Clinician View of the Use of Influence in Social Work Practice

William K. Motlong

Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_theses

Part of the Social Work Commons

Recommended Citation
https://ecommons.luc.edu/luc_theses/4307

This Thesis is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Master’s Theses by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License.

Copyright © 1997 William K. Motlong
Loyola University Chicago

Clinician View of the Use of Influence in Social Work Practice

A Dissertation Submitted in Partial Fulfillment of the Degree of Doctor of Social Work

Department of Social Work

By William K. Motlong

Chicago, IL
May, 1997
We hereby recommend that the dissertation prepared under our supervision by

William K. Motlong

entitled

Clinician View of the Use of Influence in Social Work Practice

be accepted in partial fulfillment of the requirements for the degree of

Doctorate of Social Work

Committee on Final Examination

Miriam Reitz, Ph.D.

Jack C. Wall, D.S.W.

Joseph A. Walsh, Ph.D., Chair
Abstract

Clinician View of the Use of Influence in Social Work Practice

The use of influence by social work clinicians is an understudied phenomenon. This study was an exploratory/descriptive project that examined the views of 104 experienced social work clinicians in regard to what they regard as constituting influence and what types of influence they themselves utilize. The study elaborated a typology of clinician influence, and a definition of clinician influence: the process of impacting, either directly or indirectly, the client's feelings, thoughts or behavior. The typology of influence consisted of six sub-categories of influence: High Level Directive, Low Level Directive, Metacommunicative, Conceptual, Contextual, and External. Two 30-item Likert-type scales, the Clinician Behavior Scale and the Influence Scale, were developed based on the typology of influence, and then incorporated into a questionnaire sent to respondents.

The study found that overall over 90 percent of respondents viewed all categories of influence as constituting influence, and that overall nearly three fourths of respondents saw themselves as actually utilizing influence as defined in the study. There was some variability in regard to sub-categories of influence. Respondents who described themselves as religiously conservative viewed High Level Directive, Low Level Directive and Metacommunicative influence as constituting influence less than those who were religiously moderate or liberal. Respondents in high authority fields of clinical practice viewed some categories of influence as constituting influence less than those in low authority fields of practice. Those respondents with greater years of clinical experience tended to
view Low Level Directive and External categories as constituting influence more than those with fewer years of experience. Respondents with a psychodynamic theoretical orientation view themselves as actually using High Level Directive influence less than those with non-psychodynamic theoretical orientations.

Nearly sixty percent of respondents also reported conflict in their clinical role regarding respecting client self-determination, a social work value directly related to the use of clinical influence. Of those, 40.4 percent reported conflicts associated with their work setting, and 59.6 percent reported conflict associated with the client's own behavior.
## CONTENTS

**ACKNOWLEDGMENTS** .................................................. iv

**Chapter**

I. **INTRODUCTION** .................................................. 1
   Context of the Problem ............................................. 1
   Introduction to the Problem ....................................... 4
   Purpose of the Study ................................................ 7
   Research Questions .................................................. 7
   Rationale for Choice of Variables ............................... 8
   Definition of Terms .................................................. 11
   Rationale for and Significance of the Study .................. 12
   Assumptions and Limitations ..................................... 15

II. **REVIEW OF THE LITERATURE** .................................. 17
   Self-determination ................................................ 17
   Limits on the Principle of Self-determination ................ 18
   Influence ............................................................ 22
      Introduction to the Concept .................................. 22
      Definition of Influence ........................................ 23
      Neglect of the Concept of Influence ......................... 24
      Values and Influence .......................................... 25
      Sources of Influence ........................................... 27
      Kinds of Influence .............................................. 28
      Influence within a Psychodynamic Perspective ............ 30
      The Unavoidability of Clinician Influence ................ 37
      A Typology of Clinician Influence ........................... 39
# III. METHODOLOGY

- Methodological Procedures and Rationale: 47
- Population and Sample: 48
- Instrument: 49
- Human Subject Protection: 53
- Pilot Study: 54
- Data Collection: 55
- Data Analysis: 55

# IV. RESULTS

- Profile of Respondents: 59
- Clinician Behavior and Influence Scale Results: 63
- Additional Measures of Clinician Behavior: 65
- Clinician Behavior, Clinician Influence and Demographic Variables: 69
- Open-Ended Questions: 72
- Self-determination: 76

# V. ANALYSIS AND DISCUSSION

- Study Questions: 79
- Critique and Suggestions for Improved Design: 86
  - Sample: 86
  - Scales and Questionnaire: 88

# VI. SUMMARY, CONCLUSIONS AND FURTHER STUDY

- Future Research: 96

# VII. BIBLIOGRAPHY

- 104
Appendix

A. Influence Questionnaire. ................................. 112
B. Cover Letter to Respondents ............................. 125
C. Informed Consent Form for Respondents. ............... 127
D. Letter from Institutional Review Board, Loyola University Chicago ............................. 129
For Craig and Elisabeth:

May you realize your dreams.
ACKNOWLEDGEMENTS

While dissertations bear the name of a single author, it is impossible for a individual to complete a dissertation alone.

All dissertations owe their completion to a long list of other people, whose invaluable assistance, ongoing support and dogged encouragement make it possible to maintain the energy and determination to complete the often grueling process that is a dissertation.

It is with humble and heartfelt gratitude that I acknowledge those without whom this project would never have happened. First of all, I thank my doctoral committee, whose guidance and direction have been most helpful and fruitful. Miriam Reitz, Ph.D. has been a longtime mentor, friend and professional colleague, who was involved from the very beginning with seminal ideas for the project, and who was crucial to its realization at absolutely every stage of its development; her kind and caring involvement, as well as essential intellectual input was absolutely invaluable in the completion of the project. Jack Wall, Ph.D. provided both broad vision to think boldly about the possibilities of the project and precise practical wisdom to refine the work. And Joseph Walsh, Ph.D., my committee chair, as I have repeatedly conveyed to him, deserves credits toward sainthood for his patient, persistent, consistent and determined pursuit of progress and production out of a doctoral student oftentimes on the verge of losing his way; Joe's fundamental good nature and incisive pragmatism, as well as his continued ability to maintain clarity of
purpose and goal to the ultimate end of the project, were amongst the most essential ingredients contributing to the success of this study.

Others contributed to the intellectual formulation of this endeavor. My thanks to the additional members of my peer consultation group, Anne Wells, Ph.D. and Moni Murdock, M.S.W., whose ideas and input were deeply valued, and who were a part of the ongoing creative atmosphere out of which much useful and productive work regularly emerged.

Some individuals were essential in completing significant elements of the project. The project would not have been completed without the yeoman effort of Tammy Dee Jones of Loyola University's Information Services Department, whose technical knowledge and support, and statistical wizardry, as well as her patient tolerance of a statistical non-wizard, were absolutely essential in actualizing the data entry and data analysis portions of the dissertation. My further thanks to Donna Nieckula, Ph.D., who assisted patiently and immeasurably in conceptualizing and talking through issues of methodology and data analysis.

My deep gratitude extends to members of the Loyola University School of Social Work Faculty. Chief among those were Randy Lucente, Ph.D. chair of the doctoral program, who offered support, encouragement, good advice and unsteadying belief in the fact that the project would be completed. As well, I particularly appreciated the always stimulating intellectual input of Carolyn Saari, Ph.D. the learnings from Sandra Condon, Ph.D.

Colleagues whose support and encouragement, and willing participation in several aspects of the project, are deeply appreciated
include particularly those at Center for Personal and Family Life, Ltd., where the atmosphere has always been one of fundamental support and acceptance: Peg Hazenbush, M.S.W., Tim Pedigo, Ph.D., Priscilla Pedigo, M.S.W., John McDonnell, M.S.W., Tony Moriarty, Ph.D., and Pamela Ruggieri, Psy.D. Two members of the office staff, Joy Maier and Laura Gryczewski, also served as essential pragmatic support, including warnings when my heavy use of the copy machine was threatening to burn it out.

Many other colleagues also provided significant support, input and pragmatic assistance. Several stand out. Marianne Piet, M.S.W., who, as a current doctoral student herself, both understood the intricacies and frustrations of the process and kept me accountable for finishing the task. Leonard Szymczak, M.S.W., who was producing his own creative literary work at the same time as this author was working on his, served as the kind of close friend, confidant and personal resource who can comprehend the agonies involved, and, through the depth of his understanding, serve to soothe the artist's soul. I also appreciate the members of my doctoral cohort, who served to produce both a supportive atmosphere and an intellectually fertile ground for ideas and cognitive growth to abound: Joyce Stephens, D.S.W., Janice Gagerman, D.S.W., Julia Wade, and Aramis Defort.

I am also grateful to the many masters and doctoral level students who capably and willingly participated in the pilot study process, and whose input was greatly appreciated and significantly helped refine the study.

Finally, my most heartfelt gratitude is extended to my family. To Barbara Motlong, M.S.W., professional colleague and wife of 34 years,
who withstood my absences, both mental and emotional, with forbearance and understanding, and who not only provided the first line of assistance, but also hung in there to the finish line, my deepest thanks. And to Craig, my son, and Elisabeth, my daughter, who had faith that their father would complete his degree even as they eclipsed him and completed theirs, my thanks for your love, understanding and belief in me.
CHAPTER I.
INTRODUCTION.

Context of the Problem. Within the helping disciplines, clinical social work has defined itself as the profession which views clients within a biopsychosocial perspective. This viewpoint requires the clinical social work practitioner to be aware of clients' physical issues, problems and needs; their inner psychological, mental and emotional states; the social context (family, friends, subculture) within which they live; and the clients' environmental surround (their immediate physical environment, neighborhood, etc.). Clinical social workers, then, have the task of sifting and sorting, with the client, the various factors bearing upon the issues the client brings to the worker for assistance, and then to determine the most appropriate or effective avenues for intervention into any one or combination of the biopsychosocial sphere.

Because of the breadth of this mission, clinical social workers are professionals who intervene in a variety of ways, and from a multiplicity of roles. Clinical social workers not only act within a psychotherapeutic role, but also as providers, locators, or creators or services, and as interpreters, mediators and advocates with others on clients' behalf (Woods & Hollis, 1990). This multiplicity of role frequently requires the clinical social worker to be an active intervenor into situations with clients, and to have her impact clearly felt.

In clinical social work, the worker is clearly intended to impact the client, whether to "cure" him, "empower" him, or simply "problem-solve" with him—or some combination of all of the above. This influence on the part of the clinician is sanctioned by the profession. Indeed, in an era of diminishing resources in social agencies, demands are placed
increasingly upon the clinician to work more briefly, more effectively and more efficiently, which implies a focused, actively interventive worker-client interaction. The advent of managed care has brought additional pressures upon the clinician to be efficiently effective, and some managed care organizations even suggest treatment protocols for specific diagnostic categories (CIGNA, 1991; MCC, 1992). Hasenfeld (1987) emphasizes that the clinical social worker exercises the power of expertise, persuasion, and sanctioned authority, and also controls the resources within the setting available to the client, thereby possessing a significant amount of influence on the client.

There is, then, an emphasis within clinical social work, upon effective impact by the clinician upon the client or client system. Generally, within clinical social work, this process is a mutually agreed upon and defined process, in which the client and worker collaborate as to the nature and direction of the change. Within this explicit interactional context, the clinician is expected, utilizing her skills and knowledge, to assist the client in making the needed and desired change—that is, to influence and impact the process in the desired direction.

In contrast to this position of explicitly defined and desired influence is another clinical social work value and principle, which emphasizes the need for client autonomy. Foremost amongst these values is the principle of client self-determination, which, as a part of the National Association of Social Workers’ Code of Ethics (National Association of Social Workers [NASW], 1997), explicitly enjoins the clinician to respect and promote the right of clients to self-determination. Some social work clinical practice theorists, while endorsing its
occasional necessity, caution against undue use of "direct influence," as not only interfering with client autonomy but also as being frequently ineffective (Woods & Hollis, 1990). One of the most utilized of borrowed theories in clinical social work, psychodynamic theory, has throughout its history emphasized the importance of the clinician not unduly influencing the client (Mishne, 1993). There is a current (1997) debate in the mental health field regarding "false memories," wherein therapists are accused of influencing clients to manufacture memories of previously "repressed" physical and sexual trauma (Herman & Harvey, 1993; Loftus, 1993). Emerging out of this debate is professional and legal pressure and sanction for clinicians to be absolutely circumspect and "neutral" in regard to potential influence upon clients. One author, viewing clinical social work from a post-modern perspective, cautions against the impact of clinical theories rising to the level of "truth" in the clinical environment, thereby narrowly labeling the client and limiting his options (Pozatek, 1994); she advocates maintaining a posture of "uncertainty" as the appropriate clinical stance in relationship to clients.

There is, then, a dynamic tension between the clinician's role and purpose to be effective and impact the client on the one hand, and the need to be circumspect in not influencing unnecessarily or harmfully on the other hand. Clinical social workers are caught in a tension between the nature of their work, which is to impact client's lives, sometimes with speed and efficiency, and their commitment to client self-determination, and to the professional and legal admonitions not to inappropriately or unduly influence clients lives.

Within the explicitly interactional context of the client-worker relationship, the issue of influence, then, has a dynamism which
requires significant skill on the part of the worker to manage. Some recent social work theory, which emphasizes the social construction of reality (See, for example, Payne, 1991; Saari, 1991), suggests that reciprocally influencing processes are at work at all times during the clinical process. Influence, then, is, in this view, *always* occurring.

The question, then, for clinical social workers, is not whether influence is present, but what, when and how that influence is to be. Making choices about this is a difficult professional process. And what is regarded as "good" influence vs. "bad" influence, or what is even regarded as influence, or whether clinicians are aware of their influence has been an understudied phenomenon.

It is within this context that this study undertakes to examine the concept of influence, to extend knowledge about it, and to explore how current social work clinicians understand and view the construct.

**Introduction to the Problem.** Clinicians in the social work profession have long held firm to the value of client self-determination, and to maximum autonomy of clients. Self-determination is viewed as a fundamental human right (McDermott, 1975), a therapeutic and developmental necessity (Biestek, 1951; Levy, 1983), and an absolute basic social work value (Biestek & Gehrig, 1978). Indeed, the principle of self-determination can be seen as a guiding ethical imperative of the profession, deviation from which must pass stringent peer review (Levy, 1983), no matter what the rationale for possible partial abridgment or limitation within the clinical situation (Salzberger, 1979). Within this framework, it would appear that many, if not most, clinical social workers would say that they adhere to this ideal and therefore to
principles which minimize the effect of the clinician's thoughts, feelings, attitudes, values and actions upon the client.

At the same time, it is generally accepted that clinical intervention with social work clients has, as a clear stated purpose, a change in the client or in the client's circumstances. This implies that the processes of treatment and/or the practitioner are influential in causing, precipitating or catalyzing such change. Further, in part because of the diverse populations served by social work and the range of fields of practice, social workers, perhaps more than any other helping profession, are confronted regularly with situations which are at best ambiguous with regard to the need for clinical intervention that influences the client in a particular direction. In addition, each clinician presumably operates from a theoretical perspective or perspectives, which derive from certain basic assumptions about human behavior and about the process of psychotherapy, and which guide what the clinician does (or does not do) in relationship to the client. The manner in which a clinician chooses to intervene with a client clearly has impact upon the course and outcome of clinical work.

Clinical social workers, then, are caught in something of a dilemma. The profession demands, on the one hand, as a central value, the fullest possible adherence to the principle of client self-determination, allowing maximum personal freedom and choice. The profession also expects, on the other hand, a clinical orientation and a set of skills which creates an impact upon the client, to generate some sort of altered situation, in order to fulfill the requirements of professional efficacy and usefulness to the client. This latter expectation causes the social work clinician to focus, inform, direct, limit, interpret,
prescribe or advise the client in ways that influence the client, directly or indirectly, thereby inevitably creating parameters delimiting the extent of a client’s choices and options. Such parameters are quite necessary for some sort of sense or meaning to evolve from the clinical situation.

Yet the limitations clinicians impose—whether they be the practical structures deemed necessary for clinical work, or the underlying assumptions inherent in the clinician’s theoretical orientation, or the social, legal, professional and/or ethical sanctions sometimes superimposed upon the clinical context—are often under-recognized or even unacknowledged in regard to the degree of impact and influence they might have upon the client. Clinicians are not supposed to impose anything upon clients; clients are to be self-directed. Clinicians are expected not to exercise influence or power or control with their clients; yet, influence appears to be absolutely necessary in order to be effective with clients.

Little attention has been paid to this dilemma in the literature, despite what would seem to be the ubiquitous presence of influence upon clients by social work clinicians. Indeed, while a great deal of literature appears to reflect the desirability of minimizing or eliminating influence from the practitioner toward the client, or even denies the reality of influence (Heller, 1985; Schamess, 1983), little has been done to understand clinician’s views (or even awareness) regarding issues of influence, how intentional and aware clinicians might be about their use of influence upon clients, what kinds of influence clinicians utilize with clients, and what clinicians view as appropriate and what they view as inappropriate influence.
It is argued here that, perhaps in particular because of the commitment to the social work value of self-determination, and the current social work clinical atmosphere described above (See "Context of the Problem"), the study of influence as a necessary element of the clinician's work is crucial to better understanding of the treatment process. Indeed, only through as full an awareness as possible of the use of influence clinically, can controls be exercised upon the degree of impact upon the client, and therefore informed choice be made as to the most appropriate ways of proceeding in the treatment process. And it is only through such a conscious, intentional process that clients can most fully realize their maximum autonomy, sense of empowerment within their environment, and capacity for self-determination.

Perhaps particularly for psychodynamically-oriented practitioners, whose tradition has emphasized clinician neutrality and has cautioned against intrusion and influence upon the client, an understanding of how the concept of influence is viewed would be especially useful.

**Purpose of the Study.** The purpose of this study is to explore practitioners' understanding and views of their use of influence in clinical practice. It will focus upon psychodynamically-oriented social work clinicians' awareness of their use of influence, upon what is considered by them to be appropriate or inappropriate influence, and upon what specific kinds of influence the clinician's themselves utilize.

**Research Questions.** The study will center upon the following exploratory research questions:

1. Do practitioners believe that they use influence upon clients?
2. What do practitioners regard as influence upon clients?
3. What types of influence do practitioners actually view themselves as utilizing?

4. What relationship do a) years of clinical experience, b) exposure to and experience in particular fields of practice, c) type of theoretical orientation, d) post-graduate training, e) long- or short-term orientation to treatment and f) other demographic variables (marital status, ethnicity, religious orientation, etc.) have to clinician’s perceptions of their use of influence?

5. Do clinical social work practitioners experience a tension or conflict between commitment to the social work value of client self-determination, and the expectations and demands of their role performance as clinicians?

Rationale for Choice of Variables. The several variables cited to be studied have been chosen for the following reasons:

Experience level. Although level of experience of the clinician in psychotherapy as related to positive outcome is equivocal at best, experience level is related to a positive result particularly with difficult clients, and when more intensive or complex procedures are indicated (Beutler, Crago, & Arizmendi, 1986). Presumably, the level of practitioner experience is related to greater skill level or knowledge and therefore ability to manage the situation more effectively. In this study, experience level is regarded as a variable worthy of examination, to ascertain whether, and in what direction, years of actual clinical experience have upon the clinician’s view and use of influence.

The examination of fields of practice in relationship to the view and use of influence will permit analysis of whether practitioners in more
"authoritarian" practice fields (e.g., corrections, child welfare) are more (or less) aware of and inclined to utilize influence, and have more (or fewer) strictures upon limiting their influence. Particularly when clients are involuntary, social workers are called upon to intervene "for the welfare of the client" and to make decisions that impose an external value structure, and may even impose limits on the client's autonomy (Abramson, 1989; Cingolani, 1984; Regehr & Antle, 1997). It is the intent, then, to examine whether clinicians in more authoritarian fields would be more or less aware of and use more or less influence than their counterparts in less authoritarian fields (e.g., family service, mental health or private practice).

The variable of short- or long- term orientation to treatment will permit examination of what impact time limitations upon the treatment process might have upon the use and view of influence. Research on brief therapies suggests that, because they are time-limited, there is a greater attention to goal-setting, increased amount of focus, high clinician activity, and prompt intervention (Koss & Butcher, 1986). This higher degree of clinician involvement suggests that those with a short-term orientation might be more likely to utilize influence, if for no other reason than the time constraints involved in the approach.

Additional post-master's training will be examined in regard to whether more education (and the nature and amount of the education, here limited to psychodynamically and non-psychodynamically oriented education) impacts view and use of influence. Examination of this variable will also help to control for differences that intervening education has upon the subject population, thereby providing some
control on holding constant the basic educational background of the sample population.

Because supervisors are in the position of guiding and directing other practitioners, and of being responsible for assisting in positive clinical outcomes, (and presumably aware of what their supervisees are doing with clients), does the variable of number of years of supervisory experience increase (or decrease) awareness of the issue of influence?

Theoretical orientation is seen as a potentially related to view and use of influence by practitioners. While studies of theoretical orientation have shown by and large relatively little difference in outcome of treatment (Kingsbury, 1995; Miller, Hubble & Duncan, 1995; Russell, 1990), and social workers have been largely seen as eclectic in their clinical work (Jayarante, 1978; Jayarante, 1982) as well as being more oriented toward the client's problem than to theoretical orientation (Cocozelli, 1986), nonetheless different theoretical systems represent different ways of conceptualizing the clinical situation and therefore one's theoretical position impacts clinician behavior in sessions with clients (See, e.g., Hill & O'Grady, 1985; Smith, Glass, & Miller, 1980). Certain theoretical orientations (cognitive and behavioral for example), are explicitly more interventive and directive and therefore presumably more oriented toward acknowledging and utilizing therapist influence (Beck, Rush, Shaw, & Emery, 1983). Further, while all of the clinicians in this study are supervisors in a school with psychodynamic traditions, not all may embrace that orientation as their primary approach to clients. Even with psychodynamically-oriented practitioners there is some variability amongst different psychodynamic schools, particularly in regard to the view and management of countertransference (Mishne, 1993). Examining
the variable of *theoretical orientation* with psychodynamically-oriented practitioners would yield information as to whether ego psychology-oriented practitioners and self-psychology-oriented practitioners differ from one another in their view of influence, or whether they provide a relatively unified view of the phenomenon.

Also examined as variables will be *gender, practitioner’s ethnic background, religious affiliation, age of practitioner, and primary client group* to note possible differences in view regarding influence, and to control for those factors. While the research has been equivocal regarding the impact of these factors in the clinical setting, in the area of gender, males were viewed in one study as making more directive interventions than females (Cooke & Kipnis, 1986).

**Definition of Terms.** For purposes of this study, terms utilized are operationally defined as follows:

- **Influence:** the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings.

- **Social work clinician:** a practicing social worker, with at least a masters degree in social work, with at least two years of post-masters direct clinical experience in a field of social work.

- **High and low-authority field of practice:** for this study, *high authority* fields of practice are defined by the author as corrections, child welfare, schools and health care; *low authority fields* of practice are defined as family service, mental health, Employee Assistance Programs/Managed Care, and private practice.

- **Short-term orientation to treatment** is defined as a clinician who indicates she tends to see clients for 16 sessions or fewer; *long-term*
orientation to treatment is defined as a clinician who reports she tends to see clients for more than 16 sessions.

Psychodynamically oriented practitioners are those who define themselves as primarily utilizing a psychodynamic, traditional psychoanalytic, ego psychology, object relations or self-psychology theoretical orientation in their clinical practice. Non-psychodynamically oriented practitioners are those who define themselves as utilizing a theoretical orientation other than psychodynamic, traditional psychoanalytic, ego psychology, object relations or self-psychology.

Rationale for and Significance of the Study. The issue of influence in the clinical setting appears to be an understudied phenomenon. In light of the large volume of literature designed to guide practitioners toward effective intervention intended to elicit change in the client in some manner, it would seem that more attention would be paid to the processes of how the practitioner exerts influence, other than by her specific therapeutic interventions. Further, in the context of the assertions that it is desirable to rid oneself as a clinician of any influence (which, paradoxically, if successful, would make the clinician absolutely ineffective), it would seem that a study into therapist beliefs about, attitudes toward and practices of their own influence would be a worthy undertaking.

While studies of therapy outcome have tried to measure direct impact of the therapy (and presumably the therapist), and to isolate those factors (including therapist behavior and attributes) that appear to be related to a good result (Garfield & Bergin, 1986), few attempts have been made to examine how therapists view their own use of influence.
Motlong, Murdock, Reitz and Wells (1995) have begun to identify what might be considered appropriate influence—for example to engage a client in therapy, to move the change process along, or to direct a client away from a harmful situation. They have also delineated frames of reference to examine what might guide the identification of when and how appropriate influence by the clinician might be applied. These guidelines include: strong adherence to client goals, reflection of societal values, legal sanctions, knowledge of human development, practice theory, and accumulated practice wisdom.

The current state of knowledge about practitioners' awareness and attitudes toward the issue of their influence is very limited, and appears to be primarily anecdotal. Little research has explored this dimension of clinical practice. Because the examination of the clinician's perspective upon the use of influence in psychotherapeutic practice has been limited, it would appear that study of the phenomenon would be of benefit for the following reasons: 1) to explore the degree of awareness clinicians currently have regarding the issue of influence, and to bring about greater awareness of the phenomenon; 2) to determine what clinicians view as constituting influence and what they do not consider influence; 3) to ascertain what kinds of influence practitioners see as appropriate, and what kinds of influence practitioners view as inappropriate to the clinical setting; 4) to suggest possible steps toward consistency in appropriate application of influence within clinical work.

Awareness. Because much of the literature suggests there has been a strong emphasis upon limiting, minimizing or altogether avoiding influence, it is possible that clinicians' primary awareness is focused in that direction. It appears possible that many, if not most, practitioners
may believe that they influence minimally. Since much of what directs and guides a practitioner's actions may be beyond awareness, the values, beliefs, and biases that inform clinical intervention may go unexamined. This study is in part intended to explore how the influence of the clinician can be made more manifest and available for examination.

What is and is not considered influence. It is important to know whether clinicians view what they are doing as influencing clients. If clinicians believe they are not influencing when they are, their lack of awareness may impact the clinical work. Not taking into account elements of one's clinical approach which have clear implications for how the client is impacted can be neglectful at best and potentially harmful at worst. Knowledge about how social work clinicians currently view what is and is not influence can provide data to understand clinician beliefs about the phenomenon of influence, and perhaps again heighten awareness of what ought to be made more explicit to clients in regard to the way that they will be helped.

Appropriate and inappropriate influence. In addition to knowing what is considered influence and what is not, it is also essential to know what kinds of influence, if any, are deemed as appropriate within the clinical context, and what are clearly regarded as inappropriate. While practitioners might agree that certain actions or attitudes by the clinician are in fact influence, they might disagree as to whether such actions or attitudes are appropriate. The study is intended to be suggestive of whether there is consistency amongst the social work clinicians in the study as to the types of influence they consider appropriate and inappropriate. If there is consistency, it would confirm that the profession applies certain common standards regarding the use of
influence in clinical work. If there is no consistency, then significant questions are raised about the standards by which clinicians judge when and how to use influence in clinical practice.

**Consistency in clinical work.** If influence is ubiquitous to the clinical situation, then awareness of how influence is appropriately utilized can serve to help clinicians apply standards more consistently to their clinical work. Further, greater awareness of one's own use of influence, as well as how others view the phenomenon, can only serve to heighten the conscious and intentional choices that are a part of the clinical situation, thereby increasing consistent application of standards relating to clinical work.

Clinical social workers, in particular, because of their orientation to a biopsychosocial understanding of the client-in-context and all of the actual impingements upon the client within their environment, need particularly to be aware of their influence upon the client and client system.

**Assumptions and Limitations**

**Assumptions:**

1. It is assumed within the context of this study that influence is ubiquitous and an unavoidable byproduct of all human interaction, including, and perhaps particularly, therapeutic interchanges.

2. It is further assumed that it is not desirable to eliminate influence from the clinical atmosphere, and that influence is a necessary, basic part of the clinical process, which is ultimately aimed at precipitating change in the client (See Strupp, 1973).
3. It is also assumed that many social work clinicians reflect mixed feelings regarding the use of influence because of experienced value conflicts—between what the profession values (e.g., especially client self-determination and autonomy) and what is necessary to produce change with and for a client.

Limitations

Several limitations are inherent in this study.

1. This study primarily utilizes a self-report measure and is subject to the unreliability of such measures. One bias to which this study might be most vulnerable is the potential for the respondents to have answered in a direction that conveyed greater awareness of the issue of influence because of its connotations within the social work clinical practice community.

2. The construct of influence lacks a consensus meaning and definition within the helping professions, and therefore reflects an elusiveness that may color its study.

3. The study sample (see below) represents a particular segment of social work clinicians, and may not therefore be reflective of the majority of clinical social workers. The generalizability of the study results are therefore severely limited.
Self-determination. One of the central value tenets of social work practice has been the concept of self-determination. It is a goal deemed so essential to social work practice that it is included in the National Association of Social Workers Code of Ethics, which invites practitioners, within a context of providing for the dignity and worth of the person, to "promote clients' socially responsible self-determination" (NASW, 1997, p. 5). Reflective of the strength of commitment to the value in the profession, McDermott (1975), who defines self-determination normatively as "that condition in which an agent's behavior emanates from one's own wishes, choices and decisions," writes:

Far from being a mere means to any goal, the individual's right to make his own decisions and choices affecting him has long been regarded as one of the cornerstones of the moral framework to which democratic western societies are committed, a framework determining both the goals that may be justifiably pursued and the means that may be chosen to attain them. (pp. 1-2)

Biestek and Gehrig (1978) assert that "the innate dignity and value of the human person" is the "supreme value" of the social work profession (p.1) and that "client self-determination is the first logical consequence and test of the supreme value" (p.4). Levy (1983) views the right of client self-determination as an ethical tenet of such dimension that any necessary deviation from the principle must be sufficiently clear and justified "to meet the test of unbiased and systematic peer judgment" (p. 906). Tower (1994) decries the erosion of the commitment in social work to the value of self-determination in the name of expediency, protection or cost containment.
Clinicians in general would likely support the principle of self-determination as a fundamental value, and as a central guiding practice principle. Assisting clients to move productively forward with their lives in a way that preserves their dignity and self-worth would likely describe, in the most basic terms, a consensus definition of a central goal of most social work practitioners.

**Limitations on the Principle of Self-determination.** Despite the fact that self-determination has been held to be such a central value, some fundamental questions regarding the concept have been raised within the profession.

Part of the difficulty has been in the understanding of the meaning of the concept. While self-determination can be viewed as a philosophical precept and as a basic human right that stands as a moral imperative on its own terms, the concept has been seen in various ways within the profession (Rothman, 1989): as a utilitarian practice tool to meet certain therapeutic ends (Biestek, 1957; Hollis & Woods, 1981), as an antidote to cultural alienation and a way of combating societal forces that limit individual autonomy (Perlman, 1965), as a political tool for liberating the masses (Keith-Lucas, 1975), and as a simple existential pragmatic reality, a concept that acknowledges the fact that many decisions can be made only by the person who will be affected (Keith-Lucas, 1975). Abramson (1985) likens the concept of self-determination to the notion of autonomy, which she suggests has four components relevant to the social work concept of self-determination: (1) autonomy as *free action* means that an act is voluntary and intentional; (2) autonomy as *authenticity* means that an action is consistent with the person's attitudes, values, and life plans; (3) autonomy as *effective deliberation*
means action taken when a person believes that he or she a) is in a situation calling for a decision, b) is aware of the alternatives and the consequences of the alternatives, c) has evaluated both the alternatives and their consequences and d) has chosen a course of action based on an informed evaluation; and (4) autonomy as moral reflection means the person has given considerable thought to and has accepted the moral values on which the chosen action is based. This variety of perspectives upon what is meant by self-determination undermines consensual clarity about its application in the clinical setting.

More fundamental, however, are the questions raised about whether self-determination is genuinely possible. Biestek (1957) would suggest that not all clients are equipped to assume complete responsibility for self-direction and autonomy, particularly children, the aged, developmentally disabled, and those badly mis- or under-informed. Biestek (1957) and Bernstein (1960) suggest that there are significant external restraints—legal, economic, social, familial—upon self-determination which realistically limit client choices. The social control functions assigned to the social work profession, and competing ethical and value considerations also place constraints on the exercise of self-determination (Bernstein, 1960; Rothman, 1989). Freedberg (1989) suggests that the dilemmas inherent in practice leave agencies in the position of controlling services, effectively placing pragmatic limits on self-determination. It is perhaps because of all of these constraints that Perlman (1965) concludes that self-determination, while important as an ideal, is mostly illusory.

Clearly because of the fields of practice for clinical social workers, the notion of self-determination must be constrained or at least tempered
by other considerations. In child welfare settings, the concerns regarding
the welfare of the child may interfere with permitting full autonomy of the
child or the parents. In correctional settings, the social worker must
serve the best interests of society in a context which already has placed
constraints upon the client's autonomy and choice by his very
involvement within the court and correctional system. Even in family
service, mental health or private practice settings, the client may have
come into contact with the practitioner unwillingly, e.g., as in a referral
by an employer for a drug or alcohol problem, or by a spouse who is
threatening divorce.

In addition to the practical, legal and societal constraints upon
clients, the issues impinging upon self-determination extend, in subtle
and profound ways, to more fundamental elements of the practice of
clinical social work. A central problem in clinical work resides in the fact
that the client comes to a practitioner for help with some constellation of
life issues or problems, and the clinician is an "expert" practitioner, who
has the knowledge to assist the client with those issues. The dilemma for
the clinician, then, has to do with balancing two competing ethical
principles:

(1) the self-determination or autonomy principle that states that
the person most affected by a decision should make that decision,
and (2) the benefit principle that posits that the professional social
worker has the knowledge and skill necessary to best assure a
positive outcome and is, therefore, responsible for making the
decision that will secure the optimum benefit for the client
(Lowenberg & Dolgoff, 1992, p. 97).

All social work clinicians are continuously caught by this
predicament—the wish to preserve the maximum client autonomy, as
embraced by the NASW Code of Ethics, while at the same time utilizing
the expertise of their training, knowledge and experience to assist the client. In this context, avoiding impact or influence upon the client is difficult to impossible at best, and, absolutely undesirable at worst, if the client has come for help which requires clinician skill and intervention. Indeed, there are situations which call for strong, clear and direct action upon or in behalf of the client—e.g., in response to aggressive or self-destructive behaviors, abuse and neglect—and which remove large segments of self-direction or autonomy from him.

It is little wonder, then, why there is inherent tension and confusion for the practitioner regarding these issues. The issue of self-determination creates "one of the most common and most perplexing dilemmas for social workers" (Abramson, 1989, p. 387) in determining what course of action to take in clinical work. And Kelman (1969) questions the functional feasibility of pursuing therapeutic change while at the same time providing helping influence in a neutral manner. Within this context Rothman (1989), while acknowledging the implicit value of the concept of self-determination as an ethical concept and general guide to practice, suggests that "given its long and entrenched history of convoluted usage it would be best set aside as a dominant precept in social work" (p.608). Rothman recommends a more calibrated approach, which acknowledges that

intervention. . . is guided by a professional who is charged by society to produce beneficial outcomes that are based on objective, knowledge-driven analyses and judgments. The prime responsibility, therefore, for making professional decisions about means of helping the client falls to the practitioner (p.608).
Influence.

**Introduction to the Concept.** The issue of influence within the clinical relationship has been under-discussed in the social work literature, as well as in the broader literature of the helping professions. The concept of influence has been ubiquitous—explicitly expressed or implied—in the general therapy literature. The process of clinical work is intended to create change in a direction seen both as desirable by the client and "healthy" or "productive" or at least "useful" by the clinician.

In his classic paper, Hans Strupp (Strupp, 1973) delineated the basic ingredients of psychotherapeutic change:

**Condition 1**
The therapist creates and maintains a helping relationship (patterned in significant respects after the parent-child relationship) characterized by respect, interest, understanding, tact, maturity, and a firm belief in his ability to help.

**Condition 2**
The foregoing provides a *power base* from which the therapist influences the patient through one or more of the following: (a) suggestions (persuasion); (b) encouragement for openness of communication, self-scrutiny and honesty (partly under Condition 1); (c) "interpretations" of "unconscious material," such as self-defeating and harmful strategies in interpersonal relations, fantasies, distorted beliefs about reality, etc.; (d) setting an example of "maturity" and providing a model (partly under Condition 1); (e) manipulation of rewards. (p. 132, italics mine)

Strupp's language explicitly presumes influence, suggestion, persuasion are a part of the therapeutic process, and, at that, an absolutely necessary part. Halmos (1965) concurs: "Unless we mean therapy to be therapeutic and, therefore, determining and directing in important ways, we can hardly expect to be helpful" (p. 92). Hasenfeld (1987) asserts that much of the emphasis in social work practice theory is on the formation of a relationship that is voluntary, mutual, reciprocal, and trusting. . .[and] although social work practice theory
recognizes that the worker typically exercises considerable power over the client, the impact of power on the clinical relationship and outcome remains understated." (p. 469-470)

The debate about influence or control has existed in the social sciences since the middle 1950s, when behaviorist theory and methodologies were being developed. Skinner (1956) states

All men control and are controlled. The question of government in the broadest possible sense is not how freedom is to be preserved but what kinds of control are to be used and to what ends. (p. 1059)

Skinner reflects the stance of others who take this most definitive view regarding influence (e.g., Ellis, 1972; Haley, 1963; Strong, 1968), that the therapist needs to actively assert control and influence over the client in order for the client to improve. And Gillis (1974) states that "all modern psychotherapists, whether they know it or not, engage in maneuvers and manipulations that add to their power over the patient" (p. 91). While an alternative view exists (e.g., Rogers, 1951; Gilbert, 1980), that the therapist needs to minimize his or her control and influence, it does appear that the issue of therapist influence must at the very least be addressed, in order to delineate the presence, absence and degree of influence.

**Definition of Influence.** The concept of influence is related to several other constructs--most notably power, control, and, in social work in particular, the concept of authority. It has been suggested that power, control and influence are essentially interchangeable, as there has been no consensus regarding meaningful differences between the concepts in the psychotherapeutic literature (Tracey, 1991). The concept of authority has been differentiated from power wherein the former is "the established right to make decisions on pertinent issues" and the latter "the capacity
to control the behavior of others" (Maclver, 1962, as quoted in Palmer, 1983), a distinction that takes into account social work settings which are sanctioned to exercise authority over clients (e.g., child welfare, corrections). Dworkin (1990) notes that, because they are closely related, power and authority are difficult to differentiate, and often used interchangeably in the social work literature.

The definition of power suggested by Heller (1985)—"a quality of possessing intentional and meaningful impact in relation to the self, others, and the environment," (p. 30)—comes closer to addressing the meaning of the term within the more typical social work clinical context. For purposes of this study, perhaps the simplest and most operationally useful definition of influence issues from Cooke and Kipnis (1986): "any attempt by the therapist to change a client's behavior, cognitions, or feelings." (p. 22)

For the purpose of this study, then, clinical influence is defined as follows: the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings.

Neglect of the Concept of Influence. Reflecting on the relative absence of reference to the issue of therapist influence in the therapy literature, Heller (1985) suggests that the denial and neglect of the subject has been due to several general factors: (1) traditional psychoanalysis, rooted in the medical model, valued a neutral, scientific stance, leaving little room for the role of considering therapists' feelings, thoughts or reactions; (2) negative connotations have been assigned to therapist reactions, as if they were intrusions into the flow of client expressions, and ought to be excised from the therapeutic process; (3) a tendency, and perhaps need, for clients and therapists alike to view
therapists as free from conflicts or difficulties, allowing them, therefore,
to conduct treatment without any "contamination" from their own
reactions; (4) the fact that therapy has maintained an almost exclusive
emphasis upon the client's personality, which sometimes may reflect
therapists' attempts to maintain dominance within the therapy context.

The specific reluctance to consider the issue of influence,
particularly with the psychoanalytic framework, is detailed by Gadpaille
(1972):

In analytic terms, power is a dirty word whether one has it or
doesn't, accepts it or repudiates it. The weight of analytic writing,
[however minimal], remains opposed to the exercise of anything
that might be considered power by the analyst. . . .The analyst is
envisioned as solely an enabler in the maturation of the
analysand's ego, and this function is somehow not perceived as the
exercise of power. (p. 175, italics mine)

Heller (1985) speculates that the reasons for avoiding the issue of
influence within the helping professions have to do with not wanting to
acknowledge the extent, the limitations, and the struggle with the
complexities and anxieties associated with decisions to exert influence.

Values and Influence. Rhodes (1986) expands the discussion of
influence within the social work context to include the consideration of
values. Concurring that, "whatever its form, counseling in social work is
an attempt to change others in some way—to increase their autonomy, to
enable them to love and work, to make the world better—and in this
sense it is a 'moral re-education,'" (p.83). Rhodes would contend that
social workers are, in Halleck's (1971) terms,

guided by a belief system—by some vision of the kind of change
that would improve his patient's life. He is also guided by some
moral principle that limits the extent to which he would help a
patient obtain happiness at the expense of the happiness of others.
(p. 19)
Challenging the notion that the treatment process can be value free or ethically or politically neutral, Rhodes suggests the question is *what* values, *what* ethical and political points of view should you present to the client? Noting further that, because language and thought are intertwined, language itself contains moral dimensions, and values imposed upon the therapeutic situation can come about in the very descriptions of clients. It is the social worker who answers the questions: Who needs treatment? What needs treatment? What is a successful outcome of treatment? How can the outcome best be achieved? Weick (1993) indicates the social worker, using her expert role, utilizes the language of the disease model as a means of organizing and orienting the treatment. Therefore, it may be, as McKnight (1977) suggests

> When the capacity to define the problem becomes a professional prerogative, citizens no longer exist. The prerogative removes the citizen as problem-definer, much less problem solver. It translates political functions into technical and technological problems. (p. 85)

The concepts we use are rarely free of judgment, according to Rhodes. "Need" suggests a deficiency within the client, rather than a right or condition to be met (McKnight, 1977), and the determination of what needs are "basic" or most important is to decide what human activities and desires are most important (Rhodes, 1986).

Rhodes further makes the case that judgments are inherent in terms like "illness," "symptom," "diagnosis," "treatment," and the diagnostic categories, and that social workers decide what counts as a social malfunction and which malfunctions are most serious. Thus, if we "diagnose" a client as having a "borderline personality," we are making (and accepting) judgments about how people should function and what their lives should be like. (Rhodes, 1986, p. 85, italics hers).
Dworkin (1990) adds that there may be many broader, usually unacknowledged, value determinants in the organizational, political and economic context within which treatment takes place.

**Sources of Influence.** Hasenfeld (1987) suggests that social workers have three primary sources of their influence: (1) the power of expertise, derived from social workers' specialized knowledge; (2) persuasion, which issues from the worker's capacity in interpersonal skills, especially empathy, trust and rapport with the client; and (3) the legitimate power which derives from dominant cultural values and authoritative norms. Palmer (1983), building on the work of Studt (1959), defines five kinds of authority that dwell within the social worker: (1) legally constituted authority, illustrated by the protective functions of child welfare agencies; (2) institutionally constituted authority, as reflected by the function of the adoption agency, which sets up procedures and standards whereby applicants are assessed; (3) inherent authority, which is reflected in agency function, as in a family service agency; (4) authority of expertise, based on knowledge, skill and competence; and (5) authority inherent in the person, including the ability to function independently, a knowledge of life, and the personal strength to make decisions and hold to them.

Heller (1985) provides the most richly developed categorization of the sources of power and influence for the clinician, and a basis and framework for examining influence at the pragmatic level of practice. He suggests that the view of psychotherapy in the culture has in effect assigned certain powers to therapists, attached to specific roles expected of them:
Ascribed powers inherent in the culture: (pp. 57-73)

ROLES
A. Doctor role (Amelioration of psychological distress)
B. Scientist/Expert role (Explainer of human behavior)
C. Parent role (Nurturant limit-setter)
D. Guide role (Spiritual facilitator)

CULTURAL POWERS
A. The power of knowledge (Intellectually resourceful/even omniscient)
B. Power of faith (Expectation of hope/betterment)
C. Power to comfort ("The healing touch"; ability to assuage psychic pain)
D. Power of heroism (Savior from life's distresses)
E. Power of intimacy (Fosters an atmosphere of non-threatening closeness, in which clients reveal themselves. Also fosters the power of knowledge of another human's most private thoughts and ways of being)

These ascribed powers, Heller suggests, provide the basis for the influence that the therapist possesses in relationship to the client. They represent the source from which emerges the power of the particular kinds of influence that therapists possess.

Kinds of Influence. What kind of influence does the therapist have upon the client and upon the clinical process? Little attention has been accorded this question within the field. Again, Heller (1985) suggests a typology for the kinds of influence that a clinician has within the therapeutic context:

Therapist behaviors, deriving from Cultural Powers, which may influence clients (pp. 71-73):

A. Knowledge powers (from doctor, scientist, parent roles)
   1. The power to define disease and health in any given interaction, or overall
   2. The power to label behavior and/or non-observable phenomena
   3. The power to offer explanations for those phenomena
   4. The power to assess reality and the limits of what is realistic
   5. The power to make treatment decisions
B. Faith powers (primarily from doctor, parent, and guide roles)
   1. The power to convey faith in the client's ability to change
   2. The power to convey faith in the client's untapped abilities or potential abilities
   3. The power to communicate faith in the therapeutic process
   4. The power to experience and communicate faith in one's self as a therapist
   5. The power to convey faith in other people and in the vicissitudes of life

C. Comfort powers (primarily from doctor and parent roles)
   1. The power to repair emotional wounds
   2. The power to be supportive
   3. The power to confirm the client in some pursuit
   4. The power to compensate for some specified prior deprivation
   5. The power to ease anxiety or enhance anxiety through interventions

D. Heroic powers (primarily from doctor, scientist & guide roles)
   1. The power to rescue the client from dire psychological or psychosocial circumstances
   2. The power to point toward a life course, or at least to foresee the potential pathways
   3. The power magically to undo family wrongs or at least act in contrast to these
   4. The power to champion creative energies
   5. The power to represent or model a heroic figure

E. Intimacy powers (primarily from parent and guide roles)
   1. The power to create an intimate atmosphere in the therapeutic setting
   2. The power to determine the nature of the intimacy (i.e., friendship vs. professional relationship only, etc.)
   3. The power to listen to and explore intimate personal concerns
   4. The power to reveal one's own personal concerns
   5. The power to govern the occurrence of comfort between therapist and client

Considered individually, each of these potential sources of influence upon the client would have implications for every case situation and
some of them for nearly every session. The ramifications for the practitioner are enormous, and well worth examining in a systematic manner. It is Heller's work, and his enumeration of powers inherent in the therapist, that provides the foundation for the typological formulation and resultant instruments that are utilized to examine clinician behavior in this study.

**Influence within a Psychodynamic Perspective.** The four major forms of psychodynamic thought that have been adopted and adapted by clinical social work—classical analytic thinking, ego psychology, object relations, and self psychology—all share some commonalties in terms of their underlying assumptions. Some of those assumptions include:

- intrapsychic events are the core of psychological functioning;
- much of what determines behavior is beyond awareness;
- current individual psychology is to some extent deterministic, based on earlier life experience;
- one's psychological and emotional life is based on achievement of definable developmental increments, and that deficits in appropriate development result in psychological deficits;
- certain psychological structures are necessary for appropriate human functioning and need to be in place in order for mental and emotional health to occur;
- psychotherapeutic intervention is aimed at cognitive and affective understanding of these internal psychic experiences and structures;
- the individual psyche is the primary unit of intervention and
- self awareness will foster change.
By and large, psychodynamic thought conceptualizes the treatment process as one in which the practitioner is able to remove him or her self from active impact upon the client's psyche. Interventions are generally aimed at bringing about awareness within the client, or developing intrapsychic structures that, according to the theories, govern psychological functioning. In general, the direct influence of the therapist is seen as being intentionally minimal.

The one acknowledged potential source of influence by the clinician resides in the concept of countertransference, an openly acknowledged (although not always precisely defined) phenomenon in psychodynamically-oriented treatment. Originally defined by Freud (1910) as the unconscious, unresolved responses of the clinician to the transference of the client, the concept evolved to have broader meaning to include all reactions of the clinician toward the client (Heimann, 1960). Several theorists (Kernberg, 1975; Langs, 1973; Winnicott, 1949) expanded the concept to view countertransference reactions as an inevitable part of the clinical process, which provide helpful information contributing to the understanding of the client. Racker (1957) delineated two forms of countertransference: complementary transference, in which a client induces in the clinician an earlier relationship pattern so well that the clinician feels, thinks and acts like the that significant other, a concept closely related to projective identification (Kernberg, 1975); and concordant transference, which is very close to what we conceive as well-attuned empathy and understanding of the client (Geddes & Pajic, 1990). While other analytic theorists have debated the nature of countertransference reactions, and there is further debate as to how such reactions should be utilized and fed back into the treatment
process, it is generally accepted that it is the clinician's responsibility to define, manage, and limit the impact of countertransference reactions, and to insure that they are utilized "therapeutically" (Mishne, 1993). Limits on the intrusion of the clinician's reactions into the client's psychic space are generally accepted in the psychodynamic literature as essential in actual practice.

Each analytically-oriented psychology suggests certain parameters, at least implicitly, related to the degree of influence of the clinician.

*Classical analysis*, for example, would suggest the need to limit input from the therapist, except for carefully timed interpretations (interpretations, of course, based on the model of psychic functioning elaborated by analytic theory: making the unconscious conscious). This method primarily relies upon the process of insight within the client as the principal pathway to change. Techniques derived from this model require neutrality and restraint and tend to be much more indirect, reflective and interpretive (Mishne, 1993). While such issues as countertransference are acknowledged as being potentially impactful upon the treatment and upon the patient, for the most part, countertransference within the traditional analytic model is seen as the responsibility of the practitioner to excise from any possible contamination of the treatment process. At the very least, the practitioner is expected to utilize extremely judiciously—with restraint, containment and self-awareness—insights derived from the practitioner's analysis regarding her countertransference, in order to further the treatment (Mishne, 1993; Wolstein, 1988). While clinical social work has not represented itself as primarily deriving its theory or technique from traditional classical analysis, admonitions to the
practitioner within clinical social work tend to reflect the values of the original analytic approach, and clinical social workers are advised to maintain control over their own reactions, values, and other potential intrusions into the treatment process (See, for example, Strean, 1986; Teitelbaum, 1991).

*Ego psychology*, as adapted to clinical social work, suggests the need to support and elaborate existing well-functioning ego structures and to assist, if necessary, the client in developing new ego skills (Goldstein, 1986). This permits not only interventions which promote self awareness, but also those which suggest direct action on the part of the client. Change occurs from: utilizing autonomous ego functioning to master developmental or life crises, understanding self in relation to others, learning new skills and problem-solving capacities, and corrective emotional experiences. Techniques utilized in this model include those which are generally considered to be more "sustaining, directive, educative and structured," including environmental intervention (Goldstein, 1986, p. 394). While clinician intervention within the ego psychology framework is much more reality-oriented, active, and aimed at efficiently restoring optimal functioning within the client, the primary focus of the therapist is on the client’s inner psychological life, and upon engaging the client’s active healthy ego functioning in the therapeutic process. The expectation remains that the practitioner, for the most part, keep her own influence and attitudes out of the clinical process; countertransference, in particular, is seen as the worker’s responsibility to "be understood, controlled, or resolved in all therapeutic endeavors" (Goldstein, 1984, p. 201).
In their ego psychology-derived clinical social work theory, Woods and Hollis (1990) elaborate what they consider to be direct influence, defined as the various ways the worker tries by force of opinion to promote a particular behavior by the client. This is viewed as a legitimate treatment tactic, but one to be utilized very sparingly and cautiously by clinicians. Woods and Hollis do not view other techniques—for example, exploration or description—as being therapist influenced.\footnote{This author contends that the very selection of what to explore, or what descriptions to elaborate, are impacted and shaped by the clinician.}

*Object relations theory* adds theoretical understanding to the importance of human interactions and the essential nature of appropriate relatedness in early developmental stages to psychological and emotional health. Even with the emphasis upon human interaction, most object relations theorists emphasize, in technique, the classical model of utilizing interpretation as the primary tool for change (Mishne, 1993).

The special instance of countertransference—which through projective identification by the client induces the clinician to feel and behave in a particular manner (reflecting either the client’s inner conflicts or prior unhealthy relationships)—is viewed as a diagnostic tool providing insight into the client’s inner experience. The clinician must then manage the feelings and reactions produced within the treatment context. The emphasis in object relations theory generally is upon interpreting the projective identifications (Kernberg, 1975), although other object relations theorists have emphasized the character of the therapeutic relationship as in itself healing (See Teitelbaum, 1991). As with traditional classical thinking and ego psychology, however, for the
most part, managing the countertransference reactions is viewed as the responsibility of the clinician, so as to be at least not damaging to the therapeutic process.

*Self psychology* (Kohut, 1971; Kohut, 1984; Kohut & Wolf, 1978) and its adaptation to clinical social work (Elson, 1986) elaborates the most clear indication of the direct influence of the clinician within the four major psychologies. In self psychology, the relationship between the client and clinician is considered the medium for change. Through the therapeutic process of managing transferences toward the clinician and of responding empathically toward the client (combined with inevitably occurring empathic breaks and their repair), the client is able to build and elaborate a self structure which had previously been absent because of faulty or inadequate earlier life experience within primary relationships. The theory posits that clients utilize the clinician as an appropriate and corrective selfobject, thereby developing a firmer, clearer, more functional and resilient self.

In this model influence is generated by the nature and the quality of the relationship, and it is how the relationship is managed that impacts the client. With its emphasis upon the role of empathy in furthering therapeutic ends, self psychology underlines an active role in the therapeutic process, and active mutual participation in the creation of the therapeutic context by both clinician and client.

Countertransference, viewed primarily in the other psychologies as a phenomenon essential to purge or control within the clinical environment, is viewed in self-psychology as a naturally occurring part of the clinical environment. Stolorow, Brandchaft and Atwood (1987) go so far as to state “transference and countertransference together form an
intersubjective system of reciprocal mutual influence." (p. 42) This then requires open acknowledgment of the clinician's contribution to the transference/countertransference atmosphere, so the client has free choice as to whether to accept or reject the clinician's organizing principles or his own internal psychic experience.²

Another social work theorist grounded in relational theory, Saari (1991), suggests that it is not possible for the clinician to avoid responsibility for the content nor the process of treatment:

...even if the therapist never makes any statement of belief during the course of a treatment enterprise, the content of the client's meaning system will still be influenced by the therapist's questions, which will have been formulated out of underlying theories and beliefs about treatment and human beings. (p. 166)

As can be seen, the psychodynamic model has evolved to encompass conceptualizations of the reciprocal, iterative nature of any human interaction. This is in keeping with recent constructivist thinking (Watzlawick, 1984), which suggests that reality is created within a particular framework, a framework that represents the view and perceptual set of the beholder; the reality created, then, is influenced by the beholder. Therefore, in any human interaction, a meaningful reality is created as a part of the interaction between the parties involved, with each party contributing, and each party influencing the reality-constructing process. This is no less true of the therapeutic situation (Saari, 1991), and, in fact the nature of the clinical process presupposes that the client has come in for assistance, and to be impacted in some

² This approach, then, permits a more open examination of potential influences by the clinician in the therapeutic setting, thereby increasing choices, and hence, presumably, the self-determination of the client.
sort of way through the process of interaction with a presumably more knowledgeable professional.

**Social work and systems.** Clinical social work also has at its core a basic frame of reference that includes system theory (Bertalanffy, 1968) as a core part of its approach (See, for example, Compton & Galaway, 1984; Germain & Gitterman, 1980; Pincus & Minahan, 1973). Because of its fundamental commitment to viewing people in their situational biopsychosocial context, social work necessarily understands the multiplicity of influences upon an individual's life, and the reciprocity of any human interaction, including that between client and clinician. It is this author's view that psychodynamic theory, with its evolving theoretical shift toward a more relativist point of view, has therefore come closer to system theory in recognizing the inevitability of influence by the therapist upon the client as a naturally occurring part of the treatment process. Less clear, in either set of theories (psychoanalytically-derived or systems), is precisely what is considered influence, or what is considered appropriate influence.

**The Unavoidability of Clinician Influence.** It is argued here that, like the now generally accepted notion in communication theory that one cannot not communicate (Watzlawick, Beavin, & Jackson, 1967), it is also impossible, in interaction with another human being, not to have influence upon that other. As noted earlier, some practice theories are explicit about the intention to be influential: behavior therapy (Thomlison, 1986), task-centered (Reid, 1986), and certain forms of family therapy (See, for example, Haley, 1963; Madanes, 1981; and Minuchin, 1974) are all quite clear about the intent to influence clients.
As noted above, analytic theory has paid relatively little attention to the matter of influence. However, recent psychoanalytic theory, particularly self-psychology (Kohut, 1984) is suggestive of the notion that individuals are in need of healthy selfobjects throughout the life cycle, and that clinicians serve a selfobject function in the therapeutic setting as a central means of producing therapeutic change, assisting the client to form a healthier, more functional, more elaborated "self." Therapeutic change, therefore, comes about within an interactional context and with the influence of the clinician. In his elaboration of a theory of the development of the self, Stern (1985) is even more explicit regarding the recursive interactional and explicitly social evolution of the selfhood throughout the life cycle. Elements of self are in constant redefinition and refinement in interactions with others. Implications for the therapeutic relationship are significant, and suggest that it is in part the influence of the interaction with the clinician (often providing possibilities for experiencing and elaborating the client's self in new ways) which produces change. In the context of clinical social work, Saari (1991) elaborates a clearly articulated clinical theory which is explicitly interpersonal, and in which the client's successful experience "is heavily influenced by the quality of the experience within the treatment itself (p. 182)," emphasizing a long held social work practice notion that the qualitative nature of the therapeutic relationship is crucial to successful outcome.

If, in any interactional context, there is reciprocal impact upon the parties involved in the interaction, and if the therapeutic situation is a special case of interaction in which one party is specifically intent upon receiving assistance for some sort of change from the other party, then it
clearly follows that the clinician is in the position to be expected to influence the client, and that almost every element of the therapeutic situation is designed to foster and further that influence.

It is argued here that everything a clinician does—even when she does "nothing"—influences the client. From the structure of the therapy (e.g., when and how often to meet) to the offering of direct suggestion (e.g., referral for alcohol or drug evaluation) to the theoretical constructs that guide clinician inquiries (e.g., exploration of historical experience), the clinician is continually influencing the therapeutic atmosphere, and frequently, in a quite definably direct way, the client.

The stance of this inquiry, then, is that therapist influence is ubiquitous to the therapeutic context, and cannot, indeed should not, be avoided. Influence, in this sense, is neither inherently "good" nor "bad," but simply a fact of the clinical context. The intent of the study is to determine what currently practicing, psychodynamically-trained clinicians view as influence, how they see themselves influencing, and what they see as appropriate and inappropriate influence.

**A Typology of Clinician Influence.** Drawing from Heller (1985) and Motlong, Murdock, Reitz and Wells (1995), this author proposes a typology of clinician influence. Again, the working definition of influence for this study is: the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings. Such influence can be subsumed under four separate categories: direct behavioral influence, contextual influence, conceptual influence, and external influence.

**I. Direct Behavioral influence.** In this category are included those behavioral, cognitive and affective directives which constitute a
significant portion of therapeutic interventions, as well as meta­
communication by the therapist. This would include:

1. Therapeutic Interventions. Therapeutic interventions tend to be
of two types: high-level directive and low-level directive

High-level Directive. High level directive interventions are generally
overt, and usually thought about and planned. They include:

   a. Suggestion and advice. This category would perhaps
   consensually be agreed upon as one of the clearest forms of clinician
   influence. For example:

       "I think you might try time-outs with Johnny to help with his
tantrums." (Direct Behavioral)
       "You might feel better if you did something nurturing for
yourself, like a quiet walk along the beach." (Affective)
       "Perhaps if you tried to think about a competing pleasant
thought, you might feel less anxious." (Cognitive)
       "I would strongly recommend a medication evaluation."
       (Biological)

   b. Interpretation/Confrontation. These interventions, by their very
nature reflect influence, by forcing the client to examine aspects of
internal experience, external behavior, or particular percepts about self
and the world.

Low-level Directive. Low level directive interventions are generally
overt, and may or may not be thought about or planned.

   a. Exploration. Some practitioners might not consider exploration
with a client a form of influence, but it is argued here that the choice of
which elements of what a client presents is to be focused upon for
further elaboration resides primarily with the clinician. It is the social
worker who picks and chooses which elements of a client's problems or
"story" might productively be examined in greater depth. For example:

       "Tell me how you felt about that."
"Say more about how your father used to intimidate the family."
"What was your response to her outburst?"

In each of these situations, it is the clinician, by her choice of when to intervene in which way, who influenced the flow as well as the process and content of the therapeutic interaction.

b. Reflection. The complex process of meaningfully feeding back to a client what they have communicated also can be considered influence in two ways: (1) the reflection highlights or underlines a particular aspect of the client's experience, which imbues it with a greater significance to the client, thereby impacting his view of it, and (2) reflections frequently solidify a sense of understanding and empathic connection between clinician and client, thereby contributing to an atmosphere that promotes trust and greater openness on the part of the client, impacting the client to explore further and safely necessary elements of his situation.

c. Support. Even this most benign of interventions possesses power. Support often takes the form a reinforcing something that a client has said or done. By affirming that particular thought, feeling or behavior, its importance is emphasized, usually influencing the client to magnify its importance as well. Support is usually given to elements of the client's experience that the clinician views as appropriate, thereby reflecting the clinician's bias as to what constitutes appropriate thought, feeling or behavior for a "healthy" human being. The client is inevitably influenced to view his own behaviors in a similar way (unless there is such a value conflict between what the client views as appropriate human functioning, and what the clinician views as appropriate, that the client terminates contact).
2. **Clinician metacommunication.** Metacommunication here is defined as those paralinguistic cues provided by the clinician that inform the manner in which the clinician's verbal communication is to be understood. Meta-communication by therapist is usually covert, and usually neither thought about nor planned. Amongst the metacommunicative elements are:

   a. **Use of language.** If the clinician uses "professional" or "clinical" words ("We will be making a diagnosis of your mental and emotional status, and, once we arrive at that clearly, we'll develop an appropriate treatment plan"), it will have very different meaning and impact from language couched differently ("We'll try to arrive at a mutual understanding of what your situation is, and then work together to figure out ways to make it better").

   b. **Style and tone of speech.** A somewhat authoritarian tone will have a very different impact on a client than a relaxed, informal tone.

   c. **Relative activity or inactivity of the clinician.** A high level of activity may be perceived as the therapist taking charge, or being intrusive, whereas a low level of therapist interaction may communicate disinterest or respect for the client's autonomy.

   d. **Non-verbal signals.** These include such things as the posture, gestures, and facial cues of the clinician.

II. **Contextual influence.** This would include such things as:

   a. **The setting.** Hospital, clinic, agency, private practice, etc.

   b. **Physical arrangement of the treatment room.** E.g., clinician behind the desk; examining room atmosphere; bright and airy vs. dimly lit.
c. **Parameters regarding the structure of treatment.**

   - *When*
   - *How often*
   - *Length of session*
   - *Proscribed or anticipated length of treatment process*
   - *Who is to be involved in treatment (or who *not* involved)*
   - *What is the "payment," and how is payment handled*
   - *Other "rules," e.g., limits on phone calls, payment for missed sessions, etc.*

d. **Role expectations attached to and/or accepted by the clinician.**


e. **Expectations of client role re: how treatment is to proceed.** For example, is there a formal "consent to treatment," and how is the client informed (directly or indirectly) as to the role expectations as to what the client needs to do for the treatment to be "successful."

**III. Conceptual influence.** These areas influencing the treatment process include:

a. **Theoretical orientation(s) of the practitioner.** Of all matters influencing the course of treatment, this is probably most impactful, as it reflects fundamental ideas and basic assumptions in regard to how the practitioner views mental health and illness, and how humans make changes. This theoretical belief system will color how the practitioner views the client, and will be communicated (at least implicitly) to the client.

b. **Assessment system utilized by practitioner.** If the clinician uses the *Diagnostic and statistical manual of mental disorders (4th ed.)* (DSM-IV) (American Psychiatric Association, 1994) and evolves specific treatment protocols related to particular diagnostic categories, the
impact on the client and the course of treatment will be quite different from a practitioner who uses a psychodynamically-oriented formulation relative to the client's internal processes.

c. Clinician's beliefs about therapy. These include the clinician's beliefs about the process of therapy, therapist role in therapy, and the definition of what constitutes a completed therapy.

(1) Process of therapy. Is the process client-driven, therapist-driven, theory-driven or some combination of all? Is the clinical work problem-oriented or process-oriented? Is the treatment cognitively-oriented, feeling-oriented, behaviorally oriented, or a combination of elements? Do verbal processes prevail; are non-verbal processes important?

(2) Role of therapist. Is the therapist a coach, reflector, observer, interpreter, director, adviser, or a combination, and what degree of each if a combination. What are considered appropriate or inappropriate therapist behaviors?

(3) Definition of a completed therapy. Is the therapy complete when the client is satisfied, or when symptoms abate, or when certain personality changes have been incorporated? Or is there some other criterion?

4. Practitioner's personal values, moral, ethics and beliefs. While there is considerable emphasis in the profession upon eliminating these elements from influence upon the treatment process, it would seem impossible to do so completely. For example, if the practitioner believes that affairs are highly injurious to relationships, that belief may well impact how she approaches the issue in treatment, and the degree to which she influences the client in a particular direction. A clinician who
values openness and honesty in human interaction would have a
difficult time not conveying that to a client. A clinician's personal stand
on abortion rights would be difficult to eliminate entirely from the
choices made to explore the issue with a client.

**IV. External influence.** These influences are those that are primarily
impactful upon the clinician, and then, in "trickle down" fashion, upon
the client. These include:

a. *Societal norms and expectations.* Both clinician and client are
impacted by these, although the social work clinician in particular is
often called upon to uphold these values. For example, certain societal
norms about the appropriate treatment of children are frequently
enforced by social work clinicians in child welfare settings.

b. *Professional codes and guidelines.* The clinician is bound by
professional codes and ethics to do (and not to do) certain things. The
limits on confidentiality, as one example, certainly may influence client
behavior.

c. *Legal constraints and expectations.* Clinicians in the 1990s have
to be aware of potential liability for clients. This may influence them to
influence clients in particular ways, for example, refer to other
professionals or even suggest hospitalization as an extra-precautionary
measure even when perhaps not seen as therapeutically necessary.

d. *Institutional guidelines, expectations and constraints.* The setting
of the clinician frequently places pressures or constraints on clinicians,
which in turn influences the treatment. All agencies have certain rules
for what can and cannot be done with clients, for example a recent trend,
because of limited resources and high demand, to an emphasis on short-
term treatment.
e. *Service delivery system expectations and constraints.* In an era of increased "managed care," clinicians are being exposed to diagnostically related limits on treatment length, which influences the treatment process. As well, the economic constraints of governmentally-supported agencies may eliminate treatment options for certain clients.
CHAPTER III.

METHODODOLOGY

Methodological Procedures and Rationale. In order to determine the use and view of clinician influence, a questionnaire was developed to explore the study questions. The questionnaire (See Appendix A) primarily consisted of a) open-ended questions eliciting respondents' views of clinician influence, b) two scales, the Clinician Behavior Scale and the Influence Scale, which elicited respondents' views of 30 specific clinician behaviors, c) individual questions paralleling scale-item questions that served as cross-comparisons to several scale-items, and d) demographic data about the respondents (See Appendices).

The open-ended questions were designed to gather grounded data regarding the definition of and views about the use of appropriate and inappropriate influence by clinicians, and about conflicts that respondents experienced regarding their clinical role and client self-determination.

The Clinician Behavior Scale and the Influence Scale were based upon the Typology of Influence enumerated above. Each listed 30 specific clinical behaviors, divided into six subcategories of five questions each. Each subcategory corresponded to one of the six types of influence described in the Typology of Influence: High Level Directive, Low Level Directive, Metacommunicative, Conceptual, Contextual and External. Each scale consisted of the same Likert-type items. The Clinician Behavior Scale asked respondents to list the degree to which they practiced the clinical behavior. The Influence Scale provided a specific definition of influence ("influence: the process of impacting, with directly or
indirectly, the client's behavior, thoughts or feelings”), and then asked respondents to list the degree to which they considered the behavior as constituting influence. In this way, the respondents' views of what constitutes clinical influence and what kinds of clinical influence they themselves actually practice could be determined indirectly through their responses to the scale items.

The scales yielded a global score and six subscale scores for both the Clinician Behavior Scale and the Influence Scale. These scores then provided the basis by which to analyze the various demographic variables examined in the study. The separate questions that paralleled scale items served as a cross-check in regard to consistency of response by respondents, and also served as an additional examination of important areas relating to the area of influence.

**Population and Sample.** The initial examination of the issue of influence was done with an experienced clinical social work population. It was thought that such a group should reflect the greatest awareness of the issue of clinician influence, and, as part of the study was a test of the two instruments, the Clinician Behavior Scale and the Influence Scale, such a population would produce the most sophisticated data on the scales.

The study population consisted of clinical social workers, all current social work field instructors for a large midwestern urban university for the academic year 1996-97. The population included a range of ages and years of clinical as well as supervisory experience. These allowed for examination of three different levels of experience to provide comparison as to level of experience in practice and the attitudes and beliefs about influence—e.g. whether those practitioners who are
more experienced would be more or less likely to regard more clinician behaviors as constituting influence than would lesser experienced practitioners.

This population was chosen to provide a sample group from a psychodynamically-oriented school of social work. Although not all field work instructors at the university have been trained psychodynamically, the educational base and theoretical orientation of the school has been grounded in a tradition and history of psychodynamic thought. This therefore insured that at least some of the respondents would likely be psychodynamically-oriented. Because the psychodynamic point of view has been so broadly influential within social work theory and also has been the theoretical orientation reflecting the least acknowledgment of potential clinician influence, it was thought that a survey of clinicians oriented to or aware of psychodynamic thought would serve to reflect the actual awareness of the phenomenon within this group. This group was also not exclusively psychodynamic in orientation, thus permitting an examination of differences in theoretical orientation in regard to the view and use of clinician influence in the study population.

Questionnaires were sent to virtually all of the social work field work instructors for the academic year 1996-97 at the university (N=496). The actual number of respondents was 104.

Instrument. (See Appendix A.) The instrument utilized in this study was a questionnaire administered to the sample. The questionnaire was designed to elicit information about the subjects' views regarding their awareness of and use of influence in clinical practice.

The Influence Questionnaire consisted of a brief series of open-ended questions, relevant demographic data, a number of closed-ended
questions about aspects of influence, and an extended series of closed-ended, Likert-type questions, which constituted the Clinician Behavior Scale (CBS) and the Influence Scale (IS).

*Scales.* The Clinician Behavior Scales and the Influence Scales each contained the same items—30 clinician behaviors that could be viewed as constituting possible clinician influence. These items reflected the Typology of Influence elaborated by the researcher. Within the 30 clinician behaviors, there were five each of the six types of influence defined in that typology: High Level Directive (HLD), Low Level Directive (LLD), Metacommunicative (MET), Conceptual (CP), Contextual (CXT), and External (EXT). Responses were forced-choice on a 4-point Likert-type scale for each item of clinician behaviors listed in each scale.

The Clinician Behavior Scales asked to what degree each behavior represented what the respondent typically might actually do with a client in their clinical practice (*Rarely, Sometimes, Frequently, Almost Always*).

The Influence Scales first provided a clear definition of clinician influence (*"influence: the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings"*), and then asked respondents to what degree the respondent disagreed or agreed that the same 30 behaviors constituted clinician influence (*Strongly Disagree, Disagree, Agree, Strongly Agree*).

This procedure yielded a both a global score on the Clinician Behavior Scale (CBS) and an global score on the Influence Scale (IS). It also yielded a mean score on each of the Clinician Behavior Subscales and a mean score on each of the Influence Subscales. There was a Clinician Behavior Scale mean subscore and an Influence Scale mean subscore representing each of the six types of influence (HLD, LLD, MET,
CP, CXT, EXT). The higher the score over 2.50 on the CBS scales, the more that the clinician behavior is practiced by the respondent, and the higher the score over 2.50 on the IS scales, the more the respondent regards the behavior as constituting influence. In the same way, the lower the score below 2.49, the more the respondent regards the behavior as not constituting influence.

As well, the data was examined descriptively, as a percentage of respondents scoring 2.49 or below (Rarely/Sometimes) or 2.50 and above (Frequently/Almost Always) on the Clinician Behavior Scales, and percentage of respondents scoring 2.49 or below (Strongly Disagree/Disagree) or 2.50 and above (Agree/Strongly Agree) on the Influence Scales.

It was posited that utilizing a Likert-type scale in the questionnaire items would provide greater variance in response, thereby affording some measure of both the degree to which the behavior is typical of respondents as well as the degree of influence respondents regard each item, and each category of items, to represent. It should be noted that summated rating scales such as the Likert-type may be subject to response-set bias (e.g., respondents may have a tendency toward neutral responses, extreme responses, agree responses or disagree responses) (Nunnally, 1978, pp. 655-672). While this may represent some threat to validity, such threat may also be overemphasized (Nunnally & Rorer, 1965).

Scale-item Reliability. Because the scale portion of the questionnaire represented an entirely new research instrument, a degree of reliability was established prior to its use on the subjects. So as to insure a sufficient level of independent agreement as to the relationship
between the questionnaire items and the constructs enumerated in the Typology of Clinician Influence, each of the 30 items on the questionnaire was submitted, along with the definitions of each category in the typology, to seven independent raters who had significant prior experience as psychotherapists—clinical social workers or clinical psychologists with 5 or more years of experience. Interrater reliability was measured by overall percentage of agreement with the categories assigned to the items by the researcher. This produced an initial interrater reliability level of .78. However, two items were consistently reversed in category by all seven raters, and therefore those two items were recategorized; this increased interrater reliability to .85.

Other Elements of the Influence Questionnaire. The Influence Questionnaire also asked a series of open-ended questions, including a question that asked respondents to provide their own definition of Clinician Influence. Respondents were also asked to provide examples of what they consider to be appropriate and what they consider to be inappropriate influence by a clinician upon a client. Respondents were further explicitly asked whether and how they believe their theoretical orientation and the setting within which they work influences their clients. Finally, respondents were also queried in regard to the social work value of self-determination: how it ranks in the respondent's value system, and whether and how they experience tension between the value of self-determination and the demands and expectations of their clinical role. All of these open-ended questions were posed prior to the presentation of the definition of influence provided in the questionnaire, and which was utilized to answer the Influence Scale items.
Another section of the questionnaire was intended further to elaborate specific information about respondents' activities and beliefs regarding specific aspects of influence, particularly in regard to the Contextual, Conceptual, and the External realm. For example, a series of questions regarding the use of a formal diagnosis (viewed by the researcher as one of the most impactful elements of the Conceptual Influence realm) yielded information about the degree to which practitioners use a diagnosis, the ways in which they view it as impacting their work with clients, and to what degree they share the information with the client. Answers to these Likert-type questions also provided a comparison for consistency in direction of response relative to respondents' scores on the 30-item Clinician Behavior Scales and Influence Scales.

Finally, the Influence Questionnaire queried for basic demographic information and potentially relevant variables related to the concept of clinician influence.

**Human Subject Protection.** Prior to implementation, this project was reviewed by and received the approval of the Loyola University Chicago Institutional Review Board (See Appendix D). This study utilized several procedures to protect respondents to the questionnaire.

1. Respondents were informed in the cover letter (See Appendix B) of the purpose of the study, potential risks of participating in the study (none known), their right to have any questions about procedure answered, their right to withdraw from participation from the study at any time without prejudice, and the means by which confidentiality of response would be insured.
2. Participants were provided two informed consent forms (See Appendix C) to read and sign; the forms detailed the information provided in the cover letter. Participants were asked to sign both forms, to retain one for their own records, and to return the other with their questionnaire.

3. Confidentiality of participants' response was insured by having an independent clerical worker remove the cover sheets and informed consents from the questionnaires prior to tabulation of the data. Therefore, absolutely no identifying data appeared on the questionnaires when they were tabulated.

**Pilot Study.** The questionnaire was tested initially on a purposive sample of practitioners, including both second-year masters and doctoral students in clinical social work at Loyola University Chicago. The pilot study population represented a readily available group, allowing for direct access to in-person feedback in regards to reactions and suggestions about the instrument. This pilot study population also represented a group that was aware of research methodology and was engaged in their own research, including construction of instruments, thereby increasing the potential usefulness of feedback about the questionnaire. The pilot study was intended to respond to issues of clarity and simplicity of administration of the instrument, and to refine questions within and construction of the questionnaire.

The questionnaire, cover letter and informed consent was first given to a group of 13 practitioners, who were asked to complete the questionnaire, as well as provide written or verbal reactions and critique regarding the construction, congruence and clarity of the questionnaire. The questionnaire was revised, and administered in the same way to an
additional group of 22 practitioners. The second pretest resulted in further structural refinements to the instrument, and a reordering and/or clarification of instructions of a number of questionnaire items.

**Data Collection.** The questionnaire, cover letter and informed consents were sent via U. S. Postal Service to 496 current field work instructors at the large midwestern urban university, with a return, stamped envelope, and a deadline date by which the questionnaires were to be returned.

Several questionnaires were returned unanswered, yielding a final count of 104 returned and usable questionnaires.

**Data Analysis.** There were several elements to the analysis of the data.

Because this study was in part the testing of a new instrument, the Clinician Behavior Scale and the Influence Scale, it was subjected to reliability analysis, examining variability of response (covariance and correlation) within and between respondents. This yielded a coefficient of reliability (Alpha) for each global and each subscale score for the Clinician Behavior and the Influence Scale. The was done to provide some measure for evaluating not only the reliability of the Scales, but also to lend support to the Scales' validity as instruments.

Each of the 30 item on the Clinician Behavior Scale (CBS) and the Influence Scale (IS) was structured as a Likert-type scale and had four possible responses, which were assigned a number from 1 to 4. All 30 items were summed and divided by 30 to provide a mean score on the entire scale. This then constituted the global score for both the Clinician Behavior Scale and the Influence Scale; this global score represented the degree to which respondents viewed themselves as utilizing the clinician
behaviors and the degree to which respondents viewed the behaviors as constituting influence.

In addition, each subscale of the Clinician Behavior Scale and the Influence Scale (High Level Directive, Low Level Directive, Metacommunicative, Conceptual, Contextual and External), consisted of five items each. The mean of the sum of those five items represented the individual subscore on each of the subscales of the CBS and IS for each respondent. Like the global score, each of the subscale scores represented the relative strength of response in each subcategory of the CBS and IS, in regard to the degree to which respondents viewed themselves as utilizing the particular clinician behaviors in each subscale, and the degree to which respondents viewed those same behaviors as constituting influence.

The global and subscale scores could also be represented descriptively, as a percent response: a global or a subscale score of 2.49 or below on the Clinician Behavior Scale reflected a mean response in the Rarely/Sometimes category, and a score of 2.50 and above reflected a mean response in the Frequently/April Always category. On the Influence Scale, a global or subscale score of 2.49 or below represented a mean response in the Strongly Agree/Agree category and a score of 2.50 and above represented a mean response in the Agree/Strongly Agree category. These descriptive percent responses provided an additional way of representing and presenting the data for clarity and understanding of the results.

The mean scores of the Clinician Behavior and Influence Scales were also then utilized to examine the assembled variables in the study. Although the data collected were ordinal level (Likert-type scale), the
summed mean scores were treated as interval level data in accordance with accepted statistical procedure in the social sciences (Andrews, Klem, Davidson, O'Malley & Rodgers, 1981). Using t-test and analysis of variance, the global and six subscales scores from both the Clinician Behavior Scale and the Influence Scale were examined in regard to each selected variable: age, years of practice, theoretical orientation, particular field of practice, high- or low-authority field of practice, gender, marital status, religious orientation, religious view, and nature of post-masters professional training. This examination of each of the study variables provided data regarding the statistical relationship between each variable and the mean scores on the CBS and IS global scale and subscales, thereby providing a profile of respondents' view on what constitutes influence as well as which of the clinician behaviors they actually utilize.

In addition to the examination of the scale mean scores in relationship to each study variable, several individual Likert-type questions were asked separate from the Clinician Behavior Scale and the Influence Scales. These items closely paralleled individual items on the CBS and the IS and provided a cross-check of consistency of response for respondents, assuming that this could provide some additional data regarding the reliability and therefore validity of the instruments. These individual items were cross-tabulated (utilizing chi-square) to determine whether or not there was a statistically-significant relationship between each of the pairs of individual questionnaire items.

The open-ended questions were examined and categorized by the researcher. One third of the responses were examined and tabulated, broken into conceptual categories, and then the entire data set was
tabulated in accordance with the appropriate conceptual category, by judgment of the researcher.

Finally, several single, stand-alone questions were tabulated in regard to percent of response to answer-choice: Yes/No or Rarely, Sometimes, Frequently, Almost Always.
CHAPTER IV.

RESULTS.

Profile of Respondents. The subjects for this study were drawn from all social work field instructors at a large midwestern urban university for the year 1996-97. Of 496 questionnaires mailed, 104 responses were returned (20.96%). The demographic characteristics of the respondents are summarized in Table 1.
<table>
<thead>
<tr>
<th>Profile Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>79</td>
<td>76</td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 35</td>
<td>17</td>
<td>16.6</td>
</tr>
<tr>
<td>36-50</td>
<td>47</td>
<td>45.5</td>
</tr>
<tr>
<td>51 +</td>
<td>40</td>
<td>37.9</td>
</tr>
<tr>
<td><strong>Years of Full-Time Post-Masters Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10 years</td>
<td>41</td>
<td>39.4</td>
</tr>
<tr>
<td>11-20 years</td>
<td>33</td>
<td>31.8</td>
</tr>
<tr>
<td>21 + years</td>
<td>30</td>
<td>28.8</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>71</td>
<td>68.3</td>
</tr>
<tr>
<td>Single</td>
<td>18</td>
<td>17.2</td>
</tr>
<tr>
<td>Divorced</td>
<td>14</td>
<td>13.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Ethnic/Cultural Background</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African/American</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>Latino/American</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>Asian/American</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Caucasian</td>
<td>96</td>
<td>92.3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Religious Background</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>30</td>
<td>28.8</td>
</tr>
<tr>
<td>Protestant</td>
<td>31</td>
<td>29.8</td>
</tr>
<tr>
<td>Jewish</td>
<td>23</td>
<td>22.1</td>
</tr>
<tr>
<td>Agnostic</td>
<td>4</td>
<td>3.8</td>
</tr>
<tr>
<td>Atheist</td>
<td>3</td>
<td>2.9</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Nature of Religious Viewpoint</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conservative</td>
<td>5</td>
<td>4.9</td>
</tr>
<tr>
<td>Moderate</td>
<td>26</td>
<td>25.5</td>
</tr>
<tr>
<td>Liberal</td>
<td>66</td>
<td>64.7</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4.9</td>
</tr>
</tbody>
</table>
Table 1. Demographic Profile of Respondents...Continued

Number of Years as Supervisor
- 5 or fewer: 49 (47.6%)
- 6-10 years: 26 (25.2%)
- 10+ years: 29 (27.2%)

Primary Field of Practice
- Child Welfare: 11 (10.6%)
- Family Service: 13 (12.5%)
- Corrections: 1 (1.0%)
- Health Care: 9 (8.7%)
- Mental Health: 40 (38.5%)
- Schools: 24 (23.1%)
- Private Practice: 3 (2.9%)
- Other: 3 (2.9%)

Authority Level of Field of Practice
- High Authority: 45 (44.6%)
- Low Authority: 56 (55.4%)

Clinical Orientation
- Short-term (fewer than 16 sessions): 41 (39.8%)
- Long-term (16 or more sessions): 62 (60.2%)

Primary Theoretical Orientation
- Psychodynamic (incl. traditional, ego psychology, object relations, and self-psychology): 36 (34.7%)
- Family Systems: 18 (17.3%)
- Cognitive/Behavioral: 9 (8.7%)
- Client-centered: 3 (3.0%)
- Psycho-social: 20 (19.8%)
- Problem-solving: 11 (10.9%)
- Crisis Intervention: 3 (3.0%)
- Task-centered: 1 (1.0%)

Primary Client Group
- Children: 22 (21.4%)
- Adolescents: 16 (15.4%)
- Adults: 48 (46.6%)
- Families: 3 (2.9%)
- A combination: 14 (13.5%)

† All Ns do not equal 104, as not all respondents answered every question. Percentages are based on the number of actual responses.
The group consisted of approximately three quarters female and one quarter male. The mean age of respondents was 47 years (Mode: 50), with a range from 29 to 72. Slightly over two thirds (68.3 percent; N=71) were married, and somewhat fewer (60.8 percent; N=62) had children. The group was definitely skewed in regard to ethnic background: 92.3 percent (N=96) were Caucasian with the remainder 7.7 percent (N=7) minority, an under-representation of ethnic minorities in the social work field. In this group of field work instructors, 28.8 percent (N=30) of the respondents were Catholic, 29.8 percent (N=31) Protestant, and 22.1 percent (N=23) Jewish. Most respondents (64.7 percent; N=66) consider themselves to be "liberal" in religious orientation and another 25.5 percent (N=26) view themselves as "moderate."

Mean number of years of full-time post-masters experience was 15.5, with a range of two to 41 years. Mean number of years that respondents had supervised was 8.4 (Range: no prior experience to 35), and the average number of years that each respondent had been in their current social work field of practice was 12.8. The majority (60.2 percent; N=62) were theoretically oriented toward long-term clinical practice of sixteen or more sessions per client, and 58.3 percent (N=60) were also able to actually practice in that manner in their current settings.

In a school of social work that identifies itself as being psychodynamically-oriented, 34.7 percent (N=36) of the respondents labeled that as their primary theoretical orientation (traditional, ego psychology, object relations and self-psychology combined), while the remainder were spread amongst psycho-social, family systems, problem-solving, cognitive/behavioral, crisis intervention, client-centered and task-centered approaches. If a psycho-social orientation were considered
as being psychodynamic, the total percentage of psychodynamically-oriented respondents would rise to 54.5 (N=56). Most respondents listed adults (46.6 percent) or children or adolescents (combined 36.9 percent) as the primary client group with which they work.

The vast majority of respondents appear to update their professional skills and knowledge, as 86.4 percent (N=89) reported 20+ hours of training, consultation or supervision per year (which may reflect professional licensure requirements), and 51.5 percent (N=53) reported that the training was psychodynamically-oriented.

**Clinicin Behavior and Influence Scale Results.** As indicated above, two questions on the Influence Questionnaire were structured as scales, reflecting the Typology of Influence enumerated by the researcher. These scales—the Clinician Behavior Scales and the Influence Scales—represented 30 clinician behaviors, five each of the six types of influence in the Typology of Influence: High Level Directive (HLD), Low Level Directive (LLD), Metacommunicative (MET), Conceptual (CP), Contextual (CXT), and External (EXT).

As structured, the procedure yielded both a global Clinician Behavior Score (CBS) and a global Influence Score (IS) on each behavioral item, as well as a mean Clinician Behavior Subscore and a mean Influence Subscore on each of the six types of influence (HLD, LLD, MET, CP, CXT, EXT).

The data was also examined descriptively, as percentages of respondents scoring 2.49 or below (Rarely/Sometimes) or 2.50 and above (Frequently/Almost Always) on the Clinician Behavior Scales, and percentage of respondents scoring 2.49 or below (Strongly
Disagree/Disagree) or 2.50 and above (Agree/Strongly Agree) on the Influence Scales.

*Scale reliability.* Each scale (CBS and IS) was subject to a reliability analysis, examining covariance and correlation within and between respondents.

The global scale examining Clinician Behavior yielded a strong reliability coefficient (*Alpha*=.84) while each of the Clinician behavior subscales (High Level Directive [HLD], Low Level Directive [LLD], Metacommunicative [MET], Conceptual [CP], Contextual [CXT], and External [EXT]) yielded relatively weaker reliability coefficients (HLD: *Alpha*=.45; LLD: *Alpha*=.61; MET: *Alpha*=.55; CP: *Alpha*=.54; CXT: *Alpha*=.51; EXT: *Alpha*=.57). This raises some issues about the validity of the scales in regard to measuring and accurately reflecting actual clinician behavior (See Analysis and Discussion).

The global scale examining Influence yielded a strong reliability coefficient (*Alpha*=.94), and each of the Influence subscales yielded relatively strong reliability coefficients (HLD: *Alpha*=.78; LLD: *Alpha*=.82; MET: *Alpha*=.82; CP: *Alpha*=.79; CXT: *Alpha*=.73; EXT: *Alpha*=.80), supporting the reliability and therefore the validity of this portion of the instrument.

*Responses.* Responses to the Clinician Behavior and Influence Scales are summarized in Table 2, represented as Mean Scores globally and for each of the subscales and as percent of respondents who answered "Rarely" or "Sometimes" and "Frequently" or "Almost Always" on the Clinician Behavior Scale, and "Strongly Disagree" or "Disagree" and "Agree" or "Strongly Agree" on the Influence Scale. In effect, those percentages represent an approximate degree to which the clinician
views herself as enacting the behaviors, and whether or not the clinician actually views the behaviors as constituting influence.

Table 2. Mean Scores and Percent Responses on Clinician Behavior Scales

<table>
<thead>
<tr>
<th>Scales</th>
<th>Mean Score</th>
<th>Rarely/Sometimes</th>
<th>Frequently/Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Global</td>
<td>2.73</td>
<td>26.9</td>
<td>73.1</td>
</tr>
<tr>
<td>High Level Directive</td>
<td>2.54</td>
<td>45.2</td>
<td>54.8</td>
</tr>
<tr>
<td>Low Level Directive</td>
<td>3.22</td>
<td>2.9</td>
<td>97.1</td>
</tr>
<tr>
<td>Metacommunicative</td>
<td>2.59</td>
<td>44.2</td>
<td>55.8</td>
</tr>
<tr>
<td>Conceptual</td>
<td>2.60</td>
<td>34.6</td>
<td>65.4</td>
</tr>
<tr>
<td>Contextual</td>
<td>2.76</td>
<td>31.7</td>
<td>68.3</td>
</tr>
<tr>
<td>External</td>
<td>2.88</td>
<td>24.0</td>
<td>76.0</td>
</tr>
</tbody>
</table>

Table 2. Mean Scores and Percent Responses on Influence Scales

<table>
<thead>
<tr>
<th>Scales</th>
<th>Mean Score</th>
<th>Strongly Disagree</th>
<th>Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Global</td>
<td>3.06</td>
<td>7.8</td>
<td>7</td>
</tr>
<tr>
<td>High Level Directive</td>
<td>3.26</td>
<td>4.9</td>
<td>6</td>
</tr>
<tr>
<td>Low Level Directive</td>
<td>3.08</td>
<td>9.8</td>
<td>10</td>
</tr>
<tr>
<td>Metacommunicative</td>
<td>3.00</td>
<td>14.7</td>
<td>15</td>
</tr>
<tr>
<td>Conceptual</td>
<td>2.96</td>
<td>13.7</td>
<td>10</td>
</tr>
<tr>
<td>Contextual</td>
<td>3.07</td>
<td>9.8</td>
<td>14</td>
</tr>
<tr>
<td>External</td>
<td>2.91</td>
<td>18.6</td>
<td>19</td>
</tr>
</tbody>
</table>

Additional Measures of Clinician Behavior. Respondents were also asked whether, in accordance with a prescribed definition of influence ("influence: the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings"), how much they viewed themselves as utilizing influence in their clinical work ("rarely, sometimes, frequently, almost always"). Among respondents, 84.5
percent (N=87) viewed themselves as utilizing influence "frequently" (43.3; N=45) or "almost always" (40.8 percent; N=42), while 15.5 percent (N=16) viewed themselves as utilizing influence "sometimes." When compared to the Global Influence Score, utilizing analysis of variance, those who responded "almost always" had significantly higher Global Influence Scores than those who responded either "sometimes" or "frequently" \( (F=6.57, p \leq .01) \), suggesting that those who see themselves as utilizing influence the most also more consistently view clinician behaviors as constituting influence.

Responses on individual items were also examined. Several items in the Clinician Behavior Scale were replicated as questions asking for similar data in the initial segment of the questionnaire. This permitted a cross-tabulation between questions asking for the same information to determine consistency of response regarding clinician behavior. Several items tested in this regard were found to show a statistically significant positive relationship: 1) a question about defining for clients their role in the clinical process cross-tabulated with CBS item "tell the client what they will need to contribute for the treatment to be successful" \( (X^2= p \leq .001) \); 2) a question about defining the clinician's role cross-tabulated with CBS item "indicate to the client what your role as a clinician will be" \( (X^2= p \leq .001) \); 3) a question regarding the impact of the limits of the setting on the clinician's choices with a client cross-tabulated with CBS item "tell the client about limits to service in your agency" \( (X^2= p \leq .05) \); and 4) a question about informing clients about the limits of confidentiality cross-tabulated with CBS item "inform clients about the limits of confidentiality" \( (X^2= p \leq .001) \). This suggests that respondents were answering consistently regarding questions about their behavior.
and lends support to the reliability of their responses on the questionnaire.

An examination of selected individual responses provides additional information regarding the practices and beliefs about influence of the respondents. These are represented in Table 3.

Table 3. Selected Individual Items on Clinical Behavior Scale and Influence Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Clinical Behavior</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Frequently/ Almost Always&quot;</td>
<td>&quot;Agree/Strongly Agree&quot;</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1. Inform re: limits to confidentiality (EXT)</td>
<td>85</td>
<td>81.7</td>
</tr>
<tr>
<td>2. Ask questions about feelings (LLD)</td>
<td>100</td>
<td>96.2</td>
</tr>
<tr>
<td>3. Nodding or saying &quot;um-hmm&quot; (MET)</td>
<td>66</td>
<td>63.5</td>
</tr>
<tr>
<td>4. Share theoretical orientation (CP)</td>
<td>33</td>
<td>31.7</td>
</tr>
</tbody>
</table>

While most respondents (81.7 percent; N=85) inform clients of the limits to confidentiality (which means that 18.3 percent [N= 19] do not), not quite three-fourths (72.5 percent; N=74) view such disclosure as constituting influence on the client. Further, another question, not contained in the scale, asked whether respondents had clients read and/or sign an informed consent. Nearly half (44.1 percent; N=45) did so only "rarely" (29.4 percent; N=30) or "sometimes" (14.7 percent; N=15), which might be regarded as an unexpected finding in a current legally-aware professional climate.

A widely utilized clinical behavior is "asking questions about feelings," a "frequent" or "almost always" behavior for 96.2 percent (N=100) of the respondents. While this behavior is apparently ubiquitous
in the clinical situation, fully 37.3 (N=38) percent do not regard asking about feelings as exerting influence upon the client.

While 63.5 percent (N=65) of respondents engage in the metacommunicative behavior of nodding or saying "um-hmm," and a similar percentage (63.7; N=66) regard it as exerting influence, over a third (36.3 percent; N=37) view it as not exerting influence upon the client.

Respondents indicated they share their theoretical orientation with clients somewhat less than a third of the time (31.7 percent; N=33), although nearly three fourths (72.5 percent; N=74) agree that sharing it constitutes influence on the client. A slightly different question, asked separately from the scales, inquired as to whether or not respondents thought that their theoretical orientation influenced clients (independent of whether or not it is shared) and 83.2 percent (N=84) responded in the affirmative. Of those that believe their theoretical orientation does influence clients and also responded to the question of how that orientation influences, 49.4 percent (N=40) view their theoretical orientation as providing a framework for the clinician, and 45.7 (N=37) percent view their theoretical orientation as providing a framework for the client to view his own situation. It is interesting to note that, while theoretical orientation is seen as being influential in these ways, respondents choose most of the time not to share it with clients.

Respondents indicated that they make a formal diagnosis or a formal assessment on clients "frequently" or "almost always" 72.1 percent (N=75) of the time (although fewer than half [43.3 percent; N=45] do such a diagnosis "almost always"), but only 58.3 percent (N=60) share their diagnosis "frequently" or "almost always."
Clinician Behavior, Clinician Influence and Demographic Variables. One of the questions of this study was to explore the relationship between clinician behaviors and clinician influence and a variety of demographic variables, including Gender, Age, Marital Status, Year Masters Received, Years of Post-Masters Experience, Religion, Religious View, Number of Years as a Supervisor, Field of Practice, Authority Level of Field of Practice, Primary Theoretical Orientation, and Primary Client Group. Utilizing analysis of variance, each demographic variable was compared with mean scores on the Clinician Behavior Scale and the Influence Scale, including global Scale Scores and each Subscale Score (HLD, LLD, MET, CP, CXT and EXT).

Results showed no significant differences on global scores of either scale in regard to any of the variables. Several Subscales showed selected significant differences, summarized in Tables 4 and 5.

Table 4. Selected Variables and Clinician Behavior Subscales

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Level Directive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Theoretical Orientation</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>2.37</td>
<td>.432</td>
<td>35</td>
<td>34.7</td>
</tr>
<tr>
<td>Non-Psychodynamic</td>
<td>2.64</td>
<td>.455</td>
<td>66</td>
<td>65.3</td>
</tr>
<tr>
<td><strong>Low Level Directive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Years Post-Masters Exp.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 years</td>
<td>3.26</td>
<td>.391</td>
<td>41</td>
<td>39.4</td>
</tr>
<tr>
<td>11-20 years</td>
<td>3.08</td>
<td>.496</td>
<td>33</td>
<td>31.8</td>
</tr>
<tr>
<td>21+ years</td>
<td>3.34</td>
<td>.345</td>
<td>30</td>
<td>28.8</td>
</tr>
</tbody>
</table>

a F=1.11, p ≤ .01 Mean scores for Non-Psychodynamically oriented respondents are significantly different from the mean scores of Psychodynamically oriented respondents on the HLD Subscale.

b F=3.20, p ≤ .05 Mean scores for respondents with 21+ years of experience are significantly different from respondents with 11-20 years of experience. There is no significant difference between any other pair of groups.

As can be seen, non-psychodynamically oriented respondents have a significantly higher mean score on the Clinician Behavior HLD subscale.
This would mean that psychodynamically-oriented respondents report themselves as utilizing fewer high level directive clinical behaviors than non-psychodynamically-oriented respondents. Respondents with 21+ years of experience have significantly higher mean scores on the Clinician Behavior LLD Subscale than those with 11-20 years of experience; this would indicate that those with 21+ years of experience report themselves as utilizing more low level directive clinical behaviors than those with 11-20 years of post-masters experience.

Table 5. Selected Variables and Influence Subscales

<table>
<thead>
<tr>
<th>Low Level Directive Influence</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year Masters Received</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 10 years</td>
<td>2.99</td>
<td>.525</td>
<td>44</td>
<td>43.1</td>
</tr>
<tr>
<td>11-20 years</td>
<td>3.02</td>
<td>.491</td>
<td>33</td>
<td>32.4</td>
</tr>
<tr>
<td>21+ years</td>
<td>3.32</td>
<td>.531</td>
<td>25</td>
<td>24.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># of Years in Current Field&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7 years</td>
<td>2.87</td>
<td>.539</td>
<td>32</td>
<td>31.4</td>
</tr>
<tr>
<td>8-14 years</td>
<td>3.25</td>
<td>.561</td>
<td>31</td>
<td>30.4</td>
</tr>
<tr>
<td>15+ years</td>
<td>3.12</td>
<td>.439</td>
<td>39</td>
<td>38.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religious View&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>2.60</td>
<td>.400</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>Moderate</td>
<td>2.93</td>
<td>.562</td>
<td>25</td>
<td>26.3</td>
</tr>
<tr>
<td>Liberal</td>
<td>3.17</td>
<td>.495</td>
<td>65</td>
<td>68.4</td>
</tr>
</tbody>
</table>

<sup>a</sup> F=3.44, p ≤ .05 Mean scores for respondents with 21+ years since receiving masters degree are significantly different than those respondents who have received their masters degree within the past 10 years. There are no significant differences in any other pair of groups.

<sup>b</sup> F=4.62, p ≤ .05 Mean scores for those respondents with 8-14 years in current field are significantly different from those respondents with 0-7 years in current field. There are no significant differences in any other pair of groups.

<sup>c</sup> F=4.28, p ≤ .05 Mean scores for respondents who describe themselves as having a Liberal Religious View are significantly different from those respondents who identify themselves as having a Conservative Religious View. There are no significant differences in any other pair of groups.
Table 5 (Cont'd). Selected Variables and Influence Subscales

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Level Directive Influence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religious View</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conservative</td>
<td>2.76</td>
<td>.357</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>Moderate</td>
<td>3.18</td>
<td>.470</td>
<td>25</td>
<td>26.3</td>
</tr>
<tr>
<td>Liberal</td>
<td>3.33</td>
<td>.429</td>
<td>65</td>
<td>68.4</td>
</tr>
<tr>
<td><strong>Metacommunicative Influence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religious View</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conservative</td>
<td>2.60</td>
<td>.583</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>Moderate</td>
<td>2.79</td>
<td>.438</td>
<td>25</td>
<td>26.3</td>
</tr>
<tr>
<td>Liberal</td>
<td>3.12</td>
<td>.436</td>
<td>65</td>
<td>68.4</td>
</tr>
<tr>
<td><strong>Authority Level of Field</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Authority</td>
<td>2.88</td>
<td>.481</td>
<td>44</td>
<td>44.4</td>
</tr>
<tr>
<td>Low Authority</td>
<td>3.12</td>
<td>.441</td>
<td>55</td>
<td>55.6</td>
</tr>
<tr>
<td><strong>External Influence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year Masters Received</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 10 years</td>
<td>2.83</td>
<td>.556</td>
<td>44</td>
<td>43.1</td>
</tr>
<tr>
<td>11-20 years</td>
<td>2.79</td>
<td>.507</td>
<td>33</td>
<td>32.4</td>
</tr>
<tr>
<td>21+ years</td>
<td>3.17</td>
<td>.548</td>
<td>25</td>
<td>24.5</td>
</tr>
</tbody>
</table>

\(d F=4.62, p \leq .05\) Mean scores for respondents who describe themselves as having a Liberal Religious View are significantly different from those respondents who identify themselves as having a Conservative Religious View. There are no significant differences in any other pair of groups.

\(e F=7.15, p \leq .05\) Mean scores for respondents who describe themselves as having a Liberal Religious View are significantly different from those respondents who describe themselves as having a Conservative or a Moderate Religious View.

\(f F=1.19, p \leq .01\) Mean scores for respondents in Low Authority Fields of Practice differ significantly from those in High Authority Fields of Practice.

\(g F=4.18, p \leq .05\) Mean scores for respondents with 21+ years since receiving masters degree are significantly different than those respondents who received their masters degree 11-20 years ago or within the past 10 years.

As seen in Table 5, there were differences in some Influence Subscales with regard to several variables. The results on the Low Level Directive Subscale suggest that those respondents who received their Masters Degree 21+ years ago regard low level directive clinician behavior as
constituting influence to a greater degree than those who received their Masters within the past 10 years. Year Masters Received also varied in a similar manner with External Influence Subscale Scores: those with 21+ years since receiving the Masters viewed External Influence as representing influence to a greater degree than with the less than 10 year or 11-20 year group. Also with the Low Level Directive Subscale, Number of Years in Current Field of Practice yielded significant difference with those with 8-14 years of experience as compared to those who had 0-7 years in their Current Field of Practice; the more experienced group views low level directive behaviors as constituting more influence than the group with fewer years in their current field, although there was no significant difference with those who had 15 or more years in their current field.

Those who describe themselves as having a Liberal Religious View showed significantly higher Low Level Directive scores than those with Conservative Religious Views. This was also true of High Level Directive Subscale scores, and Metacommunication Subscale Scores, where those with a Liberal Religious View also differed significantly from those with a Moderate Religious View.

Finally, those respondents in Low Authority fields of practice (Mental Health, Family Service, EAP/Managed Care, Private Practice) had significantly higher MET scores than those in High Authority fields of practice (Child Welfare, Corrections, Schools, Health Care), suggesting that they view metacommunicative behaviors as constituting influence to a greater degree.

**Open-Ended Questions.** Respondents were asked a series of open-ended questions, the results of which are summarized in Table 6.
Table 6. Summary of Responses to Open-Ended Questions Regarding Influence

<table>
<thead>
<tr>
<th>Respondents' Definition of Influence</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician acts to . . .</td>
<td></td>
</tr>
<tr>
<td>1. Change the client or the process directly</td>
<td>46.2 48</td>
</tr>
<tr>
<td>2. Provide client opportunity to evaluate options/choices</td>
<td>25.0 26</td>
</tr>
<tr>
<td>3. Provide a context for change</td>
<td>11.5 12</td>
</tr>
<tr>
<td>4. Use her position/role to effect change</td>
<td>13.5 14</td>
</tr>
<tr>
<td>5. Other</td>
<td>3.8 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondents' Definition of Appropriate Influence</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problem identification and solution generation</td>
<td>59.3 67</td>
</tr>
<tr>
<td>2. Providing a positive context for change to occur</td>
<td>25.7 29</td>
</tr>
<tr>
<td>3. Preventing client from harming self/others</td>
<td>11.5 13</td>
</tr>
<tr>
<td>4. Other</td>
<td>3.5 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondents' Definition of Inappropriate Influence</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Imposition of clinician decision upon client</td>
<td>39.7 48</td>
</tr>
<tr>
<td>2. Imposition of clinician values on client</td>
<td>24.8 30</td>
</tr>
<tr>
<td>3. Coercion through clinician's position</td>
<td>13.2 16</td>
</tr>
<tr>
<td>4. Inappropriate clinician impact on clinical process</td>
<td>12.4 15</td>
</tr>
<tr>
<td>5. Inappropriate clinician behavior</td>
<td>7.4 9</td>
</tr>
<tr>
<td>6. Other</td>
<td>2.5 3</td>
</tr>
</tbody>
</table>

Note: Figures represent multiple responses to questions; therefore percentages do not add up to 100%.

On the questionnaire, the open-ended questions were posed before the Clinician Behavior and Influence Scales were presented. Responses were sorted and analyzed for content by the researcher, then coded into categories for each question. Respondents often provided multiple responses to the open-ended questions, and the data summarized represents the percent of total responses, and therefore, the data reflect those responses that were listed most often by respondents. Not all respondents answered some or all of the open-ended questions, although approximately 85 percent (N=88) did so.

Definition of Influence. Eighty-eight of 104 respondents (84.6 percent) answered this question, and provided 104 responses (some
respondents gave multiple definitions). Responses fell into four categories: 1) clinician changing the client or the therapeutic process directly, 2) clinician providing client the opportunity to evaluate options and choices, 3) clinician providing a context for change in the clinical setting, and 4) clinician using her position/role to effect change. There were four responses that did not fall into any of these categories ("Other").

Representative responses to each of the categories are listed below:

**Clinician changing the client or the process directly:**
"Guiding or directing a client"
"Change behavior of client; change way client feels"
"Change initiated by the therapist"
"Those conscious efforts on the part of the therapist to affect the process and/or outcome of therapy with social work clients"

**Provide and evaluate options/choices:**
"To help him/her look at alternative paths, alternative viewpoints, alternative behaviors, thoughts and consequences"
"Giving options in problem-solving"
"Helping a client sort out positives and negatives"

**Provide a context for change:**
"Creating a 'holding environment' which allows the expression and processing of distressful affects that interfere with patient's self-determination"
"Clinician provides a way of relating that fosters client self-determination and conveys respect"
"Positive regard and respect for client"
"The ability to instill motivation for change; the ability to empower"

**Use of position/role/relationship:**
"Clients view professionals as authority figures based on knowledge and expertise. This carries influence of role"
"The use of self to direct a client in a certain way"
"The amount of change effected in the client because of the clinician's personality"
"The extent to which my relationship with the client has the power to alter their cognitive understanding and hopefully result in behavioral change"
**Appropriate Influence.** Respondents were asked to give an example of appropriate influence in the clinical situation. Ninety-nine of the 104 respondents (95.1 percent) answered this question, and provided 113 responses. This item produced three categories of response: 1) problem identification and solution generation, 2) providing a positive therapeutic context for change to occur and 3) preventing client from harming self or others. There were four responses that did not fall into these categories ("other"). Representative responses to each of the categories include:

**Problem identification and solution generation**
- "Identifying and exploring alternative behaviors with the client"
- "Encouraging a client to consider the pros and cons of continuing in a particular relationship"
- "Helping them select appropriate options"
- "Sharing impressions and concerns with client in order to broaden perspective"

**Providing a positive context**
- "Empathic responsiveness, creating holding environment, creating boundaries, structure, limits of therapy, being consistent and predictable"
- "Developing a therapeutic rapport that allows for the client to feel safe and he/she can trust you."
- "By treating someone with respect and sensitivity, helping them further an increase in their feelings of self worth"

**Preventing harm to client/others**
- "Setting limits and boundaries on self-destructive behavior"
- "Helping the client understand the importance of ceasing unlawful and harmful behaviors (i.e., sex offenses)"
- "Making a decision to hospitalize a suicidal client against their will"
- "A client in a psychiatric facility is suicidal to the point of requiring hospitalization"

**Inappropriate Influence.** Respondents were also asked to provide an example of inappropriate influence. Ninety-nine of the 104 respondents (95.1 percent) answered the question, and provided 121 responses. There were five response categories: 1) imposition of the clinician's decision regarding a client's issue upon the client, 2) the imposition of the
clinician's values or judgment upon the client, 3) coercion of the client through the clinician's position, 4) inappropriate impact by the clinician on the clinical process, and 5) inappropriate clinician behavior. There were three responses that did not fall into any of these categories. Representative responses for each of the categories include:

**Imposition of clinician decision**
"Giving advice"
"To give suggestions to clients instead of helping client develop process/skills for decision-making"
"Telling them what to do"

**Imposition of clinician values**
"Judgments of what should/ought to be done"
"Sharing your values or telling a client what your would do in their situation"
"Replacing a value or personal belief the client has with your own value or belief"
"Inflicting religious, political or personal views"

**Coercion by clinician position**
"By preying upon their dependent transference or other potential vulnerability to seek therapist secondary gain (e.g., "obedience," favors, etc.)"
"Punishment as allowed in school setting"
"Using an authoritarian approach encouraged by the setting"
"Attempting to use power as an authority figure to insist that the client make a choice according to the social worker's belief system"

**Inappropriate clinician impact on therapeutic process**
"Influencing the length of time they remain in treatment with you"
"Pressing clients to address issues when it is not clinically/therapeutically appropriate"

**Inappropriate clinician behavior**
"Violation of professional boundaries/ethics"
"Trying to change a client to meet my needs"
"Seducing a client"
"Yelling at a client"

**Self-determination.** The questionnaire also addressed the issue of client self-determination. Respondents were asked three questions in regard to the self-determination issue.
First, respondents were asked where the clinical social work value of client self-determination ranked in their value system. There were 101 responses (97.1 percent) to the question:

<table>
<thead>
<tr>
<th>Value Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amongst highest 1 or 2 values</td>
<td>63</td>
<td>62.4</td>
</tr>
<tr>
<td>Very high value</td>
<td>28</td>
<td>27.7</td>
</tr>
<tr>
<td>Moderate value</td>
<td>10</td>
<td>9.9</td>
</tr>
<tr>
<td>Relatively low value</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Not a value for me</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Second, respondents were asked whether they experienced conflict or tension in regard to the value of client self-determination and the demands or expectations of their clinical role. There were 103 responses (99.0 percent), of which 59.2 percent (N=61) replied in the affirmative, and 40.8 percent (N=42) replied that they did not experience conflict or tension regarding client self-determination.

Finally, respondents were asked, if they answered "yes" on the question of experiencing conflict or tension, to provide an example of such a conflict. Of the 61 who responded "yes," 57 provided an example of the conflict. The responses fell into two categories, setting-based conflicts and client-based conflicts. Setting-based conflicts involved the rules, regulations, demands and pressures of the clinician's social work setting that interfered with the provision of appropriate service to the client and therefore protection of self-determination. For example:

"My agency often has a different goal than my client."
"Agency policy and the demands of servicing so many clients at a government-funded agency can get in the way of quality."

Client-based conflicts related to those times when what the client wants to do appears not to be in their own best interest, i.e., when they return to a domestic abuse situation, or choose to continue using drugs. For example:
"Staying in abusive relationship without taking necessary precautions."
"In my work with older adults, they can make decisions that create some degree of risk."

Of the total responses, 40.4 percent (N=23) cited setting-based conflicts as impinging upon self-determination in their work with clients, and 59.6 percent (N=34) cited client-based conflicts as impinging upon the self-determination of their clients.

In sum, then respondents in this study a) hold the social work value of self-determination in high regard, b) frequently experience conflicts between their clinical role and the value of client self-determination and c) experience those conflicts as either residing primarily in their work setting or as residing primarily with the client.
CHAPTER V.
ANALYSIS AND DISCUSSION

Study Questions. This study asked several questions in regard to this issue of clinician influence.

1. Do practitioners believe that they use influence with clients? The results of this study respond to this question in two ways. First, the question was directly asked of the respondents. In response to a question that defined clinician influence, all of the respondents indicated that they did utilize influence in their clinical work at least "sometimes." Fully 84.5 percent indicated that they viewed themselves as utilizing influence "frequently" (43.7 percent) or "almost always" (40.8 percent). Therefore, it seems clear that the respondents to this study do view themselves, at least when influence is defined, and when asked directly, as utilizing influence.

Second, mean scores and percent "Agree/Strongly Agree" responses on the global Influence Scales (3.06 and 92.2 percent) suggest that respondents regard a vast majority of the clinician behavior items as constituting influence. Respondents' concomitant mean scores and percent "Frequently/Almost Always" responses on the global Clinician Behavior Scale suggest that they view themselves as utilizing these same behaviors (and therefore also utilizing influence) to a considerable degree: 73.1 percent utilize these behaviors "Frequently" or "Almost Always." Therefore, if the respondents are practicing the behaviors and they view the behaviors as constituting influence, they are affirming that they use influence with clients.

Finally, in response to the open-ended questions, respondents made it clear that they view themselves as utilizing influence, at least at
times, in the clinical situation; many of the responses could be
categorized as behaviors that fall into the High Level Directive or Low
Level Directive categories. Further, respondents demonstrated that they
even have an awareness of differences in what constitutes "appropriate"
and what constitutes "inappropriate" influence, although those
distinctions may vary widely from practitioner to practitioner.

2. What do practitioners regard as influence upon clients?
Examining the data from the Influence Subscales, it is clear that
respondents clearly view every subcategory defined in the Influence
Typology as constituting influence, at least to some degree.

The High Level Directive (HLD) Influence Subscale yielded a mean
score of 3.26 and a 95.1 percent "Agree/Strongly Agree," suggesting that
these behaviors are strongly viewed as constituting influence. The Low
Level Directive (LLD) Influence Subscale yielded a mean score of 3.08 and
a 91.2 percent "Agree/Strongly Agree," again indicating that these
behaviors are also seen as constituting influence upon the client. This is
also true with the Contextual Influence Subscale (CXT) (mean score 3.07;
91.2 percent "Agree/Strongly Agree").

While mean scores and percentages for the Metacommunicative
Influence Subscale (MET) (mean score 3.00, 85.3 percent "Agree/Strongly
Agree"), the Conceptual Influence Subscale (CP) (mean score 2.96, 86.3
percent "Agree/Strongly Agree"), and the External Influence Subscale
(EXT) (mean score 2.91, 81.4 percent "Agree/Strongly Agree"), are viewed
as constituting influence to a somewhat lesser extent, they are
nonetheless seen as representing influence by a large majority of
respondents.
Some individual items reflect some interesting data in this regard. "Nodding or saying um-hmm" (a MET Subscale item) is viewed as constituting influence by only 63.7 percent of respondents. This common clinical behavior, which could be considered a clear behavioral social reinforcer, is not necessarily seen as influencing the client. As well, "asking questions about feelings" (LLD) is seen as constituting influence by 62.7 percent of the respondents; this extremely common clinician behavior, which has an underlying assumption that feelings are important, and specifically guides the client toward exploring and expressing them, is seen as not influencing by 37.3 percent of the respondents. This may underline some blind spots in clinician's view of themselves as to what is influential in their behavior with clients.

3. What types of influence do practitioners actually view themselves as using? Examining the Clinician Behavior Subscales provides some insight into this question. These scales, it should be remembered, assume that these behaviors are to some degree in the repertoire of all practitioners, and provide a relative score or percentage that reflects the degree to which practitioners practice the behavior. They do not, however, discriminate in an either/or fashion, as do the Influence Scales.

Overwhelmingly, respondents reported themselves as utilizing Low Level Directive (LLD) behaviors "Frequently/Almost Always" (97.1 percent) with clients. Respondents view themselves as "Frequently/Almost Always" practicing Conceptual (CP) and Contextual (CXT) behaviors about two-thirds of the time, and External (EXT) behaviors about three-fourths of the time.

Other Clinician Behavior Subscales yielded results that indicate that much larger percentages fall into the "Rarely/Sometimes" categories.
Respondents see themselves as only "Rarely/Sometimes" practicing High Level Directive (HLD) behaviors 45.2 percent of the time and Metacommunicative behaviors 44.2 percent of the time.

As well, the open-ended questions also provide some data in regard to this question. In answering the question of what constitutes appropriate influence, respondents indicated clinician activities and interventions that can be viewed as falling into the High Level Directive or Low Level Directive categories. For example, typical responses like "developing goals," "persistent problem-solving," "teaching skills to client," "modeling behavior," "setting limits and boundaries" all can be seen as reflecting High Level Directive interventions. "Offering support," "helping a client look at alternatives," "keeping client aware of how they impact others," "clarifying and naming feeling states," "discussing the alternatives and consequences of life choices," can be seen as constituting Low Level Directive interventions. In fact, it can be argued that the initial two categories of response to the open-ended question regarding what constitutes appropriate influence—1) "problem identification and solution generation" and 2) "providing a positive context"—substantially correspond to High Level Directive and Low Level Directive clinician behaviors. And the third category, "preventing harm to client/others" would likely involve clinician behaviors that would, by consensus, fall into the High Level Directive category. In regard to respondents' definitions of "appropriate influence," virtually all of the responses involve HLD and LLD interventions. Since 95 percent of the respondents to this questionnaire answered the open-ended question about appropriate influence, the respondents in this study do view themselves as utilizing HLD and LLD behaviors.
It is clear, then, from the responses to the Clinical Behavior Scales and the Influence Scales and the responses to the "appropriate influence" open-ended question that respondents view themselves as utilizing influence, although to varying degrees, in each one of the subcategories of influence enumerated in the Typology of Influence.

4. What relationship do various demographic variables have to a) clinician behaviors and b) views on what constitutes influence?

Relatively few variables yielded any significant differences in reported clinician behavior or in views of what constitutes influence. Examination was conducted upon a number of variables, including Gender, Age, Marital Status, Year Masters Received, Years of Post-Masters Experience, Religion, Religious View, Number of Years as a Supervisor, Field of Practice, Authority Level of Field of Practice, Primary Theoretical Orientation, and Primary Client Group. Ethnic Background was not tested because insufficient numbers in minority groups responded to the questionnaire.

Clinician Behavior Subscales. Psychodynamically-oriented respondents report themselves as utilizing High Level Directive interventions significantly less than Non-psychodynamic respondents. This is not a surprising result, as psychodynamically-oriented practitioners, from a theoretical and practice-orientation perspective might be expected to be less likely to utilize the more highly directive interventions like giving advice, or making suggestions to clients.

Those respondents with 21 or more years of post-masters experience view themselves as utilizing more Low Level Directive interventions than those with 11-20 years of post-masters experience, although not more than those with 0-10 years of post-masters
experience. This result is therefore equivocal. It may be that with increasing experience, one is more aware of utilizing Low Level Directive kinds of behaviors, but more research would be necessary to confirm this.

No other variable reflected significant differences in regard to Clinician Behavior Subscales.

*Influence Subscales.* Religious View is one variable that may relate to the degree to which respondents see clinician behaviors as constituting influence. Respondents were asked whether they would categorize their Religious View as "Conservative," "Moderate," or "Liberal." Those with a Liberal Religious View considered High Level Directive and Low Level Directive clinician behaviors as constituting influence significantly more than those with a Conservative Religious View. Further, those with a Liberal Religious View considered Metacommunicative clinician behaviors as constituting influence significantly more than those with a Conservative or a Moderate Religious View. It may be speculated that relatively more conservative or moderate views, which might be considered to be more comfortable with somewhat more authoritarian stances and approaches, might be less inclined to see behaviors as constituting influence. However, the numbers of respondents who identified themselves as "Conservative" in this study were relatively small, and further exploration as to this dimension would be necessary to draw any firmer conclusions.

Those respondents with relatively more years of post-masters experience or greater numbers of years experience in their current field of practice had significantly higher scores than those with fewer years of post-masters or field of practice experience on Low Level Directive and
External Influence Subscales, indicating they viewed these clinician behaviors as constituting influence to a greater extent. Those with more years of experience may possess increased awareness as to what constitutes influence, although, again, the results are somewhat equivocal.

Finally, those respondents in Low Authority Fields of Practice view Metacommunicative behaviors as constituting influence more than those in High Authority Fields of Practice. This finding may be consistent with those regarding Religious View: those more accustomed to higher authority contexts simply do not consider the subtler metacommunicative behaviors as constituting influence to the same degree as those in relatively less authoritarian contexts.

What is perhaps most remarkable about these findings, is that there are relatively few relationships between scores on the Clinician Behavior Scales and Influence Scales and any of the demographic variables considered. Practicing influential clinical behaviors and considering them as constituting influence appears to be consistent throughout the range of respondent background and experience.

5. Do clinical social work practitioners experience a tension or conflict between commitment to the social work value of client self-determination and the expectations and demands of their role as clinicians? Indications in the response to this area of questioning appear to indicate that, to a high degree, respondents embrace the value of self-determination. However, they also frequently—59.2 percent of the time—experience conflict or tension between their role as clinicians and client rights to self-determination.
Respondents indicated that client rights to self-determination caused a conflict for them in two ways—1) by the constraints of the setting they were in, which placed limits on the client's self-directedness, and 2) by the experience of having clients whose self-defeating and self-destructive behaviors either required stronger intervention or whom the clinician could not help because the client declined to be helped in ways that the clinician saw as appropriate. That is, respondents appeared to imply that they were aware of 1) influence from external sources (agency constraints), 2) influence (High Level Directive) they needed to exert in order to be helpful to clients, and 3) influence that, even if exerted, did not have any significant positive impact on clients.

In regard to client self-determination, the use of influence, and practitioners in their clinical role, respondents in this study appear to recognize that there are in fact limits to their ability to protect client self-determination, and that there may be either limits to their ability to appropriately influence clients (e.g., away from self-defeating or self-destructive behavior) or that they are placed in the position of compromising their commitment to client self-determination because their role requires that they place constraints on the choices of the client.

**Critique and Suggestions for Improved Design**

**Sample.** Response to this questionnaire constituted only about 20 percent of the sample selected. Considering that the questionnaire was endorsed by the dean of the School of Social Work and the field work coordinator of the university from which the sample was taken, the response rate was somewhat disappointing. The reasons for this may be primarily related to the length and complexity of completing the
questionnaire: although, on average, it could be completed within 30 minutes, it clearly took longer for others. The actual presence and the placement of open-ended questions (early in the questionnaire) may have been a deterrent to finishing it, as open-ended questions require more consideration, thought and time to complete.

The response from the sample also yielded a small number of minority respondents: whether this reflects the make-up of the sample, or reflects less interest or less inclination on the part of that segment of the population to fill out a questionnaire of this sort, is unclear, but it is certainly a limitation of this study group as compared to the general social work profession.

While this population was chosen for its relative experience and sophistication—as reflecting a group likely to have an awareness of the issue of influence—it also contains some limitations. Supervisors and teachers of other professionals may indeed be significantly more aware of clinician behavior, and its consequent impact on the therapeutic process, than the general clinical social work population. Therefore, the usefulness of the results may be even more limited, and further research would certainly be indicated to test whether levels of awareness of the use of influence were present in the broader clinical social work practitioner population.

Finally, the sample lacks a comparison group—for example, a sample taken from the general practitioner population, which would respond to the limitation just cited. The lack of a comparison group, in addition to the presumed relative sophistication of this sample, severely constrains any generalizability of the results.
Scales and Questionnaire. Several elements of the Influence Questionnaire and the Clinical Behavior and Influence Scales deserve scrutiny in an analysis of potential improvements to this and future studies.

Discussion of Scales. A central feature of the Influence Questionnaire was the use of the two scales created for this study, the Clinician Behavior Scales and the Influence Scales, which were designed to measure the utilization of six types of clinician behavior and the degree to which those behaviors are viewed as influence. The scales were subjected to reliability pre-testing in regard to inter-rater agreement that the scale items corresponded to the constructs they were intended to measure. The questionnaire was also subjected to two pre-test groups, and modified as an instrument to modulate response bias.

The Influence Scale yielded fairly high reliability (analysis of responses within and between respondents) on the global scale and all six subscales. However, the Clinician Behavior Scale, while yielding a relatively strong global reliability coefficient ($\alpha = .84$), also yielded relatively more mediocre reliability figures on all six of the Subscales ($\alpha$ range: .45 to .61), which modulates the reliability and therefore validity of the instrument and the data generated from it.

Examining possible reasons for the reliability figures to have been lower in the Clinician Behavior Subscales than in the Influence Subscales ($\alpha$ range: .73 to .82), it should be taken into account that the instruments were intended to measure two different constructs, and therefore, while consisting of the exact same items, required a different Likert-scale response. The Clinician Behavior Scales asked respondents to answer the question: "To what extent do each of the following
behaviors represent something that you might typically do with a client." The response options were: "Rarely," "Sometimes," "Frequently," and "Almost Always." The Influence Scale response options, in regard to the question "to what extent do you agree or disagree that each of these behaviors represents exerting influence upon the client," were: "Strongly Disagree," "Disagree," "Agree," and "Strongly Agree." While the Influence Scale response options represent a more discrete progression, the Clinician Behavior Scale response options are somewhat more ambiguous.

The reliability of the Clinician Behavior instrument may have been impacted in at least three ways. First, because the character of the options is more ambiguous, responses may have been more random than if the options had been more discrete. For example, the difference between "sometimes" and "frequently" might be hard to discern for a respondent. This may have led to more inconsistency of response. Second, in retrospect, some of the items on the scales may not have been applicable to particular settings. For example, "indicate to clients what the role of managed care or third party payer might be in their case," would not necessarily likely be applicable to a school or child welfare setting. Or, third, some items may have detailed a behavior which was a relatively rare occurrence for respondents. For example, "inform client who had an ethically questionable prior therapeutic experience about appropriate professional codes and guidelines," may be uncommon for many practitioners, or may not apply very frequently (e.g., working with children in a school setting). These factors may have impacted the responses and therefore the reliability of the Clinician Behavior Instrument.
Some redesign of the CBS, including a further delineation of its component individual items, might produce an instrument more universally applicable across the spectrum of clinical settings and typical clinician experiences, and therefore one that yields higher reliability scores.

Because this is an exploratory study, part its usefulness is to test the instruments that were designed for the research. Despite the difficulties noted with the Clinician Behavior Scale, on balance the scales in this study appear to have utility in examining the issue of influence in the clinical context. Therefore, further refinement of the instruments to "fine tune" them would appear to be a productive path.

Other Elements of Questionnaire.

1. The use of open-ended questions on the Influence Questionnaire, while generating some level of grounded data regarding respondents' views of clinical influence, may itself have influenced the manner in which the rest of the questionnaire was answered. The very form and nature of the open-ended questions, which were placed in the questionnaire before the definition of influence was provided for respondents, implied that influence was being considered as a more complex phenomenon than might generally be thought. For example, the very fact that there was a question that inquired as to what respondents considered as "appropriate" influence, already contains a presupposition, that there is "appropriate" influence. It is entirely possible that some respondents might have not considered any form or element of influence as being "appropriate," until it was suggested overtly in the question (no respondent answered that there was no appropriate influence). This,
then, could have biased all subsequent responses in the questionnaire for some respondents.

To address this issue and in consideration of future exploration of the issue of influence, the study might have been broken into two separate research designs, perhaps in sequence. The first would be purely grounded, qualitative research, exploring with practitioners their views on influence, providing only a minimal frame of reference to guide their responses. This would likely best be accomplished by utilizing interviews, and, through content analysis, using the information gathered as a basis for guiding and informing further questions about the state of attitudes and beliefs regarding influence amongst practitioners. The second design would be similar to the current study, but without the open-ended questions. This would resolve the issue regarding the indirect impact on response bias raised by the open-ended questions, and would make the responses to the Clinician Behavior Scale and Influence Scale less likely to be contaminated in any way. Information from the qualitative study might also yield data that would inform aspects of the construction and content of the two Scales, making them more germane to and reliable in measuring actual clinical practice.

2. While a central underlying assumption regarding this study was that practitioners cannot not utilize influence, and that influence is ubiquitous to every aspect of clinical work, the inclusion of a very clear and comprehensive definition of influence ("the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings") may well have biased respondents toward labeling more behaviors as influence than they might have with their own internal definition of influence. While the provision of a common definition of the construct
was necessary, as it makes comparison of response more useful and reliable, there may be reflected in the Influence Scale a skew that does not accurately reflect actual views of what respondents consider constitutes influence. There is probably no way around this dilemma in a study that utilizes the Scales, but it provides a further argument for augmenting research in this area with qualitative designs that elicit views of practitioners without a preconceived frame of reference.
CHAPTER VI.

SUMMARY, CONCLUSIONS AND FURTHER STUDY

A central finding of this study is that clinical social workers—at least those who are experienced and who supervise students in their clinical work—both appear to be aware of what constitutes influence in clinical work, and are aware of utilizing such influence in their own work. This suggests a level of attunement to this dimension of practice that is relatively high, perhaps higher than might be expected, especially with the more indirect forms of influence: Conceptual, Contextual, and External. Perhaps this level of awareness was impacted in part by the design of the study (see above), wherein a clear and comprehensive definition of influence was provided, but also may in part have been impacted by the interest and focus on aspects of this issue by such things as the ongoing "false memory" debate (See Herman & Harvey, 1993; Loftus, 1993), in which clinicians have been accused of and held legally accountable for essentially inducing the recollection of inaccurate and untrue client experience simply by the nature of their interventions. Those in the social work field who work with clients who have been abused are particularly aware of the cautions now strongly suggested as guidelines for addressing abuse issues, so as not to contaminate the process and content, and not to leave themselves open to accusations of undue influence. As well, clinicians more and more find themselves in a climate of diminishing resources and therefore greater demands for "productivity" and efficient outcome with clients. The impact of a "managed care" mentality may also contribute to focus on outcomes and upon some of the external demands and constraints on the clinical
situation. This current atmosphere, then, may well be contributing to more awareness and self-scrutiny regarding the use and regulation of influence in the clinical situation.

Clinicians in this study see themselves as using the most clear and overt form of clinician influence—High Level Directive interventions (e.g., making direct suggestions, recommending something for the client to read)—less frequently than other categories of influence, except for Metacommunicative influence. It would make sense that clinicians might use the directive methods of influence less often, as those kinds of interventions most clearly have the potential for violating the client's sense of personal empowerment, and sense of self-determination, or, for that matter, could be grounds for holding a clinician accountable for unduly impacting a client. Indeed, when asked in the open-ended question as to what constitutes inappropriate influence, the most frequent answer (nearly 40%) had to do with being overly directive with clients, i.e., "telling a client what to do." What is not clear from this study is what clinician behaviors, in what contexts, constitute crossing the line between what is considered "good" or "appropriate" clinical work in helping to guide a client and what is considered "unduly influencing" and "inappropriately impacting" a client.

The fact that clinicians in this study view themselves as utilizing Metacommunicative behaviors to a lesser degree than other subcategories of influence (except High Level Directive) is an interesting finding. It may be that clinicians are simply less cognizant of their metacommunicative behaviors, as those are frequently quite beyond conscious awareness: they are simply the automatic, subtle bodily movements and voice inflections that are a part of almost all human
interaction. It would take a high level degree of awareness on the part of a clinician to notice her own subtle level behavioral cues. It may be, then, that the wording of the items on the Clinician Behavior Scale were such that the tendency was for respondents to answer "rarely" or "sometimes" with greater frequency (e.g., "leaning forward in your chair to increase rapport with client"), because of this relative lack of cognitive awareness regarding these subtle behaviors.

Clinicians in this study most affirmatively and universally utilize Low Level Directive influence. These interventions (e.g., "ask questions about feelings," "ask a client to tell you about past events that may have impacted him/her," "encourage openness of communication, self-scrutiny and honesty with clients") appear to be standard interventive tools for most of the practitioners in the study, and ones they are apparently comfortable in using. While they also agree that Low Level Directive behaviors constitute influence, it could be concluded that it is a category of influence which is regarded as appropriate and fully acceptable. It is also useful to note that clinicians in this study viewed Conceptual, Contextual and External factors as constituting influence, although nearly a fifth (18.6%) do not view External factors upon the clinical situation as reflecting influence. It may be that for those respondents, such factors seem too much removed from the clinical situation to be considered as having substantive impact.

Results regarding various demographic variables suggest that, for the most part, behaviors that reflect influence are both practiced and regarded as constituting influence by clinicians in this study across a wide range of variables. Some of the results are mildly suggestive of the possibility that greater amounts of experience may lead to a greater
awareness of and/or comfort with the use of influence, that those in settings that reflect higher degrees of authority may regard certain behaviors as representing less influence than those in lower authority settings, and that the more religiously conservative the view, the less likely a practitioner is to view at least some clinical behaviors as influence. As well, psychodynamically-oriented practitioners in this study utilize fewer High Level Directive behaviors than non-psychodynamically oriented practitioners, which, again might be considered consistent with the theoretical orientation toward greater awareness and management of relationship issues (including transference and counter-transference) on the part of psychodynamically-oriented practitioners, which lends more caution regarding being directive with clients. These suggestive findings are by no means conclusive and certainly would require further study to confirm or disconfirm.

It appears, then, that, at least in this population of experienced clinicians and trainers, there is agreement that influence exists and is utilized by the practitioner in the clinical situation.

Future Research. What this study did not address, and could be a matter for productive future inquiry, is what practitioners need to know, to consider and to do about the issue of influence. In this regard, at least several questions need to be addressed:

1. What is appropriate and what is inappropriate influence? In their answers to the open-ended questions regarding "inappropriate" influence, respondents in this study appear to be quite aware of and definitive about elements of practice that they consider not reflecting good clinical work. As noted, nearly 40% of the responses to the question related to overt imposition of directives from the clinician as being inappropriate,
and nearly 25% viewed imposition of the clinician's values upon the
client as inappropriate. This suggests that clinicians have certainly
thought about and have implicit criteria for what they consider influence
that should not be a part of the clinical atmosphere.

2. How do clinicians make good decisions regarding utilizing influence appropriately? Further study of what clinicians currently use as
criteria would be useful to determine how those criteria were arrived at,
how they are applied, how they might be modified to fit particular
contexts and contingencies within the clinical setting, and, finally, how
further to refine those criteria so as to insure influence continues to be
used appropriately and not cross the boundary into inappropriateness.

3. If there is influence, how much of that influence is it necessary to inform clients of? Should, for example, all practitioners be securing an
informed consent from clients prior to treatment? If so, what information
should be included in that consent? About 44 percent of respondents in
this study have clients sign an informed consent only "sometimes" or
"rarely," suggesting that they do not see such a procedure as essential. If
there were more consensus that informed consent is necessary, what
should be included in it? Clinicians might agree that clients should be
warned of the limits to confidentiality, but would they agree that the
client be informed of the framework for treatment or how long treatment
might appropriately last?

The central question here is how much information is necessary to
provide regarding potential influences, and what specific information
may be irrelevant?

For example, an interesting finding of this study is the relatively
high percentage of respondents who share their theoretical orientation
with clients only "rarely" or "sometimes" (68.3), while at the same time a high percentage (82.5) agree that their theoretical orientation clearly constitutes influence. One might argue that clients have a right to know under what theoretical and practical guidelines a practitioner will be operating in gathering information, assessing, and designing a plan in regard to the issues they bring to treatment, so that they could make an informed choice as to whether they feel they want to be subject to that particular view. On the other hand, it might be also be argued that theoretical orientation is irrelevant to the process, as most psychotherapy is successful roughly to the same degree, regardless of the theoretical approach of the practitioner (Garfield & Bergin, 1986), and that therefore it is unnecessary to inform clients about this issue.

It appears, at this point, that it would be productive for clinical social workers to much more fully examine this issue, to generate dialogue about what is and is not relevant to apprise and discuss with clients. Guidelines for that discussion might include such elements as:

What does an informed consumer need to know to make an intelligent choice regarding a therapeutic process?

To what degree do the risks and potential benefits of the clinical process need to be spelled out?

How much does the client need to be educated as to the process of change in order to make the treatment successful, or in order even to be aware of how the process is impacting him? Or should clients necessarily need to be aware of how the process is impacting them?

How does the practitioner determine how much information is relevant to provide to clients, and when does information become excessive? Does providing more information to clients regarding the
"influential" nature of the therapeutic process impede or promote the process itself?

How much should the practitioner involve the client in the choices of how treatment might proceed: what is the balance between what the practitioner views as an appropriate course of action and what the client might be willing to do, and how explicit should that be?

These questions, and others, may help to define for clinicians what is possible and desirable to do in regard to providing information to clients about the various aspects of potential influence, and whether providing that information does indeed mitigate and minimize the potential negative effects such influences might have. This would seem to be a worthwhile avenue of discourse for the clinical social work community to pursue.

Policy considerations. In addition to fostering further dialogue about what constitutes information that ought to be provided to the client in advance of proceeding with clinical work, it appears that it would be useful, at the broad practice policy level, to establish much clearer and consistent guidelines as to what constitutes an adequately-delineated informed consent. Such information would be essential to make certain that client and worker were congruently working together with sufficiently shared information so that the client's participation is meaningfully grounded in informed choice.

The fact that nearly half of the respondents have clients sign an informed consent only "sometimes" or "rarely" would seem to indicate that this is an issue that may be currently somewhat neglected not only by practitioners, but by agencies in general. Agency policy, it would appear, may need to more fully describe and develop clearer procedures
for providing information to clients so that they can be full participants in their treatment. While some of the data regarding the use of informed consent in this study can be explained by the fact that many respondents worked in school settings, and therefore were working with children (and many of those indicated that they obtained informed consents from parents), nonetheless it appears important to delineate, at the organizational level, just when and with whom informed consent should be an automatic part of the process. For example, at what age, and at what level of understanding should even a child be given information about what is happening in regard to being involved in a clinical relationship with a social work professional, and to what degree ought that child be able to participate in the direction and nature of his own treatment?

Certainly at the level of adult clients, it appears that agencies need to address and clarify their policies in regard to this issue. How fully a client participates in his own treatment is in part dependent upon the information provided about what is entailed in that treatment; much of that information resides with the clinician. Manning (1997) points out that providing full information about the course of treatment and about treatment alternatives empowers the client to consider all options, and that this may not always be to the advantage to the clinician, as clients may object to the usual course of action or the particular theoretical orientation of the practitioner, thereby challenging the clinician and her practice. In addition, Manning raises concerns that pressures on cost savings, profit, liability and expediency create issues in shaping the manner in which informed consent may be implemented, emphasizing expediency and function rather than values attached to the what may be
best for the client. Regehr and Antle (1997) delineate the particular problems with providing informed consent in court-mandated or other coercive settings, when there are indeed severe limitations on what is possible for the client to pursue in terms of his own self-determined goals.

This all raises critical issues, and perhaps crucial dilemmas, for agencies in regard to deciding how the informed treatment process should be implemented in their settings, in a way that is consistent with social work values and fully makes client interests the central force in determining policy.

4. How should the issues of self-determination with clinical social work clients be managed? Close to 60 percent of respondents to this questionnaire experienced some degree of conflict between their clinical role and the social work value of client self-determination. The conflicts fell into two categories: those that had to do with the limitations and constraints of the setting and adversely limited the client, and those that were related to client behaviors that appeared manifestly in opposition to their own best interest.

The issues surrounding clinical influence are certainly related to client self-determination—an influence that constrains client options is an influence that certainly may constrain client self-determination. That the value of self-determination for clients appears in the National Association of Social Workers Code of Ethics (NASW, 1997) bears testament to the degree of its importance within the profession, and over 90 percent of respondents in this study consider client self-determination as being at least a "very high value" or amongst the highest 1 or 2 of their professional values. Since self-determination holds such a central place
in the value system of social work practitioners, and since there appears to be manifest conflict with that value and the realities of clinical practice, it would seem a productive ongoing avenue of discussion and inquiry to explore the impacts and influences on clinical work that modulate the actualization of client self-determination. It appears that any discussion and exploration of the concept of influence in the clinical setting will assist in illuminating difficulties with holding to the value of client self-determination, and that dialogue about the value and its reality in actual practice will assist practitioners to be more conscious about limitations therefore placed on both them and their clients.

Policy implications. At a policy and organizational level, it appears crucial that the issues that modify client self-determination receive particular attention. It may, for example, often be ignored that one's theoretical orientation may be a very powerful determinant of the nature and direction of the clinical work, and therefore of the client's very life path. How to insure that the client participates as fully as possible in his own direction seems to be a worthy discourse at both the practice policy level and at the organizational level of agencies. It is further true that issues that inhere in the principle of self-determination are complicated by societal and institutional pressures. Tower's (1994) suggestion that self-determination is "frequently the first right to be violated in the name of expediency, protection, or cost containment (p. 191)" has led her to advocate for a more "consumer-centered" orientation toward practice. The fact that constraints and pressures on clinicians abound from both within their organizations and from outside influences (like managed care and funding sources) underlines the clear need for more examination within organizations to determine what institutional values,
policies and procedures can best insure that the principle of self-
determination be adequately and meaningfully supported. It also appears
that the issues related to self-determination, as well as to proper
informed consent are worthy subjects for extended examination and
discussion at the academic level in schools of social work, so that
currently trained social workers are themselves sufficiently informed of
the dimensions related to the issues, and appropriately prepared to
address those issues as they enter the world of practice.

In sum, then, this study appears to have produced some useful
information in regard to exploring the issue of clinician influence in
social work practice. It has identified and codified categories of influence,
identified which of those categories are utilized and which are considered
as constituting influence amongst a population of social work clinicians,
identified some variables that might be linked with behavior and belief
about clinician influence, provided some preliminary data regarding
clinicians' own definitions of aspects of influence, and raised a number of
questions regarding both the issue of influence and the related issue of
client self-determination that appear worthy of further exploration and
study.

It also appears that, while this study shows that there is
awareness amongst social work clinicians regarding the issue of
influence, there may not be sufficient productive dialogue and discussion
within the social work profession and at the institutional and
organizational level regarding this issue, and that promotion of greater
awareness and exploration of the topic can only serve to be helpful both
to clinicians and to their client constituents.
BIBLIOGRAPHY


Tracey, T. J. (1991). The structure of control and influence in counseling
and psychotherapy: A comparison of several definitions and


communication: A study of interactional patterns, pathologies, and
paradoxes. New York: W. W. Norton & Co.


Winnicott, D. (1949). Hate in the countertransference. International


APPENDIX A

INFLUENCE QUESTIONNAIRE
INFLUENCE STUDY

1. Please carefully read each question, including the instructions specific to the question.

2. The questionnaire is made up of a combination of closed-ended and open-ended questions. The open-ended questions are intended to invite and welcome individualized ideas and input regarding this study subject.

3. Attached are two copies of an Informed Consent:
   The Institutional Review Board of Loyola University of Chicago requires that an Informed Consent be signed by each study participant. As indicated in the cover letter, there are no known risks to participation in this research. Please sign one copy of the informed consent, and send it back with your questionnaire. Retain the other copy for your records.

4. The questionnaire should take about 30 minutes of your time. Upon completion, please place in enclosed postage-paid Return Envelope, and mail.

PLEASE RETURN QUESTIONNAIRE BY NOVEMBER 15, 1996

A summary of the intent and findings of this research will be available at the completion of the study. If you would like a copy of that summary, please mark the box below.

☐ Yes, I would like to receive a copy of the summary findings of this study when it is completed.

Name:______________________________________________________

Address:____________________________________________________

Cover Sheet and Informed Consent will be detached from questionnaire by a Research Assistant prior to tabulation.
This questionnaire is intended to explore the question of clinician influence in the practice of clinical social work. **SECTION I** involves a combination of closed-ended and open-ended questions, intended to invite your input regarding this topic, and about how you conduct your clinical work.

**SECTION II** consists primarily of two multiple part questions, eliciting your responses regarding specific behaviors of social work clinicians.

**SECTION III** is devoted to demographic information relevant to this study.

### SECTION I

1. Do you make a formal diagnosis or formal assessment on clients?
   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always

2. If so, what diagnostic or assessment system(s) do you utilize? *(Check all that apply)*
   1. DSM-IV
   2. Biopsychosocial
   3. Psychodynamic formulation
   4. Systems analysis
   5. Other *(please specify)*

3. How does your diagnosis or assessment impact how you proceed with the treatment of clients? *(Check all that apply)*
   1. Gives me a means of understanding client dynamics
   2. Helps set client goals
   3. Helps set my goals as therapist
   4. Helps define treatment protocols
   5. Helps define specific interventions
   6. Assists in defining what my expectations are of the client
   7. Assists in determining the likely length of therapy
   8. Other ______________________

4. Do you share all or some part of your diagnosis with your client?
   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always

5. Do you have clients read and/or sign an informed consent for treatment?
   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always
6. Do you define for the client your role and function as a therapist in the clinical situation?

   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always

7. Do you define for the client your expectations as to what the client's role in the clinical situation needs to be?

   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always

8. To what extent does your current setting—institutional expectations, rules, constraints, and/or treatment protocols—impact your choices in your clinical work with clients?

   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always

9. To what extent do professional codes of ethics impact your clinical work?

   1. Rarely
   2. Sometimes
   3. Frequently
   4. Almost always

10. Do you inform clients of the limits of confidentiality?

    1. Rarely
    2. Sometimes
    3. Frequently
    4. Almost always

11. If you inform clients about the limits of confidentiality, do you feel this may impact what the client may be comfortable in discussing?

    1. Rarely
    2. Sometimes
    3. Frequently
    4. Almost always

Go on to next page}}}}
Open-ended Questions

Some practitioners view what they do with clients as influencing those clients, and that such influence is a necessary part of the clinical process; other practitioners regard influence as something to avoid with clients as much as possible. This range of views may in part be due to some uncertainty as to what the term influence means in the context of clinical social work. This study is interested in your view of the notion of clinician influence.

12. Please indicate below what you would regard as your definition of clinician influence with social work clients.

13. Please give an example of what you consider appropriate influence upon a client.

14. Please give an example of what you consider inappropriate influence upon a client.

15. Do you believe that your theoretical orientation constitutes influence upon the client? _Yes _No

16. If Yes, how does it influence the client?

17. In your work with clients, where does the clinical social work value of client self-determination rank in your value system?
   1. Amongst the 1 or 2 highest values
   2. Very high value
   3. Moderate value
   4. Relatively unimportant
18. Do you experience conflict or tension in regard to the value of client self-determination and the demands or expectations of your clinical role?  
___Yes   ___No

19. If yes, please provide an example of such a conflict:

SECTION II.

Above, you were asked to provide your definition of the concept of clinician influence, as it is related to the practice of clinical social work. Below is another definition of the notion of clinician influence.

**Influence**: the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings.

24. In general, in accordance with **this** definition, would you say that you utilize clinical influence upon clients:
   1. ___ Rarely
   2. ___ Sometimes
   3. ___ Frequently
   4. ___ Almost always

Next Page }}}} Please note that Questions 25 and 26, while in the same format, are two separate questions. Please answer each completely.
25. Below is a list of possible actual behaviors by clinicians:

To what extent do each of the following behaviors represent something that you might typically do with a client:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Please circle your response</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Make suggestions about dealing with other family members</td>
<td>Rarely</td>
</tr>
<tr>
<td>b. Ask questions about feelings</td>
<td>1</td>
</tr>
<tr>
<td>c. Nodding or saying &quot;um-hmm&quot;</td>
<td>1</td>
</tr>
<tr>
<td>d. Determine who will and who will not be included in the treatment</td>
<td>1</td>
</tr>
<tr>
<td>e. Indicate to clients what the role of managed care or third party-payer might be in their case</td>
<td>1</td>
</tr>
<tr>
<td>f. Affirm and reinforce a client's actions when you see them as helpful to his/her situation</td>
<td>1</td>
</tr>
<tr>
<td>g. Tell clients about limits to service in your agency</td>
<td>1</td>
</tr>
<tr>
<td>h. Make interpretations</td>
<td>1</td>
</tr>
<tr>
<td>i. Inform clients about the structure of treatment (time, frequency, fee, etc.)</td>
<td>1</td>
</tr>
<tr>
<td>j. Let clients know how long treatment is likely to last</td>
<td>1</td>
</tr>
<tr>
<td>k. Inform clients of some of your personal values and beliefs</td>
<td>1</td>
</tr>
<tr>
<td>l. Use a strong emphatic tone in your voice to make a point with a client</td>
<td>1</td>
</tr>
<tr>
<td>m. Suggest a client read something or do a task you feel relevant to the problem</td>
<td>1</td>
</tr>
<tr>
<td>n. Ask a client to tell you about past events that may have impacted him</td>
<td>1</td>
</tr>
<tr>
<td>o. Arrange the chairs in the treatment room before the client arrives</td>
<td>1</td>
</tr>
</tbody>
</table>
Please respond to the following (a through dd) by circling your response.

25. *(Continued).* Below is a list of possible actual behaviors by clinicians:

To what extent do each of the following behaviors represent something that you might *typically do* with a client:

Please circle your response

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>p. Make a formal or informal treatment contract with clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>q. Adjust your position (e.g., leaning forward in your chair) to increase rapport with client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>r. Inform client who had an ethically questionable prior therapeutic experience about appropriate professional codes and guidelines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>s. Tell clients how they will know when treatment is finished</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>t. Modulate volume level of voice to match client's</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>u. Encourage openness of communication, self-scrutiny and honesty with clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>v. Model a specific behavior for the client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>w. Inform clients about the limits of confidentiality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>x. Share your theoretical orientation with the client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>y. Encourage a client to examine whether a relationship is good for them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>z. Provide clients with feedback about aspects of how they relate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>aa. Modify your language to assist client in feeling more comfortable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>bb. Tell the client what they will need to contribute for the treatment to be successful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>cc. Discuss with clients how societal norms and expectations may be impacting them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>dd. Indicate to client what your role as a clinician will be</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**PLEASE GO ON TO QUESTION 26, WHICH ASKS A DIFFERENT QUESTION REGARDING THE ABOVE ITEMS**
26. **Influence:** the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings.

Utilizing the definition of influence cited above, please respond to the following question, with each of the items below (a through dd), ranking your degree of disagreement or agreement from 1 to 4:

Considering the following clinician behaviors, to what extent do you agree or disagree that each of the behaviors represents exerting influence upon the client?

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make suggestions about dealing with other family members</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ask questions about feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Nodding or saying &quot;um-hmm&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Determine who will and who will not be included in the treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Indicate to clients what the role of managed care or third party-payer might be in their case</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Affirm and reinforce a client's actions when you see them as helpful to his/her situation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Tell clients about limits to service in your agency</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Make interpretations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Inform clients about the structure of treatment (time, frequency, fee, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Let clients know how long treatment is likely to last</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Inform clients of some of your personal values and beliefs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Use a strong emphatic tone in your voice to make a point with a client</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Suggest a client read something or do a task you feel relevant to their problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ask a client to tell you about past events that may have impacted him/her</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Arrange the chairs in the treatment room before the client arrives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Question 26 Continues on Next Page
26. **Influence**: the process of impacting, either directly or indirectly, the client's behavior, thoughts and/or feelings.

Utilizing the definition of influence cited above, please respond to the following question, with each of the items below (a through dd), ranking your degree of disagreement or agreement from 1 to 4:

**Considering the following clinician behaviors, to what extent do you agree or disagree that each of the behaviors represents exerting influence upon the client?**

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Please circle your response</th>
</tr>
</thead>
<tbody>
<tr>
<td>p. Make a formal or informal treatment contract with clients</td>
<td>1</td>
</tr>
<tr>
<td>q. Adjust your position (e.g., leaning forward in your chair) to increase rapport with client</td>
<td>1</td>
</tr>
<tr>
<td>r. Inform client who had an ethically questionable prior therapeutic experience about appropriate professional codes and guidelines</td>
<td>1</td>
</tr>
<tr>
<td>s. Tell clients how they will know when treatment is finished</td>
<td>1</td>
</tr>
<tr>
<td>t. Modulate volume level of voice to match client's</td>
<td>1</td>
</tr>
<tr>
<td>u. Encourage openness of communication, self-scrutiny and honesty with clients</td>
<td>1</td>
</tr>
<tr>
<td>v. Model a specific behavior for the client</td>
<td>1</td>
</tr>
<tr>
<td>w. Inform clients about the limits of confidentiality</td>
<td>1</td>
</tr>
<tr>
<td>x. Share your theoretical orientation with the client</td>
<td>1</td>
</tr>
<tr>
<td>y. Encourage a client to examine whether a relationship is good for them</td>
<td>1</td>
</tr>
<tr>
<td>z. Provide clients with feedback about aspects of how they relate</td>
<td>1</td>
</tr>
<tr>
<td>aa. Modify your language to assist client in feeling more comfortable</td>
<td>1</td>
</tr>
<tr>
<td>bb. Tell the client what they will need to contribute for the treatment to be successful</td>
<td>1</td>
</tr>
<tr>
<td>cc. Discuss with clients how societal norms and expectations may be impacting them</td>
<td>1</td>
</tr>
<tr>
<td>dd. Indicate to client what your role as a clinician will be</td>
<td>1</td>
</tr>
</tbody>
</table>
### SECTION III. DEMOGRAPHIC INFORMATION:

27. Age __

28. Sex: 1 Female  2 Male

29. Year you received your Masters' degree: ____

30. 1 Married, or in committed relationship  
2 Single  
3 Divorced  
4 Widowed  
5 Other ____________

31. Do you have children? 1 Yes  2 No

32. Ethnic/Cultural Background  
1 African-American  
2 Latino-American  
3 Asian-American  
4 Native-American  
5 Caucasian  
6 Other ____________

33. Religion  
1 Catholic  
2 Protestant  
3 Jewish  
4 Muslim  
5 Hindu  
6 Agnostic  
7 Atheist  
8 Other ____________

34. Would you consider your religious views and orientation:  
1 Conservative  
2 Moderate  
3 Liberal  
4 Other ____________

35. Do you now, or have you previously, supervised other clinicians?  
1 Yes  2 No

36. If yes, approximately how many years have you supervised others? ____

37. Number of years of full-time, post-masters' direct practice experience, or equivalent (20+ hrs. per work week ____

38. List your current primary field of practice:  
1 Child Welfare  
2 Family Service  
3 Corrections  
4 Health Care  
5 Mental Health  
6 Schools  
7 EAP/Managed Care  
8 Private Practice  
9 Other ____________

39. Number of years in this setting: ____
40. Previous experience, with number of years equivalent full-time experience, in each setting (please check all that apply):

<table>
<thead>
<tr>
<th>Previous experience</th>
<th># Yrs. in setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>40a. Child Welfare</td>
<td>40b. _____________</td>
</tr>
<tr>
<td>2. Family Service</td>
<td></td>
</tr>
<tr>
<td>3. Corrections</td>
<td></td>
</tr>
<tr>
<td>4. Health Care</td>
<td></td>
</tr>
<tr>
<td>5. Mental health</td>
<td></td>
</tr>
<tr>
<td>6. Schools</td>
<td></td>
</tr>
<tr>
<td>7. EAP/Managed Care</td>
<td></td>
</tr>
<tr>
<td>8. Private Practice</td>
<td></td>
</tr>
<tr>
<td>9. Other</td>
<td></td>
</tr>
</tbody>
</table>

41. In terms of your actual practice, on average, do you practice short-term (16 or fewer sessions per client) or long-term (more than 16 sessions per client)?

1. Short-term
2. Long-term

42. In terms of your clinical orientation (regardless of actual practice), would you primarily consider your orientation: short-term (16 or fewer sessions per client) or long-term (more than 16 sessions per client).

1. Short-term
2. Long-term

43. If there is a difference between your clinical orientation and actual practice, please state the reason for the difference.

44. Which of the following Post-Masters' clinical training have you received? (Check all that apply)

1. Additional degree: ___ Field:
2. Seminars and Workshops
3. Consultation with other mental health professional(s)
4. Supervision
5. Non-degree training program
6. Other: ____________

45. Of the Post-Masters' Training you have received, what do you consider has been the most influential upon the conduct of your practice? (Check only one)

1. Additional degree
2. Seminars and Workshops
3. Consultations with other mental health professional(s)
4. Supervision
5. Non-degree training program
6. Other: ____________

46. On average, per clinically-active year since you received your M.S.W., would you say that you have had:

1. 20 or more hours of training/consultation/supervision per year
2. Fewer than 20 hours of training/consultation/supervision per year

47. Has the majority of your Post-Masters' Training and Education been primarily:

1. Psychodynamically-oriented
2. Not psychodynamically-oriented
3. In areas other than clinical
48. Theoretical orientations you utilize
   (Check all that apply)
   1. Psychodynamic
   2. Traditional psychoanalytic
   3. Ego psychology
   4. Object relations
   5. Self-psychology
   6. Family Systems
   7. Cognitive/behavioral
   8. Client-centered
   9. Feminist theory
   10. Psychosocial
   11. Functional
   12. Problem-solving
   13. Crisis intervention
   14. Task-centered
   15. Ecological
   16. Other(s) ________

49. Which theoretical orientation listed above would you consider your primary orientation? ________

50. What client group do you primarily work with?
   1. Children
   2. Adolescents
   3. Adults
   4. Families
   5. Couples
   6. Groups
   7. A Combination: (Please specify): ________

Thank you for participating in this research!

Please fold Questionnaire in half, place in Return Envelope, and Mail.
Please be sure to include one signed copy of the Consent Form.
APPENDIX B

COVER LETTER TO RESPONDENTS
Dear Colleague:

I am writing to invite your participation in a study of clinical social workers in regard to their views about influence with clients in the clinical situation.

This study, a doctoral dissertation, will involve the completion of the enclosed questionnaire that will take approximately 30 minutes of your time. The purpose of the questionnaire is to elicit respondents' views of clinical influence, an area of inquiry of some current interest in the profession. There are no known risks to participation in this study, and it is hoped that the results of the study will assist in illuminating several aspects of this question, thereby contributing in a pragmatic way to social work practice.

The sample for this study is drawn from field work instructors for Loyola University of Chicago School of Social Work, and is being conducted with the knowledge and approval of Dean Joseph Walsh of Loyola. This study seeks the respondent's own opinions and experience in regard to the subject matter.

Complete confidentiality of response will be carefully insured. While each questionnaire's cover sheet is numbered to permit follow-up and thereby boost response rate, the cover sheet and Informed Consent will be initially processed by a clerical assistant, and identifying information removed before being forwarded to the researcher. All data will then be processed and presented as grouped data, with no possibility for individual identification of respondents.

In participating in this research you have the right to inquire about any of its procedures, and, of course, you have the right not to participate, or to discontinue participation, at any time you choose. Any questions or concerns can be directed to the researcher at the address and telephone number provided above.

As a participant in this process, you are welcome to receive a summary of the results when the study is completed. If you want such a summary, please mark the appropriate box on the questionnaire cover sheet.

I thank you in advance for your participation and assistance in this study, and for taking the time from your busy schedule to contribute to the research knowledge in clinical social work.

Sincerely yours,

William K. Motlong, M.S.W.
Principal Researcher
APPENDIX C

INFORMED CONSENT FORM FOR RESPONDENTS
INFORMED CONSENT TO PARTICIPATE IN INFLUENCE STUDY

Project Title: Clinician View of the Use of Influence in Clinical Practice

Purpose of Study: To increase the knowledge about social work clinicians' views about the use of clinical influence.

Risks and discomforts: There are no known risks to participants in this study.

Potential benefits: Increased knowledge about current clinical social work practitioners' views about the phenomenon of clinician influence upon clients.

I acknowledge that William Motlong has fully explained the risks involved and the need for the research; has informed me that I may withdraw from participation at any time without prejudice; has offered to answer any inquiries which I may make concerning the procedures to be followed; and has informed me that I will be given a copy of this consent form.

I understand that biomedical or behavioral research such as that in which I have agreed to participate, by its nature, involves some risk of injury. In the event of physical injury resulting from these research procedures, emergency medical treatment will be provided at no cost in accordance with the policy of Loyola University. No additional free medical treatment or compensation will be provided except as required by Illinois law.

In the event that I believe that I have suffered any physical injury as a result of participation in the research program, I may contact the Chairperson of the Institutional Review Board for the Protection of Human Subjects for the Lake Shore, Water Tower and Mallinckrodt Campuses of Loyola University (telephone (312) 508-2471.

I freely and voluntarily consent to my participation in the research project.

(Signature of Investigator or his/her assistant) (Date)

(Signature of Subject) (Date)

This Informed Consent will be removed from the Questionnaire prior to tabulation to insure confidentiality of response.
APPENDIX D.

LETTER FROM INSTITUTIONAL REVIEW BOARD
LOYOLA UNIVERSITY CHICAGO
Dear Colleague,

Thank you for submitting the following research project for renewal by the Institutional Review Board for the Protection of Human Subjects:

Project Title: Clinician View of the use of influence in Social Work Practice

After careful examination of the materials you submitted, we have renewed our approval of this project for a further period of one year from the date of this letter.

Approximately eleven months from today, you will receive from the IRB a letter which will ask whether you wish to apply once more for renewal of IRB approval. If you do not return the form enclosed with that letter by July 8, 1997, however, your approval will automatically lapse.

You are reminded that the routine review procedure administered by the IRB itself in no way absolves you personally from your obligation to inform the IRB in writing immediately if you propose to make any changes in aspects of your work that involve the participation of human subjects. The sole exception to this requirement is in the case of a decision not to pursue the project—that is, not to use the research instruments, procedures or populations originally approved. Researchers are respectfully reminded that the University's willingness to support or to defend its employees in legal cases that may arise from their use of human subjects is dependent upon
those employees' conformity with University policies regarding IRB approval for their work.

Should you have any questions regarding this letter or the procedures of the IRB in general, I invite you to contact me at the address or the telephone number shown on the letterhead. If your question has directly to do with the project we have just re-approved for you, please quote file number 1293.

With best wishes for your work,

Sincerely,

Matthew Creighton, SJ