to participate in the re-rating process. The average score of the three other classical experts was substituted for that reviewer's score.

Table 1: The three Q-sort item categories with sample items

Category	Sample Item
Anchor Classical (AC) or Anchor Relational (AR) items Statements that achieved consensus among experts of both orientations.	Countertransference fantasies are a rich source of information, but enactment of these fantasies should be avoided as much as possible. (AC) Therapist self-disclosure is an inevitable part of the process. The question is not whether to disclose, but how and when to do so. (AR)
Split Consensus items (S) Experts were split in their endorsement of the statement as relational or classical**.**	Neutral does not equal total non-expressiveness. Therapists may be neutral and still have a personality, be genuine and present, in essence, be themselves.
Bridging items (B) Statements difficult to classify according to one orientation**.**	It is only by participating in the therapeutic relationship and experiencing the kind of affective response (or lack thereof) that a patient evokes in you that you can begin to know what is most important about a patient and how to proceed in treatment.

Participants

Doctoral students (Ph.D. or Psy.D.) in clinical psychology were recruited via word of mouth and the "snowball effect" from contacts with other students in the field. They were contacted by the PI via telephone or email. The PI also recruited participants by visiting classrooms of local doctoral programs and making a brief announcement about the study.

Eligible participants had to have completed a minimum of one year conducting supervised psychodynamic psychotherapy with adults. At most, they were in their first year post-licensing to qualify as beginning clinicians.

Prospective participants were told that this study would examine the thinking and practice of beginning clinicians being trained to conduct psychodynamic psychotherapy. They were advised that data collection would involve completion of a Q-sort or card sorting task, an interview and a brief questionnaire, and would take one-and-half to two hours; that participants would be met at a time and place convenient for them; and that participants would receive a $10 bookstore gift card as compensation for their time and involvement in the project. They were also told that prior participants had welcomed the opportunity to reflect upon their training and clinical work.

Administration of the Q-sort, interview, and questionnaire

Once participants signed their consent forms (Appendix C) they were presented with written instructions for completing the Q-sort (Appendix D). Sorting instructions were also given verbally. Materials included a stack of Q-sort statements on 3x5 index cards and a blank distribution grid on which to record the results of their sort (Appendix A). Participants were asked to allow a minimum of 30 minutes to complete the Q-sort.

The PI remained in the room to answer questions but did not directly observe the sorting process so that the participant would not feel scrutinized.

The PI and participant then together reviewed the completed sort, and the PI administered the semi-structured interview (See Appendix E). Questions one through six of the interview protocol invited the participants to elaborate on their experience of the Q-sort and their sorting choices. Question seven, which asked for a clinical vignette, was a further vehicle for this discussion but also served as a check on whether trainees were, in fact, practicing according to the ideas and practices they claimed to value. With the Q-sort data then collected, participants were lastly explicitly asked the kinds of questions (eight and nine) about their orientation and training that the Q-sort was designed to explore more implicitly.

While the participants completed the demographic and training questionnaire (Appendix F), the PI collected the Q-sort cards and recorded the Q-sort data on the grid. The questionnaire was designed to collect demographic data and provide a profile of the participants' training experience.

Statistical analysis of the Q-sort data

Thirty clinical psychology doctoral students from six New York area graduate programs completed the Q-sort, interview, and questionnaire. The student sample was comprised of 24 women and 6 men, with a mean age of 31. Twenty-six of the participants were in their second to sixth years of training, with 3 and 4 being the modal years in training. Four participants were newly licensed recent graduates. For the entire sample, the number of years conducting dynamically oriented psychotherapy ranged from 1 to 7, with a mean of 3 years.

The Q-sort data represent each student therapist's subjective rating of the 54 Q-sort statements on aspects of psychodynamic psychotherapy practice. Factor analysis explored commonalities in the way the students sorted the Q-sort cards, grouping students according to the statements they prioritized. The final factors yielded groupings of trainees who were similar in the way they construe their role as therapists. Q-sort data was analyzed by the PI, in consultation with an experienced statistician, using the SPSS and SAS statistical programs and following established factor analytic procedures (Brown,1991-1992; McKeown & Thomas, 1988; Snelling, 1999). The stages of factor analysis may be summarized as follows:

- Creation of a correlation matrix and factor extraction
- Calculation of factor scores
- Creation of a factor array

These stages will be described, below, along with a discussion of the distinction between Q-methodology and traditional factor analysis.

The correlation matrix and factor extraction

When a Q-sort is complete, each statement has been placed in one column along the "least agree" to "most agree" continuum. The level of agreement or disagreement among all participants is then presented in a correlation matrix. The correlations themselves are not of interest. Rather, as Brown (1991-1992) has noted, "The correlation matrix is simply a necessary way station and a condition through which the data must pass on the way to revealing their factor structure" (chap. 5, ¶6). The initial correlation or 'R' analysis resulted in a 30 x 30 correlation matrix.

Factor analysis is a mathematical procedure that examines the correlation matrix to reveal "family resemblances" (Brown, 1991-1992, chap. 6, ¶2) among the Q-sorts. It reveals how many different kinds of Q-sorts exist among the participants' sorts, based upon how they sorted the items. The significance of a factor is determined by theoretical as well as statistical criteria. According to McKeown and Thomas (1988): "Common sense offers the best counsel when determining the importance of factors, that is, their contextual significance in light of the problems, purposes, and theoretical issues in the research project" (p.51).

Factor rotation is the procedure which changes the "vantage point" from which the data are viewed (McKeown & Thomas, p.52). The presentation of the factors is simplified to highlight the distinctions among groups of participants whose Q-sorts are the most similar to each other. Different approaches to factor rotation exist. A Varimax rotation is commonly used and assumes that the factors are orthogonal or independent of each other. Alternately, theoretical concerns may lead to the choice of an oblique rotation, used when factors are not independent.

In the present study, the 30x30 matrix was transposed so that the factor analytic procedure would yield groupings of participants as opposed to groupings of statements. Six factors with eigenvalues greater than 1 were extracted using Principal Component Analysis of the correlation matrix. Anticipating the underlying interrelatedness among factors, the factors were rotated obliquely using the Promax method. The factor solution accounted for 66% of the variance.

This step also yielded each participating student's loading on each factor. A statistically significant factor loading was determined by calculating the standard error score based upon the number of items in the Q-sort:

1 / square root of 54 = 0.136

Statistical significance is conventionally considered to be a value between 2 or 2.5 times the standard error (Brown, 1991-1992, chap.5, ¶5), which in this case yields a cutoff of 0.35. In order to minimize the loading of participants on one or more factor (i.e. to maximize the number of pure loadings), the decision was made to use a more conservative factor loading cutoff of 0.41. In the final six-factor solution, only one participant loaded on more than one factor. In an effort to preserve this student's data, her loadings were included in the creation of factor scores for both of the factors on which they loaded. Conceptually, given the overlap of viewpoints in the literature and in the sample, it was feasible for a student to identify with more than one factor or aspects of different factors, and so it was decided that she would be permitted to contribute to the construction of multiple factors. Finally, one participant was not loaded on any factor.

Calculation of factor scores

Factor scores were calculated in order to facilitate interpretation of the factors, to determine which Q-sort statements each of the six groups of students agreed and disagreed with. The factor score is an average score given to each Q-sort statement by all of the Q-sorts associated with each factor. More specifically, the factor score is also a *weighted* score which accounts for each Q-sort's relative loading on or contribution to that factor. The views of the students who loaded more heavily on a given factor are thus

given more weight in the calculation of factor scores. The weights (w) for each statement were obtained according to the formula:

$$w = f \text{ (factor loading for that person)} / 1 - f^2$$

Weighted factor scores were then obtained for each statement for each factor. This calculation is one of the key features distinguishing Q-analysis from conventional factor analysis.

The difference between Q-methodology and traditional factor analysis

Standard factor analysis on this data set would have revealed groupings of *statements* according to their relative endorsement by the participants. That would have meant that for a sample of 30 trainees, when one statement from a given factor would be endorsed, the other statements from that factor tended to be endorsed as well. The transposition of the data (or switching of database columns and rows) created a database of *people*, not of test items (Kitzinger, 1999) in order to reveal groupings among—or factors consisting of—the participants themselves.

Whereas traditional factor analysis interpretation proceeds according to the analysis of factor loadings, Q-sort analysis involves interpretation of the factor scores (McKeown & Thomas, 1988). The difference may be explained as follows: Analysis of factor loadings would involve looking immediately at the groupings of statements, particularly those with highest factor loading values. In Q-methodology, the item-by-item analysis is deferred. Groups of *participants* are obtained. Factor loadings are, thus, the loadings of people. They are “people scores” not item scores.

The Q-sorts of the participants with the most significant loadings for each factor are then reviewed and factor scores are calculated. As described above, factor scores are

weighted item scores that take into account the relative rankings of the item by the participants most representative of the factor. The item-by-item analysis for each factor *follows* and is dictated by how the participants are grouped and how they sorted the Q-sort statements.

Creation of a factor array

Following the procedure recommended by McKeown and Thomas (1988) and Brown (1991-1992, chap.7, ¶2), factor scores for each item, calculated separately for each factor, were manually converted into numbers ranging from -4 through +4 and scaled according to the original -4, -3, -2, -1, 0, +1, +2, +3, +4 distribution used for the Q-sort (See distribution grid, Appendix A). The items with the three highest factor scores were thus ranked +4; the items with the next five highest factor scores were ranked +3 and so on, through -4. The distribution of these converted factor scores along this continuum created, in essence, a model Q-sort for each factor. The factor array which follows permits a comparison of item rankings across factors. The presentation of a factor array is a standard means of presenting Q-sort data (See Snelling, 1999; Stainton Rogers & Kitzinger, 1995; Westen, et al., 1997) and a key precursor to Q-sort data interpretation.

Table 2: Factor Array

The category into which each item was placed following the expert review process, AR, AC, B, or S, is noted parenthetically after each item.

Q-sort items	**I**	**II**	**III**	**IV**	**V**	**VI**
1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality. (S)	3	0	1	0	-3	-2
2. Recent advances in our understanding of object relations and the evolution of the self do not diminish the need to understand the powerful organizing influence of biologically-rooted drives. (B)	-3	1	-1	0	0	2
3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient's way of being with others. (AR)	-1	0	-2	0	-4	-3
4. The aim of a psychodynamic treatment is the resolution of neurotic conflict. A stance of relative neutrality permits memories, associations and any conflictual material to emerge in the transference so they may be interpreted and worked through. (AC)	-3	0	-1	-1	3	2
5. Therapists should be willing to answer patients' personal questions to the extent that they feel comfortable doing so. Such willingness to disclose enhances the therapeutic alliance, models honesty and genuine connection in a relationship and, in some cases, validates a patient's reality testing. (B)	0	-1	-2	2	-4	0
6. The dynamics of transference and countertransference are critical in any treatment, but it is important not to focus on them too exclusively. Attention to the real transactions that constitute the therapeutic alliance is also important. (B)	2	3	0	-1	-3	0

Table 2: Factor Array

7. One therapeutic stance may be of value with a given patient or at a given moment in a treatment, while an entirely different approach may be required with another patient or at a different moment with the same patient. Flexibility should be the therapist's rule-of-thumb. (S)	2	4	-1	1	0	4
8. Countertransference fantasies are a rich source of information, but enactment of these fantasies should be avoided as much as possible. (AC)	0	-2	0	1	0	-1
9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change. (S)	0	-3	3	-3	4	0
10. Neutral does not equal total non-expressiveness. Therapists may be neutral and still have a personality, be genuine and present, in essence, be themselves. (S)	1	4	2	0	-1	2
11. Therapist self-disclosure is an inevitable part of the process. The question is not whether to disclose, but how and when to do so. (AR)	0	1	0	4	-2	-1
12. Therapist neutrality is required in the interest of maintaining as much objectivity as possible and to enable patients to recognize transference reactions as coming from within themselves, not simply as responses to the actual behavior or characteristics of the therapist. (AC)	-2	-1	-2	-2	2	0
13. It is only by participating in the therapeutic relationship and experiencing the kind of affective response (or lack thereof) that a patient evokes in you that you can begin to know what is most important about a patient and how to proceed in treatment. (B)	1	-1	2	-2	1	-1
14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)	2	-1	2	2	-1	3

Table 2: Factor Array

15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions. (AC)	-3	-4	0	-4	4	-1
16. The stance of neutrality, often linked to abstinence and non-gratification, can leave the patient feeling un-cared for and hinder therapeutic progress. (AR)	0	1	0	-1	-3	1
17. The therapist's effort to be anonymous can impede a treatment's progress by, for example, evoking for the patient an absent or unknowable parental figure. (AR)	-2	0	-2	2	-2	-2
18. When the therapist tries to influence the patient as little as possible or reveal as little as possible about herself, the transference is able to become clearer. (AC)	-1	-2	-4	-2	-2	0
19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well. (S)	3	2	4	1	1	0
20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion. (B)	3	3	3	4	1	2
21. In order to ensure that the patient's repressed fantasies and wishes become intense enough to be manifested in the session, it is important that the therapist try not to gratify the patient's infantile or drive aims. (AC)	-4	-3	-4	-1	3	0

Table 2: Factor Array

22. It is a mistake to interpret the patient's experience of the therapist too exclusively as a repetition of something earlier. The therapist is also a new object and this new relationship contributes importantly to transforming the patient's inner life. (AR)	1	2	1	0	-2	3
23. On the oft-debated subject of therapist self-disclosure, every clinician must decide what feels right for them, in a given clinical context, with each patient. There should be no pre-set rules on such a personal matter. (B)	-1	3	1	-1	-2	3
24. A therapist will inevitably make errors of practice or judgment (e.g. forgetting an appointment). Nevertheless, it is the *patient* who is in treatment, and it is *his* or *her* feelings about the error that should be the primary subject of discussion. (B)	0	1	1	-3	-1	-4
25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations. (B)	3	0	4	3	3	3
26. The therapist should not be primarily concerned with a patient's practical problems, nor should she aim to influence the patient's daily activities. (AC)	-2	-4	0	-4	-1	-2
27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist. (B)	3	3	1	-1	2	4
28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely *can* be controlled, are not appropriate. (AC)	-3	-2	-3	-3	1	-1

Table 2: Factor Array

29. The therapist's personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are often useful to share, since they are key elements in the treatment. (AR)	0	-2	-3	-1	-1	-3
30. At times, the therapist may find it constructive to admit to difficulty managing or understanding her reaction to the clinical material or to share her evolving and not yet fully formulated thought process with a patient. (B)	0	-1	1	3	2	-2
31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values. (B)	-1	1	2	4	-4	-3
32. At any time, the therapist may be a model, teacher, advisor, transference figure, new or old object–or any combination of these. (B)	4	-1	-1	1	2	2
33. There are often good reasons to withhold personal information or remain 'anonymous' to our patients, and it is a mistake to overlook this. (B)	1	0	-1	3	1	4
34. Whatever one's views may be about intersubjective or two-person models of treatment, the psychotherapy patient and the psychotherapist have fundamentally different roles, needs, responsibilities and liabilities. Mutuality does not mean equality. (S)	2	2	3	1	-1	1
35. Remaining silent about our experience can be as much a countertransference enactment as any other kind of response. (S)	1	0	0	2	1	1
36. Traditional ideals of neutrality or anonymity amount to the pursuit of an illusion. Once we recognize that we are always "known," in some way, by our patients, we must relinquish neutrality as a therapeutic ideal. (AR)	0	0	2	0	-2	-4

Table 2: Factor Array

37. The therapeutic relationship, in its most fundamental aspects, is based on the parent-child relationship, and it is important that the impact of this powerful underlying structure be understood. (B)	-2	1	3	3	2	-3
38. When the therapist reveals personal information, fantasies or thoughts to a patient, she intrudes upon the development of the transference and the fantasies the patient may have about her. (AC)	-1	-3	-1	-2	0	0
39. It is important that the therapist adopt a neutral stance in order to have equal access to the id, ego and superego elements in the patient's behavior and experience. (AC)	-4	-1	-4	-4	1	-2
40. Countertransference disclosures should always be made cautiously, and only in response to an inquiry from the patient. (S)	-1	-3	-2	-3	-3	-1
41. Neutrality in a therapist is just what some patients need in order to feel free to express themselves fully in the treatment setting. (B)	0	1	0	0	4	2
42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)	4	4	-1	2	0	-1
43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient. (AC)	-2	-4	0	2	3	-4
44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experiences and inner life. (AR)	4	-2	1	0	-1	3
45. Interpretations can never really be objective. They always significantly include the therapist's particular take on the material the patient presents. (B)	2	0	0	0	0	1

Table 2: Factor Array

46. Therapists are no longer expected to be blank screens. Nevertheless, they should strive to be as neutral as possible, establishing a baseline against which changes in the patient's perceptions of them can be recognized as deriving from within the patient. (AC)	-1	2	-1	-2	1	1
47. Therapists should de-mystify the process of therapy as much as possible, in order to put the patient at ease. It is appropriate for therapists to 'educate' the patient regarding the frame of treatment and the nature of what is to be expected. (B)	1	2	-3	1	0	-2
48. Whatever a patient's reaction to his or her therapist may be, wishes, fears, and defenses originating in childhood have a very important part in it. (B)	1	3	4	3	2	0
49. The therapist's expression of genuine feelings for the patient must be kept in check in order to further the therapeutic process and the patient's self-exploration. (B)	-2	1	2	-3	0	0
50. Addressing the patient's day-to-day problems in living and attempting to help the patient change problematic interpersonal patterns is an important and useful part of the overall therapeutic effort. (B)	2	2	-3	1	0	1
51. The therapist withholds affective responses, not because she does not care for or feel compassion towards the patient, but to ensure that feelings stirred for her in the work do not distract her or the patient from the therapeutic task. (B)	-3	-1	-2	0	-1	1
52. The disclosure of personal information need not put an end to patients' fantasies about the therapist. Indeed, a disclosure may stimulate and encourage discussion about these fantasies. (AR)	1	0	3	1	-3	-3

Table 2: Factor Array

53. Transference is the most powerful force behind the patient's behavior and experience in the sessions. Too much focus on the 'real' or 'working' relationship apart from the transference is likely to diminish the depth of the treatment. (AC)	-4	-3	1	-2	3	1
54. Examining behavior from the perspective of id, ego and superego dimensions remains an important and helpful organizing idea in understanding clinical material. (AC)	-1	-2	-3	-1	0	-1

Results

Results of this study indicate that the majority of the students in the sample reject classical ideology and practice, although they do not endorse a relational approach. The Q-sort items that have the broadest appeal for today's trainees are those that bridge orientations. These findings will be explicated through: 1) the presentation of mean item scores for each item in the Q-sort, including a breakdown of mean item scores according to experienced clinicians' ratings; 2) the presentation of model Q-sort distributions of these ratings for each factor; and 3) interpretation of the Q-sort results factor by factor, based upon the factor array and incorporating interview data from the students who loaded significantly on each factor.

Mean item scores and expert clinicians' item ratings

In the Q-sort, each item was ranked by participants along a continuum of -4 to +4, from most strongly disagree to most strongly agree. What follows is a list of the Q-sort items with the ten highest mean scores and the ten lowest mean scores. Also included here is the rating each item received by the experts, either AR (Anchor Relational); AC (Anchor Classical); B (Bridging); S (Split Consensus). The full table of mean item scores and expert ratings is presented in Appendix G.

Table 3: Mean item scores and expert clinicians' item ratings for the ten highest and ten lowest scoring items

Mean Score	Expert Rating	Q-sort items with the ten highest mean scores
2.10	B	20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion.
2.00	B	42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic.
2.00	B	25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations.
1.90	S	19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well.
1.80	B	27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist.
1.80	S	7. One therapeutic stance may be of value with a given patient or at a given moment in a treatment, while an entirely different approach may be required with another patient or at a different moment with the same patient. Flexibility should be the therapist's rule-of-thumb.
1.73	B	32. At any time, the therapist may be a model, teacher, advisor, transference figure, new or old object–or any combination of these.
1.60	B	14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur.
1.37	AR	44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experiences and inner life.
1.23	S	34. Whatever one's views may be about intersubjective or two-person models of treatment, the psychotherapy patient and the psychotherapist have fundamentally different roles, needs, responsibilities and liabilities. Mutuality does not mean equality.

Table 3: Mean item scores and expert clinicians' item ratings for the ten highest and ten lowest scoring items

Mean Score	Expert Rating	Q-sort items with the ten lowest mean scores
-1.40	AC	43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient.
-1.50	AC	12. Therapist neutrality is required in the interest of maintaining as much objectivity as possible and to enable patients to recognize transference reactions as coming from within themselves, not simply as responses to the actual behavior or characteristics of the therapist.
-1.63	AC	38. When the therapist reveals personal information, fantasies or thoughts to a patient, she intrudes upon the development of the transference and the fantasies the patient may have about her.
-1.67	AC	53. Transference is the most powerful force behind the patient's behavior and experience in the sessions. Too much focus on the 'real' or 'working' relationship apart from the transference is likely to diminish the depth of the treatment.
-1.77	S	40. Countertransference disclosures should always be made cautiously, and only in response to an inquiry from the patient.
-1.83	AC	26. The therapist should not be primarily concerned with a patient's practical problems, nor should she aim to influence the patient's daily activities.
-1.83	AC	15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions.
-1.90	AC	21. In order to ensure that the patient's repressed fantasies and wishes become intense enough to be manifested in the session, it is important that the therapist try not to gratify the patient's infantile or drive aims.
-2.10	AC	28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely can be controlled, are not appropriate.
-2.33	AC	39. It is important that the therapist adopt a neutral stance in order to have equal access to the id, ego and superego elements in the patient's behavior and experience.

According to the above mean score rankings, Bridging and Split Consensus statements are the ones most heavily represented at the highest end of the mean score list, Anchor Relational items are sprinkled near the top and middle of the mean distribution, and Anchor Classical items are primarily grouped at the low end of the distribution. Among the top ten most highly ranked items, seven were B or Bridging items; two were S or Split Consensus items; and one was AR or Anchor Relational. Among the ten lowest ranked items, nine were AC or Anchor Classical and one was S or Split Consensus.

The distribution of expert clinicians' item ratings for Factors I –VI

Following is the distribution of expert clinicians' scores for each of the six factors. Factors I – IV reveal similar patterns, each with three Anchor Relational items at the high end of the distributions and Anchor Classical items toward the middle and low end of the distributions. In Factor V this trend is reversed. In Factor VI, Anchor Relational and Anchor Classical items are spread throughout around the distribution.

Figure 1: Factor-by-factor distribution of expert clinicians' item ratings[12]

Factor I

				B				
				AR				
			AC	B	AR			
			AC	AR	B			
		B	S	B	B	B		
	B	AC	AC	AR	S	B	B	
	AC	B	B	AR	B	S	B	
AC	AC	AC	B	S	AR	B	B	AR
AC	AC	AR	AC	AC	B	S	S	B
AC	B	AC	AR	B	S	B	S	B
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor II

				AR				
				B				
			B	AR	B			
			AC	S	B			
		AC	B	B	B	B		
	AC	AR	B	B	B	B	B	
	S	AR	B	AR	B	AC	B	
AC	AC	AC	B	AC	AR	S	B	B
AC	AC	AC	AC	AR	AR	AR	B	S
AC	S	AC	B	S	B	S	B	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor III

				B				
				AC				
			AC	B	AC			
			B	S	AR			
		B	AC	AC	B	B		
	AC	S	B	AR	B	AR	AR	
	B	AR	B	AC	B	B	B	
AC	B	AC	S	AR	B	B	S	B
AC	AR	B	AC	AC	AR	B	B	B
AC	AC	AR	B	B	S	S	S	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

[12] The distributions of expert clinicians' item ratings for each factor are re-printed, below, at the start of each section in which that factor is discussed.

Figure 1: Factor-by-factor distribution of expert clinicians' item ratings (cont.)

Factor IV

				B				
				B				
			AC	AR	AR			
			AR	B	B			
		AC	AC	AR	B	AC		
	B	AC	B	AR	S	B	B	
	S	AC	AC	S	B	S	B	
AC	AC	AC	AR	AR	S	AR	B	B
AC	B	B	B	B	AC	B	B	B
AC	S	AC	AC	S	S	B	B	AR
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor V

				AC				
				B				
			B	B	AC			
			AR	B	AC			
		AR	S	B	S	B		
	AR	B	AR	B	B	B	AC	
	S	AR	AC	AC	AC	B	AC	
B	AR	AC	B	AC	B	B	B	B
B	B	AR	B	S	S	B	AC	AC
AR	S	AR	S	B	B	AC	AC	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor VI

				B				
				B				
			AC	AC	AC			
			B	AC	B			
		B	S	S	B	B		
	AR	AC	AC	AC	AC	B	AR	
	B	B	AC	AC	B	B	B	
AC	B	AC	B	S	S	S	B	B
AR	AR	AR	AR	B	S	AC	AR	B
B	AR	S	AC	B	AR	B	B	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor-by-factor interpretation

What follows is an interpretation of each of the six factors based upon the six distributions of Q-sort items presented in the factor array. The factor array is the entry point to a comparison of participants' views within and across factors. Each interpretation is a "plausible story about the choices made by the research participants whose Q-sorts load on that factor, seeking to explain the pattern of their rankings" (Kitzinger, 1999, p.269). The mean item rankings and categorization of items according to the expert validators, above, offer representations of the data that are not mediated by the PI's interpretations. In contrast, it is in the interpretation of the factor array that "the researcher's own biases and limitations may be most apparent and may result in meanings being inadvertently imposed on research participants" (Kitzinger, 1999, p.269). In an effort to minimize bias, researchers (Kitzinger & Stainton Rogers, 1985; Snelling, 1999; Stainton Rogers & Kitzinger, 1995) have relied upon participant interviews to further illuminate the factor exegesis.[13] Furthermore, the factor array format serves as an additional corrective for the researcher's interpretive biases by making available to the reader the means to compare item rankings and evaluate the researcher's conclusions independently.

According to Kitzinger (1999), factor array interpretation should incorporate: 1) Discussion of item scores *within* (in this case the six) factor arrays, particularly the items that are in extreme positions (i.e. -4, -3, +3, +4), as these are the items with which participants loading on that factor agree or disagree most strongly; 2) Review of salient items toward the center of the factor array distribution. Such items must be viewed in the

[13]Admittedly, the inclusion of interviews opens to door to further interpretation that may similarly reflect the biases of the investigator.

context of other items in the factor array and have the potential to challenge our assumptions about what kinds of ideas "go together;" 3) Consideration of apparent discrepancies in the ranking of items or seemingly contradictory views within a factor; and 4) Inspection of items *across* factors—that is, of the relative ranking of a given item from factor to factor. Items with differing rankings across factors are the key to factor differences. Items with similar rankings across factors are not discriminating but rather point towards views held consensually by different groups of trainees.

Following this model, factor exegesis will begin with extreme scores and proceed to consideration of additional scores within and then across the six factor distributions. The interpretations will proceed thematically, making the case for distinctions among the groupings of students. Kitzinger's model will be applied generally but also in the service of these distinguishing themes. Extreme item scores (+ or - 4 and + or -3) will always be considered while more moderately scored items will be discussed insofar as they elucidate the factor themes. Across-factor comparisons will be made as well. However, instead of a full item-by-factor comparison (which would yield a completely unwieldy 54x54x54x54x54x54 matrix), an effort will be made to highlight the most relevant distinctions among the factors as the discussion proceeds from Factors I through VI. Statements strongly endorsed or rejected by multiple factors will also be discussed and considered in the context of their accompanying statements. Excerpts from the interviews will be used throughout to support and expand upon the Q-sort interpretations.

Factor I

Factor I is comprised of 13 participants, 12 women and 1 man, ranging in age from 27 - 36 and representing each of the six doctoral programs included in the study. The mean year in training for in-school trainees is 4 and two of the participants were in their first year post-licensing. The primary descriptors[14] used by these students to define their orientation include: "psychodynamic" (4); "interpersonal" (3); "relational" (3); "eclectic" (1); "integrative" (1); and "psychoanalytic" (1). Other descriptors include: "flexible," "CBT," and "systemic." Students in this group have been working psychodynamically for a mean of 3 years and a range of 1 - 6 years.

Distribution of expert clinicians' item ratings for Factor I

				B				
				AR				
			AC	B	AR			
			AC	AR	B			
		B	S	B	B	B		
	B	AC	AC	AR	S	B	B	
	AC	B	B	AR	B	S	B	
AC	AC	AC	B	S	AR	B	B	AR
AC	AC	AR	AC	AC	B	S	S	B
AC	B	AC	AR	B	S	B	S	B
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Nearly half of the participants in this study (13 students) loaded significantly on Factor I.[15] If this overall sample of students is representative of beginning

[14]"Primary descriptors" refers to the first answer given in response to the questionnaire item inquiring about students' orientation. "Other descriptors" refers to the second written response in cases where more than one orientation label was given. It should be noted that the questionnaire responses do not uniformly match the way participants describe their orientations in the interviews.

[15]Twelve of the 13 students had pure loadings on Factor I, loading only on this factor. One student loaded on this factor as well as on Factor VI. Her profile will be examined in the discussion of Factor VI.

psychodynamic psychotherapists in the field today, then the views of Factor I trainees represent a kind of norm. The statements they most strongly agree with reveal a way of conceptualizing the role of the therapist and the terminology that resonate for close to a majority of participants in this study. The statements with which they disagree represent the ideas and practices considered out of vogue among many students in training today.

This group of trainees was inclined toward statements offering theoretical or epistemological perspectives on clinical work. The model of practice endorsed by these students is one that describes the patient-therapist relationship in terms that are often used by proponents of a "two-person" model and that portray the treatment process as a collaborative one. The items they reject are unambiguously linked with a classical approach. A review of the distribution of expert validator scores for this factor reveals that Anchor Classical items reside in the negative to neutral columns. It should be noted, however, that only three Anchor Relational items were placed on the positive end of the distribution, with only one placed above +1 (a single +4 ranking). In this respect, the students who comprise Factor I are, indeed, representative of the overall sample who—with their placement of Anchor Classical items on the low end of the distribution—reject classical views but shy away from endorsing the views that most unambiguously represent (according to the expert validation ratings) a relational approach.

Not unexpectedly, given that Factor I trainees comprise nearly half of the sample, the three items in the study with the highest mean scores over all 30 participants were also strongly endorsed by students whose Q-sorts loaded on Factor I.[16]

[16] Although only one of these three (item #42) was in the very top group for this factor (that is, a ranking of +4), the other two were also ranked highly (both with +3 rankings). The other two items that received a ranking of +4 for Factor I will be presented and discussed shortly.

4[17] 42. Therapists must first establish a working alliance with their patients. This 'real' relationship is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)

3 25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding is inevitably filtered through our life experience and perceptual inclinations. (B)

3 20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion. (B)

These items reflect the current norms, the foundational beliefs of clinicians entering the field today.[18] Students elaborated on their selection of these items in interviews as they looked back over their Q-sorts.

> Well, the therapist must establish a working alliance with their patients. And that's good, the basis. If you don't have a working alliance, the patient's not going to show up. (Carie, 2nd year student)

> It's unrealistic to think of the therapist like a surgeon...I don't think therapists go in and fix something while the patient is anesthetized and then…the patient wakes up cured. I don't like that analogy at all. And the same thing with the reflecting mirror, that the patient is very passive and the therapist is the knowing one in the session. And embedded in that is that the therapist is human...and can't not have feelings…and being aware of those feelings can be very helpful. (Veronica, 5th year student)

[17]This number reflects the ranking of the item in the factor array.

[18]The above three items were ranked highly by students loading on a number of the other factors as well, and so do not exclusively characterize the beliefs of the students of Factor I alone. Rather, they create the context for which this group's more uniquely endorsed items may be interpreted.

> I just think the relationship is key because in the context of comfort or feeling safe, I think people are more willing to open up and to be vulnerable...and to be open to feedback from the therapist, whether something is going on in the moment or in their lives in general. I think that only if people can truly feel we care for them...or that we're connected to them...or only once they're connected to us in a certain way will we really get a lot of work done. (Sandor, 1 year post-graduate)

For the majority of participants in the study, the value of establishing a working alliance, the pervasive influence of countertransference, the engagement of the therapist's affect as well her intellect, are standard concepts that they prioritize and that form the basis for their clinical work and for trusting therapeutic relationships.

The above statements are agreeable ones, both in that they garner a good deal of agreement among students in the study but also in being relatively uncontroversial ideas. They are non-polarizing Bridging statements that the experts were unable to classify as either relational or classical and that do reveal the professional attitude of this group. The top three items selected specifically by students whose Q-sorts loaded on Factor I also included the following:

4 32. At any time, the therapist may be a model, teacher, advisor, transference figure, old or new object–or any combination of these. (B)

This item further presents the therapist as agreeable, open-minded, flexible, and willing to accommodate the needs of the patient. As Michelle, a recent graduate said:

> You could be an old or a new object. You could definitely guide patients...A lot of patients don't have access to their emotions. So I think you are a teacher sometimes or a model sometimes, even if you do dynamic therapy.

The profile of Factor I trainees is refined a bit more distinctly with their endorsement, also among their top three statements, of one Anchor Relational statement:

4 44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experience and inner life. (AR)

This item was one of only two Anchor Relational items to be ranked +4 on any of the factors. It reveals how Factor I students conceptualize their stance vis-a-vis their patients. Joy, a 4th year student and the participant with the highest loading on Factor I, explains what joint meaning-making means for her:

> I guess a lot of what I've come to believe and have read too...especially in my work with trauma has been that sort of forming a...coherent narrative with the patient about their life, like regardless of whether or not it is real or true or not, is what's most therapeutic.

For Joy, joint meaning-making is also part and parcel of a relationship grounded in a strong working alliance.

> I guess it goes along with sort of working jointly with someone...if the working alliance is based in trust and like the feeling that your therapist is trying to understand you and that they have empathy for you and that they're not being bossy or interrupting you...if that doesn't exist than I think the resistance is going to be much, much higher.

Statement #44 about joint meaning-making is one of the clearest depictions among all the Q-sort items of a two-person therapeutic process. (See Aron, 1990; Frank, 1999; Wachtel, 1997). It is an assertion about technique that also bespeaks a particular epistemology regarding how the therapist comes to know a patient as well as how the patient makes use of treatment.

The following statements, also ranked relatively high, similarly depict the therapeutic process as one in which the therapist's subjective and affective experience are vital aspects of the treatment. They reveal the egalitarian sensibility and epistemology of the Factor I therapists:

3 19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient their own contribution as well. (S)

2 14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)

3 1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality. (S)

3 27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist. (B)

These students understand their role as therapists as that of meaning-makers and constructors of their patients' experience. They come to know their patients through a collaborative process. They believe in the inevitability of enactments, of participating in the very dynamics which will yield valuable information about the patient. The students who comprise Factor I participate in the therapeutic work with the aim of understanding the patient's contribution to the relationship dynamics as well as their own. They want their patients to see them as human beings, real people with whom to connect. Reacting to these statements, students said:

> I believe that psychotherapy [is] not only about discovering the patient's past or issues. I believe the relationship is also constructing a reality and talking about the reality that is constructed is important. And that the relationship itself can be so healing. (Michelle, 1 year post-graduate)

> I feel like this whole idea of empathy and humanness...[it] goes along with the therapeutic alliance...And I'm not really comfortable with there being a power differential in the room. (Lori, 5th year student)

Lori believes it is more therapeutic for the patient to feel connected to the therapist as a person than to believe that the therapist has any kind of healing power.

The items ranked highly by the students loading on Factor I reveal the terminology that has come to form the lexicon of many beginning therapists. But although the terminology they favor is clear, the ideas behind them are still being worked out in students' minds and practice and are not uniformly understood by all trainees. According to Lisette, a 3rd year student:

> I think you have to keep in mind as a therapist that it is a two-person relationship. But I don't think that you should put yourself so much into it. Because it is about the patient...It's very important to always remind yourself that you do have a role [in relation to] and a responsibility toward the patient, like, not to get overly involved, where you kind of lose yourself in that relationship.

In contrast with Lori, above, who described her ambivalence about the patient-therapist power differential, Lisette is sensitive to an inequality inherent in the relationship. She identifies with the two-person label even as she is sorting out her feelings about just what it means to work within this model.

Statements given low rankings by Factor I therapists, conversely, reveal the sensibility and language that is most out of vogue with this student sample. The four Anchor Classical items they reject most strongly are notable for their use of language closely linked with classical theory. Three of those items are presented here, along with one Bridging item that was also given a low ranking.

-4 21. In order to ensure that the patient's repressed fantasies and wishes become intense enough to be manifested in the session, it is important that the therapist try not to gratify the patient's infantile and drive aims. (AC)

-4 39. It is important that the therapist adopt a neutral stance in order to have equal access to the id, ego and superego elements in the patient's behavior and experience. (AC)

-3 2. Recent advances in our understanding of object relations and the evolution of the self do not diminish the need to understand the powerful organizing influence of biologically-rooted drives. (B)

-3 4. The aim of a psychodynamic treatment is the resolution of neurotic conflict. A stance of relative neutrality permits memories, associations and any conflictual material to emerge in the transference so they may be interpreted and worked through. (AC)

These statements articulate and bear the linguistic markers of classical theory, ideology, and epistemology. Factor I students are not simply rejecting traditional ideas or practices but also a culture of psychodynamic psychotherapy as represented by a particular kind of language. Statement #2, while rated a Bridging statement, is also a particular kind of epistemological statement that describes a classically-oriented pre-cursor to the two-person model embraced by these students (although not one that necessarily precludes it).

While the placement of these items on the low end of their distribution reveals students' antipathy toward a classical approach, their interviews reveal a range of attitudes regarding how to integrate classical ideas and terminology into their understanding and practice. Reflecting on these statements, Zoe, a 4th year student said:

> I don't particularly subscribe to drive theory...So in terms of not gratifying [patients' infantile or drive aims], I mean, then you get into the question of if the patient feels [that] is withholding. I don't know how therapeutic that really is. But mostly...I just don't really believe in the drive theory. And the same thing with the structural model of the mind, id, ego, superego. [And] 'the resolution of neurotic conflict.' Again, I feel it's like a language I don't speak in.

Reflecting upon statement #39, Amy, a 6th year student said:

> I just don't think of patients so much in that way. It's not so helpful for me to break it down that way. I mean theoretically it's helpful. [But] in terms of applying it to an actual case in the therapy, I don't know.

Reflecting upon statement #21, Joy said:

> I guess I wasn't even sure what that meant. Because it's in language I would (laughs) never even use...If a patient were to hear you talk like that about their infantile aims, I mean, it's insulting.

Initially dismissing of classical terminology—even acknowledging her own ignorance of its full meaning—Joy subsequently gives the question more serious consideration.

> Most of what I read, you know, like theory or research, aren't using this language....It just seems like there's something limiting in it. Like I think that the ideas of the id, ego and superego can be interesting and can enlighten your view of a client, more like a case formulation. But as far as the actual treatment goes...I'm not sure that they're as useful as they were to Freud.

These students distinguish between a way of thinking that is relevant to their clinical practice and ideas that, while intellectually useful or academically significant, are not alive or meaningful for them.

Interestingly, Lori recounted feeling intrigued, recently, when listening to a case presentation by an analyst she describes as "very Freudian" and hearing the way the case was conceptualized in classical/structural terms:

> ...And it made sense to me, like, 'Oh, that's so beautiful, how well that fits together...How nice.' And then I think, maybe I'm being too hard. Maybe I need to go back and revisit that...Maybe I've been too influenced by [the] relational-interpersonal side of things.

Lori demonstrates how trainees' disconnection from a classical approach does not necessarily mean that they are completely closed off to it. It may reflect lack of adequate exposure or instruction.

Factor I students further reject items that counter their view of the therapeutic relationship as an egalitarian, co-constructed one or that devalue the working alliance.

-4 53. Transference is the most powerful force behind the patient's behavior and experience in the sessions. Too much focus on the 'real' or 'working' relationship apart from the transference is likely to diminish the depth of the treatment. (AC)

-3 28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely *can* be controlled, are not appropriate. (AC)

-3 51. The therapist withholds affective responses, not because she does not care for or feel compassion towards the patient, but to ensure that feelings stirred for her in the work do not distract her or the patient from the therapeutic task. (B)

Rejection of statement #28 is consistent with this group's embracing of countertransference fantasies as valuable and enactments as inevitable. In a similar vein, Factor I trainees reject the depiction of a therapist who operates at an emotional remove from his or her patients. Reacting to statement #51, Sandor spoke about the value of the therapist's emotional involvement in treatment:

> I think that affective responses might be very important or that our responses to our patients is often very helpful for them to understand what they are or what we experience. And to think of that as a distraction just felt wrong to me. Now if our emotional responses to the patient didn't stem from the patient...if it's sort of our own stuff that we bring...I can imagine how that would be a distractor [sic] but if the emotional reactions are coming specifically from the relationship with the patient, I think they're not such distractors [sic].

For Sandor, any affective material that emerges from within the dyad, on the part of either participant, is valuable for the treatment.

As I noted, while students whose Q-sorts loaded on Factor I endorsed only one Anchor Relational item, the ideas they embrace have the flavor of a two-person approach as outlined in the writings of relational theorists. When, in interviews, these students

describe the ideas and practices they associate with a relational approach, many of the themes of the statements they endorse emerge in their definitions:

> Relational would be...two persons in the room, like, what's going on between you and me. In the room. And I think, like, the patient may be talking about something in their lives but also trying to relate, why are they bringing it up at this moment? Because it has something to do with what's going on between you and the person. (Lisette, 3rd year student)

But while these students embrace relational *ideas*, they do not necessarily identify with the orientation. The student quoted here has a positive association to the relational approach she described above but says, "I think it can get overused."

According to Joy, a relational supervisor is one who would "encourage a mutual making of the therapy." She continues:

> You're obviously not equal partners...but there's a feeling of not denying that you are a human being who cannot control their own enactments....And I guess always looking at how you're feeling. I think all dynamic therapists would say that this was true...Your feelings, your countertransference, your stuff, is really important in understanding the client...at least that would be some of it.

But Joy had a relational supervisor early in her training who would "push" her to disclose her feelings to her patient. This left her with the impression that a relational approach was "too intense, too confrontational. Like that sometimes it wasn't neutral enough...it was a little bit too in your face."

Reluctance towards relationally-allied practices or positions among Factor I students also came through in their Q-sorts. Despite their egalitarian approach to treatment, there are certain aspects about joining with the patient that do not appeal strongly to these students:

0 11. Therapist self-disclosure is an inevitable part of the process. The question is not whether to disclose, but how and when to do so. (AR)

0 29. The therapist's personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are often useful to share, since they are key elements in the treatment. (AR)

In their item rankings and presumably in their clinical work, Factor I trainees are identifying a zone of comfort when it comes to joining with their patients in the treatment. Faced with the prospect of being even more forthcoming, according to more strongly worded Anchor Relational ideas, these students are not exactly rejecting but are certainly lukewarm or neutral.

The majority view embraced by students whose Q-sorts loaded on Factor I offers valuable information about the mind-set of students entering the field today. Indeed, these students reinforce what the expert therapist-validators revealed about ideas such as the value of enactments, use of countertransference, and use of the therapist's own feelings in understanding patients: that such ideas are widely accepted across lines of orientation and are not the purview of relationalists. Indeed, on the importance for the treatment of the therapist looking at his or her own feelings, Joy said, "I think all dynamic therapists would say that this was true." Significantly, Factor I students are drawn to the model of the therapist who embraces a two-person epistemology. The markers of this epistemology include ideas of joint meaning-making and therapist-as-constructor of the patient's experience. Despite overlap of these idea with the themes echoed in Anchor Relational items and in the writings of relational theorists, Factor I students do not necessarily identify as relational and are somewhat put off by the label. Finally, statements that evoke classical theory and ideology reside largely on the negative end of this group's distribution, reflecting an alienation from classical ideas.

Factor II

Factor II is comprised of 4 participants, 3 women and 1 man, ranging in age from 30 - 40 and representing two of the six doctoral programs included in the study. The mean year in training for in-school trainees is 4.5. The primary descriptors used by these students to define their orientation include: “psychodynamic” (1); “eclectic” (2); and “relational” (1). The other descriptor used is “integrational.” Students in this group have been working psychodynamically for a mean of 2.75 years.

Distribution of expert clinicians’ item ratings for Factor II

				AR				
				B				
			B	AR	B			
			AC	S	B			
		AC	B	B	B	B		
	AC	AR	B	B	B	B	B	
	S	AR	B	AR	B	AC	B	
AC	AC	AC	B	AC	AR	S	B	B
AC	AC	AC	AC	AR	AR	AR	B	S
AC	S	AC	B	S	B	S	B	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

In contrast to Factor I, the four students whose Q-sorts loaded on Factor II eschewed language of theory and epistemology favored by their peers, selecting cards that speak more to the feeling aspects of therapeutic work. Statements ranked most highly by this group also reflect an effort to walk a boundary encountered by the therapist in navigating the dual pulls of the real relationship versus the transference; the therapeutic benefits of technique versus a stance of empathy; being neutral and being known; the past and the present. They value highly the principle of flexibility in their work and, in interviews, identify their training and personal orientation as eclectic.

Factor II students are in harmony with their Factor I peers[19] in prioritizing generally agreeable "new norm" statements describing the humanness and affective engagement of the therapist and the benefits of a strong working alliance.

I	**II**	
3	3	20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion. (B)
3	3	27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist. (B)
3	4	42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)
-4	-3	53. Transference is the most powerful force behind the patient's behavior and experience in the sessions. Too much focus on the 'real' or 'working' relationship apart from the transference is likely to diminish the depth of the treatment. (AC)

Reflecting upon statements #27 and #53, Ellen, a 6th year student who had the highest loading on Factor II, says:

> It's all about working from within, who you are. To me that has all to do with a good working relationship, showing your good will, letting that be felt. [It is] something that is beyond understanding or technical skill.

For Ellen, the therapist's participation in a good working alliance is something almost intangible. The alliance is based upon an inner quality that the therapist offers up to the patient apart from technique.

From this point on, the statements endorsed by Factor II students take a different turn. Whereas the Factor I students outlined their position in terms of the egalitarian principles of joint meaning-making and the co-construction of the patient's reality, such

[19]Factor array scores for Factors I and II will be presented side by side in this section.

statements received rankings of -2 and 0, respectively, in Factor II's distribution. This second, smaller group of students is somewhat less enamored of two-person terminology when compared with their Factor I peers. Ellen says: "This thing about co-creation, one of the foundational [relational] ideas, is very good. You are both in the room, right? So of course things are co-created." The language is not un-descriptive, or disagreeable; it is as if she takes it for granted. But citing the writings of a prominent relational theorist on themes related to principles of co-construction, Ellen refers to them as "esoteric" and says, "[What this theorist writes] no longer has any close relationship to the work I do as a therapist."

One theme of key importance for Factor II students is the flexibility of the clinician.

2 4 7. One therapeutic stance may be of value with a given patient or at a given moment in a treatment, while an entirely different approach may be required with another patient or at a different moment with the same patient. Flexibility should be the therapist's rule-of-thumb. (S)

-1 3 23. On the oft-debated subject of therapist self-disclosure, every clinician must decide what feels right for them, in a given clinical context, with each patient. There should be no pre-set rules on such a personal matter. (B)

When Factor I students endorsed the idea of flexibility, they did so in terms of the myriad of roles they might occupy for their patients.

4 -1 32. At any time, the therapist may be a model, teacher, advisor, transference figure, old or new object–or any combination of these. (B)

Highly endorsed in Factor I, this statement received a mildly negative ranking by Factor II trainees and contributed little to their conceptualization of flexibility. The difference may be that Factor I students identify with the flexibility of clinical roles whereas Factor II students focus on the variability of the patient's needs. Further, the items favored by Factor II, in general, have a more personal flavor. Rather than offering a theoretical stance or overarching conceptualization of clinical work, they speak to the affective experience of patient and therapist.

A second theme that emerges as critical for students whose Q-sorts loaded on Factor II is that of therapist neutrality and the issue of disclosure. This group is quite clear on the matter of therapist disclosure as something that may be in the patient's best interest.

-2 -4 43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient. (AC)

-1 -3 40. Countertransference disclosures should always be made cautiously, and only in response to an inquiry from the patient. (S)

-1 -3 38. When the therapist reveals personal information, fantasies or thoughts to a patient, she intrudes upon the development of the transference and the fantasies the patient may have about her. (AC)

As is evident here, by comparison to Factor I, this second group also differs in some of the items they most strongly reject, namely statements that absolutely disparage varieties and uses of therapist disclosure.

Interestingly, one of the top three items endorsed by Factor II students expresses the view that therapist neutrality, to some degree, is important as well.

1 4 10. Neutral does not equal total non-expressiveness. Therapists may be neutral and still have a personality, be genuine and present, in essence, be themselves. (S)

-1 2 46. Therapists are no longer expected to be blank screens. Nevertheless, they should strive to be as neutral as possible, establishing a baseline against which changes in the patient's perceptions of them can be recognized as deriving from within the patient. (AC)

Statement #10 is unique in expressing a relatively un-specified view of neutrality. It does not say what being neutral *is*, rather it suggests what neutrality does not preclude. This statement also builds upon Factor II trainees' image as valuing qualities of humanness and realness in the therapist, as item #10 suggests, as valuing a therapist who is genuine and present. Item #10 was rated S or Split Consensus by the experts, meaning that they were split as to whether it reflected a relational (or relatively relational) or classical (or relatively classical) viewpoint. This points to a quality in many of the statements favored

by Factor II students suggesting that they are frequently "split" in their thinking, that they want to remain open to a range of options, to identify with both ends of ideological spectra. They critique the notion that therapist-disclosure is self-serving, but also believe that the therapist may remain neutral to some degree. Statement #46 above, is an Anchor Classical item that presents a more specific rationale for maintaining a stance of neutrality. But it is also a particular kind of statement that offers a balanced position on neutrality, i.e. Therapists need not be blank screens *but* they should strive to be as neutral as possible. The pattern is similar for item #10: Therapists may be neutral *but* be expressive and have a personality. The items favored by Factor II trainees portray a therapist who is attempting to find her footing along a particular kind of boundary in her therapeutic role.

In her interview, Ellen spoke about this kind of balancing act with respect to her understanding of neutrality.

> A term like neutrality must be de-constructed. I think neutrality is important in providing space for a patient to say anything he or she wants...You can provide space without being a blank screen...To provide neutrality you must balance when you are expressive or disclosing, what is appropriate given what [is going on].

For Nathaniel, a 3rd year student, neutrality implies being "objective" or "trying not to let your own personal feelings influence how you're reacting." However, Nathaniel has not "made up his mind completely" about how neutral he wants to be.

> Nathaniel: Part of me thinks it's important to be there and be present as me, as a person. But if you are too neutral, I think it takes away from that. So I guess it's a balance.
>
> PI: If you're too neutral then—
>
> Nathaniel: Then you're sacrificing some of yourself.
>
> PI: And the patient needs that?

Nathaniel: Yeah.

The notion of finding a balance continued to emerge in the statements selected by these students. With another highly ranked statement, Factor II students demonstrate that they believe transference and countertransference are important but that so are the real transactions in a treatment.

2 3 6. The dynamics of transference and countertransference are critical in any treatment, but it is important not to focus on them too exclusively. Attention to the real transactions that constitute the therapeutic alliance is also important. (B)

Recall that Factor II trainees prioritize therapist flexibility in the consultation room. They strive to balance being present for their patients while maintaining a position of neutrality, to balance the transference with the real relationship and working alliance.

Factor II students' commitment to the "real" here-and-now aspects of the treatment is reinforced by their strong rejection of the following:

-2 -4 26. The therapist should not be primarily concerned with a patient's practical problems, nor should she aim to influence the patient's daily activities. (AC)

Interestingly, while they did not endorse highly statements that *assert* the value of the therapist intervening in patients' lives in a hands-on manner (See #31, ranked +1), they strongly reject the portrayal of the therapist who merely interprets, who is unwilling to offer advice or have a role in the resolution of patients' day-to-day problems.

0 -3 9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change. (S)

-3 -4 15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions. (AC)

On the merits of interpretation and its value in treatment, Ellen reflects upon statement #9 and says:

> This is simply not true in my experience as a patient or a therapist. What really helps is the patient's felt experience in session and experience of support.

It is not any one practice, such as interpretation, that is critical to Ellen in her clinical work. It is, rather, the quality of connection in the therapeutic dyad.

Factor II students continue to balance their commitment to the here-and-now with the belief that the patient-therapist dynamic is shaped by the patient's early experience.

1 3 48. Whatever a patient's reaction to his or her therapist may be, wishes, fears, and defenses originating in childhood have a very important part in it. (B)

The therapist should not avoid addressing patients' day-to-day problems, should not simply interpret or over-emphasize transference interpretations. Nevertheless, a patient's early experience is critical for the transference and the treatment. Again, Factor II students can be found balancing the past and present, the conscious and unconscious aspects of the patient's life and experience.

The themes of flexibility and balance came through further in interviews with the four students whose Q-sorts loaded on Factor II as they talked about their own developing clinical orientations. Ellen spoke about her approach to the different theoretical models to which she has been exposed as a student.

> Ellen: I feel I have reached a point where I have my own sense of what kind of therapist I am. That was not true two years ago. I like it because [there is no] wholesale rejection of one school or the other; I'm picking and choosing what is best from each school.
>
> PI: Do you feel entitled to that?
>
> Ellen: After six years of training, yeah! I hope so! I don't want to be like a lemming that does what my supervisor tells me to do.

Simone, a 4th year student, believes her training has been "eclectic." She as been influenced by relational, interpersonal, and object relations perspectives and "minimally influenced" by classical Freudian and cognitive behavior orientations. She says:

> I do believe that...in terms of being flexible, that you should know different orientations and where they're coming from. Maybe you can employ certain techniques that are helpful for your patients....Maybe ten years from today my orientation will be much more fixed...At this point, I'm trying to integrate and find my own.

Like Ellen, Simone possesses an openness to different orientations and approaches. But Simone attributes her flexibility to her inexperience rather than the confidence to pick and choose what is most useful.

Similarly, Nathaniel considered the influences of his training and said:

> I take what makes the most sense to me. It's like my own personal preference. I don't think [in my training] I was directed towards one way of doing [clinical work]. It was more something I had to figure out for myself...Just figure out what made the most sense...keep and leave certain parts.

In fact, in his Q-sort, Nathaniel claimed to have the most difficulty sorting cards that were framed in absolute terms.

Margo, a 5th year student and the fourth and final participant to load on Factor II, also described her training and supervision as "eclectic." She said:

> Flexibility, I'm very much into that. Flexibility with different techniques, so I can get a taste out of all of them...I'm not there yet but hopefully I'll be an integrated therapist one day.

The open-mindedness of Factor II students leaves them at odds in some of their rankings, when compared with other factors. While Anchor Classical statements reside predominantly on the negative to neutral end of their distribution, in comparison with

their Factor I peers these students appear to be more open to aspects of a classically-oriented approach:

-3 1 2. Recent advances in our understanding of object relations and the evolution of the self do not diminish the need to understand the powerful organizing influence of biologically-rooted drives. (B)

-4 -1 39. It is important that the therapist adopt a neutral stance in order to have equal access to the id, ego and superego elements in the patient's behavior and experience. (AC)

Their mild rejection of statement #39 allies the trainees of Factor II more with the trainees of Factors V and VI, to be discussed later, who were the only groups of trainees to endorse Anchor Classical items. Also, recall that Factor II trainees reached into the classical domain for an item that reflects their view of neutrality (item #46). Further, it can be seen that Factor II students are less likely to follow trends (like lemmings?), as indicated here:

[3 **0** 4 3 3 3][20] 25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations. (B)

The neutral score given to this very popular statement (the item with the second highest mean score in the study) stands out when all other factors have this item ranked as +3 or +4. It may be that, for trainees who are so comfortable with areas of grey, nothing about clinical work should ever be considered "inevitable."

To summarize, this second, smaller group of students prioritizes the principle of flexibility in technique and in their own theoretical identifications. They consider themselves "eclectic" and strive to be "integrated" in their practice. Currently, Factor II students are weighing the different theoretical influences to which they are being exposed and are attuned to the range of options open to them in their clinical work. That they are

[20]These are the factor array scores for this item for Factors I - VI, with the Factor II score in boldface.

engaged in a kind of balancing act of different influences is reflected in their selection of statements that portray a clinician who is constantly negotiating different ends of ideological spectra. In this way, Factor II students stand apart from their Factor I peers, whose Q-sorts exuded a certitude and allegiance to two-person, egalitarian principles.

Factor III

Factor III is comprised of 2 women, ages 30 and 34, trained at the same doctoral program. One student is in her 4th year of training and has been working dynamically for 2.5 years. The other student is in her first year post-licensing and has been working dynamically for 6 years. The primary descriptor used by both women to define their orientation is "object relations." One woman also used the descriptor "intersubjective."

Distribution of expert clinicians' item ratings for Factor III

				B				
				AC				
			AC	B	AC			
			B	S	AR			
		B	AC	AC	B	B		
	AC	S	B	AR	B	AR	AR	
	B	AR	B	AC	B	B	B	
AC	B	AC	S	AR	B	B	S	B
AC	AR	B	AC	AC	AR	B	B	B
AC	AC	AR	B	B	S	S	S	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor III comprises the factor loadings of two students trained at the same doctoral program. Their loadings on this factor were quite strong (0.82 and 0.76 respectively), encouraging the conclusion that these two students are the bearers of a distinct though minority viewpoint among their peers. Their factor array distribution is notable for certain uniquely high and low item ratings in comparison to other distributions. Thematically, these trainees are committed to intra-psychic processes in therapy and less interested in the 'real' or pragmatic aspects of treatment. Their interviews reveal a shared appreciation for authors representing an object relations perspective. According to the above grid of expert validator scores, Anchor Relational

items are scattered throughout their distribution, in both extreme negative and positive positions, while Anchor Classical items received low to neutral rankings.

The commitment to the intra-psychic life of the patient is strongly characterized by the high ranking of items that reflect the importance of the patient's childhood for the transference and that portray the patient-therapist dynamic in parent-child terms.

[-2 **3** 3 2 -3] 37. The therapeutic relationship, in its most fundamental aspects, is based on the parent-child relationship, and it is important that the impact of this powerful underlying structure be understood. (B)

[1 3 **4** 3 2 0] 48. Whatever a patient's reaction to his or her therapist may be, wishes, fears, and defenses originating in childhood have a very important part in it. (B)

That the therapist may most usefully intervene in the intra-psychic realm is reinforced by these students' valuing of the role of transference interpretations.

[0 -3 **3** -3 4 0] 9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change. (S)

Factor III students have a particular take on the therapist's involvement in the treatment. On the one hand, they clearly value the image of the therapist who participates in the treatment, explicitly or implicitly. They recognize that they are involved in the treatment process, according to the widely endorsed (by many study participants) view that the therapist's understanding is filtered through her countertransference and the milder but also positive endorsement of the notion that enactments are inevitable.

[3 2 **4** 1 1 0] 19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well. (S)

[3 0 **4** 3 3 3] 25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations. (B)

[2 -1 **2** 2 -1 3] 14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)

These students gave two of the above three items the highest ranking in the study. Read together, the items portray a therapist invested in the intrapsychic aspects of the treatment, including, her own intrapsychic process.

However, the participation of Factor III trainees appears to be primarily oriented toward the transference or countertransference dynamic and interactions that serve to illuminate these dynamics. On the subject of offering input in decision making or intervening in day-to-day aspects of patients' lives, these students are still agreeable but slightly more neutral:

[-1 1 **2** 4 -4 -3] 31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values. (B)

[-2 -4 **0** -4 -1 -2] 26. The therapist should not be primarily concerned with a patient's practical problems, nor should she aim to influence the patient's daily activities. (AC)

[-3 -4 **0** -4 4 -1] 15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions. (AC)

[4 -1 **-1** 1 2 2] 32. At any time, the therapist may be a model, teacher, advisor, transference figure, new or old object–or any combination of these. (B)

These students are unwilling to say that the therapist should *avoid* involvement in choices facing the patient, "although she tries to avoid imposing her own values." Despite their strong belief in the value of transference interpretations, they are unwilling to say that interpretations are the most effective means of intervention. But the idea that the therapist takes on different roles vis-a-vis the patient (#32) receives a mildly negative ranking. (See also item #7 on flexibility, ranked -1.)

Also ranked on the neutral to negative end of Factor III's distribution is the idea that the "real relationship" is the basis for investigation of transference or countertransference.

[4 4 **-1** 2 0 -1] 42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)

[2 3 **0** -1 -3 0] 6. The dynamics of transference and countertransference are critical in any treatment, but it is important not to focus on them too exclusively. Attention to the real transactions that constitute the therapeutic alliance is also important. (B)

Factor III students stand out among those comprising other factors reviewed thus far (although they are not alone in the study) in ranking the idea of establishing the working alliance on the neutral to negative end of their distribution. Related to this subtle de-valuing of the working alliance, perhaps, is their strong negative ranking of the following statement:

[1 2 **-3** 1 0 -2] 47. Therapists should de-mystify the process of therapy as much as possible, in order to put the patient at ease. It is appropriate for therapists to 'educate' the patient regarding the frame of treatment and the nature of what is to be expected. (B)

It is as if, for these students, the patient-therapist relationship is grounded in and takes its power from a parent-child transference dynamic and is rooted there as soon as treatment commences. The more mundane aspects of the treatment are a distraction, perhaps, from the real work of therapy. The treatment and the patient-therapist relationship are not supposed to be "demystified."

The favoring of the transferential over the real aspects of the therapeutic relationship and the importance of the patient's childhood emerged, as well, as themes in the interviews with the two students whose Q-sorts loaded on Factor III. Anna, a 4th year student, who has been influenced by Klein, Bion, and Winnicott and considers herself "neo-Kleinian" in her orientation, talked about her therapeutic stance. She describes her

clinical interests and focus as heavily influenced by the interplay of therapist and patient fantasies. Of all the items in the Q-sort, she was least drawn to items that are "reality-based." She discussed her approach to clinical work:

> I'm very present, emotionally there. In the beginning, I like to be lost in the emotions being evoked. I like to tease out what is mine and what is yours, and explore my fantasies and the patient's fantasies. A lot is evoked in me...but not shared...A lot is shared non-verbally.

In the clinical vignette she felt was to be illustrative of her work, she talked of working "on the border" of fantasy and reality. In her own treatment with an analyst whom she describes as relational, Anna has found that "when you allow more space for fantasies and dreams [the focus of the treatment] goes back to early childhood."

Melissa is a recent graduate, newly licensed, and cites Kohut, Winnicott, the object-relations focus of her training, and attachment theory as influences. In terms of her own orientation, she says, "I'm more comfortable with object relations than the term relational." In her clinical work, Melissa has been "struggling recently with allowing for the broadest ideas" to come through, for allowing her patients "space, room to play." She is making an effort not to step in and interpret but rather to allow for "silence" by just "being present and allowing the transference to develop, allowing her patient[s] to reflect on [their] own." Both she and Anna speak to a quality of what can emerge in a treatment when there is ample "space," namely the transference, memories, or fantasies. They share the view that this space should not be excessively occupied by the real aspects of the treatment or by the educating voice of the therapist.

Factor III students also gave the highest ranking in the study to the idea that the treatment relationship is not one of two equal participants.

[2 2 **3** 1 -1 1] 34. Whatever one's views may be about intersubjective or two-person models of treatment, the psychotherapy patient and the psychotherapist have fundamentally different roles, needs,

responsibilities and liabilities. Mutuality does not mean equality. (S)

The two-person ideas of joint meaning-making and co-construction that were so foundational for Factor I students received comparatively neutral rankings on Factor III's distribution.

[3 0 **1** 0 -3 -2] 1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality. (S)

[4 -2 **1** 0 -1 3] 44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experiences and inner life. (AR)

The interview data, too, support the conclusion that Factor III students do not favor a two-person model of treatment. As a doctoral student, Melissa had a negative impression of interpersonalist professors who were "infatuated with co-construction," an idea that she finds intellectually interesting but disconnected from the notion of therapeutic effectiveness. In her interview she recalled how one interpersonal supervisor suggested she disclose to a patient how bored she felt in session:

> I was coming from the perspective of trying to understand the patient's problem. That's more central than trying to understand all these [two-person] ideas. To start with ideas of co-construction is bewildering. You cannot start from that perspective...You must help the client figure out dynamics, conflicts, diagnoses. Then you can start talking about how to respond to them.

It is particularly hard for beginners, says Melissa, to "have a feeling for what's going on in the room [between therapist and patient]." As a student therapist, Melissa's desire for supervision that would give form and focus to her treatment felt more pressing than the need to understand the dynamics between her and her patient.

Interestingly, Melissa goes on to juxtapose her supervisor's approach with a more classical model of treatment:

> Freud did something well. He had an idea about a structure, what the problem was, what etiology was, and the interpretation flowed from that structure...If I didn't have a sense of what was going on with the patient and [his or her] psychopathology, [talking about the patient-therapist relationship] is useless. You must begin with a good grasp.

Nevertheless, despite this heralding of Freud, Anchor Classical items reside in the negative to neutral columns of Factor III's distribution.

[-1 -2 **-3** -1 0 -1] 54. Examining behavior from the perspective of id, ego and superego dimensions remains an important and helpful organizing idea in understanding clinical material. (AC)

Further, the items with the strongest negative rankings also reveal that, although these women turn to the realms of fantasy and transference to guide their understanding and conduct of therapy, they do not do so using the lens of classical theory. They very much reject the notion that the route to transference is a neutral clinician.

[-1 -2 **-4** -2 -2 0] 18. When the therapist tries to influence the patient as little as possible or reveal as little as possible about herself, the transference is able to become clearer. (AC)

[-4 -3 **-4** -1 3 0] 21. In order to ensure that the patient's repressed fantasies and wishes become intense enough to be manifested in the session, it is important that the therapist try not to gratify the patient's infantile or drive aims. (AC)

As Anna said, "[Item #18] is too simplistic. The idea that neutrality teases out what is you and what is the patient, I don't agree with that."

These students favor the therapist acknowledging errors and their contributions to ruptures in the treatment (see #19, above, ranked +4). But there are limits to the kinds of explicit "sharing" which Factor III students will comfortably engage in. They strongly reject the Anchor Relational view that the therapist's feelings or impressions are to be shared:

[0 -2 **-3** -1 -1 -3] 29. The therapist's personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are often useful to share, since they are key elements in the treatment. (AR)

But they also reject the Anchor Classical view that countertransference disclosures can and should be controlled.

[-3 -2 **-3** -3 1 -1] 28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely *can* be controlled, are not appropriate. (AC)

The co-ranking (as -3) of these two statements reflects something that was evident in Factor II students' rankings, as well, namely the effort to balance opposing views and theoretical influences in clinical decision making. Said Melissa: "I feel fine about self-disclosure...By keeping feelings in check, by being vigilant, (referring to #49) you are not avoiding countertransference!"

The women whose Q-sorts loaded on Factor III stand apart from their Factor I and II peers in their stated theoretical orientations—not two-person, not eclectic, but object relations. They also put a high value on the influence of the patient's childhood upon the treatment. They adopt a stance of relative non-intervention, favoring interpretation over other interventions, but they are comfortable with some degree of therapist disclosure. Finally, these students view the treatment as a place where transference and a patient's inner life and fantasies are brought to the fore, although they do not seek to accomplish this via classically-oriented methods.

Factor IV

Factor IV is comprised of 4 participants, 3 women and 1 man, ranging in age from 29 - 35 and representing three of the six doctoral programs included in the study. The mean year in training for in-school trainees is 2.6, and these students have been working dynamically for approximately that length of time. One of the participants in this group was in her first year post-licensing and has been working dynamically for 7 years. The primary descriptors used by these students to define their orientation include: "psychodynamic" (2); "relational" (1); and "two-person" (1). The other descriptor used is "CBT."

Distribution of expert clinicians' item ratings for Factor IV

				B				
				B				
			AC	AR	AR			
			AR	B	B			
		AC	AC	AR	B	AC		
	B	AC	B	AR	S	B	B	
	S	AC	AC	S	B	S	B	
AC	AC	AC	AR	AR	S	AR	B	B
AC	B	B	B	B	AC	B	B	B
AC	S	AC	AC	S	S	B	B	AR
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Four students in the study had significant loadings on Factor IV. The defining characteristic of this group is a concern with the question of therapist disclosure. What comes through in their factor array is not so much a position on therapist disclosure—although they can be seen as favoring it—but rather a wrestling with the nature and function of disclosures. Factor IV students share certain priorities with their peers who loaded on other factors, including a general valuing of the working alliance and the importance of a patient's early experience for the transference. Nevertheless, Q-sort and interview data reveal that the issue of therapist disclosure stands out as a strong and

abiding concern for these trainees. The interviews further illuminate the impact of the disclosure issue on these students' emerging identities as clinicians.

Factor IV students concur with the majority of their peers that the therapist's subjective and affective experience are critical aspects of the treatment.

[3 3 3 **4** 1 2] 20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion. (B)

[3 0 4 **3** 3 3] 25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations. (B)

However, the unique aspects of the Factor IV profile emerge with the conspicuously strong endorsement of the following Anchor Relational item which stands out as the highest ranking of this item in the study.

[0 1 0 **4** -2 -1] 11. Therapist self-disclosure is an inevitable part of the process. The question is not whether to disclose, but how and when to do so. (AR)

Additional statements ranked highly by students whose Q-sorts loaded on this factor build a steady case in favor of varieties of therapist disclosure in treatment, including some that were less emphatically endorsed by their peers on other factors.

[-1 1 2 **4** -4 -3] 31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values. (B)

[0 -1 1 **3** 2 -2] 30. At times, the therapist may find it constructive to admit to difficulty managing or understanding her reaction to the clinical material or to share her evolving and not yet fully formulated thought process with a patient. (B)

[0 -1 -2 **2** -4 0] 5. Therapists should be willing to answer patients' personal questions to the extent that they feel comfortable doing so. Such willingness to disclose enhances the therapeutic alliance, models

honesty and genuine connection in a relationship and, in some cases, validates a patient's reality testing. (B)

When comparing Factor IV scores on the above items with those of other factors, it seems that these students have a willingness to disclose in areas where other students are more reluctant to do so. They are very willing to offer input in patients' decision-making process. They are willing to share their own thought process, however unrefined, with patients. Uniquely in this sample they take the position that disclosures—which they view as inevitable—can be therapeutic.

But the picture is not entirely straightforward. While favoring therapist disclosure, Factor IV students also appear to be weighing considerations about therapist anonymity. The factor array scores for the following two items are among the highest rankings for these items in the study.

[1 0 -1 **3** 1 4] 33. There are often good reasons to withhold personal information or remain 'anonymous' to our patients, and it is a mistake to overlook this. (B)

[-2 -4 0 **2** 3 -4] 43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient. (AC)

The item rankings presented thus far offer a seemingly contradictory picture, namely a strong endorsement of therapist disclosure as therapeutic alongside the caution that a stance of withholding can be in the best interest of a patient, that disclosures can even be detrimental. The following statements (again, more strongly endorsed by Factor IV trainees in comparison to their peers) further complicate the picture by offering the view that a stance of *non*-disclosure can be risky.

[1 0 0 **2** 1 1] 35. Remaining silent about our experience can be as much a countertransference enactment as any other kind of response. (S)

[-2 0 -2 **2** -2 -2] 17. The therapist's effort to be anonymous can impede a treatment's progress by, for example, evoking for the patient an absent or unknowable parental figure. (AR)

We are left with the impression that, for the students whose Q-sorts loaded on Factor IV, the issue of therapist disclosure can be a double-edged sword.

This impression bears out in interviews with these four students. They share what can be described as a pre-occupation with this matter that includes both support for and ambivalence regarding therapist disclosure.

> 'Therapist self disclosure is more likely to serve the needs of the therapist and not of the patient.' I believe there's always a willingness to be [self-disclosing] but I think that it's sort of a good guiding principle to think of before disclosing. Because I think the tendency is maybe to over disclose or disclose without really thinking about it....I have more instances where I felt disclosement [sic] wasn't useful than I had where I restrained self-disclosing and then wish I had disclosed. (Daniel, 3rd year student)

Daniel believes that, in comparison to his peers, he is "probably more structure oriented" and more inclined than others to "maintain boundaries" with patients. However, he struggles with the issue of disclosure, fearing that an unwillingness to disclose can make it harder to "build up the therapeutic alliance." He goes on to describe a first meeting with a patient who was wearing a T-shirt of a band Daniel liked. He had an impulse to acknowledge their shared musical taste but did not, trying to be "neutral." When the patient dropped out of treatment a week later, Daniel wondered if a disclosure might have kept him in therapy:

> Daniel: And so part of me thinks, well, you know maybe if I could help build the alliance by being less neutral with him...It's hard to juggle, you know, when do you disclose? When do you not?
>
> PI: Is it your fantasy that if you had been able to say...Oh God I love that group...
>
> Daniel: Right, there might have been a connection.

Daniel goes on to talk about the pressures on student therapists in training clinics to build and keep a small case load and maintain momentum in supervision as contributing to his self-doubt and the "what if" concerns expressed here.

For Eve, a 3rd year student, the pre-occupation with therapist disclosure has been shaped by the prominence of this subject in her own treatment:

> Well I'm in analysis now with a relational analyst. I was in analysis before with someone who is–I'm not sure exactly how I would conceptualize his orientation. But definitely not as relational as this. And [therapist disclosure is] something that has always been a topic of discussion in the analysis because it's been a lot to adjust to. And it's really changed my thinking a lot. It's something I deal with on a weekly basis...Of there being more self-disclosure, more blurring of the lines. Of the roles. Even more collaboration...I'm more open to those thoughts now than I used to be. And I'm also more biased in favor of them, in favor of more disclosure because that's kind of what I'm investing in now.

Eve speculates that she would have sorted the Q-sort cards differently prior to this treatment.

On the negative end of Factor IV's distribution are the items which portray a therapist whose subjectivity and personal experience is held at bay in the treatment. These students reject the therapist as an interpreter and as someone who does not interject their subjectivity into the treatment or intervene in the patient's day-to-day life.

[0 -3 3 **-3** 4 0]	9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change. (S)
[-3 -4 0 **-4** 4 1]	15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions. (AC)

[-2 -4 0 **-4** -1 -2] 26. The therapist should not be primarily concerned with a patient's practical problems, nor should she aim to influence the patient's daily activities. (AC)

[0 1 1 **-3** -1 -4] 24. A therapist will inevitably make errors of practice or judgment (e.g. forgetting an appointment). Nevertheless, it is the *patient* who is in treatment, and it is *his* or *her* feelings about the error that should be the primary subject of discussion. (B)

Other statements that received strong negative rankings depict the therapist as reluctant to disclose or as not sharing.

[-1 -3 -2 -**3** -3 -1] 40. Countertransference disclosures should always be made cautiously, and only in response to an inquiry from the patient. (S)

[-3 -2 -3 -**3** 1 -1] 28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely *can* be controlled, are not appropriate. (AC)

Furthermore, the following item received the lowest ranking in the study on Factor IV:

[-2 1 2 -**3** 0 0] 49. The therapist's expression of genuine feelings for the patient must be kept in check in order to further the therapeutic process and the patient's self-exploration. (B)

The picture is further complicated by the fact that not all 'pro-sharing' statements received high rankings:

[0 -2 -3 **-1** -1 -3] 29. The therapist's personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are often useful to share, since they are key elements in the treatment. (AR)

[3 2 4 **1** 1 0] 19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well. (S)

An interesting ranking is the following, which could have proven a way to reconcile the contradictory profile of this group. It might have been possible to say that the answer to the conundrum of therapist disclosure is a stance of flexibility. And yet, this item received a relatively low to neutral ranking.

[-1 3 1 **-1** -2 3] 23. On the oft-debated subject of therapist self-disclosure, every clinician must decide what feels right for them, in a given clinical context, with each patient. There should be no pre-set rules on such a personal matter. (B)

What accounts for this weak endorsement of "flexibility?"[21] From this ranking, it does not appear that Factor IV students want to be left to their own decision-making process on the subject; they are *not* seeking to resolve conflicting messages and impulses on the matter of disclosure by taking a position of 'to each his or her own.' Rather, the critical issue may be the struggle itself, the knowledge that disclosures are inevitable and may be therapeutic *and* the concern that the patient may be better served by a stance of non-disclosure.

Critically, decisions on such matters represent choice-points for therapists in moments that may feel highly charged for patient and therapist alike. Knowing this makes decision making around disclosures even more difficult. Eve initially viewed therapist disclosure as a "taboo." When she experienced her current therapist's tendency to be more disclosing she felt, "Whoa! What's he doing?"

> Eve: And it was really scary. And we talked about that. But it's just something that as time has gone on I've become more open to. And it's been really a challenge for me to open my mind to...exactly the thing which is taboo. And as a clinician...there's no right approach...It makes me realize how important it is for a clinician to be really a whole person. And really their own thinker...because these choices and opportunities come up so much…I don't feel like there is a rule. And reliance on rules is something that is distasteful to me in general. And if there's not gonna be a rule to rely on then you've gotta really be there.

[21]Indeed, flexibility does not emerge as a strong priority for this group. See a score of +1 for item #7, articulating the view that "flexibility should be the therapist's rule-of-thumb."

> PI: What is a "whole person"?
>
> Eve: Being able to make your own choices. Sort of roll with it as it goes. Not to be too rigidly married to...any canon.

Eve has come to a position of greater openness after initially reckoning with her therapist's disclosures as violations of therapeutic taboos. It seems that she agrees with the notion that there should be "no pre-set rules" and yet the weight and impact of these decisions is very much on her mind.

Serena, a 3rd year students whose Q-sort had the highest loading on Factor IV, also discussed how fixed one's approach to disclosure should be. She does not reject the stance of flexibility but the very word connotes to her a kind of unwarranted casualness toward this subject. She also takes issue with the idea that there *can* be any kind of rule on disclosure. A rule would take out of the therapist's hands a decision for which he or she bears great responsibility.

> I don't think therapists should be flexible. But at the same time I don't think you should be rigid...I think you sort of have to be you and...sort out what your beliefs are. But at the same time, some flexibility. But it's not like flexibility should just be the rule of thumb.

The matter of therapist disclosure demands that the therapist make highly personal decisions about her therapeutic stance.

For beginning therapists, in particular, this seems to be an issue that simultaneously pulls for the trainee's desire for guidance and structure and tests the limits of her autonomy. As Serena said:

> It's so hard to manage so much when you are learning that I think having more strict rules helps you and guides you. But then as you start learning more, it restrains you. And then you feel like you can't really go anywhere.

Like Eve, Serena experienced shifts in her views on therapist disclosure over the course of her training. She and her classmates entered training thinking they were "never" to

disclose. A relational professor exposed her and her classmates to the use of disclosures in treatment, challenging the "never disclose" assumption. Personally, Serena feels this professor helped her to develop an affinity for a relational approach that she finds to be more accepting of the willingness to disclose. She said:

> [A relational approach] fits more my personality because I feel like I can't be neutral...I can't have a neutral face. I've very expressive. So how can I be neutral when my body is not neutral?

For Serena, a relational paradigm that supports the therapist's willingness to disclose feels more syntonic with her personality.

Amanda, a recently licensed graduate, expressed a similar willingness to disclose. Like Eve and Serena, she associates this stance with a two-person or relational approach.

> There has to be a process between two people in the room. So I do believe that disclosures are appropriate. I think they should be thought through before you say them, but I do think they are [appropriate]. I am often very, very moved by my patients. And I'm inclined to say so.

Furthermore, referring to statement #40 and the subject of countertransference disclosures:

> I don't think that transference disclosures should always be in response to an inquiry from a patient. Actually in countertransference disclosures I often don't wait for a direct inquiry from the patient...But I agree it has to be done cautiously.

Amanda goes on to describe how patients learn to take a new perspective from seeing the therapist's emotional reaction to their circumstances and their difficulties. She is convinced of the therapeutic merits of disclosures saying, "When I've expressed genuine feelings for my patient it does further the therapeutic trust...And I think it opens up space for compassion with the patient." In contrast, a stance of non-disclosure can "create a sense of estrangement."

Amanda, like her peers who loaded on this factor, sounded a similar note on this subject: that the treatment alliance can turn on an axis of connection-estrangement and is impacted by the therapist's stance on disclosure. Amanda, too, has been influenced in this matter by her training and by her own experiences in treatment, first with a "Freudian" therapist and currently with a relationally-oriented clinician. Before entering graduate training, Amanda was in a twice per-week, three year treatment with a therapist whom she found through her employer at a time when she felt "desperate." At that time, she says,

> I just didn't have the education to know there were different kinds of therapists out there...And all throughout the three years I consistently felt that something is wrong, or that I didn't feel comfortable or something wasn't quite right. It wasn't working for me. And then when I got to my first year of graduate school I started learning that therapists can work very differently. And I realized that he was a very Freudian therapist...He hardly disclosed anything. Nor did he say much. And I remember having this feeling...that there was this genuine lack of interest. But I consistently felt that I was boring him, and, you know, we talked about it a lot...And he recognized that it was very difficult for me...but we just could not move out of that space...And I didn't feel safe enough.

After being out of treatment for two years, Amanda commenced her new treatment. The impasse she described above has not recurred. However, she continues to wrestle with the issue of knowing and connecting with her therapist.

> It comes up when she won't disclose something and I feel like, you know, I want to know her and why can't I know her. But you know one of the [Q-sort] cards that I did get was about that...you can be known in a way that's not necessarily articulated, that can be therapeutic. That can be internalized. That can move the patient forward. It doesn't have to be

> based on information. And that, I think, is probably true...[I] can imagine that that's so. But that card made me feel hopeful about the process. And I'm not someone who just completed a successful analysis. But I'm holding out faith that that's true.

Amanda's description of her treatment history portrays her as turning toward a relational approach to which she is also drawn as a clinician. And yet, she recognizes that similar issues emerged for her in both treatments. She believes in the potential for a more disclosing stance to build connection, but also describes multiple ways of knowing and internalizing the person of the therapist. Amanda resists dichotomizing these approaches as disclosing vs. non-disclosing. Ultimately, she attributes the impasse in her first treatment not simply to the fact that her therapist was classically oriented or that he was silent and non-disclosing but chiefly to the fact that they could not find a way to address the dynamic that came up for her around issues of knowing, communication, and connection. These issues are of enduring importance in Amanda's current treatment, in which she has found a "safe" environment to sit with and explore them.

To summarize, the students whose Q-sorts loaded on Factor IV discussed at length their thinking on the subject of therapist disclosure. It is a topic that has impacted them deeply as students, patients, and therapists, often simultaneously. Personal experiences have led to shifts in their thinking about and understanding of therapist disclosure. These experiences have kept the issue very much alive and made it a defining concern of their training and clinical work. In the absence of a one-rule-fits-all guideline, the question demands great care—even when disclosures are indicated. The pre-occupation with this question transcends personal style. Irrespective of their tendencies to disclose or not, these students are *thinking about* the use of disclosures for building the therapeutic alliance and for general therapeutic effectiveness. Each student associates the willingness to disclose with a relational approach and expressed either an affinity for or identification with this approach.

Factor V

Factor V is unique in being the only factor where Anchor Classical items reside primarily on the high end of the factor array continuum and Anchor Relational items reside on the low end. Substantively, the factor array rankings reflect points of view that differ when compared to Factors I - IV. Two students had positive loadings on this factor, representing a relatively small minority of the study participants with a strong affinity for classically-oriented statements. Two other students' Q-sorts had *negative* loadings on Factor V, meaning that their Q-sorts most resemble the *inverse* of this distribution. They most agree with the items on the *low* end of the factor array continuum for Factor V and reject those on the *high* end, presumably the classically-oriented views that reside there. These two groups of students will be discussed separately and referred to as Factor V-a (two students with positive loadings) and Factor V-b (two students with negative loadings).

Distribution of expert clinicians' item ratings for Factor V

				AC				
				B				
			B	B	AC			
			AR	B	AC			
		AR	S	B	S	B		
	AR	B	AR	B	B	B	AC	
	S	AR	AC	AC	AC	B	AC	
B	AR	AC	B	AC	B	B	B	B
B	B	AR	B	S	S	B	AC	AC
AR	S	AR	S	B	B	AC	AC	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

Factor V-a

Factor V-a is comprised of 2 women, ages 27 and 45, representing two of the six doctoral programs included in the study. Their mean year in training is 3.5. One has

been working dynamically for 1 year and the other for 3 years. The primary descriptor used by these students to define their orientation is "psychodynamic." The other descriptor used by one student is "flexible." Students in this group have been working psychodynamically for a mean of 2.75 years.

As with Factor II, the coherence of themes represented by Factor V-a's distribution and interviews supports the hypothesis that these two students uphold a distinct if minority viewpoint among beginning clinicians. Notably, these students take the opposing position on several issues of importance to their peers who loaded on Factors I - IV. To begin with, Factor V-a students stand out for being in favor of neutrality.

[0 1 0 0 **4** 2]	41. Neutrality in a therapist is just what some patients need in order to feel free to express themselves fully in the treatment setting. (B)
[0 1 0 -1 -**3** 1]	16. The stance of neutrality, often linked to abstinence and non-gratification, can leave the patient feeling un-cared for and hinder therapeutic progress. (AR)
[-1 0 -2 0 -**4** -3][22]	3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient's way of being with others. (AR)

Among their top ranked items is the view that "neutrality is just what some patients need" (#41). Their support for a neutral therapist is further outlined in the rejection of the above two Anchor Relational statements: Item #16 depicts neutrality as a hindrance to treatment and the neutral therapist as an uncaring therapist. Similarly, item #3 expresses the idea that the therapist as a constant stimulus in the room can be a limiting factor in the treatment. Leila, a 4th year student whose Q-sort had the highest loading on Factor V

[22]The reader will note some similarities in the factor array rankings for Factors V and VI. These comparisons will be addressed below in the discussion of Factor VI.

responded to this statement saying, “I see it [in] totally the opposite [way]. The therapist should be a constant in the room to widen the scope, to lead to a deeper approach to conflict, to provide structure [to the treatment].”

Factor V-a trainees take a similarly strong negative stance on the related issue of therapist disclosure:

[0 -1 -2 2 **-4** 0]	5. Therapists should be willing to answer patients’ personal questions to the extent that they feel comfortable doing so. Such willingness to disclose enhances the therapeutic alliance, models honesty and genuine connection in a relationship and, in some cases, validates a patient’s reality testing. (B)
[-2 -4 0 2 **3** -4]	43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient. (AC)
[1 0 3 1 **-3** -3]	52. The disclosure of personal information need not put an end to patients’ fantasies about the therapist. Indeed, a disclosure may stimulate and encourage discussion about these fantasies. (AR)

The Anchor Classical view that disclosures serve the needs of the therapist over the patient is endorsed (#43), and the Anchor Relational view that disclosures can stimulate a patient’s fantasies to the good of the treatment is rejected (#52). These students strongly disagree (even by comparison to Factors II and III where item #5 resides on the negative end of those distributions) that “therapists should be willing to answer patients’ personal questions to the extent that they feel comfortable doing so.” Leila, for one, emphatically rejected this statement:

> Comfortable? What kind of comfortable? This [item] is sneaky. And honesty? What honesty? Come on! You’re not drinking a bottle of wine with this person. [There is] no need to validate a patient’s reality testing.

For Leila, the principle of therapist neutrality is a premise of the treatment relationship and therapist disclosure, an imposition:

> The whole idea is about freedom, the freedom to talk freely, say anything, talk about any kind of experience...Self-disclosure by the therapist can ruin

> what you have created with the principle of freedom and the emergence of the transference.

She says further that a disclosure on the part of the therapist can be experienced as a "rough intrusion" that is "not acceptable at all." If one has disclosed then it should be discussed. But the therapist should not disclose on purpose.

On the subject of the 'real' or working relationship versus the transference, Factor V-a students emphasize the latter, in contrast with many of their peers.

[-4 -3 1 -2 **3** 1]	53. Transference is the most powerful force behind the patient's behavior and experience in the sessions. Too much focus on the 'real' or 'working' relationship apart from the transference is likely to diminish the depth of the treatment. (AC)
[2 3 0 -1 -**3** 0]	6. The dynamics of transference and countertransference are critical in any treatment, but it is important not to focus on them too exclusively. Attention to the real transactions that constitute the therapeutic alliance is also important. (B)
[4 4 -1 2 **0** -1]	42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)

Accompanying the strong rankings of statements #53 and #6, above, is the neutral ranking of the view that the working alliance is the basis for the transference, a view strongly endorsed by trainees comprising Factors I and II and the item with the second highest mean rating in the study.

Leila is a believer in the power of transference and finds it to be "inclusive" of and "incorporating aspects of the working relationship," as she describes here:

> 'Transference is the most powerful force.' [Transference] is created not by being silent but it comes through in that situation. The patient experiences you as any person. Roles change over time, roles are transposed. It's a scary but joyful experience.

Leila supports this view with her clinical vignette. She described her work with a middle-aged African-American woman of working-class origins who was pursuing a doctorate. This woman had had an intake with a white male therapist who pushed her to talk about his being white and, consequently, she "nearly fled" the clinic. In contrast, Leila made no direct attempts to talk about their relationship. The space and freedom she gave this patient, Leila believes, enabled the development of a transference to Leila of the woman's thesis advisor.

Factor V-a trainees also strongly reject the view that the patient's reality is constructed in the context of the treatment:

[3 0 1 0 **-3** -2] 1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality. (S)

Says Leila:

> There is no construction. Construction is manipulation, implying you want to change the patient. You must be absent from any wish to change patients, from imposing your own values.

Related to this comment, Factor V-a participants also take a strong negative position on providing input in patients' decision making.

[-1 1 2 4 **-4** -3] 31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values. (B)

This position stands in opposition to the placement of this item on other factors, particularly on Factor IV.

Factor V-a is also characterized by a favoring of interpretation over other kinds of interventions.

[0 -3 3 -3 **4** 0] 9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change. (S)

[-3 -4 0 -4 **4** -1] 15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions. (AC)

Notably, the strong positive ranking of #15 is the only positive ranking for this statement in the study.

Finally, the profile of Factor V-a is shaped by a classical epistemology of the treatment process.

[-3 0 -1 -1 **3** 2] 4. The aim of a psychodynamic treatment is the resolution of neurotic conflict. A stance of relative neutrality permits memories, associations and any conflictual material to emerge in the transference so they may be interpreted and worked through. (AC)

This item is notable for its use of classical terminology. It should be noted, however, that these students are selective in their endorsement of Anchor Classical statements. Consider the following rankings:

[-1 -2 -3 -1 **0** -1] 54. Examining behavior from the perspective of id, ego and superego dimensions remains an important and helpful organizing idea in understanding clinical material. (AC)

[-4 -1 -4 -4 **1** -2] 39. It is important that the therapist adopt a neutral stance in order to have equal access to the id, ego and superego elements in the patient's behavior and experience. (AC)

Factor V-a's rankings for these items using the language of structural theory are the highest in the study, but they are still relatively neutral. It can be said, therefore, that the classical profile of this minority group is primarily expressed though a position on issues of neutrality, therapist disclosure, the role of interpretation, and a valuing of the transference over the 'real' relationship.

Leila, in her interview, clearly described an affinity for a classical orientation. In her view, classical and object relations perspectives offer the "most rich frames" for clinical work. She has stood out in her doctoral program for her strong psychodynamic leanings in general and says, regarding a newer relational approach, "This is not much for me." She recalled a relational supervisor who told her that the patient is "born in the

treatment room," that a patient's history is not relevant, a patient's past not important. She finds that theory "shallow and limited" and says, reflecting on a course on Freud's model of the mind, that "we are not born interpersonally." At a recent conference, she found the speakers from relationally/interpersonally-oriented institutes to be "hostile" and "pushy" in their defense of their views over more classical positions. Leila believes her point of view has been influenced by her own European roots since "interpersonalism is an American invention." She does note that her dissertation advisor is an interpersonalist and has always been accepting of her views. She also referred to Bion and Guntrip as "interpersonalists" whom she finds useful.

Sandra is a 3rd year student and the second participant with a positive loading on Factor V-a. In contrast to Leila, Sandra feels her orientation is moving in a relational direction. Nevertheless, her loading on Factor V-a appears to be the result of more classically-oriented leanings on issues of neutrality, therapist disclosure, and the nature of the therapist's participation in the therapeutic dyad.

Sandra placed Q-sort cards favoring therapist disclosure on the neutral to negative range of her distribution. Reflecting on these choices she says:

> I think the reason [I put them there] is because self-disclosure can be a bunch of different things. It could mean 'I'm white' or it could mean that 'I have feelings that I'm attracted to you'...There's aspects of self-disclosure that are totally inappropriate...I feel like some disclosures would end a patient's fantasy…or could affect it too much.

The lack of clarity on therapist disclosure in the Q-sort cards, as well as her own mixed feelings on the subject, led her to rank the items toward the lower end of her distribution.

Similarly, Sandra reported having a "hard time with the concept" of neutrality and a consequent difficulty placing Q-sort cards about neutrality. She recognizes that patients do know things about their therapists but also feels that therapist neutrality permits the emergence of the transference:

> Sandra: I am fairly neutral. I mean, being neutral is fairly impossible. Just looking at us people know stuff about us. [But] I aim to be neutral.
>
> PI: Can you say something about what aiming to be neutral means for you?
>
> Sandra: I try to be non-judgmental and accepting...When I think of neutral I really think of just like trying to be an object for the patient to be able to experience transference with. But also recognizing that there are certain aspects of me that are not ever going to be neutral and that there's parts of me that are going to influence a client.

Sandra also expressed ambivalence on the matter of intervening in patients' practical problems:

> So this [Q-sort card is] talking about you shouldn't be concerned with a patient's practical problems. And although I do think the real work is not looking at day-to-day issues, by ignoring what...the patient's coming in with...it's probably really hard to be there for the patient and be real. On the one hand, you do need to be aware of their practical problems. But on the other hand, you shouldn't be...advising.

Again, a mixed view on how active a therapist should be contributed to Sandra being grouped with Leila.

Sandra further believes that a therapist can, to some degree, control her participation or the involvement of her subjectivity in treatment. The following item received a low to neutral ranking on Factor V-a's distribution.

[2 -1 2 2 **-1** 3] 14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)

Sandra reflects on this item:

> Although I agree with the beginning of it...I feel like enactments don't inevitably occur. I mean I feel like there is some control there. So even

> though you might choose to enact some things, on the other hand, just assuming that things are going to happen...It kind of seems a little too passive to me.

In comparison to Leila, who knows very clearly where she stands on matters of neutrality and self-disclosure, Sandra is wrestling with the nature of the therapist's voluntary and involuntary participation in treatment.

Sandra's views at this point in her training have been shaped, in part, by a very difficult treatment of six months' duration with a 25 year-old Caucasian man who has low self-esteem and a troubled history in his relationships with women. He frequently shares his feelings and graphic fantasies about Sandra with her. She reports feeling uncomfortable in his presence and struggling to keep these feelings out of the treatment:

> I'm trying my best to allow him to explore the transference and explore the feelings behind it and then to relate it to his life...In terms of my own role, I really am neutral in that...a lot of my reactions I kind of am hiding...It really bothers me sometimes, some of the stuff he says. I mean, he's very very graphic...But in order to allow him to get to the reasons why this is happening I try to kind of leave [my experience of him] out of it and just reflect. So in my mind, it is a very neutral thing...I'm a woman to him. But that's all he's really seeing and that's what he's reacting to.

Her supervisor, whom she describes as relational, has been supportive and has helped her to "think about what's going on with this client in terms of [the treatment] relationship." At this stage, the supervisor is helping her to tolerate her own discomfort and explore the patient's material "without having to talk about [her] reactions as of yet." Given his

history of discomfort with women, Sandra says, it is striking that he is able to talk openly with her. She wants him to feel "safe" and so has not challenged him about the aggression she perceives in the material. In the future she may approach him differently:

> Eventually I think ideally I will be able to say to him a little bit more about my own personal feelings when this is going on.

Having such a case so early in her training has "forced" Sandra to think "a lot more in depth" about matters such as therapist neutrality than she might have otherwise. "I'm sure it's affecting me in terms of my feelings about countertransference. And that's obviously something I'm still trying to figure out."

Interestingly, Sandra's thinking has also been affected by a recent didactic experience. Through her doctoral program, she was able to study for a week at the Anna Freud Center in London. She described the experience:

> I think this recent experience for me was eye-opening in terms of how little I actually know and how much more there is to learn about the [psychoanalytic] approach. I guess in terms of my approach, I'm still trying to figure out what makes the most sense. I always assume that I will be a very eclectic therapist, which I think is kind of the popular way to go now.

In terms of being eclectic, Sandra anticipates learning to conduct cognitive behavioral therapy once she leaves her psychodynamic doctoral program and says the relational approach of her current supervisor is "making a lot more sense" to her. She also wants to learn "all the new stuff," the kind of treatments for which therapists can be reimbursed. "On the other hand," says Sandra:

> I think going and studying at the [Anna Fraud Center] was really showing me that a lot of these traditional ideas really can be applied. So I guess I'm being a little vague because I'm not really sure right now.

Sandra is an example from this study of a therapist-trainee whose orientation and therapeutic stance are very much in development. The influences of her supervisor and clinical training experiences are mingling with her own conceptualization of the field and the therapist's role. Despite her claim to becoming more relational, in her uncertainty, she takes a more conservative approach to the therapist's participation in the treatment dyad.

Factor V-b

Factor V-b is comprised of 1 women and 1 man, ages 30 and 31, representing one of the six doctoral programs included in the study. Their mean year in training is 2.5. One has been working dynamically for 1 year and the other for 1.5 years. The primary descriptor used by these students to define their orientation is "psychodynamic." The other descriptors used by these students are "eclectic" and "relational."

The views endorsed by these two students who loaded negatively on Factor V are opposite to those discussed in connection with students who loaded on Factor V-a. Consequently, this second group of students can be understood to: oppose the notion of therapist neutrality; favor some degree of therapist disclosure; endorse the view that there is a 'real' or working relationship apart from a transferential one; accept that a therapist may actively intervene in patients' day-to-day lives or decision making; and reject interpretation as the paramount form of intervention. In terms of the factor array, the Q-sorts of Factor V-b students were most similar to the inverse of the Factor V-a students'

Q-sorts. Factor V-b students endorsed the negative end of the Factor V distribution and rejected the positive end. Thus, whereas Factor V-a students rejected more Anchor Relational items than any other group in the study, Factor V-b students *endorsed* more Anchor Relational items than any other group in the study. According to the expert validator rankings, these are the students who most clearly identify with a relational viewpoint. Who are they?

Adina is a 2nd year therapist. She considers her orientation to be "psychodynamic" and "eclectic." In her interview, she reflected upon Q-sort card #19 and the idea that therapists should acknowledge their contribution to treatment ruptures:

> There are two people in the room...It is inevitable that the other person, the therapist, is engaged in the process. That their own psyche, fantasies, wishes, etcetera, etcetera, are going to somehow play a part. That doesn't mean that I think it should all be open, you know, and disclosed. But I think that on a personal level for everyone, that means both patient and therapist, to figure out when they're responsible for something that's happened, versus the other person, versus the combination of the two. You know, like in relationships in general. 'Well, he did that. And I disagree with what he did. And I feel like it's his fault. But how am I contributing to it?' So I feel like we try to get our patients to take on that perspective...We need to do that, too, and not pretend that we're not in the room. And I also think that modeling for them is important also. So to take responsibility for what you bring into the room...is important.

Adina clearly construes the patient-therapist dyad in two-person terms, where the therapist's subjective experience mingles with that of the patient.

In an interesting contrast to Leila (above on Factor V-a) who asserted that the treatment dyad in no way resembles a non-therapeutic relationship in which two people may sit down and comfortably "share a bottle of wine," Adina suggests that there are lessons from "relationships in general" that may be brought to bear on the therapeutic relationship.[23] Leila does not believe therapists must go out of their way to validate patients' reality testing. Adina suggests the opposite, that patients need to understand the impact of their behavior and their role in patient-therapist interactions. Reacting to card #6, Adina concurs that attention must be paid to real transactions in the treatment dyad as well as the transference:

> You know every experience will be some combination of what is really occurring between you and the other person and...your own internalized objects, dramas, fantasies, desires...But it's important to help a patient parse those things out...That's why it's important to talk not only about the countertransference and the transference, but also the real transactions...to see what is real and what isn't real.

Therapists owe it to their patients to name the dynamic that is occurring between them. In any interaction, she says, "The patient is on center stage." But she always considers, "Well how am I contributing to this?"

On the matter of therapist disclosure, Adina feels that disclosing one's countertransference requires "bravery" and that this bravery, in itself, can model

[23]Freud (1912/1960), too, feared beginners would treat the therapeutic relationship like a friendship or the patient as an equal.

something important for patients. In her experience, even relatively uncontroversial disclosures have made the difference in a treatment. She agrees with card #36 that neutrality is an "illusion" and recent supervisory experiences have helped her to feel that she does not need to be neutral. Early in her training, says Adina, she frequently felt as if "I was hiding what I really wanted to say. So I felt like it was somehow not fully genuine." She continues:

> I think now that I can be more myself in the therapy room, maybe I can go back to discover neutrality in a different way. But at the same time, I don't feel like in my mind, internally, I'm ever neutral.

Her position has been shaped, in part, by supervision that has freed her to feel more genuine in her role as a therapist. Even so, she is open to re-discovering the merits of some kind of neutrality.

Adina's views are not entirely reified. On the matter of interpretation versus other kinds of interventions, she has seen some patients benefit from interpretations while others benefit much more from the therapist's support and empathy, something they may not experience outside of treatment. Thinking of one patient with a history of abuse, who never had a consistent care-giver, she reflected:

> I feel like sometimes she doesn't see the support when it's there. So sometimes I feel bad if I deny her an interpretation. Because I feel like, 'Well, at least I can give her the interpretation.' But then I feel like the interpretation would feel too much like an assault. So it's always really tricky...The reason I disagree with [card #15] is because I think it's just not true for all patients.

Adina is not entirely unlike Sandra, above on Factor V-a, in that she is sorting through different approaches. An interesting feature of the Q-sort, however, is that it forced participants to make decisions about their priorities, in essence, to identify with certain positions over others for the time being, with the end result that even beginning clinicians with changing viewpoints do coalesce around certain poles of opinion. For Adina, this means a relational pole.

The V-b factor array distribution displays an endorsement of all nine Anchor Relational items. Substantively, Adina's position is characterized by an openness to the place of her subjective experience in the treatment dyad. Ben, a 3rd year student and the second student who loaded on Factor V-b, considers himself to be "psychodynamic" and "relational." Sounding a note similar to Adina's, Ben has found it "excruciatingly difficult to stay neutral" in his work as a therapist and discussed his struggle, as a beginner, to effectively navigate his patients' and his own subjectivities:

> In the past I was just kind of like flying by the seat of my pants. I think I was doing a very kind of Rogerian, kind of humanistic, you know, 'Let's explore your subjective experience.' But I'm learning now...I was almost completely immersed in the other person's subjective experience. And that seemed actually very helpful for them. And they often had a sense of relief and feeling understood. But I'm starting to agree that I was left out of that. That I wasn't aware of my...subjective experience at the same time.

As with Adina, Ben's training has helped him to feel less constrained with his patients and more "open to as many possibilities of the type of interaction you can have with a patient." In the moment, with patients, he has wondered how spontaneous he may be:

> I think when I'm working well [what to say] just kind of occurs to me. And I think that...whatever I'm experiencing or whatever fantasy or thought I'm having...is informing that.

Reflecting upon one patient, a depressed, schizoid middle-age man who has no telephone, Ben has hypothesized that it is anxiety producing for this man to think about enjoyable or pleasurable aspects of life. Ben reports how this man once described having a refrigerator full of food. Ben shared his association and the exchange that followed from it:

> And I guess my mind was wandering a little bit. And I actually imagined him like actually being outside of his apartment, like in the supermarket, like buying meat... And it just occurred to me [and I said] 'Do you like food shopping?'...And he kind of smiled, he was like, 'Yeah.' And I was like. 'What do you like about it?' He said, 'I like to get a value.' And that opened up a whole thing.

For Ben, this represents a clinical moment that he associates with a relational approach, an unformulated, spontaneous association shared with a patient.

Ben reports reading extensively on psychodynamic theory and, when asked, offered his understanding of relational as an integration of interpersonal and object relations theories:

> I've actually given this some thought. Kernberg wrote a book he called *External Reality and Internal World*. And I feel like the theme of that book is that that's kind of where life is lived, like at the nexus between the internalized world of fantasy and unconscious and the actual events...And like a detailed inquiry of the interpersonal tradition is that kind of more of a focus on, 'Well, what did you say? What did you do? What happened before that?' And then also trying to integrate that with the internalized object world. I think the relational position is an attempt to integrate an interpersonal tradition, which is kind of like 'Get the facts.' And then try to understand...how that is elaborated internally.

Similar to students loading on Factor I, Ben believes some relational clinicians go "too far" by "disclosing whatever comes to mind." On the other hand, he says: "But maybe...you know what? In a stalled analysis, to have a genuine reaction...I think there's something to that."

Ben believes beginners are pushed too quickly to use their countertransference in their clinical work. Clinicians in training are "so bombarded by the patient's associations and what they're talking about that you're just trying to track your patient in the beginning." Cognitively, he argues, it is just too much to ask of a beginner to be mindful of his countertransference. For trainees, says Ben, the shift from sitting in the patient's seat to the therapist's seat is tantamount to sitting in a race car that accelerates from "zero to one-hundred in like two seconds...And [you] can't control it!" Supervisors should acknowledge, then, that the best a beginner can do is to offer patients a "reflective statement." Students should know that by doing so they are "often adding something extra" and helpful. Says Ben:

> I think we all start out one person. And through training and experience and study, we can become more relational, two person.

Ben estimates that a trainee can begin to work relationally approximately five years into training.

To summarize, Factor V-b represents the views of students who, a few years into their training, identify more with Anchor Relational items than any other group in the study. They cite their relational supervisors as helping them to find a place for their subjective experience in the treatment of their patients and for helping them to feel freer and more spontaneous as therapists.

Factor VI

Factor VI is comprised of 3 participants, 2 women and 1 man, ranging in age from 28 - 37 and representing two of the six doctoral programs included in the study. The mean year in training for these students is 4.67. The primary descriptors used by these trainees to define their orientation include: “psychodynamic” (2); and “eclectic” (1). Other descriptors used by these students include “object relations” and “ego psychology.” Students in this group have been working psychodynamically for a mean of 4 years.

Distribution of expert clinicians’ item ratings for Factor VI

				B				
				B				
			AC	AC	AC			
			B	AC	B			
		B	S	S	B	B		
	AR	AC	AC	AC	AC	B	AR	
	B	B	AC	AC	B	B	B	
AC	B	AC	B	S	S	S	B	B
AR	AR	AR	AR	B	S	AC	AR	B
B	AR	S	AC	B	AR	B	B	S
-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**

The students whose Q-sorts loaded on Factor VI are more difficult to characterize than the students loading on Factors I - V. In short, they are a mixed lot. Certain themes are evident in the factor array distribution and interviews with these students, but these themes reiterate the priorities of students loading on other factors as well. Explication of Factor VI is also complicated by the fact that one of the three students loading on the factor had a similarly positive loading on Factor I (loadings of 0.47 on Factor I and 0.44 on Factor VI), although the other two students have pure loadings on this factor. In terms of the expert validator scores, when compared with Factors I - IV, Anchor Classical items reside more toward the center than the negative end of the distribution and Anchor Relational items more toward the negative end. This pattern suggests a greater

acceptance of classically-oriented views and a more critical attitude toward a relational approach in comparison to Factors I - IV (where Anchor Classical items resided toward the low end of the distribution and Anchor Relational items predominantly toward the center). Unifying themes, as evident in the factor array, will be discussed. However, interview data for these students will reveal that the motivations behind their item rankings are not uniform.

One of the items most strongly endorsed by students whose Q-sorts load on Factor VI describes the value of flexibility:

[2 4 -1 1 0 **4**] 7. One therapeutic stance may be of value with a given patient or at a given moment in a treatment, while an entirely different approach may be required with another patient or at a different moment with the same patient. Flexibility should be the therapist's rule-of-thumb. (S)

As with many students in this study (particularly those representing Factors I and, more strongly, Factor II) the idea of the flexible therapist holds great appeal. In interviews, flexibility also emerged as a strong priority for each of the three students whose Q-sorts loaded on Factor VI. Alex, a 4th year student, feels that "flexibility is key," that it is important for therapists to be able to "switch modes" and vary techniques. Treatment should be directed by the patient, he says, "as opposed to any therapeutic doctrine," and therapists much match their style to the patient's needs. Treatment cannot work if a therapist is "too rigid," says Alex.

Joanne, a 5th year student, learned about the merits of being flexible from a recent treatment. She describes her typical therapeutic stance as "not that active," but she became more active when one patient, a 20 year-old college student, began "making some very poor decisions" that might lead her to fail out of school. Joanne describes the effect of this change in her stance:

> Joanne: I think the change in my disposition was immediate and noticeable. I think I became much more...involved in helping her to conclude some things. And she noticed and made a comment in her session.
>
> PI: And how was that for you?
>
> Joanne: She just couldn't describe it when I asked her, you know, to say more about it...She just would say in a general sense that there was a difference. So she couldn't tell me what, but I knew, and I think was actually worried that maybe I had gone too far...We talked about it the next session [and I don't think I did]. I didn't go too far but it was good for me to realize you have to be flexible.

Flexibility, for Joanne, means a variation in the extent of her involvement in her patients' decision making and her overall participation in the treatment.

Hope, a 5th year student whose Q-sort also loaded on Factor I, talked about flexibility a great deal saying, "I think all patients are different, and my responses to all patients are different." She is flexible in terms of treatment modality, shifting gears from her insight-oriented treatments in a university counseling center to addressing the concrete problems of living with patients in a City hospital. In terms of her orientation, she describes a strong affinity for a relational or two-person approach and has been involved in relational psychotherapy research.[24] And yet, she seems to value flexibility of orientation over any one model. She reported having ongoing debates with a professor who is strongly opposed to countertransference disclosures:

> He's of the opinion that it's never, never indicated. And frankly I don't know of anything that's...never indicated. I'm not a big supporter of the

[24]This strong affinity for a two-person model, as well as some of the themes iterated in her interview such as a favoring of a strong working alliance and the humanness of the therapist, explain Hope's loading on Factor I. This section will attempt to examine her concomitant grouping with students whose Q-sorts loaded on Factor VI.

> word ‘never’ or ‘always,’ and I think that one of the things that I am trying to become is a flexible therapist that, you know, is obviously dynamically trained...but is really trying to treat a patient and not...prolong the life of any one particular model...I find that the best supervisors I’ve had have been the most flexible ones.

Flexibility is something Hope wishes to maintain even as she becomes more experienced over the course of her career.

A second theme that emerged as important for Factor VI trainees is that of therapist disclosure. On this theme, however, what stands out is the lack of clarity—both in the factor array and in students’ views. The factor array presents a contradictory picture of this group’s approach to therapist disclosure. On the one hand, according to the factor array, there are good reasons for a therapist to withhold personal information and disclosures impede the development of the transference.

[1 0 -1 3 1 **4**] 33. There are often good reasons to withhold personal information or remain 'anonymous' to our patients, and it is a mistake to overlook this. (B)

[1 0 3 1 -3 **-3**] 52. The disclosure of personal information need not put an end to patients’ fantasies about the therapist. Indeed, a disclosure may stimulate and encourage discussion about these fantasies. (AR)

[0 -2 -3 -1 -1 **-3**] 29. The therapist’s personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are often useful to share, since they are key elements in the treatment. (AR)

On the other hand, these students feel that therapists have a responsibility to “share” their experience, for example, in the face of an error on their part. These students also allow that disclosures can benefit the patient.

[0 1 1 -3 1 **-4**] 24. A therapist will inevitably make errors of practice or judgment (e.g. forgetting an appointment). Nevertheless, it is the *patient* who is in treatment, and it is *his* or *her* feelings about the error that should be the primary subject of discussion. (B)

[-2 -4 0 2 3 **-4**] 43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient. (AC)

The matter may be resolved with the view the there should be no pre-set rules on therapist disclosure.

[-1 3 1 -1 -2 **3**] 23. On the oft-debated subject of therapist self-disclosure, every clinician must decide what feels right for them, in a given clinical context, with each patient. There should be no pre-set rules on such a personal matter. (B)

Alex, in his interview, reflected on the seemingly contradictory placement in the same Q-sort column of cards opposing and favoring a transparent therapeutic stance:

> On the surface [these items] are conflicting but they don't have to be. Some patients need you to be more anonymous. There is a little tension between being anonymous and also believing in enactments, but that depends on what is more appropriate with each patient.

For Alex, a willingness to be flexible resolves the tension between the dual pull for anonymity and more transparent involvement on the part of the therapist.

Alex, above, referred to enactments. The relevant Q-sort statement, #14, received its highest ranking (+3) on Factor VI and is joined in this ranking by the generally accepted view expressed in statement #25:

[2 -1 2 2 -1 **3**] 14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)

[3 0 4 3 3 **3**] 25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations. (B)

Factor VI trainees do recognize the inevitable involvement of their own subjectivity in the form of enactments or even, as many of their peers have asserted, in the influence of their countertransference on their understanding. And yet the picture is not entirely clear

since they also reject the view that therapists are always “known” by their patients or that a neutral stance is a limiting factor in treatment.

[0 0 2 0 -2 **-4**] 36. Traditional ideals of neutrality or anonymity amount to the pursuit of an illusion. Once we recognize that we are always "known," in some way, by our patients, we must relinquish neutrality as a therapeutic ideal. (AR)

[-1 0 -2 0 -4 **-3**] 3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient’s way of being with others. (AR)

And they also reject the view that the therapist should offer input in patients’ decision making.

[-1 1 2 4 -4 **-3**] 31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values. (B)

How else might these apparent contradictions be understood?

In interviews, both Joanne and Hope expressed attitudes of caution with respect to therapist disclosure, although each is cautious for a different reason. Joanne, again, expressed her tendency to be less active and less transparent in her therapeutic stance. Reflecting on item #30, Joanne says, “I don’t think I agree with this. I know some people do.” The item and her thoughts follow:

[0 -1 1 3 2 **-2**] 30. At times, the therapist may find it constructive to admit to difficulty managing or understanding her reaction to the clinical material or to share her evolving and not yet fully formulated thought process with a patient. (B)

> I may say things like, ‘I’m not sure.’ But I don’t normally…try to work something out with [patients]. But I guess when I looked at that question I was thinking of more of, you know, an interpersonal way of kind of going

> back and forth and talking about...how you're responding...I don't know. I don't take that approach.

If circumstances were such that she as a therapist was responsible for a treatment rupture, as described in card #19 ("Like if it's not about them...If it is you.") she would take active responsibility for her error.

[3 2 4 1 1 **0**] 19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well. (S)

If Joanne missed an appointment, for example, she would "pay for that appointment...Yeah, at least that I would do." But in general, neutrality remains a priority for her.

> You're neutral but there are certain things you can't hide under. They get to know you and your personality and...how you're going to respond to the things they do. But you can't hide your gender or your race, how you dress, your office. That's just there. You do try to remain neutral. You don't want to include your thoughts...You want it to be as much of the patient as possible...I guess when I interpret neutral it's...I'm not intentionally imposing my views.

Joanne makes it a priority not to reveal her thoughts or views, although she allows that some information about her will be revealed to patients.

Hope, in contrast, is pre-disposed towards a stance of openness and transparency. Regarding the therapist who acknowledges her contribution to ruptures, Hope is adamant that the therapist be up-front as a rule and not, as for Joanne, as an exception.

> I think that's remarkably important [for the therapist to acknowledge their contribution to ruptures]. It's in fact what my dissertation is on. And I think that, again, going back to the collaborative aspects of psychotherapy, you know, I'm not really big on pathologizing the patient or being this

> blank screen, neutral person. In fact, I think that it works in the opposite direction. It's been my experience that if you overly pathologize the patient or minimize your impact on the situation, I just think it really alienates or has the potential to really alienate someone...We make mistakes. We're human. So to not be able to admit to them seems really dishonest.

And yet despite these assertions, Hope professes to be struggling with her position on therapist neutrality. On the view that there are often good reasons for the therapist to remain anonymous (Q-sort card #33) she says:

> I have very neutral views on self-disclosure...I've worked on prison units, I've worked on a lot of child units, and I think that it's just disorganizing to some people to know too much about you.

Her work with certain patient populations has challenged her assumptions about how revealing a therapist should be. She continues:

> Hope: You know my views change often. I don't really have a problem disclosing things about my personal life. For example, I wear my wedding ring where some people don't...I know in my own analysis, where my analyst kind of let it drop that her husband was a lawyer, something about that just was so touching to me that she felt like she could trust me to let me in just, you know, that little bit. I have very mixed feelings about it.
>
> PI: What do you think is influencing your placement of this idea [card #33] near the top?
>
> Hope: I think I was uncomfortable. Because I'm not entirely comfortable with my kind of ambiguity or ambivalence on this topic. I don't think you need to have a hard and fast rule on these things, but I think I'd like to have a better understanding of where I stand on that matter, so this was one that I

> could easily agree with...Because I definitely do agree that there are sometimes or often good reasons [to withhold].

Hope has experienced the relationship-building impact of a therapist disclosure in her own treatment. However, she reports that her recent work on a child inpatient unit has shown her "how important boundaries can be" and has led her to examine further her general tendency do be disclosing. Her own ambiguity led her to take a more conservative position on therapist disclosure in the Q-sort.

Another theme evident in Factor VI's distribution is the role of the past versus the present. These trainees prefer to frame the patient-therapist relationship as a new relationship, unburdened by parental transference or the patient's early experience.

[1 2 1 0 -2 **3**] 22. It is a mistake to interpret the patient's experience of the therapist too exclusively as a repetition of something earlier. The therapist is also a new object and this new relationship contributes importantly to transforming the patient's inner life. (AR)

[-2 1 3 3 2 -**3**] 37. The therapeutic relationship, in its most fundamental aspects, is based on the parent-child relationship, and it is important that the impact of this powerful underlying structure be understood. (B)

[1 3 4 3 2 **0**] 48. Whatever a patient's reaction to his or her therapist may be, wishes, fears, and defenses originating in childhood have a very important part in it. (B)

Alex articulates this position very clearly saying that framing the therapeutic dyad in terms of a patient-child relationship "bothers [him]." He says, "I like to work more in the here and now." In his experience, an over-reliance on a patient's past is a "hindrance."

Hope similarly says,

> I think really focusing on the here and now and focusing on interactions, be they enactments or just kind of real interactions, is remarkably important and, you know, is a real window into how people are reacting with others and...a major part of their life and their makeup...I don't think transference is the only route to helping somebody.

An emphasis on the 'here and now' over the past is another feature bringing the students of Factor VI together. It is also an aspect of the Q-sort results that sets them apart from Factors III and V, for whom the patient-child element of the transference is very important.

With the benefit of all other factors having already been explicated, there is a pull to make comparisons with other groups. Indeed, there are flashes of other factors in the priorities endorsed by Factor VI. For example, flexibility was a key theme for students whose Q-sorts loaded on Factor II. But it is equally important to remember that, apart from Hope's dual loading on Factor I, these students did not load on any other factors. Factor VI thus challenges our assumptions about the inevitable co-existence of certain points of view that we have discussed so far. Some of the commonalities and differences with Factors I - V will be discussed briefly.

Factor VI students ally with their Factor I (and II) counterparts in embracing the "humanness" of the therapist over technical finesse.

[3 3 1 -1 2 **4**] 27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist. (B)

Says Alex:

> Humanness is very important. Empathy and humanness–that's what separates our field from others in the health profession. We create a safe environment for exploration. Trust is an important issue in therapy but how is trust achieved? [Through] empathy and...humanness.

Despite the agreement with their Factor I and II peers on the merits of therapist empathy and humanness, Factor VI students do not load on those factors, instead grouping to form their own distinct factor. In another example of a commonality between the views of Factor VI trainees and other participants, Factor VI and Factor I trainees share high rankings of Anchor Relational statement #44 in favor of joint meaning-making**:**

[4 -2 1 0 -1 **3**] 44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experience and inner life. (AR)

But although Factor VI students rank this item highly, the interviews with Alex and Joanne suggest they do not favor the two-person, egalitarian stance that was the purview of Factor I students. The +3 ranking of this item was likely influenced by Hope's strong endorsement of joint meaning-making, but this cannot entirely explain its placement in the factor array. More information may be needed to fully explain how the item came to be endorsed by groups of participants with otherwise differing views, representing distinct factors. As a start, we may allow that joint meaning-making can mean different things to different therapists. For some, it may describe an epistemological hallmark of a two-person approach. For others, this statement may depict an empathic therapeutic stance that resonates with how some trainees see themselves.

Hope did load on Factor I, but her Factor VI peers do not share her egalitarian sensibilities. Alex associates a relational[25] approach with a tendency to "over-interpret things going on the room." He continues:

> [A relational approach] seems very self-indulgent, like, I don't know, too much exaggeration of meaning that's going on in every nook and cranny.

He admits to not having done sufficient reading on relational theory or practice but has an association to it that is in the range of "neutral to negative."

Joanne describes her development over the course of her five years of training as a process of becoming increasingly open minded to varied orientations. Her associations to a relational approach include greater emphasis on the treatment relationship, active intervention, and increased therapist disclosure. Regarding this approach Joanne says, "I

[25]Recall that students whose Q-sorts loaded on Factor I described an affinity for relationally-allied *ideas* and *practices*, although they did not necessarily identify with the label 'relational' and, in some cases, disparaged it.

don't think it's a bad thing. It's just not my style." Indeed, students again can be found selectively identifying with certain practices, ideas, and terminology, but not necessarily the orientations in which these are rooted.

The distribution of expert validator scores for Factor VI revealed a more balanced placement of Anchor Classical items on Factor VI's distribution in comparison to Factors I - V. But is there, in fact, an affinity with the views of Factor V-a? These two factors do stand out in the sample as sharing some similar rankings.

[-1 0 -2 0 **-4 -3**] 3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient's way of being with others. (AR)

[-1 1 2 4 **-4 -3**] 31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values. (B)

Notably, Factors V and VI share the endorsement of item #4, below, reflecting a classical epistemology and use of classical terminology. This item received its second highest ranking in the study by Factor VI trainees.

[-3 0 -1 -1 3 **2**] 4. The aim of a psychodynamic treatment is the resolution of neurotic conflict. A stance of relative neutrality permits memories, associations and any conflictual material to emerge in the transference so they may be interpreted and worked through. (AC)

Explanations for the endorsement of this Anchor Classical item by these students are varied. Alex expressed his complex relationship to classical drive theory and the following item,[26] which received its highest ranking in the study on Factor VI:

[-3 1 1 0 0 **2**] 2. Recent advances in our understanding of object relations and the evolution of the self do not diminish the need to understand the

[26] Item #2 was rated as B or a Bridging item by the expert validators, implying that both classical and relational clinicians are likely to believe in the organizing influence of drives. Despite this rating by the experts, the item served as touchstone for Alex to express his views on classical drive theory.

powerful organizing influence of biologically-rooted drives. (B)

Alex: We are bombarded with these ideas...They are like a monkey on our backs! We can't get rid of drive theory. I feel guilty putting it on the other [negative] side of the distribution. [It would be like] stepping on years of training. I must give it the respect it deserves.

PI: Who makes you feel guilty?

Alex: A voice from the past. These ideas have been drilled into you so many times: 'This is it, this is it!'

Alex estimates that ten years from now he would feel more comfortable rejecting drive theory and placing classically oriented statements on the left end of the distribution.

In great contrast, Hope described her own endorsement of classical epistemology and the belief that, "Examining behavior from the perspective of id, ego and superego dimensions remains an important organizing idea," a position apparently not shared by her Factor VI peers.

[-1 -2 -3 -1 0 -**1**] 54. Examining behavior from the perspective of id, ego and superego dimensions remains an important and helpful organizing idea in understanding clinical material. (AC)

Says Hope:

I find that helpful in exactly what it says, in organizing and understanding my patients. I don't think that I use that all that much in actual work, in terms of interpretations or any sort of interventions. But I do find it helpful thinking about things in terms of...those three dimensions in really organizing how I see my patients or how, you know, what the strongest of the three is for one person of the other.

Whereas Alex placed cards reflecting a classical approach higher on the distribution than he might have, out of a sense of fear or obligation, Hope genuinely feels that structural theory informs her clinical work in a meaningful way. While it was not addressed in

Joanne's interview, we can hypothesize that her rejection of a two-person or relational approach may have led her to rank certain Anchor Classical items higher in her distribution than her peers who loaded on other factors.

To summarize, Factor VI is characterized by students who share certain views with their Factor I - V peers but hold other views that led to their loading on an entirely different sixth factor. These students value therapist flexibility, as did others, but they are not (apart from Hope) embracing of a two-person approach like their Factor I peers, nor do they call themselves "eclectic" like the students loading on Factor II. Note, also, their ranking of item #42:

[4 4 -1 2 0 **-1**] 42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)

These students embrace the "here and now" but do not necessarily cite the working alliance as a strong priority. The patient-child aspect of the transference was important for students loading on Factors III and IV but not for this final group. Factor VI trainees, further, share with their Factor IV peers a pre-occupation with therapist disclosure, and they, too, may be going through the same kinds of developmental shifts with respect to finding their position on this matter. However, Factor VI students are more ambivalent about disclosures generally, and their overall item rankings were different enough from Factor IV students' rankings to set them apart. Finally, Factor VI students are more positively inclined towards certain classically-allied viewpoints and/or behaved in their rankings as if they were. Nevertheless, their Q-sorts do not sufficiently resemble Factor V-a.

The profile of Factor VI students is the least coherent of any group in this study. Usefully, however, the Factor VI factor array distribution challenges our assumptions about the kinds of ideas that go together among this student sample and in the field at-

large. This is most evident in discussion with Hope, who identifies strongly with a relational orientation. And yet, the variability of her training experiences has her struggling to find her position on therapist neutrality and disclosure and taking, for the time being, a more conservative position on these matters. Her openness toward structural theory makes her among the hardest to categorize of all students.

The need to reconcile the views of Factor VI trainees, additionally, invites a critique of this methodology, presenting as it does factor array results that are not seamlessly supported by the interview data. The critique is a fair one. Any methodology and any one project can only go so far to organize data in all its natural complexity. In this case, where the data are the views and practices of developing clinicians, results can be expected to reflect, to a degree, the unevenness of this developmental process. This study has nevertheless endeavored to locate points of clarity and trends within this very process.

Discussion

This Q-methodological study was undertaken to explore the ideas and practices prioritized by beginning clinicians who are training to conduct psychodynamic psychotherapy in the current post-relational challenge climate. The Q-sort was designed to enable participants to express their affinity for classically- or relationally-oriented approaches as well as for ideas and practices that are not easily categorized as either classical or relational. Statistical results yielded six factors and (given the two poles of Factor V) seven groupings of students according to the following views: I) those committed to an egalitarian, collaborative approach to treatment, similar to the two-person model outlined by relational theorists (although these students do not necessarily identify as relational); II) those who consider their approach to be eclectic and who value therapist flexibility in practice and orientation; III) those most influenced by object relations theory, who emphasize their patients' and their own intra-psychic processes; IV) those who are grouped for their pre-occupation with therapist disclosure; V-a) those who do prioritize a classically-oriented approach, primarily in terms of how they construe the participation of the therapist in the treatment dyad; V-b) those most clearly allied with a relational approach, whose identification is expressed by their prioritizing the importance of therapist subjectivity; and VI) a final mixed group of trainees who are difficult to categorize.

This sample of therapist trainees proved to be diverse in many ways. Also evident in this sample are a range of views on beginners' training needs; disparities in the degree of confidence they have about their practice; different personalities and therapeutic stances, with some tending to disclose and others not; and different attitudes

about the field at-large. These trainees do, however, coalesce around the priorities evidenced in the Q-sort results. A good deal of overlap exists in the kinds of ideas these groups of beginners embrace and reject. Indeed, the Q-sort items that have the broadest appeal for today's trainees are those that *bridge* orientations and not those that divide them. Nevertheless, despite the diversity of the sample and overlap in the factor themes, general conclusions may be drawn.

The data clearly reveal that the majority of this sample of beginning clinicians does not prioritize classically-oriented ideas or practices. Also definitive is the finding that the majority of trainees in this sample do not wholly embrace relationally-oriented ideas or practices although they have adopted a selection of them. For example, it was found that small subgroups of this sample consider their approach best described as either eclectic or inspired by object-relations theory. Certain concepts and therapist qualities, such as the notion of flexibility and the inevitable impact of countertransference on the therapist's perspective, have broad appeal among today's trainees. In contrast, many beginning clinicians are struggling to reconcile conflicting messages from the field and contradictory impulses about the appropriateness of therapist disclosure or the value and meaning of neutrality. These findings will be discussed with an eye towards discerning the needs and concerns of this sample as expressed through their Q-sorts and interviews.

Bridging items and beginning clinicians

Beginning clinicians in this sample reserved for their highest rankings the statements that bridge the classical-relational divide. Of course, the experienced clinicians who validated the Q-sort items recognized that many of the ideas and practices captured by the Q-sort are of value to therapists regardless of orientation. Among this

sample of trainees—who are disaffected from traditional psychoanalytic models and not entirely enamored of newer ones—these consensual items carried the day. To be sure, it is not easy to take issue with the idea that clinical work affects the therapist deeply or that feelings are an important part of the therapist's tools and not an intrusion. The following items were the highest ranked Bridging items in the study.

[3 3 3 4 1 2]	20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion. (B)
[3 0 4 3 3 3]	25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations. (B)
[3 3 1 -1 2 4]	27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist. (B)

During the development of this project, it was hypothesized that beginning clinicians would gravitate toward these 'feel-good' items (L. Weinstein, personal communication, 2002) precisely because of how non-controversial they are. What new therapist would not want to be seen or to see herself as a feeling, self-aware, and genuine clinician?

There may be an element here of social desirability response bias in that participants selected statements that make them look good. But the appeal of these items may represent a more substantive dynamic among the sample and in the field. Historically, as Farber (1985) has noted, interpersonal therapeutic qualities were undervalued when juxtaposed with technical finesse in the supervision of new psychoanalytic clinicians. He suggests that relational paradigms give new credibility to

the ability to forge therapeutic connections over the mastery of technique. The expert validator ratings indicate that these Bridging items are, in fact, in harmony with both contemporary classical and relational positions. These ratings, plus the students' endorsements, may also reflect a shifting of priorities in the field away from technique as defined under a classical paradigm, as paramount, and toward a greater valuing of general relationship and frame-building skills (in the case of an item such as #27) and of the place of therapist's subjectivity in treatment (in the case of items #20 and #25) (See also Mills, 2005). Twenty or thirty years ago these items might not have been valued by beginners as appealing, feel-good ideas—*or* as making them look good—but rather as naive or beside the point or even misguided. Today, they are consensually viewed, by experts and beginners, as core elements of clinical practice and even as therapeutic objectives.

The idea that there is a quality of interaction between patient and therapist that is grounded in a 'real' relationship between two people and that exists apart from the transferential dynamic is hardly a new one. Greenson (1967) and Zetzel (1956, 1970) articulated the importance of a therapeutic or working alliance that keeps the patient engaged in treatment. These authors were articulating these ideas in contrast to or in addition to what were the dominant views of their time. Today, more than half of the trainees in this sample placed a very high value on the working alliance and the importance of the 'real' relationship versus the transference-countertransference dynamic. The following statement received the second highest mean rating in the study.

[4 4 -1 2 0 -1] 42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic. (B)

Despite being rated as a Bridging statement by the expert validators, participants are not unanimous with respect to the issue of the working alliance or the real relationship. Students loading on Factors I and II value it quite highly while those loading on Factors III, V, and VI place it in the neutral to mildly negative range. The students who favor the working alliance described it as the "basis" of their work but others were less inclined to cite the real or working alliance as a top priority.

In the review of results for Factor V, an implicit debate emerged between Leila (V-a) and Adina (V-b) as to whether therapeutic relationships resemble other non-clinical relationships, what Adina referred to as "relationships in general." Leila is emphatic that psychodynamic psychotherapy is not about making the patient "comfortable," that "you are not drinking a bottle of wine with this person!" This 'sharing a drink' image evokes Freud's (1912/1960) concern that the beginning clinician is at risk for wanting to treat patients as equals. Freud cautioned that "in psycho-analytic relations things often happen differently from what the psychology of consciousness might lead us to expect," and admonished the therapist to function as a mirror. Leila criticizes the notion that the therapist would model the treatment relationship after a friendship or another more equal dyadic bond.

Mills (2005), in his insider critique of relational psychoanalysis, notes:

> The hallmark of a relational approach to treatment is that it approximates the way real relationships are naturally formed in patients' external lives, including the rawness, tension, and negotiability of the lived encounter, with the exception that the process falls under analytic sensibility. (p.180)

The acknowledged approximation of "real relationships" is viewed by Mills as a positive development that, nevertheless, creates new challenges for analytic technique. Adina, one of two students who endorsed the full range of Anchor Relational items, has thus absorbed this as an influential relational idea. It is striking that the two students who, respectively, most strongly identify with classical and relational points of view diverge so clearly on this matter. This is perhaps a clue to one issue by which today's trainees orient themselves toward or away from a particular paradigm.

It seems only natural for beginners, still learning to integrate technique and theory, to feel that they can offer a patient therapeutic, human qualities, that they can draw upon their own life experience and extra-clinical skills to help build a solid working alliance with a patient. Daniel (Factor IV) felt the urge to engage with one patient about their shared musical tastes in order to build a therapeutic alliance. Ben (Factor V-b) described "the incredible pull to the social norm." He continues:

> It's very much easier to talk about the weather than why you're not answering [the patient's] question about why I chose to be a therapist.

Ben believes it is part of his job as a therapist to resist this pull to normative social exchanges and views his struggle with this as a function of his inexperience. Future research should further consider the degree to which emphases on the real vs. transferential aspects of the relationship are a key to what divides orientations. It must also be considered whether this tension represents the pre-occupation of beginners but not of more experienced clinicians. Supervisors of new therapists would serve their supervisees well to help them stay in touch with what feels familiar to them about their stance as therapists, perhaps what they recognize from their conduct in other

relationships—whether countertransferentially or more transparently in terms of their personality styles or habitual interactions—and in what ways their developing professional identity is forcing them to function in new, role-specific ways.

Split consensus within and between clinician cohorts

Eight of the Q-sort items were rated as S or Split Consensus items, meaning the experts disagreed whether the item reflected a relational or classical viewpoint. It was hypothesized that the relative placement of Split Consensus items among Anchor Relational or Anchor Classical items in a factor array would confirm the particular slant of that S item for that factor. Alternately, Split Consensus items would be seen as contributing to an original viewpoint. In the end, each hypothesis proved viable. The presence of Split Consensus items in the factor array in some instances leads the reader to speculate over their 'true' classification by the trainees. In others, any 'true' classification is of less interest than the relevance of the idea for the trainees on that factor given the other items selected. Interestingly, the Q-sort rankings also evoke an unspoken dialogue between the trainee and expert cohorts on the classification of a particular idea or practice. Examples will follow.

[3 0 1 0 -3 -2] 1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality. (S)

With a ranking +3 for Factor I, #1 is most usefully read as expressing the collaborative values embraced by these trainees. Its -3 ranking on Factor V, where Anchor Classical items were endorsed, suggests that Factor V-a trainees—of course blind to the expert rankings—included it among the other negatively ranked Anchor Relational items and likely understood it to belong to a category of views they reject (and that Factor V-b trainees, conversely, accept). Notably, this was an item whose expert ranking

surprised the developers of the Q-sort who had anticipated it would receive a more resounding Anchor Relational rating. Whereas the beginners of Factor V seem to have found a sure place for it among their other anchor items, the experts' caution with respect to its classification is even more telling about the complex identity of this concept in the field today.

[3 2 4 1 1 0]	19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well. (S)
[2 2 3 1 -1 1]	34. Whatever one's views may be about intersubjective or two-person models of treatment, the psychotherapy patient and the psychotherapist have fundamentally different roles, needs, responsibilities and liabilities. Mutuality does not mean equality. (S)

Favored by students loading on Factor I, the above items speak first to the collaborative spirit valued by this cohort (#19) and then sound a note of caution that the therapist not see herself and the patient as equals (#34), the latter a perspective that Factor I students opted to include near the high end of their distribution. Also of interest are these items' respective +4 and +3 rankings in the array for Factor III. We can assume that these items strongly reflect priorities consistent with these trainees' pro-object relations views. However, recall that while object relations theory falls under the rubric of relational perspectives these women were rejecting of the relational label and of the two-person ideals that appealed to their Factor I peers. This comparison highlights commonalities among groups of students who, despite asserting distinct priorities and theoretical identifications, are each weighing how participatory they wish to be as therapists.

[0 -3 3 -3 4 0] 9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change. (S)

Statement #9, too, was endorsed by Factor III trainees and is more meaningful in that array for its content, demonstrating that these intrapsychically-oriented trainees value transference interpretations, than for any detectable 'true' classification. Trainees on Factors II and IV ranked this item -3 among Anchor Classical, Bridging, or Split Consensus items in that column. These groups thus likely viewed this item in the spirit of the classically-oriented or possibly less-classifiable ideas that they reject. As a high ranking item for the trainees of Factor V-a (and low ranking item for V-b), we can hypothesize that this group viewed it as another classically-oriented item to endorse (or for the V-b trainees to reject).

[1 4 2 0 -1 2] 10. Neutral does not equal total non-expressiveness. Therapists may be neutral and still have a personality, be genuine and present, in essence, be themselves. (S)

This item found prominence on Factor II, alone, among highly ranked Bridging items where it, too, may be most valuable to these eclectically-oriented trainees for being an unclassifiable but appealing idea. The appeal of Bridging items to participants in this study overall reinforces the important place of unclassifiable ideas—or ideas about which there is poor consensus—in the Q-sort and in the field. Ideas and practices that do not garner easy agreement among the experts may be appreciated by the participants *because* of their bridging or consensus-proof (e.g. non-divisive) qualities.

[-1 -3 -2 -3 -3 -1] 40. Countertransference disclosures should always be made cautiously, and only in response to an inquiry from the patient. (S)

The uniformly negative rankings for #40 speak most meaningfully in favor of the pro-countertransference views of these participants, to be discussed below. This item

may have been particularly immune to agreement or classification as it expresses two related but distinct ideas. Nevertheless, trainees' consensus in the form of a (even mildly) negative reaction to this depiction of countertransference disclosures is an interesting counterpoint to the disagreement among the experts about the ownership of this idea in the field.

The following item garnered similar rankings but in the neutral to mildly-positive range.

[1 0 0 2 1 1] 35. Remaining silent about our experience can be as much a countertransference enactment as any other kind of response. (S)

The participants' response to this item is consistent with the spirit of the item: This statement affords the beginning therapist a means of taking a position on a charged clinical issue without having to do anything. The item may have divided the experts because it points to the way in which a therapist's thought process, and not simply her behavior in session, is indicative of her views, perhaps rendering them—and the therapist herself—harder to classify by orientation.

The following and final Split Consensus item is also a relatively non-polarizing idea that failed to garner consensus among the experts:

[2 4 -1 1 0 4] 7. One therapeutic stance may be of value with a given patient or at a given moment in a treatment, while an entirely different approach may be required with another patient or at a different moment with the same patient. Flexibility should be the therapist's rule-of-thumb. (S)

The significance of flexibility for this sample will be discussed, below. But this is a perfect (+4) item for the eclectic therapists of Factor II as well as the manifestly open-minded therapists of Factor VI who, for different reasons, endorsed Anchor Classical and Anchor Relational items. The experts in the study were divided on how to classify this

item. Trainees may have been drawn to it, in part, because it enabled them to identify as "flexible" therapists even as they were being asked to take a stance with each placement of the Q-sort cards.

Anti-classical currents among beginning clinicians

An effort was made in the development of the Q-sort to ensure that a classical approach not be caricatured in the Q-sort statements. Q-sort items were drafted, evaluated by expert validators, revised, and then reevaluated. In addition, the decision was made to use the six factor solution that maximized the emergence of classical (Factor V-a) and quasi-classical positions (Factor VI). Recall, however, that 23 of the 54 Q-sort items were rated as Bridging items that were difficult to classify or as Split Consensus items that divided the expert validators. Most of the items favored by the participants fall into these categories (See 9 out of 10 of the items with the highest mean ratings, Appendix G). Thus, it is evident that participants do identify with many views that are, arguably, in synch with a contemporary classical position (as they are with a contemporary relational position). This being the case, the prominence of Anchor Classical items on the low end of the distributions for Factors I, II, III, IV, V-b and, to a lesser degree, VI, is all the more meaningful: These Anchor Classical items emerged from the expert' rating process and were judged, by relational and classical clinicians alike, to be representative of a viable contemporary classical position. It was these items that were rejected by the majority of beginning therapists in the sample.

Excluding Factor V, Anchor Classical items reside primarily on the low end of each factor array distribution. Within Factor V, as was discussed, only the two students who loaded positively on the factor could be said to endorse these items. Interviews with

these trainees showed, further, that only Leila identified her approach to clinical work as influenced by classical views. Sandra, her partner on Factor V-a, agreed with certain Anchor Classical ideas but her own orientation is very much in flux and her identification with and understanding of a classical approach is, by her own admission, tentative. But Leila, an older, European student (hailing, literally, from the "old world"), stands alone in her views and has experienced herself as an outsider in her training program. She is also an outsider in the current sample of trainees.

In interviews, participants' attitudes toward classically-oriented theory and practice emerged as a mixture of antipathy and aloofness as well as some admitted ignorance. For some students, classical or structural theory feels irrelevant to their thinking and practice[27] ("I guess I wasn't even sure what that meant." -Joy, Factor I; or "I just don't really believe in drive theory."- Zoe, Factor I), even though it can "enlighten [one's] view of a client, more like a case formulation." One reason for this disaffection may be the relatively limited exposure to classical theory and technique on the part of some beginners. Some students suggested that their rejection of a classical approach is premature, their interest foreclosed ("Maybe I need to go back and revisit that" -Lori, Factor I; or "This recent experience [at the Anna Freud Centre] for me was eye-opening in terms of how little I actually know." - Sandra, Factor V-a.) The degree to which participants' views reflect either an informed rejection of classical theory or their limited

[27]Another small but telling indicator of the degree to which classical theory and technique have been sidelined in the minds of current trainees is that neither "classical" nor "structural" are included among the 23 separate orientation descriptors culled from the questionnaires. Potentially relevant classically-inclusive descriptors include "psychoanalytic" "psychodynamic." But unlike the decidedly non-classical alternatives (e.g. "relational," "interpersonal," "object relations") used by students to identify their orientation, no overtly classical label is to be found among them.

exposure to it is difficult to know with certainty. But the Q-sort data were unambiguous in representing trainees' devaluing of the most classical ideas and practices in the Q-sort.

If this sample of students is representative of today's beginning clinicians, classical or structural views and techniques are being left behind by a large majority of new therapists. Some students have undergone shifts in thinking about their clinical work that mirror the shifts that have occurred in the field from a historically dominant classical analytic perspective to one influenced by contemporary relational views. For Eve and Amanda (Factor IV), this shift occurred with their transitions from classically- to relationally-oriented therapists of their own. Others, like Ben, Adina (Factor V-b), and Serena (Factor IV), have trained with supervisors or professors who encouraged them to exchange the supposedly classically-influenced views they held at the start of their graduate training ("We thought you had to, you know, never disclose." -Serena) for a contemporary alternative shaped by relational views. For each of these trainees, the result of this transition was the freedom to feel less constrained, more genuine, more like themselves in their role as clinicians.

Whether in the hands of professors, supervisors, or other clinicians, contemporary classical and structural theory has failed to make the case for itself among these trainees as a living, viable clinical paradigm. As Joy said, "I'm not sure that [Anchor Classical items are] as useful as they were to Freud." Although Freud is far from the most recent representative of a classical approach, the use of his name here is indicative of just how remote a classical approach feels to her. For Joy, and for others, the terminology of the tripartite model of the mind, especially, represents an archaic approach irrelevant to beginners' clinical practice.

Interestingly, students in the sample who expressed a positive association to classical/structural theory tended to appreciate it as an organizing framework similar to that which their less sympathetic peers found useful only on paper. Melissa (Factor III), also citing Freud as the spokesperson for the classical paradigm, believes that "Freud did something well. He had an idea about a structure, what the problem was, what the etiology was, and the interpretation flowed from there." Lori (Factor I) found herself reflecting upon a case presentation by a classical analyst and remarking about "how well that fits together." Classical theory may represent a reification of thinking and practice that beginners at once view as outmoded but also as offering a structure lacking in the contemporary alternatives to which they have been exposed (Maroda, 2002).

The rejection of Anchor Classical views in this sample was not absolute. Anchor Classical items that were favored by some participants were those describing a classically-oriented approach to the therapist's participation in the treatment dyad. For example, the eclectic/flexible therapists of Factor II had one Anchor Classical item on the high end of their factor array distribution:

[-1 **2** -1 -2 1 1] 46. Therapists are no longer expected to be blank screens. Nevertheless, they should strive to be as neutral as possible, establishing a baseline against which changes in the patient's perceptions of them can be recognized as deriving from within the patient. (AC)

And Factor IV students included the following among their varied and pre-occupying positions on therapist disclosure:

[-2 -4 0 **2** 3 -4] 43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient. (AC)

As I will discuss below, therapist disclosure and neutrality are among the most perplexing issues for today's trainees. The endorsement of these Anchor Classical items reflects an

awareness of the range of extant viewpoints on the issue of neutrality. Additionally, their placement in the factor array represents a degree of model mixing on the part of today's students. As hypothesized, while theorists are preoccupied with the delineation of one model in comparison to another, practicing clinicians at all levels are comfortable drawing from different orientations (Frank, 1999).

The state of relational: Confusion and denial

Among the clearest findings is that a classically-oriented approach to psychodynamic therapy is out of vogue among this sample of beginning clinicians. However, there is greater ambiguity with respect to what new therapists *endorse*. Beginners have internalized a critique of a classical/structural approach, but it is not clear the extent to which they embrace or even fully comprehend the "relational challenge" as outlined by proponents of that paradigm.

Using the expert validator ratings, only 2 of the 30 students in the study (those constituting Factor V-b, for whom all Anchor Relational items reside on the high end of their distribution) prioritize Anchor Relational items in their Q-sorts. The picture is further complicated by the fact that the nine students who included "relational" among the orientation descriptors in their questionnaires loaded on four different factors (I, II, IV and V-b) and therefore are not uniform in their priorities. Others, such as Lisette and Joy (Factor I) or Melissa (Factor III), prioritize certain relational ideas but are critical of the relational paradigm as a whole. Furthermore, the kinds of ideas students identify as relational were not necessarily rated as such by the expert validators. These results paint a confusing picture and a picture of the current confusion among beginning therapists as to what exactly their relationship to 'relational' is.

Certain terminology and ideas grounded in the relational tradition have made a mark as relational with today's beginners:

[4 -2 1 0 -1 3] 44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experiences and inner life. (AR)

This item, the highest ranked Anchor Relational item in the study–although ninth overall in its mean rating (See Appendix G)–reveals an aspect of a relational approach that has taken hold among some students in this sample. The next highest ranked Anchor Relational item, 17th in its mean ranking, is the following:

[1 2 1 0 -2 3] 22. It is a mistake to interpret the patient's experience of the therapist too exclusively as a repetition of something earlier. The therapist is also a new object and this new relationship contributes importantly to transforming the patient's inner life. (AR)

And the third highest ranked Anchor Relational item–21st in its mean rating–offers a relational view of therapist disclosure.

[1 0 3 1 -3 -3] 52. The disclosure of personal information need not put an end to patients' fantasies about the therapist. Indeed, a disclosure may stimulate and encourage discussion about these fantasies. (AR)

An epistemology defined by joint meaning-making, the view of the therapist as potentially a new object, and the view that therapist disclosures need not close off the expression and exploration of fantasy are all aspects of a relational approach that appeal to beginning clinicians. And yet even these are not among the most widely endorsed Q-sort items.

What Anchor Relational ideas are students least engaged by? Following are the Anchor Relational items with the three lowest mean ratings (38, 37 and 35 respectively):

[0 -2 -3 -1 -1 -3] 29. The therapist's personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are

	often useful to share, since they are key elements in the treatment. (AR)
[-1 0 -2 0 -4 -3]	3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient's way of being with others. (AR)
[-2 0 -2 2 -2 -2]	17. The therapist's effort to be anonymous can impede a treatment's progress by, for example, evoking for the patient an absent or unknowable parental figure. (AR)

Item #29 stands out among the Q-sort statements as an emphatic pro-disclosure item, evoking a therapist who possesses a disclosing stance as a matter of course. Statements #3 and #17, also widely rejected by participants, are Anchor Relational critiques of a classical position on therapist anonymity. Students in the sample thus *rejected* these efforts to strip the clinician of her anonymity and opted to protect the dynamic in which a more neutral stance on the part of the therapist fuels the treatment rather than impedes it.

The non-endorsement or mild rejection of these Anchor Relational perspectives also found voice in interviews with students who believe that techniques associated with a relational model can be "overused," that they are "too much," or represent an approach that is "too intense, too confrontational." Specifically, trainees identify a relational therapist as one who is more disclosing and who calls attention to dynamics occurring in the treatment dyad. These qualities are also embedded in the personae of certain influential supervisors or professors. When asked her associations to a relational approach, Sue (a 5th year student, Factor I) immediately thought of a particular "quirky" professor whom she describes as "out there" and who, in or out of the classroom, "will just say something to you about having a countertransference reaction to you, like in the

moment." Sue acknowledges that this is a caricature and says she likes this professor; but this professor is also portrayed as intrusive and out of control.

Students have varying degrees of comfort with their relational mentors, therapists, and professors. Eve (Factor IV) had to adjust to there being "more self-disclosure, more blurring of the lines" in her treatment with a relational analyst but is now inclined in favor this approach. Ben (Factor V-b) and Serena (Factor IV) have found their contact with relational mentors to be freeing, as helping them to feel more genuine in their role. But the stereotype of a relational clinician makes others, like Joy (Factor I), wary of being pushed too hard to make disclosures beyond their comfort level. They fear a breakdown of boundaries between themselves and their patients or possibly, as with Sue, even in the moment between themselves and their mentors. The very aspects of a relational approach that are so appealing to some trainees turn others off to it.

A premise of this project is that, despite overlapping priorities, classical and relational approaches do represent distinct paradigms. Indeed, participants may have endorsed many Bridging statements, but they are not ignorant of the polarization of views in the field and have found their own footing along this divide accordingly. Carie (Factor I) shares her view on the impact of the relational critique:

> I kind of feel like it's a little bit extreme for me but it needed to happen. In a way, it's innovative, and it allows a discussion to take place. But not everybody has to be at that extreme edge. Just like not everybody has to be a blank screen. And in fact, like nobody can be either one. But people write as if they are.

Carie's non-endorsement of an "extreme" relational approach is meaningful. She is aware that a radical rebuke to a traditional analytic approach exists, that there are theorists who write about and work at the "edge" of a relational paradigm. But this approach is, for her and for others, too extreme.

Michelle (Factor I), recently licensed and in her sixth year of practice, believes that the relational therapist needs "to be able to take risks." Earlier in her training, she was "not able to do that."

> I think that what happened initially when I just started doing therapy...I really felt like I was not sure what I'm doing. And in order to maybe stay cautious or on the safe side, I would resort much more to reflecting and using more Rogerian style which felt comfortable but didn't require me to be too active...Or to really share myself. To know when to share and how to share. And to make interpretations. So I think I was providing a very good holding environment. But I was not as active.

With experience and increased confidence Michelle has been able to take more risks and be more active with her patients. In addition, her exposure to non-dynamic approaches including cognitive behavioral and Dialectical Behavioral therapies has helped her to cultivate a more active stance.

For Nathaniel (Factor II), the existence of a relational paradigm is what sanctions his own "eclectic" stance. He says a relational approach "is the one I find most useful." He continues:

> You know there's a lot of different ideas that go in there...I mean that it's very broad and you can pick and choose, you know, within that.

Under the relational rubric, Nathaniel finds an assortment of ideas to suit him in his practice. For other trainees, a constructivist or relational mind-set is something they embrace in an unqualified way. Says Christopher,[28] "I grew up on like Sullivan and...the idea that you are always co-participating. You're always co-creating." Christopher associates a classical paradigm with a formula or regimen of techniques such as transference interpretation that will lead to a positivist "truth," to "a certain product, a certain result." A relational approach, in contrast, feels more in synch with his view that therapy is an "art" and not a science.

Beginners have mixed views regarding the merits of working relationally at this stage in their training. This matches the range of positions on training expressed in the literature (and reviewed above). In the introduction to this thesis, I cited the views of Joan Berzoff and Maria de Lourdes Mattei (1999), instructors and supervisors of beginning psychodynamic therapists, who have concluded from experience that beginners should not be trained to work from an intersubjective model. They recommend that new therapists first be instructed in classical analytic psychologies of drive, ego, object relations, and self psychology, with the frameworks they provide, as they learn to sit with and listen to their patients. An intersubjective approach, while of great value, poses unique problems for the beginner. They write:

> There is always a paradox and an inherent tension in expecting students to maintain a stance of not knowing when they are desperate to be effective and know something. Student practitioners need to understand whether the client suffers from a deficit or from a conflict. They need to know

[28]Christopher, who loaded negatively on Factor V, would have been grouped with Factor V-b, but his factor loading was just below the cutoff for inclusion on this factor.

> about the client's level of structure and psychological organization in order to know when to interpret and when to provide relational support. They need to understand the phenomena of transference and counter-transference *first as separate and only later as co-constructed* [italics added]...These tasks need to be accomplished before they can understand the subtle interplay between their own subjectivity and that of the client. (p.381)

Despite the PI's own challenge to this position, participants were sympathetic and expressed similar views. Melissa (Factor III), who identifies most strongly with an object relations perspective, felt it was premature for her supervisor to expect that as a beginner she could "have a feel for what's going on in the room" between herself and her patients. "To start with ideas of co-construction is bewildering," she says. Similar to the recommendations of Berzoff and de Lourdes Mattei, Melissa believes trainees should first be schooled in understanding patients' unconscious dynamics, conflicts, and diagnoses before moving on to the patient-therapist relationship.

Strikingly, the view that working intersubjectively is unsuitable for beginners is also held by *proponents* of this approach among the sample. Ben (Factor V-b) is one of two students who endorsed all Anchor Relational items, and yet, he too feels that the push to work intersubjectively is even cognitively too challenging for trainees who must sort through a great deal of incoming information as they learn to sit with their patients. Ben believes "we all start out one person" and become more two person or relational as we become more experienced.

A premise of this project is that a relational approach does force clinicians to tolerate a great deal of ambiguity and uncertainty in their work even as it affords an expressive freedom not considered appropriate under a classical paradigm. Berzoff and de Lourdes Mattei (1999) believe this to be the case for clinicians working intersubjectively; they conclude: "For the novice clinician, this uncertainty can be creative and exciting at its best; at its worst it can be relativistic and potentially damaging to the therapeutic endeavor" (p.374). Results of the study confirm that beginners, having been exposed to the relational critique of a classical analytic approach, do experience a mixture of freedom and excitement as well as wariness of a model that can feel unboundaried in its demands.

Students are encountering the paradox of desiring structure but also feeling constrained by traditional psychoanalytic practice frameworks. This tension was articulated by Serena (Factor IV) who said:

> It's so hard to manage so much when you are learning that I think having more strict rules helps you and guides you. But then as you start learning more, it restrains you. And then you feel like you can't really go anywhere.

Serena is a beginner who feels she has been freed by her introduction to a relational approach, and yet, she too acknowledges a need for greater structure on the part of beginners. Amy (Factor I) believes flexibility in practice and orientation comes with time but says, "When you're starting off, it's easier to say these are the rules and I'm going to abide by the rules." Joy (Factor I) says, "I think beginners are more rigid. I mean, there's

a need to be more rigid because you can't absorb everything in [sic] the same time. Tara (Factor I) agrees:

> When you're first starting out, you kind of wanna hold onto some tenets, rules, and things, something to guide you by [be]cause...it can be an overwhelming experience. There's so much uncertainty...The more you know, the more you can loosen some of the rules. The more you can integrate a lot of other perspectives and experiences.

For Tara, flexibility will come with time.

But not all students concur with the directionality of this structure-to-flexibility trajectory. Simone (Factor II) believes that beginners are, in essence, more flexible. They are "much more appreciating different...ways of understanding the patient. And different techniques." Over time, she says,

> You can become more critical of opposing views [be]cause you know more...It's not only knowledge. But also working with the patients and then deciding what's really working.

In a similar vein, Lisette (Factor I) describes herself as frequently "acting on feeling" or acting "impulsively" in her clinical work and hopes, with experience, to become "more informed...more objective about [her] countertransference." She hopes to internalize more structure, more rules to guide her practice.

Put together, these trainees are expressing a version of what Hoffman (1998) has described as the dialectic between the ritualized and spontaneous aspects of psychoanalytic work. The particular dynamic associated with being a beginning clinician leaves some trainees, like Amy and Joy, desiring a guiding framework. Others anticipate

that their practice will become more structured in the future. Simone cites the potential of the fresh and open-minded beginner to absorb different approaches. Alternately, Lisette describes herself as feeling a bit too free, wishing that her subjectivity and spontaneity were more bound. Serena describes how the desires for freedom as well as a framework co-exist in the mind of the beginner. One initially wants more rules, but that need can change when "you start learning more" and begin to feel constrained by these rules. In a learning process that is far from linear, one can assume that the desire for structure will surface again, alternating with the desire for freedom.

The presence of this freedom-framework tension may also be evidence on the training level of what Karen Maroda (2002) has described as a turning of the tide among advanced clinicians who initially experienced relief with the introduction of newer constructivist paradigms but who have subsequently grown confused, anxious, and frustrated with their relativism (p.102). Maroda argues that the problem lies in the failure of relational theorists to translate theory into practice.

> The analytic situation has expanded, leaving more room for the individuality of the analyst and patient, and more room for the unknown. It seems we are currently much better at talking about what we cannot know than what we can. As much as most clinicians understand that our countertransference contributes to the patient's mood, thoughts, and responses and feel comforted by the acknowledgment of this interaction, we are unnerved by the thought that nothing is absolutely knowable. We do not like questioning everything we think and feel about the patient. And we certainly do not like going from the position that we know

> everything to the position that we cannot absolutely know *anything*. Reluctant to prescribe any new techniques, we failed to translate adequately our theoretical revisions into new clinical practice rooted in theory. *Using one's intuition may work for experienced, master clinicians, but how can we teach our approach to young clinicians looking for guidelines and hands-on information* [final italics added]? (p.102)

The lukewarm acceptance of the relational alternative to a classical approach among beginning clinicians in this sample may reflect a failure on the part of its proponents to offer beginners something they can use, a structure to replace the traditional psychoanalytic structures they find irrelevant. Results of this study suggest this to be the case.

Christopher has found Maroda's assertion to be accurate. He has sought a model for his preferred relational practice in his work with a supervisor who is "very involved in the relational community." At year's end he said to this supervisor: "I feel like I still didn't get enough about how you work. It's frustrating for me." The supervisor's response was that Christopher was not sufficiently experienced for the focus of supervision to shift beyond the basics of managing the treatment frame. He reserves a more constructivist approach to treatment for his post-graduate supervisees. But Christopher protests, claiming to be comfortable with the ambiguity associated with working relationally:

> All you can do is keep on trying to clarify, keep on trying to clarify the interaction...As opposed to the classical guys who are more confident in what's going on...They make more definitive statements. And that serves

> the purpose, for whatever it is. You know, to me, I see it as just irritating the patient. And...making them have a transference reaction, and it's kind of a reaction to someone who maybe made an un-empathic, definitive statement about something in their experience.

For Christopher, the structure and rigidity he associates with a classical model is a strong detractor. In a relational approach, he continues, "It's harder, I think. Because you don't have these rules. And you're searching around. But I think that's the nature of relationships anyway."[29] Christopher accepts that there are fewer rules under the relational paradigm, and yet he still wants to know *how to work* relationally. Furthermore, as a marker of the diversity of opinion in the sample, we can compare the views of Christopher with those of Ben. They are both inclined to adopt a relational paradigm but have very different ideas about what beginners need.

Mills (2005) sees the relational approach as having revolutionized analytic training, ensuring the demise of the "prototypical solemn analyst who is fundamentally removed from relating as one human being to another in the service of a withholding, frustrating, and ungratified methodology" and, in its place, encouraging "free thinking, experimentation, novelty, spontaneity, creativity, authentic self-expression, humor, and play" (p.177). In Mills's view this amounts to "the relational position's greatest contribution: the way they practice" (p.177). But he concedes that changes in *practice* have not ensured the development of a teachable methodology or technique. Put differently, the paradigm as it exists suffers from disconnects among the strands of epistemology, theory, and practice.

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[29]Again, the appeal to "relationships anyway" recalls Adina's (Factor V-b) appeal to "relationships in general" as a marker of how to work relationally.

This disconnect perhaps begins to explain what this researcher found to be genuine confusion among beginners with respect to exactly what the term ‘relational’ means or encompasses. Consider the following responses from participants across all factors, when asked to describe their association to a relational approach. To begin with, trainees are sorting out the terminology of relational vs. interpersonal vs. object relations:

> I’m not sure I can give a definition because I always get a different definition. (Joy, Factor I)

> Different theories fall under it. You know, actually focusing on the relationship in a session and what’s going on between the two people....It’s broad, it could mean a lot of different things. It’s not very specific. But I like that. (Nathaniel, Factor II)

> PI: If I said relational, a relational approach, what does that mean to you? What do you think of? What are your associations?
> Simone (Factor II): Well, I would ask is it more interpersonal? Is it more object relations?

> Relational, interpersonal...It isn’t always clear where...one begins and the other ends. (Talia, Factor I)

> I think the interpersonalist does more sort of, you know, Sullivanian inquiry, where you really try to sort out what’s coming from the past, and

> really what's in the present now...I think of a relational person...it's probably harder to define than interpersonal. Oh my God. I think of relational as being more about the like, collaborative co-construction of a personal narrative. Okay, that's it. So, that the emphasis is on the person's experience…with less emphasis on whether it's a distortion or whether it's reality. There's less of that teasing apart of distortion and reality. It's more [of an emphasis on] like personal meanings and...creating like a cohesive narrative of the person's life story. (Zoe, Factor I)

If the results of this study force some relationalists to question the state of relational theory and practice in the minds of beginning clinicians, they might consider that beginners cannot be expected to identify with a paradigm that they cannot fully define, whose theoretical parameters are unclear. However, when participants did undertake to define or share their associations to the term 'relational' there were commonalities among their definitions:

> I think the focus is more on the real relationship. On forming a meaning of the experience together. Mutuality. But I think that within relational, there are like a dozen different ways to do it. (Amy, Factor I)

> I guess I think of there being less control and more likely to talk...Relational is actually [the] more current mode. That's more interactive and more likely to have conversations...you know instead of

one person interpreting the other, you're working together to construct something. (Daniel, Factor IV)

Something about the quality of the analyst's presence in the room. The analyst is more open to sharing their own experience, to being used by the patient. It's about being more attuned to countertransference reactions, it [refers to] a quality of openness. The subjectivity of the therapist is not denied or undervalued. (Anna, Factor III)

[The] emphasis more on the [patient-therapist] relationship. Talking more. More self-disclosure. (Joanne, Factor VI)

I would say...really looking at the relationship between the therapist and the client and recognizing that it's representative of relationships in the outside world, and really...using that relationship, including the therapist's own countertransference, you know, in order to help the patient recognize patterns with relationships in the outside world. Yeah, I mean, I just think really here and now, like there's a big connection, you know, here and now but applying it outside. (Sandra, Factor V-a)

Really thinking about two-person psychology and really focusing on the relationship between patient and therapist and what emerges in that. And that being the kind of window into somebody's relational pattern and

> really being able to work very specifically moment-to-moment and, you know, really specific interactions, and tease them apart with somebody, be they maladaptive or not. (Hope, Factors I and VI)

> It's important that the patient's perspective on the therapist is through a particular lens...The patient has an internal representation in the therapy...And that it's really important to stay attuned to what that perspective is. And then to be able to see that difference between what the patient perceives you as and then who you are...In relational therapy, I help the patient make those distinctions. And in classical therapy, the patient through some free association...will come to that on their own. And I think that's just too much to ask....In relational therapy, I see the therapist as having a key role...You could offer something, based on who you are, that helps shift the patient. (Amanda, Factor IV)

> I think more of…an emphasis on two people being in the room...And not just an object relationship but...people being in the room and there being a relational matrix that is formed. And therefore, you know, the therapist being responsible for what she's bringing into the room. And then also an emphasis on you know the here-and-now interactions. (Adina, Factor V-b)

Certain themes are consistent across students' associations to a relational paradigm: a focus on the patient-therapist interaction; a therapist who is more active, more interactive, and disclosing; increased use of the therapist's own experience and countertransference; a

co-construction of meaning; increased talk or conversation and less interpretation; less of a focus on the past and more on the here-and-now or in-the-moment interactions.

To be sure, the crossover of terminology and themes in these attempts at definitions points to a consistency in the way beginning clinicians comprehend a relational approach to psychodynamic practice. But the looseness and variability in the definitions—as well as some trainees' struggle to come up with an answer and other trainees' sense that "there are a dozen different ways to do it"—betrays confusion. It is as if they know the right ideas but not necessarily how to string them together. They understand the general intellectual or epistemological premise of the relational challenge but not the practice implications. Others believe they know what relational practice looks like but do not find the theoretical framework to be meaningful. To my mind, the inconsistency in these results is more compelling than the commonality of themes.

To review, this study found only two students who endorsed all Anchor Relational items. Ben, loading on Factor V-b, endorsed all Anchor Relational items but believes beginners should start out "one person." Adina, who also loaded on V-b, describes her orientation as "psychodynamic" and "eclectic." For the majority of the sample (Factors I, II, III, IV) the identification with relational views is selective. The students who load on Factor I adopt a two-person epistemology but only three Anchor Relational ideas, and some of these trainees resist the relational label. One of the therapists who loads on Factor III cites object relations as her orientation but is decidedly opposed to the constructivist stance that was the bias of her interpersonal supervisor. Trainees loading on Factor IV believe that self-disclosure is inevitable (Anchor

Relational item #11) but allow that it is more likely to serve the needs of the therapist than the patient (Anchor Classical item #43).

The data reveal disconnects among the labels used by beginners to identify their own orientations and the practices they endorse. Some students are practicing according to a two-person or relational model while not taking on the labels. Furthermore, the language used above by students to define 'relational' is found not only in Anchor Relational items but also in Bridging and Split Consensus items such as these:

[3 0 1 0 -3 -2] 1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality. (S)

[2 -1 2 2 -1 3] 14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)

Certain ideas identified by students as relational are, in fact, more mainstream than they realize. This accounts for students listing "relational" among their orientation descriptors but loading on factors with few highly ranked Anchor Relational items. Of course, this is also an indicator of the degree to which the field has integrated principles that originated with the relational critique of the classical model (Mills, 2005).

With the exception of Factor V, Anchor Relational items are *not* grouped together in the way that Anchor Classical items are. For the most part, Anchor Relational items were selected out by students loading on several factors and used to construct configurations of views that were otherwise formed with items that bridge orientations or divide the experts. I conclude from this that many students in this sample identify with a relational ethos, that they pick and choose among ideas originating from a relational paradigm or titrate the concepts that appeal to them, for example, with respect to use of therapist disclosure or a more narrowly-defined object relations framework (Factor III).

In the introduction to this thesis I questioned whether it was possible to take on a particular epistemology but not the associated practices. Results indicate that beginners are attempting to do just that. They may have adopted a generalized constructivist "two-person" posture or a vaguely relational orientation but are selective in the practices they adopt. Additionally, they do not feel compelled to buy into the paradigm as a whole or take on the relational label. The trainees in this sample reject a classical approach in favor of a non-polarizing theoretical middle ground, but they also feel free to draw from a classically-oriented position when it serves their need, for example, to express the desire for more structure or expanded practice options. Nowhere is this unevenness more evident than with respect to the issue of therapist neutrality.

Disclosures vs. non-disclosures and the persistence of 'neutral'[30]

The issue of therapist disclosure vs. anonymity and the meaning of therapist neutrality are among the most perplexing issues for beginning clinicians. Students loading on all factors talked about their struggles to balance the need or wish to remain neutral to some degree ("I think neutrality is important in providing space for a patient to say anything he or she wants" - Ellen, Factor II) with the view that neutrality is never entirely possible ("Being neutral is fairly impossible, just looking at us people know stuff about us. But I aim to be neutral" -Sandra, Factor V-a; or "I'm very expressive. So how can I be neutral when my body is not neutral?" -Serena, Factor IV). Therapist disclosure is complicated for how it brings therapists into contact with an element of risk and exposure that can be a source of discomfort. Moments that push for disclosures or non-disclosures also represent choice-points for therapists, moments in which the decisions made may affect the course of treatment ("And so part of me thinks...maybe if I could

[30] This heading is offered with a nod to Paul Wachtel (1987).

help build the alliance with him by being less neutral...It's hard to juggle…when do you disclose? When do you not?" -Daniel, Factor IV). The anxiety associated with being a beginning clinician makes these moments all the more charged.

The issue of therapist disclosure emerged as one of critical importance for this sample, with students' personal struggles mirroring debates in the field regarding appropriate therapeutic boundaries (Mills, 2005).[31] In the review of the literature I cited J. Timothy Davis (2002), who describes how learning to work with disclosures is a central challenge for beginning psychodynamic therapists. In contrast with Berzoff and de Lourdes Mattei (1999), who are wary of beginners disclosing, Davis argues that beginners are at equal risk for errors of *withholding*.

> It is unavoidable for psychotherapists in training and their supervisors to grapple with "the question of the degree and nature" of the use of self-disclosure by the beginning therapist with respect to each patient. Of particular importance is providing assistance to the beginning therapist in reflecting on and managing the countertransference temptations that often influence decisions to self-disclose, as well as decisions to withhold self-disclosures. (p.443)

The disclosure vs. withholding dilemma is complex because it cuts very quickly and directly to the heart of a central challenge of clinical practice for beginners: It brings them into immediate contact with the feelings evoked in them by their patients and, potentially, the full force of a patient's transference. Davis says that learning to be open to and work non-defensively with patients' intense transference reactions is "perhaps the

[31] According to Mills (2005), therapist disclosure is among the most controversial and divisive issues in the field. This controversy emerged as a result of the relational challenge to the disclosure prohibitions associated with traditional analytic practice.

most important line of development in practicing psychoanalytic psychotherapy" (p. 442). Davis is speaking to the intensely personal nature of clinical work, to how emotionally involving it is, and acknowledges the pressure on beginners to learn to mange their own intense reactions.

Zoe (Factor I) concurs. When asked what beginning clinicians need the most to be able to do their work she replied:

> What do beginner's need? Wow. Honestly, I think beginners need their own therapy...I think if someone really was aware of themselves that they could work effectively like that because they would, you know, know what to disclose and how to work that way in a way that wouldn't be confrontational or angry or reactive.

For Zoe, the link between self-knowledge and the management of countertransference reactions and disclosures is an obvious one.

The issue of therapist disclosure, itself a fashionable subject (See article by E. Goode, *The New York Times*, 2002), may be so not only because the possibility of a disclosure challenges, as Eve (Factor IV) said, traditional "taboos." I propose that uncertainty in matters of disclosure and therapist neutrality has them functioning as proxy issues for the general anxiety associated with learning to work as a therapist. Choice points about how expressive, participatory, revealing, or anonymous one is to be as a therapist are moments in which the tension between desiring freedom (a sanctioned disclosure) and a structured framework (as represented by a prohibition against disclosures) are actualized. What is critical, as Davis notes, are not the actual disclosures

but the intensity of feeling evoked in the therapist by the transference and in the decision-making process.

It is my impression that the Q-sort items that addressed issues of transference and countertransference evoked less commentary than the items about disclosure. This may reflect the fact that beginners are more preoccupied with the dos and don'ts, with the manifestation of core challenges of managing our feelings, than with questions about transference or countertransference. As Gill (1984) said, with respect to transference, "the therapist is likely to see only that which he is capable of dealing with" (p.175).

No controversy over countertransference

The power of countertransference to evoke or stifle a therapeutic intervention is key to Davis's description of therapist disclosure as a central training dilemma. The ranking of the following two items, those with the two highest mean scores, reflects the degree to which trainees accept as a given the centrality of countertransference in their work.

[3 0 4 3 3 3] 25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding is inevitably filtered through our life experience and perceptual inclinations. (B)

[3 3 3 4 1 2] 20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion. (B)

These items emerged from the Q-sort as non-controversial Bridging ideas. Trainees in this sample take as a matter of course their deep and emotional involvement in their clinical work and the impact of their subjective experience of a patient on the therapeutic process.

There was also little disagreement about the *impact* of this subjectivity on their treatments. Item #28, below, was the second lowest mean ranked item (meaning it was strongly rejected) in the study and #14 was the eighth highest (meaning it was highly endorsed).

[-3 -2 -3 -3 1 -1]	28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely *can* be controlled, are not appropriate. (AC)
[2 -1 2 2 -1 3]	14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur. (B)

In interviews, many students rejected the view that countertransference was something that could be controlled or that such a disclosure was never appropriate. Statement #28 was placed in the neutral range of Factor V-a's distribution, implying only the mildest of agreement from this classically-oriented factor. Furthermore, the view that countertransference enactments are inevitable (item #14) was also generally accepted or only mildly rejected.

Bearing in mind Davis's argument, the placement of these items belies the complexity of the matter. It may be that while the impact and use of countertransference are personally challenging, they are, for this sample, *theoretically* non-controversial. Students take for granted that they will be forced to reckon with their countertransference as clinicians. Berzoff and de Lourdes Mattei (1999) may be correct that beginners require more structured guidance and exposure to traditional frameworks as part of their training. But, as I have suggested, these authors fail to acknowledge the extent to which students are, in their practice, having the kinds of clinical encounters that put the use of

one's subjectivity to the test moment to moment. Davis's call for providing students with the guidance to help them face these moments head on, regardless of how their subjectivity is used or expressed, would meet the real needs of trainees today.

Flexibility: The journey from theory to practice and back again

A dominant theme for most of the participants in this study is that of flexibility. It was cited as a priority for trainees loading on Factors I, II, and VI, for some of the Factor IV trainees preoccupied with disclosure, and for Sandra on Factor V-b. Interviews clarified that this concept has different meanings for different trainees. For Simone (Factor II), it reflects the tentativeness she experiences as a beginner, a marker that she is still learning and not sufficiently experienced to commit to a particular model of practice. For Ellen (Factor II) and Hope (Factor VI), it is a value of clinical practice they hold dearly. For Joanne (Factor VI), it was a lesson learned of necessity on the job.

The flexibility found here is most akin to what Wachtel (1997) has described as "technical eclecticism," reflecting a "willingness to look in all directions for techniques that work rather than limiting their search to those produced by only one orientation" (p. 303). It is flexibility primarily at the level of practice. Overall, participants in the sample acknowledge their freedom to choose among different approaches and to select the technique that best meets the need of a given patient at a given time. Eve (Factor IV) declared that being a "whole person" as a therapist means being responsive to the patient and to the clinical imperatives of a given moment rather than being bound by "rules" or any one "canon." Ellen (Factor II) does not want to be like a "lemming" that follows any one supervisor or dictate. Hope (Factors I and VI) imagines that she will remain flexible even with more experience.

In the introduction to this thesis, I questioned whether students experience a dialectical tension between the pull of disparate theories and models of practice that exist in the literature (Hoffman, 1998). While students have been exposed to the polarization of paradigm—a Freudian analyst followed by a relational analyst, supervisors with opposing views, warring professors of different orientation—the frequent appeal to flexibility points to an inclination toward open-mindedness. Trainees are resolving the pulls of opposing orientations to a greater or lesser degree. They may experience tension in the moment on certain matters, such as therapist disclosure, but do not feel the necessity to choose one orientation in a way that completely precludes some acceptance of another.

For example, Sue (Factor I) struggles with how neutral or participatory to be in her treatments, and she is aware that different approaches represent theoretical debates in the field but says:

> I almost don't pay as much attention to that...I'm learning what works best for me and my patients, and that's more important to me than what [sic] the books and the journals and who's arguing what.

Her peers in the sample find the tension in the field baffling and unhelpful.

> It's only now that I'm understanding the feuds between the different schools of psychoanalysis just within New York City. How, you know, one school completely disagrees with the other, etcetera. I didn't even have any idea that that existed. (Claudia, not loaded)

> There's some rivalry. An important person in our faculty and my relational supervisor have like a huge problem...and people have camps about it. You know, are you gonna go with him or are you gonna go with him? And, like, as far as I can tell, it's just a personal problem. (Joy, Factor I)

> The polarity in the literature is unnecessary. The consequence is that people think the schools are so different. Some things are, like transference interpretations and the way that is exclusively supported in classical analysis. But other than that I don't think the importance of relationships is so different. A lot is made of therapist self-disclosure, but even within new trends there is disagreement. [There is an] unnecessarily divisive effect of the way folks talk about things. (Ellen, Factor II)

Trainees have reckoned with the impact of theoretical tensions in the field, finding it counterproductive to the training process. They have managed their discomfort in different ways. When Simone (Factor II) referred to a particular orientation she made quote marks with her fingers, signaling an ironic relationship to labels and estrangement from them. Her current stance is an integrative one, although she imagines that in the future her orientation "will be much more fixed."

Lori (Factor I) feels she has internalized the tension between older, more "conservative" classically oriented professors and younger interpersonal or relational professors in her doctoral program, particularly with the "pull to pick a camp" when choosing a faculty mentor. She says, "There's definitely a division. And I think it's hard as a trainee to kind of navigate that." The tension led her to dismiss, perhaps

prematurely, all aspects of a classical approach. And yet, even within the relational parameters that appeal to her, efforts to elucidate the differences between relational and interpersonal have been unsuccessful.

> I've asked numerous people over the years, like what's the difference really? And the only consistent answer I get is politics.

The whole realm of theory is unnecessarily murky and politicized.

Sandor (Factor I) reportedly chose his graduate program because it is one that would expose him to different theoretical orientations so he could "integrate" or try on "different hats." His own approach is a mixture of drive structural, object relations, self, family systems, and cognitive behavioral techniques, but mostly he does not think about orientation, preferring to use the patient as the guide. The only tension he has encountered is with supervisors who do not integrate. He encountered such tension with both classical and interpersonal supervisors during internship. But the struggle remains an externalized one.

> So that's [in supervision] where I've faced a certain degree of conflict when it comes to integrating models. Not so much in figuring out how to do it in my own work, but then working with someone who's a little more of a purist and doesn't draw from so many sources....So when I think about tension in the field I think about the various infighting within the department in my program or even within the analytic community.

The focus of Sandor's energy and attention is largely below the radar of theoretical disputes. Certainly any dialectical tension that trainees do experience—far from being energizing, as Hoffman (1998) suggests—is counterproductive.

More relevant than any one orientation, for Sandor and for others in this sample, are approaches that are "flexible," "eclectic," and "integrative." Sue (Factor I), for one, considers her orientation to be "psychodynamic" and "interpersonal." However her clinical experience with a range of populations has taught her "that that doesn't always work with everyone. And that you have to be really flexible to be able to work with a much broader range of clients." This has shaped how she construes her own orientation:

> I think that an eclectic bag of tools with a psychodynamic, psychoanalytic understanding of the patient is sort of the way I intend to work. And I think that's what's best for me, and hopefully for my patients.

Moreover, some beginners have the impression that flexibility is what the field requires of them. Says Sandra (Factor V-a): "I always assumed that I will be a very eclectic therapist, which I think is kind of the popular way to go now." Margo (Factor II) says similarly:

> I don't think anyone works clean. You know, just one theory in mind. And I don't think it exists much anymore.
>
> PI: At any level?
>
> Margo: At any level of experience.

Margo imagines that, in the future, she will get better at integration: "I hope I won't be focused just on one theory...I don't like theories...I think it limits."

Having felt free to reject the structure of a classical analytic paradigm, and with no rigidly defined or fixed paradigm to replace it, today's trainees choose among different points of view and/or prioritize ideas and practices that fit within diverse theoretical paradigms. The appeal of flexibility, as well as the broad appeal of Bridging

statements in this study, points to the a-theoretical tendencies in this sample. By and large, trainees are not theory driven in their approach to clinical work. There are some exceptions: The students of Factor III define their orientation as object relations, and Leila (Factor V-a) is clearly bound by a classical analytic approach. But the eclectic students loading on Factor II are completely unbound by theoretical pressures, and the students loading on Factor IV, struggling with questions of disclosure, are caught between the implications of different theories. Students loading on Factor I are the clearest example of those who have taken to certain principles in what amounts to a loosely theoretical two-person approach.

Despite some beginners' negative feelings about relational psychoanalysis and its influence upon their developing orientations, the flexibility they value may reflect one aspect of the relational challenge's impact on mainstream practice and training. Mills (2005) suggests that relational practice is characterized by "malleability."

> The relationalists demand malleability in the treatment frame rather than applying a rigid, orthodox, or authoritarian procedure; malleability is necessary in order to cater to the unique contingencies of dyad, and this necessitates abolishing any illusory fixed notions of practice that can be formulaically applied to all situations...*The best we can aim for is to have an eclectic skill set (under the direction of clinical judgment, experience, self-reflectivity, and wisdom) to apply to whatever possible clinical realities we may encounter* [italics added]. (p.180)

The pull to eclectic practice, to flexibility, and to using the patient as a guide all may reflect a relational sensibility among beginners regardless of how relational they believe

themselves to be or their affinity for the label. In this environment, Mills says, "The question of uniform technique becomes illegitimate, because context determines everything" (p.180). As has already been discussed here, this relativism poses a particular challenge to the beginner who may be tempted to conclude that "anything goes" (p.180). Among the participants in this study, a strong theoretical allegiance appears distinctly out of vogue while an attitude of flexibility is reinforced. Beginners have thus, perhaps, been tricked by the field into thinking that technique equals rigidity and so believe that in order to be as flexible as possible they must remain aloof to all theories. This carries the danger of simply not thinking through clearly enough the basis for what one is doing or of confusing a theoretical label with theorizing per se.

It is also possible that new practitioners are unavoidably blind to theory and prescriptions for technique. On the beginner's journey from theory (the classroom) to practice (the consultation room), theory frequently gets lost along the way, if only temporarily. In the words of Serena (Factor IV):

> I think when you're sort of starting out the last thing you're thinking about is whether the id, superego, or anything—I mean, you're thinking about what the hell I'm doing in this room...When you're sort of learning you're slowly, you know, trying to figure out what you believe in and how you're gonna work, and how everything plays a role.

As a beginner, says Serena, it is frequently hard to connect what is going on in the room to a given theory. The theoretical discussions that seem relevant in supervision are less prominent in the moment when, as Serena says, "I have to think about what I'm gonna

say next." Tara (Factor I) concurs that theoretical concerns are frequently too much for beginners to hold in mind.

> It's not always easy at the beginning to integrate, like, theoretical ideas and practical ideas and try to hold it all into your head. But I think...the more you go on sometimes the theory becomes clear. Like, 'Oh, now I understand this.'

Tara describes how the journey of the beginner is one from theory to practice and back to theory again. From her perspective, one learns best when one has had diverse supervisory experiences. Once again, flexibility is the solution.

For Claudia (not loaded), the gap between theory and practice is one she nearly takes for granted at this stage. Rather than being instructed in meaningful differences among different theoretical perspectives, she says:

> We were taught sort of this blob of theory without really understanding what the different pathways were...We learned a little bit about the various theorists but nothing that could...help me figure out how to work with an individual client. You know, you just kind of worked your way through it with your supervisor. And really theory didn't inform much of my practice of what I did.

It may be the lot of beginning clinicians to be at a loss to understand the finer theoretical distinctions in their struggles to integrate theory and practice. Claudia and Tara have attempted to make this integration happen but have met with professional and pedagogical obstacles to doing so. Others, like Ellen and Sandor, may be perfectly happy to exchange theoretical options for an integrative or eclectic stance, for flexibility. Either

way, theoretical proponents, whether relational or classical, are unlikely to find many followers in this sample. Some trainees may truly be developing an integrative stance, in which the "theoretical underpinnings of the separate approaches" are combined to construct an "encompassing and overarching theoretical framework to guide both therapeutic work and our understanding of personality development and dynamics" (Wachtel, 1997, p.307). Other trainees are simply dis-inclined to ally with one paradigm. What are the implications of this disinclination toward theory?

Wachtel (1997) has advised clinicians that there are

> dangers [to] keeping theory in the background. For when it is kept hidden like an embarrassing relative one would rather the world not notice, theory is not eliminated but simply unexamined and, thereby, rendered especially capable of leading us on a voyage of its own making, without one's realizing what has happened. (p.310)

These words evoke the Factor I two-person therapists who are not necessarily anchored in any particular theoretical model. Alternately, it could apply to the eclectic therapists of Factor II who expressly value their freedom from theoretical allegiance. These trainees sometimes speak as if they are on a voyage of their own making, whether out of necessity (insufficient exposure to or only cursory instruction in different models) or an inability to translate theory into practice.

Beginners may find themselves so frequently at sea with respect to theory precisely because of this translation gap. Different theoretical models and paradigms do have different practice implications. Training programs must make a concerted effort to ensure that the theoretical literature not remain unexamined, even with the understanding

that beginning clinicians, in the moment, may not be able to make use of what they have studied. Training programs can also endeavor to make the practical implications of different theories more explicit, providing greater structure to a learning process that will nevertheless remain a highly personal and unpredictable one. Learning to become a clinician is a personal voyage, but trainees need not be so untethered as they find their way.

In supervision, even the most theoretically muddled or disinclined trainee would benefit, in this writer's view, from being invited to articulate his or her orientation, stance, or epistemology, whether or not these views ally with a particular orientation delineated in the field. Such an articulation could take place at a point well into a particular treatment and would enable the therapist to recognize what aspects of his or her approach are driven by a particular "theory" about the case, by his or her personality, by the supervision, or by the transference-countertransference dynamic. The framing of one's own views would be, itself, an exercise in developing the therapist's own self awareness. Borrowing a page from Berzoff and de Lourdes Mattei (1999), an effort could also be made to help a supervisee construe a case from the frameworks of different orientations as an exercise in the application of theory and as a means of gaining perspective on one's own approach via consideration of alternate approaches. Each of these efforts, in the classroom and in supervision, would help students make the trek from theory to practice and back to theory once again.

Limitations of the study

The Q-methodology literature (Brown, 1991-1992; McKeown & Thomas, 1988) cites the sufficiency of small samples to generate meaningful data, "qualitative categories

of thought" that would not necessarily be enriched by additional participants since no single factor score would be affected by increased sample size (Brown, chap. 7, ¶3). That said, researcher and reader alike will legitimately question the degree to which results of this exploratory study are generalizable to other trainees. In additional administrations of the Q-sort, of interest would surely be the replicability of the seven factor groupings, particularly the factors comprised of small numbers of participants. The sample size of 30 may thus be taken not as a limitation of the study, per se, but rather as a feature of the project of which the reader should be aware as she looks to the broader population of trainees with an eye towards recapitulating these categories or locating seeds of still more viewpoints.

Participants in the study were, however, limited in what they could convey to us by the domain of Q-sort items they were presented with. Despite efforts to create a comprehensive set of statements, certain ideas were surely missed. In the midst of the exercise participants were asked to reflect upon any missing items. Several suggestions were offered. One participant noted the relative absence of any explicit reference to power, specifically the power of the therapist, a salient and charged issue for beginners new to their role. Other suggestions for missing items included the role of humor and "the idea of playfulness or play." Another participant sought a reference to bodily experience as a feature of treatment. Related to this, several students expressed confusion about item #2 regarding the influence of biologically-rooted drives. They sought clarification that the card was indeed referring to analytic drive theory and not to biology in general, as they were seeking a statement that would speak to their conviction

regarding the biological bases of many mental illnesses, another issue not addressed in the Q-sort that may impact clinical practice.

The Q-sort did prove effective in de-constructing ideas and practices from orientation labels and providing participants with the means to select the priorities of importance to them apart from these labels. The expert validator ratings (in delineating the items as relational, relatively relational, etc.) in effect, permitted a *re*construction of the Q-sort items back into the orientation classifications, while also suggesting other groupings. Seven groupings of participants emerged as a product of the exploratory factor analysis applied to the Q-sort data; it has been acknowledged that these represent *viable* groupings, *plausible* configurations of student views that would have varied with an alternative factor loading cut-off or factor solution (for example, a four- or five-factor solution as opposed to the six-factor solution used), each legitimate. The selection of a six-factor solution allowed for more nuanced distinctions to be evident. Fewer factors might have brought into greater relief some of the paramount distinctions while obscuring other meaningful ones. But as McKeown and Thomas (1988) have noted, Q-methodology is often driven by theoretical choices, not simply statistical criteria.

> At a practical level, common sense offers the best counsel when determining the importance of factors, that is, their contextual significance in light of the problems, purposes, and theoretical issues in the research project. (pp.51-52)

The use of the six-factor solution was guided by the wish to ensure that the widest range of views would be represented. The findings of this study could be used to guide methodological choices in future administrations of this Q-sort.

Another limitation of the methodology was made evident in the configuration of Factor VI, and to some degree of Factors II and V-a, where interviews with participants revealed disparities in the motivations of trainees with similar Q-sorts. The groupings reflect similarities in what these therapist trainees believe and do. Loading on the same factor, however, does not mean that participants' views are identical or that they do not also share the views of their peers loading on other factors; it also does not account for the differences in motivation or the contexts in which trainee's views are evolving. An alternate factor solution would have yielded a variation in these groupings. This only reinforces the need for follow-up with Q-sorters, whether by interview or other means, to explore the thinking behind participants' sorting choices.

The on-the-spot interview and review of the Q-sort distributions valuably captured participants' thought processes at the point at which they had been evoked. A disadvantage to this approach versus post-hoc contact with participants is that the interview protocol was shaped by the questions guiding the study. Alternately, interviews conducted following the factor analysis of the entire data set would have made it possible to refine the interview based upon the study's *findings*, inviting all participants speak directly to questions that emerged from the data. As it was, the interviews were guided by each participant's Q-sort and by the statements the participant favored or disfavored. Each participant thus spoke to overlapping but different sets of issues, rendering uneven the ways in which the interviews could be used for the purpose of data interpretation.

Another obvious limitation of the study was its focus on psychodynamic orientations. This choice reflected the bias of the PI's training to date but was also an

effort to limit the scope of inquiry, affording the project a measure of depth if not breadth. Lacking (although it came through a bit in interviews, such as with Michelle, Factor I) was an exploration of the influences of non-psychodynamic orientations and practices on the training of these clinicians. Participants were recruited with the intent to attract psychodynamic therapist-trainees. Participants' non-psychodynamic descriptors were noted in their profiles. However, this study invited participants to bracket these non-psychodynamic experiences with the result that a fuller understanding of their richness and impact upon trainees' development—even upon their psychodynamic work—were not well captured. It is this writer's more recent experience that the impact of non-psychodynamic models inevitably bleeds into one's thinking and practice in any framework.

Questions for future research

The first and most obvious question concerns the replicability of these findings among other student populations or among other therapist samples. It would be particularly important to see if the factors with the smallest numbers of student loadings are replicable. In particular, is there a viable "object relations" or "eclectic" factor. With further administrations of this Q-sort would the two students loading on Factor V-a, the "classical" factor, be joined by others or would this factor remain a distinct minority view?

Future research could also involve re-administration of the Q-sort with the current sample to determine how students' views evolve. With a similar aim, the Q-sort could be completed by an unrelated sample of therapists 10 (or some number of) years out of training. Assessment of slightly more experienced therapists would test the durability of

the themes found in these six groups and reveal whether these are uniquely ‘beginner themes’ or whether they are to be found universally among psychodynamic clinicians. I would hypothesize that the trainees who loaded on Factor IV, with their preoccupation with therapist disclosure, would be grouped differently with more experience. They may be led to adopt an eclectic stance that reflects a willingness to draw from different approaches. Alternately, increased experience with therapist disclosure may lead their views to coalesce more firmly around a particular epistemological position, either one-person or two-person in nature.

Additional administrations of the Q-sort would test the patterns found here regarding the groupings of Anchor Classical and Anchor Relational items. If other samples of therapists, especially more experienced groups, were found to be more polarized in their groupings, this would provide data about the particular value of Bridging items, of bridging *ideas*, for beginners.

In future administrations of this instrument an effort could be made to pair participants, perhaps supervisors and trainees, clinical training directors and a sampling of doctoral students, to assess matches and discrepancies of views in these training relationships. Such an exercise would provide trainers with a litmus test of their student therapists with an eye towards shaping curricula or guiding supervision.

Further research may be conducted on this data set, with greater attention paid to the coding of this interview data. One line of investigation could involve teasing out further the meaning of terms such as “flexibility,” “eclectic,” or “integrative,” etc. to determine what kinds of differences exist among students who refer to themselves with these labels.

Practically, this Q-sort could be administered to larger numbers of students in a way that could be less labor-intensive. While it would necessitate a change in the approach to collecting interview or follow-up data, the Q-sort itself could be easily administered by others (not only PI) or even self-administered.

Conclusion

This study was designed to invite a comparison of viewpoints *apart* from orientation labels. The finding that the most widely held views are those that bridge orientations is certainly a positive one, signifying a measure of harmony among the upcoming generation of psychodynamic clinicians and a willingness to look beyond dividing lines of orientation. Nevertheless, I conclude this discussion with a reflection on how the data raise questions about the relevance and primacy of theoretical frameworks for beginning clinicians.

This has been an abiding concern of mine since the start of my training. My own archival research yielded a paper written in my first year of graduate school in which I explored my relationship to theory as a new student. I wrote:

> As a first year doctoral student, I have newly made a high level commitment to the field of psychology and wish to arm myself with theoretical terminology. Becoming conversant in the language of the field is an important step toward developing my identity as a clinical psychologist...My new fluency will sanction my presence in the field.

At that time, I imagined that learning to talk the talk of clinical theory would be (at least part of) my ticket to feeling like a legitimate psychologist.

> I am coming to see this desire for theory as perhaps a way of concretizing a more abstract desire for an authoritative voice handing me answers to my as of yet unstated questions.

Like my peers in this study, at the earliest stages of my training I sought out rules to guide me in my work, hoping that theory would have the power to help me manage the anxiety associated with becoming a clinician.

When the above words were written, I was poised to make the transition from the classroom to the consultation room. As of this writing, I am facing the transition from beginner to (as they said back in summer camp swim class) advanced beginner. This project emerged from questions that arose for me as I began to make my way from the realm of practice back to theory once again and wondered how my peers were experiencing the same journey. It occurs to me now that while the newest clinicians are often too overwhelmed to make use of the book learning that predated their entree into clinical work, slightly more advanced clinicians[32] are ideally poised to return to text study. With the benefit of some clinical experience behind us, a more integrated approach to the study of theory and its application can proceed more meaningfully.

Typically, however, the advanced doctoral student is increasingly immersed in clinical practice to the exclusion of other kinds of learning. At this stage, clinical practica take the place of theoretical course-work. In these case-study seminars, the learning process is driven by the clinical material presented while more organized examination of theory is limited. Students' energy is frequently focused on the clinical challenges they

[32]Recall that Ben (Factor V-b) believed that beginners are all one-person clinicians and then become two-person clinicians as they gain more experience. The timetable he suggested for this transition was five years. This raises questions about more subtle potential differences in the current sample between the attitudes of second year students and those who are in their fifth or sixth years of practice.

and their classmates are encountering. But this setting is perhaps a missed opportunity for meaningful discussion about theory and its applications. The fate of theoretical examination is left to the individual student who may or may not endeavor to read and learn more on her own. The effort on the part of training programs and supervisors to interweave theory and practical instruction might serve to increase beginning clinicians' engagement with and understanding of different theoretical models, usefully, as their base of clinical experience grows.

As I have begun, now, to practice in contexts other than the campus and community clinics where I have trained, questions of what I believe and what orientations are represented by my views are very much on my mind (and my time to re-engage the literature even more limited). Once again, I find myself craving the structure and guidance that will enable the lessons learned in graduate school to crystallize as I encounter new clinical phenomena and work within new treatment frameworks such as cognitive behavioral and Dialectical Behavioral therapies. At the same time, I am curious to test the limits of my freedom in new clinical settings and wonder how my voice as a clinician will evolve. As a therapist, I have more autonomy than ever before, and yet I feel myself to be calling out to theoretical frameworks for a deeper understanding of the phenomena I am encountering. It is my hope that my newest mentors will nurture this process and support the dialectic of structure and freedom that I expect will endure for some time.

Appendix A: Q-sort Distribution Grid

ID #
Date

			-		-			
		-				-		
	-						-	
-								-

-4 Please Choose 3	**-3** Please Choose 5	**-2** Please Choose 6	**-1** Please Choose 8	**0** Please Choose 10	**+1** Please Choose 8	**+2** Please Choose 6	**+3** Please Choose 5	**+4** Please Choose 3

"Least Agree"	**"Neutral"**	**"Most Agree"**
Ideas that *least* reflect my views about and practice of psychotherapy	Ideas I feel less strongly about	Ideas that *best* reflect my views about and practice of psychotherapy

Appendix B: Validation Scale *(Sample Page)*

Instructions:

Please read the following 53 statements and score each one on a scale of 1-5, indicating whether it reflects a **Primarily Classical** viewpoint;

1. **Relatively Classical** viewpoint;

2. viewpoint that is **Difficult to Classify** as either a classical or relational;

3. **Relatively Relational** viewpoint; or a

4. **Primarily Relational** viewpoint

In addition, please feel free to note any concerns you may have about the clarity of the statements or any redundancies among them. Please note also any aspects of psychodynamic practice which are not included here and which you believe ought to be.

---

1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality.

Primarily Classical	**Relatively Classical**	**Difficult to Classify**	**Relatively Relational**	**Primarily Relational**
1	**2**	**3**	**4**	**5**

2. If the therapist has been in treatment herself and has thorough knowledge of technique, her countertransference is likely to be relatively mild and will not interfere unduly with her ability to function as a clinician.

Primarily Classical	**Relatively Classical**	**Difficult to Classify**	**Relatively Relational**	**Primarily Relational**
1	**2**	**3**	**4**	**5**

3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient's way of being with others.

Primarily Classical	**Relatively Classical**	**Difficult to Classify**	**Relatively Relational**	**Primarily Relational**
1	**2**	**3**	**4**	**5**

Appendix C: Consent Form for Study of Beginning Clinicians **ID #**

Principal Investigator: Deborah A. Gillman
The City College of The City University of New York

I understand that I am being asked to take part in a study of how varying theoretical perspectives on psychodynamic psychotherapy impact the thinking and practice of beginning clinicians.

I understand that as part of this inquiry, I will be asked to indicate my agreement or disagreement with a range of ideas about the practice of psychodynamic psychotherapy, based upon my own practice as a therapist at this time. I will also be asked to respond verbally or in writing to related questions regarding my training, orientation and other factors that have influenced my development as a therapist, including experiences I have had in treatment. If I choose to participate in this study, I agree to complete a sorting task and to be interviewed about the sorting task. I agree to have my interview recorded on audio tape and have been asked not to name any names in my responses to the questions. I will also be asked to complete a brief questionnaire. This will take approximately two hours.

I understand that all of the data derived from my participation in the study will remain confidential, and that I will be identified in any report of the study's findings by my identification number or pseudonym.

My participation in this study is voluntary, and I may choose not to answer a question, stop participation and/or revoke my consent at any time, without penalty.

I have been given the opportunity to ask any questions I have about my participation in this study, and all questions have been answered to my satisfaction. I understand that some of the issues regarding my work and development as a therapist may be of a personal or sensitive nature and may cause me to feel self-conscious or embarrassed. I have been told that if, at any time, I become concerned about any aspect of this project, I may contact the primary investigator, Deborah Gillman (Tel. XXX-XXX-XXXX or dgillman528@yahoo.com), or Dr. Paul Wachtel, Professor of Psychology at CUNY (Tel. XXX-XXX-XXXX). In addition, any questions or complaints about my rights as a participant in this study may be addressed to Ms. XXX, Institutional Review Board Administrator, at (XXX) XXX-XXXX, during office hours.

I also acknowledge that participation in this study may enable me to reflect upon my training in a way which I will find personally and professionally helpful. I will also receive a $10 gift certificate as compensation for my participation.

The use of human participants in this study has been approved by the CCNY Institutional Review Board. I have been given a copy of this form to keep. I consent to take part this study of the impact of varying psychodynamic perspectives on the thinking and practice of beginning therapists.

Name (Print): _____

Signature: _____ **Date:** _____

Researcher: _____ **Date:** _____

Participant Copy / Researcher Copy

Appendix D: Instructions for the Completion of the Q-sort

Thank you very much for agreeing to participate in this study.

First, **please do a preliminary sort of the cards into three piles**: an "agree" pile; a "disagree" pile; and a "neutral" or "unsure" pile. This will familiarize you with the statements and prepare you for the sort. It may seem difficult, at first, to keep track of such a large pool of statements, but it will become easier as the items become more familiar to you.

Next, **begin sorting the 54 cards according to the following distribution**: 3, 5, 6, 8, 10, 8, 6, 5, 3. The cards on the left side of the distribution should represent "ideas that least reflect my views about and practice of psychotherapy" and cards on the right should represent "ideas that best reflect my views about and practice of psychotherapy." Please remember that placement of cards on the left side of the distribution does not necessarily imply an outright rejection of those statements. It is merely an indication that those ideas are less of a priority for you as a therapist at this time, relative to the ideas on the right side of the distribution. The reverse is true, as well. Please make an effort to be as honest with yourself as possible in the placement of the cards.

Please allow yourself at least 30-45 minutes to complete the sort.

Once you have completed the sort, **please leave the cards in place** on the table so that we may discuss your distribution of the statements and your experience of the sorting process. Enjoy the sort!

Appendix E: Interview Questions

1. What was your experience completing the Q-sort? (Follow up: How was it to be forced to make choices about your priorities?)

2. Which statements were the most challenging for you to place? What made them challenging?

3. Are there any ideas that guide your work as a therapist that were *not* included among the statements? What are they?

4. Were you aware of any influence(s) guiding your decision-making during the sorting process? (Probe further: Was there anything or anyone that you were thinking about while you were sorting? Such as a supervisor, or something you have read?) If so, what were they/was it telling you?

5. Please look with me at the statements you ranked most highly. Can you elaborate on why you chose these items? What do they say about your values as a therapist? (Alternate probe: Which items excited you and why?)

6. Please look with me at the statements you ranked at the low end of the continuum. Can you elaborate on why you chose these items? What do they say about the values you reject as a therapist? (Alternate probe: Which items were the most problematic for you and why?)

7. Please think of an example from your clinical work, a moment or a kind of time in which you made a decision which exemplifies how you see yourself as a therapist. Alternately, you may consider a moment when you did something you regretted, in which you realized how you would *not* want to practice. Why was this (example, choice, etc.) important to you?

At this point in the interview, the PI discussed more explicitly the questions driving the study. The participant was then asked:

8. Do you experience a tension between relational and more traditional approaches in your own work? Have you experienced this in the course of your training?

9. How do you understand the term 'relational?' What are your associations to this term? Are these associations positive or negative?

ID#
Date:

Appendix F: Questionnaire for Study of Beginning Clinicians

Name of Participant Age:

Telephone Number(s) Email(s):

Address

School: Year in training:

How would you describe your orientation as a clinician?

Number of years conducting psychodynamically informed psychotherapy under supervision:

Number of years conducting therapy in other modalities:

Please describe the orientation of your clinical training program:

Does your program offer courses in the practice of psychotherapy or psychotherapy technique? If yes, please describe.

What other academic courses have informed your thinking and practice of psychodynamic psychotherapy?

Please describe the orientation of the psychotherapy supervisor(s) who have been the most personally influential in your practice of psychodynamic psychotherapy. If you are unable to cite their orientation, please describe (in a few sentences only) the ideas about psychotherapy practice most emphasized by each supervisor. Please consider up to three supervisors.

1.

2.

3.

Are you currently or have you ever been in treatment? If so, when and for how long? Please indicate whether or not this treatment has overlapped with your psychotherapy training.

Please also describe the nature of this treatment (i.e., psychoanalysis? psychotherapy?)

What is/was the orientation of your therapist? Alternately, what ideas seem to most guide his or her practice?

Which of the following factors[33] have been the most influential in the development of your practice, orientation and/or style as a therapist? Please circle the three most influential factors:

Academic courses or seminars	Readings from books or journals assigned in graduate school
Independent reading of books or journals	Experience in therapy with patients/clients
Formal supervision or consultation	The culture or climate of the institutions in which you practice
My own therapist (how he or she works)	Informal consultation with colleagues
Doing research	Observing therapists in workshops, or on films, or audio tapes.
My own therapy (my experience as a patient/client)	Working with co-therapists
Experiences in personal life outside of therapy	My work as a supervisor/instructor of more junior clinicians
My personality in general	Other (please specify)

[33]Factors in this table were taken from the study by Orlinsky, Botermans, Ronnestad and the Society for Psychotherapy Research (2001) on psychotherapist development.

Appendix G: Table 4
Mean item scores and expert clinicians' item ratings for all items

In the Q-sort, each statement was ranked by participants along a continuum of -4 to +4, from most strongly disagree to most strongly agree. What follows is a presentation of the mean item score for each statement, for the entire sample, along with the score that item received by the experts, either AR (Anchor Relational); AC (Anchor Classical); B (Bridging); S (Split Consensus).

Mean Score	Expert Rating	Q-sort Statement
2.10	B	20. The idea that the therapist must be like a surgeon or a reflecting mirror no longer holds in light of our present understanding. Clinical work often affects the therapist quite deeply, and feelings that arise are an important part of the therapist's tools, rather than an intrusion.
2.00	B	42. Therapists must first establish a working alliance with their patients. This 'real relationship' is the basis for the therapeutic work and for any investigation of the transference or countertransference dynamic.
2.00	B	25. The influence of countertransference upon the therapist's perceptions can never be eliminated. Our understanding of the patient is inevitably filtered through our life experience and perceptual inclinations.
1.90	S	19. When misunderstandings or ruptures occur in the therapeutic relationship, therapists should not only explore the patient's contribution but do their best to understand and, ultimately, acknowledge to the patient, their own contribution as well.
1.80	B	27. Technical skill and accurate understanding of the patient's unconscious are important, to be sure, but the patient must first and foremost be certain of the empathy and 'humanness' of the therapist.
1.80	S	7. One therapeutic stance may be of value with a given patient or at a given moment in a treatment, while an entirely different approach may be required with another patient or at a different moment with the same patient. Flexibility should be the therapist's rule-of-thumb.
1.73	B	32. At any time, the therapist may be a model, teacher, advisor, transference figure, new or old object–or any combination of these.
1.60	B	14. Therapists derive valuable information not only from their countertransference fantasies, but also from the enactments that inevitably occur.

Appendix G: Table 4
Mean item scores and expert clinicians' item ratings for all items

1.37	AR	44. The most therapeutic interpretations are those which arise from a process of joint meaning-making about the patient's experiences and inner life.
1.23	S	34. Whatever one's views may be about intersubjective or two-person models of treatment, the psychotherapy patient and the psychotherapist have fundamentally different roles, needs, responsibilities and liabilities. Mutuality does not mean equality.
1.20	S	10. Neutral does not equal total non-expressiveness. Therapists may be neutral and still have a personality, be genuine and present, in essence, be themselves.
1.20	B	48. Whatever a patient's reaction to his or her therapist may be, wishes, fears, and defenses originating in childhood have a very important part in it.
1.13	B	50. Addressing the patient's day-to-day problems in living and attempting to help the patient change problematic interpersonal patterns is an important and useful part of the overall therapeutic effort.
1.10	B	6. The dynamics of transference and countertransference are critical in any treatment, but it is important not to focus on them too exclusively. Attention to the real transactions that constitute the therapeutic alliance is also important.
.93	B	33. There are often good reasons to withhold personal information or remain 'anonymous' to our patients, and it is a mistake to overlook this.
.80	S	1. The therapist is involved in the construction, not merely the discovery, of the patient's psychic reality.
.77	AR	22. It is a mistake to interpret the patient's experience of the therapist too exclusively as a repetition of something earlier. The therapist is also a new object and this new relationship contributes importantly to transforming the patient's inner life.
.73	B	45. Interpretations can never really be objective. They always significantly include the therapist's particular take on the material the patient presents.
.60	B	47. Therapists should de-mystify the process of therapy as much as possible, in order to put the patient at ease. It is appropriate for therapists to 'educate' the patient regarding the frame of treatment and the nature of what is to be expected.
.57	S	35. Remaining silent about our experience can be as much a countertransference enactment as any other kind of response.
.57	AR	52. The disclosure of personal information need not put an end to patients' fantasies about the therapist. Indeed, a disclosure may stimulate and encourage discussion about these fantasies.
.47	AR	11. Therapist self-disclosure is an inevitable part of the process. The question is not whether to disclose, but how and when to do so.

Appendix G: Table 4
Mean item scores and expert clinicians' item ratings for all items

.40	B	23. On the oft-debated subject of therapist self-disclosure, every clinician must decide what feels right for them, in a given clinical context, with each patient. There should be no pre-set rules on such a personal matter.
.33	AR	16. The stance of neutrality, often linked to abstinence and non-gratification, can leave the patient feeling un-cared for and hinder therapeutic progress.
.30	B	30. At times, the therapist may find it constructive to admit to difficulty managing or understanding her reaction to the clinical material or to share her evolving and not yet fully formulated thought process with a patient.
.20	B	13. It is only by participating in the therapeutic relationship and experiencing the kind of affective response (or lack thereof) that a patient evokes in you that you can begin to know what is most important about a patient and how to proceed in treatment.
.13	AR	36. Traditional ideals of neutrality or anonymity amount to the pursuit of an illusion. Once we recognize that we are always "known," in some way, by our patients, we must relinquish neutrality as a therapeutic ideal.
.00	B	37. The therapeutic relationship, in its most fundamental aspects, is based on the parent-child relationship, and it is important that the impact of this powerful underlying structure be understood.
-.03	B	5. Therapists should be willing to answer patients' personal questions to the extent that they feel comfortable doing so. Such willingness to disclose enhances the therapeutic alliance, models honesty and genuine connection in a relationship and, in some cases, validates a patient's reality testing.
-.03	B	41. Neutrality in a therapist is just what some patients need in order to feel free to express themselves fully in the treatment setting.
-.17	B	31. It is useful for the therapist to provide input, where appropriate, in decisions and choices facing the patient, although she tries to avoid imposing her own values.
-.27	AC	8. Countertransference fantasies are a rich source of information, but enactment of these fantasies should be avoided as much as possible.
-.40	AC	46. Therapists are no longer expected to be blank screens. Nevertheless, they should strive to be as neutral as possible, establishing a baseline against which changes in the patient's perceptions of them can be recognized as deriving from within the patient.
-.57	S	9. Of all interpretations, transference interpretations are the most likely to reinforce therapeutic change.

Appendix G: Table 4
Mean item scores and expert clinicians' item ratings for all items

-.57	AR	17. The therapist's effort to be anonymous can impede a treatment's progress by, for example, evoking for the patient an absent or unknowable parental figure.
-.60	B	24. A therapist will inevitably make errors of practice or judgment (e.g. forgetting an appointment). Nevertheless, it is the patient who is in treatment, and it is his or her feelings about the error that should be the primary subject of discussion.
-.73	AR	3. Therapists often try to be a relatively constant stimulus in the room in order to focus on what comes from the patient. But this restricted behavior of the therapist may limit the range of the patient's behavior, evoking only a narrow portion of the patient's way of being with others.
-.83	AR	29. The therapist's personal impressions, feelings and fantasies about the patient are the heart of what she has to offer, and are often useful to share, since they are key elements in the treatment.
-.90	B	2. Recent advances in our understanding of object relations and the evolution of the self do not diminish the need to understand the powerful organizing influence of biologically-rooted drives.
-.90	AC	4. The aim of a psychodynamic treatment is the resolution of neurotic conflict. A stance of relative neutrality permits memories, associations and any conflictual material to emerge in the transference so they may be interpreted and worked through.
-1.10	B	49. The therapist's expression of genuine feelings for the patient must be kept in check in order to further the therapeutic process and the patient's self-exploration.
-1.23	AC	54. Examining behavior from the perspective of id, ego and superego dimensions remains an important and helpful organizing idea in understanding clinical material.
-1.27	B	51. The therapist withholds affective responses, not because she does not care for or feel compassion towards the patient, but to ensure that feelings stirred for her in the work do not distract her or the patient from the therapeutic task.
-1.40	AC	18. When the therapist tries to influence the patient as little as possible or reveal as little as possible about herself, the transference is able to become clearer.
-1.40	AC	43. Therapist self-disclosure is more likely to serve the needs of the therapist than those of the patient.
-1.50	AC	12. Therapist neutrality is required in the interest of maintaining as much objectivity as possible and to enable patients to recognize transference reactions as coming from within themselves, not simply as responses to the actual behavior or characteristics of the therapist.

Appendix G: Table 4
Mean item scores and expert clinicians' item ratings for all items

-1.63	AC	38. When the therapist reveals personal information, fantasies or thoughts to a patient, she intrudes upon the development of the transference and the fantasies the patient may have about her.
-1.67	AC	53. Transference is the most powerful force behind the patient's behavior and experience in the sessions. Too much focus on the 'real' or 'working' relationship apart from the transference is likely to diminish the depth of the treatment.
-1.77	S	40. Countertransference disclosures should always be made cautiously, and only in response to an inquiry from the patient.
-1.83	AC	26. The therapist should not be primarily concerned with a patient's practical problems, nor should she aim to influence the patient's daily activities.
-1.83	AC	15. Therapeutic progress is most enhanced by the resolution of the patient's difficulties as much as possible via interpretations rather than through support, advice, or other kinds of interventions.
-1.90	AC	21. In order to ensure that the patient's repressed fantasies and wishes become intense enough to be manifested in the session, it is important that the therapist try not to gratify the patient's infantile or drive aims.
-2.10	AC	28. It is not possible for therapists to control completely the sharing of personal information with patients. In time, data about one's affiliations, activities or life events (such as illness or pregnancy) make their way into the treatment frame. However, countertransference disclosures, which largely can be controlled, are not appropriate.
-2.33	AC	39. It is important that the therapist adopt a neutral stance in order to have equal access to the id, ego and superego elements in the patient's behavior and experience.

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