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**Getting the Feel of Therapy:  
Understanding Therapists' Views and Experiences Regarding  
Social-Emotional Skills in Practice**

A thesis presented in partial fulfilment of the requirements for the degree of

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## **ABSTRACT**

Emotions are arguably at the heart of psychotherapy. While clients' emotions in therapy have received a great deal of research attention, outside the realm of psychoanalytic and psychodynamic research, therapists' emotions have largely been neglected. When applied to therapy, the concept of social-emotional skills describes therapists' ability to be aware of their own and their clients' emotions and then draw on that information to manage those emotions and in turn, the therapeutic interaction. As therapists' social-emotional skills are a relatively new area of enquiry, this qualitative study sought to contribute to the literature by exploring therapists' views and experiences regarding social-emotional skills in practice. Semi-structured interviews were carried out with ten practicing therapist participants between the ages of 31 and 62. Using Thematic Analysis, The Centrality of Emotions in Therapy was determined as a meta-theme and this was further organised into four main themes; Emotional Principles, Emotional Awareness Strategies, Emotional Practices as well as the Learning and Training of Social-Emotional Skills. The findings were visually represented using 'The Tree of Therapists' Social-Emotional Interactions' model. Implications of the findings, limitations of the current study and future research directions are discussed.

## ACKNOWLEDGEMENTS

Despite all the words contained in this thesis, it is difficult to verbalise the immense gratitude I feel for all those who have made this journey possible for me. And yet, I will attempt to use words to the best of my ability, to express my feelings and thanks.

Firstly, I thank God, the creator of all things – for the fantastic support network He has cushioned my life with, for all of the happy times, all the light-bulb moments, the rich learnings, the ups and the downs – all of which I consider blessings. I am forever indebted to Your unconditional grace and kindness.

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Peter – my husband and rock. His name literally means rock! I've saved the best for last with you. You have been so supportive, so encouraging, selflessly loving me every step of the way. During my bouts of stress and moments of self-doubt – there you always were (and are). I love you with each and every cell in my body. We did it baby! I can't wait to see what the future holds for us now.

I want to conclude this section with a quote that resonates deeply within my heart. It's a famous quote with personal value to me, one that I believe forms an appropriate summary of this journey and my overwhelming gratitude to all those who have walked this long path with me:

*"If I have seen further, it is by standing on the shoulders of giants." ~ Isaac Newton*

## PREFACE

*“The starting point of all achievement is desire.” ~ Napoleon Hill*

I have always been interested in therapy. Many years before I started training, I was eager to learn about this mysterious dynamic called therapy that seemed to bring about a great deal of healing to those that were engaging in it. How did it work? What was involved? As I commenced my training in a rather traditional psychology course, I studied the broad range of mental health problems and tried to memorise all the accompanying symptoms of the different psychological disorders. I was subsequently introduced to evidence-based treatments that were able to be utilised in a therapeutic environment to alleviate or address these symptoms. The focus always seemed to be on the client; what they were presenting with, whether it was causing them distress and how their symptoms had affected an important area of their functioning. The therapist’s job, as I understood it then, was about listening carefully to their client, identifying what’s troubling them and then using their knowledge from training to collaboratively work on a plan to address their presenting difficulties - to reduce their distress and help them live the life they wanted to live. I loved the idea of being part of that, but the exposure to real clients was saved for later on in my training. I needed to learn the theories first.

Soon after I had started my doctorate in clinical psychology, I was reading staff members’ research interests and luckily stumbled upon Dr Shane Harvey. He was interested in the social-emotional practices of therapists. I wasn’t familiar with the concept of social-emotional skills but after learning what it was, I got really enthusiastic. There it was, the other piece of that mystery I had been curious about earlier in my training but couldn’t name. I was very fortunate in that the SYLFF

Foundation also provided me with the opportunity to travel to the USA, meet with experts in the field and present my research to experienced therapists to ascertain their perspectives.

Initially, the research involved recruiting therapist participants, assessing their social-emotional skills through a self-rated measure and recruiting one of their clients so that both could provide initial insights about how therapists' emotional skills influence the therapeutic process (e.g. the client-therapist relationship) and client outcomes. Despite my excitement and this being a gap in the literature as well as very useful clinical information, therapist recruitment turned out to be unexpectedly difficult. Although disheartening, it was also a very interesting phenomenon. Therapists seemed so interested when I initially discussed the research with them but so few were willing or able to participate. What was this about? The million dollar question that drove me crazy. I had ensured that research participation would not take up much of their time, included compensation and assured them their contributions would be confidential and anonymised.

After further unsuccessful attempts at recruiting therapists, I decided to try collecting similar information about therapists' social-emotional skills using a different method; semi-structured interviews. To my surprise, recruitment became much easier using this method. I made a point of asking therapists during the interviews about whether they had any ideas about my initial difficulty at recruiting therapist participants. The answers they provided were fascinating. Below are some examples.



- Giselle:** Did they think that they were being tested?
- Interviewer:** Maybe?
- Giselle:** I think that would've been it.
- Interviewer:** That they were being tested?
- Giselle:** Yeah, cos it wasn't like that was a lot of time cos I think that's why some people don't wanna take part in research cos it takes time. Maybe they all felt anxious - I'm going to fail!
- Nancy:** That's pretty exposing and terrifying for a psychologist I think because it's a real assessment of their work...I mean it's a great study idea, I think that your problem would be recruiting people. I think most psychologists would be a bit too scared of that.
- Ruth:** I think that most therapists would be really anxious about being rated by their clients.
- Interviewer:** How come?
- Ruth:** Lots of people don't ask their clients questions about how they're going in therapy and I think therapists would probably mostly hope that they're doing well but fear that they're doing badly...I think mostly it would just be people's anxiety about what you were going to get, even if it was anonymised.
- Sylvia:** Like I said before, it's scary. You're being rated as to how good a therapist you are, that's what it feels like.

In an interesting turn of events and despite the stress, I am glad things worked out the way they did - that I had the initial difficulties with recruitment. The rich information gathered from interviewing therapists in this study could not have been attained via the quantitative method I had originally planned. This research sheds light on the importance of understanding therapists' social-emotional skills

and it is my hope that the findings will pave the way for further, quantitative and qualitative enquiry into this area. Therapists need not be afraid of looking into their practices. As with most helping professions, being a therapist involves a lifelong learning process. No one will ever be perfect at it. I hope that such research will in time, not be feared but embraced as studying therapists' social-emotional skills can potentially make significant contributions to therapist training programmes both in New Zealand and abroad to enhance client outcomes.

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## **THESIS OVERVIEW**

This thesis consists of eight chapters. Chapter One provides a conceptualisation of emotions, outlines the history of emotion research in psychotherapy, demonstrates therapists' contributions to therapy and highlights the importance of considering therapists' emotions within this context. Chapter Two introduces the concept of social-emotional intelligence and then applies the theory of social-emotional intelligence to therapists. As the concepts of transference, countertransference and emotional contagion bear some similarities with this, these are briefly outlined in this chapter and then differentiated from the concept of social-emotional intelligence. The current study along with its rationale are subsequently presented

Chapter Three describes the methodology underlying this study then provides an overview of the data collection and analysis methods. Subsequently, the quality criteria for the current study along with an account of the researcher's positioning are outlined. Chapters Four to Seven present the study's findings, which are structured according to the determined themes. Throughout these chapters, relevant literature is incorporated so that the themes can also be understood in relation to previous research. Chapter Eight presents a discussion which summarises the major findings, outlines the implications and limitations of the current study then proposes recommendations for future research directions.



## CHAPTER ONE

*"All perception is coloured by emotion." ~ Immanuel Kant*

### **Conceptualising Emotions**

The term 'emotion' originates from 'emovere' – a Latin word that means 'to move away' (Elnicki, 2010). But what is an emotion? That was the exact question posed by William James in his 1884 essay, where he explained emotion as the feeling of particular bodily responses to a situation (James, 1884). Following James' contribution, cognitive theorists of emotion proposed that emotional experiences were triggered by individuals' cognitive appraisals of a physiological arousal (Schachter & Singer, 1962). Since then, the pursuit to understand emotion has been anything but a simple endeavour and even today, there remains no universally accepted definition of emotions (Dixon, 2012; Mulligan & Scherer, 2012; Thompson, 2013).

Frijda, Kuipers and Ter Schure (1989), who also viewed emotions through the lens of cognitive theory proposed that an emotion is a reaction to an affectively significant event. From their perspective, emotion consisted of an individual's affect, their awareness of an emotional object and their appraisal of it, along with their readiness to take action in response to it and their autonomic arousal. Similarly, Scherer (2005) proposed 'the componential theory of emotion' which employed cognitive theory to describe emotions as the product of cognitive, physical and perceptual processes working together in synchrony.

In contrast to the work of those who adopted a cognitive stance to describe emotions, other researchers attempted to theorise emotions by focussing on

somatic factors and the ways through which emotions are structured. In terms of somatic theories, researchers such as Plutchik (1980), Ekman (1984) and Tomkins (1984) all proposed that physical responses within individuals' bodies, rather than cognitive appraisals are responsible for emotions. Furthermore, two main, but opposing theories regarding the structure of emotions were proposed. One theory proposed that emotions have a discrete structure, while the other proposed a continuous emotion structure. In accordance with Darwin, Ekman and Prodger (1998) as well as Ekman's (1992, 1999) works, the discrete theory of emotion emphasised that there are at least six basic emotions (happiness, sadness, anger, fear, disgust, surprise) that are universally expressed and recognised. In contrast, the continuous theory focussed on the physiological aspects of emotions such as heart rate and proposed that there are at least two dimensions that describe and differentiate emotions (Barrett & Russell, 1999). An example of this can be found in Scherer's (2002) work which describes emotions in terms of two dimensions; valence (*positive* or *negative*) and activation (*active* or *passive*).

In an effort to devise an agreed upon definition of emotion, Kleinginna and Kleinginna (1981) compiled a list of almost one hundred different definitions of emotion before proposing their own. While Kleinginna and Kleinginna's (1981) efforts did not result in the unifying definition of emotion they had hoped for, a consensus has since been reached amongst the majority of researchers regarding the constituents and functions of emotions. Briefly, that is that emotions consist of neural systems that attend to emotion processes and that emotions influence both cognitions and behaviours (Izard, 2010). Emotions are proposed to influence cognitions by providing information to the individuals experiencing them. Such information can take the form of cognitive appraisals or ongoing cognitive

interpretations of the feelings they experience. In terms of behaviours, emotions are said to have the ability to influence individuals to engage in either approach or avoidance actions (Izard, 2010). For example, in terms of the latter, a pedestrian may observe a large vehicle within close proximity as they are crossing the road. In response, they might feel fearful, avoid crossing the road and rush back to the sidewalk to prevent a collision.

Researchers assert that individuals make sense of their experiences through two related modalities; emotions and cognitions, both of which interact together to contribute to behaviour and promote healthy human functioning (Dolcos, Wang & Mather, 2015; Greenberg, 2008). According to Angus and Greenberg (2011), emotions and thoughts are always interacting through language in order to enable individuals to create meanings from their experiences. This is in contrast to the historical, common-sense view of emotions which emphasised them as being an after-effect of cognitions that were disruptive and therefore needed to be stringently controlled (Lewis, Haviland-Jones & Barrett, 2010).

More recently, there has been an emphasis on this interactive relationship between emotions and cognitions (Dolan, 2002; Greenberg, 2002; Phelps, 2006). Furthermore, emotional over-control and emotional avoidance are viewed as potentially problematic since emotions provide individuals with vital information to help them respond adaptively to situations (Greenberg & Paivio, 2003). For example, in light of the aforementioned example of the pedestrian, the emotion of fear induced a 'flight' response that enabled the pedestrian to respond adaptively to the perceived threat posed by the oncoming vehicle (Lewis, et al., 2010). This is consistent with Damasio's (1999) earlier work which asserted that emotions

function via somatic markers that quickly direct individuals' attention towards the most advantageous options and thereby, simplify decision-making prior to them even consciously registering any problems.

As illustrated above, the majority of emotion theories have focussed on explaining the structure and constituents of emotions or have taken to describing the intrapersonal experiences of emotion. While such theories undoubtedly provide a useful platform from which to conceptualise emotions, they largely neglect the social or interpersonal functions of emotions. Although emotions are able to be experienced completely internally, they generally tend to be interpersonally expressed through a variety of ways (Niedenthal, Krauth-Gruber & Ric, 2006). For example, an internally experienced feeling of happiness may be outwardly expressed through an individual's facial expression, voice tone and body language. Alternatively, individuals may explicitly share their emotions with others through the use of words. However, regardless of the means through which an individual shares their emotions, these emotions are frequently expressed to others, who consequently respond, highlighting the social nature of emotions (Parrott, 2001; Reis & Collins, 2004).

### **The Social Function of Emotions**

If the functionality of emotions were solely restricted to the intrapersonal level, emotions would not be expressed on individuals' faces, which are generally only viewable to others (Ekman, 2007). Beyond the intrapersonal functions of emotions are significant interpersonal functions (Parrott, 2001). To explain, in order to relate to and interact effectively with others, individuals frequently draw on others' emotional expressions (Keltner & Haidt, 2001). This is referred to as the

social-functional view of emotion and represents the stance of the current study. In other words, this study focusses on the ways in which emotions are used to coordinate social interactions by transmitting information about the 'emoter's' feelings, needs, motives and appraisals of a given situation to others. Social psychology researchers also advocate a social-functional view of emotions, whereby they are viewed as necessary for regulating interpersonal interactions (Parrott, 2001).

### **Emotions in Psychotherapy**

Psychotherapy involves an interpersonal relationship between a therapist and one or more clients for the purpose of treating mental or emotional difficulties (Eskin, 2012). In order to treat their clients effectively, therapists must rely on the social function of emotion. For example, therapists routinely attend to clients' verbally expressed emotions as well as non-verbal emotion cues such as their clients' facial expressions, voice tones and body language (Prout & Wadkins, 2014).

The importance of identifying and exploring unpleasant or painful emotions through psychotherapy in order to alleviate client distress was emphasised by early theorists such as Rogers (1951), Freud (1961) and Perls (1969). For instance, the cathartic expression of emotion was viewed as a key component of treatment in early psychoanalytic therapies, where client symptoms were seen as arising from repressed memories and emotions. Expressing such emotions through catharsis was considered a curative experience and an important goal of psychotherapy (Kosmicki & Glickauf-Hughes, 1997). Similarly, the cathartic expression of clients' emotions was also promoted by therapists using psychodrama (Moreno, 1946) as well as primal therapists (Janov, 1972). In contrast, prior to the 1980s, those

engaged in cognitive therapy practice and research stressed that negative emotions arose as a result of faulty thoughts or cognitions and that the only way to alleviate individuals' negative emotions was to focus on modifying their cognitions (e.g. Beck, 1979; Kovacs & Beck, 1978).

In the 1980s, Greenberg and Safran (1984, 1987, 1989) documented the significant role of emotions in therapy and advocated the relationship between emotions and therapeutic change. Within their framework, psychological difficulties were said to arise as a result of individuals' blocking or avoiding emotional experiences. Rather than being viewed as the problem, emotions were emphasised as being an adaptive means of processing information and preparing individuals to respond to their environment in ways that promoted their well-being (Greenberg & Paivio, 1997). In working with clients' emotions, Greenberg and Paivio (1997) proposed that therapists needed to assist clients to overcome their resistance to emotions so that they could better access emotional experiences. This included differentiating client emotions in terms of two dyadic categories: *adaptive* or *maladaptive* and *primary* or *secondary*, as each of these were viewed as requiring different interventions.

In Greenberg and Paivio's (1997) work, primary emotions represented individuals' direct and initial reactions to a given situation, while secondary emotions represented individuals' prior thoughts or feelings. Moreover, while maladaptive emotions were viewed as unhelpful and required transformation, adaptive emotions were sought out and used in therapy in order to help bring about therapeutic change (Greenberg, 2002). The adaptiveness of a given emotion was viewed as being contextually dependent, where one emotion could be considered

adaptive in one context but maladaptive in another (Johnson & Greenberg, 2013). Greenberg and Paivio's (1997) emotion dyads were similar to other works which also differentiated emotions using a dyadic category of *basic/primary* or *secondary* (e.g. Damasio, 1994; Ekman, 1992, 1993; Izard, 1977; Kemper, 1987). Basic or primary emotions such as anger, disgust or sadness were described as developing earlier in life and arising quickly in a reactive manner based on sympathetic nervous system arousal. Such emotions are said to require only minimal cognitive processing (Coon & Mitterer, 2012; Lewis, et al., 2010; Sander & Scherer, 2014). For example, an individual may experience disgust immediately after seeing a dead insect inside a spoonful of food that they are about to consume. In contrast, secondary emotions are more complex than basic emotions in that they are developed later in life, are more cognitively-oriented and are influenced by an individual's social environment (DeLamater, 2006; Mozdierz, Peluso & Lisiecki, 2013). For instance, resentment and embarrassment are secondary emotions that may be experienced by an employee who expects a promotion but then discovers that this was given to a less hard-working colleague after he had already informed his family of his upcoming promotion.

As with Greenberg and Paivio's (1997) dyadic emotion categories, the aforementioned differences between *basic* and *secondary* emotions have implications for the ways they can be worked with in therapy. Furthermore, in light of the importance of emotions for healthy human functioning (Mayne & Bonanno, 2001), recent research has demonstrated that regardless of a therapist's theoretical orientation, the focus on client emotion is central for effective therapy (Borum & Goldfried, 2007; Coombs, Coleman & Jones, 2002; Greenberg & Paivio, 2003; Mennin & Farach, 2007; Whelton, 2004). For example, Coombs et al., (2002) found that

collaborative exploration of client emotions was related to reductions in client depression scores, demonstrating the importance of emotion processes for therapeutic change. Similarly, in his review of the use of emotion across different therapeutic modalities, Whelton (2004) outlined several studies that found a significant relationship between clients' emotional experiencing within the therapeutic context and more positive client outcomes.

Within clinical psychology, cognitive behavioural therapy is commonly misconstrued as deemphasising or ignoring the importance of emotions in favour of focusing on cognitive distortions, which are viewed as the cause of maladaptive emotions and behaviours (Bazzano, 2013; DiCaccavo, 2010; Wydo, 2001). Consistent with this, Samoilov and Goldfried (2000) emphasise the lack of emotional focus within therapeutic interventions based on cognitive behavioural therapy. However, Curwen, Palmer and Ruddell (2000) stress that this is not at all the case. According to cognitive behavioural theory, negative emotions arise as a result of misinterpretations as well as negative beliefs about the self, world and future (Westbrook, Kennerley & Kirk, 2011). Therapists working from the cognitive behavioural therapy orientation attend to emotions as they are tasked with helping clients identify their "hot cognitions" or emotionally-charged thoughts and working with these in therapy (Westbrook et al., 2011). Moreover, Padesky and Mooney's (1990) five-part, cognitive behavioural therapy model is frequently introduced by therapists to help clients identify their emotions and any associated physiological or somatic experiences that accompany their emotions. The view is that individuals' thoughts, emotions, physiological responses and behaviours are all constituents of a unified system, where change in any one constituent will lead to changes across the others (Grant, 2010). Moreover, cognitive behavioural therapists' empathetic



responses to clients' emotions are viewed as central to the development of the therapeutic relationship - the context in which clients' maladaptive thoughts and in turn, their emotions are addressed (Westbrook et al., 2011).

Greenberg (2012) proposes that emotional experiences can occur before, and independently of conscious thoughts. As such, he emphasises that long-lasting emotional change is unlikely to occur through merely cognitive work. This is the basis of his theory of emotional change, which suggests that therapists need to focus on facilitating emotional change within their clients as opposed to behavioural or cognitive changes on their own. To change emotions, Greenberg (2002, 2010) outlines six emotional processes that therapists need to use with their clients during therapy. These processes include: emotional awareness, expression, regulation, reflection, changing emotions and corrective emotional experiences.

The first of Greenberg's (2002, 2010) processes (awareness) was proposed as being the most important as it involves assisting clients to become aware of their emotional experiences. In the second process (expression) clients are encouraged to express their emotions, which in turn, also helps prevent avoidance of their emotional experiences. In the third process (regulation), clients are assisted to tolerate and manage their emotional experiences as they experience them through the implementation of self-soothing techniques. During the fourth process (reflection), the therapist guides clients to reflect on their emotional experiences so that they can enhance their understanding of them and potentially view their experiences differently, including considering aspects they had not previously considered. In the fifth process (transformation), clients' primary maladaptive emotions (e.g. shame) are reversed by activating adaptive emotions to replace them

(e.g. self-compassion). The final process (corrective emotional experience), involves the introduction of a novel experience that changes the older emotion and enables a new way of perceiving the previous emotional experience. All of the aforementioned processes are emphasised as occurring within the safe context of the therapeutic relationship, which Greenberg (2008) refers to as the 'crucible of emotional processing'.

The evidence supporting the efficacy of emotion-focussed therapies is increasing, although proponents of emotion-focussed theories continue to acknowledge the importance of both cognitive and behavioural techniques for client change (Greenberg, 2008; Greenberg & Paivio, 2003). A variety of research has been carried out that supports the utility of different emotion-focussed treatments for mood (e.g. Greenberg & Watson, 2006) and anxiety (e.g. Elliott, 2013; Shahar, 2014) disorders as well as trauma (Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010). For example, in two studies that employed emotion-focussed therapy for depression, emotion-focussed therapy was reported as an effective treatment. Furthermore, in both studies, emotion-focussed therapy was found to be as effective as cognitive behavioural therapy for the treatment of depression (Goldman, Greenberg & Angus, 2006; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003).

### **Therapists' Contributions to Therapy**

The role of the therapist in emotion-focussed therapies is predominantly based around generating emotional experiences in clients and then using these to facilitate change. While the efficacy of this process for client outcomes continues to be demonstrated, these models do not guide how therapists should best manage client emotions that arise spontaneously. Furthermore, therapists' own emotions

are notably left out of emotion-focussed therapies. The latter may be understood in light of how psychotherapy research has traditionally focussed on clients' presenting problems and the efficacy of different interventions that are designed to reduce or alleviate these problems (Bergin, 1997; Beutler, 1997). In contrast, consideration of the treatment provider - the therapist, has been largely omitted (Crits-Christoph & Mintz, 1991; Wampold, 2001) as therapist effects have been assumed to be either non-existent or unimportant (Elkin, Falconnier, Martinovich & Mahoney, 2006; Wampold, 1997; Wampold & Imel, 2015).

Some researchers were puzzled by the tendency to omit consideration of therapist variables and in response, re-analysed data from previous clinical trials to estimate the variability in client outcomes that can be attributed to therapist variables (e.g. Blatt, Sanislow, Zuroff & Pilkonis, 1996; Crits-Christoph & Mintz, 1991; Huppert et al. 2001; Luborsky, McLellan, Diguier, Woody & Seligman, 1997). For example, Crits-Christoph and Mintz (1991) analysed 27 treatment groups and found that 8.6% of the variance in client outcomes could be attributed to therapists. This was also consistent with Kim, Wampold and Bolt (2006) who reported that therapists were responsible for 8% of the variance in client outcomes. Given that estimates of therapist variability in client outcomes range from 6-10% across the aforementioned studies and that whether or not participants receive a treatment intervention has been estimated to account for only 13% of the variability in their treatment outcomes, therapist variability of 6-10% is comparatively important (Wampold, 2001). Researchers have also asserted that failure to acknowledge therapist effects carries important consequences when examining client outcomes. Specifically, leaving therapist effects unexamined increases the prevalence of Type 1 Error and inaccurately inflates the effect sizes that are estimated based on the

outcomes of treatment interventions (Crits-Christoph & Mintz, 1991; Wampold & Serlin, 2000).

Studies that have examined the influence of therapist demographic factors such as age, gender, ethnicity as well as the 'fit' or similarities across these factors between therapists and their clients have demonstrated mixed findings. For instance, early studies such as that by Beck (1988), investigated therapists' age in attempt to explicate the specific factors which contribute to the differences between therapists' outcomes. The results found an insignificant relationship between therapists' age and client outcomes. Similarly, Huppert et al.'s (2001) study reported no significant differences in client outcomes based on therapists' age. Consistent with these findings, clinical research involving older adults, youth and children where the ages of therapists and their clients are expected to be significantly different have concluded that age is a weak predictor of client outcomes (Thompson, Gallagher & Breckenridge, 1987; Weisz, Weiss, Han, Granger & Morton, 1995). In contrast to the studies which demonstrate that therapists' age is unimportant for client outcomes, Dembo, Ikle and Ciarlo's (1983) found a significant relationship (albeit a small one) between similarities in client-therapist age and client outcomes. This was in line with Beck (1988) who found poorer client outcomes when there was a greater than 10 year age difference between therapists and their clients compared to therapists and clients who were closer in age.

Therapists' training background and professional experience have also been examined in relation to client outcomes. For instance, Smith, Glass and Miller's (1980) study found that clients experienced slightly better outcomes when they were treated by a psychologist as opposed to a psychiatrist. In terms of experience

delivering therapy, Vocisano et al. (2004) found that therapist experience, as measured by the number of years they had practiced individual psychotherapy, had no significant relationship with client outcomes. In contrast, other studies have reported the relationship between experience and better client outcomes (Sandell et al. 2002; Crits-Christoph et al. 1991; Stein & Lambert, 1995). Similarly in Huppert et al.'s (2001) study, which also measured experience by number of years therapists had practiced psychotherapy, therapist experience was significantly related to client outcomes. Specifically, clients who were treated by more experienced therapists demonstrated greater improvements in comparison to those seen by less experienced therapists. Interestingly, in relation to therapists' emotional skills, a more recent study found that both therapists' age and experience were associated with reductions in therapists' emotional awareness, where therapist training actually lowered participating therapists' emotional awareness skills to the level of less experienced therapists (Curtis, 2016).

Ricker, Nystul and Waldo (1999) reported that a shared ethnic background between therapists and their clients was predictive of therapeutic outcomes. This is unsurprising as researchers have discussed the ways in which similarities between clients and their therapists contribute to the formation of the therapeutic relationship and in turn, client outcomes (Luborsky, 1994). Huppert et al. (2001) examined the effect of gender in relation to therapeutic outcome and reported no significant effect. This was consistent with Zlotnick, Elkin and Shea's (1998) research, which found no significant effect on client outcomes based on whether there was a gender match between therapists and their clients. Interestingly however, Marwick's (2016) research indicated that in relation to emotional skills, gender was significantly associated with differences in therapists' social-emotional

therapeutic styles. Specifically, female therapists reported emotional self-awareness as a greater feature in their practice as compared with male therapists, while male therapists reported greater self-confidence.

To summarise, although the aforementioned studies have demonstrated mixed findings regarding the importance of different therapist characteristics, they have also highlighted the ways in which therapists vary significantly in terms of their treatment success. Alongside these mixed findings, more recent research has begun to investigate therapists' emotions in therapy. However, information regarding the links between therapists' emotional characteristics and client outcomes is still lacking.

### **Therapists' Emotions in Psychotherapy**

In order to work effectively with clients' emotions, therapists also need to be able to recognise and manage their own emotions (Mozdzierz, Peluso & Lisiecki, 2009; Skovholt & Jennings, 2004). Beck, Freeman and Davis (2003) emphasise that therapists' emotions are not mistakes or signs of failure at being a therapist, but normal human responses. Like all people, therapists' emotions can be triggered by their perceptions of their professional role, their culture, values or beliefs and from their interactions with clients' difficult behaviours (Kimerling, Zeiss & Zeiss, 2000). In the psychoanalytic and psychodynamic literatures, therapists' emotions in response to clients are viewed as being important to monitor and work with as they are considered a useful source of information about a given client's effect on others as well as their general patterns of interacting (Gabbard, 2010; Gelso & Hayes, 2012; Rossberg, Karterud, Pedersen & Friis, 2010).

However, while therapists' emotions in the context of therapy have been extensively discussed in the psychoanalytic and psychodynamic literatures and more recently in the context of relational theory (e.g. Benjamin, 2003), very little can be found in the cognitive behavioural therapy literature about therapists' emotional responses towards their clients. Given that researchers have documented the importance of therapist characteristics for client outcomes (Crits-Christoph et al. 1991; Kim, et al. 2006; Lutz, Leon, Martinovich, Lyons & Stiles, 2007) and how common therapists' emotional responses are (Thomas & Hersen, 2010; Kimerling et al. 2000), the understudied nature of this domain is rather surprising.

Research has demonstrated that therapists' emotions are related to the client-therapist relationship, therapist empathy, client treatment engagement and clients' rates of treatment completion (Hoffart & Friis, 2000; Wolff & Hayes, 2009). To contribute to the literature on therapists' emotional reactions to clients, Najavits and Colson (1992) created the Ratings of Emotional Attitudes to Clients by Treaters (REACT). The REACT is a self-report measure that captures both positive and negative therapist reactions to clients across four domains: (1) positive client connection (e.g. empathy) (2) therapist self-conflict (e.g. confusion) (3) therapist needs (e.g. boredom) and (4) therapist conflict with client (e.g. helplessness) on a 5-point Likert scale (Najavits et al., 1995). Use of this measure with therapists demonstrated that therapists from different theoretical orientations possessed varying degrees of negative emotional reactions towards their clients and that therapists' emotional reactions to clients were related to the therapeutic relationship (Najavits et al., 1995). More recent studies using this measure have also found that client ratings of the therapeutic relationship and therapist empathy could be reliably predicted using therapists' emotional reactions to clients as measured by

the REACT (Wolff & Hayes, 2009). Such studies illustrate how important it is for therapists to attend to their emotional responses to clients, including in the context of cognitive behavioural therapy where therapists' emotions tend to be neglected. This is noted by Kimerling et al. (2000) who stressed that cognitive behavioural therapists should not only focus on understanding their clients' thoughts, emotions and behaviours, but also attending to and monitoring their own emotions.

The ability to attend to one's own and others emotions, and to then use this information to manage these emotions in the self and others are not only core therapist skills but also the components of what is interchangeably referred to as emotional intelligence or social-emotional intelligence (Bar-On, 2006; Goleman, 2001). Social and emotional intelligence also enables individuals to successfully interact with others and use emotions to problem solve (Salovey & Mayer, 1990). Consistent with this, Ellis and Conboy (2004) asserted that therapists' social and emotional skills were important for the therapeutic relationship as not only do they enhance therapists' understanding of their own experiences, but also provide insight into their clients' emotions. The following chapter explores social-emotional intelligence in more depth.



## CHAPTER TWO

*“Getting angry is okay so long as you get angry for the right reason, with the right person, to the right degree, using the right words, with the right tone of voice and appropriate language.” ~ Aristotle*

### **Social-Emotional Intelligence**

While the study of cognitive intelligence has received a lot of attention for its ability to predict educational and professional achievement, Brody (1992) highlighted that cognitive intelligence could not fully predict successful functioning across all life domains. Consequently, emotional intelligence was suggested to account for some of what could not be explained by cognitive intelligence alone. In line with this, Goleman (1995) wrote and published a best-selling book entitled ‘Emotional Intelligence: Why it Can Matter More Than IQ’. In his book, Goleman (1995) outlined the literature in support of emotional intelligence and proposed that this accounted for a significant proportion of individuals’ life success, over and above cognitive intelligence.

Several researchers have proposed models of emotional intelligence (Bar-On, 1997; Goleman, 1995; Salovey & Mayer, 1990). Salovey and Mayer (1990) were the first to use the phrase ‘emotional intelligence’. In their conceptualisation, emotional intelligence was defined as a type of social intelligence that includes an individual’s ability to monitor their own and others’ feelings, discriminate among these feelings, and then use this information in order to guide their thoughts and behaviours. Moreover, Salovey and Mayer (1990) proposed that emotional intelligence is comprised of three main abilities: emotion appraisal and expression, emotion regulation, as well as the utilisation of emotion for planning, thinking creatively, attention redirection and motivation.

According to Salovey and Mayer (1990), individuals have different capacities for understanding and expressing emotions, which influences their ability to engage in both social and emotional interactions and, in turn, their overall well-being. However, these emotional skills can be taught to allow individuals to experience improvements across these domains (Bechara, Damasio & Bar-On, 2007; Mayer & Salovey, 1997; Sluyter & Salovey, 1997). Salovey and Mayer carried out several studies in order to exemplify the significance of emotional intelligence. For example, in one study they found that those who had a better ability to accurately perceive and understand other peoples' emotions were also able to respond with greater flexibility to social environment changes (Salovey, Bedell, Detweiler, & Mayer, 1999). Furthermore, Salovey and Mayer asserted that emotional intelligence could be assessed via self-report and ability measures (Mayer, Salovey, Caruso & Sitarenios, 2003; Salovey, Woolery & Mayer, 2001). Thus, they contributed to the development of a widely used ability based assessment of emotional intelligence called: 'The Mayer-Salovey-Caruso Emotional Intelligence Test' (MSCEIT; Mayer, Salovey, Caruso & Sitarenios, 2003).

Following Salovey and Mayer's (1990) contributions, Goleman (1995) proposed the 'Mixed Model' of emotional intelligence which included both personality traits and emotional abilities. In his model, Goleman (2001) defined emotional intelligence as individuals' ability to both recognise and regulate their own and others' emotions. Bar-On (1997, 2006) proposed a similar conceptualisation of social-emotional intelligence known as 'The Bar-On Model of Social-Emotional Intelligence'. In this model, emotional and social skills were viewed as being a set of interrelated abilities that enable individuals to attend to and manage their own and others' emotions. This is also consistent with Belsten's

(2010) definition of social and emotional intelligence which is described as individuals' ability to be aware of their own and others' emotions in the moment, and then draw on this information to manage both themselves and their relationships.

Although the aforementioned researchers of emotional intelligence provided slightly different conceptualisations of the term, their models all agree that there are four domains of emotional intelligence. These are: (1) self-awareness, (2) self-management, (3) social awareness and (4) social or relationship management, although the wording for these domains vary slightly across the different models (see Figure 1). In line with the aforementioned conceptualisations, this study will use the concept of social-emotional intelligence to refer to therapists' ability to attend to, or become aware of, their own and their clients' emotions and use this information to manage both their own and their clients' emotions in the context of the therapeutic relationship.

Self-Awareness	Social Awareness
Self-Management	Social/Relationship Management

*Figure 1: Social-Emotional Intelligence Domains adapted from Belsten's (2010) Four-Quadrant Model of Social and Emotional Intelligence.*

## **Therapists' Social-Emotional Intelligence**

Therapists are in a unique role of working alongside clients who present with a range of aroused emotions such as anxiety, sadness and anger (Greenberg & Watson, 2006; Norcross & Wampold, 2011). Moreover, therapists themselves experience emotions within the therapeutic setting (Hayes et al., 1998; Pope & Tabachnick, 1993). Therefore, it follows that it would likely be a desirable attribute for therapists to be able to recognise, understand and effectively work with both their own and their clients' emotions (Bar-On, 2006; Salovey & Mayer, 1990). However, there is currently a lack of research to substantiate the usefulness of therapists' emotional skills within the therapeutic context.

One area that has attended to therapists' emotions is the research on therapists' emotional intelligence (e.g. Cooper & Ng, 2009; Kaelber & Schwartz, 2014; Kaplowitz, Safran & Muran, 2011). Although the literature on emotional intelligence has been thriving for many years across varied domains, the attention paid to therapists' emotional intelligence is comparatively a more recent and understudied phenomenon. The capacity to recognise and understand one's own and others' emotions is particularly useful for therapists as they can draw on this information to manage themselves and their interactions with clients. For a therapist, social-emotional intelligence may involve recognising client anger, knowing when sitting with a client's silence is better than speaking and understanding when to affirm a client when this is required (Dryden & Spurling, 2014; Kottler, 2010).

A literature review on published articles about therapists' emotional intelligence demonstrated the scarcity of research in this area. Specifically, over the

last two decades, only eight studies have been carried out measuring therapists' emotional intelligence in relation to various aspects of their practice (Cooper & Ng, 2009; Easton, Martin & Wilson, 2008; Kaelber & Schwartz, 2014; Kaplowitz et al., 2009; Easton, Martin & Wilson, 2008; Kaelber & Schwartz, 2014; Kaplowitz et al., 2011; Martin, Easton, Wilson, Takemoto & Sullivan, 2004; Miville, Carlozzi, Gushue, Schara & Ueda, 2006; Rieck & Callahan, 2013; Stanton et al., 2011). It is important to note that all of these studies employed a quantitative research design, were published between 2004 and 2014, with the majority (six out of the eight articles) being published after 2006, demonstrating the limited but recent interest in this area.

The eight aforementioned studies demonstrated that therapists' emotional intelligence is important for seven key aspects of therapists' practice including: their competence, self-efficacy (Easton et al., 2008; Martin et al., 2004), empathy (Miville et al., 2006), the supervisory relationship (Cooper & Ng, 2009), client outcomes, client drop-out and client assessment compliance (Kaplowitz et al. 2011; Rieck & Callahan, 2013). Furthermore, Kaelber and Schwartz (2014) found that therapists' emotional intelligence did not differ significantly between Western and Eastern cultures while Stanton et al. (2011) and Martin et al. (2004) showed that the components of emotional intelligence differed across counselling-focused and non-counselling focused professions. Moreover, although Easton et al. (2008) found that involvement in a counsellor training programme increases therapists' emotional intelligence over time, this was inconsistent with Kaelber and Schwartz (2014), who reported that length of therapist training did not have a significant impact on therapists' emotional intelligence.

## **Transference, Countertransference and Emotional Contagion**

Another area that has attended to therapists' emotions is the rich psychoanalytic and psychodynamic literatures on a concept called 'countertransference'. To understand countertransference, a related concept called 'transference' must first be explicated. Both transference and countertransference are used to refer to the emotional responses that therapists and clients can experience towards one another (Gelso & Hayes, 2012). Transference describes the process by which clients are viewed as unconsciously transferring or redirecting their feelings about significant individuals from their past onto their therapist. These processes are also sometimes referred to as 'undifferentiated' or 'displaced' associations to highlight the idea that clients' past issues are reflected into their current relationship with their therapist (Goldstein & Goldberg, 2006; Jones-Smith, 2014). Transference is viewed as a form of mental defence which functions unconsciously to protect individuals from their unresolved childhood experiences with significant others. For example, individuals may experience strong feelings of attraction or anger towards their therapist or others as a result of 'repressed emotions' experienced in early relationships, where the client misunderstands the present relationship with their therapist in terms of a past relationship (Goldstein & Goldberg, 2006).

Transference is typically triggered if the therapist possesses any characteristics that are similar to a significant individual in the client's past. For instance, a client may view their therapist in the same way they viewed a significant individual such as a parent or sibling and thus, relate to them in a manner consistent with this (Dryden & Mytton, 1999; Jones-Smith, 2014). McWilliams (2004) explained that this unconsciously prompts individuals to try to re-live their past in

a more satisfactory way than they did originally during their childhood. Moreover, since transference involves the reassignment of feelings from past situations to the present, it also influences the development and maintenance of the client-therapist relationship (Gelso & Hayes, 2012). Sanders and Wills (2005) outline some common indications of transference. These include sudden changes in clients' non-verbal behaviours such as their facial expression, eye gaze or an unexpected change of topic.

Countertransference describes therapists' emotional responses to their clients' transference as well as therapists' own transference. That is, therapists' unconscious transfer or redirection of feelings on to their clients based on their own historical and unresolved issues with significant others (Corey, 2015; Gelso & Hayes, 2012). Both transference and countertransference were founded on the idea that individuals' early formative experiences, particularly their childhood relationships, construct their internal representation of relationships which are subsequently mirrored with others throughout their lifetime (Freud & Strachey, 1953). In other words, emotional responses by clients or therapists towards each other do not originate from either of them, but from the foundational or significant individuals in each of their emotional development histories. This suggests that the core of the fondness or hostility that therapists or clients may feel towards one another through transference are actually feelings about another primary individual from their personal lives such as their mother or father (Nevid & Rathus, 2016). As countertransference can have both positive and negative implications on the therapeutic relationship, Gelso and Hayes (2012) emphasised that it is important for therapists to identify and attend to their countertransference. While Freud encouraged therapists to overcome any emotions towards their clients so as not to

impede treatment (Storr, 1989), others have suggested that countertransference emotions are an important source of information that can be effectively utilised in therapy (Corey, 2015; Gelso & Hayes, 2012).

Although traditional conceptualisations of countertransference emphasised them as being emotional responses based on the therapists' past relationships and unresolved issues, other researchers have expanded this to include all therapists' emotional responses to their clients (Betan, Heim, Zittel Conklin & Westen, 2005). This is known as the 'totalistic' view of countertransference (Hayes, 2004) which has been criticized as diluting or making redundant the original conceptualisation of the term. For example, Gelso and Hayes (2012) argue that if all therapists' emotional responses to clients were to be construed as countertransference, the term would become useless as such responses could just be referred to as: therapists' emotional responses. Furthermore, from their perspective, if this were to become the case, then both therapists and researchers alike would need to clearly differentiate between countertransference that arises as a result of therapists' past relationships and unresolved conflicts versus those that arise as a result of the normal, expectable responses to their clients' presentation (Gelso & Hayes, 2012).

Consistent with Gelso and Hayes' (2012) perspective, some researchers have split the concept of countertransference into two different subtypes; subjective and objective, where the former represents emotional responses based on the therapists' past relationships and unresolved conflicts while the latter is used to describe the normal and expected emotional responses based on clients' presentations (e.g. Kiesler, 2001). However, Gelso and Hayes (2012) argue that the term countertransference should be strictly used to denote the traditional



conceptualisation of the term. That is, therapists' emotional responses to clients based on their past relationships and unresolved conflicts, while the remainder of therapists' emotional responses should be referred to as just that - therapists' emotional responses.

A related concept to transference and countertransference is 'emotional contagion'. As the term implies, emotional contagion views emotions as being "contagious" in the sense that within a therapeutic relationship, a client's emotions can essentially be 'passed on' or 'caught' by their therapist and vice versa (Hatfield, Cacioppo & Rapson, 1994). Studies have previously demonstrated support for the idea of 'catching' emotions such as anxiety (Donner & Schonfield, 1975) and depression (Joiner & Katz, 1999). Hatfield et al. (1994) explained that it is possible for individuals to 'catch' others' emotions due to the innate human tendency to mimic and behave in synchrony with others. In the context of therapy, this process can occur at either a conscious or unconscious level, although researchers have proposed the latter as being the more common of the two. When a client's emotions are unconsciously 'caught' by their therapist, the therapist may experience their client's particular emotion as their own and can be negatively affected by this, even when that emotion is incongruent with the therapist's own identify or beliefs (Hatfield et al., 1994).

### **Differentiating Social-Emotional Intelligence from Transference, Countertransference and Emotional Contagion**

In line with Gelso and Hayes' (2012) aforementioned views, this research conceptualises countertransference in the traditional and more widely used manner. That is, as therapists' emotional responses to clients or clients' transference based on therapists' own past relationships and unresolved conflicts. This section

will differentiate between therapists' social-emotional intelligence and the psychoanalytic/psychodynamic concepts of transference and countertransference as well as the concept of emotional contagion. In doing so, it will also argue for the greater utility of a concept such as social-emotional intelligence over the concepts of transference, countertransference and emotional contagion across multiple theoretical orientations.

As described above, therapists' social-emotional intelligence refers to therapists' ability to attend to, or become aware of their own and their clients' emotions and to then use this information to manage both of these in the context of the therapeutic relationship. Although this may bear similarities to the traditional concepts of transference and countertransference as well as the concept of emotional contagion, they differ in an important way. The main similarity between all of these concepts is that they all acknowledge that both therapists and clients can experience emotions in the context of their therapeutic interactions. Moreover, such emotions are considered important information and the therapist is tasked with attending to and managing these emotions in ways that most benefit client-therapist interactions and therefore, the therapeutic relationship.

The key difference between social-emotional intelligence, transference/countertransference and emotional contagion is the source of emotional experiences. To explain, transference and countertransference both emphasise that the source of therapists' and clients' emotions are their past relationships and unresolved conflicts (Betan et al., 2005). Emotional contagion focusses on how the emotion experienced by Person A can be 'caught' and experienced by Person B (Hatfield et al., 1994). In contrast, social-emotional

intelligence does not place any restrictions on the source of individuals' emotions. The source of therapists' emotions may very well be a mimicking of the emotions experienced by their clients (emotional contagion) or they may have arisen due to the therapist's own past relationships or unresolved historical conflicts (countertransference), but these are merely two options of many that can be used to explain why a therapist may experience particular emotions in the context of their therapeutic interactions with a client. For example, if a therapist experiences frustration towards one of their clients, this is not necessarily due to the therapist's mirroring of the client's own frustration or due to the client reminding the therapist of a salient caregiving figure who frustrated them, although both of these explanations are plausible. Alternative explanations for the therapist's frustration include the possibility that this particular client has simply done something that has frustrated the therapist such as consistently arriving late, cancelling sessions at the last minute or negating the majority of ideas that have been discussed in therapy in attempt to alleviate some of their distress. The therapist's hypothetical frustration in the example above could also have arisen from a raft of other factors including a poor therapeutic relationship or even prejudices that the therapist may hold regarding particular characteristics of their client such as their age, gender or cultural affiliation (O'Donohue & Cummings, 2006; Wisch & Mahalik, 1999).

Another important consideration is that although the concepts of transference and countertransference were initially exclusively used across psychoanalytic and psychodynamic therapies, they are slowly being adopted by researchers from other theoretical orientations. However, there is still a lot of resistance to using these concepts in order to describe the emotional responses of therapists and clients. For example, Kimerling et al. (2000) assert that it is a mistake

for therapists delivering cognitive behavioural therapy to use concepts such as 'countertransference' as such concepts are embedded in psychoanalytic and psychodynamic frameworks which explain these emotional experiences as being determined by events outside the therapeutic relationship namely, the therapists' learning history. Furthermore, the idea that therapists can merely 'catch' their client's emotions as one could catch a common flu as proposed by the emotional contagion concept can be viewed as problematic given that Hatfield et al (1994) do not actually outline the mechanism by which this transfer of emotions occurs. Furthermore, emotional contagion implies that therapists who attend to clients' negative emotions are likely to inadvertently be negatively affected by these emotions themselves, simply by virtue of the client having felt that emotion first. If that were the case, therapists' ability to assist clients with their negative emotions would be contingent on their ability to limit their susceptibility to 'catching' their clients' negative emotions. Rempala (2013) found that dissociation was the only effective means of reducing emotional contagion. But who would want to share their troubling emotions with a therapist who needed to dissociate in order to avoid catching the emotion themselves? The concept of social-emotional intelligence maintains that therapists can attend to their clients' negative emotions but also manage their own responses to these while assisting clients to manage theirs.

In light of the aforementioned considerations, the current study proposes that a concept such as therapists' social-emotional intelligence or skills is potentially a more useful, unifying and user-friendly concept to employ when describing therapists' emotional responses in therapy.

## **The Current Study**

Chapters one and two presented a conceptualisation of emotions, explicated the importance of emotions in psychotherapy and introduced the idea of using the concept of social-emotional intelligence to denote therapists' ability to attend to and manage their own and their clients' emotions. The current literature on therapists' contributions to the therapeutic process and client outcomes continue to be inconsistent and limited (Lambert, 2013; Beutler, 1997; Garfield, 1997). Moreover, although some therapist variables have been investigated and a few studies have provided initial insights regarding therapists' social-emotional skills, there are only eight known published studies on this to date (Cooper & Ng, 2009; Easton et al., 2008; Kaelber & Shwartz, 2014; Kaplowitz et al., 2011; Martin et al., 2004; Miville et al., 2006; Rieck & Callahan, 2013; Stanton et al., 2011) indicating that this is still a relatively new and understudied area of enquiry.

The eight studies that have been carried out thus far on therapists' emotional intelligence are not without limitations. For example, all but three of these studies (Easton et al., 2008; Martin et al., 2004; Stanton et al., 2011) employed trainee therapists as participants rather than professional therapists. Furthermore, all but two of these studies (Kaelber & Schwartz, 2014; Stanton et al., 2011) were carried out and published in the United States which provides limited information regarding the relevance of the findings to other socio-cultural contexts, including that of New Zealand. In addition, given that emotional intelligence is only a relatively new area within psychotherapy research, none of these studies have incorporated qualitative interviews that sought practicing therapists' views and experiences regarding social-emotional intelligence in their practice. Moreover, while emotion-focussed therapies (e.g. Greenberg, 2002, 2004; Greenberg et al., 2006) focus on how

therapists can generate emotions in their clients in order to facilitate change, they omit therapists' own emotions and do not provide sufficient guidelines regarding how to manage clients' spontaneously arising emotions. The current study aims to fill these gaps by exploring therapists' perspectives regarding not only how they work with clients' emotions, but also how they work with their own emotions in therapy.

While at first sight, the concept of social-emotional intelligence may bear a resemblance to the well-known concepts of transference and countertransference as well as the concept of emotional contagion, it is proposed that social-emotional intelligence is a more user-friendly concept for a variety of theoretical orientations to use as it includes the latter concepts as possible sources of therapist emotions without placing restrictions or theoretical binds on the source of emotions. As well as advancing current knowledge by highlighting therapists' perspectives and experiences regarding social-emotional skills, this research also carries significant implications for the mental health professions. Understanding therapists' social-emotional skills in relation to their practice will better enable therapists to work towards achieving more positive outcomes for their clients. Moreover, as social-emotional skills can be learned (Bechara et al., 2007; Bar-On, 2006), if the research findings indicate that social-emotional skills are useful and important for the therapeutic practice of therapists, then with further research, these skills can be incorporated into therapist training programmes. Consequently, these skills can be used to positively influence therapist-client interactions and in turn, client outcomes both within New Zealand and overseas.

It must be noted that purpose of this thesis is not to argue that therapists' use of their own and their clients' emotions is a form of intelligence. Instead, the concept of therapists' social-emotional intelligence is used to highlight the ways in which therapists make use of their own and their clients' emotions in therapy. However, the term 'intelligence' implies an innateness, something that people are born with that has only limited scope for change. Given that social-emotional intelligence is conceptualised as something that can be both learned and taught, this research will intentionally not use the word 'intelligence' and focus on the social-emotional 'skills' of therapists instead. In other words, 'therapists' social-emotional skills'.

The word 'skill' is defined as the ability to do something well or a learned ability to do something competently (Stevenson, 2010). This fits the definition of social-emotional intelligence used in this study. Finally, while the previous sections included references to 'emotional intelligence' and 'social-emotional intelligence', they both refer to the same concept but the latter term emphasises the social or interactive nature of the concept. Given that this study adopts a social functional view of emotions, the phrase 'therapists' social-emotional skills' will be used throughout the remainder of this thesis to refer to therapists' ability to be aware of and manage their own and their clients' emotions.

## CHAPTER THREE

*“Not everything that can be counted counts, and not everything that counts can be counted.” ~ Albert Einstein*

### METHODOLOGY

This chapter will outline the methodology and methods used in this research. Initially, the study design will be presented followed by a description of the research methods, the study's quality criteria and a brief account of the researcher's positioning.

#### **Study Design**

This study employed a qualitative research design. Qualitative studies enable researchers to understand and explain social phenomena with minimum disruption to the natural settings in which the phenomena of interest occur (Merriam & Tisdell, 2015). It is an ideal methodology for exploring participants' emotions, thoughts and behaviours within their socio-cultural context (Strauss & Corbin, 1998). This includes information about their experiences (Elliot, Fischer & Rennie, 1999), perspectives and belief systems (Barbour, 2013).

According to Denzin and Lincoln (2008), qualitative methodology attends to process and meaning in a manner that is unable to be sufficiently captured through a quantitative enquiry. Furthermore, as qualitative research aims to provide rich, quality insights, the sample sizes of qualitative studies can be much smaller, although still able to provide insights regarding a broader population (O'Leary, 2004). McLeod (2011) emphasises the appropriateness of qualitative methodology for psychotherapy research due to the suitability of this design for studying individuals in all their complexity.



## **Method**

### **Ethics**

Massey University's Ethics Screening Questionnaire was completed which deemed this research as being Low Risk, meaning that it did not require full review through Massey University's Human Ethics Committee (see Appendix A). This was clearly indicated on the participant information sheet along with the research supervisor's contact details in case there were any ethical queries or complaints.

### **Recruitment**

Initial participants were approached via 'Talking Works', a New Zealand-based website that connects members of the public with registered counsellors, psychotherapists and psychologists. This website includes a directory which can be searched via locality. Each therapist on this website has a dedicated page which outlines the population they work with (e.g. children, adults, families) and provides their contact details. Starting with the Auckland region and subsequently Hamilton, therapists who specified that they worked with adults were initially contacted via this website. All therapists who responded to the initial contact were emailed this study's information sheet (see Appendix B) and consent form (see Appendix C). As this process did not yield sufficient participant numbers, the researcher proceeded to use Google to search for therapy practices in Auckland. This search provided links to further therapists' pages who were subsequently contacted (via email) about this research. Potentially interested therapists were subsequently sent the study's information sheet and consent form.

The information sheet outlined the current study as well participants' rights. Therapists who returned their completed consent form (either via email or post)

were recruited to this research. The aforementioned recruitment processes yielded nine therapist participants and one of the participants linked the researcher with a colleague, who was subsequently also recruited. It was considered that ten therapist participants enabled the data to reach 'saturation' whereby no further new information was being collected from participant interviews (Denzin & Lincoln, 2008). The total number of participants in this research was also consistent with that of similar studies seeking to understand the views and experiences of a pre-specified set of individuals, in this case registered therapists (e.g. Condon & McCarthy, 2006).

### **Participant Inclusion Criteria**

There were two inclusion criteria for therapist participants in this study. The first was that they needed to be registered as a counsellor, psychotherapist or psychologist in New Zealand. The second was that they needed to be engaged in individual therapy sessions with adult clients (over 16 years old) as part of their practice. The reasoning behind the second criterion was that therapists' social-emotional skills and experiences were thought to likely differ when working with children as this population is likely to be less emotionally developed (Saarni, 2011). Consequently, working with children may require the incorporation of different emotion-eliciting activities e.g. drawing, story-telling and play on the part of the therapist. Furthermore, working with children's emotions also differs from working with those of adults as the former tend to be less filtered or processed and children have little (if any) influence over their ability to enhance their own emotional skills (Von Salisch, 2001). Therapists of any age, experience level and theoretical orientation were invited to participate in this research.

### **Participant Exclusion Criteria**

As per the description above, therapists who were predominantly engaged in therapy with children (under 16 years old) or groups were excluded from this research as it was thought that different social-emotional skills would likely be used across these two contexts.

### **Participants**

A total of ten therapists (eight female and two male) between 31 and 62 years old participated in this research. Seven therapists identified as being New Zealand European, one as New Zealand Māori, one as European and one as Caucasian. Therapist participants consisted of nine psychologists and one psychotherapist. They were employed across a variety of public and private settings. Therapists had different levels of experience delivering therapy which ranged between three and 40 years. They spent between 4 and 26 hours per week delivering individual therapy to adult clients and held different theoretical orientations. Four therapists reported that they used mixed or eclectic therapeutic models, while the rest stated they used a relational, CBT, Psychoanalytic, ACT or Psychodynamic approach.

### **Semi-Structured Interview**

Following the return of participant consent forms, participants were provided with a brief guide for the interview (see Appendix D). A time and location were subsequently arranged for the face-to-face interview. A semi-structured interview format was selected for the purposes of this research so as not to over-confine the interview and allow it to flow in a similar manner to a natural conversation. This interview format was also considered suitable as it enables interviewers to pursue elaborations of interviewees' responses (Fylan, 2005).

Initially, the interview was piloted with three clinical psychology students who were working with clients in the context of their internship. The purpose of this was to assess the timing, content and flow of the interview with the view of making changes based on the feedback received from the three interviewed students. As a result, minor changes were made to the order and wording of some of the guiding interview questions and prompts.

Once the piloting and subsequent minor changes were completed, all therapist participants were interviewed by the researcher at a location and time of their choice. At the beginning of each interview, the purpose of the research was briefly reiterated to participants and they were asked to re-confirm their consent to voluntarily participate. It was emphasised that while the research was interested in their views and experiences regarding social-emotional skills within the context of their practice, they were free to contribute any other information they considered important and that there were no 'right' answers to the questions being asked.

The semi-structured interviews included open-ended questions around therapists' views and experience regarding social-emotional skills (see Appendix E). Verbal prompts were provided by the researcher to introduce a topic area or elicit further information from the participants (Fylan, 2005). All interviews were audio-recorded and then transcribed. Subsequently, participants were offered the opportunity to review their completed transcripts to ensure they reflected their views and experiences prior to the data analysis stage of the research.

### **Data Analysis**

Thematic Analysis (TA) was selected as a means of analysing the data in this study. Braun and Clarke (2006) outlined the utility of using TA to identify, organise,

analyse and report patterns within a data set. TA was considered the most appropriate for the current study as it can be used to explore the views and experiences of participants (Braun & Clarke, 2006). Braun and Clarke (2006) asserted that despite some researchers viewing TA as only part of an analytic method, TA is a flexible, self-sufficient method that does not need to be embedded in any particular theoretical framework or epistemology. Consistent with this viewpoint, TA is a commonly used method for analysing qualitative information in psychological research (Marks & Yardley, 2004). Within this method, the data are used to furnish the TA themes, where themes are the common, recurring patterns within the data (Braun & Clarke, 2006). In TA, these themes provide insights about a collective experience concerning a particular phenomenon (Braun & Clarke, 2006), in this case, therapists' views and experiences of social-emotional skills in practice.

There are different means of going about analysing data through TA. This study used TA in an inductive, semantic and critical realist manner (Braun & Clarke, 2006). In an inductive thematic analysis, themes are identified in a '*bottom-up*' manner where they are linked with the collected data to provide an analysis of the entire data set. In this study, themes were also identified at a *semantic* or *explicit* level (Boyatzis, 1998; Braun & Clarke, 2006). This means that the identified themes were explicit within the collected data and the researcher did not search for anything in the data beyond what was explicitly stated by the participants in this study. Participants' views and experiences in relation to social-emotional skills were organised to demonstrate the patterns in the data, summarised and then interpreted in light of existing literature (Braun & Clarke, 2006).

In thematic analysis, the chosen ontology and epistemology guide the researcher's stance on the nature of reality, what counts as acceptable knowledge and therefore, the ways in which meanings can be theorised (Braun & Clarke, 2006). While positivism and interpretivism occupy opposite ends of the ontological and epistemological continuums, critical realism is a post-positivist approach that situates itself in the middle. Within this middle position, the existence of an objective reality or real world is advocated but researchers are cautioned to take into account the inherently subjective and fallible ways that this reality may be known. This is because the critical realist approach holds that our observations of reality are always coloured by our socio-cultural and historical contexts. In that sense, this approach rejects both the positivist and the interpretive theories of knowledge and upholds an epistemology that brings both together – an externally existing world alongside a socially determined understanding of it (Benton & Craib, 2001). Given this, any research outputs are viewed as being inseparable from both the researcher and participants' world views and cultural experiences (Madill, Jordan & Shirley, 2000).

### **Data Analysis Process**

As just described, the current study used TA in an inductive, semantic and critical realist manner. Following completion of the interviews and transcriptions, the transcriptions were uploaded to ATLAS-ti, a computer programme that enables an electronic analysis of qualitative research. Through ATLAS-ti, the data were analysed in accordance with Braun and Clarke's (2006) six steps for carrying out TA. An explanation for how themes in this study were arrived at is detailed below. The term 'arrived at' has been intentionally employed here to demonstrate the researcher's position about how themes do not just 'emerge' from or 'exist within'

the data. Instead, it is considered that themes are developed from a researcher's engagement with the data, in light of the research area of interest (Braun & Clarke, 2006). Given this, it is important to note the researcher's active role in the theme development phase. Fortunately, TA acknowledges the active role of the researcher in theme development (Taylor & Ussher, 2001).

Consistent with the first step of Braun and Clarke's (2006) steps for TA, the interview transcriptions were initially read and re-read by the researcher to ensure accuracy, enhance familiarity with the data and record initial ideas. Subsequently, initial 'codes' were generated in line with Braun and Clarke's (2006) second step of TA. These codes were basically summaries of the researcher's interpretation of what was being spoken about by the participants in the interview transcripts or summaries of anything that seemed interesting within the transcripts. Any segments of the transcripts that were identified by the researcher as being similar to an already established code were highlighted and tagged with the pre-existing code. Any segments that did not appear to fit with any of the initial codes were assigned a new code. ATLAS-ti enabled the researcher to easily view the final list of codes as well as select individual codes along with their respective extracts from the data set that had been categorised under each code.

Once the coding process was completed for all of the interview transcripts, initial themes were developed by reviewing the entire list of codes and joining similar codes together into meaningful groups in accordance with Braun and Clarke's (2006) third step of TA. A more concise phrase for each group of codes was then created by the researcher to capture each group's overall meaning. It was during this process that the researcher also considered how each of the groups,

which were now 'initial themes' could be related to each other and whether they could be structured into levels (e.g. main themes and sub-themes). Completion of this phase resulted in several potential main themes and sub-themes with their respective supporting extracts that had been coded from the data set.

Based on Braun and Clarke's (2006) fourth step of TA, the initial themes were then reviewed to ensure their consistency with the coded extracts initially and subsequently the consistency of the initial themes in relation to the entire data set. To check the themes' consistency with the coded extracts, the researcher re-read the coded extracts that were used to support each initial theme. A decision was made at that point that the initial themes formed a coherent pattern in their current state and therefore, did not require re-working. Following this, the researcher re-read all the transcripts to determine if the current themes reflected participants' views and experiences across the entire data set. During this phase, a few further extracts were coded from the data set, which were placed under the current themes as these had been missed during the initial coding. At the conclusion of this step, the themes were clarified and the relationship between the different themes was established in terms of the overall story they depicted about therapists' views and experiences of social-emotional skills in practice.

In accordance with Braun and Clarke's (2006) fifth step for TA, the study's themes were subsequently refined, defined and named by reviewing the collated data extracts contained under each theme to ensure that each captured an important facet of the data and that each theme's name identified the 'essence' of what it was about. The broader story that these themes were telling about the data was also considered during this stage in relation to therapists' social-emotional



skills in practice. In addition, further sub-themes were developed in order to structure the themes and explicate the hierarchy of meaning across the data. Specifically, the themes were refined into one meta-theme and four main themes, with relevant sub-themes contained under each. The meta-theme was; *The Centrality of Emotions in Therapy* while the main themes were: *Emotional Principles*, *Emotional Awareness Strategies*, *Emotional Practices* and *The Learning and Training of Social-Emotional Skills*. Each of these are presented in Chapter Four in line with Braun and Clarke's (2006) sixth and final step of TA; 'producing the report'.

### **The Study's Quality Criteria**

Debates surrounding the trustworthiness or rigor of qualitative research can be found in the literature. This is particularly the case among proponents of quantitative research, who raise concerns regarding whether the quality of qualitative studies is able to be assessed given the inability to determine validity and reliability in the same manner as quantitative studies (Shenton, 2004). The current study adopted the stance that it is important to evaluate the quality of any research, regardless of whether it employs quantitative or qualitative methodology. Several options have been proposed to incorporate measures of validity and reliability in qualitative research (e.g. Healy & Perry, 2000; Morse, Barrett, Mayan, Olson & Spiers, 2002). However, Flick, von Kardoff, Steinke & Janner (2004) assert that such terminology is incompatible with qualitative studies and that alternative concepts are required to assess the quality of qualitative research. Consistent with this, Guba's (1981) criteria for assessing the quality and trustworthiness of qualitative research (credibility, transferability, dependability and confirmability) were adopted. These criteria are briefly outlined below along with an explanation for how they were implemented in the current study.

## **Credibility**

Internal validity describes a means of assessing whether a particular study measures what it sets out to measure (Robertson & Williams, 2009). The concept of credibility in qualitative research is akin to the concept of internal validity in quantitative studies. Lincoln and Guba (1985) asserted that credibility is a central criterion for establishing the trustworthiness of a qualitative project. The credibility criterion was incorporated into the current study in several ways. The first was through the use of research methods that are both well established and appropriate for the research question. In this case, this meant the use of qualitative methodology with thematic analysis to analyse the data. Secondly, therapists in this study were given opportunities to refuse participation. Furthermore, they were encouraged to provide their honest views at the beginning of their interview and were advised that there were no right or wrong answers to the interview questions. These strategies were employed to ensure that the collected data reflected the genuine views and experiences of therapists who were interested in offering these voluntarily. The third way that the credibility criterion was incorporated into the current study was through interview checks. To do this, interviewed therapists were provided with the opportunity to review their transcripts to ensure that these accurately reflected their views and experiences (Shenton, 2004).

## **Transferability**

Transferability is equivalent to the quantitative concept of external validity or generalisability. That is, the extent to which one study's findings can be applied to other contexts (Robertson & Williams, 2009). However, given that the findings of qualitative research studies are specific to a particular set of individuals and environments, transferability is focussed on providing a comprehensive description

of the phenomenon of interest to enable other researchers to draw comparisons between that and the same phenomenon in different situations. The idea is that the accumulation of studies about the same phenomenon across different settings may provide a more inclusive view of that phenomenon (Shenton, 2004). To allow the current study to form a baseline understanding of therapists' views and experiences of social-emotional skills in practice and therefore, transferability of the findings, the researcher ensured that the study's boundaries were well explicated across this thesis. For example, the researcher made explicit the following information: the specific population of interest including inclusion and exclusion criteria, the number of participants in the final study who contributed to the data as well as the data collection and analysis procedures (Shenton, 2004).

### **Dependability**

Another quality measure that requires the explicit outlining of the participant selection procedures, research design and data gathering methods is dependability — the qualitative equivalent of reliability (Shenton, 2004). In quantitative studies, reliability requires the use of techniques to demonstrate that if the same study were repeated under the same conditions, stable and consistent results would be obtained (Robertson & Williams, 2009). While dependability in qualitative research is also about the consistency of the research findings, it does not assume that the findings can be entirely replicated, as qualitative research acknowledges the constantly changing nature of reality (Grinnell & Unrau, 2010). The current study addressed the dependability criterion by explicating all of the research processes in detail to enable a future researcher to repeat the study, whilst also acknowledging that repetition may not necessarily yield exactly the same findings (Gunawan, 2015). Braun, Clarke and Terry (2014) emphasise that this is

because there is not one 'accurate' means of coding in thematic analysis and that coding is an active process that inevitably reflects the researcher's engagement with the data set. Consistent with this, Yardley (2000) asserted that engaging multiple coders in a research project and calculating inter-rater reliability scores are unnecessary procedures in qualitative research as such techniques do not lead to more 'accurate' coding. Instead, they indicate the extent to which several researchers have been taught to code a data set in the same manner (Yardley, 2000). Furthermore, these techniques are inappropriate as they are based on the quantitative assumption that the data set contains an accurate reality that can be captured through the coding process. Instead, the interpretations offered throughout this thesis are viewed as *one* means of understanding the data set rather than the *only* means (Braun et al., 2014).

### **Confirmability**

In qualitative research, confirmability assesses whether the study's findings are based on the collected data rather than "figments of the inquirer's imagination" (Tobin & Begley, 2004, p.392). This is comparable to the quantitative concept of objectivity, which denotes the absence of researcher biases in studies that aim to reveal 'truths' about the world (Ross, 2012). However, qualitative researchers oppose the idea that individuals can be passive observers of external information and acknowledge the subjective nature of all interpretations (Morrow, 2005). Confirmability was incorporated into this study through the ongoing use of extracts from the interview transcripts to exemplify each theme. The provision of extracts demonstrates the relationship that the themes have with the data set and enables readers to check the researcher's interpretations against these extracts (Shenton, 2004).

### **Reflexivity: The Researcher's Positioning**

Reflexivity in qualitative work requires an awareness of one's own roles in the processes and outcomes of their research. It invites researchers to consider how their thinking in relation to the topic of interest came to be, and the ways through which this may have shifted during their engagement with the research. It calls for researchers to reflect on their socio-cultural experiences and invites them to be curious regarding the ways through which these may have shaped aspects of their work and therefore, their interpretations of knowledge (Merriam & Tisdell, 2015).

I acknowledge that I entered this research with a strong theoretical and applied understanding of cognitive-behavioural therapy. This was the primary modality that was taught, emphasised and tested throughout my training in clinical psychology. Cognitive-behavioural therapy acknowledges emotions, but helping clients to change their thinking so that they can experience changes in their emotions is the key.

I also came into this research with a strong understanding of the quantitative approach. That was the method I was most familiar with from my training, all those journal articles I had read. It was also the method that I had planned to use with the original project that this research evolved from. The method that would give me the numbers that will be able to give weight to my research, the method that would help me make the most valuable contribution to science.

I came into this research with my cultural background, as an Egyptian, raised in New Zealand. Egyptians have a tendency to be loud with their emotions and expressing them is common-place in this cultural context. Having migrated to New Zealand, I noticed a cultural shift in emotional-expressiveness. Here emotions

tended to be much quieter. Growing up, I heard phrases like “take a concrete pill” and “harden up” – phrases that I interpreted as being discouraging of both emotional experiencing and expression. I eventually found a comfortable area somewhere on that continuum, albeit more towards the emotional expressiveness side and this formed the space from which I continued to engage with my emotions and the emotions of others around me.

The above paragraphs depict where I started, but not where I ended because as I consider I influenced this research, so too do I consider this research and my gradually increasing exposure to client work influenced me. Over time, I started noticing that the most ‘stuck’ moments I had with clients and the ‘breakthrough’ moments tended to be emotional. I started experimenting more with emotions in the room, reading more about the different perspectives on emotions and introducing myself to emotion-focussed therapies. I also made an effort to enhance my knowledge of qualitative approaches to research. Throughout that process, doing this research and practicing, I noticed that I began to see more emotion around me and I started to experiment with it more in my work with clients. I also noticed that I did not need to hold a ruler up to emotion to understand its value. The benefits of reporting rich views and experiences as opposed to numbers. The idea that both can offer valuable contributions, depending on what ontological and epistemological positions one holds and what question(s) they wanted to answer with their research.

## CHAPTER FOUR - FINDINGS

*“There are no facts, only interpretations.” ~ Nietzsche*

### Results Outline

This study explored therapists’ views and experiences regarding social-emotional skills in practice. Through thematic analysis of the interviews, one meta-theme: *The Centrality of Emotions in Therapy* was determined and this was further organised into four main themes: (1) *Emotional Principles*, (2) *Emotional Awareness Strategies*, (3) *Emotional Practices* as well as (4) *The Learning and Training of Social-Emotional Skills*.

This chapter re-introduces the definition of social-emotional skills and presents interviewed therapists’ perspectives regarding the definition of this concept. Subsequently, an in-depth analysis of the identified themes along with their respective sub-themes is outlined in the context of relevant literature.

### Social-Emotional Skills – A Definition and Therapists’ Perspectives

As discussed in the introductory section of this thesis, the term ‘social-emotional skills’ describes a set of competencies or skills that enable individuals to be aware of their own and others’ emotions and then use that information to manage these emotions within their interactions. Interviewed therapists were introduced to a therapy-specific version of this definition. This described social-emotional skills as a set of competencies/skills that enable therapists to be aware of their own and their clients’ emotions and then draw on that information to manage those emotions and in turn, the therapeutic interaction. Therapist participants were then asked about their perspectives of this definition in the context of their practice. Seven of the

therapists interviewed described their agreement with the aforementioned definition.

**Giselle:** That sounds right and I'm aware that that's what I'm doing.

**Rebecca:** I think that's really sound.

**Sylvia:** I think it's a pretty fair definition.

In contrast, three therapists disagreed with the definition due to its wording or because they viewed it as a way of re-packaging the well-known terms of 'transference' and 'countertransference'.

**Eva:** It just feels like different wording for the same stuff. It feels like it's talking about relational stuff and how to manage relationships because emotions always come into relationships. "Competencies" sounds again like a different kind of language to how we might talk about it.

**Dave:** I've got an issue about calling a thing a "skill" because that means the thing you do rather than the process but an 'interactive emotional process', yeah, I like the word.

**Ruth:** Yes, it's called transference and countertransference. Freud talked about it 110 years ago.

### **Meta-Theme – The Centrality of Emotions in Therapy**

One commonly observed theme across all of the interviews was the centrality of emotions in therapy and as such, this was selected as a meta-theme. The meta-theme *The Centrality of Emotions in Therapy* encapsulated therapists' views regarding the importance of both their own and their clients' emotions. Below are a



few extracts that describe the role therapists identified emotions play in their practice.

**Dave:** You can't do good depth work, most good work, without an important connection and a use of emotions and feelings I would say of your own and your clients.

**Ruth:** Realistically, they play 100% of the role since we have emotions before we have cognition. They are the bedrock of doing any kind of therapy.

**Giselle:** Feelings is what it's all about. Why have they come to see us? They've come because they're overwhelmed of anxiety or they're sad and unhappy or they're irritable all the time or they're overwhelmed anytime one little thing goes wrong. That's why they're there so that's a vital part of the work.

These views were consistent with a wide range of previous work (Greenberg, 2004; Greenberg and Paivio's 2003; Lewis, et al., 2010; Newman, Jacobson & Castonguay, 2014; Safran & Greenberg, 1991) that emphasised the importance of adopting a focus on emotions in psychotherapy. As some therapists in this study pointed out, clients seek therapy for a range of emotional difficulties (Barlow, Allen & Choate, 2004). According to Olfson and Marcus (2010), two of the most common presenting problems in psychotherapy are depression and anxiety, both of which are types of negative emotions that are also characteristic of two highly co-morbid emotional disorders; Major Depressive Disorder and Anxiety (Moses & Barlow, 2006; Fava et al., 2000; Kaufman & Charney, 2000). Although an array of definitions exist for both of these disorders, depression typically involves feelings of sadness, which usually arise as a result of significant past events such as a loss of a loved one.

Anxiety on the other hand tends to be future-oriented, such as an anticipated apprehension about a possibly harmful impending event. For example, getting robbed or hurt (Eysenck, Payne & Santos, 2006). Therapists' role is to attend in one way or another to their clients' emotional difficulties, regardless of the particular theoretical orientation they hold (Greenberg, 2002), as this only specifies the manner in which such emotional difficulties are addressed. In order to begin this process of attending to clients' emotional difficulties, therapists must possess an awareness of their own and their clients' emotions, with the former being a required pre-requisite for the latter (Goleman, 1998; Safran & Greenberg, 1991). This order of approaching emotions is also echoed by Jacobs (1993) who stated that therapists' inner experiences provide a "valuable pathway" into understanding clients' inner experiences.

### **Theme One - Emotional Principles**

A *principle* is defined as a belief or value which guides an individual's behaviour (Stevenson, 2010). In this study, the majority of interviewed therapists discussed two emotional principles that appeared to guide their therapeutic practice. These have been categorised according to two sub-themes: (1) *Importance of Emotional Self-Awareness* and (2) *Importance of Emotional Client-Awareness*, which are presented below.

#### **Sub-Theme One: Importance of Emotional Self-Awareness**

*"As the process unfolds, I try to listen to my centre. This is the most authentic place that I can engage with another" ~ Arthur Robbins.*

In the context of this research, emotional self-awareness was defined as therapists' recognition of and attention to their own emotions in the context of their

sessions with clients (McLeod & Julia, 2014). Half the therapists interviewed for this study emphasised awareness of their own emotions as an important aspect of being a therapist.

**Sylvia:** I think a lot of it is having an awareness of your own self...unless we have an idea of who we are, what we're okay with, what we're not okay with...I don't think you can be a good therapist. You can't be empathetic, emotionally aware (of others) or anything without being able to be aware of yourself first.

**Nancy:** Becoming attuned with what's going on inside of you is key to how you're dealing with clients.

**Dave:** So that was the first bit of, for me, emotional connection or the first bit of me being a bit useful. So, how do I do this? I listen to what I'm feeling.

Therapists' views regarding the importance of emotional self-awareness were consistent with previous research which emphasises therapists' self-awareness (including awareness of their own emotions) as a central component in psychotherapy (Coster & Schwebel 1997; Ehrlich, 2001; Jacobs, 1991; Jennings & Skovholt, 1999; Mattison, 2000; Safran & Muran, 2000; Uhlemann & Jordan, 1981). Safran and Greenberg (1991) stated that therapists who are unable to access or attend to particular emotions such as sadness or anger within themselves would struggle to attend to these same emotions in their clients. Such biases in emotional awareness are described as potentially impeding for therapy.

The importance of emotional self-awareness has also been demonstrated across all levels of clinical experience. That is, therapists' within-session self-awareness has been determined as a critical component in psychotherapy across

studies using both experienced (Williams & Fauth, 2005) as well as trainee therapists (Fauth & Williams, 2005). In Fauth and Williams' (2005) study, trainee therapists perceived their self-awareness as having been helpful during sessions with clients. Furthermore, client participants in Fauth and Williams' (2005) study also corroborated this by reporting that they felt both more supported and closer to the therapists who were more self-aware.

All interviewed therapists in this study described a range of emotions they had experienced during their engagements with clients. These included both unpleasant emotions such as anger, frustration, fear, dislike, anxiety, inadequacy and boredom as well as more pleasant emotions such as empathy, enthusiasm and engagement.

**Sylvia:** I was very frustrated with her.

**Eva:** I didn't like him.

**Nancy:** I felt a lot of empathy.

Pope and Tabachnick (1993) surveyed 285 psychologists and found that over 80 percent of those surveyed had experienced emotions such as fear or anger towards their clients. Similarly, Hayes, et al. (1998) reported that therapists experienced feelings such as anger, frustration, inadequacy and anxiety towards their clients in the context of brief therapy. Despite this, there is some evidence that therapists are reluctant to admit emotional responses in relation to clients, particularly when these are negative (Pope, Sonne & Greene, 2006). In contrast, the majority of therapists in this study described the range of emotions they experienced with their clients as being normal, human responses.

**Rebecca:** We get all sorts of feelings, we're human and we can feel insulted by a client or annoyed or frustrated or a whole raft of things.

**Nancy:** Some clients you don't want to see and some of them you don't like and some of them make you feel angry. Some of them make you feel really frustrated. Like you have the full range of human emotions.

Two of the therapists interviewed easily acknowledged their dislike for working with clients with narcissistic personality disorder:

**Giselle:** I do very poorly with narcissist things quite quickly because I actually don't like them.

**Ruth:** I personally don't particularly like dealing with people with narcissistic personality disorder.

Only one therapist stated that it was difficult to admit to disliking a client. While reflecting on two clients she had worked with, she said:

**Sylvia:** He was a very nice guy, very personable guy whereas the other one was a woman who was very hard to like. I hate saying that...It's hard to say that because it's not something you want to admit to people.

According to psychoanalytic researchers, countertransference can potentially account for therapists experiencing negative feelings such as dislike towards their clients (Aviv and Springmann, 1990; Goldberg, 2001). For example, it is proposed that the client may remind the therapist of someone with whom they had a problematic relationship (Kottler, 1992). In line with this, the dislike that Giselle and Ruth reported in relation to working with narcissistic clients may be due

to previously experienced difficulties or resistance while working with this particular clinical presentation. However, it is important to acknowledge that client dislike may also arise for a number of reasons outside the realm of countertransference. For instance, a therapist may experience dislike towards a client due to interpersonal conflicts arising from personality differences and mismatched conflict resolution styles (Blackwell, 2005; Field & Cartwright-Hatton, 2015). Alternatively, the therapist may hold negative biases regarding a client's sexual orientation (Bartlett, King & Phillips, 2001; McHenry & Johnson, 1993), values (Kelly & Strupp, 1992) or the nature of a client's criminal convictions (Farrenkopf, 1992; Moulden & Firestone, 2010). From a physiological perspective, other negative emotions such as defensiveness, frustration, sadness or anxiety can also be experienced by therapists through sympathetic activation, which sends stress signals through the nervous system and activates a 'fight or flight' response. For example, if a client is directing their anger towards a therapist, the therapist may feel defensive or anxious. Feelings of frustration may also be evoked in the therapist if they consider that their client's anger displays are unproductive for therapy or if their attempts at calming their client down have been unsuccessful (Mozdzierz, Peluso & Lisicki, 2014).

While experiencing some form of negative emotions towards clients, be it frustration or dislike, can occur among therapists (Mozdzierz et al., 2014; Liotti, Mollon & Miti, 2005; Leiper & Kent, 2001), outside of the countertransference literature, information about this is scarce. This could potentially be influenced by social desirability, which may make it difficult for therapists to acknowledge experiences of negative emotions towards their clients (Grimm, 2010). Within the marital therapy literature, Layton (2005) discusses being unsuccessful in facilitating

positive change due to her dislike of a client. In contrast, despite Mark's (1997) initial dislike for her clients, she was able to use her awareness of her emotions as a means of understanding and addressing this dislike, in order to work effectively with those clients. This suggests that therapists' awareness of negative feelings towards clients do not necessarily preclude therapeutic effectiveness, provided such feelings are within the treating therapists' awareness. That way, they can either be addressed in therapy or the client can be referred on to a more suitable therapist.

In this research, therapists' awareness of their own emotions in relation to particular client presentations or characteristics were described by half of the participants as a reason for not working alongside those clients, as they perceived they would not be able to work effectively with them.

**Sylvia:** I know I don't wanna work with abused kids because I have children of that age that it would trigger too much in me, to be able to be objective and do a good job.

**Jamie:** Sometimes now when I take a phone call and I hear a particular tone, I will not take the client on because I don't think I'll be good for them and I'll refer them to someone I think will, like Steve here...he's very good with macho men. I'm not.

Such responses to client presentations may or may not be considered to be 'countertransference' depending on the theoretical orientation one holds. However, as discussed in the introduction section, a focus on social-emotional skills would not prioritise locating therapists' emotional responses to clients within therapists' personal conflicts, biases or difficulties. Instead, the focus would be on the importance of therapists becoming aware of the presence of such emotions as they occur and addressing them in a manner that would benefit the therapist-client

interaction. Eight therapists in this study described utilising their emotions as clinical information as a means of benefiting their interactions with clients. This was consistent with Corey (2015), who discussed the usefulness of emotions as clinical information.

**Bianca:** If I've got an emotion about a client then it's a message like what's going on, why am I thinking about this client and why am I having these feelings?

**Giselle:** If you're thinking thank goodness they're coming in today, you're enjoying it too much or really disliking them, it's giving you information.

**Rebecca:** I've probably become better at thinking something's not working, we need to stop and reflect on what's not working so use the emotion as information.

The idea that therapists' emotions in relation to clients are an important source of clinical information is far from new. Heimann (1950) proposed that therapists' emotional responses function as an important guide to understanding their clients' worlds. In line with this, several countertransference researchers maintain that therapists' reactions to clients (including their emotional responses) are able to shed light on both clients' diagnoses and their interpersonal patterns. For example, Betan and colleagues (2005) studied the reactions of 181 therapist participants to randomly selected clients with a variety of clinical presentations. The results found that therapists' tended to have expected emotional reactions based on clients' presentations, regardless of the particular theoretical orientations held by the participating therapists.



Winnicott (1949) coined the term 'objective countertransference' which is described as therapists' reactions to their clients' personalities or behaviours. In accordance with this, if a client is relating to the therapist in a maladaptive manner, the therapists' reactions to this provide helpful information about the potential emotions of others in that client's life. Three of the therapists in this study had responses consistent with this as demonstrated below.

**Nancy:** I sort of listen to my own gut instinct a lot. And also about how that person makes me feel in the session...it gives me a clue as to how they relate to other people.

I see that as really helpful information. That if I'm feeling really annoyed by this person maybe that's why they're having difficulty out in the world because they do that to a lot of people.

**Rebecca:** We're probably feeling the same responses that other people in the person's life feel towards them but the difference between us, what we've got is an opportunity...We can maybe talk about it in a respectful way and say..."I wonder if your wife's felt as defensive as I did when you say..." so that's good information

**Eva:** I would feel like a ragdoll in the session with them, I'd be tossed around and I started feeding back to them that this is what I suspected their children felt like...So again, I used my feelings of distress to inform them this is what the family dynamic was.

In the extracts above, Rebecca and Eva described using their own emotional responses towards clients as a way of understanding how others in their clients' lives are likely feeling. Consistent with Willer (2008), they suggested this as a potentially useful method of helping clients gain insight about their impact on others, so that they can start to improve their relationships. However, relaying this

information must be carried out in a sensitive manner to enhance clients' receptiveness to it and reduce the likelihood that they will respond defensively (Wells, 1994).

### **Sub-Theme Two: Importance of Emotional Client-Awareness**

In addition to the importance and utility of therapists' emotional self-awareness, six of the therapists interviewed in this study emphasised the importance of being aware of their clients' emotions. For the purposes of this research, this has been termed *Emotional Client-Awareness*. Emotional Client-Awareness is defined as therapists' ability to recognise and attend to their clients' emotions. This section outlines some examples of the importance therapists attributed to emotional client-awareness alongside a selection of relevant literature.

**Bianca:** I think the most important is the relationship with the client.

**Interviewer:** What about the relationship?

**Bianca:** I understand what's happening for them, how they're feeling and they know that I get it.

In the extract above, Bianca describes emotional client-awareness as taking place within the context of the therapeutic relationship. Furthermore, rather than merely being aware of her clients' emotions, Bianca emphasises the importance of communicating this awareness to her clients. This is consistent with Erskine's (1997) work on 'affective attunement', which proposes that reflecting clients' emotions allows therapists to check the accuracy of their assumptions while also enhancing the therapeutic relationship through the validation of clients' feelings.

In the extract below, Crystal describes emotional client-awareness as an ongoing process that can occur at both a conscious and unconscious level.

**Crystal:** You're always watching for that (clients' emotions). I could get a sense from a client that she wasn't very happy with something that I'd said and I knew that, oh, gosh, this is gonna be hard work to get her back and I was right. You're observing them all the time whether I'm consciously aware of it or not.

Crystal's views are consistent with Greenberg and Paivio's (2003) work, which proposes that emotions are interpreted through a variety of conscious and unconscious processes. In the extract above, Crystal described using her emotional client-awareness in a conscious manner to monitor what she perceived to be a therapeutic rupture – a tension or breakdown in the relationship between a therapist and client (Safran & Muran, 2006). It makes sense that in order to identify that a rupture had taken place, Crystal needed to be consistently aware of and monitoring her client's emotions.

In the extracts below, both Rebecca and Sylvia describe the importance of emotional client-awareness – Rebecca from her personal experience of being in therapy as a client and Sylvia from her experience of providing therapy to a client.

**Rebecca:** You have to be alert to where are they at...I never had personal extended therapy but I've had little blocks of a few sessions here and there and I know from personal experience how important that was. If you didn't feel the person got you ... that would be enough to make me wanna run a mile so I'm very aware. I think it's very important that the person, I was gonna borrow a phrase from the attachment literature, 'feels felt'.

**Sylvia:** Thinking back to that client that I've been seeing for six months - she's had some really tough sessions, she lost a baby, it's not easy. It's not something I've experienced but I, as a mother,

know that would be soul destroying and heart breaking. I think if she thought I didn't get that, she wouldn't have been coming back. She wouldn't have invested all that time and money in being here... For her in particular, that was really important that someone got it, that someone understood her.

In line with Bianca's comment above, Rebecca uses the term "feels felt" to emphasise that a necessary component of emotional client-awareness is the therapist's communication of that emotional awareness to their clients. This two part process of emotional client-awareness is also emphasised by other researchers of 'empathic attunement', a similar concept that is used to describe a continuous effort on the part of therapists to remain aware of the feelings and experiences of their clients (Bohart, Elliott, Greenberg & Watson, 2002; Greenberg & Elliott, 1997; Safran & Muran, 2000).

## CHAPTER FIVE

### Theme Two – Emotional Awareness Strategies

The emotional principles in the previous two chapters established the importance that therapists in the current study placed on being aware of both their own and their clients' emotions. This chapter will discuss two sub-themes: (1) *Emotional Self-Awareness Strategies* and (2) *Emotional-Client Awareness Strategies*. For the purposes of this study, emotional self-awareness strategies were used to describe what therapists did to become aware of their own emotions.

#### Sub-Theme One: Emotional Self-Awareness Strategies

Six therapists described becoming aware of their own emotions while in sessions with clients by attending to their bodies and/or their somatic sensations.

**Dave:** I understand more about it in my body, in my feelings. That's the somatic stuff...It's to be aware of what's going on so the sensations that I'm having in the room with a person, it's a bit like mindful scanning...somatically so if you start feeling something strange.

**Jamie:** For example, with borderline individuals, people that have that diagnosis, whatever that means, strangely, if they walk into my presence and they're sitting in the room with me I have trouble breathing, so my body tells me that there's something going on and it feels like all the air is disappearing and I find myself doing this [deep breathing] quite a lot. I start struggling to breathe so my body starts to respond in a really interesting way.

**Eva:** It helps to be somatically aware. So I'm aware of what's going on in my body...If my stomach is rumbling I know I'm anxious.

Somatic sensations describe an individual's subjective or visible experience of any bodily or physiological states. This can include but is not limited to changes in their breathing, heart-rate and alertness (Bakal, 2001). It is unsurprising that therapists in this study described turning their attention to their bodies in order to become aware of their own emotions as Damasio (1999) describes emotions as the body's way of responding to situations. Similarly, Vazquez (2012) proposes that all emotional experiences are accompanied by some form of bodily or somatic experience. Anger for example, is frequently experienced along with tension in the chest area. Notably, the somatic features of individuals' emotions can be present even when they are unaware of, or are denying, the associated emotion (Vazquez, 2012). Aron and Anderson (1998) describe therapists' bodies as the 'primary arenas' of emotional processing, indicating the importance of being aware of one's body in order to understand and process emotions. They proposed that information that therapists pick up from their clients can initially be felt in therapists' bodies, particularly through their breathing, which is in line with Jamie's description of experiencing breathing difficulties above.

Therapists' somatic sensations have been discussed theoretically (Ross, 2000) and researched (Booth, Trimble & Egan, 2010; Egan & Car, 2008; Shaw, 2004) as a component of countertransference, termed 'somatic', 'embodied' or 'body-centred' countertransference. Geller and Greenberg's (2002) research found that therapists who were fully present in their therapy sessions with their clients experienced physical sensations that reportedly guided their understanding of, and responses to, their clients. However, consistent with the countertransference perspective, the focus of such literature has largely limited the understanding of therapists' somatic sensations to those exclusively arising from their clients. In

other words, somatic sensations that therapists experience as indicators of their own emotions, which may not be directly related to their clients, are not considered. While Shaw (2004) encourages therapists to be 'body literate', he opposes using terms such as 'countertransference' to describe therapists' somatic sensations as he states that this shifts the focus to the client, rather than where the focus should be when considering therapists' somatic sensations - on the therapists. Approaching this from a balanced perspective, Wallin (2015) emphasises the importance of therapists observing the momentary changes in their own bodies in order to become aware of their own emotions and in doing so, ready themselves for becoming aware of their clients' emotions.

### **Sub-Theme Two: Emotional Client Awareness Strategies**

As well as tuning into their bodily sensations to become aware of their own emotions, therapists in this study commonly discussed using specific strategies in order to become aware of their clients' emotions. These have been termed *Emotional Client Awareness Strategies* and will be referred to as such throughout the remainder of this thesis.

All interviewed therapists provided examples of a range of client emotions they had become aware of during their therapy sessions. To do this, therapists commonly described employing three strategies: asking clients how they felt, attending to their clients' non-verbal cues, and attending to their own feelings in relation to their client. Each of these strategies will be described below along with some examples from the interviews.

Four therapists in this study stated that they became aware of their clients' emotions by simply asking them how they felt:

**Eva:** I might say, “Tell me about any traumas you’ve had in your life,” or, “Tell me about what could be troubling you the most at the moment,” and then you find out that he’s anxious about his son who’s sick.

**Ruth:** You ask them questions about how they feel.

This is consistent with a range of therapeutic modalities that encourage therapists to enquire about clients’ feelings in order to understand their experiences (Feltham & Horton, 2012). Pomerantz (2012) cautioned therapists against being overconfident about their abilities to read their clients’ emotions. That is, rather than assuming or telling clients how they are feeling, Pomerantz (2012) emphasises the importance of therapists asking their clients, as they are viewed as the experts on their own emotions.

However, the process of asking clients how they feel, whether in relation to a specific situation or more generally, is more difficult with clients who lack insight about their emotions, are unwilling to discuss their emotions (Greenberg, 2015), or lack the vocabulary required to express their emotions (Meier, 2012). In the current study, one of the participants highlighted this difficulty:

**Nancy:** Because often as I’ve said, they don’t say or they won’t tell you but you’re drawing on a whole lot of things.

As Nancy suggests, for a myriad of reasons clients may not always verbalise their emotions (Greenberg, 2015). When that is the case, therapists are required to attend to further signals to understand how clients are feeling (Westland, 2015). In this study, seven therapists discussed becoming aware of their clients’ emotions by attending to non-verbal cues such as their clients’ body language.



- Crystal:** Non-verbal cues...their facial expressions, whether there's any tears, their positioning, especially eye contact. When people are really depressed or anxious they're not looking at you as much... Sometimes if they're anxious they'll sit forward like they're on edge. If they're more relaxed with you they'll take a step back. Some people will put their head back and when people are really down it's just looking down and crying all the time.
- Rebecca:** Sometimes it will be obvious because they'll become tearful or they'll suddenly stop and the emotion is visible on their facial expression. Sometimes it will be you're having to read the whole person, the non-verbal cues
- Ruth:** You track their physical and physiological state. You listen to the tenor, range and quality of the sounds they make, so their voice.

Interviewed therapists' opinions about attending to their clients' non-verbal cues in order to understand their emotions were in line with Mohacsy (1995) who proposed that observing clients' non-verbal behaviours such as their postures or gestures can provide important clues into internal experiences that they are either verbally withholding or that have not yet entered their conscious awareness. The importance of attending to clients' non-verbal communication was also echoed by Westland (2015) who emphasised that therapists should not merely focus on clients' verbal expressions, as valuable information can be gained from attending to clients' body language, facial expressions and voice tones.

Aside from attending to clients' non-verbal cues in order to understand their emotions, five therapists in this study described becoming aware of their clients' emotions by attending to their own emotions during their interactions with their clients.

- Eva:** That will come through unconsciously and that will give me such a good indicator of how frightened this man is, through my own feelings. I'll be feeling wobbly or I'll be feeling a bit anxious and I'm thinking, I'm not anxious. It's his stuff that I'm feeling.
- Jamie:** My boredom was probably as much about my boredom as it was about his stuck-ness.
- Dave:** I was feeling what he was unable to feel. So this is a superior, intellectual person talking to a little boy so I got a bit of a sense of what it must be like in his life.

Palmer (2015) discusses how therapists' emotional reactions to clients can also provide information about their clients' feelings, including those that the clients themselves feel, but are not yet able to recognise or express. In the psychoanalytic orientation, there is a long-standing concept called 'projective identification' where clients are viewed as being able to project unwanted or unconscious emotions onto their therapist in a manner that can recreate interactions they have had with significant people from their lives (Budd & Rusbridger, 2005; Casement, 1985; Ogden, 1979). The therapist may initially believe these feelings are their own but then by relating their feelings to the interaction and their clients' history, they can begin to understand that these feelings are not their own, but projections from the client. Subsequently, these can be used to understand their clients' emotional experiences in therapy (Budd & Rusbridger, 2005; Mitrani, 2001).

Regardless of theoretical orientation, therapists can also draw on their own emotions in order to understand their clients' emotions through the process of empathy. Empathy is commonly defined as imagining oneself in another person's

shoes or situation (Decety & Lamm, 2006). In this study, four therapists discussed this in the context of understanding clients' emotions:

- Eva:** To know what that person's feeling like...You have to stand in that person's shoes.
- Jamie:** It's that sense of being able to climb into the other's shoes.
- Rebecca:** Empathy being more attunement of putting yourself in their shoes.

Stotland and Smith (1994) describe that empathy involves observing an emotion in another individual and then experiencing this emotion as a consequence. This is consistent with neurological studies which demonstrate that similar brain and autonomic activation patterns are produced when individuals directly experience emotions themselves and when they observe others' emotions (Decety & Jackson, 2006). Niedenthal, Barsalou, Rick and Krauth-Gruber's (2005) work on the perception and recognition of emotions suggests that observers of emotions are able to understand others' emotions through a process of experiencing the observed emotions themselves and subsequently translating their experience into an assessment of how the observed individual feels.

## CHAPTER SIX

### Theme Three – Emotional Practices

While emotional self and client awareness are both critical in psychotherapy, their value may be lost if therapists do not use or utilise the information gained from this to benefit their interactions with clients. The majority of therapists in this study discussed a range of emotional behaviours they carried out in relation to both their own and their clients' emotions. These were termed *Emotional Practices* for the purposes of this research. This section has been broken down into three subthemes: (1) *Own Emotions*, (2) *Clients' Emotions* and (3) *Emotional Boundaries*. The first subtheme will deal specifically with emotional practices that therapists discussed carrying out in relation to their own emotions. The second subtheme will address emotional practices therapists discussed carrying out in relation to their clients' emotions, while the third subtheme will describe therapists' practices pertaining to emotional boundaries.

#### Sub-Theme One: Emotional Practices - Own Emotions

**Bianca:** We are in a professional role. We have that responsibility to make a decision about what we do with our own emotions in the session.

All the therapists interviewed described engaging in a range of emotional practices in response to their own emotions before, during or after their sessions with clients. These practices included emotional disclosure, reflection, supervision and self-care. Each practice, along with relevant extracts are presented below.

## **Emotional Disclosure**

Emotional disclosure was defined as therapists' purposeful expression of their own emotions or emotional experiences to their clients (Cherbosque, 1987; Mathews, 1989; Weiner, 1983). The literature demonstrates that over 90 percent of therapists use disclosures in their practice (Edwards & Murdock, 1994; Mathews, 1989). Seven therapists in this study described instances where they had disclosed their emotions or emotional experiences to their clients. Examples are presented below under their intended purpose. For the therapists interviewed, the intended purpose of their emotional disclosure was either to normalise clients' experiences or enhance the therapeutic relationship.

### **Normalising Experiences**

- Giselle:** Sometimes I've said it, "I felt really moved by that." ACT therapy would say that that is fine, self-disclosure is fine and, not only that, appropriate because you're wanting to normalise people's responses.
- Nancy:** I do disclose a bit about myself with clients. I do often say that "I can understand that", "I've been through that". So I'll give out little bits so that often they'll feel that I've been through some stuff too. And I've had feedback from clients that they really liked that.
- Sylvia:** I'm happy to sit with a pregnant woman or someone who's post-natal and say, "I cried when that happened," and "I was really upset when that happened," and "I found this tough." For some clients, that self-disclosure stuff, is important in terms of normalising a little bit.

## Enhancing the Therapeutic Relationship

**Nancy:** So I work with terminally-ill clients and sometimes that's really hard. And sometimes I will tear up. Quite often that will happen. But I'll always say to the client that's what's happening. I'll say "oh gosh, you're making me feel emotional". And from feedback I've had in the moment, I think clients feel really supported in that moment. That I'm feeling something for them.

**Interviewer:** If you're feeling used by a client or something like that, would you always tell them or show them what you're feeling?

**Rebecca:** I think I would because I would see that as important information for them to have as well as important for our ongoing relationship cos if I'm sitting there feeling resentful then I'm not gonna be able to give of my best so it's almost like clearing the air.

Although therapists from different orientations in this study discussed their use of emotional disclosure, the literature demonstrates that this is a controversial practice that varies largely depending on therapists' theoretical orientation (Farber, 2006; Winget, 1991). For example, Freud (1912) was of the opinion that therapists needed to be "impenetrable to the patient" and reveal nothing of themselves. In line with this, some psychodynamic therapists limit their emotional disclosures as this is viewed as a form of countertransference that can have a 'contaminating' effect on transference (Basescu, 1990; Goldstein, 1994, 1997). In contrast, therapists working from the humanistic or eclectic orientations reportedly use emotional disclosures more frequently in an attempt to be more open and genuine with their clients (Farber, 2006; Simon, 1990). Such disclosures have also been proposed as having an enhancing effect on the therapeutic relationship by fostering a sense of authentic

connection (Knox & Hill, 2003; Rabinor & Nye, 2003; Rogers, 2012). Yalom (2005) highlights that clients often feel distressed when they think that they are suffering alone. Therapists' emotional disclosure may alleviate some of this distress by providing clients with a sense of shared experience that normalises their emotions or situation (Chelune, 1979).

Some researchers have proposed guidelines for therapists to consider in order to decide on the appropriateness of disclosure (Hill & Knox, 2001; Mahalik, Van Ormer & Simi, 2000). For example, Mahalik et al. (2000) discussed three key disclosure considerations. The first is that therapists should make disclosures if they consider that this will enhance the therapeutic relationship. Secondly, therapists' disclosures should prioritise the needs of the client, not the personal needs of the therapist. Thirdly, therapists' disclosures need to be relevant and connected to clients' presenting concerns so that they continue to be the primary focus of the therapeutic encounter. Similarly, according to Norcross and Hill (2002), therapist disclosures can be used infrequently for the purpose of validating clients' realities, normalising clients' experiences, enhancing the therapeutic relationship or to provide clients with alternative means of thinking or behaving. However, they assert that such disclosures should be avoided if they are carried out in service of the therapists' needs, re-directing the focus away from clients or tampering with therapeutic boundaries.

### **Emotional Reflection**

All the therapists interviewed for the current study also described emotional reflection as a practice they carried out in response to their own emotions. Emotional reflection was defined as any time that therapists took to ponder or

consider their own emotions in relation to a client. Across all therapists interviewed for this study, the emotional purpose of their reflections was therapeutic clarity.

**Bianca:** Occasionally there'll be somebody that I don't feel there's a connection with in the same way so I will definitely reflect on that...why's it not happening? Why is there not this feeling of connection? Is it something about me and what I'm doing as a therapist, is it something about them and their formulation, is it something about the relationship between us or something altogether else?

**Jamie:** If you're noticing that it's an uphill battle, that you're hating the person that's sitting in front of you and sometimes we do. Later on you can bear that cos you've liked them for a period of time and then suddenly you start hating them and you think, gosh, why do I suddenly hate this person? It doesn't make any sense, so then you can start to reflect on it.

**Rebecca:** I don't go away and think, right, now I've got 20 minutes' reflection time. It would just naturally be happening. I'll be in the course of my day, going to make a cup of tea, thinking about this person and thinking, what are we gonna do next and thinking actually, I'm really a bit annoyed that I wrote her that letter and then she didn't appear. There were excuses three weeks running and she didn't need me anymore. Then there's drama and she does so I'm recognising that there's a pattern emerging and then recognising that actually I'm not happy about her using me as a drop in.



Skovholt, Ronnestad and Jennings (1997) emphasise the importance of therapist reflection when they say: “a therapist and a counsellor can have 20 years of experience or one year of experience 20 times. What makes the difference? A key component is reflection” (p. 365). That is, effective therapists are those who are aware of and continuously practice self-reflection. According to Bennett-Levy (2006), reflection is an important contributor to therapists’ ‘clinical wisdom’, which helps them decide on the therapeutic processes to follow. As the therapeutic process occurs, therapists can experience a range of both positive and negative emotions (Gelso & Hayes, 2002). In order to make sense of these emotions and use them in a therapeutically helpful manner, or at least a manner that is non-disruptive to therapy, the therapist is required to ‘step back’ from the situation and reflect on their experiences. It is through this process that Lauterbach and Becker (1996) describe ‘hidden’ information can be better understood. Skovholt and Ronnestad (1992) reported that ongoing reflection also enhances the development of therapists’ competence. Interestingly, therapists in this study most frequently described reflecting when things were not going well in therapy or when they were experiencing negative emotions as opposed to when things were going well or when they were experiencing more positive emotions.

### **Supervision**

Another emotional practice nine therapists discussed carrying out in response to their own emotions was supervision. For the purposes of this research, supervision was defined as any discussions that therapists had with a dedicated supervisor or colleague(s) in relation to their emotional experiences in the context

of treating a client. For the therapists interviewed in this study, supervision appeared to serve two main purposes; therapeutic clarity and emotional de-brief.

Four therapists in this study described using supervision in order to gain therapeutic clarity.

**Bianca:** I think we had about four sessions and we just didn't connect. And I felt judgemental of him as well...I did take it to supervision and I think the bottom line is that he was actually not willing to change or reflect on his own part in what was happening in his relationship.

**Eva:** We have a weekly peer supervision group where we talk about this stuff...I presented a case last week where I was left with a lot of confusion and foginess with this one client.

**Giselle:** I'd probably take that to supervision to think about how I might approach them differently.

Six of the interviewed therapists described using supervision as a means of emotional de-brief.

**Bianca:** I think it's important to debrief if there's been some sort of strong emotion. I would take it to supervision definitely but if I didn't have supervision coming up I might talk to a colleague. So I have colleagues who I have informal peer supervision with so I might do that.

**Jamie:** Connecting with a supervisor which might not happen after every session but once in a while you get to talk to a supervisor and debrief a little bit.

**Dave:** I started feeling or started realising that I had felt from the beginning, not very useful and not very good and somewhat excluded. Now, these didn't all come in one insight, over a while I presented to a few supervision groups and as you talk I sort of realised, that's what I'm feeling, that's the funny, strange feeling that's going on with me.

Supervision has been a widely discussed therapist practice that has been viewed as a means of enhancing therapists' skills, confidence, competence (Borders, 1991; Inskipp & Proctor, 1993), therapists' self-awareness (Borders, 1991; Raichelson, Herron, Primavera & Ramirez, 1997), clients' treatment outcomes (Bambling, King, Raue, Schweitzer & Lambert, 2006) and therapists' well-being (Hawkins, Shohet, Ryde & Wilmot, 2012; Inskipp & Proctor, 1993; Spence, Wilson, Kavanagh, Strong & Worrall, 2001) Wheeler and Richards' (2007) more recent literature review on supervision concluded that not only does supervision impact therapist skills, but it also contributes to their self-awareness, self-efficacy and client outcomes.

The idea of using supervision as a platform for therapeutic clarity and emotional debrief was echoed by Hunter and Schofield's (2006) research which outlines the importance therapists place on supervision for both managing cases and processing personal responses to clients' presentations. In their study, therapists reported that good supervisors were those who they could turn to for advice and direction regarding their work with clients, as well as people they could de-brief with following difficult cases that may have involved trauma. In that same study, informal de-briefing and group supervision with colleagues were also valued by therapists as an important coping strategy that was possible through team

confidentiality policies. Speaking to colleagues about emotional responses to clients enabled therapists to feel both heard and validated within their work environments (Hunter & Schofield, 2006).

### **Mental or Physical Self-Care Activities**

**Sylvia:** Unless you actually start looking after yourself, in every aspect, you're gonna fall over. It's something that I've protected quite strongly, is that whole self-care idea.

Another emotional practice eight therapists discussed carrying out in response to their own emotions following their engagements with clients were mental or physical activities for the purpose of self-care. For this research, self-care was defined as any tasks carried out by therapists to deal with unpleasant or residual emotions or improve their sense of well-being following their engagement with a client. Examples of the emotional self-care practices are listed below according to whether these were mental or physical activities.

### **Mental Self-Care Activities**

**Bianca:** Every time as I left the building I would clear my head and I'd say all you children and families, you can all go back into the files now and out of my head...If they came into my head at night, I just imagine putting them on a spaceship and sending them back to their parents or carers.

**Nancy:** One thing that has been really useful is choosing a landmark on the way home and then allowing yourself to think about work before but not after the landmark.

**Physical Self-Care Activities**

- Eva:** Sometimes I would try and leave the emotions behind and I would try and have a shower or go for a walk or something like that.
- Jamie:** Things like going for a run or exercising...just taking a bit of time out so I might not go straight home and I might go and sit by the water's edge.
- Nancy:** I think it's important to switch off because we do a lot of thinking in our work. We do a lot of thinking about emotion and there's a lot of stress compared to any other profession. You're thinking deeply about difficult things all the time. So you need to learn also how to switch off from that... so what I would do is watch TV series, go to the gym, listen to podcasts that aren't to do with psychology.

Attending to clients' emotional needs can be emotionally draining for therapists (Norcross & Guy 2007). Several researchers have discussed the concept of 'compassion fatigue' which is a kind of burn-out often experienced by therapists as a result of the intensive emotional labour involved in their work (Deighton, Gurriss & Traue, 2007; Figley, 2002; Weiss 2004). Within the therapy professions, stress has been linked with emotional exhaustion (Rupert & Morgan, 2005), lower work satisfaction (Horton & Varma, 1997) and a reduced ability to develop a therapeutic relationship with clients (Enochs & Eitzbach, 2004). Consequently, therapist self-care is incredibly important (Weiss, 2004).

In this study, the physical self-care activities therapists' described were similar to the self-care activities described by Pearlman and Mac Ian (1995) who

researched trauma therapists. In their research, trauma therapists included watching movies and exercising as being among the top ten most helpful self-care activities. Other physical self-care activities cited in the literature include changing outfits, listening to music, and meditation (Mahoney, 2003; Neumann & Gamble, 1995). Moreover, the mental activities described by Bianca and Nancy from the current study are in line with Norcross and Guy's (2007) work which encourages therapists to make clear mental separations between their home and work lives. In turn, this enables therapists to be more effective when attending to their clients' emotions at work.

### **Sub-Theme Two: Emotional Practices - Clients' Emotions**

This section deals specifically with emotional practices that therapists in this study discussed carrying out in response to their clients' emotions. The first set of practices therapists discussed can be described as emotion regulation behaviours. These are behaviours that therapists carried out with the purpose of increasing, maintaining or decreasing their client's emotional experiences. The other commonly discussed practice was that which related to the setting, maintaining and crossing of emotional boundaries.

#### **Emotion Regulation**

Therapists carry out a range of practices to assist clients to regulate their emotions so that they can learn to tolerate them and prevent them from becoming maladaptive (Greenberg, 2004, 2015). Emotion regulation practices are also able to modify the intensity of emotional responses that are experienced by clients (Aldao, Nolen-Hoeksema & Schweizer, 2010; Campbell-Sills & Barlow, 2007). For example, while some emotion regulation practices will increase clients' emotional experience, others will serve to maintain or decrease aspects of clients' emotional experience.

Poorly regulated emotions have been associated with the development and maintenance of several mental health disorders (Greenberg, 2002; Mennin & Farach, 2007), particularly depression and anxiety which are widely considered to arise due to problems in emotion regulation (Campbell-Sills & Barlow, 2007; Mennin, Holoway, Fresco, Moore & Heimberg, 2007). Consequently, emotion regulation difficulties have been incorporated into several models of psychological disorders including those for major depression (Rottenberg, Gross & Gotlib, 2005), borderline personality (Linehan, 1993), generalised anxiety (Mennin et al., 2007), social anxiety (Kashdan & Breen, 2008), bipolar (Johnson, 2005), substance use (Sher & Grekin, 2007) and eating disorders (Clyne & Blampied, 2004). To assist clients with emotion regulation, therapists in this study discussed employing several practices to increase, maintain or decrease clients' emotional experiencing. Each of these practices are presented with relevant extracts below.

### **Emotional Purpose: Increase Clients' Emotional Experiencing**

#### **Practice: Labelling Emotions**

One practice therapists' used to increase their clients' emotional experience was labelling emotions, which in turn, also enhanced clients' emotional awareness. According to Greenberg and Paivio (2003), emotional awareness enables individuals to organise and structure their emotions and in doing so, helps them better understand and cope with their emotional experiences. Emotional awareness is viewed as a key goal in emotion-focussed therapy. In working towards this goal, therapists from this orientation assist clients to become aware of their emotional experiences by helping them label or name their emotions (Greenberg, 2004). Similarly, contemporary cognitive behavioural therapies involve helping clients to

identify and describe their emotions as a key component of treatment (Westbrook et al., 2011). Six therapists in this study discussed carrying out this practice.

**Bianca:** So the first step would be helping them to become aware of whatever their emotions are, maybe through naming them.

**Crystal:** You can name them. You can say, "I see you're really angry right now."

**Sylvia:** I tend to name it (the emotion)...Particularly with men - a lot of my work with men, they've never learned how to identify emotions.

### **Practice: Encouraging Emotional Expression**

Another practice discussed by therapists in this study to increase clients' emotional experience was encouraging their emotional expression. Greenberg (2002) asserts that in order to process their emotions, clients must first express them. Allowing clients to express their emotions through catharsis for example has historically been supported as change practice in therapy (Nichols & Zax, 1977). Moreover, outcome research from the emotion-focussed therapy literature on depression demonstrates that emotional expression in the middle of treatment is predictive of better treatment outcomes (Warwar, 2003). Similarly, positive outcomes across behavioural exposure research on post-traumatic stress disorder following rape were predicted by clients' expression of fear as they recounted their traumatic memories (Foa, Riggs, Massie & Yarczower, 1995; Jaycox, Foa & Morral, 1998).

Researchers assert that emotional expression is central to the ability to reflect on and evaluate one's emotional experiences (Pennebaker, 1995). However,



clients will not always express their emotions outright in therapy and, as such, therapists may be required to play a facilitative role in encouraging clients' emotional expression (Greenberg, 2015). In this study, eight therapists described encouraging clients' emotional expression through both verbal and behavioural means:

**Bianca:** I might just allow the tears because it's okay. So I might say it's okay and pass the tissues.

**Giselle:** I might try to actually intensify the emotional response.

**Interviewer:** What's the purpose of that?

**Giselle:** Because the idea is that some of the forward emotions, like often anger, is actually not the most dominant thing, that usually it's about feeling pain or abandonment or something and you need to be able to get the person to express that instead of shutting them down.

**Dave:** That's simply a case of tolerating the feelings and encouraging them to express some more.

### **Emotional Purpose: Maintain Clients' Emotional Experiencing**

In this study, therapists discussed two validation practices that they used to maintain clients' emotional experiences; acknowledging clients' emotional experiences as reasonable or understandable in the context of their history or circumstances and accepting their full emotional experiences just as they are presented. Both of these forms of validation have been discussed by researchers (Linehan, 1993; Nezu, 2015; Shea, 2015) and require empathy on the part of the therapist coupled with an accurate understanding of the clients' unique experiences and perspectives (O'Donohue, Fisher & Hayes, 2004). Validating clients' emotional

experiences is an important practice as it reduces client distress (Bohart & Greenberg, 1997), enhances the therapeutic alliance, and helps clients to feel understood (Gilbert & Leahy, 2007) which in turn, enables them to continue to experience their emotions (Greenberg, 2004).

Pederson (2015) proposes that validating clients who have experienced invalidation from others in their lives for expressing their emotions will communicate that their emotions are accepted within the therapeutic setting and in doing so, will help them feel safe enough to continue disclosing their emotional experiences over time. According to Linehan (1993), validation is particularly important for clients with interpersonal problems and poorly regulated emotions. With such clients, Linehan (1993) suggests that validation can be used to teach clients how to self-validate or to illicit further information about their emotional experiences. In this study, seven therapists discussed validating their clients' emotional experiences by acknowledging these as reasonable/understandable and demonstrating an acceptance of their full emotional experiences just as they are presented.

### **Emotional Purpose: Maintain Clients' Emotional Experiencing**

#### **Emotional Validation**

#### **Practice: Acknowledging Clients' Emotional Experiences as Reasonable or Understandable**

**Sylvia:** I will actively say, "That's really sad," or "That's really awful and that shouldn't have happened to you," or "I understand how you'd be feeling that way."

**Giselle:** What you need to do is validate that it is hurtful and disappointing if someone backs out on a plan that you've had.

**Practice: Demonstrating an Acceptance of Clients' Full Emotional Experience**

**Eva:** So I needed to show her I was robust enough for her to bring whatever feelings she had, that I could sit with it and I'm not gonna run away and I'm not gonna try and change her feelings. Her feelings need to be her feelings and whatever feelings she had, we could sit with them.

**Crystal:** They come in and I always say to them, "this is your time to practice being exactly who you wanna be. If you're grumpy, you come in grumpy. If you're sad, you come in sad. If you're happy, you can come in happy."

In this study, six therapists also discussed employing two relational practices to maintain clients' emotional experiencing. These included active listening as well as mirroring their client.

**Relational Practices**

**Practice: Active Listening**

Active listening forms the foundation of therapy (Meier & Davis, 2010). Actively listening to clients' emotions involves more than just giving the client space to talk, nodding one's head and collecting information. It requires a high level of attentiveness which allows the therapist to reflect the emotions that clients have expressed back to them in a manner that communicates the therapists' understanding of their experiences (Rimondini, 2010). Reflecting clients' emotions also enables therapists to check the accuracy of their interpretations while also instilling a safe environment that allows clients to continue exploring and

expressing their emotional experiences (Cohen & Zinaich, 2013; Ivey, Ivey & Zalaquett, 2015). Mearns and Cooper (2005) highlight the depth of listening required in therapy through the concept of 'holistic listening' where therapists are described as 'breathing in' their clients' 'emotional-cognitive-physical being'. Two examples of therapists' use of active listening are presented below.

**Bianca:** I just had to listen. So in terms of the priority, the priority is that I listen and understand then feedback what I get and she gets that I get what's been happening... And their emotional world is part of that. So that they get that I get how they feel.

**Dave:** I've listened to what the client's feeling and I'll talk about that.

### **Practice: Mirroring**

Another practice therapists described employing, that serves to maintain clients' emotional experiencing, was mirroring. Mirroring is the process by which therapists make adjustments to their non-verbal behaviours in order to match the non-verbal behaviour of their clients (Feldman, 2014). In this study, therapists discussed the importance of mirroring their clients' emotional tone, body posture and pace. Some researchers describe this process as 'synchrony' to represent the harmony that occurs when therapists' and clients' non-verbal behaviours are in sync. Mirroring has been well-documented in the literature as a means of establishing or strengthening rapport (Feldman, 2014; Navarre, 1982; Tickle-Degnen & Rosenthal, 1987, 1992; Trout & Rosenfeld, 1980), as well as demonstrating empathy (Maurer & Tindall, 1983), both of which enable clients to continue experiencing and expressing their emotions. Feldman (2014) stresses that

mirroring does not entail mimicking all of the clients' non-verbal behaviours. Instead, the focus for therapists should be on ensuring that their overall demeanour is in line with that of their clients. For example, if a client presents in a relaxed manner where they are sitting back on their seat with crossed legs, the therapist can sit in a similarly relaxed manner.

Although therapists in this study described consciously mirroring clients' emotional expressions and body postures, researchers have described that this can also take place unconsciously when one is attending to or is very focussed on another individual (Lundqvist & Dimberg, 1995; Staemmler, 2011). Although the benefits of client mirroring have been well documented in terms its positive effects on therapeutic rapport (Feldman, 2014; Tickle-Degnen & Rosenthal, 1992), the timing and type of mirroring have been proposed as important considerations for determining the appropriateness of client mirroring. For example, it would not be appropriate or helpful for a therapist to mirror an anxious client's body posture by sitting with their face down and their arms and legs crossed tightly. Such behaviours may be perceived by clients as mockery, inadvertently escalate the client's anxiety or shift the client's focus away from their emotional experiences and negatively influence the therapeutic relationship (Sharpley, Halat, Rabinowicz, Weiland & Stafford, 2001). In the examples below from the current study, Nancy describes various mirroring practices she uses in therapy but also notes that when mirroring, she does this in a manner she considers appropriate to the situation. In contrast, Jamie discusses the importance of mirroring clients' emotional pace and the potential implications to the therapeutic relationship and ultimately client retention if therapists adopt a different pace than that of their client.

**Nancy:** I often try to mirror how the client is. So if they're really happy then that will bring more energy to the room. And I will try to match them with that energy and obviously in an appropriate way. You know so if the client is joking and smiling then I will be doing that too if it's appropriate. If the client is crying or angry or anxious, then my face will mirror that...I also mirror the way the client sits as well...So if the client is sitting up straight and dressed very smartly and is very formal in their presentation then I will try to be more formal in my presentation. So I won't sit slumped on the chair.

**Jamie:** A client had brought me a situation where she was hearing voices and she was talking a little bit about that and she was being chased by ghoulish-like creatures that nobody else could see and I started reflecting on what I thought the emotional tenor might have been and the emotional feelings that went with that. I was talking about it a little bit and going into it and then suddenly she stops me from speaking and she says - these are her words almost verbatim, "I feel like there's a park here and there's new grass and it's got a sign up saying "do not walk on the grass" and I feel like you've just put your gumboots on and just trampled all through it!" It was just a beautiful moment in time where you can realise momentarily that you might be somewhere and you might be somewhere important but the person in front of you might be nowhere near you, even if it's their world you're in...I've had clients in my room where I've obviously got too close emotionally and they've never returned so I've moved too quickly somehow and, for some, not quickly enough...They tell you. They leave. They don't come back.

## **Emotional Purpose: Decrease Clients' Emotional Experiencing**

In this study, six therapists described using two practices to decrease their clients' emotional experiencing in order to prevent or reduce the extent to which their clients feel overwhelmed, become distressed or dissociate. These practices included introducing grounding techniques and shutting down emotional discussions.

### **Practice: Introducing Grounding Techniques**

**Giselle:** If someone's getting overwhelmed I might just sit with them and talk about their breathing and slowing their breathing down and get them to do something that's about I guess you'd say self-soothing.

**Crystal:** You can see their distress is getting up there. I tend to just get them to do some breathing or count how many coloured things around the room, how many green things in the room, anything to bring them back to the moment or put their feet on the floor. I guess that's emotional, teaching people to manage their emotions in therapy.

**Dave:** I could see they were starting to dissociate, "Stop, ground yourself, describe the room, don't go there for now." I'd say it as clearly as that.

Grounding describes a set of techniques that are used for the purpose of re-orienting clients back to the current moment or the 'here-and-now' (Sanderson, 2006). Consistent with therapists' discussions in this study, grounding techniques are commonly introduced to reduce clients' emotional experiencing when they are feeling overwhelmed by their emotions or when they start to dissociate. That is,

when aspects of a client's identity, consciousness, memory or perceptions of their environment become disrupted (Spitzer, Barnow, Freyberger & Grabe, 2007). Examples of grounding techniques include assisting clients to slow down their breathing, asking them questions that orient them back to person, place or time and instructing them to name or count objects in their immediate surroundings (Kleinberg, 2015).

Breathing techniques are used across a range of therapies for the calming effects they produce (Hazlett-Stevens & Craske, 2009). For example, in dialectical behaviour therapy, therapists assist clients to slow down their breathing in order to elicit physiological relaxation when they are experiencing overwhelming or distressing emotions (McMain, Korman & Dimeff, 2001). Similarly, in the treatment of generalised anxiety disorder, clients are taught to use breathing for self-soothing when they experience emotional arousal or feel overwhelmed (Mennin, 2004). According to Hazlett-Stevens and Craske (2009), assisting clients to focus on their breathing reduces distress by reverting overactive fight or flight responses to a resting state, promoting relaxation.

### **Practice: Shutting Down Emotional Discussions**

Therapists in this study described shutting down emotional discussions with clients when they judged that clients were emotionally overwhelmed or likely to become overwhelmed.

**Giselle:** I might be assessing somebody in an early phase, say session one or two, before we've started work and I know it's trauma, I know that already from what you've got. You might start to get yourself somewhere you shouldn't go at that point, they might be starting to tell you what happened and get into a bit more of



a discussion about it - I might actually shut that down at that point...I don't want to leave them in a mess at the end of the session...It could be that I think that I need to teach them containment as the first thing rather than exploration of what happened, that I might know that they're gonna run off and slash and burn or I might already know that they're using, drinking or drugging or over eating or something to contain themselves when they feel overwhelmed so I don't wanna get them overwhelmed until I've got something else happening.

**Bianca:** So if they're getting into overwhelm then I might switch the focus from the feeling to the thoughts. Like what's running through your mind when you're feeling like this?

Therapists' responses were consistent with Timulak (2015) which suggests that when working with emotionally overwhelmed clients, therapists may need to assist clients to initially distance themselves from the distressing emotional experience and equip them with the ability to tolerate distressing emotions prior to revisiting them. As suggested by Giselle and Bianca, this may involve directing clients to slow down their breathing or temporarily shifting to a cognitive focus in attempt to clarify and give further meaning or coherency to their emotional experience and in turn, make it less overwhelming. Similarly, when working with traumatised clients, therapists are urged to work on gradually expanding clients' emotional tolerance until they are able to revisit their trauma, accept it and express the unpleasant emotions associated with it (Ford & Courtois, 2013).

### **Sub-Theme Three: Emotional Boundaries**

**Jamie:** It's entirely emotional. Boundary - knowing where I begin and end. It's so important. Knowing that I don't have to move towards you or don't have to move into your field in order to be with you, that we can be with each other independently. Knowing what those boundaries are.

As well as discussing a range of practices they carried out in response to their own and their clients' emotions, therapists in this study also commonly discussed practices in relation to emotional boundaries. The term 'boundary' is a spatial metaphor that represents the separation or area between two individuals and, in turn, defines the purpose and meaning of their relationship (Epstein, 1994). In the context of psychotherapy, that is, the relational space or framework within which a therapist and their client operate, where boundaries structure the limits within the therapeutic relationship. For instance, they dictate which behaviours are appropriate or inappropriate between a therapist and their client. (Friedman, 2015; Johnston & Farber, 1996; Luchner, Mirsalimi, Moser & Jones, 2008). The importance of boundaries has been widely recognised in the literature for the therapeutic relationship (Okamoto, 2003; Rand, 2002), as well as client and therapist safety (Westbrook et al., 2011; Zur, 2007). In this study, six therapists discussed emotional boundaries, which were the context within which the emotional practices described in sub-themes one and two above were carried out. Specifically, therapists discussed setting, maintaining and crossing emotional boundaries with clients.

### **Practice: Setting Emotional Boundaries**

Unlike practical boundaries, two therapists in this study (Jamie and Sylvia) described that emotional boundaries were not set in an explicit manner with their clients.

**Jamie:** Being close but not too close.

**Interviewer:** How do you strike that balance? How do you get close but not too close?

**Jamie:** You feel into it with the client.

**Sylvia:** I'm working in the community I also live in so I often will discuss the practicalities of boundaries. I have a client whose child is at the same school as my children. We didn't know that to start with but we discovered that after a couple of sessions. I do say to them, "If I see you out in the community, I'm not going to rush up and say, "Hi" but if you wanna say, "Hi" you're welcome to come and say, "Hello". Setting those kinds of boundaries become a functional/practical thing. In terms of emotional boundaries, I don't know that I actively make them explicit but I've got my own idea of where I feel safe in the room, too.

Sylvia discussed setting practical boundaries with her client in order to guide their behaviours should they cross paths while going about their personal lives, outside of the psychotherapy setting. Emotional boundaries, however, were not verbally discussed. Instead of making emotional boundaries explicit, Jamie referred to a process through which emotional boundaries are "felt into" through the interaction between the therapist and client. Both Sylvia and Jamie's discussions were consistent with Epstein's (1994) work which outlines that although some boundaries are explicitly discussed, others are communicated non-verbally within the therapeutic relationship. Researchers emphasise the importance of establishing

clear and consistent boundaries with clients, particularly since for some clients, this may be their first experience with this kind of relationship. For those clients, a relationship with clear boundaries can instil a sense of safety and become a model for similar relationships outside of therapy (Zur, 2007).

### **Practice: Maintaining Emotional Boundaries**

As well as discussing the importance of establishing emotional boundaries, some therapists in this study also described maintaining emotional boundaries.

**Jamie:** I remember a client once with me, she had dissociative identity disorder, still does and one aspect of her wanted me to hug her and kept on insisting, getting really distressed and really angry and quite violent at times...and I maintained my boundary, “No, I’m not hugging you. I’m not hugging you. I’m not hugging you.”

**Giselle:** This is a difficult one but you can’t fuse with your client. You can’t become too emotionally involved in their journey so that’s another thing, the capacity to see them as other, even when their story might be similar.

The maintenance of boundaries is essential for effective therapy (Borys, 1994; Zur, 2007). Harper and Steadman (2003) explain that therapists can maintain boundaries with clients by ensuring that their behaviours are carried out in service of their clients’ therapeutic needs, not their own. According to Zur (2007), the main purpose of maintaining boundaries is to ensure the safety of both the client and therapist and provide a sense of security within the therapeutic relationship that does not impinge on the personal lives of either party. In the extract below, Jamie eloquently corroborates the view that maintaining boundaries provides clients with

a sense of security, even when this is initially perceived by them as hurtful or distressing.

**Jamie:** That's knowing boundaries. Knowing where I begin and end and you begin and end. So if I'm running into you as a therapist and you keep moving then I've got nowhere to stop and if I keep going through, I'm gonna get distressed and I'm gonna be repeating something from my history. But if you stand still and suddenly I run into you and bounce back, then actually that bounce back gives me a sense of where you are. Now, it might hurt me too much and I might get narcissistically injured or I might get distressed in some way and I might leave you but there's also something important about being able to run into something that doesn't move.

The consequences of not maintaining boundaries can be understood on a continuum that ranges from harmless or even therapeutically valuable boundary crossings to boundary violations, which are likely to have negative consequences on both the client and the therapeutic relationship (Pope & Keith-Spiegel, 2008; Smith & Fitzpatrick, 1995; Zur, 2007).

### **Practice: Crossing Emotional Boundaries**

Gutheil and Gabbard (1998) explain boundaries as being "the edge of appropriate behaviour" (p. 410) which are adapted to suit the unique needs of the client. However, just as no two clients are the same, no two therapists are the same and therefore, ideas about where the 'edge' that Gutheil and Gabbard (1998) refer to lies may vary between therapists (Zur, 2007). In this study, some therapists discussed occasions where they had crossed emotional boundaries with clients.

**Dave:** The session before last was his birthday, “You know how old I am?” He said, “I turned [client’s age] today.” So it’s interesting. I sort of knew how old he was cos I said, “Surely not, I’m the young one.” “Turned [client’s age] today” ...So I shake his hand, which I may or may not do with others and I feel, cos I’m sort of working analytically, as a bit of a frame break or a bit of a therapeutic rut you’re doing this but...it’s someone’s birthday so you shake their hand. He quite likes that actually and then he says, “How old are you?” I say, “[Dave’s age]”. Now, that’s definitely a frame break for me. I’m like, you don’t tell clients. Maybe/maybe not, depending on what sort of model.

In the example above, Dave describes shaking his clients’ hand for his birthday and disclosing his age as “frame breaks”. A therapeutic ‘frame’ is another term that is used to describe the boundaries within the therapeutic relationship, where the frame represents the rules that guide the therapy (Langs, 1998). This includes rules around where therapy sessions should take place, how long sessions should be, confidentiality, the extent of therapists’ self-disclosure, and whether any physical contact is permitted. As the therapeutic frame is flexible, it can be crossed for justified reasons such as when this is judged to be in the interests of the client or the therapeutic relationship. These situations are referred to as a ‘boundary crossing’ which Zur (2007) asserts can be helpful without causing any harm to clients or the therapeutic relationship. In contrast, a ‘boundary violation’ is when a therapist misuses their power by acting in a manner that harms or exploits the client for their own benefit. For instance, by engaging in a sexual relationship with them (Zur, 2007). In the example below, Giselle discusses another boundary crossing scenario.

**Giselle:** I'm the age of her mother and she's the age of one of my children so there was definitely this transference going on that I had to bring up in supervision - am I thinking of being like her mum? Sometimes you do things that are just on the edge of what's acceptable. She had a little apartment in [Name of city in New Zealand] with an outside area and she'd grown flowers and there were some little yellow primulas and they'd all been ruined. I found one for \$2.50 somewhere at a garden centre and I bought it for her and I gave it to her and I said, "Here's hope." She's back in [Name of city in New Zealand] now so she emails me and now I get a photo of the blessed flowers, the significance of those or I'll remember it's the [Name of city in New Zealand] Anniversary and I'll send her a note. Now, is that moving me outside my role? Maybe it is, she's not my client anymore.

Gift-giving within the therapeutic relationship is a phenomenon that has received only limited research attention (Knox, Hess, Williams & Hill, 2003; Spandler, Burman, Goldberg, Margison & Amos, 2000). Zur (2007) highlights therapists' hesitance to discuss gift-giving in an open fashion due to fears they will be viewed as having violated therapeutic boundaries. One of the boundary issues discussed by Guthiel and Gabberd (1998) is gift-giving between therapists and clients. In the extract above, Giselle describes her gift-giving behaviour as being "on the edge of what's acceptable", a description consistent with Guthiel and Gabberd's (1998) definition of a boundary. As gifting the client is outside the realms of common practice in psychotherapy, it could be viewed as a boundary crossing.

As pointed out by Dave in the extract above, one of the ways in which therapists can identify boundary crossings or boundary violations is by considering the theoretical orientation from which they are operating. From this, therapists can

decipher whether their behaviour falls within or outside of this and if it does, whether it can be justified as appropriate based on the interests of the client or the therapeutic relationship (Zur, 2007). For example, while analytic therapists advocate boundaries that include strict rules against gift-exchange within the therapeutic relationship, therapists operating from the humanistic, feminist, cognitive behavioural and family therapy traditions are more likely to be supportive of appropriate gift-exchange if this is likely to enhance aspects of the therapy (Lazarus & Zur, 2002; Zur, 2007). However, given that a therapist's theoretical orientation determines the appropriateness of gift-giving, it is both difficult and potentially inaccurate to propose blanket or universal statements about the appropriateness of such practices or make assumptions about whether such practices cross therapeutic boundaries. In line with this, Corey (2016) emphasises that while maintaining boundaries is important, therapists should exercise flexibility and not simply adhere strictly to boundaries if appropriate boundary crossing may benefit the client or the effectiveness of therapy.



## CHAPTER SEVEN

### **Theme Four – The Learning and Training of Social-Emotional Skills**

The final theme in this study was *The Learning and Training of Social-Emotional Skills*. Interviewed therapists discussed their perspectives about whether social-emotional skills could be learned/taught, whether their therapist training programmes had contributed to their social-emotional skills as well as training activities that may be used to teach budding therapists social-emotional skills. This section is divided into three sub-themes; (1) *Learning Social-Emotional Skills*, (2) *Contributions of Therapist Training Programmes* and (3) *Training Activities*.

#### **Sub-Theme One: Learning Social-Emotional Skills**

All the therapists interviewed discussed whether they considered social-emotional skills could be learned or taught. Four therapists viewed that social-emotional skills could be learned or taught but the remainder of the participants viewed that these skills were either largely natural and/or that there were individuals who would not be able to learn social-emotional skills.

#### **Learnable/Teachable**

**Bianca:** I think it can definitely be learned and taught.

**Ruth:** I think everyone can learn how to be present, whether people can learn it at a level that enables them to work effectively with people is a different question.

#### **Natural or Not Entirely Learnable/Teachable**

**Crystal:** I think it's 80% natural I would say. There's only so much you can teach people.

**Nancy:** I think it has to be within you...I think some people aren't cut out for it.

**Jamie:** My sense is that some people won't be able to find intuitive emotional connection at deeper levels for all kinds of different reasons. I had a friend who was a counsellor and he'd come and chat to me and we'd talk and eventually he gave it up but the conversations often went something like this, "why don't people just change? If you've got all that going on, they can talk to me for hours about it and, sure, I can reflect and challenge and validate it but why don't they just change?" He'd called himself a psychologist but therein lies the problem – he can't quite feel it, he can't quite intuit something... I just think that some people just don't have it.

**Interviewer:** Have what?

**Jamie:** The depth of emotional connection. They can't connect.

Therapists' responses in this study regarding the potential innateness of social-emotional skills were consistent with some researchers' views regarding the development of emotional intelligence. Like personality or cognitive intelligence, some researchers have proposed an innate component to emotional intelligence. They propose that, just as individuals' early temperament contributes to the development of personality, temperament may also influence the development of elements of emotional intelligence (e.g. Izard, 2001). Izard (2001) notes that infants' capacity to understand and respond to emotions has some innate determinants. In contrast to the focus on genetics, some therapists in the current study discussed having learned social-emotional skills from their family environments as children:

**Eva:** I had a mother that talked a lot about feelings. She would often complain that my father didn't talk enough about feelings so already I've got that right in the family in the beginning.

**Interviewer:** What do you think you learned from being in that environment?

**Eva:** That feelings need to be talked about. Expressed.

**Sylvia:** I think it all depends a lot on upbringing as well. My mother was very liberal, for example, and made us think for ourselves, made us really sit down and say, "What do you think? How do you feel about this? What's going on here?" as was my Dad but some people don't have that. Some people have more authoritative parents who will say, "This is what you think, these are your politics, this is how we do this, these are the prejudices."

Consistent with therapists' responses, socialisation has been determined as important in the learning of social-emotional skills. Saarni (2000) asserts that parents play a significant role in the development of their children's emotional intelligence. Similarly, researchers propose that children acquire their social and emotional knowledge through their familial environment, termed 'family socialisation'. The family environment is the context through which children observe parents and others' use of emotions and how these are regulated, which in turn, forms their understanding of emotions and emotional regulation (Garner, Jones & Miner, 1994; Mayer & Salovey, 1997). Two therapists in this study viewed that they had learned social-emotional skills through their secure attachments to parental figures.

**Interviewer:** Where do you think you picked up those skills?

**Ruth:** I got them from my family....I'm a lucky person. I have a very secure attachment to both of my parents... we come from a pattern of securely attached children and parents.

**Dave:** You learn it from day one with your mother. That's the most important thing. What you haven't learnt then, you're gonna struggle to learn. Mother, father, adoptive aunt or whatever it is, as long as there's some good bonding and attachment, moderate attachment and you learn that thing and it's not taught as a skill, you just watch it, mother just loves you and you grow up and you have to separate and individuate from her and she doesn't get too freaked out. The first four, five, ten years is the most important. Then how life treats you and the sort of partners you find but I think the template's sort of set.

Ruth and Dave's views on the learning of social-emotional skills through early attachment with family members is consistent with Matthews, Zeidner and Roberts (2004) who emphasise the relationship between empathy, emotional regulation abilities and the quality of children's early attachments with caregivers. Notwithstanding the important influences of genetics, early socialisation and attachment on the development of social-emotional skills, there is evidence that social-emotional skills can be both taught and learned (Bagshaw, 2000; Matthews et al., 2004). Emotional intelligence training has been effectively demonstrated across a wide variety of settings and professions. For example, in the organisational literature, Slaski and Cartwright (2003) provided once weekly emotional intelligence training sessions to managers across four weeks. The results found that when compared to a matched managers group, those who received emotional intelligence training attained significantly higher emotional intelligence scores. These findings are consistent with subsequent studies in the organisational domain which demonstrate that emotional intelligence training can be used to effectively enhance employees' emotional intelligence (Groves, McEnrue & Shen, 2008; Kirk,

Schutte & Hine, 2011). Similarly, researchers have demonstrated the effectiveness of emotional intelligence training for athletes (Crombie, Lombard & Noakes, 2011), school children (Brackett, Rivers, Reyes & Salovey, 2012; Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011; Payton, et al., 2008), university students (Reuben, Sapienza & Zingales, 2009; Schutte & Malouff, 2002), and individuals with mental health difficulties (Ruiz-Aranda et al., 2012).

### **Sub-Theme Two: Contributions of Therapist Training**

Although it makes intuitive sense that to be an effective therapist, one must be able to attend to and manage one's own and clients' emotions, six of the therapists interviewed stated that therapist training programmes did not contribute to the development of social-emotional skills:

- Giselle:** I don't think we're particularly taught what to do with that stuff (emotions). The training's probably vastly improved but I just became so aware when I graduated that I didn't know very much and I learnt off other professionals, interestingly.
- Dave:** I think universities knock it out of us...you can talk to a psychologist at a bus stop, as long as they don't know you're a psychologist and ask him something and they'll give you quite an emotional sort of response. You see them in a clinical room and they leave their feelings outside.
- Rebecca:** I have to say I was very disappointed with my training. I was thinking how clients come with a fear of their emotions and in my training we were trained almost to be frightened of them as well. So hence when the client first starts crying hysterically in my room I'm terrified, I feel totally ill equipped. It was very intellectualised.

Given that Giselle, Dave and Rebecca were all senior psychologists, one factor that may shed light on the viewpoints they described above is the socio-cultural context in which they were trained. Historically, psychology training programmes were focussed on either behaviourism or cognitions, as emotions were largely viewed as disruptive (Safran & Greenberg, 1991). As psychology was working to establish itself as a scientific discipline and emotions were largely perceived as being immeasurable, their role tended to be de-emphasised (Damasio, 1994; Kruglanski & Stroebe, 2012), potentially explaining the lack of emphasis on emotions across some therapist training programmes.

### **Sub-Theme Three: Training Activities**

In this study, therapists described training activities that they considered had contributed to their own development of social-emotional skills as well as social-emotional training activities that they viewed as useful for trainee therapists. Mandatory personal therapy, realistic role-plays, and experiential therapy groups were the most commonly discussed activities, with the former being the most prominently discussed training activity among all the therapists interviewed.

#### **Role-Plays**

Three of the therapists in this study viewed that social-emotional skills could be taught through role-plays. Bianca's perspective is presented below as an example. As well as having completed her own training, Bianca was involved in teaching trainee therapists. She described the usefulness of videotaping role-plays in groups of three (Therapist, Client and Observer) using real life situations to help therapists recognise and manage emotional issues with clients.

**Bianca:** I think it really is an active learning situation....So we'll have the students get into groups of three. One's a therapist, one's a client and one's an observer and they basically just practice and then debrief. So it's around did you pick up the feelings that your client was experiencing?... In my own training we used to video tape the sessions when we were doing counselling micro skills. So it was about bringing issues from your own lives and it was very real and the emotions are real as well. So it really is about practicing and then debriefing and fine-grained analysis of okay so, what were you feeling as a client and did the therapist pick it up and validate you? And as a therapist what were you feeling, what did you think the client was feeling? And the observer is able to ask questions and tune in as well..."so I noticed that this happened when that happened". Might be things like facial expressions or things people say or body language... If we don't include at least this kind of training in micro skills using personal issues as part of the training then there's a risk that when they become a therapist, they aren't going to be able to a) recognise and b) manage those issues with their clients

Role-plays are frequently utilised as a teaching technique in therapist training programmes (Baker, Daniels & Greeley, 1990; Corsini, 2010; Gillem, 1999; Low, 1996). While primarily used for teaching purposes, the use of role-plays has also been documented as a means of enhancing therapists' sense of self-efficacy (Larson, 1998). Anderson, Gundersen, Banken, Halvorson & Schmutte (1990) described a common scenario where students are paired up and asked to alternate between playing the roles of the therapist and client. However, one of the main criticisms of role-plays is that some trainees will lack the ability to play their roles convincingly, detracting from the learning. To circumvent this issue, some clinical psychology programmes incorporate real actors/actresses to role-play clients (e.g.

Lane, 1988). Bianca's aforementioned suggestion of using realistic role-plays based on real-life situations is a possible alternative. Further in line with Bianca's training suggestion, researchers have supported the videotape method of training in counselling (e.g. Huhra, Yamokoski-Maynhart & Prieto, 2008). Videotaping trainees facilitates the opportunity for more thorough feedback from others such as instructors and peers, while also enabling self-reflection of one's own performance. In addition, videotaping allows the pausing and re-watching of role-plays which may provide further information about performance issues that were initially missed, so that these can be discussed and addressed through further training.

### **Personal Therapy**

Eight of the therapists interviewed in this study discussed the importance of personal therapy as a means of understanding their clients' emotional experiences and dealing with their own issues so that these do not impinge on the therapeutic relationship or treatment.

**Dave:** It's the most important part of your training. My sense is, probably not mine but I believe this and it comes from somewhere, the most important part of being a therapist is to be a client... We used to have twice a week therapy for a lot of these trainings, twice a week. For analytic training it's four times a week for five years... so you know what it's like to be on the other side and to be aware of your own issues.

**Eva:** You've had to have been in therapy for at least a year and a half before you start dealing with clients yourself... As an experienced therapist, it's very important to remember or to try and remember what it was like when you first went into therapy.



- Interviewer:** In terms of what?
- Eva:** How frightening it is when you start peeling back all the layers and I can sit here and say, "Oh well, it is what it is," and you sit with a feeling and you just be with the feeling but it's also really important to remember how difficult things are...It is very exposing, you're talking about stuff that you feel ashamed about and you feel embarrassed about so how gentle it needs to be.
- Ruth:** One of my criticism is of orthodox clinical psychology is that it doesn't require personal work of psychologists. So I think it's pretty hard to be insightful and thoughtful about these issues if you don't have a good handle on yourself.
- Interviewer:** What do you mean by personal work?
- Ruth:** Therapy. Having gone and had the personal experience of therapy. My experience of people who get themselves into difficulties as therapists is that it's often because of stuff they haven't worked through themselves. At least if you've been to therapy for 12 sessions, you'll have some sense of what it is to engage in a relationship over time and become more aware of your unconscious processes and the things from your experiences that may impact on how you relate to or understand somebody else...we are just normal human beings too, but at least it makes you thoughtful about some things or aware of where your edges might be or how you react to things... I think anyone who wants to sit with a person or people and do therapy on them should have to have done some therapy as well.

Interviewed therapists' views on the importance of personal therapy were consistent with a range of studies that have described the indispensability of personal therapy for therapists' well-being (Stevanovic & Rupert, 2004), client outcomes (Sandell et al., 2006) and their professional development (Norcross,

2005). Personal therapy also heightens therapists' understanding of their personal dynamics and provides them with a first-hand experience of what it is like to be a client (Bennett-Levy, Lee, Travers, Pohlman & Hamernik, 2003); the latter has been reported as being a particularly valuable experience for therapists (Norcross, 2005). According to Norcross and Guy (2005), therapists operating from the psychoanalytic or eclectic traditions seek personal therapy more frequently as compared with therapists from other theoretical traditions, particularly behavioural therapists, who are much less likely to seek personal therapy.

Many therapist training courses require therapists to engage in personal therapy, although the number of hours vary based on the programme (Kumari, 2011). In contrast, clinical psychology training programmes in New Zealand do not require any mandatory therapy. In line with interviewed therapists' assertions in this study regarding the importance of personal therapy, Buckley, Karasu and Charles (1981) explored the value of personal therapy from the perspectives of therapists. The results found that ninety percent of the therapists viewed that personal therapy had positively contributed to both their professional and personal development. Similarly, Peebles (1980) found that therapists' personal therapy was related to greater therapist empathy, acceptance and congruence. Consistent with this, more recent research supports the value of personal therapy for therapists (Geller, Norcross & Orlinsky, 2005; Orlinsky, Ronnestad, Willutzki, Wiseman & Botermans, 2005).

### **Experiential Therapy Groups**

The last activity that interviewed therapists viewed as helpful for the development of social-emotional skills was participation in experiential therapy

groups. Experiential therapy groups describe a form of therapy that is usually carried out with a group of therapist trainees and either a facilitator or experienced therapist. These are a mandatory component of some therapist training programmes, particularly for counsellors and psychotherapists (Shumaker, Ortiz & Brenninkmeyer, 2011). Experiential therapy groups involve the processing of attendees' personal experiences with the purpose of providing a first-hand experience of the therapeutic process, as well as an opportunity to explore and work through personal issues. The group environment is also thought to provide personal meaning to the theoretical components taught as part of therapists' training programmes and enhance trainee therapists' empathy towards other group members (Brabender, Smolar & Fallon, 2004; Yalom & Leszcz, 2005). Two extracts from the current study that demonstrate therapists' experiences and perspectives regarding experiential therapy groups are provided below.

**Eva:** We'd have a group, an experiential group where we talk and there's obviously a facilitator but you talk about personal stuff, stuff that you're getting triggered about, your family stuff that's coming up.

**Interviewer:** So real life experiences?

**Eva:** Absolutely... All of those are very important things. You can read about it afterwards but you have to have experienced it as well. Some people hated that. I didn't, I loved it.

**Jamie:** They have these experiential groups, psychotherapists and actually they sit around once a week and process material so you get this processing with one or two facilitators and they simply sit there and they process and people start processing and they get to experience what it's like to have the process of and to have a listener and observer who might be doing that

with them and then others in the class get to see someone doing it and feeling their way into something. But also getting to feel themselves with what the material might bring up for them. That process feels really important.

According to Grauerholz and Copenhaver (1994), experiential activities frequently require trainees to disclose a greater degree of personal information as compared with other means of training. Elliott, Watson, Goldman and Greenberg (2004) used focus groups to ascertain the perspectives of current and former trainees on the experiential therapy group component of their training. The results found that consistent with Eva's assertions regarding the importance of these groups, the majority of informants reported that the experiential therapy group was a key aspect of their training. Researchers propose that the value of experiential groups may be enhanced if group members do not solely focus on the development of professional skills. Instead, their focus should also be on developing interpersonal communication skills, enhancing their ability to express their own emotions and addressing personal issues as they arise (Bayne & Jinks, 2010; Ieva, Ohrt, Swank & Young, 2009; Yalom & Leszcz, 2005).

## CHAPTER EIGHT

### Discussion

This chapter begins by summarising the major findings of the current study. Following this, ‘The Tree of Therapists’ Social-Emotional Interactions’ model is introduced as a visual representation of the study’s findings. The implications and limitations of this study are subsequently discussed along with recommendations for future research.

### Major Findings

This study sought to explore therapists’ views and experiences regarding social-emotional skills in practice. Using thematic analysis, one meta-theme: *The Centrality of Emotions in Therapy*, as well as four main themes: *Emotional Principles*, *Emotional Awareness Strategies*, *Emotional Practices* and *The Learning and Training of Social-Emotional Skills* were identified along with their respective sub-themes

### The Centrality of Emotions in Therapy

All the therapists interviewed in this study, regardless of their theoretical orientations, area of expertise or years of experience emphasised that emotions were at the centre of their therapeutic practice. Notably, this emphasis was not only in reference to their clients’ emotions, but also in relation to their own emotions as well. This was an important finding as different theoretical traditions tend to emphasise different aspects of therapy for therapists to attend to and work with (Okun & Suyemoto, 2012). However, the manner in which all the therapists in this study emphasised emotions suggested common roots of therapy that underlie and unite, rather than divide therapists in terms of their therapeutic practice.

## **Emotional Principles**

As well as emphasising the importance of emotions for their therapeutic practice, therapists in this study also commonly expressed two principles; the importance of emotional self-awareness and the importance of emotional client-awareness, both of which appeared to form the foundation of their practice. These principles were represented across two sub-themes. The first principle: *Importance of Emotional Self-Awareness* described therapists' beliefs about the importance of recognizing and attending to their own emotions in therapy. They described becoming aware of a range of both pleasant and unpleasant emotions during their engagements with clients, which the majority of therapists viewed as normal. In fact, therapists in this study also viewed their emotional awareness as a useful means of collecting clinical information and a way of determining their perceived effectiveness with particular client presentations (e.g. those with narcissistic personality disorder). The second principle: *Importance of Emotional-Client Awareness* described therapists' beliefs about the importance of recognising and attending to their clients' emotions in therapy. They viewed that this process of recognising and attending to their clients' emotions took place within the therapeutic relationship either consciously or unconsciously and that it helped clients to 'feel felt' and understood.

## **Emotional Awareness Strategies**

While therapists identified the importance of recognising and attending to their own and their clients' emotions, the ways in which they did that were also commonly discussed. This was captured under the *Emotional Awareness Strategies* theme which was divided into two sub-themes; *Emotional Self-Awareness Strategies* and *Emotional Client-Awareness Strategies*. The majority of therapists described

becoming aware of their own emotions by attending to their bodies or somatic sensations, such as changes in their breathing or stomach. In order to become aware of their clients' emotions, therapists described using three strategies. These were (1) asking clients how they felt, (2) attending to their clients' non-verbal cues such as their body language and (3) attending to their own emotions in relation to their clients.

### **Emotional Practices**

Interviewed therapists commonly described engaging in a range of emotional practices. These were behaviours therapists carried out in response their own and their clients' emotions. *Emotional Practices* were separated into three sub-themes; (1) *Emotional Practices – Own Emotions*, (2) *Emotional Practices – Clients' Emotions* and (3) *Emotional Boundaries*. Practices that therapists described carrying out in response to their own emotions included disclosing their emotions to clients. These emotional disclosures were carried out either to normalise their clients' experiences or to enhance the therapeutic relationship. Another practice therapists described carrying out in response to their own emotions was emotional reflection for the purpose of therapeutic clarity. Supervision was also another practice that therapists carried out in order to enhance therapeutic clarity, but also as a means of de-briefing their emotions. The final practice therapists discussed carrying out in response to their own emotions were mental and physical self-care activities.

Emotional practices therapists described carrying out in response to their clients' emotions were classified as emotion-regulation behaviours. These were reportedly employed by therapists with the intention of assisting clients to regulate their own emotions. To do this, therapists described using a range of practices to

increase, maintain, or decrease clients' emotional experiences. These practices included: labelling emotions, encouraging clients' emotional expression, acknowledging clients' emotional experiences as reasonable or understandable, demonstrating an acceptance of clients' full emotional experience, active listening, mirroring, introducing grounding techniques, and shutting down emotional discussions. The last category of emotional practices described by therapists in this study were those pertaining to emotional boundaries. These formed the context in which all therapists' emotional practices in response to both their own and their clients' emotions were carried out. Therapists described setting emotional boundaries, maintaining emotional boundaries and also crossing emotional boundaries within the therapeutic relationship when this was considered conducive to therapy.

### **The Learning and Training of Social-Emotional Skills**

Therapists in this study discussed the ways they considered they had learned social-emotional skills as well as training activities they viewed as being useful for the teaching of social-emotional skills. Three sub-themes were identified; (1) *Learning Social-Emotional-Skills*, (2) *Contributions of Therapist Training* and (3) *Training Activities*. Under the first sub-theme, therapists described their views regarding whether social-emotional skills were teachable/learnable. Despite the literature demonstrating that social-emotional skills can be effectively learned/taught (Bar-On, 2006; Bechara et al., 2007), the majority of therapists in this study considered that social-emotional skills were either innate or not entirely learnable/teachable. Several therapists viewed that they had learned social-emotional skills during their childhoods as a function of their family environment and early attachments. Interestingly, the majority of interviewed therapists



considered that therapist training programmes did not contribute to the development of social-emotional skills. This was captured under the second sub-theme and considered in light of the socio-cultural context in which therapists were trained. In the last sub-theme, therapists described three training activities they considered useful for training social-emotional skills. These activities were role-plays using real-life situations, involvement in experiential therapy groups and engagement in personal therapy. The latter was emphasised by the majority of therapists as being an essential activity for understanding clients' emotional experiences and attending to personal issues, so that these do not interfere with the therapeutic relationship or treatment.

### **Social-Emotional Skills - A Tension and a Proposal**

The majority of therapists in this study expressed their agreement with the therapy-specific definition of social-emotional skills at the outset of this research. However, two therapists disagreed with the use of the term 'skill' as they were of the view that this term neglected the interactive process that is inherent to a social-emotional practice. Furthermore, the findings of this study demonstrated a tension between the nature of social emotional skills, how therapists come to learn these and therefore, whether social-emotional skills could be trained.

As mentioned in the major findings section, the majority of interviewed therapists perceived that social-emotional skills were either innate or not entirely learnable/teachable, despite several studies demonstrating that these are able to be effectively taught and learned (e.g. Bagshaw, 2000; Groves et al., 2008; Kirk et al., 2011; Matthews et al., 2004; Slaski & Cartwright, 2003). Some therapists in the current study described social-emotional factors as being more akin to personality

characteristics and therefore, considered that these could not be taught as 'skills'. In contrast, others described having learned social-emotional skills early in life through their familial environments and the quality of their attachments. This suggests that social-emotional skills may be trainable later in life if early opportunities for such learning were missed or were not learned sufficiently to be useful for carrying out an emotionally-focussed therapeutic practice. In support of this, there were three activities that interviewed therapists discussed as being helpful for fostering a socially and emotionally focussed practice in trainee therapists. These were role-plays using real life scenarios, experiential therapy groups and engagement in personal therapy.

The literature provides evidence for both an innate (e.g. Izard, 2001) and a trainable component of social-emotional skills (e.g. Brackett et al., 2012; Crombie et al., 2011). Throughout this thesis, a variety of these works were drawn on to explicate and support both of these views as they were observed across the therapist interviews in this study. Rather than suggesting that readers opt for one perspective or the other, this thesis takes the position that both stances are equally valuable and proposes that they can co-exist. To explain, the findings of this study demonstrate therapists' stance regarding the existence of both an innate and a trained component of their social-emotional practice. That is, interviewed therapists' perceived that the ability to interact with clients in a manner consistent with social-emotional intelligence theory can be influenced by childhood experiences such as emotional socialisation (Garner et al., 1994; Saarni, 2000) and early attachments (Matthews et al., 2004) as well as later training opportunities using emotion-focussed activities such as role-plays, experiential therapy groups and personal therapy. However, therapists' ability to implement these learnings into

their interactions with clients is likely also influenced by other factors that are known to contribute to interpersonal interactions such as their personality characteristics (Daly et al., 1998; Knapp & Daly, 2002) and proficiency across other complementary skills such as active listening and social communication skills (Greene & Burleson, 2003; Hargie, Saunders & Dickson, 1994).

If practicing as a therapist in a manner consistent with social-emotional intelligence theory were merely down to 'skills', then all therapists would be equally successful in their practices. However, research demonstrates that therapists vary considerably in this area (Okiishi et al., 2006). Furthermore, the term 'skills' seems to carry a connotation of self-sufficiency. It says: 'do something in this way and if you do it well, you will master it'. Instead, it is proposed that consistent with the perspective of a participant in this study, we move away from the term 'skills' and talk about 'the social-emotional interactions of therapists'. The term 'interactions' is considered to be a more inclusive alternative to 'skills' as it speaks to the emotion-focussed process that with training, therapists can implement into their practice. However, this is not at the exclusion of innate personality characteristics, which studies have shown impact on individuals' interaction ability (Rhodewalt, 2012). Furthermore, the term 'interactions' is considered to represent both the private and observable social-emotional practices of therapists. To explain, observable social-emotional interactions are therapists' practices in response to emotions that can be observed by clients in a therapy setting. For instance, therapists' disclosure of their own emotions or their active management of their clients' emotions. In contrast, therapists also interact with their private social-emotional context through a variety of practices that are unseen by their clients. For example, their attendance at supervision or their engagement in physical and mental self-care activities.

## The Tree of Therapists' Social-Emotional Interactions Model

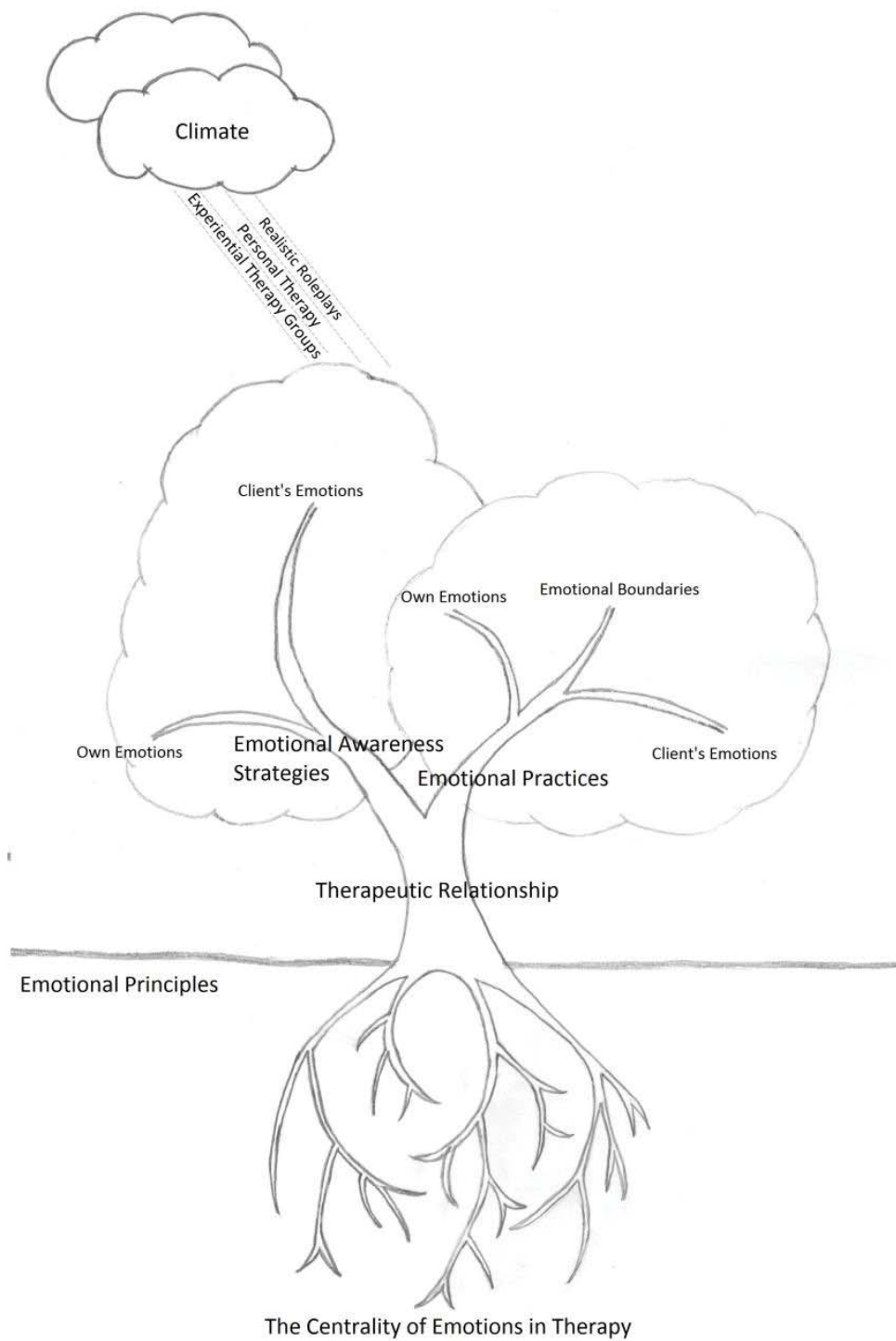


Figure 2: The Tree of Therapists' Social-Emotional Interactions

In light of the aforementioned themes and considerations, ‘The Tree of Therapists’ Social-Emotional Interactions’ model (See Figure 2) was developed as a visual representation of the study’s findings. A tree was selected for use in this model because its ability to grow fruitfully is reliant on both biological factors as well as the right climatic conditions, the latter representing the trainable elements identified by the therapists in this study. In a similar manner, the tree in this model is used to represent the social-emotional interactions of therapists’, albeit with a focus on the trainable aspects of this given that innate characteristics are much more difficult to change (Matthews, Deary & Whiteman, 2003). The Tree of Therapists’ Social-Emotional Interactions model is presented above and brief explanations for each of its components are provided below.

### **Roots**

The Tree of Therapists’ Social-Emotional Interactions is ‘rooted’ in *The Centrality of Emotions in Therapy*, consistent with the meta-theme in this study. This meta-theme was represented as the ‘roots’ of the tree to symbolise the essential role that all interviewed therapists considered emotions played in therapy, irrespective of their own theoretical orientations.

### **Foundation**

The first main theme in this study: *Emotional Principles* is represented as the foundation of the tree as interviewed therapists emphasised that their emotional practices were grounded in two beliefs: *The Importance of Emotional Self-Awareness* and the *Importance of Emotional Client-Awareness*. These were the sub-themes categorised under the *Emotional Principles* theme.

## Branches

The tree has two main branches with five further branches that split off from the two main branches. The main branch on the left hand side along with the two branches that split from it represent the strategies interviewed therapists described employing to become aware of their own and their clients' emotions as discussed in theme two: *Emotional Awareness Strategies*. The other main branch on the right hand side along with the three branches that split from it represent what therapists *actually did* in response to becoming aware of their own and their clients' emotions, consistent with the third theme: *Emotional Practices*. Within this branch, therapists described carrying out several behaviours in response to their own emotions, their clients' emotions as well as behaviours pertaining to the management of emotional boundaries. These elements are represented by the three branches that split off from the main *Emotional Practices* branch.

## Trunk

Holding all the aforementioned branches up strongly is the tree trunk, which represents the therapeutic relationship. Although not used as one of the main themes in this study, interviewed therapists discussed carrying out two of the main themes; *Emotional Strategies* and *Emotional Practices* (symbolised by the two main branches) all within the context of the therapeutic relationship. In other words, in the absence of a strong therapeutic relationship, this would not be a tree of therapists' social-emotional interactions, as the focus would merely be on therapist emotions, rather than clients' and therapists' emotions. Furthermore, without the therapeutic relationship, therapists would not be able to use strategies to become aware their clients' emotions in the context of therapy (left branch) or carry out any practices in response to these emotions (right branch). It is the therapeutic

relationship that engenders a sense of trust and safety within the therapist-client interaction and enables clients to share their emotional experiences with their therapists (Feltham & Horton, 2012). Consequently, this enables therapists to recognise expressions of emotion in their clients and carry out particular behaviours (practices) to respond to their own and their clients' emotions, while also managing emotional boundaries as appropriate.

### **Climate**

The cloud on the top, left-hand side of the tree represents the climate as well as the last theme: *The learning and Training of Social-Emotional Skills*. Just as trees require particular climatic conditions such as rain to grow optimally, therapists in this study proposed that trainee therapists could develop their social-emotional interactions in therapy through three main training activities; Realistic Role-Plays, Personal Therapy and Experiential Therapy Groups. Each of these are represented in the model by the rain drops falling down towards the tree and thereby, contributing to its development.

### **Study Implications**

As previously discussed, researchers have demonstrated that therapist factors account for significant variance in client outcomes (e.g. Crits-Christoph & Mintz, 1991), even more so than client variables (Baldwin, Wampold, & Imel, 2007) and treatment variables (Lambert & Ogles, 2004). However, the literature on therapists' contributions to therapy is both inconsistent and limited (Lambert, 2013). What is common to all therapies, regardless of therapists' theoretical orientations is the interpersonal communication that occurs between therapists and their clients. As discussed earlier, clients often present to therapy for emotional

difficulties which are subsequently relayed to therapists during therapy (Barlow et al., 2004).

The current study has advanced current knowledge by explicating therapists' views and experiences regarding social-emotional interactions within their therapeutic practice in light of social-emotional intelligence theory. The views of therapists' in this study were visually represented using the 'tree' model which can be used as a simple means of introducing trainee therapists to the emotional interactions that can take place between clients and therapists. However, it must be noted that this model was developed based on interviews with therapists who volunteered to share their views about emotions and who were already emotion-focussed in their practices. Consequently, this model may not capture the views, experiences or practice preferences of other therapists who are less emotionally focussed and/or less willing to discuss emotions.

This study also explored therapists' perspectives regarding the nature of social-emotional interactions. Specifically, the findings indicated therapists' views that innate personality characteristics, early childhood-based learning and later therapist training activities can contribute towards therapists' ability to employ social-emotional interactions in their practice. In terms of childhood-based learning, emotional socialisation, such as that which occurs when caregivers are willing to discuss and help their children label emotions highlight the importance of early relational environments that make emotions feel safe to explore and utilise within the self and others. It is suggested that such early distal experiences can be likened to 'the soil' in the 'tree' metaphor. Soil comprises of minerals, which can vary in quantity and quality between one tree to the other. The trees that have a plenitude



of good quality minerals can be expected to grow quicker and produce more fruit than a tree with less minerals of an inferior quality, which does not provide the tree with optimal foundational conditions. In a similar manner, if clients or therapists are raised in an environment that promotes healthy emotional development, they may be more inclined towards emotionally-focussed ways of relating to themselves and others as adults. However, that is not to say that those who have not had optimal minerals in their soil (e.g. through abuse or neglect) cannot grow a tree that bears fruit. According to McCrory et al., (2013) people with abusive backgrounds may actually be more perceptive to emotional cues as these were tied with a survival function.

The metaphor of the tree encourages consideration of the foundational soil, but does not propose that this necessarily determines the future of the tree. Different trees also require different forms of soil for optimal growth and in a similar manner, it is anticipated that different people, with different emotional histories may require different conditions to grow fruitfully. The training activities suggested by therapists in this study and represented as the 'climate' are also not necessarily the most suitable for different kinds of people but represent merely a starting point that may prove optimal for some types of trees and less so for others. As further research is carried out in this area, the proximal climatic conditions (e.g. mandatory therapy, realistic role-plays, and experiential therapy groups) can be adapted to suit different people based on their foundational experiences but also their preferred theoretical orientations in the context of therapy.

Interestingly, some of the areas identified by interviewed therapists as core components of a social-emotional practice in the current study (e.g. emotional

awareness and 'climate' or therapist developmental activities) were consistent with Marwick's (2016) work which documented the importance of similar areas, albeit describing them with different terms and identifying them through a different methodology. Moreover, this research has provided preliminary insights regarding how therapists' 'social-emotional interactions' may be a useful and more inclusive concept for understanding the duality in the ways that therapists work with their clients' emotional experiences, while also being aware of and managing their own emotional experiences in therapy.

Although concepts such transference and countertransference have been used by some researchers to discuss therapists' and clients' emotions in therapy, these concepts are embedded in psychoanalytic and psychodynamic theories which explicate the source of emotions in terms of therapists' past conflicts and relationships. Similarly, the concept of emotional contagion has also been used to discuss how therapists can essentially 'catch' emotions from clients and vice-versa. This research has distinguished between the concepts of therapists' social-emotional skills, countertransference and emotional contagion. In doing so, it initially proposed social-emotional skills as a broader and more inclusive concept for understanding therapists' emotions as this can encapsulate countertransference without placing restrictions or theoretical binds on the source of therapists' emotions. To further refine this, the concept of 'social-emotional interactions' was subsequently proposed in line with two interviewed participants' views as this term encompasses both the innate, learned and trainable components of a socially and emotionally focussed therapeutic practice.

As other studies have demonstrated that social-emotional skills can be effectively taught and learned (Bar-On, 2006; Bechara et al., 2007), understanding therapists' social-emotional interactions and how elements of this may be developed in trainee therapists also has important implications for clinical training. As an initial starting point, with further research and refinement, the concept of social-emotional interactions can be introduced to trainee therapists as a means of enhancing their emotional awareness and encouraging their reflections on the social-emotional components of their practice. Furthermore, therapists in this study identified three training activities (role-plays using real life situations, personal therapy and experiential therapy groups) that they viewed as important contributors to the development of a socially and emotionally focussed practice. With further research, these activities can be incorporated into clinical training programmes both within New Zealand and abroad to develop trainee therapists' social-emotional interactions prior to their engagement with clients. This would be particularly beneficial given that other researchers have demonstrated the importance of therapists' emotional skills for therapist competence, self-efficacy (Easton et al., 2008; Martin et al., 2004), empathy (Miville et al., 2006), the supervisory relationship (Cooper & Ng, 2009), client outcomes, client drop-out and client assessment compliance (Kaplowitz et al., 2011; Rieck & Callahan, 2013).

### **Study Limitations**

As with all research, there were limitations in the current study. The first limitation relates to participant demographics. It was hoped that recruited participants would be a mixture of both male and female therapists from different therapy disciplines such as counsellors, psychotherapists and psychologists. Instead, out of the ten participants in this study, there were only two male therapists

and all but one of the ten participants were psychologists. As therapist training varies depending on discipline and therapists' views and experiences may differ based on training, this research may have captured different views and experiences had it involved more psychotherapists and counsellors. Similarly, although the views and experiences of the interviewed male participants seemed consistent with the views and experiences of the female participants, differences may have been observed had more male participants been recruited to this research.

Another limitation in this study was a potential self-selection bias during recruitment. To explain; given the research was advertised as a study on therapists' social-emotional skills, it is likely that only therapists who already viewed this as important were willing to participate. This suggests that the views and experiences of therapists who place less value on emotional practices were not represented by the current research. Furthermore, unlike the research on master therapists, this study did not pre-select therapists with exemplary practices to participate. As such, there was no way of determining whether the interviewed therapists' views and experiences were consistent with exemplary therapeutic practices or not.

The initial use of the term 'skills' to discuss therapists' social-emotional interactions in the participant interviews is considered a further limitation of this study. This term was initially adapted from the literature to replace the phrase 'therapists' social-emotional intelligence' as it was thought that this was biased towards the innate components of a socially and emotionally focussed practice, at the exclusion of the learned or trainable components. However, based on the feedback of two participants, this is acknowledged as a limitation as the term 'skills' may have been biased in the other direction due to its focus on the learned and

trainable components of a socially and emotionally focussed practice, at the exclusion of the innate contributors. In attempt to address this limitation, the research adopted a participating therapists' suggestion and used the phrase 'social-emotional interactions' of therapists in the latter part of the thesis as this concept was thought to combine both the innate, learned and trainable components discussed by interviewed therapists. Furthermore, this phrase was also used to develop 'The Tree of Therapists' Social-Emotional Interactions' model which was proposed as a summary and visual depiction of the study's key findings.

Although the ten interviews in this study yielded a rich source of data, the interviews were one-off and limited by time constraints. This may have limited the information that could have been collected from therapist participants regarding their views and experiences of social-emotional interactions. Finally, although therapist participants appeared to speak openly and freely regarding their views and experiences, given the potential sensitivity of the topic area, there may have been social-desirability effects. For example, some therapists may have minimised or avoided discussing negative emotions they had experienced towards clients (Grimm, 2010).

### **Recommendations for Future Research**

As therapists' social-emotional interactions are currently under-researched, there are several possibilities for future research in this area. Given the demographics in the current study, it is recommended that this study be replicated with a broader range of therapist disciplines (counsellors, psychotherapists and psychologists) to explore their views and experiences of social-emotional interactions and determine whether these differ based on training. If this study were

to be replicated, it would be ideal to have two rather than one interview with each therapist-participant in order to reduce time constraints and enable further dialogue. The first interview could be focussed on exploring therapists' views and experiences while the second interview could be used to follow up on information attained from the initial interview. It would also be ideal to include more men in the replication study as well as more therapists with less therapy experience to explore any differences in therapists' views and experiences about social-emotional interactions that may be related to gender or experience.

In the current study, some participants discussed crossing boundaries in the context of their therapeutic work with clients. A future research project could explore whether such boundary crossings tend to be preceded by the presence of positive (as opposed to negative) emotions on the part of therapists. It would also be interesting to explore therapists' perceptions regarding the ease or comfort with which they would be able to disclose negative or positive emotions towards clients. For example, is it easier to take feelings of dislike towards a client to supervision or feelings of liking a client? Which feelings are viewed as being more or less acceptable?

Despite this research being qualitatively oriented, quantitative directions for future research in this area are also possible. Reliable and valid measures of social-emotional intelligence are available (e.g. SEIP-SV, Belsten, 2010, MSCEIT; Mayer, Salovey & Caruso, 2000 and EQ-i; Bar-On, 1997). One of these can be used to assess therapists' social-emotional intelligence to examine whether this relates to aspects of the therapeutic process and client outcomes. For example, whether therapists' social-emotional intelligence relates to their ability to accurately identify their

clients' emotions in session, their ability to form a therapeutic alliance with their clients or whether therapists' social-emotional intelligence contributes to changes in their clients' symptoms across a pre-selected number of sessions. It would be interesting to include client participants in such a study as well and have them rate therapists in terms of observed social-emotional factors.

Finally, given that this study identified training activities that therapists viewed as particularly useful for the development of social-emotional interactions, it would be valuable to ascertain the perspectives of trainee therapists in clinical psychology programmes about participating in these activities. Consequently, any barriers to participating in such activities can be addressed. Trainee therapists' social-emotional interactions could subsequently be assessed using an aforementioned measure of social-emotional intelligence prior to participating in these activities and afterwards to determine whether they effectively enhance trainees' social-emotional interactions. It is hoped that with further research and the availability of such training opportunities, that both highly experienced or trainee therapists alike will feel encouraged, supported and well-equipped to maintain a focus on social-emotional interactions at the heart of their psychotherapeutic practice. Consequently and perhaps most importantly, it is further hoped that clients' experiences in therapy will be also be richly benefited by therapists' integration of social-emotional interactions within their practice.

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## APPENDICES

### Appendix A: Ethics Approval Letter



Dear Verena Boshra

Re: Ethics Notification - 4000015215 - **Getting the Feel of Therapy: Therapists' Accounts of Social-Emotional Skills in Practice**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please go to <http://rims.massey.ac.nz> and register the changes in order that they be assessed as safe to proceed.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

**A reminder to include the following statement on all public documents:**

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research."*

*If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director - Ethics, telephone 06 3569099 ext 86015, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).*

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Dr Brian Finch  
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

**Research Ethics Office, Research and Enterprise**  
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 350 5573; 06 350 5575 F 06 355 7973  
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## Appendix B: Participant Information Sheet



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North Shore Mail Centre  
Auckland, 0745  
T 64 9 414-0800 extn 41244  
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### INFORMATION SHEET

#### *Getting the Feel of Therapy: Understanding Therapists' Views and Experiences Regarding Social-Emotional Skills in Practice*

My name is Verena Boshra and I am currently studying towards a Doctorate in Clinical Psychology at Massey University. As part of my degree, I am required to complete a doctoral-level research (thesis). My research is interested in gathering therapists' views and experiences regarding social-emotional skills within the context of their therapeutic practice. I would like to invite you to take part in this study and would be very grateful for your participation.

Currently, there is a wealth of research regarding the usefulness of social-emotional skills for effective interactions. Within psychotherapy research, the majority of research has focused on the efficacy of different therapeutic interventions for the treatment of specific problem presentations. However, the research regarding therapists' contributions to therapy is more limited. Even more limited is the research regarding how social-emotional skills are used by therapists to assist the therapeutic process and client outcomes. This study aims to not only add to the literature in this area, but contribute to a foundation of research that can be used to inform therapist training programmes in New Zealand and overseas.

According to the literature 'Social-Emotional Skills' describe a set of competencies that enable individuals to be aware of their own and others' emotions and then draw on that information to manage their social interactions effectively. As a therapist, you are in a unique role that involves regular engagement with emotions, sometimes on a daily basis. The clients who walk through your door this week may be carrying anger, sadness, anxiety, or all of the above. I am really interested in learning about how you manage your emotional interactions with clients and your perceptions regarding the impact this has on the therapeutic process and client outcomes.

Participation will involve attending one semi-structured interview with the researcher which will take approximately 45 minutes to one hour. The interview will be carried out face-to-face at a time and place that is convenient for you. A \$20.00 petrol voucher will be provided to cover your time / travel costs. The interview will be audiotaped and transcribed for analysis. Your information will be securely stored in a locked filing cabinet and kept for 10 years. All audiotapes, transcripts and data will be destroyed after 10 years. To ensure confidentiality and anonymity, your name will only be known to myself and your interview audiotape and transcript will be identified using a pseudonym. This pseudonym will also be used in all analyses and publications. You will have an opportunity to review your interview transcript should you wish to do so prior to the finalisation of the results.

Although your contribution to this research would be highly valued, participation is completely voluntary. If you do decide to participate, you have the right to decline to answer any questions. You have the right to ask for the tape to be switched off at any time during the interview and withdraw from the study at any time without having to provide a reason. You also have the right to ask any questions about this study and be given access to a summary of

the project findings at the conclusion of this research. Although excerpts from your transcript may be included in the thesis, you will not be identifiable as any material which could personally identify you, including your name, will not be used in any report of this study.

If you have any questions or would like to discuss this study further, please contact me via email: [Verena.Boshra@gmail.com](mailto:Verena.Boshra@gmail.com). Alternatively, you can contact my supervisor, Dr. Shane Harvey on (09) 414 0800 Ext 81742.

Thank you for taking the time to read this information sheet and I hope you will consider participating in this valuable research.

**Verena Boshra**  
Doctoral Candidate

**Dr. Shane Harvey**  
Clinic Director and Senior Lecturer, Massey University

*This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.*

*If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director - Ethics, telephone 06 3569099 ext 86015, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).*

## Appendix C: Participant Consent Form



**Massey University**  
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### CONSENT FORM

*Getting the Feel of Therapy: Understanding Therapists' Views and Experiences Regarding Social-Emotional Skills in Practice*

I confirm that I have read and understood the information sheet which outlines the study on therapists' views and experiences regarding social-emotional skills in practice. I have had the details of the study explained to me and have had an opportunity to ask questions and discuss this study. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand that:

1. Taking part in this study is voluntary and that I have the right to withdraw at any time and/or decline to answer any particular questions.
2. My participation is confidential and that no material which could identify me will be used in any reports on this study.
3. The researcher will be audiotaping the interview and then the interview will be transcribed using a pseudonym to protect my anonymity.
4. My responses will be analysed for the purposes of this research and that excerpts of some of my responses may be included as direct (but anonymised) quotations.
5. The results of this project may be published but my anonymity will be maintained and any personal information will remain confidential.

Based on the above information and the information contained within this study's Information Sheet, I \_\_\_\_\_ (Full Name)  
agree to participate in this study.

My contact details are as follows and I am happy to be contacted in relation to this study:

Contact Number:

Contact Email:

Signature: \_\_\_\_\_ Date \_\_\_\_\_

At the conclusion of this study:

Would you like to receive a summary of the results?

YES/NO

## Appendix D: Semi-Structured Interview Guide for Participants



### Semi-Structured Interview Guide for Participants

Thank you for agreeing to participate in this research. I am really looking forward to speaking with you about your experiences and opinions regarding Social-Emotional Skills within your practice. This document will provide you with an idea of the areas we will likely cover during the interview, should you wish to ponder some of these in advance. The interview does not require any preparation ahead of time. However, this document can be referred to if you would prefer to have an idea of the likely discussion areas before your interview.

Please note that as the interview will be carried out using a semi-structured format, it will run more like an open conversation, where some areas may be elaborated on more than others depending on the flow of the discussion. During this interview, you will be viewed as the expert on your own experiences and opinions. All of your identifying information will remain confidential. As a researcher, I am really interested in your views and perspectives, so there are no right or wrong answers. Please ensure that you also raise points that you may think are relatively obvious as these may not be obvious to myself or others.

The interview will begin with the collection of basic demographic information about you and your practice so that these can be used to describe the sample of participants from which data were gathered.

The following sections may not be addressed in the order specified below depending on the conversation, but generally, the interview will cover the following areas:

- How you understand and conceptualise Social-Emotional Skills.
- The role and use of emotions within your practice. In this section, I will be really interested to understand not only how you respond to your own emotions in session, but how you typically respond to client emotions as well.
- How you picked up Social-Emotional Skills.
- The outcomes of using Social-Emotional Skills for you as a therapist, for your clients and for your practice as a whole. In this section, I will ask you to reflect on two specific clients you have worked with: one whose outcomes you were very pleased with and another whose outcomes you were less pleased with. You will not be asked any identifying questions about these clients as the questions will be focussed on your work with them. You may wish to select these clients ahead of the interview but this is not necessary.
- The final section will gather your views around advancing research in this area and any potential barriers that may hinder research into Social-Emotional Skills.

I hope that the above provides a brief outline of what you can expect during this interview. Please note that once your interview has been transcribed, you will also be provided with an opportunity to review your transcript to ensure that it reflects your opinions/experiences.

Warmest Regards,

Verena Boshra  
 Doctoral Candidate  
 Massey University

## Appendix E: Researcher's Semi-Structured Interview Prompts

### Therapists' Social-Emotional Skills in Practice

#### Interview Prompts

#### Demographic Information

1. Gender:                      Male    Female
2. Age:
3. Ethnic Group:
4. Professional Degree / Licence Type (e.g. counsellor/psychologist/psychotherapist):
5. How many years have you conducted individual therapy with clients?
6. How many hours per week do you spend conducting individual therapy across all work settings?
7. What is the main theoretical orientation that you tend to use with clients?

#### What are 'Social-Emotional Skills' and how do therapists use them?

1. The concept of 'Social-Emotional Skills' has been appearing in the literature over the last two decades. What springs to mind when you hear this term?
2. The literature defines (SES) as a set of competencies that enable individuals to be aware of their own and others' emotions then use that information to manage their interactions effectively.
  - a) What are your thoughts about this definition?
  - b) What role do emotions play in your practice/work?
  - c) How do you know how you/ your clients' are feeling during sessions?
  - d) Clients typically express emotions in therapy – what is your response?
  - e) What about with your own emotions?
  - f) Which social-emotional skills are important for your practice?
  - g) Could you give me some examples of how you would use these?
3. Are social-emotional skills something you work on? If so how?
  - h) What do you do to be more \_\_\_\_\_ (e.g. emotionally aware/empathetic)?
  - i) How do you prepare to be \_\_\_\_\_ (e.g. emotionally aware/empathetic)?
  - j) How do you use \_\_\_\_\_ to guide your practice?

#### Where do therapists pick up Social Emotional Skills?

4. Where do you think you picked up social-emotional skills / how to use them?
  - a) What
  - b) Where
  - c) How
5. What is your opinion about whether SES are innate?
6. If you were to teach therapists, what would you teach them about SES?
  - a) How might you teach this?
  - b) What are some of the challenges with teaching SES?
  - c) What is the best time/context to teach SES?
7. To what extent do you think experience in delivering therapy influences the social-emotional competency of therapists?
  - a) How do therapists use their experience to influence their social emotional practice?

**What is the outcome of using Social Emotional Skills (for therapists/clients/practice)?**

1. What makes the most difference when it comes to client outcomes?
2. How influential is the therapeutic model that the therapist uses?
3. In your view, how do therapists' use emotions to influence:
  - a) The client-therapist relationship?
  - b) Clients' symptoms and functioning?
  - c) Client satisfaction?
  - d) Whether a client returns for additional sessions or DNAs?
4. Are there SES that you tend to model to clients during therapy sessions? If yes:
  - a) Which ones?
  - b) How do you model this?
  - c) What guides this?
  - d) What impact have you noticed this having on clients?
5. Please describe a situation where you found it really difficult to engage with a client.
  - a) How did you get around that to maintain rapport?
6. Please think about two clients you have worked with in the past, one who therapy went really well with/you were pleased with their outcomes and the other who therapy didn't go so well with/you were much less pleased with their outcomes.
  - a) In retrospect, what do you consider accounted for the different outcomes in these cases? (if self/client – ask: what about self/client?)
  - b) Where there any differences in the social-emotional skills you used with each of these clients? If so, can you please speak to these differences?
  - c) What do you think your emotions were telling you in each case?
  - d) What did you do with these feelings?
  - e) Did either of these cases lead you to change your practice in subsequent sessions or with future clients?

**My Journey and Barriers for Research**

7. When have you talked/thought about SES before? In what context?
8. Thanks very much for being part of this study and talking openly with me about your views.
  - a) Is there anything that we haven't touched on that you'd like to comment on?
  - b) Just before we finish, I'd like to briefly tell you about my journey to this research and get your impressions.....what do you think may have accounted for this?