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Understanding the Link Between
Emotional Recognition and Awareness,
Therapy, and Training

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

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Abstract

Therapy is an emotionally laden event, both for individuals seeking therapeutic intervention and the therapists who provide it. While the recognition of emotions in the general population has been a popular topic of research, very little research has been conducted into the emotional competencies, or more specifically, emotion recognition and awareness of therapists. In addition, there are few studies on the effectiveness of emotion recognition training for therapists' emotional competencies, which is surprising given the innately emotional moments that clients and therapists experience during therapeutic work. This study aimed to address these gaps by investigating the association between emotional recognition, awareness, practice, and training. Fifty five therapists made up of clinical psychologists, counsellors, and a psychotherapist completed an online task that involved completion of a social-emotional orientated questionnaire and an emotion recognition task. Of these 55 participants, 26 completed an emotion recognition training before completing the same task again, two weeks later, while the remainder 29 participants were instructed to participate in no emotion recognition training. The results revealed that, compared to the no treatment condition, those who received emotion recognition training were more accurate in their recognition of emotions and also reported higher use of therapeutic emotional practice.

Unexpectedly, participants who completed emotion recognition training reported less emotional awareness than the control group. Related to this, an inverse relationship was found between emotion recognition ability and self-reported emotional awareness, as well as the finding for some support for an inverse relationship between emotion recognition ability and self-reported use of emotional practice. There are two implications of this research; first, emotion recognition training increases therapists' accuracy in emotion recognition, and second, therapists may need to be provided

emotional practice feedback by an alternative form rather than through supervision or client outcome. This is due to an inverse relationship being found between participants' actual and perceived emotional awareness. Therefore, future research into social-emotional practices and client outcomes will be advised to be considered. The limitations of the study and areas for future research are also discussed.

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Dedication

To my parents, Craig and Sue,

Thank you for everything -

This is for you.

Prologue

I was interested in mental health and treatment when I first met my supervisors. I had found my undergraduate papers fascinating, especially those on behaviour and cognition, and I had investigated the relationship between rumination and depression as part of a directed study. After listening to my supervisors' research backgrounds, it appeared evident that not enough research had been conducted on emotion in therapy, and especially in relation to therapists' emotional skills. This surprised me. I found it difficult to understand why emotion, which I could envisage being at the forefront of therapy, had not received much research interest. Would it be helpful to study emotion in therapy? My honours research topic was created from these discussions and wonderings.

My inquiry began when I investigated the relationship between therapists' emotional practices and their ability to recognise emotion in my honours research. I also compared the accuracy of therapists' emotional awareness with how accurate they perceived themselves to be. Support was found for the use of emotional skills to positively influence therapists' ability to recognise emotion, and for greater feedback needed for therapists' regarding their emotion awareness skills. However, several questions were left unanswered, and out of these questions my current doctorate research emerged. Would a training specifically aimed at improving emotion recognition ability have an influence on therapists' emotional practice and awareness? Are such skills able to be learnt and/or improved? Consequently, the core aim of this current project is to investigate the effectiveness of emotion recognition training on therapists' practice, as this gap was evident within the literature. If support can be found for emotion recognition training and thereby increasing therapists' ability to recognise client emotions', then it could be hypothesised that the implementation of such training

could lead to positive therapeutic outcomes. Since therapy is an emotional interaction, possible beneficial outcomes of training could include therapists being better able to recognise their clients' emotions in therapy as well as how they respond emotionally during therapy.

Throughout my research journey I have considered what potential barriers could explain the lack of research on therapists' emotional skills. A potential explanation that seemed to be continually evident was therapist apprehensiveness to participate. Based on my own and others' experience conducting emotion-based studies, it was often difficult gaining therapist participant interest and maintaining participation. On reflection, I could see how such apprehension could form. It could be intimidating; being deemed a qualified mental health professional and having your emotion skills tested, as surely a therapist would do well at such task, right? After all, is therapy not a space for people to discuss and address their emotions? Is it expected that emotional skills are taught to therapists so they become proficient at recognising emotion? As a real life example of the apprehension I am referring to, I distinctly remember discussing my research with a healthcare professional at a casual event; they appeared shocked that such research was being conducted, and seemed to feel challenged and intimidated at the thought of participating.

Thinking about my own training to become a therapist, emotion was not a topic that was dealt with extensively, unlike the emphasis placed on cognitions and behaviour. Emotion-based therapies were discussed in my training, but discussions were very few regarding emotion recognition, how this might influence practice, and/or possible implications of such moments. In a practical sense, it personally was not until my internship year during supervision when the importance of client emotions became particularly evident to me. Some of the most challenging questions my supervisors

asked me were my perceptions of my clients' feelings. I remember feeling hesitant answering these questions, as I often had an opinion but I felt it was based on intuition rather than something I had explicitly been taught. Maybe the feeling I had in these moments was a demonstration of how therapists might feel about participating in emotion research. Are there right answers when it comes to emotion recognition, and if so, how do you know if you are right? Is it something that can be taught and improved?

It was, and still is, exciting to be contributing to an area of limited research that involves the profession I am striving to be a part of. My hope is that this research will encourage a discussion about the importance of emotion recognition in therapy. In addition, I hope this will provide thought for those constructing therapist training programmes; that emotion recognition will be considered as a topic in the therapist-training curriculum. If emotion recognition training was found to have a beneficial effect on client outcomes, then it would seem appropriate for therapist training programme providers to teach skills to allow training therapists to recognise their clients' emotions. Furthermore, doing so would enable therapists to be competently responsive to the emergence of emotion in therapy. I have experienced the positive impact of accurately reflecting to a client the emotion they were referring to during therapy. My impression of such moments is it communicates to the client that their therapist is engaged and understands their world. This in turn promotes a stronger therapeutic relationship. Furthermore, teaching emotion-based skills to therapists may improve their confidence in handling emotions, enabling them to view emotions as opportunities to foster rapport and change rather than a powerful force to avoid.

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List of Abbreviations

Acronym	Full Name
η_p^2	Partial Eta Squared
η^2	Eta Squared
ANOVA	Analysis of Variance
AU	Action Unit
CCA	Canonical Correlation
EPFS	Emotional Practice Film Stimulus
EQ-i	Emotional Quotient Inventory
ERA	Emotion Recognition Ability
FACS	Facial Action Coding System
IBM	International Business Machines
M	Mean
MOSS	Method of Successive Sorts
PCA	Principal Components Analysis
SD	Standard Deviation
SD Card	Secure Digital Card
SEA	Self-reported Emotional Awareness
SEP	Self-reported Emotional Practice
SETT	Subtle Expression Training Tool
SPSS	Statistical Package for the Social Sciences
TEIQue	Trait Emotional Intelligence Questionnaire
TSEIQ	Therapist Social-Emotional Interactions Questionnaire
TSEIQ-R	Therapist Social-Emotional Interactions Questionnaire Revised

Introduction

Books and articles have been written about the topic of emotion, and many authors and researchers have dedicated their time, resources, and indeed, their lives to its study.

More specifically however, there are very limited writings and research conducted on therapists' ability to recognise emotion in their clients, their emotional competencies, and whether they can be trained in emotion recognition. This is astounding given the prominence of emotion in the therapeutic setting. Also, surprisingly little has been developed to enhance therapists' recognition of emotions in the therapeutic setting. The emotion literature lacks a clear consensus, making it a complex topic to research.

Debate ranges around the definition of specific emotions, how these are classified, and the universality of emotional expression and recognition. Furthermore, different theoretical views of emotion exist, and methodological concerns are often raised with studies. Since a comprehensive review of emotion literature is unfeasible for this thesis, a brief overview of the early and current research on emotion follows, as well as a presentation of the literature supporting the need for research to investigate therapists' accuracy in emotion recognition and their emotional competencies. Subsequent sections include the methodology, data analysis and results, discussion, suggestions for future research, and ends with an overall conclusion of the current study.

Chapter One: Literature Review

Machado, Beutler, and Greenberg (1999) argue emotion is especially relevant to psychotherapy and psychotherapy research. However, little has been done to identify and measure the role emotions and emotional awareness has in effective therapy.

Emotions are innately important in therapy; clients are motivated to seek therapy for emotional difficulties, therapy itself is an emotional process for both clients and therapists, and therapists are guided by the presence of emotions in their clients and themselves. It is logical to assume therefore that an effective therapist needs to be aware of their clients' emotions, as this awareness of emotion is used to actively guide the therapeutic process.

To understand the role of emotions and emotional awareness in therapy, it is imperative to first understand how emotions are defined, positioned, and operationalised. Although emotion per se has received much attention in the research literature, an established definition of emotion remains elusive. Scherer (2005) highlights this problem when he stated no accepted definition of emotion exists. Scherer argues this failure to arrive at a common consensus of agreement in the definition has been detrimental to the field, as it is difficult to uphold discussions about emotion when there is no firm consensus as to what it is. Different theories also exist as to how emotions are generated, adding an additional layer of complexity to attempts at defining emotion. For example, Darwinist's would argue that emotions are neuropsychological in nature, shaped by both biology and the environment (Izard, 1992). Other theories centre on emotion being influenced solely by biology (Buck, 1999), both psychobiology and culture (Scherer, 2009), and some view emotion as being purely socially constructed (Boiger & Mesquita, 2012).

Despite different theories of emotion generation existing, a rare general consensus amongst scholars is that emotion can be transmitted visually through the face and accordingly received and interpreted by others. The face is therefore an important source of emotion-based information in the understanding of others' emotion. There is extensive research regarding the universality of facial emotion expression and interpretation, largely driven by Dr Paul Ekman and his colleagues (i.e., Ekman & Friesen, 1969a, 1971, 1986, 2003; Ekman & Heider, 1988; Ekman et al., 1987). However, refuting arguments against the universality concept do exist, for example Lisa Feldman Barrett's (2006) work, although her opinions appear to be less well received within the literature.

Emotion, and the function or purpose of emotion, is essential to understand. We know that emotion can serve to enable communication (Elfenbein, Polzer, & Ambady, 2007) and more specifically, emotion recognition is seen as an important skill for empathetic responding and social functioning (Owen & Maratos, 2016). Consequently, in order to appropriately communicate with others, one needs to be able to accurately recognise one's own and others' emotional states, as doing so provides us with information regarding others' thoughts and feelings (Lawrence, Campbell, & Skuse, 2015; Shapiro, 2011). Proficiency in emotional skills would no doubt be advantageous for everyday life, and it stands to reason that accurately recognising emotion would be helpful for professionals who directly encounter emotion, such as therapists.

With these ideas in mind, it can be safely assumed that effective therapeutic practice is guided by the intelligent use of emotion. Clients often attend therapy because of emotional difficulties they experience, and the delivery of therapy requires recognising, raising awareness of, sitting with, verbalising, and intervening with emotions. Accordingly, it could be hypothesised that a therapist who was proficient at

recognising their clients' emotion would be likely to be accurate in noticing, interpreting, and responding to emotion within their therapeutic practice, and this could very well correspond with better therapeutic outcomes.

While many studies have been conducted on the mechanics of facial expression of emotion, limited research has involved community-based samples (Owen & Maratos, 2016), and almost no research has been conducted on therapists' ability to recognise emotion. Consequently, there is a dearth of research on therapists' emotion recognition abilities and accuracy (Domico, 2010), and how it influences therapeutic practice. This is surprising, and also concerning, given the importance for therapists to recognise clients' emotion when working therapeutically.

Johnsen (2013) was the first known study to investigate the association between therapists' social-emotional practice, their ability to identify facial emotion, and their perceived emotional awareness. The current study intends to extend upon this research to further address therapists' emotional competencies by investigating whether an emotional training intervention influences therapists' emotional recognition, practice, and awareness. Three core research questions stem from this query: first, does an emotion training intervention (which is aimed at enhancing individuals' skills in emotion recognition) increase therapists' ability to accurately identify expressed client emotion in therapy; second, does an emotional training intervention influence therapists' self-reported use of emotion in their therapeutic practice, and; third, does an emotion training intervention influence therapists' self-reported emotional awareness. Such investigations will provide insight into how therapists may handle clients' emotion, an area in need of research attention.

To provide some background to the ideas linking emotion within the therapeutic setting, a brief overview of the emotion literature will be provided first. This will

highlight early research on emotion, followed by a discussion of the notion of emotion universality and the most widely used measuring system for emotions. A brief review of some emotion theories follows, before providing a more specific evaluation of emotion in therapy, emotions in relation to therapists, and the potential for emotion recognition training for therapists. The section concludes with a description of the foundational research, along with the hypotheses and aims for the current study.

Emotion and Universality

Early research on emotion. Sir Charles Bell, a Scottish surgeon, was an early writer of empirical research on facial emotion expression. His research was published in *Essays on the Anatomy of Expression in Painting* in 1806, presenting the value of considering anatomy within the fine arts, especially for painting. Bell was of the opinion that if artists were to devote more of their attention to the face and its proportions, they would create paintings of higher quality. Bell's research received attention from Darwin who went on to conduct studies on facial expressions to refute Bell's claim that God deliberately gave humans facial muscles so they could express emotions exclusive to them alone (Domico, 2010). Darwin (1872) also felt Bell had neglected to delve into why different muscles are engaged when one feels differing emotions. In addition, Darwin was of the belief that facial emotional expressions are a universal phenomenon, which was largely based on his view of emotions being influenced by biology (Domico, 2010). Darwin also believed that there were core emotions, which was to the contrary of French physician and physiologist Guillaume-Benjamin-Amand Duchenne's (de Boulogne) view that there were dozens of separate emotions (Snyder, Kaufman, Harrison, & Maruff, 2010). Duchenne de Boulogne research found differences in peoples' ability to voluntarily move facial muscles or groups of muscles, and also found evidence to suggest that muscle movement associated with genuine emotions are more

difficult to activate voluntarily (Gosselin, Perron, & Beaupré, 2010). However, since Darwin's work and arguments many studies have been conducted regarding the universality of emotions, and the majority of these studies have found support for such a notion. Facial expression as a means of emotional communication has continued to be an area of interest since Darwin's ground breaking research, including his writings on the evolution of emotion expression in mammals (Bassili, 1979; Snyder et al., 2010).

The nature of emotion expression. There is a general consensus that a core channel through which emotion is conveyed is through the face. The face is viewed as the principal means of emotion expression (Leathers & Eaves, 2008; Richmond, McCroskey, & Hickson, 2012). This is because when emotions are felt, visual signs are reliably produced on the face (Ekman & Friesen, 2003). Sato and Yoshikawa (2007) highlight that facial expressions would have been an important part of evolution as they would have not only aided collective decisions to be made during potentially life threatening situations, but also been important during the formation of intimate relationships with others. Accordingly, analysis of the face provides humans a rich source of information about others'; it allows contemplation of temper, interests, and intent, as well as permits direction of our resources to appropriate stimuli (Haxby, Hoffman, & Gobbini, 2002). Haxby et al. (2002) state the identification of facial expression to be one of the most developed human perceptual abilities.

Ekman and Friesen (1969a) argue that if verbal accounts of emotion are an accurate representation of facial emotion expressions and body movements, then there would be no need to conduct research on facial expressions of emotion. However, this is clearly not the case and discrepancies exist. The notion of universally expressed emotion has become largely championed by Ekman and his colleagues, who have produced an extensive evidence base supporting this.

Universality of emotion identification. Ekman et al. (1987) argued against the view that facial expressions signified different emotions across cultures. Instead, they found support for accurate identification across cultures occurring with seven primary emotions; anger, contempt, disgust, fear, happiness, sadness, and surprise (Ekman & Friesen, 2003; Mehta, Ward, & Strongman, 1992). Contempt as a defined universal emotion was added more recently to the original list of six (Ekman & Friesen, 1986; Ekman & Heider, 1988; Matsumoto, 1992).

Many studies have sought to compare facial emotion recognition cross-culturally. Ekman and Friesen conducted multiple connected studies in 1969, as well as many following this, which included different participant populations with the core aim of investigating whether there was support for the universality of emotion. For some examples of such research, Ekman and Friesen (1969a) showed participants photographs of male and female faces to individuals from different cultures. Participants were college educated and from Brazil, the United States, Argentina, Chile, and Japan, as well as two preliterate cultures who had widespread contact with Western cultures; the Sadong of Borneo and the Fore of New Guinea. The aim of these studies was to elucidate whether the same facial expressions would be given the same emotion label irrespective of the viewers culture. The participants were asked to select which emotion they believed to be portrayed in the photograph from a specified list. Overwhelmingly, the participants identified the same facial expressions with the same emotion labels, although the association for the preliterate culture was not as strong (Ekman, Sorenson, & Friesen, 1969). Others replicated Ekman and Friesen's work with different groups and found corresponding results, for example Izard (1968). This was despite Izard working independently from Ekman and Friesen, and he also used a different stimulus set.

Although Ekman and colleagues interpreted their results as support for universal facial expressions, it was possible there was another explanation of the results. Since the cultural groups involved in Ekman and Friesen's (1969a) study had exposure to mass media it could be possible that they had learnt the facial expressions of their culture, and they did receive criticism for this. To address this potential alternative explanation, Ekman and Friesen (1971) constructed a study with the aim to provide clarification as to whether emotion labelling of facial behaviours are influenced by their exposure to presentations of facial expressions through media. Their study involved participants from the Fore of the South East Highlands of New Guinea, who had no exposure to mass media. The participant inclusion criteria were for individuals to not have seen any movies (neither in English or Pidgin), not having resided in any Western settlement or government towns, and having never worked for a Caucasian. Ultimately 189 adults and 130 children met the criteria, which represented about three-percent of all members of the Fore culture. In addition to recruiting Fore members who had no exposure to Western culture, Ekman and Friesen (1971) also collected data from Fore members who had the greatest contact with Western culture; the inclusion criteria implemented for these participants were that they spoke English, had seen movies, lived in a Western settlement or government town, and had attended a missionary or government school for more than one year. This participant group was composed of 23 male adults.

Ekman and Friesen's (1971) results revealed that even when involving a participant group with no exposure to media, they identified the same facial expressions with distinct emotions, except for one. The only significant difference between the preliterate and literate Fore members was for selecting the correct picture for fear rather than for surprise. Ekman and Friesen suggest this exception lends support for cultures not making all of the same emotional distinctions, but nevertheless does not take away

from the overwhelming finding that most of the same emotional distinctions were made across cultures. The researchers argue the above results supports the association between facial expressions with distinct emotions as being a universal phenomenon.

Many studies have been conducted since Ekman and Friesen's initial work. For example, Ekman et al.'s (1987) study used a more complex method for the emotion judgment task. For each emotion expression participants were asked to indicate multiple emotions and also rate the intensity of each emotion. The terms provided were: anger, contempt, disgust, fear, happiness, sadness, and surprise. Members of ten cultures were included in the study: Japan, Sumatra, Estonian S. S. R., Germany, Greece, Hong Kong, Italy, Scotland, Turkey, and the United States. Ultimately 18 black and white head-on photographs of Caucasian adult men and women between 30 to 40 years old were shown to the participants. The study found a consensus regarding the identification of the most intense emotion expression label across cultures, even when more than one emotion label was permitted to be selected. Furthermore, some support was found for cultural selection of the second most intense emotion, as well as for the emotion expression intensity within the same emotion.

Haidt and Keltner (1999) is another example of a study that found support for the universality concept; they concluded that their results provide evidence for cross-cultural similarity, and for this effect to not be principally explained by methodological artifacts of a forced-choice paradigm. Biehl et al.'s (1997) study too found similar results regarding the reliability of Matsumoto and Ekman's (1988) Japanese and Caucasian Facial Expressions of Emotions (JACFEE) stimulus, as well as tests for potential cross-cultural differences. Biehl et al.'s results revealed a high agreement for identifying facial emotion expressions across participants in the differing countries, however there were differences for the level of intensity of the emotion ascribed to the

photos, as well as differences found for the exact level of agreement for photo depictions of the following emotions: anger, contempt, disgust, fear, sadness, and surprise. Agreement levels were found to be highest for happy and surprise facial emotion expressions, while agreement for fear was found to be the lowest.

Dynamic aspects. With and Kaiser's (2011) study is an example of research that utilised dynamic films to investigate the universality of emotion concept. The study entailed videoing dynamic emotions in a naturally occurring emotion elicit task; the filmed participants were asked to recall emotional memories, although provided with no indication of emotion labels they should attempt to convey. The participants who later watched segments of the film—with the segments intended to portray emotional expressions—were found to agree on five emotional factors being: enjoyment, hostility, embarrassment, surprise, and sadness. Additional support was found for segments of film rated as high on one of the emotional labels to be characterised by specific sequences of facial action units, eye and/or gaze movements. Therefore, this study provided support for facial displays, as well as nonverbal signals, being important for the accurate identification of emotion expressions during face-to-face encounters.

In-group effects. Elfenbein and Ambady's (2002a) meta-analysis provides additional support in suggesting emotions are universally recognised at levels greater than chance. However, they found a moderator to participants' accuracy was membership with the cultural group expressing the observed emotion. Similar results have been reported by Thibault, Bourgeois, and Hess (2006); Thibault et al. found accuracy of identifying facial emotional expressions increased when the individual expressing the emotion was part of the same social group as the perceiver. The authors explain this result may be an artifact of an increased degree of effort required when decoding emotion expressed by someone who is not part of one's own group. A more

recent study conducted by Young and Hugenberg (2010) found comparable results; their experiments found support for a distinct processing model for the facial emotional identification of members from their in-group and outgroup. Young and Hugenberg suggest the in-group advantage they witnessed to result from a higher motivation to encode emotional expressions of members from our own in-group. Consequently, there is support for the emotional expression of our own in-group to be encoded at a greater degree than those emotional expressions of outgroup members. Because the accuracy of emotion detection is enhanced when identifiers are akin to the social group they are observing, participants' social group is an important consideration when conducting emotion identification research.

New Zealand research. One known New Zealand study has investigated emotion recognition; Mehta et al. (1992) presented individuals with posed facial expressions of both Māori and Pākehā models expressing the basic emotions. The emotions presented to the participants were: anger, contempt, disgust, fear, happiness, sadness, surprise, and a neutral expression. The results revealed accuracy at a level above chance for all emotions, except for fear. Furthermore, the emotional expression of the Māori models were more accurately recognised by the participants, while the Pākehā participants were more accurate in their emotion identifications as compared to the Māori participants. Therefore overall there was no evidence of an advantage for Māori or Pākehā participants' accuracy in identifying emotion expressions posed by models of their same ethnic group. Therefore an in-group advantage was not witnessed for the participants in this particular New Zealand study. This finding is contrary to the studies described previously, whereby in-group advantages were apparent. Mehta et al. suggested factors such as the familiarity of testing, education backgrounds, language

differences, and/or perceived cultural appropriateness of the tasks may have influenced the results.

Critics of the universality concept. Although there is overwhelming support for the universality of facial emotion identification, some researchers have reported conflicting results and differences in the meaning, interpretation, and associated display rules of facial expressions (Olszanowski et al., 2015). For example, Fiorentini, Schmidt, and Viviani's (2012) study found an overall mean accuracy of undergraduates identifying six emotions (i.e., anger, disgust, happiness, fear, sadness, and surprise) to be 76%. Other studies investigating the recognition rates of identifying the aforementioned six basic emotions have found accuracy levels both higher and lower than Fiorentini et al. These include studies by Ekman (1994; 83% for Western participants and 71% for non-Western participants), and Galati, Scherer, and Ricci-Bitti (1997; 51% for Western university student participants identifying facial expressions), although Galati et al. used the term joy rather than happiness. Fiorentini et al. suggest possible explanations for the variation in results of such studies may be due to ecological validity and procedural issues.

Some studies have found support for individual differences in emotion detection and interpretation ability to be due to the ways in which individuals communicate nonverbally across cultures (Mehta et al., 1992). It has been proposed cross-cultural differences are largely due to individual developmental differences along with variation in attending behaviours and interpretation skills (Domico, 2010). Izard (1991) postulates it is possible individuals from different social and cultural backgrounds may learn different facial movements.

Lisa Feldman Barrett is one critic towards the idea that emotion can be identifiable and labelled against clear and consistent criteria. Her criticism is also

directed towards the dominant emotion theories, and argues that empirical evidence doesn't support the assumption that emotions are distinct units (Barrett, 2006). Instead, Barrett prefers the concept of emotional entities existing in nature (natural kinds), and proposes individuals experience emotion when they experience affect. Barrett's belief is that the categorisations made of experienced emotion is largely influenced by their embodied knowledge of emotion, and it is only through asking will we know what emotion someone is experiencing.

The relativist approach extends further on Barrett's (2006) view by arguing all emotions and emotional expressions are socially derived and dependent on context (Frank & Stennett, 2001). Frank and Stennett (2001) highlight Russell and Fehr's (1987) relativist approach, which views facial expression as occurring along a continuum, in this case along a dimension of arousal and pleasure, rather than categorical expressions.

Additional research support against the emotion universality concept is from Krumhuber and Scherer (2011). These authors researched the facial correlates of five emotion expressions: anger, fear, joy, relief, and sadness. They found no support for the contention that there are specific patterns of facial responses for emotion expressions. They instead suggested emotion portrayal might be the result of different expressions that make use of similar facial actions. A more recent study in agreement with Krumhuber and Scherer is by Du, Tao, and Martinez (2014); they argued and found support for the presence of more emotions than what has been referred to as "basic emotions." Du et al. defined what they call compound emotion categories, which are combinations of the basic emotion categories to create new facial emotion expressions. Based on the results of the two studies discussed above, it may be that there are more than the core set of the often referred to basic emotions; a mixture might be present too.

In summary, tensions exist in the relationship between idiographic and nomothetic expressions of emotion, the degree of universality seen, and the parameters under which emotions are individually, culturally, or universally shared. Nevertheless, a core set of universally displayed and recognised emotions are thought to exist and this has strong research support. However, there is criticism surrounding the way in which emotion recognition research has been conducted.

Methodological concerns of previous research. Frank and Stennett (2001) highlight the issue that many studies investigating and/or citing the universality concept still use posed photos of facial expressions, which are then shown to a range of different groups. These groups are then asked to select which emotion they believe is shown in the photograph from a selection of six to nine. Frank and Stennett present six possible issues with utilising the forced-choice methodology that is commonly used in research investigating the universality concept, which were also raised by Russell (1994). Firstly, participants are given the opportunity to preview the facial expressions, which is not the case in reality. Secondly, studies employing a within-subject design, which, like previewing, allows comparisons to be made. Thirdly, there is no systematic manipulation of the order of the expression stimuli. Fourthly, the photographs ultimately used in the research are preselected on the basis of being judged similarly by a panel; therefore agreement rates are inherently going to be higher. Fifth, the expressions are often posed and therefore are not a reflection of real world expressions. And lastly, one emotion is to be selected from a set number of options, which may be too limiting given the array of terms we have in our vocabulary to describe emotions, and this also suggests emotion expression is mutually exclusive.

Additional arguments made by Frank and Stennett (2001) are that the forced nature of the forced-choice paradigm may artificially generate agreement across

individuals. In response to the concerns primarily raised by the last issue mentioned, Frank and Stennett set out to test whether adding a “*none of these terms are correct*” option to the original forced-choice paradigm supported an artifact agreement of emotion expression across individuals. The addition of the “*none of these terms are correct*” option was not found to significantly influence the agreement rates of previously reported results using the standard force-choice paradigm. Furthermore, when additional emotion options were added along with the inclusion of the “*none of these terms are correct*” option, there was no significant influence on the agreement rates. However, it is argued that the positive effect of the “*none of these terms are correct*” addition is participants have an option when they were presented with novel faces, rather than being forced to make a decision they felt was incorrect. In concluding, Frank and Stennett suggest all research on facial expression use the modified forced-choice format, whereby an option is added to allow participants the choice to select there to be no applicable emotion labels presented.

In summary, there is literature that provides support for universally agreed upon facial expressions (e.g., anger, contempt, disgust, fear, happiness, sadness, and surprise), but there is also evidence of variation in individuals’ ability to recognise and make inferences concerning others’ facial expressions (Domico, 2010). The implication for the existence of a range of universally agreed upon facial expressions, is that it lends itself to the assessment and measurement of emotional expressions. Reliable measurement of expressions then enables the testing of accuracy in which individuals perceive emotions.

Measuring Facial Expressions

A widely used means of measuring emotions within the literature is through micro-expressions. Micro-expressions are defined as very briefly presented fragments

of emotional expression configurations—while not often detectable by others—accurate identification of these are able to be taught (Ekman & Friesen, 1969b). According to Warren, Schertler, and Bull (2009), the main sources of facial leakage from repressed emotional expressions are presented in the form of subtle micro-expressions. Warren et al. define micro-expressions as presentations of suppressed or masked expressions that only involve part of the muscular configuration expected for a particular emotion. It is argued these presentations cannot be falsified, suppressed, or masked, so therefore are conceptualised to provide an accurate insight into the way in which the individual feels (Ekman & Friesen, 2003).

Facial Action Coding System. The Facial Action Coding System (FACS; Ekman & Friesen, 1978; Ekman, Friesen, & Hager, 2002) is the most commonly used instrument for analysing facial expressions (Valeriani et al., 2015), and has been considered to be the most comprehensive and valid tool for analysing facial activity (Gosselin et al., 2010). FACS is a tool designed to enable users to differentiate facial expressions into emotional categories, and is based on the universality of emotions. It allows reliable, objective coding of visible facial movements (Bänninger-Huber, 1992). It measures the change in facial action from a neutral face to one which is displaying emotion (Suzuki & Naitoh, 2003). It therefore describes facial movement by measuring visually present facial movement anatomically. This is achieved by the use of nine specific action units in the upper face and 18 in the lower face. An action unit is a defined facial movement, or muscle innervations, and specific actions units are combined to represent an emotional concept (Bänninger-Huber, 1992). Additional FACS procedures allow for coding of positions and movements of the eyes and head, miscellaneous action units, action descriptors, gross behaviours, and visibility codes (Cohn, Ambadar, & Ekman, 2007). Since affect processes occur extremely quickly,

FACS coding is conducted at a micro level at a high resolution (Bänninger-Huber, 1992). FACS coding ultimately categorises the facial emotion expression from seven archetypes that are: anger, contempt, disgust, fear, happiness, sadness, and surprise (Ekman & Friesen, 1986, 2003).

In order for an individual to be certified as a FACS coder they are required to successfully complete a proficiency test and also code video tapes of spontaneous expressions with a high level of agreement to reference coders (Sayette, Cohn, Wertz, Perrott, & Parrott, 2001). Sayette et al.'s (2001) study investigated the reliability of the FACS in studies of spontaneous facial expression drawing on a typical design whereby emotion was elicited in participants within a laboratory setting. The FACS was found to have good to excellent reliability for spontaneous facial emotion expressions and for 90% of the action units. Two of the action units, AU7 (orbicularis oculi, pars palpebralis; lower lid raised and drawn medially) and AU 23 (orbicularis oris; lips tighten), had only fair reliability even when the presentation was slowed. In addition, the reliability of action unit intensity was also found to be good. Sayette et al. concluded their data supported FACS to be used reliably to code spontaneous facial emotion expressions.

Furthermore, research conducted by Suzuki and Naitoh (2003), which drew on six of the seven basic emotions listed above (i.e., excluded contempt), found Japanese undergraduate students' judgments of static facial emotion expressions to be highly correlated with the associated FACS scores. This finding is supported by an earlier study conducted by Wiggers (1982), which found Dutch college students' emotion classification and perceived intensity of emotions to concur with FACS of the facial emotion expressions. In addition, Wiggers argues the shared action units present in the different emotions could explain the discrepancies regarding these two accounts, which

occurred most commonly for fear and anger facial emotion expressions. Wiggers also found that for each of the emotions employed in their study (happiness, fear, disgust, sadness, surprise, shame, anger, and contempt), one or two action units for each, except for disgust, appeared to be particularly important when judging the intensity of the expressed facial emotion.

Another study that investigated the use of the six basic emotions (i.e., again, excluding contempt) and the FACS was Gosselin et al.'s (2010) study. Their study involved showing young adults filmed facial action units from the aforementioned basic emotions and then asked these participants to reproduce the action units they saw. Overall the study found the young adults to activate the majority of the action units they viewed, 18 out of the possible 20, however the participants were also found to activate action units other than those that were intended. Support was too found for some action units to be better able to be controlled than others.

In summary, there is research support for the FACS being a valid and reliable measure for the identification of emotion expression. The ability to identify emotion is considered one of the core skills of emotional intelligence, and an integral step towards guiding the use of subsequent social-emotional responses. Given this, it seems logical that awareness of emotion would be a guiding element in the effectiveness of psychological practice.

Emotional Practice

Therapy is an emotional event. It is common for individuals seeking help from a therapist to present with emotional difficulties (Gross & Munoz, 1995). Greenberg, Rice, and Elliott (1993) view clients' emotion as adaptive, as the biological function of the experience is to promote survival and reproduction by providing feedback on an organism's experiences. Furthermore, emotions are also adaptive in that they also

motivate individuals to seek support, for example, attending therapy. Therapists are likely to encounter the manifestations of emotion in a number of forms, and awareness of these guide therapists to respond in ways that benefit their clients (Kalat & Shiota, 2007). Responding with composure and empathy for instance, is one such therapeutic response a therapist can choose when detecting negatively construed client affect (Markowitz & Milrod, 2011). Other benefits have been found to arise from emotionally guided responses. Raingruber (2000) for instance, found clinicians who appropriately focused on their clients' feelings in therapy sessions, not only aided their clients to understand themselves, but also enhance the client-clinician relationship. However, having such ability also entails clinicians being adept at recognising when they should no longer pursue particularly emotional material during therapy sessions. Raingruber therefore argues clinicians should put effort into practicing their emotional skills due to its advantageous nature.

Cartwright and Gardner (2016) state one of the main challenges therapist trainees encounter is fostering rapport with their clients, which is an important factor for engaging clients in therapy and building a therapeutic alliance. Other influential factors include therapists' skills and personal attributes (Horvath, 2001). Furthermore, Hall et al. (2014) state the accurate perception of patients' presentations to be important for therapy, as this is conceived to contribute to better diagnoses, provide insight into possible nonadherence, influence the therapeutic relationship, and aids in revealing the patients' reaction towards clinicians. Therefore, unsurprisingly, the nature of the interaction between the client and their therapist is immensely influential from the outset of therapy.

Facial expressions communicate in social settings. In a therapeutic context, this would imply that a less aware therapist will miss elements about what their client is

communicating. Likewise, an aware therapist will have access to their clients' emotional communication and therefore can respond intelligently to this information, which in turn guides how best to craft responses that are beneficial for their client.

Emotional Intelligence

The notion that there is an emotional intelligence, which is argued as a form of intelligence anyone can hold, has gained popularity over the years (Matthews, Emo, Roberts, & Zeidner, 2006). Salovey and Mayer (1990) were however the first to write extensively about emotional intelligence. Mayer and Salovey (1997) describe emotional intelligence as involving five core competencies that include: identification, expression, understanding, regulation, and utilisation of one's own emotions and the emotions of others. Ever since these first writings, emotional intelligence has received extensive academic interest (Lohiser, 2012) and has also become part of everyday language because of books aimed at the public (e.g., Goleman, 1996). However, the popularity and widespread nature of emotional intelligence has also meant that emotional intelligence has become somewhat of a promotional device largely due to the inclusion of the term 'intelligence' (Matthews et al. 2006).

Some researchers and practitioners view the expansion of emotional intelligence as good, while others see it as a debacle (Murphy & Sideman, 2006). Lee, Miller, and Moon (2004) highlight that there are inconclusive discussions as to whether emotionally intelligence is definable. Matthews et al. (2006) summarise the differing definitions and conceptualisations of emotional intelligence by stating there to be no consensus of what emotional intelligence is or what it entails. In support of this, Waterhouse (2006) lists four issues with emotional intelligence theory; 1) issues with supposed empirical evidence, 2) use of inconsistent constructs, 3) unclear differentiation from personality and intelligence measures, and 4) that it does not provide real-world benefits. However,

Cherniss, Extein, Goleman, and Weissberg (2006) report some of these claims to be flawed based on three grounds, they argue; 1) there is a clear differentiation between personality and intelligence measures from those relating to emotional intelligence, 2) Waterhouse to not have conducted enough research into the advantages of emotional intelligence in the real-world, and 3) there is evidence to suggest emotional intelligence competencies can be taught, and doing so has produced positive social, emotional, and academic outcomes.

Nevertheless, one definition of an emotionally intelligent person is someone who reflects on others' emotions and feelings, can distinguish between emotions, and has the ability to reflect on their awareness to influence their personal thoughts and actions (Abraham, 2004).

Models of emotional intelligence. Owing to the popularity of emotional intelligence, multiple authors have presented differing emotional intelligence models. Four such models are Salovey and Mayer's (1990) emotional intelligence model, also referred to as an ability-based model, Bar-On's (2006) Model of Emotional-Social Intelligence, Goleman's Emotional Competencies Model (Goleman, 2000), and Petrides and Furnham's (2000) Trait Emotional Intelligence Model. Even though there are differences in these models, the common theme uniting them is that they all agree that emotion perception is an important part of emotional/emotional-social intelligence. Although a compressive review of each model is outside of the scope of this thesis, a brief description of each model follows.

Salovey and Mayer (1990) position emotional intelligence as part of a global social intelligence framework, and describe it as the capability to understand and manage the self and others' emotions. Salovey and Mayer's model has been described as an ability model of emotional intelligence since it includes the prerequisite of mental

abilities (Fletcher, Leadbetter, Curran, & O'Sullivan, 2009). Bar-On's Emotional-Social Intelligence model differs from Salovey and Mayer's model in that it includes an explicit social component. Goleman's Emotional Competencies Model includes five main competencies from both personal and social facets theorised as comprising an emotional competence framework, these are: empathy, motivation, self-awareness, self-regulation, and social skills (Goleman, 2000). Petrides and Furnham's (2000) Trait Emotional Intelligence model differs again by focusing on the consistent behavioural traits of an individual across situations as opposed to a person's information processing aptitude, which is more of an ability (Petrides & Furnham, 2000).

Therapists. Kaplowitz, Safran, and Muran (2011) were the first to publish research on psychotherapists' emotional intelligence. They found therapists rated as having high emotional intelligence attained better therapist rated outcomes, had fewer client dropouts, and had greater client assessment compliance compared to those therapists with lower emotional intelligence. Consequently, it could be predicted that therapists who develop emotional skills and competencies may attain better client outcomes, as clients' difficulties could be dealt with sensitively and appropriately. Doing so would promote a smoother therapeutic relationship, foster accurate identification of issues and/or reactions, and guide the implementation of therapy.

Training. Rieck and Callahan (2013) suggest it is probable that individuals range in their innate level of emotional intelligence, but their personal development and experiences are likely to influence the level of this ability. It is therefore no surprise that there is research support for the successful training of emotional intelligence in a variety of different populations; for example, adults (Kotsou, Nelis, Grégoire, & Mikolajczak, 2011), managers (Slaski & Cartwright, 2003), medical students (Fletcher et al., 2009), psychology students (Nelis, Quoidback, Mikolajczak, & Hansenne, 2009), and

undergraduate students (Nelis et al., 2011). Not only has evidence been found for emotional intelligence to increase following the training of these skills, but additional associated positive effects have been found for other areas. Examples of such benefits are for health and wellbeing (Kotsou et al., 2011; Nelis et al., 2011; Slaski & Cartwright, 2003), relationships and employability (Nelis et al., 2011).

Limitations. There are however limitations to the emotional intelligence construct: A) it is described as being an innate ability and it therefore would hold that it could not be taught, but emotional learnings are regularly witnessed not only just in therapeutic settings, but in everyday life; B) it appears difficult to be measured well, which could largely be due to the many differing perspectives on what it entails; C) it does not appear to accurately account for the very social nature emotions can have; D) it does not take into account the many ways we detect emotions (e.g., movement, tone of voice, body posture etc.) and is largely based on self-report; and lastly E) it is not clearly linked to performance.

Emotion and Therapy

Emotion recognition and its' consequences. Of all the facets of emotional intelligence, emotion recognition is argued to be the most validated component (Elfenbein & Ambady, 2002b; Elfenbein, Foo, White, Tan, & Aik, 2007). Furthermore, due to the popularity of emotion recognition, many researchers have investigated the influence emotion recognition has on a range of factors. For example, Blanch-Hartigan, Andrzejewski, and Hill (2012) assert accurate perception of others emotions is associated with enhanced social and emotional competence. As another example, Clark, Winkielman, and McIntosh (2008) suggest perception of others' emotions may be a necessary antecedent for building empathy, and empathy has been said to be at the heart of psychology (Welch, 2003). This is important for therapists, as empathy is considered

an imperative therapeutic ingredient regardless of therapist paradigm (Rogers, 1957). Furthermore, Owen and Maratos (2016) state emotion recognition to be a prerequisite to empathetic responding, as well as to be immensely important for social functioning. Bänziger, Grandjean, and Scherer (2009) support Clark et al.'s claim by arguing emotion recognition is imperative for empathy, and further contends emotion recognition enables the interpretation of behaviour and prediction of a person's response. Therefore, emotional recognition would seem vital for smooth social interaction, as it enables one to communicate emotionally.

Curtis (2017) is one of few studies on therapists' emotion recognition ability and the influence of training. Curtis' results were mixed, as some support was found for emotion recognition training to increase the therapists' emotion recognition abilities. Training was found to be largely effective for single emotions, apart from for sadness, however training had limited effect on masked and leaked emotional expressions. Another finding was that more experienced therapists had greater training efficacy compared to less experienced therapists.

The importance of emotion recognition has been identified in other literature areas too. Within the medical education literature, Riess and Kraft-Todd (2014) highlight the need to acknowledge and teach trainees about nonverbal signals and their insights into emotion communication. They argue that failing to identify nonverbal cues has a negative impact on patient satisfaction, health outcomes, and also influences malpractice claims. In addition, nonverbal behaviour is likely to be more important as a source of information when having contact with individuals of a different culture. Despite this however, there is a lack of training of nonverbal communication skills, such as emotion recognition, within medical and therapy training courses. Regarding psychotherapy training, Bibeau, Dionne, and Leblanc (2016) highlight that there is

instead a prevalent focus on imparting knowledge to trainees as opposed to teaching therapists how to be present during therapy.

In the medical field, teaching of emotional self-awareness and management of reactions to patients is argued to be important factors that need to be considered in training. An example of how nonverbal communication skills have been taught is presented by Riess and Kraft-Todd (2014), who describes an acronym derived by Riess, and suggests it be used as a tool for the assessment of nonverbal communication of patients. This acronym is EMPATHY; E (eye contact), M (muscles of facial expression), P (posture), A (affect), T (tone of voice), H (hearing the whole patient), and Y (your response).

Studies investigating individuals' ability to recognise emotions appear to have however neglected community-based samples, and such studies often only use posed, purposeful stimuli (Owen & Maratos, 2016). As mentioned earlier in this review, there are multiple examples of studies that have been conducted on emotion recognition but these frequently involve individuals from clinical populations rather than the general population, and near to none include therapists.

Emotional communication and cues. Clients are likely to present emotional cues during therapy. An emotional cue has been defined in the literature as a hint, either verbal or nonverbal, that signals there to be an underlying emotion that requires explanation from the health care professional (Del Piccolo, Goss, & Bergvik, 2006; Del Piccolo, Goss, & Zimmermann, 2005). Research on emotional cues have mainly been conducted in the medical field, but are however addressed in the current literature review since little research has investigated therapists' recognition of their clients' emotion in therapy.

According to Jansen et al. (2010), it is critical to address cues, as they are likely to bestow insight into the client's perspective and feelings. This is especially since words in and of themselves do not fully express clients' meanings and intentions (Welch, 2003). More generally, good healthcare communication is likely to aid clients to feel more comfortable revealing information, increase their treatment compliance, and enhance their willingness to change their behaviour for the good of their health (Mechanic, 1996).

Emotion research has largely investigated verbal emotion cues or verbal content of interactions (Butow, Brown, Cogar, Tattersall, & Dunn, 2002; Eide, Quera, Graugaard, & Finset, 2004; Kim, Kols, Prammawat, & Rinehart, 2005), neglecting the investigation of health provider's ability to identify their patients' nonverbal emotion cues (Blanch-Hartigan, 2011; Hall, Roter, Blanch, & Frankel, 2009). This is surprising given that nonverbal behaviour seems particularly important during consultations. Robbins, Kirmayer, Cathébras, Yaffe, and Dworkind (1994) suggest physicians who are sensitive to nonverbal emotion might be more likely to recognise undesired emotion that is indirectly expressed. Consequently being aware of nonverbal information would undoubtedly be a beneficial skill to have.

There is evidence that suggests emotional cues are frequently missed (Jansen et al., 2010) and ignored by health care providers (Zimmermann, Del Piccolo, & Finset, 2007). In a study conducted by Maguire et al. (1984), participants were found to miss approximately 70% of the verbal cues expressed by the simulated patients. Although there is evidence suggesting medical professionals are missing emotional cues presented by their patients, studies have found it to be more common for information cues to be presented by clients in medical interactions in comparison to emotional cues. For example, Jansen et al. (2010) found 11% of the cancer patients who participated in the

research did not express any emotional cues to nurses, while information cues were approximately presented 13.9 times per consultation compared to just 6.4 emotional cues. Furthermore, two-thirds of the cues given by patients in Butow et al.'s (2002) study were informational as opposed to being emotional or of a questioning nature. However, there is literature that has found contradicting results. Levinson, Gorawara-Bhat, and Lamb (2000) found 76% of patient clues in primary care and 60% in surgical setting to be emotionally laden; 2.6 and 1.9 mean number of clues per visit with clues in primary care and surgery respectively. Furthermore, Levinson et al. found the majority of emotional clues (80%) presented by patients in general medical practice to be psychologically and psychosocially in nature (i.e., related to family and life stressors).

Another study investigating the use of emotion in the medical field is by Zimmermann et al. (2007), who analysed peer-reviewed research literature on cues and concerns from 1975 to 2006. Fifty-eight articles that involved the analysis of audio or videotaped medical consultations were included in the review. Despite cues or concerns being defined differently, and there being differences in the methodological approaches taken by the differing authors, physicians were overall found to miss the majority of cues and concerns. Furthermore, the physicians who participated in the reviewed research were frequently found to discourage patients from disclosing information.

Research has found ignoring patients' emotional cues to be associated with reduced patient recall of information shared with them by the professional during their consultation, while greater use of minimal encouragers by nurses resulted in greater recalled information by the patient (Jansen et al., 2010). Furthermore, physician use of silence, minimal encouragers, and affirmation has been found to significantly increase patients' expression of their concerns (Eide et al., 2004). It is likely the above techniques are effective as they indicate the physician is interested in the patient (Butow

et al., 2002). A further discussion of the benefits of recognising clients' emotion in therapy follows.

Benefits of recognising emotion. There are a multitude of benefits associated with the accurate identification of client emotion, which are likely to apply to interactions across the healthcare spectrum. Accurate identification of others' emotions has been found to be associated with heightened social and emotional competence, increased quality of relationships, and also to benefit psychosocial factors (Hall, Andrzejewski, & Yopchick, 2009). In support of this, Wolff and Hayes' (2009) found therapists' emotional reactions towards their clients to predict their clients' ratings of the working alliance and the therapist's empathy. Furthermore, research conducted by Hall, Roter, et al. (2009) found emotional cue identification accuracy to be positively correlated with medical students' self-reported patient-centered attitudes and increased client engagement. In further support, DiMatteo, Hays, and Prince (1986) found a relationship between physician sensitivity to audio communication and client compliance. Sensitivity was measured through use of the short form of the Profile of Nonverbal Sensitivity (Rosenthal, Hall, DiMatteo, Rogers, & Archer, 1979). Therefore there are many client benefits to having a therapist who is emotionally aware and skillful.

Grace, Kivlighan, and Kunce's (1995) study found exerting greater effort into recognising clients' nonverbal behaviour to benefit therapy. Half of the participating counsellor trainees were randomly assigned to a nonverbal sensitivity condition, which trained them to make overt remarks about their client's nonverbal behaviour. The other half of the trainees received empathy training only. All trainees rated their own sensitivity to nonverbal behaviour, counselling self-efficacy, and focus on their clients' nonverbal behaviours. The trainees' clients also completed the Session Evaluation

Questionnaire and the Working Alliance Inventory before and after the intervention. The trainees' therapy sessions were recorded and raters scored the trainees extent to which they focused on their clients' nonverbal behaviour. Trainees in the nonverbal sensitivity condition not only increased their focus on their clients' nonverbal behaviours, but their clients also reported increased working alliance ratings. Therefore increasing therapists' attention to nonverbal behaviours is likely to produce therapeutic benefits.

Accurately perceiving others' emotions would no doubt be an advantageous skill for therapists to hold, as the recognition of emotion is especially relevant to psychotherapy and psychotherapy research (Machado et al., 1999). The current research is therefore important and timely. Investigating therapists' emotion recognition ability, and self-reported emotional practice and awareness, will provide an insight into therapists' emotional skills and practice, which are areas that have overall been ignored.

Therapists and Emotion

Therapist characteristics. Therapist characteristics have largely been neglected from psychotherapy and outcome research (Beutler, 1997; Blow, Sprenkle, & Davis, 2007; Sullivan, Skovholt, & Jennings, 2005). This is surprising given that research has suggested therapists contribute to client therapeutic outcome even when seeing clients with comparable difficulties and utilising structured treatments (Huppert et al., 2001). More specifically, Wampold (2001) predicts 6-9% of the variance in client outcome to be due to the therapist, which explains a greater proportion of the variance than the use of different treatment types. However, not all therapists work the same or are viewed by their clients similarly, and it could be hypothesised this would have an influence on their efficacy. As an example, Nissen-Lie, Monsen, Ulleberg, and Rønnestad's (2013)

study found therapists who had better patient outcomes to report greater professional self-doubt.

Therapists vary in their effectiveness (Blow et al., 2007), which undoubtedly will influence the clients' therapeutic experience. For example Lafferty, Beutler, and Crago (1989) found individuals receiving psychotherapy from less effective psychotherapists to feel misunderstood by their therapist. In addition, Lafferty et al. found limited empathy to be associated with the reduction in therapist effectiveness. Furthermore, the emotional competence of the therapist seems to influence clients' perceptions of their therapist. Research has found clients view the quality of therapeutic interviews as dependent on the capability of the interviewer to understand their emotions and detect messages they are conveying (Groth-Marnat, 2009).

Crits-Christoph and Mintz (1991) argue that since therapists are found to produce different therapeutic effects, the therapist should be included as a random factor in statistical analyses. Additional suggestions come from Lambert (2013) who purports conducting research on empirically supported psychotherapists rather than researching empirically supported treatment. The intention of such research would be to reveal what therapist variables are most important for successful treatment, which would act to improve outcomes as well as aid in influencing the training of new therapists (Karver, Handelsman, Fields, & Bickman, 2006). Nevertheless, Lambert argues research on the dissemination of efficacious treatments is likely to soar within the next decade. This is largely due to mental health services searching for empirically supported interventions and best practices. Therefore, if the therapist per se is strongly linked to better outcomes, then research into the therapists' characteristics and their social-emotional interactions becomes an important focus.

Emotional self-awareness. The exploration of emotions in the therapeutic context is considered crucial to the delivery of effective therapy irrespective of the therapeutic theoretical approach (Greenberg & Pascual-Leone, 2006). According to Kimerling, Zeiss, and Zeiss (2000) becoming a therapist is more than simply learning therapeutic techniques it also involves growing emotionally and gaining insight through reflecting on emotional responses. Furthermore Bliss (2005) argues meaningful emotional contact with others is a derivative of being aware of one's own emotions, therefore reflecting upon one's own emotion is likely to be a beneficial therapeutic skill. Research supports this, as individuals who are emotionally self-aware have been found to be more accurate when identifying emotion in others (Machado et al., 1999). Therefore, it may be that therapists who are emotionally self-aware may be able to reflect upon emotions to a greater degree in therapy than those therapists who are not.

Markowitz and Milrod (2011) suggest that therapists' should use and reflect on their emotions in therapy. Doing so conveys a connectedness between the client and therapist, as well as provides evidence the therapist is attending and attempting to understand the client. In addition, therapists' emotions act as an important source of information in therapy. Therapists' emotional reactions towards a client not only signals the impact the client's behaviour has on them, but also provides a glimpse into what effect it may have on other people (Batten & Santanello, 2009). Therapist distress has also been found to provide therapists' additional insights into their clients' difficulties and signal potential different beneficial treatment options (Alves de Oliveira & Vandenberghe, 2009). Therefore, therapists' self-awareness and emotional practice is likely to be important for the therapeutic relationship and therapy in general.

Despite the apparent benefits of therapists being emotionally self-aware, limited research has been conducted within this area. Therapists' emotions are rarely

investigated empirically, with some potential barriers to research being whether therapists are able to—as well as being willing to—report their emotions (Najavits, 2000). Two known studies have investigated the link between therapists' emotional awareness and the influence of this on their practice, however neither are complimentary to therapists' personal insights. For instance, Johnsen (2013) found no relationship between clinical psychologists' emotional awareness and their self-perceived emotional awareness. Similarly, DePaulo, Charlton, Cooper, Lindsay, and Muhlenbruck (1997) meta-analysis found only a limited association between individuals' accuracy in detecting deception and their self-reported confidence in their ability.

Research regarding confidence and accuracy more generally, Miller, Spengler, and Spengler (2015), found a small statistically significant correlation between therapists' confidence and accuracy in their clinical judgment. However, the authors warn the small results should be treated with caution, as they state confidence to not be a great representation of accuracy. The difference between self-perception and application may therefore mean therapists require more feedback regarding their emotion-based skills.

What makes therapists' self-awareness even more important to consider is that even general research into therapists' self-perception of their therapeutic skills has found therapists' to be inaccurate. For example, Walfish, McAlister, O'Donnell, and Lambert's (2012) study found 25% of their sample of mental health professionals to rate their therapeutic skills in the 90th percentile, and none reported themselves to be below average regarding their skills. This type of result has been referred to as the *Dunning-Kruger Effect*, whereby individuals overestimate their competencies (Dunning, 2011; Kruger & Dunning, 1999). Many other studies report clinicians to be inexact in their reporting of their abilities; for example Creed, Wolk, Feinberg, Evans, and Beck's

(2016), and Mathieson, Barnfield, and Beaumont's (2009) studies on the inaccuracies of clinicians' perceptions of their Cognitive Behavioural Therapy (CBT) skills. Waltman, Frankel, and Williston (2016) raise potential reasons why this discrepancy in confidence and accuracy is present for therapists, therapists may: believe they are above average in their skills, be unaware of their actual skills due to burnout, and/or experience an unconscious shift in their employed treatment model. The mismatch between perceived and actual competence is especially concerning given therapeutic competence is not static, it is not complete once achieved, but instead requires continued attention and development (Knapp, Gottlieb, & Handelsman, 2017a).

A recent study conducted by Martin et al. (2015) investigated clinicians' recognition and management of their emotions during difficult conversations with others in the healthcare system. This study revealed most of the clinician participants reported their emotional state to influence the quality of the care they provide their clients. The participants also rated themselves as being "somewhat" to "quite" capable of recognising and managing their emotions, although they did acknowledge that this is an area in which they could improve on. The authors therefore argue for education to be provided to clinicians that aims to increase clinicians' identification, reflection, and management of emotion for healthcare conversations. Alves de Oliveira and Vandenberghe's (2009) research into how therapists manage upsetting experiences in session found the four therapists involved in the study to express a preference for discussing the emotional impact of the upsetting experience within the session with some of their clients. However it was rare for the therapists in the study to act on this apparent preference in practice, even though the outcomes of such disclosures and discussion were often found to be helpful when carried out in the session in which they occurred.

The notion of being self-aware is present in key documents for therapists, for example in the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017). Therefore, therapists are expected to have self-awareness skills, and to display and act on them in therapy. Furthermore, self-awareness has been identified as an imperative characteristic of effective therapists (Knapp, Gottlieb, & Handelsman, 2017b), and therapists who manage their emotions have better therapeutic outcomes (Hayes, Gelso, & Hummel, 2011). Clearly more research is needed on therapists' self-awareness to promote a greater understanding of how it functions, as well as to investigate whether or not it can be improved and/or taught to therapists.

Not only has there been minimal research conducted on therapists' emotional self-awareness, therapists' emotion recognition abilities in the psychological field have received limited research attention.

Psychotherapists' emotion recognition. The role of emotion in psychological practice is an area that has been fundamentally ignored (Ehrenreich, Fairholme, Buzzella, Ellard, & Barlow, 2007) even though an affective revolution has been reported to occur sometime ago (Fischer & Tangney, 1995). Hall (2011) and Hall et al. (2014) highlight that there is a great number of studies conducted on how clinicians should speak and act, as well as on their overt behaviours. However they state there is a scarcity of research on the accuracy of their perceptions and associated responses to others and patients. There is also very limited research regarding any relationships such emotional accuracy may have on other client related variables. Hall and colleagues therefore argue research should be conducted on clinicians' ability to accurately perceive and appropriately respond to their clients due to such a factor having an important role in the quality of care provided.

Few studies have investigated therapists' ability to recognise facial emotion in clients, and of those that have, many are not written in English. For example, Láng and Papps' (2012) Hungarian study, involved 45 psychotherapist candidates and a control group of non-therapists. Sixty portraits of facial expressions of Ekman's six basic emotions were shown to the participants. Overall the groups' performance did not differ on their accuracy; however the psychotherapist candidate group was more accurate in identifying surprise.

Machado et al.'s (1999) study is one of the only other studies to have investigated psychotherapists' ability to identify emotion. Machado et al. found psychotherapists to be more accurate at identifying emotion in a therapy session than non-therapists. The limited research conducted on psychotherapists' ability to recognise emotion is concerning given the many previously discussed influential effects such accurate identification has. There are many arguments made in the emotion literature that highlight therapists' awareness of emotion to be important for effective practice (Knapp et al., 2017b). Therefore, research investigating psychotherapists' emotional abilities is timely due to the apparent value of emotion recognition and emotional understanding in therapeutic settings. If research were to find support for psychotherapists' emotional abilities as being important to the therapeutic process and client outcome, training such skills would likely be beneficial.

Training in Emotion

Emotional training. Several intervention studies have reported change in emotion recognition skills of children, adults, and clinical populations (Blanch-Hartigan et al., 2012). Nelis et al. (2011) is an example of a study on the impact of emotion training conducted with adults; emotional training was provided that comprised 18 hours of initial training with email contact at follow-up. They reported improvement in

adults' emotion regulation, understanding, and emotional competence immediately after the training compared to a control group that remained stable at 6-months post-intervention. Increases in participants' emotional competence were found to be associated with positive changes for psychological well-being, subjective health, relationships, emotional stability, sociability, and employment prospects. Similarly, Blanch-Hartigan (2012) found a 30-minute emotion recognition training intervention significantly increased participants' emotion recognition compared to a no-treatment control group. Another study by Elfenbein (2006) found emotion recognition training, provided to university students via a feedback process, improved the participants' emotion perception.

There are no known studies that have investigated the effect of emotion recognition training on therapists' emotional skills and outcomes, which is surprising, as it could be hypothesised that such training would be of benefit given the advantages listed by those studies mentioned above. Despite this however, there is research that has investigated the effect of emotion training in the medical field, and more specifically, emotion training for medical students. For an example, Satterfield and Hughes (2007) reviewed research on emotion skills education programmes for medical students and found a range of studies that had been conducted between 1980 to the time their research was conducted. Satterfield and Hughes concluded that, of the controlled research (i.e., random controlled trials and those studies that employed objective measures) they reviewed, there were positive outcomes from emotion skills training, such as greater use of empathy and supported behaviours by medical students.

Ekman and colleagues have constructed training aimed at enhancing the identification of subtle and micro expressions, named the Subtle Expression Training Tool (SETT) and Micro Expression Training Tool (METT) respectively. The SETT was

created to improve subtle emotional expression recognition, which are small facial movements commonly seen in one area of the face being the brows, eyelids, cheeks, nose or lips (Paul Ekman Group, 2011). The SETT comprises facial expressions and the viewer is asked to identify the emotional expression from the seven universal emotions: anger, contempt, disgust, fear, happiness, sadness, and surprise.

There is empirical support that emotional recognition and understanding can be trained for a range of populations. Some evidence suggests these increases in emotional competence can lead to other beneficial changes which are maintained over time. It therefore stands to reason that emotion training can enhance therapists' emotional awareness and provide other potential benefits in their practices. What follows is a discussion of how therapists' emotional practice can be profiled.

Profiling therapists' emotional practice. Harvey, Marwick, Baken, Bimler, and Dickson (2017) devised a means of conceptualising therapists' social-emotional competencies into a three-dimensional model. Harvey et al. found evidence for twenty elements of therapists' social-emotional competencies: therapists' client beliefs, therapy collaboration, emotion regulation, client determination, cultural awareness, individualisation of therapy, positive emotional connection, emotional awareness of their client, response to connection issues, emotionally self-aware, guiding, clarifying, emotionally reflective, open to feedback, self-aware systems, current in literature, discrete behaviour, therapist beliefs, language use, and structure. Poles were labelled that conceptually sit in the same space as the items, they were: emotionally aware of the client (D1+), emotionally self-aware (D1-), discrete behaviour (D2+), therapist collaboration (with the client) (D2-), therapist' beliefs (about the client and therapy) (D3+), and structure (D3-).

Marwick's (2011) research drew upon Harvey et al.'s (2017) 109 items as a means of profiling the social-emotional characteristics therapists report using in their practice. The 109 items were reduced to 51 items through arranging the items in a hierarchical tree, or dendrogram, to reveal the similarities between the items so they could be removed. The 51-items were then given to 48 therapists in a modified version of a Method of Successive Sorts (MOSS; Block, 1961) Q-Sort. The Q-Sort involved participants deciding the order of items based on how the items related to their own therapeutic practice. The participants' responses were incorporated into the map generated by Harvey et al., which provided evidence for the most frequent social-emotional competencies reported, as well as the patterns of competencies endorsed.

Ultimately Marwick (2011) identified and labelled ten 'hot-spots', which represents a core node of meaning or broad theme (Bimler & Kirkland, 2001) that in this case summarised the clinicians' therapeutic emotion use. The identified hot-spots were: meaning making, self-improvement, empathy, therapy collaboration, tailoring therapy, clarifies, discrete behaviours, emotional communication, guides, and emotional self-awareness and self-acceptance. See Table 1 for the hot-spot descriptions.

Table 1

Description of Marwick's (2011) Hot-spot Labels

Hot-spot Label	Hot-spot Description
Meaning making	The therapist finds meaning in clients' experiences
Self-improvement	The therapist aims to learn and to improve their therapeutic practice
Empathy	The therapist draws on their own emotions and information to relate to the client
Therapy collaboration	The therapist promotes collaboration with the client
Tailoring therapy	The therapist adjusts their approach specifically to suit the client
Clarifies	The therapist seeks assurance that they understand the client
Discrete behaviours	The therapist modifies their behaviour to facilitate client outcome
Emotional communication	The therapist conveys warmth when communicating with the client
Guides	The therapist is directive in therapy
Emotional self-awareness and self-acceptance	The therapist knows themselves emotionally and values aiding others

Furthermore, Marwick found evidence for seven different response profiles based on the therapists' self-reported endorsement of the ten hotspots. These were labeled as: unemotional guider, overt behaviours and unguiding, emotion centered and unguiding, client centered and individualising, moderates, self-improver, and partnership not warmth. Marwick's research therefore found therapists' self-report of their social-emotional competencies to be highly relevant to their practice with their clients. The importance of these findings is likely to augment any investigation into the social-emotional practices and emotional awareness of therapists in two ways. Firstly, such research will enable therapists' social-emotional practices to be identified and compared to their ability to recognise emotion. Secondly, it will enable the measurement into any changes in emotion recognition to be correspondingly assessed by self-reported social-emotional practice.

The Current Study

Criticisms of expressed emotion recognition research. Wallbott and Scherer's (1986) article highlights reasons why the scientific study of emotion has been difficult. They report that devising a methodology that is both ethical while remaining naturalistic and spontaneous to be difficult. Additional criticisms of literature on emotion continue to be reported. For example, Bänziger et al. (2009) raise three main criticisms of emotion recognition research. The first is there has been limited development of psychometrically and validated tests of emotional expression accuracy. The second criticism is the majority of emotional expression tests have included the face or the voice rather than combining the two, and thirdly, tests are limited in that they generally include only a small number of emotion labels. To counteract criticism three, Bänziger et al. suggests forming an emotional recognition measure that presents a large number of emotion labels to choose from. This is recommended as increasing the number of

choices will act to reduce the chance of the person making correct judgments purely through guessing.

With and Kaiser (2011) raise issues with the generalisability of the results for studies investigating emotion identification ability. Firstly, the authors highlight that research in this area often uses facial emotional expressions that are produced by actors, and the actors are often given strict instructions on the way in which they are required to pose for the emotion. Secondly, they raise the issue that such research often involves the removal of important additional elements that would normally be part of communication in reality, for example, contextual cues. Finally they argue that static images are unable to portray unique information, such as dynamic factors, which would be available when one is interacting with someone face-to-face. They summarise that all of the above factors are likely to influence real-life ability to accurately perceive emotions.

The implications of these criticisms are that the gold standard for research into emotion identification, or recognition, should involve real life situations. This is logical given emotional instances or events often involve other people, and consequently occur in a social setting, not in an artificial environment. It therefore seems neglectful to generalise research on non-authentic emotional instances to real life situations, as it is evident that such findings would not portray an accurate representation. Examples of how more real life experiences can be integrated into emotion recognition research comes from Keightley, Chiew, Anderson, and Grady's (2011) research; these authors found that scenes involving at least one person were better recognised by participants than pictures of faces. They state their results suggest visual presentation of stimuli influences memory for emotion recognition. Similarly, Fernández-Dols' (2013) argue that research on facial behaviour needs to utilise a dynamic approach, so research is

representative of real life expressions. This seems to be a reasonable expectation given it enables individuals' emotion recognition skills to be measured in comparable contexts to which they are likely to operate in. As clients present with a wealth of information of their mental state; understanding can be derived from considering someone's appearance, expressions, tone, and posture during dynamic exchanges with their therapist. However, other research has found contradicting evidence. Fiorentini and Viviani (2011) found no difference between participants' accuracy when examining expressive movements and static pictures. However, methodological issues may explain Fiorentini and Viviani's result of a failure to detect a difference in identification when examining static versus dynamic presentations. The authors state a ceiling effect was present, which would have influenced the results, as the static stimuli presented were of fully developed expressions, while the dynamic stimuli presented the unfolding of an expression.

Foundation research. Therapists' social-emotional competencies have been linked to how practice is conducted with clients. An example of this is Marwick's (2011) research which was discussed previously. However, no known study had investigated the association between clinicians' social-emotional practices, their accuracy in emotional facial recognition, and self-perception in their awareness of their clients' emotions until Johnsen's (2013) study. Thirty four clinical psychologists completed a modified version of the Therapist Social-Emotional Interactions Questionnaire (TSEIQ; Marwick, 2011) and an emotion recognition task. Results from the study supported the same ten key social-emotional therapeutic practices, or hot-spots, identified in Marwick's (2011) study.

Other findings from Johnsen's (2013) study were that the clinicians' ability to perceive emotions accurately was associated with particular social-emotional practices.

For instance, practices associated with empathy and emotional self-awareness and self-acceptance were positively correlated with the clinicians' ability to recognise emotions.

This suggests that those who report spending a significant part of their practice being empathic and emotionally self-aware and self-accepting are more effective at recognising their clients' emotions. In addition, the use of the *guides* hot-spot as a core practice was found to negatively correlate with the accuracy of clinicians' emotion recognition. This suggests that those who report spending a significant part of their practice guiding are less effective at recognising their clients' emotions. Six predominant social-emotional practice profiles emerged from the data collected. See Figure 1 for a graphical representation of the six profiles generated.

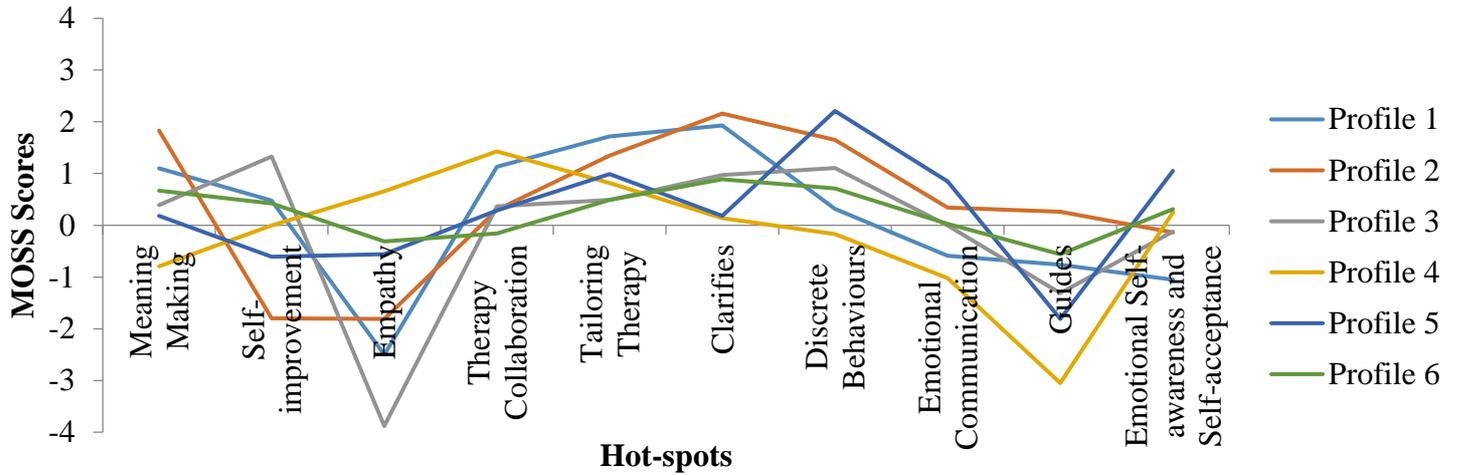


Figure 1. Graphical depiction of the variation in the participants' social-emotional profiles formulated from their questionnaire responses.

Note: a high or low score refers to greater and lower hot-spot endorsement respectively.

Profile three was characterised by a low score on *empathy* and a high score on *self-improvement*. Profile four was characterised by a low score on *guides* and a high score on *therapy collaboration*. The older participants were largely grouped in profile three, which had the lowest score on *empathy* and highest score on *self-improvement*. The youngest participants were mainly grouped in profile five, which had the second lowest *guides* score and the highest score on *discrete behaviours*. The analysis on practice experience showed the same pattern as the age analysis (which is expected as they are connected); participants with the least experience were predominantly grouped in profile five, while the participants with the greatest experience were mostly grouped in profile three.

In Johnsen's (2013) study, those clinicians who identified *empathy* and *emotional self-awareness and self-acceptance* as core practice areas had their data

combined into an emotion practice group. Data from the remaining participants were grouped into a limited emotion-practicing group. The participants' emotion recognition performance scores were compared between the two groups. The results suggested that the emotion recognition performance of the emotion practice group was higher compared to that of the limited emotion-practicing group. In addition, no relationship was found between clinicians' emotional awareness and their self-perceived emotional awareness. In other words, clinicians' beliefs about their accuracy in detecting emotion were unrelated to how accurate they actually were. Given participants tended to consider their emotional awareness to be highly accurate, it may mean clinicians require more feedback regarding their emotion capabilities. However, the finding that there was no association between the clinicians' self-perceptions of their abilities to recognise emotion needs to be interpreted with caution, as a ceiling effect was present. Furthermore, since Johnsen's study was the first to have employed the original questionnaire developed by Marwick (2011) to profile clinicians' social-emotional practices, further research should look to replicate the method to see if similar social-emotional profiles emerge with larger samples.

In conclusion, there is support for emotional competencies as being relevant in therapy. In addition, the generation of Marwick's (2011) and Johnsen's (2013) profiles lends support to social-emotional skills of therapist being able to be measured and then placed into emotional profiles based on the differences in self-reported practice. However, additional questions have been raised by the results from Johnsen's (2013) research, and these questions will form the core of the investigations for the current study.

Summary. Although therapists are likely to be conceived as being skilled at perceiving others' emotions, limited research has been conducted to support this assumption. There is also a dearth of research that has considered therapists' decoding skills and emotional practice, and whether providing emotion training to therapists will enhance these abilities. This is surprising given the numerous studies and articles that argue therapists' emotional competencies to be an important contributing factor for therapy in general and to therapeutic outcome. The current study is therefore timely, as it aims to address this gap in the literature.

Aims

The purpose of the current research is to further explore therapists' emotion recognition abilities, their self-reported emotional practices and awareness, and what influence training has on these variables. Since the current research is interested in recognising commonly occurring emotional displays supported in the literature, the primary emotions as proposed by Ekman will be used in the current study. Furthermore, all participants in the current study will be drawn from the New Zealand population, so the cultural backgrounds of the participants will remain as consistent as possible. This consideration is made to reduce any possible participant variation in emotion recognition, such as variance that might be present due to participants being from different cultural groups. This will therefore ensure increased accuracy for all participants.

Based on the previously conducted literature review, six research questions were formulated and will be addressed later in this thesis, these include whether: 1) emotion training, which is aimed at enhancing emotion recognition, increases therapists' ability to accurately identify expressed client emotion in therapy; 2) emotion training enhances therapists' self-reported emotional practice (where self-reported emotional practice is measured through the level of endorsement of emotional practice items on a social-emotional questionnaire); 3) emotion training increases therapists' self-reported emotional awareness; 4) a relationship exists between therapists' ability to recognise emotion during therapy and their self-reported emotional practice; 5) a relationship exists between therapists' ability to recognise emotion during therapy and their self-reported emotional awareness; 6) A relationship exists between therapists' self-reported emotional practice and their self-reported emotional awareness. The current study will provide much needed research into an area that, despite being discussed and

hypothesised about, has been scarcely investigated. If the training intervention were found to enhance emotional abilities in the therapist participants, and any associated change was also found to be beneficial for client outcome, this would provide support for the implementation of such trainings for therapists.

Chapter Two: Methodology

Ethics

The study was reviewed and approved by the Massey University Human Ethics Committee: Southern A, application 13/65 (see Appendix A).

Overview

To achieve the study aims, specific resources were developed to support the measurement of emotion recognition. The first methodological step was to create the Emotional Practice Film Stimulus (EPFS). This allowed the measurement of any change following an emotion recognition training intervention. Once the EPFS was developed, it was uploaded onto a website that was designed for the purposes of testing the hypotheses of the current research. In addition to the EPFS, the website included other measures, therefore permitting the main study to be conducted entirely online. See Appendix B for screenshots of the website. Participants and their recruitment, the consent processes, research apparatus, and procedure for the EPFS generation are described in more detail below.

Development of Emotional Practice Film Stimulus

Participants and recruitment. Written permission was sought and obtained from the Director of the Massey University Psychology Clinic Palmerston North (PN), requesting permission to recruit from the clinic client and therapist pairs, and therapists independent to the research (see Appendix C). The client and therapist pairs were recruited for the purpose of filming therapy sessions, and an independent therapist was sought to reduce the possibility the client would feel obligated to participate in the research.

Therapists working in the Massey University Psychology Clinic (PN) were informed of the research by the researcher during a morning team meeting, and research

advertisements were displayed in the clinic for both clients and therapists (see Appendix D and E respectively). Therapists were asked to mention the research project to eligible clients. Eligible therapist participants were required to be registered as a psychologist or psychotherapist and currently be practicing. These inclusion criteria were imposed to maintain continuity with the main study, which recruited participants from a similar population. To be eligible to participate as a client, inclusion criteria required someone to be over the age of 16 years, paying for the session privately, and attending therapy alone. The purpose of these criteria was to reduce the possibility of confounding variables contributing to the clients' presenting problems. The criteria meant clients had to provide their own consent, the film was able to be purely focused on the emotional expressions of one individual, and the client had the opportunity to receive a free therapy session. Those therapists and clients who expressed an interest in the research were provided with an information sheet and asked to make contact with the researcher through their preferred mode of contact (see Appendix F, G, and H for these information sheets).

Consent processes and materials. The researcher followed up with interested clients utilising the contact method they preferred (i.e., via email and/or telephone). During this initial contact the researcher ensured the client had a copy of the information sheet, answered any questions about the research, and discussed the client's availability for their therapy session to be filmed. If the client agreed to participate a convenient date and time was scheduled for their therapy session to be filmed. If the client did not agree to participate they were thanked for their time and no further contact was made with them regarding participation in the research. See the Figure 2 below for a visual representation of the participant recruitment for the filming phase of the research.

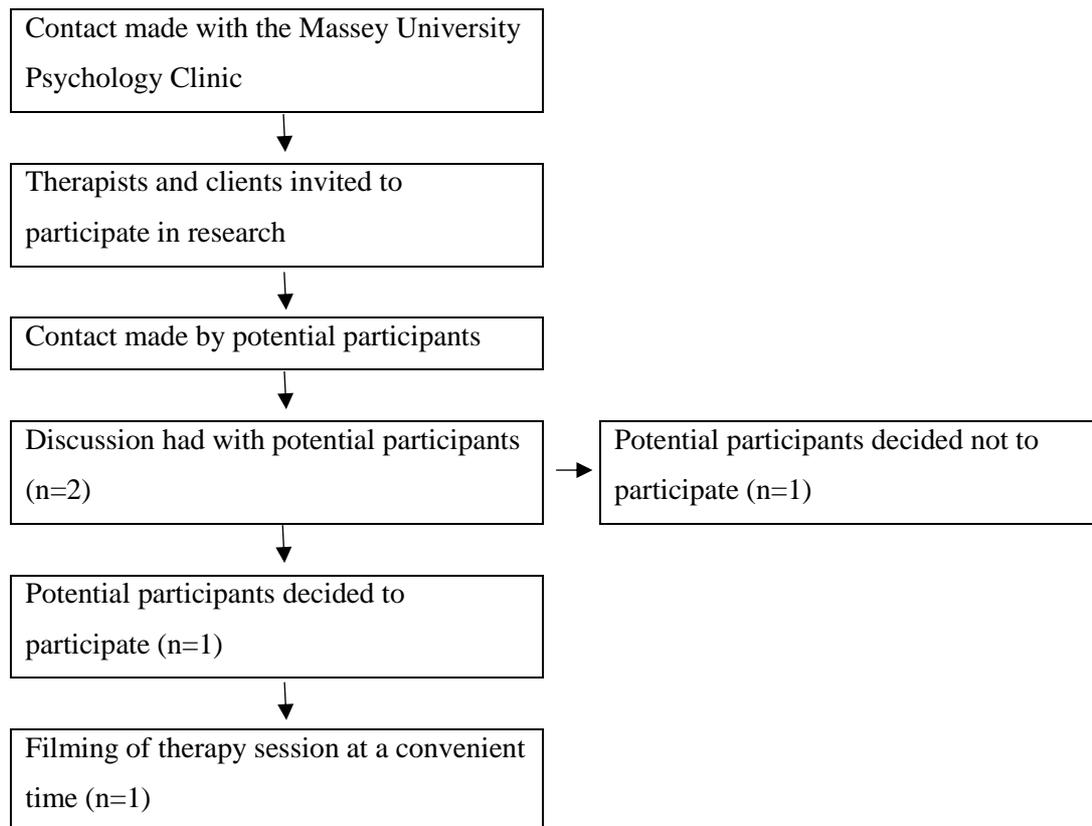


Figure 2. Participant recruitment for filming of stimulus.

The current study initially planned to film four therapy sessions and select one segment from the films. However, a suitable segment was found in the first session and this was therefore used. Consent was sought at different stages for each of the participants involved in the filmed therapy session. The four stages of consent are explained below, and also shown visually in Figure 3.

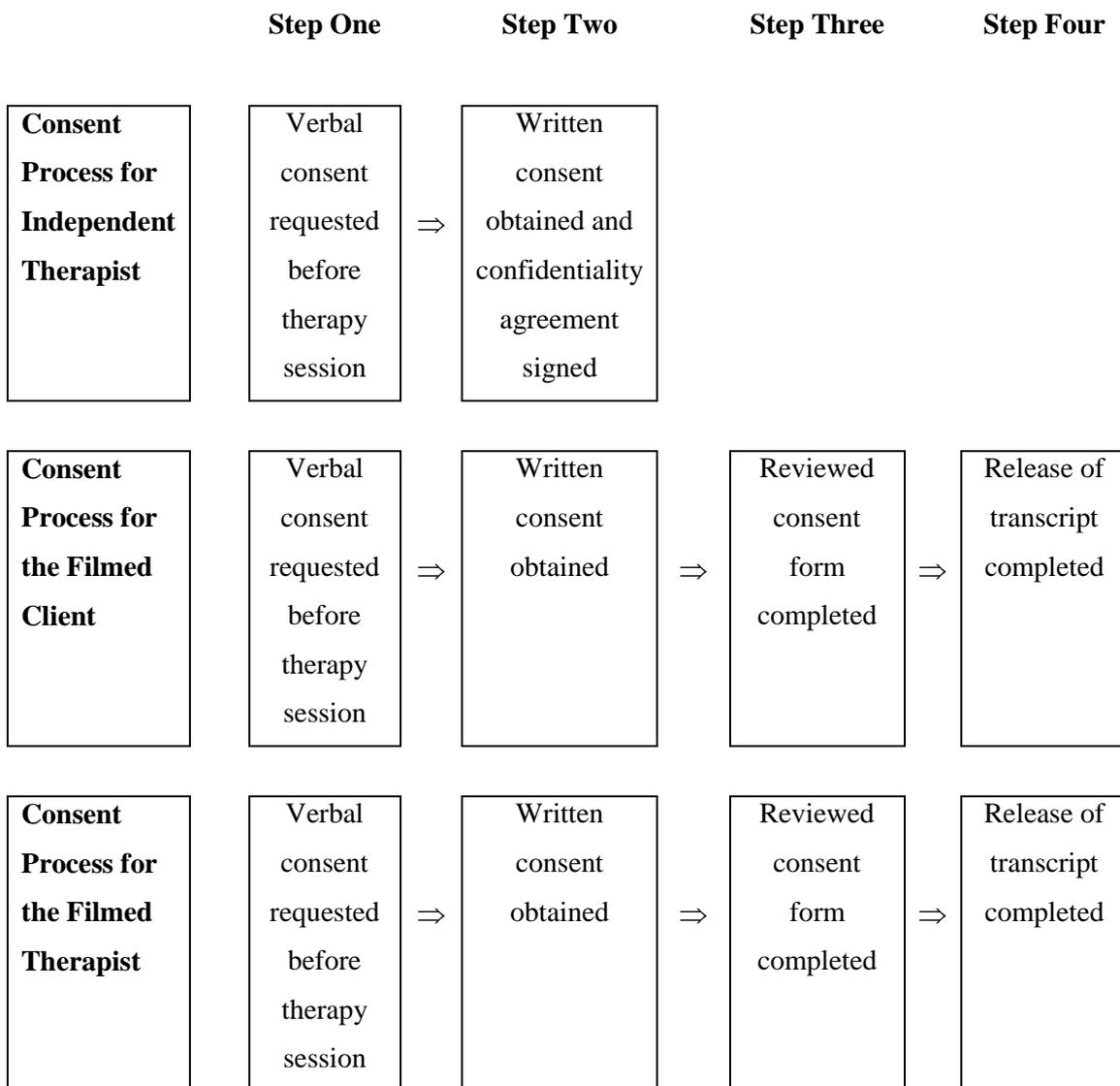


Figure 3. Consent process for filmed participants.

The researcher contacted the client before their scheduled therapy session to ask for their verbal consent to be involved in the research. This contact was made to reduce the chance of the client feeling coerced into being filmed on the day they arrived for their scheduled therapy. The researcher also held discussions with the consenting therapists to ensure they were still willing participants.

On the scheduled day for filming, written consent was obtained, which was the second step of consent. Firstly the researcher asked the therapist participant and

independent therapist to sign a participant consent form (see Appendix I and J, respectively), and a confidentiality agreement for the independent therapist (see Appendix K). To minimise the potential of coercion, an independent therapist conducted a separate consent process. This involved the independent therapist entering the therapy room where the client was seated, invited them to ask any questions, asked them to complete the participant consent form (see Appendix L), and checked whether they wanted to receive the research results (see Appendix M). This took place before the client's therapist entered the therapy room for their therapy session and prior to the session being recorded.

The third consent process was only applicable to the client and therapist whose therapy session was used in the research. Both the client and therapist who were filmed were given the opportunity to review the selected therapy session segment before it was sent to two Facial Action Coding System (FACS; Ekman & Friesen, 1978) certified coders. The filmed client and therapist were asked to complete a reviewed consent form, which meant the participants consented to their selected film segment being sent to the FACS coders (see Appendix N and O for the client and therapist form respectively).

The last step of consent entailed asking the filmed client and therapist to agree to the final segment being used in the research (see Appendix P for the release of transcript forms completed).

Apparatus and procedure. To capture the video segment to be used to evaluate therapists' emotional competencies, a typical therapy room was used at the Massey University Psychology Clinic. In the therapy room, a portable Panasonic HC-V700 Full High Definition 1920x1080 Camcorder with 21 optical zoom and optimal image stabilisation technology was set up on a tripod prior to the therapy session taking place. The camcorder was situated behind the therapist's shoulder and faced towards the

client. The client's face and body was included in the filming view, and the audio of the therapy session was also recorded. However, the therapist's voice was ultimately removed from the final filmed segment to avoid the therapist's responses influencing the participating therapists during a later phase of the research.

At the therapist's request, the researcher turned on the camera when both the therapist and client were seated in the therapy room before the session commenced. The therapist who was filmed with their client turned off the camera at the conclusion of the therapy session.

After the scheduled therapy session, the researcher held an interview with the filmed client to ask questions about key emotional moments they experienced during their therapy session. An interview schedule was followed (see Appendix Q), and this interview was not recorded. On leaving the therapy room, the secure digital (SD) card was removed from the camera and the video was promptly transferred and securely stored on a password-protected computer. The original video copy was then destroyed from the SD card.

Although the intention was to use the client's report of emotional moments during the interview to inform the selection of film segments in the main study, the client reported being unable to identify any discrete emotional responses. In order to avoid placing pressure on the client into inaccurate reporting, the underlying reasons for this was not followed up. Furthermore, potential underlying reasons for why this information was not reported by the client is outside of the scope of this research. The current research is interested in identification of emotional responses, not the reasons for such responses.

As compensation for the client's and therapist's time, the cost of the therapy session was paid by the research budget.

Film segment. The researcher completed the Subtle Expression Training Tool (SETT) developed by Dr Paul Ekman until an expert level was achieved (i.e., obtained an accuracy level above 85% for the practice phase of the training). The researcher then personally watched the full-filmed therapy session in real time, pausing and noting down emotional instances they were able to identify. Since this therapy session was found to contain enough emotion expressions, it was deemed to be sufficient by the researcher to be used for the EPFS and further recruitment for filming was stopped.

The selection criteria for identification of targeted film segments included the following:

1. approximately 20 minutes in length,
2. contain sufficient emotion instances, greater than one per minute,
3. contain enough information for an individual to follow the discussion between the client and therapist, and
4. to lend itself to the removal of any identifying information.

Of the total 69 minute and 48 second therapy session that was filmed, the researcher settled on a 20 minute and 53 second video segment from the beginning of the therapy session. There was one instance where the filmed client referred to another individual in the segment, and this was consequently edited out. The rest of the client's voice however remained in the segment and, as previously mentioned, the therapist's voice was edited out of the segment.

Facial Action Coding System Analysis. To identify the filmed client's emotion expressions during the filmed therapy session segment, the segment was sent for review to two FACS certified coders, based in in New Zealand (see Appendix R for the confidentiality agreement that was completed by the FACS coders). A two-step process ensued; the first step was to verify the segment contained emotional instances, and the

second step was to identify and label the emotional instances according to the FACS. The FACS coders both watched the full segment independently in real time to identify emotional instances were present, which they both agreed there were. After this they were asked to indicate the nature of the emotional expressions made by the client throughout the selected filmed segment, and conducted FACS coding of the apex frame of each emotion identified. The apex frame is defined as the peak of the expression.

Verification of identified emotions. The two FACS coders' emotion identifications were mapped to survey concordance. For the emotions identified by both coders, the first and last time of the emotion that was identified were taken; this resulted in an initial 16 identified emotions. There were also 15 emotions that were not agreed upon between the two coders; the timeframes of these emotions were sent to the FACS coders who were asked to validate the discrepancies for agreement. Of the 15 non-agreed emotions, 12 emotions were resolved through the FACS coders having a discussion, and these were ultimately added to the list of 16 originally agreed upon emotions. Consequently this process resulted in 28 agreed upon emotions that were expressed in the main study.

Additional confidentiality agreements. The website programmer and technical support member, who assisted with the editing of the film, also completed confidentiality agreements (see Appendix S and T respectively).

Pilot

Before the main study was conducted, a research panel was asked to pilot the online task and to provide feedback on any areas that could be improved. The research panel was made up of a range of potential participants for the main study; two experienced psychologists (both male), an intern psychologist (female), and two

psychology students (both female) who were on placement at the Massey University Psychology Clinic. Issues raised were:

1. A trilemma task, that was originally planned to be included in the current study, was too complicated. This task involved presenting the participants with a set of three questions, or trilemma, where they were asked to select one that would best describe their response. The trilemmas were to be presented via pop-up on the website after an emotional instance decision was made by a participant. The item sets were created from the questionnaire to be used in the main study, whereby the items were reworded to represent a behavioural response. However, this task was described by the reviewers as confusing and difficult, and many felt it did not fit well with the other tasks asked of the participants.
2. Technological problems (i.e., error messages appearing when attempting to access the website from a cellphone, lagging of the video, and sound quality issues).
3. Many steps that participants needed to remember (i.e., where and when to login).
4. Forgetting the presented emotion options, which influenced ability to accurately response to expressed emotion in the film.
5. Video was reported to be too small.

In response to the feedback above:

1. The trilemma task was removed from the study.
2. Technological issues were resolved with the help of the website programmer involved in the project (i.e., the video file size was made smaller to speed up

the loading time, making it faster, and it was specified that the study had to be completed on a laptop or computer).

3. Participant login dates were made accessible for the researcher so they could see when logins were made and consequently send reminders, rather than relying on participants' memory, and a checklist was also added into the instructions.
4. An on-screen list of the emotions that could be selected was provided to remind the participants of potential options.
5. The video was made as large as possible.

Main Study

Design. The independent variable of the current study was the randomly assigned participant condition (training or no-training group). The dependent variables were the participants' accuracy in identifying emotions, their self-reports of their use of emotional practices, and their self-reported emotional awareness. This study was therefore a pretest-posttest control group design.

Participants and recruitment. An invitation and brief advertisement was sent to New Zealand professional bodies for counsellors, psychologists, and psychotherapists with a request that they distribute it to their members (see Appendix U for the item sent). The professional bodies contacted were the: New Zealand Association of Counsellors, New Zealand Christian Counsellors Association, New Zealand Psychological Society, New Zealand College of Clinical Psychologists, New Zealand Association of Child and Adolescent Psychotherapists, New Zealand Association of Psychotherapists, and the New Zealand Institute of Psychoanalytic Psychotherapy. The professional bodies who made contact after the initial advertisement email was sent to them, and those who also forwarded the research

invitation via email to their members, were recontacted a second time with a request that they resend the advertisement once more. This second contact was made with the New Zealand Christian Counsellors Association, New Zealand College of Clinical Psychologists, and the New Zealand Association of Psychotherapists. The second request was sent approximately two months after the first request. Interested individuals who fulfilled the criteria were asked to make contact with the researcher via email and sent a more detailed advertisement and information sheet if they wished (see Appendix V and W respectively). Although a total of 103 potential participants expressed their initial interest in participating in the study, ultimately a sample of 55 therapist participants completed all parts. See Figure 4 below for a visual representation of the recruitment process.

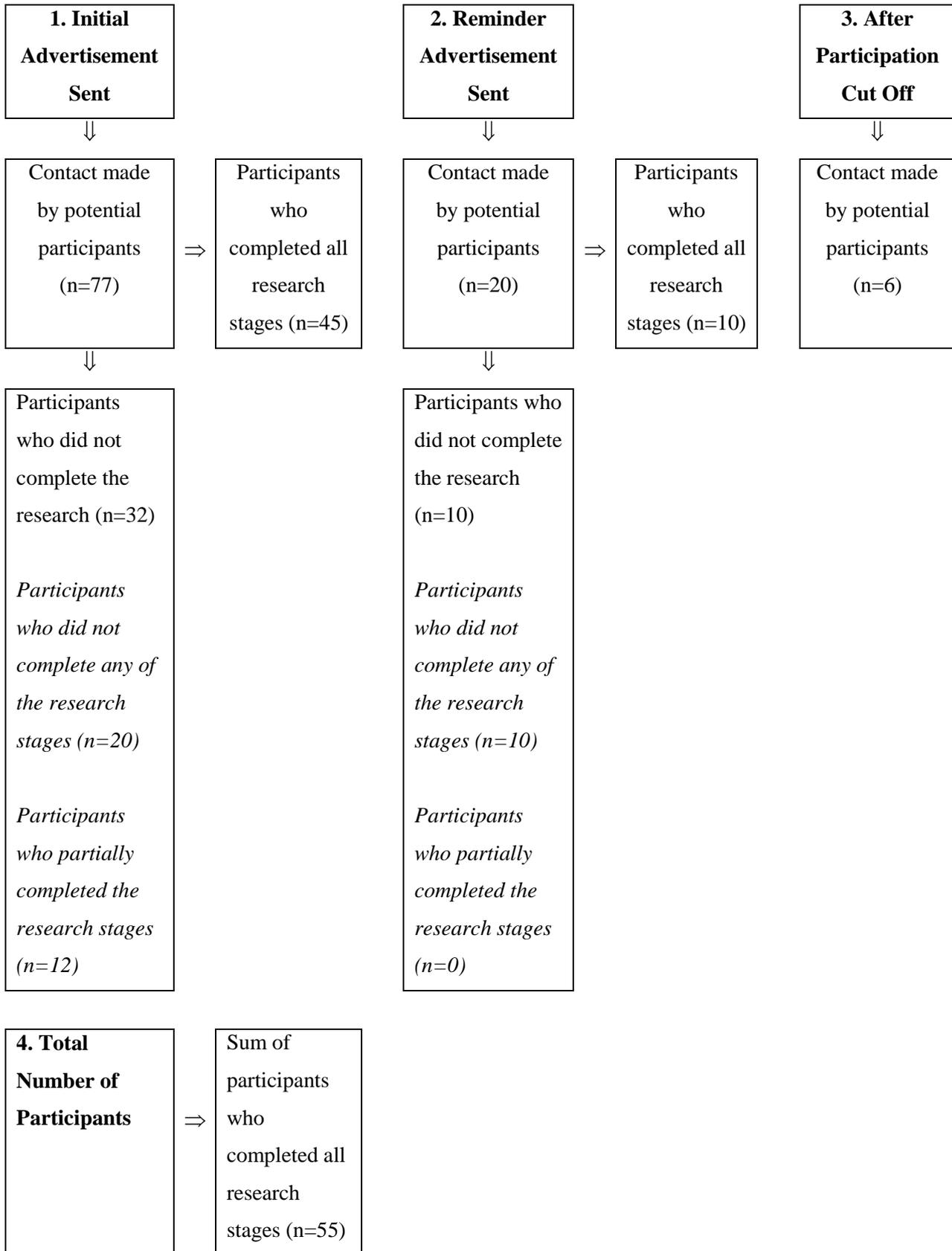


Figure 4. Participant recruitment stages for the video task.

The current study is interested in clinically significant effects that are noticeable and have a considerable influence on clients and their therapists, as therapy inherently elicits emotional instances; therefore a large effect is suspected. A large effect size is considered acceptable in this study based on previous research and the importance of clinical significance and utility of emotion recognition skills in therapy. In support of this rationale, previous emotion recognition research has been conducted by Kurtz and Richardson (2011) and Lopata et al. (2010). These studies investigated individuals diagnosed with schizophrenia and high-functioning autism, respectively, and found medium to large effect sizes for training effects. However, no other studies with a similar methodology and participant population could be found in this research area that have reported effect sizes. Martinez, Falvello, Aviezer, and Todorov (2016) study employed a methodology closest to that of the current, and while they do not report on effect sizes, or provide a justification for the use of their participant numbers, they included a similar number of participants to that used in the current study. Martinez et al. (2016) involved 32 undergraduate students for their first study and 60 volunteers from the community for their second.

The involvement of 52 participants was calculated to be sufficient for the current study when interested in mean differences, an alpha level of .05, a power value of .80, and a suspected large effect size of Cohen's $d = .80$ (see Cohen, 1992). The current sample size of 55 participants therefore met this target.

Demographic data collected from participants included their gender, ethnicity, location (city and country), and age. Additional collected information included the participants' years of experience, professional training, and foremost therapeutic approach. The participant group was composed of 31 psychologists, 23 counsellors, and one psychotherapist. The participants were predominantly female (48 female, 87%;

seven males, 13%), with a large percentage (86%) of participants identifying as European (47 European), five Middle Eastern/Latin American/African, two Asian, and one Pacific Peoples. All of the participants were located in New Zealand, with 62% from the North Island and 36% from the South Island (note that one participant did not indicate which island they reside). The participants' ages ranged from 25 years to 69 years with a mean of 46 years, and years of experience from half a year to 30 years with a mean of 10 years of experience. Cognitive Behavioural Therapy (CBT) was the most popular reported therapeutic approach used by the therapists (51%). Other therapeutic approaches noted were: Narrative Therapy (9%), Person-Centered Therapies (9%), Acceptance and Commitment Therapy (7%), and 24% classified their therapeutic approaches as "other."

A list of 60 numbers were put into an online random number generator from <https://www.randomizer.org> to generate two groups. Each number (or participant number) then represented a randomly assigned group condition, either into the training or no-training group. Each time a therapist expressed their interest, they were allocated into one of the 60 spots and this determined which group they were in. For those participants who initially responded but did not start or complete the research, their spot was then reallocated. The procedure section below will provide more detail as to what the therapists completed and when, but first, the materials deployed will be described.

Materials. Two measurements were utilised for this study; a questionnaire aimed to measure participants' self-reported use of emotion in practice (with added emotional awareness items), and the Emotional Practice Film Stimulus (EPFS) generated in the first phase of the research and used to measure participants' accuracy in identifying emotion. The Subtle Expression Training Tool (SETT) was also used, although not as a direct measure; it was the emotion recognition training administered to

those participants randomly assigned into the training group. The questionnaire, EPFS, and SETT will be described in more detail next.

Therapist Social-Emotional Interactions Questionnaire-Revised. The Therapist Social-Emotional Interactions Questionnaire-Revised (TSEIQ-R; Marwick, 2016) was used in this study as a measure of therapists' social-emotional interactions with their clients. The TSEIQ-R is 71 items with each item rated on a five-point Likert scale regarding "how true" each item relates to therapists' clinical practice. The five options provided were: "very true", "mainly true", "unsure", "slightly true", and "not true at all." The TSEIQ-R is based on the Therapist Social-Emotional Interactions Questionnaire (TSEIQ; Marwick, 2011), which is a 51 item questionnaire addressing clinicians' emotional competencies. The TSEIQ-R focuses on the same theme as the original TSEIQ but the items were refined and added to. See Appendix X for the TSEIQ-R.

Marwick (2016) labelled eight "hotspots" present in the TSEIQ-R, which are defined as being the co-occurring clustering of items, and are therefore argued to approximate common participant response patterns. See Table 2 below for an adapted version of Marwick's (2016) table that defines the eight hot-spots, provides a description of each, and also presents a brief list of the three most representative TSEIQ-R items for each hot-spot.

Table 2

Hot-spots, Descriptions, and Items Defined from the TSEIQ-R

Hot-spot and Description	Items Within the Hot-spot
Deliberate therapeutic behaviours (DTB)	I model the appropriate way to act for my clients
Intended therapeutic behaviours	I dress in a way that support my professional position I engage in deliberate therapeutic practice
Emotion coaching (EC)	I reflect or communicate an understanding of the client's feelings
Recognising emotion, realising the potential opportunity of the emotion and learning from it, and empathising	I am attentive to my clients' reactions I validate clients' experiences
Emotion self-awareness (ESA)	I regulate my level of emotional attachments to clients
Being conscious of emotions in all aspects of life	I monitor whether or not my emotions are useful during therapy I am aware of my own emotions during therapy
Altruistic growth (AG)	I am comfortable with referring clients on when required
Questioning of own practice	My therapeutic effectiveness is important to me I am satisfied by my work
Directive (D)	I am directive during therapy
Guiding the therapeutic process	I encourage clients to move on when emotional I offer hunches about client experiences
Self-confidence (SC)	I expect quick, significant change
Being confident in own therapeutic abilities	I believe that I am the expert I believe clients often seek to be influenced
Client empowerment (CE)	I encourage clients to find own motivation for change
Extent of client encouragement	I discuss the possibility of relapse with clients I explicitly encourage clients to be open and honest with me
Therapeutic collaboration (TC)	I view the therapeutic relationship as a primary tool of therapy
Therapist's skill in collaborating therapeutically with their client	I view treatment as a partnership for change I ensure that therapy occurs in an atmosphere of mutual respect

Adapted from Marwick (2016)

Additional emotional self-awareness items. Four additional items were added to the questionnaire phase of the current study to specifically examine participants' self-reported emotional self-awareness. These items were: "*I am aware of others' emotions*", "*I can recognize the emotions of others*", "*I empathize with others' emotions*", and "*I am able to understand others' feelings*". Johnsen (2013) originally used these four items; they were developed through first examining a range of validated emotional awareness measures. Johnsen presented a pool of nine items to a research panel consisting of five members from an emotion research group. Members of the research panel were asked to create three unique items they believed captured the essence of emotional self-awareness, while also drawing on their own emotion based knowledge, and considering the nine items presented. The nine items therefore were not used directly, but instead used as prompts to inspire the individuals on the panel to create paraphrased, summarised versions that captured the single underlying construct. Of the nine items initially presented, two were taken from the Emotional Quotient Inventory (EQ-i; Bar-On, 1997) and seven from the Trait Emotional Intelligence Questionnaire (TEIQue; Petrides & Furnham, 2003). The participants' responses were examined and compared to find the prevalent themes, and ultimately four items created from the participants' 15 responses were selected. A Cronbach's alpha analysis was conducted on these four additional items in Johnsen's study to assess the internal consistency reliability, as well as to test whether there was support for these items to be used as one concept and ultimately one score. The Cronbach's alpha was a moderate high value of .77, which suggests the items could be seen as conveying one construct.

Emotional Practice Film Stimulus. As discussed previously, the EPFS was created so it could be used as a measure of therapists' ability to identify client emotion in a real life therapy session. The EPFS was uploaded on an emotional practice website

established for this study. The therapist participants in the main study were instructed to click on the film when they could identify an emotion displayed by the client.

Following this click, a master list of emotions was then provided for the participants to choose which best represented the emotion of the client. The list of emotion labels consisted of: anger, contempt, disgust, fear, happiness, sadness, or surprise. These were selected as the response options as they are argued in the emotion literature to represent universal emotions. Furthermore these labels were utilised in the emotion recognition training employed in the current study, which intends to increase one's ability to identify these emotions. After the participants made their emotion label selection, they were able to continue playing and responding to the EPFS.

Two seconds were added to the exit point of identified emotional displays identified by the FACS coders. The addition of this two seconds was permitted to take into account recognition of emotions and likely reaction time (see Atkinson, Dittrich, Gemmell, & Young, 2004; Kret, Pichon, Grèzes, & de Gelder, 2011; Martinez et al., 2016). Participants were unaware of how their responses were scored, therefore there should have been no incentive for participants to either over or under respond for the sake of their performance.

Subtle Expression Training Tool. The SETT, which was created by the Paul Ekman Group, was used as the emotion recognition training tool in the current study to improve subtle emotional expression recognition. Subtle expressions are defined as small facial movements commonly seen in one area of the face (Paul Ekman Group, 2011). The SETT is comprised of facial emotion expressions from the seven universal emotions that again are: anger, contempt, disgust, fear, happiness, sadness, and surprise. The speed that the facial expressions are viewed at can be varied to aid learning, although participants were asked to keep this set at the “normal” rate. On conclusion of

the learning phases there was a practice stage, whereby emotion expressions are shown and the individual participating in the training is required to make a decision as to what emotion expression they think was being expressed. Once the practice phase is complete, the individual is provided with an accuracy score.

Procedure. Following the therapists' expression of interest in the research, scheduling of a convenient date for their participation was organised. Therapists were informed of the time commitments required to participate in the study:

1. The TSEIQ-R would take them approximately 15 minutes to complete,
2. The filmed therapy segment was approximately 20 minutes in length, and
3. Their training commitment would be dependent on what group they were randomly assigned to.

For participants randomly assigned to the training group, they were required to complete four sessions of the SETT over a two-week period. This equated to approximately two-hours of training time in total, as each SETT set took approximately 30-minutes. For the participants randomly assigned into the no-training group, they were instructed not to engage in any facial emotional training for the intervening two-weeks before the final phase. Four sessions of the SETT spaced over a two-week period was selected based on previous research that has used a two-week period of training (Calkins, McMorran, Siegle, & Otto, 2015; Hoorelbeke, Faelens, Behiels, & Koster, 2015) with studies using between two to ten session of training (Calkins et al., 2015; Hoorelbeke et al., 2015; Klimecki, Leiberg, Lamm, & Singer, 2013; Warren et al., 2009). The time commitment required from participants was also an important factor considered, as the current study did not want to be a burdensome task for participants.

The participants were provided with their relevant instructions via email (see Appendix Y and Z for the instruction sheets for the training and no-training group

respectively). The date each participant started the first phase of the study was recorded so reminders could be sent to the participants regarding when they needed to complete the remaining phases of the study. On the day the participants selected to begin their participation, they were instructed to follow the steps set out in the instruction sheets. This involved them first logging into a password protected website with an individualised password, which had been provided for them. After logging into the website the participants completed a consent form, confidentiality agreement, a request for results option, and provided demographic information. They then answered the TSEIQ-R along with the additional emotional awareness items used in Johnsen's (2013) study, as described previously. After the participants completed the questionnaire they proceeded to watch the film segment. As previously mentioned, see Appendix B, which contains screenshots of each of these online screens, although excluding any images of the filmed client to maintain their confidentiality.

The participants randomly assigned to the training group were instructed to email the researcher the date and the score obtained each time they completed a session of the SETT. A recording sheet of this information was provided in the instructions for the training group, for the participants' own records.

After the two-week training or no-training period the participants again logged into the website using their login and password and completed the same steps they had initially on the website, excluding the demographic data screen. The participants in the no-training group, who had not received access to the SETT, were instructed to email the researcher to request this access on completion of the study. See Appendix AA for these instructions.

The participants' responses to the TSEIQ-R and the EPFS both prior and post the two-week training or no-training intervention were recorded in an excel spreadsheet

and saved within the website. The website programmer was instructed to retrieve the saved data once all participants had completed the study. This data was then transferred into an International Business Machines (IBM) Statistical Package for the Social Sciences (SPSS) data file so the data could be analysed.

Chapter Three: Data Analysis

Overview of Research

Figure 5 below will be referred to within this section, as it provides an overall summary of the variables, hypotheses, and statistical analyses relating to the current study. The first box in the figure, which is unnumbered, represents the first statistical analysis step undertaken, as before the main statistical analyses could be run to address the hypotheses, the raw data needed to be examined to ensure its structure and appropriateness for any following analyses. The small boxes on the right hand side of Figure 5 represent the six hypotheses of the current study, and the larger boxes to the left of these (numbered one to six also) state the resulting six relationships of variables that are of interest to each hypothesis. The italicised text is the statistical analyses run for each of the variable relationships of interest, or hypotheses. A detailed description of Figure 5 follows.

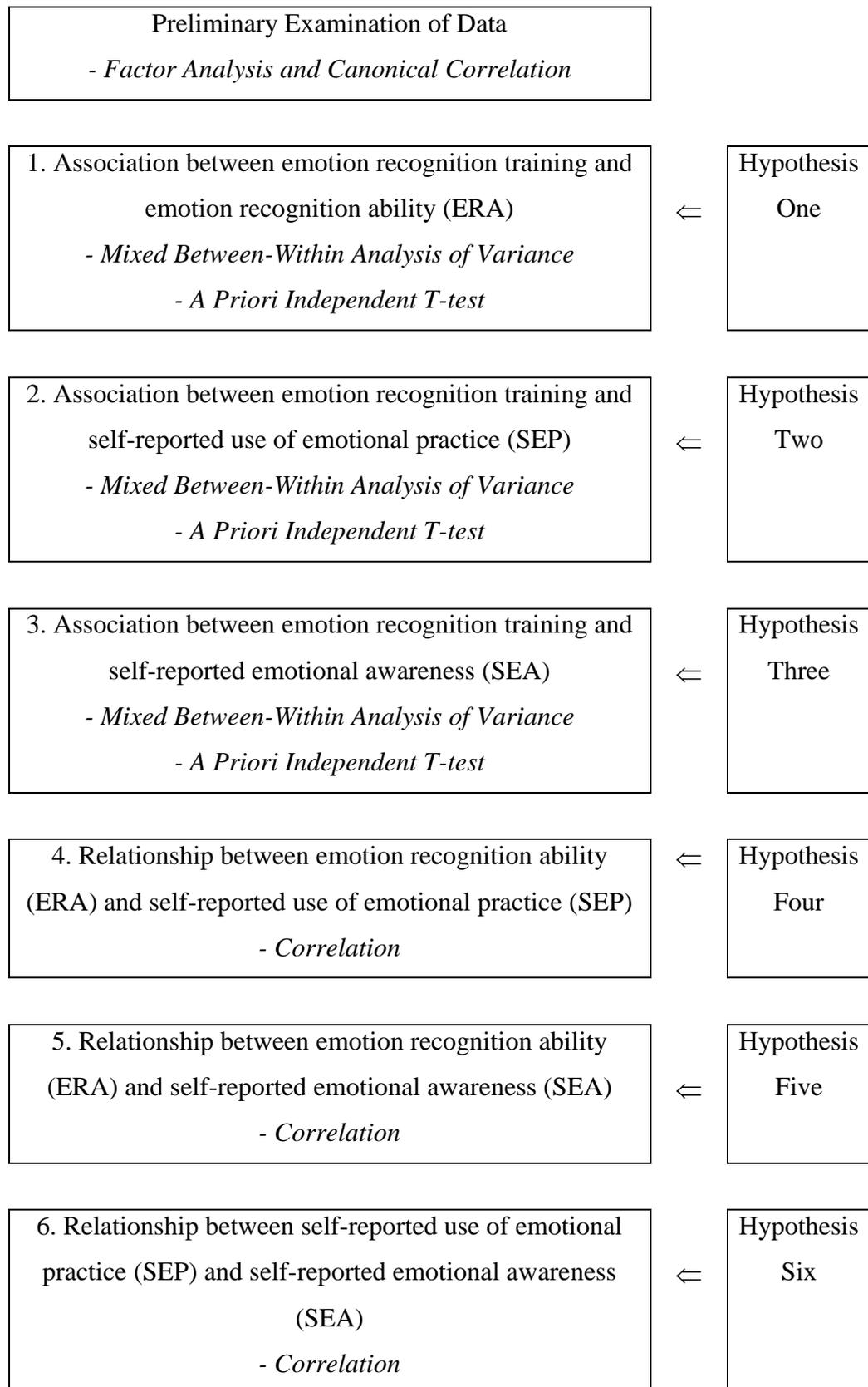


Figure 5. Conceptual overview of the research variables, hypotheses, and data analysis phases to be undertaken in the current study.

Six research questions and associated hypotheses emerged from the review of the literature, which, as mentioned previously, are displayed in Figure 5 above. These included whether:

1) Emotion recognition training would increase therapists' ability to accurately identify expressed client emotion in therapy. I hypothesised that participants receiving emotion recognition training would be more accurate in their emotion recognition once they have completed the Emotional Practice Film Stimulus (EPFS) compared to participants who have not. To test this hypothesis, an emotion recognition ability (ERA) score was calculated for each participant at time one and time two (based on the participants' responses on the EPFS). Their ERA scores were added as a dependent variable into a mixed between-within subjects analysis of variance (as referred to Tabachnick and Fidell, 2013). Additionally, a planned a priori independent t-test comparison was conducted comparing the ERA scores of the training and no-training group at post-test. The purpose of these statistical analyses were to evaluate whether participants in the training group had higher emotion recognition scores at time two, as compared to those in the non-training group.

2) Emotion training would increase therapists' self-reported emotional practice, as measured by higher endorsement of emotionally valenced items on the Therapist Social-Emotional Interactions Questionnaire-Revised (TSEIQ-R; Marwick, 2016). More specifically, participants who received emotion recognition training would self-report greater use of emotional practice compared to those participants who have not. To test this, a self-reported emotional practice (SEP) score was calculated for each participant at time one and time two (based on the participants' responses on the TSEIQ-R), and these scores were added as a dependent variable into a mixed between-within subjects analysis of variance. There was also a planned a priori independent t-test

comparison conducted that compared the SEP scores of the training and no-training group at post-test. These statistical analyses were ultimately used to evaluate whether participants in the training group had higher self-reported emotional practice at time two, as compared to those in the non-training group.

3) Emotion training would increase therapists' self-reported emotional awareness. In this regard, I anticipated that participants who have received emotion recognition training will self-report greater use of emotional awareness compared to those participants who have not. To test this, a self-reported emotional awareness (SEA) score was calculated for each participant at time one and time two (based on the participants' responses on four additional specific self-awareness items), and these scores were added as a dependent variable into a mixed between-within subjects analysis of variance. Comparisons of the SEA scores between the training and no-training conditions at post-test were conducted using a planned a priori independent t-test comparison. The purpose of this analysis was to identify whether participants in the training group had higher self-reported emotional awareness at time two compared to those in the non-training group.

4) A relationship would exist between therapists' ability to recognise emotion during therapy and their self-reported emotional practice. I predicted a positive relationship would exist between participants' emotion recognition ability (ERA) and their self-reported emotional practice (SEP), irrespective of what condition they were randomly assigned to. To test this prediction, participants' ERA scores at time one and time two were each separately correlated with the participants' SEP scores at time one and time two. This statistical analysis will guide the evaluation on whether a positive and statistically significant correlation will be found between participants' emotion

recognition ability and self-reported emotional practice at time one and time two separately.

5) A relationship would exist between therapists' ability to recognise emotion during therapy and their self-reported emotional awareness. My hypothesis here was that a positive relationship between participants' emotion recognition ability (ERA) and their self-reported emotional awareness (SEA) would exist, irrespective of what condition they were randomly assigned to. To test this hypothesis, participants' ERA scores at time one and time two were each separately correlated with the participants' SEA scores at time one and time two. This statistical analysis was used to evaluate whether a positive and statistically significant correlation was found between participants' emotion recognition ability and self-reported emotional awareness at time one and time two separately.

6) A relationship would exist between therapists' self-reported emotional practice and their self-reported emotional awareness. The prediction was that a positive relationship between participants' self-reported emotional practice (SEP) and self-reported emotional awareness (SEA) would occur, irrespective of what condition they were randomly assigned to. To test this prediction, participants' SEP scores at time one and time two were correlated with the participants' SEA scores at time one and time two. Like the previous two research questions and associated hypotheses, this statistical analysis was used to evaluate whether a positive and statistically significant correlation was found between participants' self-reported emotional practice and self-reported emotional awareness at time one and time two separately.

Figure 6, which is provided below, illustrates the study's research questions and hypotheses. The arrows radiating from the *training* box in Figure 6 represent hypothesised causal relationships, and the numbers represent the six hypotheses made

for this current study (refer to Figure 5 and associated description above). Furthermore, the training box in this diagram represents hypothesised effects that the intervention has on the other variables, or remaining boxes. The remaining boxes represent the variables of interest, or dependent variables, of the current study: emotion recognition ability (ERA), self-reported emotional practice (SEP), and self-reported emotional awareness (SEA).

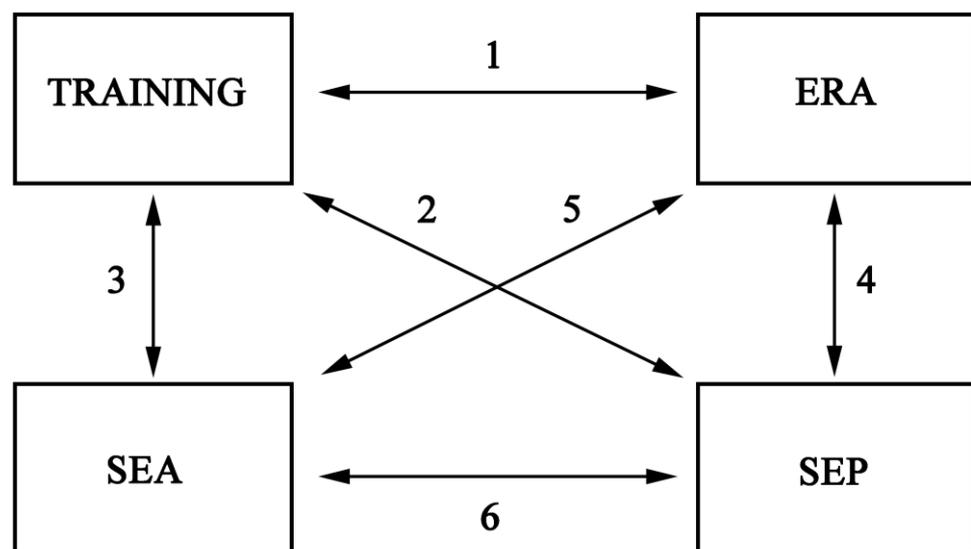


Figure 6. Visual depiction of the relationship between the hypotheses and variables of the current study.

Note: hypotheses are denoted by the six numbers, and variables are shown in the four boxes.

Analysis

Data were analysed using IBM SPSS version 24 (for Mac). The outcome measures for the analyses were statistical significance, which was set at $p < .05$, unless

otherwise stated. This alpha level is commonly accepted as an appropriate level for avoiding type 1 and type 2 errors. Type 1 error is when the null hypothesis is rejected when it is actually true, and type 2 when the null hypothesis is not rejected when it is actually false. Type 1 and type 2 errors are related, in that as one controls for type 1, type 2 error increases with the opposite also being true; when type 2 error is controlled type 1 error increases.

Effect sizes were estimated using either eta squared (η^2) or partial eta squared (η_p^2). Pallant (2010) reports and utilises the following guidelines proposed by Cohen (1988) to interpret the magnitude of change. These data are interpreted as follows: .01 for small, .06 for moderate, and .14 for large effects. These are the rules that were used for determining effect sizes in the current study. Where appropriate, Wilks' Lambda will be used to report on the power of tests.

Chapter Four: Results

Preliminary Examination of Data

Factor analysis and canonical correlation for the current study's items. The 71 items of the Therapist Social-Emotional Interactions Questionnaire-Revised (TSEIQ-R) at time one and time two were separately subjected to a factor analysis (principal components analysis; PCA). On inspection of the correlation matrix (22 components for each time period), 12% of both the time one and time two coefficients were .3 or above for the questionnaire items. The calculation of both the Kaiser-Meyer-Olkin value (Kaiser, 1970, 1974) and Bartlett's Test of Sphericity (Bartlett, 1954) was unsuccessful, as there were more items present than participants. Consequently, results suggested there was limited support for the suitability of the data for factor analysis. However, since the aim of this study is largely exploratory, factor analysis results were still examined, under the caveat of exercising caution due to the limitations of the data.

The principal components analysis provided support for five principal components, as five accounted for a significant proportion of the overall variance, and there was a visual slope of the curve, or the elbow, seen at the fifth component for each of the scree plots from the factor analysis. See scree plots in Figure 7 and 8 for the variance accounted for by successive factors for time one and time two respectively.

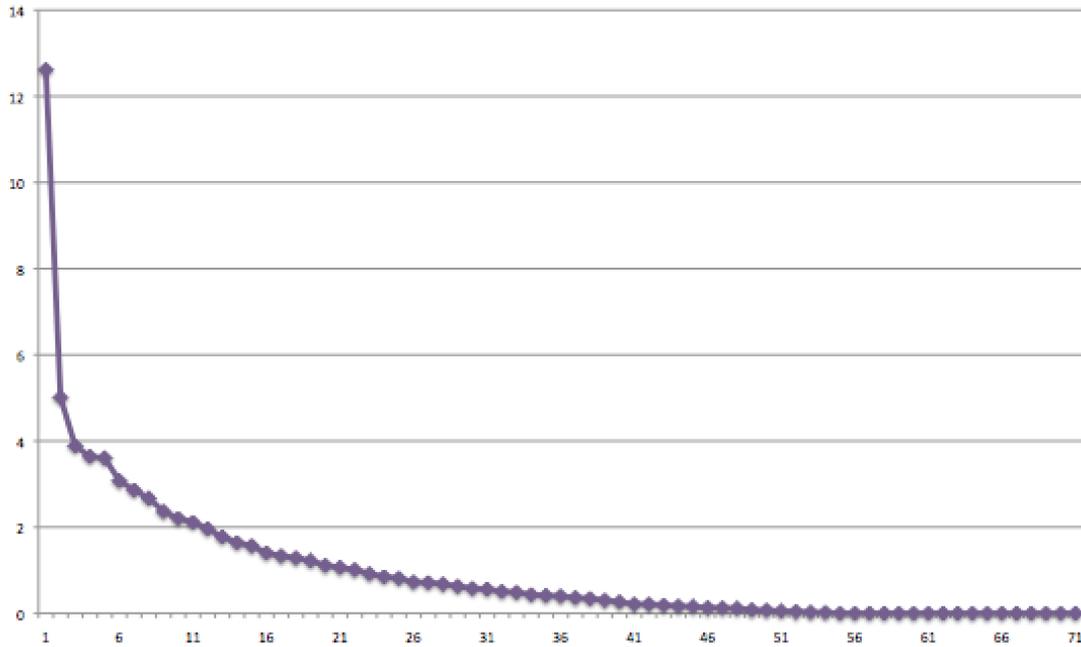


Figure 7. Scree plot of component by associated eigenvalue for the Therapist Social-Emotional Interactions Questionnaire-Revised (TSEIQ-R) data administered at time one.

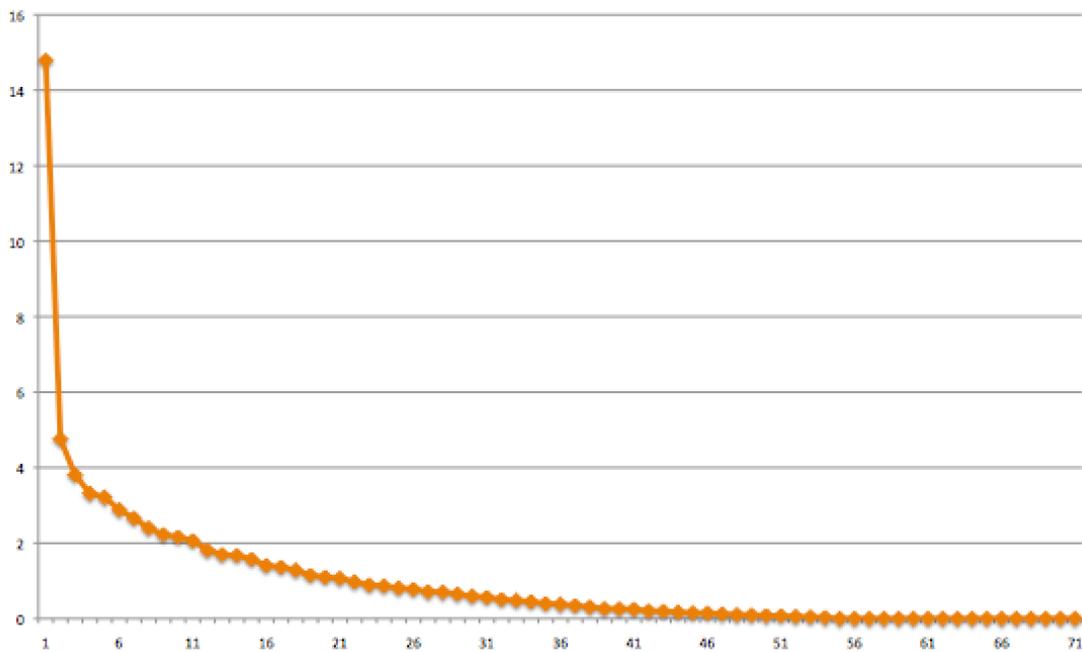


Figure 8. Scree plot of component by associated eigenvalue for the Therapist Social-Emotional Interactions Questionnaire-Revised (TSEIQ-R) data administered at time two.

An additional principal components analysis was run retaining five principal components from both of the data sets, from time one and time two. The reduction of the retained principal components was carried out as a means of reducing the degrees of freedom of the analysis. The loadings of each item on each factor produced in the components matrix were then inserted into SPSS. Such step achieves this by reducing the chance of false positive (type 1) and false negative (type 2) errors, as potential irrelevant factors are limited.

A canonical correlation analysis (CCA) was run on the values from the components matrix produced for both of the data sets from the principal components analysis. This was conducted to allow for the comparison of the factor structure of the two data sets (data at time one and time two). A CCA is a statistical analysis that allows the comparison of two sets of variables when a researcher wants to investigate whether the two sets are related (Tabachnick & Fidell, 2013). It is a form of multiple analysis of variance that calculates the number of autonomous dimensions contained in one model that have identifiable, statistically significant complements in a second model (Harvey, Bimler, Evans, Kirkland, & Pechtel, 2012). A canonical correlation is a correlation between a canonical variate from one set of data with the corresponding canonical variate from another data set, therefore the number of canonical correlations that can be performed is limited to the smallest number of data between the two data sets. See Table 3 below for the results of the CCA.

Table 3

*Canonical Correlations of Therapist Social-Emotional Interactions Questionnaire-
Revised Data*

Function	Correlation	Wilks' Lambda	F	Numerator DF	Denominator DF
1	.89***	.04	12.73	25.00	228.11
2	.79***	.19	8.62	16.00	190.05
3	.64***	.50	5.58	9.00	153.48
4	.35*	.85	2.62	4.00	128.00
5	.17	.97	1.83	1.00	65.00

Note. *** $p < .001$. ** $p < .01$. * $p < .05$.

Wilks' lambda is a representation of the variance unexplained by a model, and 1 minus this value represents the effect size of the full model in a r^2 metric (Sherry & Henson, 2005). A Wilks' lambda value of zero is ideal, as it implies no unexplained variance with the independent variable exists. The full CCA model for the set of five canonical functions was statistically significant (see Table 3); the r^2 type effect size was .96, suggesting the full model explains 96% of the shared variance between the variable sets. Of the five yielded canonical functions, four were found to be significant. The fifth function did not explain a statistically significant amount of shared variance between the variable sets. These low unexplained variance and the statistically significant findings suggests that the pattern of inter-item correlations remained the same, even though the questionnaires were completed at time different time points; time one and time two, two weeks apart.

Comparison of current study with Marwick (2016). In a similar process to that explained above, a canonical correlation analysis was also run with the data from the current study and with Marwick's (2016) data in order to compare the factor structure of these two studies. If the two data sets were found to be similar, even though the data were collected from two different participant groups, then this would provide evidence for the robustness of the Therapist Social-Emotional Interactions Questionnaire-Revised (TSEIQ-R) and also permit the use of previously formulated algorithms used in Marwick (2016) to be applied to the data in the current study.

Since data indicated participants in the current study answered the TSEIQ-R in a similar way at time one and time two, these two data sets were combined. The factors from this combined data set were then compared with Marwick's (2016), which had been completed at one time point.

Marwick's (2016) factor analysis of the 1-71 TSEIQ-R items indicated five factors, and a scree plot of the data also indicated the presence of five principal components based on a visual elbow at five factors. Consequently five factors were extracted from Marwick's study to be used as a comparison to the current study. As mentioned previously, results of the current study suggested five principal components also; therefore five principle components from the factor analyses of the TSEIQ-R items from each study were used for the canonical correlation analysis (CCA). The values produced from the two components matrices were then copied and pasted into a new SPSS data file in preparation for CCA. It should be noted that the equal number of components from the two studies was not a requirement for CCA, as CCA does not demand an equal number of variables in both sets for the comparison to be made.

The CCA generated five pairs of canonical functions; again, each pair maximises the correlation between the two variables, subject to the requirement that the

second and subsequent functions are orthogonal to all of the previous functions (Sherry & Henson, 2005). See Table 4 for the results of the CCA.

Table 4

Canonical Correlations of Therapist Social-Emotional Interactions Questionnaire-Revised Data from the Current Study and from Marwick's (2016) Study

Function	Correlation	Wilks' Lambda	F	Numerator DF	Denominator DF
1	.83***	.15	6.16	25.00	228.11
2	.68***	.47	3.35	16.00	190.05
3	.32	.86	1.10	9.00	153.48
4	.21	.95	.77	4.00	128.00
5	.03	1.0	.04	1.00	65.00

Note. *** $p < .001$.

Using canonical correlations, the first two factors were found to be statistically significant. Wilks' lambda was .15 and type r^2 effect size was .85 for the full model, suggesting 85% of the variance between the two models can be explained. This result suggests that both sets of subjects used the questionnaire items 1-71 in similar ways, even though the two samples comprised different people who were describing themselves. This provides evidence for the robustness and comparability of the data from the current study with Marwick's (2016) data.

Calculation of Dependent Variables

Before any further statistical analyses could be run for the main study, calculation of the emotion recognition ability (ERA), self-reported use of emotional

practice (SEP), and self-reported emotional awareness (SEA) for each participant was required.

Emotion recognition ability (ERA) was calculated based on participants' correct responses to the Emotional Practice Film Stimulus (EPFS). For each correct response participants made while watching the EPFS at time one and time two, the participants received a point. Incorrect responses were not penalised. A response was deemed correct if the participant had responded with the correct emotion choice within the time period the Facial Action Coding System (FACS; Ekman & Friesen, 1978; Ekman et al., 2002) coders signaled the emotion had begun, up until two seconds after the end of the coded emotion expression. The addition of these two seconds was decided upon due to studies having found it to take participants approximately two seconds to accurately identify emotions (Martinez et al., 2016) and also to add a buffer for reaction time. This resulted in an ERA score at time one and two for each participant.

As mentioned earlier, since the canonical correlation analyses provided evidence for the participants in the current study to have answered the questions in a similar way to those participants in Marwick's (2016) study, this provided support for the use of the same eight hotspots identified in Marwick's study. Therefore, for self-reported use of emotional practice (SEP), a previously formulated Microsoft Excel spreadsheet from Marwick's (2016) study was utilised to calculate these scores. The eight hotspots identified in this study were used. These hot-spots were labelled: *deliberate therapeutic behaviours (DTB)*, *emotion coaching (EC)*, *emotional self-awareness (ESA)*, *altruistic growth (AG)*, *directive (D)*, *self-confidence (SC)*, *client empowerment (CE)*, and *therapeutic collaboration (TC)*. It needs to be noted however that these hotspots are not mutually independent; there is some interdependence present between the hot-spots. The participants' scores from the TSEIQ-R were therefore added into the spreadsheet to

determine each participant's hot-spot values. The spreadsheet normalised the values to a mean of 0 with a standard deviation of 1, and then formulated weighted averages in order to reduce them to profiles. The participants' values for the hotspots *emotion coaching* and *emotional self-awareness* were then summed to form a score for the participants' self-reported use of emotional practice (SEP). Weighted sums of rescaled responses were therefore given to items previously identified as having an emotion-practice orientation. These hotspot scores were added together as the descriptions of the hotspots covered all of emotion in practice. This summation of hotspot scores was conducted for the participants' data at time one and two, separately. Consequently participants had two SEP scores.

Self-reported emotional awareness (SEA) was calculated by summing each individual participant's endorsement of the four additional emotional awareness items. These four items were: "*I am aware of others' emotions*", "*I can recognize the emotions of others*", "*I empathize with others' emotions*", and "*I am able to understand others' feelings.*" Each participant therefore had their own SEA score at time one and time two, as well as an emotion recognition ability (ERA) and self-reported use of emotion practice (SEP) score and time one and time two. Consequently each participant had six scores.

Assumption Testing

General assumptions for analysis of variance (ANOVA), which are presented in Pallant (2010), were considered before this statistical analysis was applied to these data. The considerations included the level of measurement of the data (1), the nature of the sampling of the data (2), the independence of the data (3), the distribution (4), and the homogeneity of variance (5) of the data. There were no serious violations noted. See below for a more detailed discussion of each of these considerations.

1. The dependent variables were measured at the interval or ratio level, as the values assigned were calculated based on the participants' ability levels and their endorsement of questionnaire items.
2. This study focused on registered therapists as the population of interest, and therapists were defined as being a counsellor, psychologist, or psychotherapist. From these therapist population pools, participants were recruited through use of advertisements, some of which were sent to all registered therapists through their affiliated associations. Other advertisements included in the Massey University Psychology Clinic, Palmerston North. These steps adhered as close as possible to a random sampling method, while still being within the constraints of the current study. Constraints included ethical and physical considerations, for example filming of therapy sessions being in a location close to the researcher to allow appropriate consent processes and efficient set up of filming apparatus.
3. Regarding independence of observations, the film material was collected at one moment in time and therefore could not have been influenced by individuals who were not present in the therapy room at the time the therapy session took place. In addition, the therapist participants who completed the online task were bound by confidentiality, therefore therapists agreed to not speak about the nature of the study. The participants were also instructed to complete the study in a quiet place away from distractions. Therefore, even if there were therapist participants working in the same practice, they were not permitted to speak about the nature of the online material to their colleagues. Consequently their responses could not influence the responses of other therapist participants.

4. It is assumed that data were normally distributed, as the overall sample size was greater than 30 participants. In addition, most parametric statistical techniques are seen to be robust, or amendable to violations of the normality assumption (see Pallant, 2010).
5. Homogeneity of variance is tested by running Levene's test for equality of variances through SPSS, as this tests to see whether the variances across groups are or are not equal. However, Pallant (2010) states that if Levene's test is significant, and therefore suggests that the variances are equal, analysis of variance (ANOVA) tests are robust even given violations to this assumption, provided that the size of the groups under investigation is similar.

An additional assumption suggested by Pallant (2010) specifically for mixed between-within subjects ANOVA is homogeneity of intercorrelations. Homogeneity of intercorrelations means that for each level of the between-subjects variable, there should be the same pattern of intercorrelations among the within-subjects variable. This assumption is tested through Box's M statistic, which is provided as part of the mixed between-within subjects ANOVA. Ideally, Box's M statistic should not be significant. The result of Box's M statistic will be presented in the current study's statistical analyses below. It should be noted there were no missing data in the data set.

As mentioned at the beginning of the results section, eta squared (η^2) or partial eta squared (η_p^2) will be used as estimations of effect size in the current study. Pallant reports and utilises guidelines proposed by Cohen (1988), which are the following for the associated level of effects: small (.01), moderate (.06), and large (.14). These levels will therefore be used in the current study. Eta squared and partial eta squared range from a value between zero and one, and is an effect size measure that indicates the

proportion of variance of a dependent variable that is explained by an independent variable. SPSS calculates partial eta squared as part of its analysis when running an ANOVA. Regarding the power of the tests used in the current study, Wilks' Lambda will be the statistic that is reported where appropriate.

Current Study Statistical Analyses

Research questions one, two, and three. Before the results are reported, it needs to be acknowledged that Levene's Test of equality of error variances was violated for emotion recognition ability (ERA) scores at time two, as it was found to be ($p = .578$ for ERA at time one, and $p = .027$ for ERA at time two). This result indicates the group variances in the population at time two were unequal, consequently violating the assumption of the homogeneity of variances. Levene's Tests for the remaining dependent variables (self-reported emotional practice, SEP; and self-reported emotional awareness, SEA) were found to be non-significant ($p = .369$ for SEP at time one, $p = .948$ for SEP at time two, $p = .424$ for SEA at time one, and $p = .466$ for SEA at time two). However, as mentioned previously, Pallant (2010) argues that analysis of variance is a reasonably robust statistical analysis, provided that the group numbers are reasonable similar. In this study, there were 29 participants in the no-training condition and 26 in the training condition. Therefore the decision was made to continue with the statistical analysis of ERA, although interpreting the results from this variable with caution. See Figure 9 below for a plot of the ERA variable across time and group.

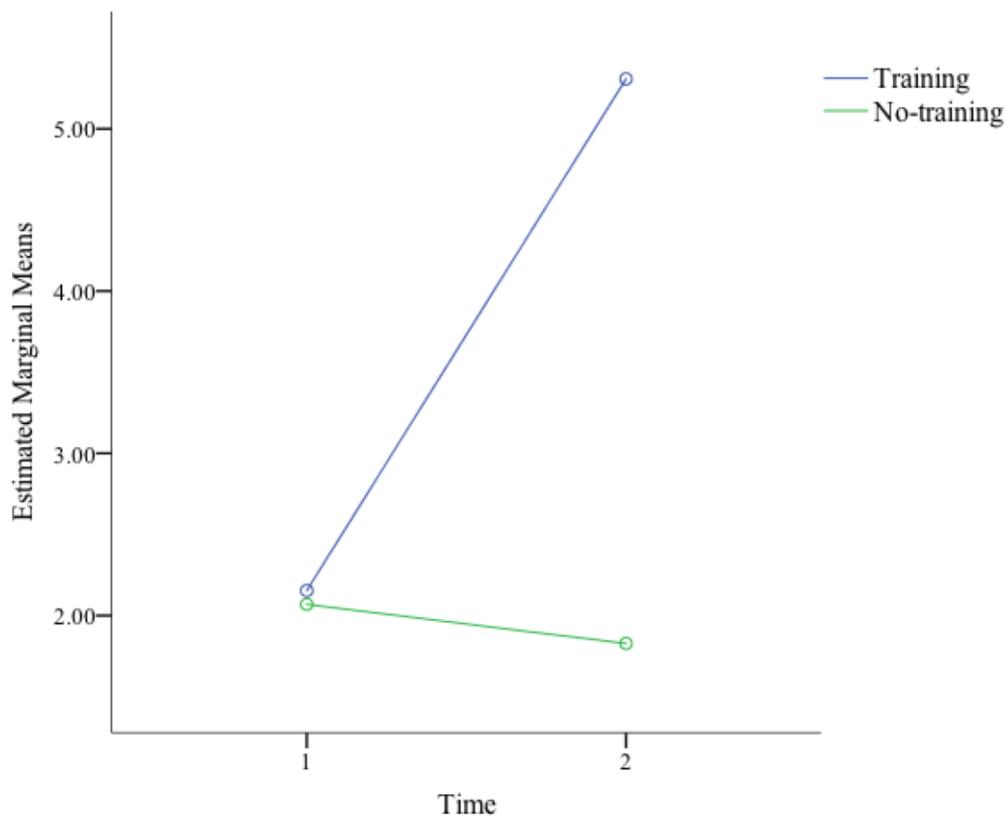


Figure 9. Estimated marginal means for emotion recognition ability across time (time one and time two) and condition (training versus no-training).

Box's Test of equality of covariance matrices tests the null hypothesis that the dependent variables covariance matrices are equal across groups. For the current study, Box's Test was found to be non-significant at $p > .001$ for all three of the analyses ($p = .029$ for emotion recognition ability, $p = .727$ for self-reported emotional practice, and $p = .094$ for self-reported emotional awareness). Since the results of Box's Test for all three dependent variables supported the equality of covariance matrices across groups, along with there being no major violations of the assumptions for analysis of variance noted earlier, there was support for the use of parametric statistics in the current study. Three mixed between-within subjects ANOVA were therefore conducted to assess the impact of the two conditions, either emotion recognition training or no emotion

recognition training, across two time periods (at time one and at time two, with time two being two weeks after time one). A priori (or planned) t-tests were also run at posttest to test for any effect of group.

Mixed between-within subjects ANOVAs were selected, as the same individuals were tested on more than one occasion (time one and time two), and there were also individuals who were not in the same group (training versus no-training group; See Pallant's (2010) discussion on choosing statistical techniques). The mixed between-within subjects ANOVAs, along with the planned post t-tests, will allow the investigation of whether there is a change in the dependent variables (emotion recognition ability, ERA; self-reported emotional practice, SEP; and self-reported emotional awareness, SEA) over the two time periods (time one versus time two), which examines the main effect of time. It will also allow the investigation of whether the intervention, or training, effected the scores on the dependent variables (ERA, SEP, and SEA), which examines the main effect of group. Lastly, the analysis will investigate whether change in the dependent variables (ERA, SEP, and SEA) over time (at time one or time two) was different for the two groups (training versus no-training), which examines whether there is an interaction effect.

For all three of the mixed between-within subjects ANOVAs, the between subjects independent variable was group (either training or no-training group) and the within subjects independent variable was time (either at time one or time two; time two being two weeks after the intervention, or training). Each of the mixed between-within subjects ANOVAs were run for the three dependent variables: emotion recognition ability (ERA), self-reported emotional practice (SEP), and self-reported emotional awareness (SEA). See Table 5 below, which provides a visual depiction of the data that was collected from the participants.

Table 5

Visual Depiction of the Research Procedure

Condition	Time	Variable		
		Emotion Recognition Ability (ERA)	Self-reported Practice (SEP)	Self-reported Emotional Awareness (SEA)
Training	One (T1)	ERA (T1)	SEP (T1)	SEA (T1)
	Two (T2)	ERA (T2)	SEP (T2)	SEA (T2)
Non-training	One (T1)	ERA (T1)	SEP (T1)	SEA (T1)
	Two (T2)	ERA (T2)	SEP (T2)	SEA (T2)

Since there were only two levels of measures, and therefore only one set of difference scores to test whether the assumption of sphericity was violated, the sphericity of the current study was assumed.

Regarding the emotion recognition ability (ERA) scores, the analysis revealed a significant main effect for time ($F(1, 53) = 17.18, p < .001$; partial eta squared (η_p^2) = .245), indicating that there was a statistically significant difference between ERA scores at time one and time two, namely that there was a higher ERA score at time two (see Table 6 below for the ERA mean scores). However, this main effect of time need to be interpreted with caution, as there was a significant interaction of time by condition (training versus no-training), $F(1, 53) = 23.35, p < .001$; $\eta_p^2 = .306$. This result suggests the impact of one variable is influenced by the level of the other, or more specifically, the effect of condition (training versus no-training) depends on the time (at time one or time two). At time one, there is a small difference between conditions, but at time two

there is a large difference. The main effect comparing the two groups (training versus no-training) was significant ($F(1, 53) = 17.13, p < .001; \eta_p^2 = .244$); therefore there was a significant difference in ERA mean scores for the two groups; for those who received training and those who did not.

Table 6

Emotion Recognition Ability Mean Scores for the Training and No-training Groups at Time One and Time Two

Time	Training			No-training		
	n	M	SD	n	M	SD
One	26	2.15	2.34	29	2.07	1.69
Two	26	2.31	2.48	29	1.83	1.67

For self-reported emotional practice (SEP) scores, there was no significant interaction between time by condition (training versus no-training), $F(1, 53) = .17, p = .680; \eta_p^2 = .003$, nor a significant main effect of time, $F(1, 53) = 1.48, p = .229; \eta_p^2 = .027$. The main effect comparing the two conditions (training versus no-training) was however significant ($F(1, 53) = 7.59, p < .01; \eta_p^2 = .125$), suggesting there is a significant difference between the SEP scores for the training and no-training group. See Table 7 below for the SEP mean scores.

Table 7

Self-reported Emotional Practice Mean Scores for the Training and No-training Groups at Time One and Time Two

Time	Training			No-training		
	n	M	SD	n	M	SD
One	26	-1.69	1.69	29	-2.77	1.35
Two	26	-1.98	1.54	29	-2.91	1.43

The analysis for self-reported emotional awareness (SEA) revealed a non-significant interaction between time by condition (training versus no-training), $F(1, 53) = 2.43, p = .125; \eta_p^2 = .044$, and a non-significant main effect of time, $F(1, 53) = .93, p = .339; \eta_p^2 = .017$. The main effect comparing the two conditions (training versus no-training), was almost significant at the $p < .05$ level ($F(1, 53) = 3.63, p = .062; \eta_p^2 = .064$). See Table 8 below for the SEA mean scores.

Table 8

Self-reported Emotional Awareness Mean Scores for the Training and No-training Groups at Time One and Time Two

Time	Training			No-training		
	n	M	SD	n	M	SD
One	26	7.23	2.17	29	7.83	1.71
Two	26	7.08	2.33	29	8.48	2.41

The next step was to conduct the planned a priori t-test comparisons to test hypotheses one to three, referring to the presence of training effects at time two for the three dependent variables; ERA, SEP, and SEA.

Three independent samples t-tests were conducted. Independent samples t-tests were chosen as the two groups were independent from each other, the post intervention/training data are of interest, and it was hypothesised that participants' responses will be different across the groups. For all three of the independent samples t-tests, the independent variable was the condition, either training or no-training, while the dependent variables differed (i.e., either emotional recognition ability, ERA; self-reported emotional practice, SEP; or self-reported emotional awareness, SEA). For ERA, there was a significant difference in scores for the training ($M = 5.31, SD = 2.48$) and no-training ($M = 1.83, SD = 1.67; t(43) = 6.04, p < .001$, two-tailed) conditions. The magnitude of the differences in means (mean difference = 3.48, 95% *CI*: 2.32 to 4.64) was interpreted as very large (eta squared (η^2) = .407). For SEP, there was a significant difference in scores for the training ($M = -1.98, SD = 1.54$) and no-training ($M = -2.91, SD = 1.43; t(53) = 2.33, p < .05$, two-tailed). The magnitude of the differences in means (mean difference = .93, 95% *CI*: .13 to 1.74) was moderate to large ($\eta^2 = .093$). Finally, for SEA, there was a significant difference in scores for the training ($M = 7.08, SD = 2.33$) and no-training ($M = 8.48, SD = 2.41; t(53) = -2.19, p < .05$, two-tailed), however the no-training group had a larger mean score than the training group, which was not hypothesised. The magnitude of the differences in means (mean difference = -1.41, 95% *CI*: -2.69 to -.12) was moderate to large ($\eta^2 = .08$).

Support was found for hypotheses one and two, but not three. The training group was found to have larger positive scores for ERA and SEP at time two as compared to obtained scores in the no-training group, but not for SEA.

Research questions four, five, and six. Before conducting correlation analyses, Pallant (2010) suggests running scatterplots for a visual depiction of structure of the data, as well as to check for any violations of the assumptions of linearity and homoscedasticity. Figures 10 to 15 display scatterplots for each of the dependent variables (emotion recognition ability, ERA; self-reported emotional practice, SEP; and self-reported emotional awareness, SEA) collected at the two data collection points; time one and time two. No significant concerns were noted, enabling the correlation analysis to proceed

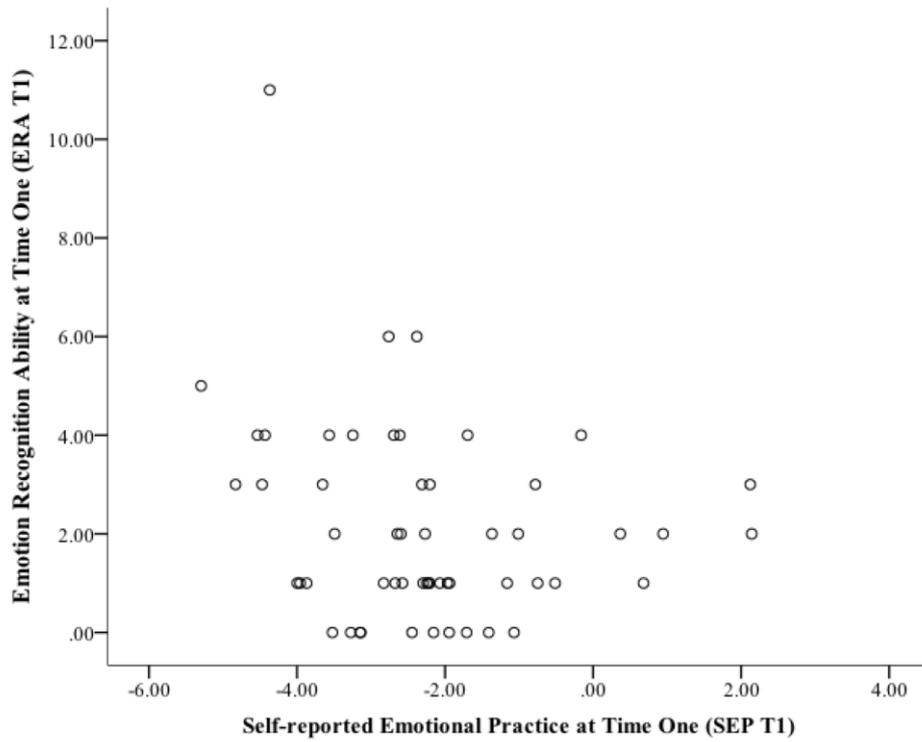


Figure 10. Scatterplot of emotion recognition ability and self-reported emotional practice at time one for all participants.

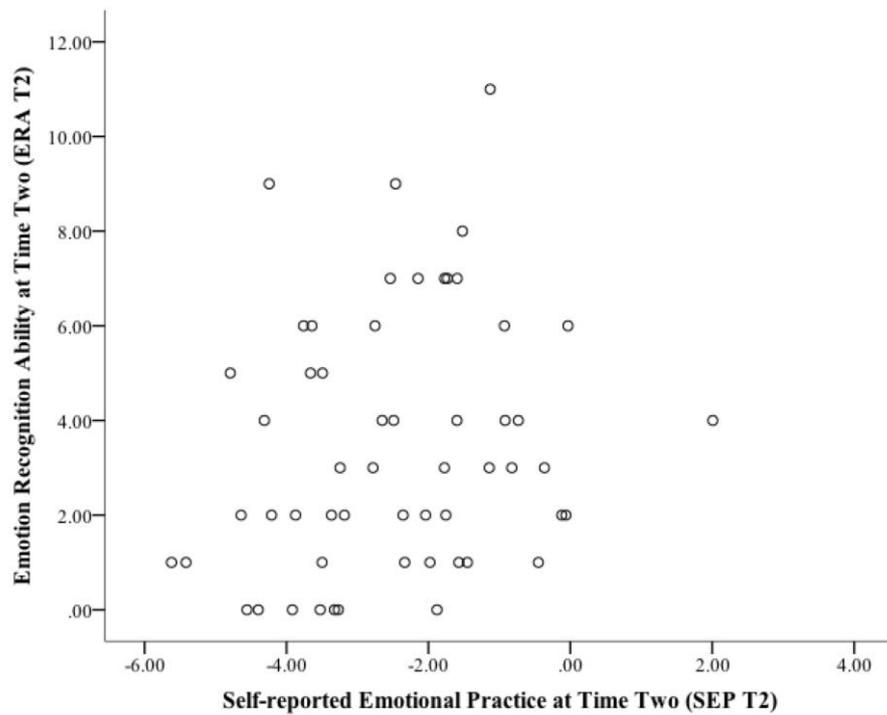


Figure 11. Scatterplot of emotion recognition ability and self-reported emotional practice at time two for all participants.

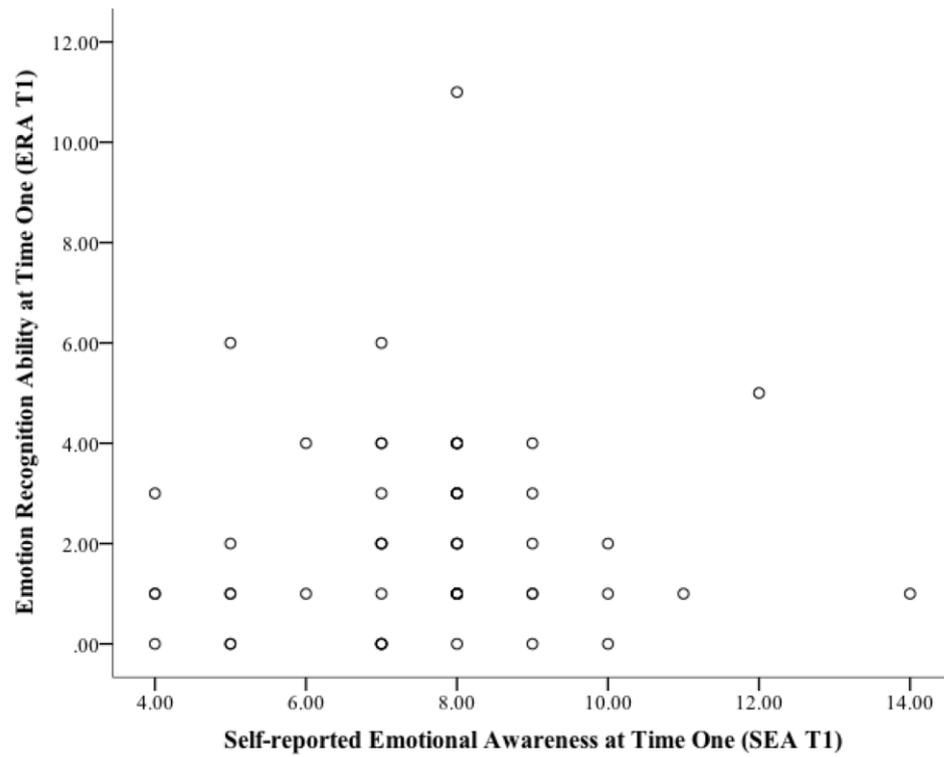


Figure 12. Scatterplot of emotion recognition ability and self-reported emotional awareness at time one for all participants.

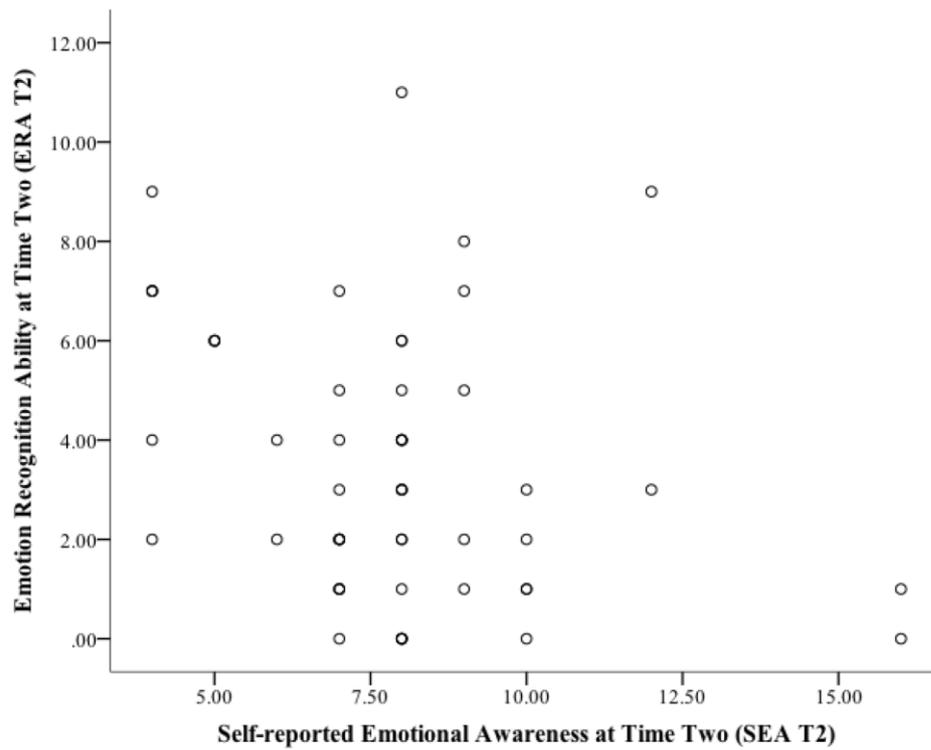


Figure 13. Scatterplot of emotion recognition ability and self-reported emotional awareness at time two for all participants.

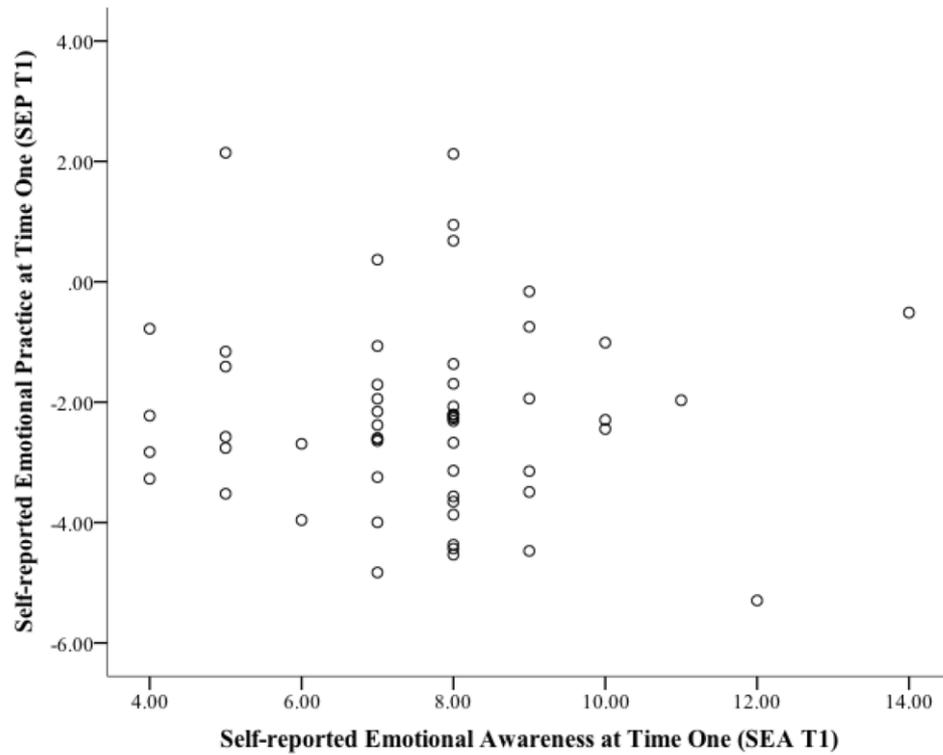


Figure 14. Scatterplot of self-reported emotional practice and self-reported emotional awareness at time one for all participants.

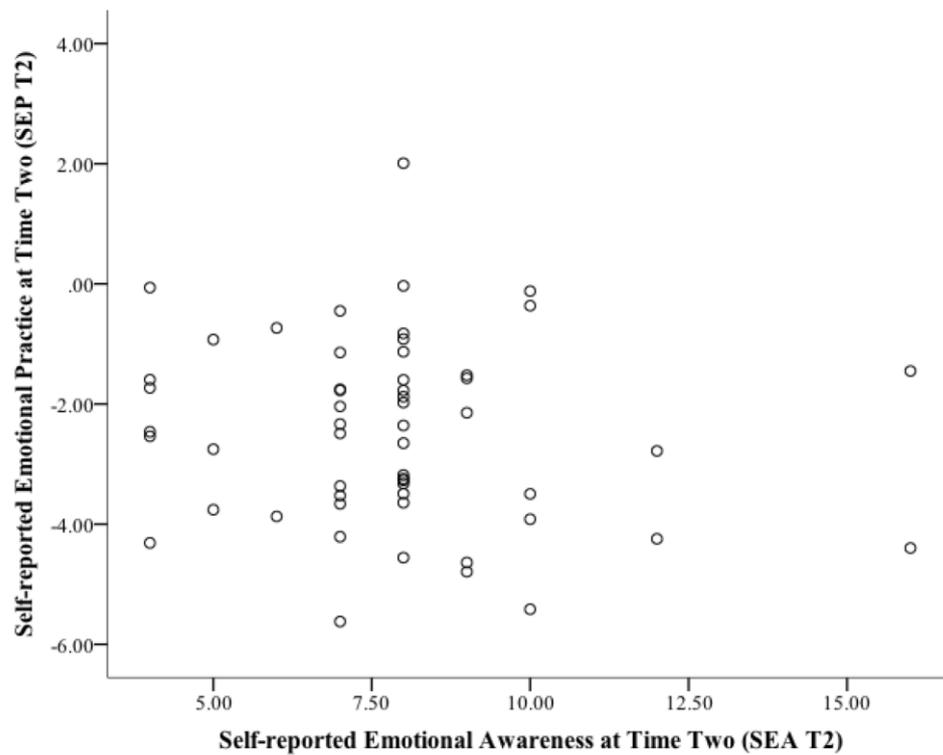


Figure 15. Scatterplot of self-reported emotional practice and self-reported emotional awareness at time two for all participants.

The correlation analysis revealed three significant correlations, one that was negative (for SEA T2 and ERA T2) and two that were positive (for SEP T1 and SEP T2, and for SEA T1 and SEA T2). Two correlations approached significance; ERA T1 and SEP T1 ($r(55) = -.231, p = .09$) and ERA T2 and SEA T1 ($r(55) = -.249, p = .07$). See Table 9 for the correlations.

Table 9

Correlations (Pearson r) Between Dependent Variables for all Participants

Variable	Variable					
	ERA T1	ERA T2	SEP T1	SEP T2	SEA T1	SEA T2
ERA T1	-	.167	-.231~	-.164	.070	.019
ERA T2	.167	-	.187	.199	-.249~	-.312*
SEP T1	-.231~	.187	-	.659***	-.034	-.121
SEP T2	-.164	.199	.659***	-	-.083	-.128
SEA T1	.070	-.249~	-.034	-.083	-	.631***
SEA T2	.019	-.312*	-.121	-.128	.631***	-

Note. *** $p < .001$. ** $p < .01$. * $p < .05$. ~ $p < .10$

Key: self-reported emotional awareness (SEA), self-reported emotional practice (SEP), emotion recognition ability (ERA), time one (T1), and time two (T2).

No support for hypothesis six was apparent in these analyses, as no significant correlations emerged between SEP and SEA. Some support was found for hypothesis four, as a borderline significant (albeit negative) correlation between ERA T1 and SEP T1 was noted. Stronger support was observed for hypothesis five. This was evident in

the significant negative correlation for ERA T2 and SEA T2, and borderline significant (again negative) correlation for ERA T2 and SEA T1.

Chapter Five: Discussion

Overview

Despite references, discussions, and hypotheses being made in the literature about the nature of emotion in therapeutic setting, this area has been scarcely investigated. More specifically, near to no research has investigated therapists' emotion recognition skills (Domico, 2010). Johnsen (2013) is the first known study to investigate therapists' facial emotion recognition ability, social-emotion practice, and their self-perceived emotional awareness. The current study extends upon Johnsen's initial research, and provides much needed additional insights into an area where there is a paucity of research.

The core question I embarked on with this study was to investigate whether emotion recognition training could influence therapists' emotional recognition ability, self-reported emotional practice and awareness. I also questioned the relationships between these concepts.

Research Questions and Hypotheses

This research began with the question about whether emotion recognition training increased therapists': 1) ability to accurately identify expressed client emotion in therapy; 2) self-reports of their use of emotional practices; and 3) self-reported emotional awareness. An additional three questions included whether a relationship existed between therapists': 4) emotion recognition during therapy and their self-reported emotional practice; 5) emotion recognition during therapy and their self-reported emotional awareness; and 6) self-reported emotional practice and their self-reported emotional awareness.

Support for research hypotheses one, two, and five were found, with mixed support for hypothesis four. Minimal support occurred for hypothesis three and six. Unexpectedly for hypotheses four and five, inverse relationships were found.

Hypothesis one. As predicted, participants in the training group were comparatively more accurate in recognising emotions displayed by the filmed client post training. These results are consistent with findings by Blanch-Hartigan (2012), Grace et al. (2005), and Curtis (2017). However, the participants in these studies were different to those who participated in the current study; Blanch-Hartigan participants were undergraduate students, Grace et al.'s were graduate counselling students, and Curtis' were psychologists.

Using a 30-minute emotion recognition training protocol, Blanch-Hartigan (2012) found those in the training group performed better on an emotion recognition task than a control group. Likewise, Elfenbein's (2006) study on emotion recognition training found an increase in participants' emotional perception following training. The participants were more accurate in their emotion identifications post-training compared to their pre-training ability. Furthermore, Grace et al. (1995) found nonverbal sensitivity training to increase therapists' recognition of nonverbal behaviours displayed by clients, and Curtis (2017) found support for emotion recognition training to increase the therapists' emotion recognition abilities for single emotions, apart for sadness. These studies, along with the current, provide consistent support for the implementation of emotional recognition programmes in order to enhance emotional recognition with practitioners. Although, the long term maintenance of these skills was not investigated.

Hypothesis two. Consistent with my prediction, the training group self-reported greater use of emotional practices on the TSEIQ-R questionnaire after training compared to those assigned to the control group. These findings correspond to findings

reported by Nelis et al. (2011), whose emotional training to adults (not therapists) led to an improvement in participants' emotion regulation, understanding, and emotional competence, and these changes remained stable at 6-months post-intervention. Like the current study, Nelis et al.'s study involved both tested and self-reported measures of emotional competencies. Therefore, the results from the current study along with those of Nelis et al. suggest that increases in emotional awareness may generalise to other emotional practices, for example, emotion regulation, knowledge, and competence.

It also needs to be considered that professional competence is not something that is ultimately achieved, but instead is likely to fluctuate and be a course of continued growth so it can remain relevant in an ever changing profession due to enhancements in knowledge (Knapp et al., 2017b). Therefore, emotion recognition training could be a channel through which practice growth occurs. For instance, being aware of clients' expressions may act to highlight their expressions following the implementation of practices, and this in turn could lead to a cycle of reflection and indirect changes in practice and outcomes.

Hypothesis three. Unexpectedly, participants in the training condition reported less emotional awareness post intervention than those in the control group. It is difficult to compare and contrast studies that have investigated similar variables, as none can be specifically found that include both emotion recognition training and the influence this has on self-reported emotional awareness. However, Knapp et al. (2017b) state effective therapists are aware of their strengths and weaknesses; effective therapists know what they are good at providing and are also aware of where they might achieve poor client outcomes. Therefore, it is possible the emotion recognition training provided to the participants in the training group deepened their insight into their emotional awareness ability. The training may have made the participants realise they need to improve their

emotional awareness skills. Also, if the participants realised their emotional acuity was lower than they believed through the process of training and feedback, then they may have ended up rating themselves worse even though their awareness increased. This means greater actual emotional awareness has an inverse relationship with self-reported emotional awareness.

Research has investigated therapists' accuracy in their self-awareness of their competencies, but this has not shown therapists to demonstrate exemplary self-awareness. Many studies have found weak to no relationships between individuals' self-perception and actual ability, often with a tendency found towards an overestimation of skill (Mathieson et al., 2009). For instance, Knapp et al. (2017b) reports that professionals have a tendency to be inaccurate in their estimation of their competences. Walfish et al.'s (2012) survey of mental health professionals was not complementary to their perception of their skills; a large percentage (25%) of the participants rated themselves as being in the top range for their therapeutic skills (in the 90th percentile). Furthermore, none of these participants viewed their skills as being below average and they were also inaccurate in their view of their clients' progress; overestimating their clients' improvement and underestimating client deterioration. Other research by Miller et al. (2015) found a small statistically significant correlation between therapists' confidence and accuracy in their clinical judgment, but the authors warn that confidence is not an exact reflection of accuracy. These findings suggest a mismatch is common between therapists' beliefs and their actual awareness, a finding that may explain the negative relationship in this study between perceived and actual emotional awareness.

Mathieson et al. (2009) note that even if individuals' perceptions of their abilities are inaccurate this is useful, as it can provide information about the nature of an individual's confidence as well as their perceived strengths and weaknesses. Knowing

someone has overestimated their abilities provides the opportunity to realign their confidence so it accurately reflects their level of skill. Although overconfidence carries the risk of potential harm to clients, an alternative case has also been made. Knapp et al. (2017b) identified overestimating one's ability may encourage therapists to persevere through difficulties as well as provide a means to boost clients' own confidence. This point has not received research support however. For instance, Nissen-Lie et al. (2013) found the clients of therapists who reported greater professional self-doubt had better patient outcomes than those who did not.

Self-awareness is therefore likely to be important for the professional development of training therapists, as strengths and weaknesses can be identified (Mathieson et al., 2009). Future research is needed to bolster the limited research that has been conducted on therapists' emotional competencies (i.e., recognition, self-awareness, and emotional practice) and the effectiveness of emotion recognition training for not only these therapists' skills, but also for their clients and their outcomes. Whether emotion recognition training translates to better client outcome is unknown, although Raingruber (2000) asserts that clinicians who invest in practicing their emotional skills are likely to improve clients' positive outcomes. Other examples of potential benefits include aiding the client to understanding their own reactions and themselves, as well as augmenting the therapeutic relationship. Markowitz and Milrod (2011) argues that therapists use of emotional practice conveys they are attending to and attempting to understand to the client, which in turn fosters a level of connectedness with their clients.

Additional research is needed to gain a better understanding of the relationship between therapists' emotional self-awareness, confidence, training, and feedback. This raises a number of important questions. For example, whether emotional feedback

through observation, supervision, and/or client outcomes, has an effect on therapists' emotional self-awareness. If so, this raises the issue about which method and type of feedback is best suited to provide to therapists. By extension, could it be that training emotional skills to therapists increases related emotional practices and competencies (e.g., emotion coaching) as well as their confidence. These questions are required to be answered if serious consideration is to be given to the implementation of emotion recognition skills in student-practitioner training.

Hypothesis four. Partial support was found for there being a significant relationship between emotion recognition ability and self-reported emotional practice. However, the relationship was not hypothesised to be negative, but rather positive. This finding is in contrast to that reported by Blanch-Hartigan et al. (2012) and Hall et al. (2014), as these authors found accurate identification of others' emotion is associated with enhanced social and emotional competence. This result is interesting, as studies have reported emotion recognition as being important for social functioning (Owen & Maratos, 2016) and allows one to predict other behaviour and responses, and to respond accordingly (Bänziger et al., 2009). However, in the current study, the results would suggest that as participants increased the acuity of recognising emotion, their self-report of their use of emotion in practice reduced. This is not too dissimilar to the finding discussed in hypothesis three, where the increase in emotion recognition scores resulted in corresponding decreases in self-reported awareness. This lack of support for hypothesis four could be explained by the idea that as participants became better at recognising emotion, they potentially became increasingly accurate in identifying their emotional practices and/or they may have judged themselves more harshly. It is also possible that with practice therapists' emotion recognition became more automatic so they were less aware of when they were actually using their emotional skills. In support

of these possibilities, Waltman et al. (2016) suggest discrepancies emerge between self-perception and accuracy when people consider themselves to be above average in their skills, not in tune with their actual skills due to burnout, and/or experience a change in their alignment with their predominantly therapeutic modality. Certainly these considerations may have been present for the therapist participants in the current study.

Hypothesis five. Contrary to my expectation that a positive relationship would occur between emotion recognition ability and self-reported emotional awareness, the unanticipated (albeit significant) result suggested a negative relationship existed instead. This finding corresponds to the trend evident with the previous two hypotheses. An important question here concerns the direction of this relationship; would higher emotion recognition ability lead to a lower self-reported emotional awareness, vice versa, or is it a dynamic bi-directional relationship? Would new discordant information create a reappraisal of ability and realignment of beliefs, which in turn constantly updates self-perception by using seeking evidence of ability?

Although the above results differ to Machado et al.'s (1999) findings, who found that emotionally self-aware individuals are able to recognise emotions in others more accurately, their data could be interpreted differently in light of the current findings. Instead of the results of Machado et al.'s research being interpreted as an increase in the participants' accuracy of their emotional self-perception, it is feasible that the participants' self-perceptions were inaccurately optimistic before they participated in the research.

The current study found those who reported being more emotionally self-aware were less accurate in their emotion identification of others. This implies self-report is an indication of someone's confidence in their own emotional self-awareness, which in turn is inversely related to their accuracy in detecting emotion in others. Akin to this

idea, DePaulo et al.'s (1997) meta-analysis found a limited relationship between individuals' accuracy in deception detection and their self-reported confidence in such skill. Similarly, Johnsen (2013) found no relationship between therapists' emotional awareness and their self-perceived emotional awareness. Consequently, there appears to be a difference evident between therapists' self-perception and application, and actual accuracy and confidence in their accuracy. These findings provide support for establishing emotion-based feedback loops for therapists, possibly through the use of video in forums like supervision. However, the effectiveness of this suggestion is also reliant on the ability of the supervisor to recognise emotion in others.

Hypothesis six. No support was found for a relationship between self-reported emotional practice and self-reported emotional awareness. This finding might be explained by emotional practice and awareness being different constructs; whereby practice describes the participants' therapeutic behaviours and awareness is related to internal processes. However, very few studies have investigated self-reported emotional awareness, and none have been found that involve therapist participants. Nevertheless, when considering more general research into therapists' self-perception of their abilities, the results are not favourable, as therapists have been found to be inaccurate when assessing their own skills (Creed et al., 2016; Mathieson et al., 2009).

Study Implications

Two main implications emerge from this current research. First, the finding that emotion recognition training enhances therapists' emotion recognition accuracy highlights the importance of its worthwhileness in the training of therapists. Secondly, the nature of the link between actual and perceived emotional awareness raises the issue around how therapists' receive feedback on their emotional practices through established practices such as supervision or client outcome.

Despite the emotion recognition training being very brief (two hours over two weeks), the finding that change occurred supports the position that emotional awareness can be learnt. This implies emotional awareness can be positioned as a practice skill, rather than an innate fixed ability. The improvement evidenced in emotion recognition and self-reported emotional practices following training suggests this could be considered in the training of therapists, particularly if a beneficial link is found with client outcome, client satisfaction, rates of no-shows by clients, and the emergence of other forms of social-emotional practices. Satterfield and Hughes (2007) supports this notion in medical practice, recommending that emotion skills should be considered in the same vein as physical examinations: definable, teachable, and measureable. In addition, suggestions have been made for ways in which therapists can improve their self-reflection, which include building professional networks, receiving their own therapy, engaging in extra education, requesting feedback from others, participating in Balint groups (for information on Balint groups, see Balint, 1957), using writing as a means of expression, and/or engaging with mindfulness techniques (Knapp et al., 2017a). Regarding accuracy of therapists' self-awareness of their competencies, Waltman et al. suggest therapists engage in peer consultation, utilise objective measures for competence assessment, and that they also consider becoming certified through accredited professional bodies.

Although there is limited research on the effectiveness of emotion recognition training in the therapeutic context, there are synergies from this field with the emotional competence and emotional intelligence training literature. Because emotional awareness and management of ones' own and others' emotions is central to the theory of emotional intelligence (Cherniss et al., 2006), it is safe to assume that findings from emotional

intelligence training could be generalised to guide what might be expected from emotional awareness training.

Many studies report emotional intelligence to be effectively taught and lead to improvements in awareness and practice. For example, Slaski and Cartwright's (2003) study found the following specific emotional competencies to increase following emotional intelligence training: intrapersonal, adaptability, stress management, and general mood (from the Emotional Quotient Inventory, EQ-i; Bar-On, 1997), as well as self-awareness, emotional resilience, motivation, interpersonal sensitivity, and influence (from the Emotional Intelligence Questionnaire, EIQ; Dulewicz & Higgs, 1999, 2000). Further to this, Fletcher et al. (2009) found significantly greater EQ-i change scores from baseline for a training group as compared to a control group. Other emotional competencies that have been found to increase following emotional intelligence training include: emotion identification and emotion management of self and others emotions (Nelis et al., 2009); emotion recognition and understanding, as well as emotional intelligence in general (Nelis et al., 2011). There has also been some research into the association between therapist' emotional intelligence and their client outcomes. For example, Kaplowitz et al. (2011) found therapists rated as having higher emotional intelligence to have better therapist rated outcomes, have lower client dropout rates, and also gain greater client assessment compliance. Therefore, it would appear those therapists who are emotionally intelligent are likely to gain better client outcomes, as compared to those therapists who are not as emotionally proficient.

However, Waterhouse (2006) argues that education in emotional intelligence does not equate to real-world benefits and concludes that emotional intelligence competencies should not be taught. It is however understandable that there is skepticism about the application of emotional intelligence by researchers such as Waterhouse,

given the exaggerated claims made by the early communicators of emotional intelligences (i.e., Goleman, 1996, 2000). What is unclear however is what Waterhouse meant by “real-world.” For therapists, emotional practices are central to their work and in that sense, form the “real-world” of the therapy room. The findings from the current study suggest emotional recognition can be trained and learnt, yet the literature is uncertain about the influence this specific practice may have on client outcome.

The second implication relates to the unexpected finding that therapists’ self-perception of emotional awareness is inversely related to their actual accuracy of their emotion recognition. This finding is important for consideration when creating emotional feedback loops for therapists. Peer supervision, for instance, predominantly relies on therapists’ report of clients’ emotions for garnering support, guidance, and advice. Possibly enabling more video-enhanced supervision could foster better self-reflection and emotional awareness. Ensuring clients provide regular feedback on their emotional responses becomes more central in therapeutic practice. For this to be effective however, emotion recognition training may also be necessary for the supervisor providing feedback.

The results of the current study are important considering emotional awareness has been linked to beneficial outcomes such as the delivery of effective therapy (Greenberg & Pascual-Leone, 2006), aiding meaningful emotional contact with others (Bliss, 2005), greater emotion recognition accuracy (Machado et al., 1999), conveyance of connectedness with the client (Markowitz & Milrod, 2011), and also provides therapists’ with a perspective of how the clients emotions may impact others (Batten & Santanello, 2009). Knapp et al. (2017b) supports this, stating a lack of awareness of emotions is likely to be detrimental to the quality of therapy provided, and this in turn can be harmful to clients.

Study Limitations

The sample size was limited for pragmatic reasons such as funding and client availability. This was evident for the filmed client and their therapist. It would have been beneficial to have had a variety of film segments to choose from for the Emotional Practice Film Stimulus (EPFS). Having had larger samples would have provided more examples of emotional expressions, however the current study valued the reality of the involvement of real clients and their therapists, and consequently this limited the number of individuals willing to be involved. Nevertheless, the low expression of interest in participation was the compromise that was favoured in order to film the most genuine therapy session for use in the stimulus.

Despite the aim of the methodology to create a naturalistic environment for measuring emotional awareness, the current study still represents a step away from experiencing a dynamic interactive therapy session. Furthermore, the presence of a camera in the client's sight would serve as a reminder that they were being observed and so may have altered their reactions. Although a less obtrusive camera would have been more desirable, this was unavailable for the current study.

Some therapist participants stated they found the emotion recognition task difficult. The most common complaint was the small size of the video, as a few participants felt it stopped them from successfully detecting all expressed emotions. However, the video size was limited to the size of a computer screen, and obviously viewing a video on a computer screen is different to sitting with the client. The size of the video was coded in such a way to ensure it was the same size for all participants; participants were unable to enlarge the video screen. Also it is acknowledged that the participants' responses were compared against codes made by Facial Action Coding System (FACS; Ekman & Friesen, 1978; Ekman et al., 2002) coders, who code

expressions in very fine detail; slowing down films and zooming into muscle movements. The FACS was used to rate emotion, as this is the most verified and well known emotion coding system (Gosselin et al., 2010; Valeriani et al., 2015). Therapist participants were required to view the client's emotion expressions in real film time from a distance, unlike FACS coders. However, if one was to attempt to remedy these issues above, then the task would become more artificial, which was what the current study was designed to avoid. The study was interested in real time emotion recognition of a filmed naturalistic client therapy session.

Future Research

It is noticeable that very few studies investigate therapists' emotion recognition, despite the centrality of emotion to therapy. Clearly more research is needed to better understand the relationship between therapists' emotion recognition skills, training, and self-reported emotional awareness and practice.

Replicating this study with a larger sample size and linking emotional practices to client outcome would ensure the findings are convincing, providing more confidence in the results found. Investigation into whether there is an association between therapists' emotion recognition training and client outcome is an important area for future research, as this would indicate whether emotion recognition training would be worthwhile to include in therapist training programmes. If advantageous client outcomes were witnessed after therapists undertake emotion recognition training, it could then be argued that emotion recognition training should be included in therapist training programmes.

The unexpected negative relationship between emotion recognition training and therapists' self-reported emotional awareness provides opportunities to follow this finding up. If this finding was confirmed in other studies, the inverse relationship

between confidence and self-awareness certainly poses interesting questions. In training for instance, would it be appropriate to actively reduce student therapists' confidence for the expressed purpose of improving their emotional awareness? Although students' confidence is often anecdotally observed in training programmes to decrease, the ethics around reducing confidence as a specific focus are questionable at best and would decrease the standing of any training programmes likely to implement it. However, unless training programmes actively teach emotion skills, therapists are unlikely to improve the accuracy in their perceptions of emotion either. The expectation that clinicians develop emotion recognition skills without specific training implicitly assures student therapists to believe they not only possess these skills, but are competent in the use of them. It is therefore suggested future research investigate whether emotion recognition training provides participants in a training condition heightened insight into the limitations of their emotional perception, and therefore influence their self-reporting of their skills.

Conclusion

There is a dearth of research into therapist emotion recognition, practice, awareness, and the effectiveness of emotion recognition training for therapists. This is despite what would seem obvious benefits to therapeutic practice, both for the client and therapist. The current study aimed to provide much needed insights into this under-researched area by investigating these concepts. Fifty five therapists completed an online emotion-related task, of which 47% were randomly assigned into an emotion recognition training group. The results revealed that those allocated to the training group were able to recognise emotions more accurately and also reported greater use of emotion in their practice, as compared to those participants who did not. Surprisingly, those participants in the training group reported less emotional awareness as compared to the control group. Furthermore, a negative relationship was found between emotion recognition ability and self-reported emotional awareness, along with some support for a negative relationship between emotion recognition ability and self-reported emotional practice. There are two implications of the research, 1) emotion recognition training enhances therapists' accuracy in emotion recognition, and 2) there may be an issue regarding how therapists' receive emotional practice feedback, as there was an inverse relationship between the participants' actual and perceived emotional awareness. It is recommended that larger samples are drawn on in future research and further work be undertaken to investigate the relationship between emotion recognition training, emotional awareness, and client outcomes. Finally, the effectiveness and implementation of emotion recognition training in formal therapy programmes as well as in supervision could be further explored.

The focus of the current study was to investigate therapists' emotional skills (emotion recognition and awareness), their emotional practices, as well as the effect of

emotion recognition training. This study is positioned in a relatively underdeveloped field of practice. Therefore the conclusions drawn from these results, while informative, still remain preliminary and in need of further validation. Perhaps in the future we will begin to see the emergence of emotion recognition training as a regular fixture in therapist training.

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Appendices

Appendix A: Ethical Approval Letter



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

27 November 2013

Amanda Johnsen
59 Sutherland Crescent
Westbrook
PALMERSTON NORTH 4412

Dear Amanda

Re: HEC: Southern A Application – 13/65
Does emotional awareness inform emotional practice? An investigation into therapists' emotional competencies

Thank you for your letter dated 20 November 2013.

On behalf of the Massey University Human Ethics Committee: Southern A I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch, Chair
Massey University Human Ethics Committee: Southern A

cc Dr Shane Harvey
School of Psychology
PN320

Dr Don Baken
School of Psychology
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Dr Peter Cannon
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Appendix B: Screenshots of the Website

Understanding the Link Between Emotional Awareness, Therapy, and Training.



MASSEY UNIVERSITY

Email

Password

[Login](#)

Understanding the Link Between Emotional Awareness, Therapy, and Training. Logout

Information Sheet

Who is doing this research?
My name is Amanda Johnsen and I am a student at Massey University, Palmerston North. I am conducting this research project as a requirement for the completion of a Doctorate in Clinical Psychology. My main supervisor is Dr. Shane Harvey, along with co-supervisors Dr. Don Baken and Dr. Peter Cannon.

Project Description and Invitation
This study is an investigation of therapists' awareness of emotion in practice. I also intend to investigate whether an emotion training intervention influences therapists' self-reported emotional practice. You are invited to participate.

Who can participate?
Therapists who are currently in practice and have not previously completed any emotion recognition training can participate. Therapists are required to be proficient in English and either be a counsellor, psychologist, or psychotherapist. Only 50 therapists are able to participate in the research. Of these 50 participants 25 will be randomly assigned to a training group. The other 25 participants will be randomly assigned to a control group who will receive no training during the study. However, participants receiving no training will be given free access to the training on completion of the research phases. It is possible that you may become uncomfortable during participation. If this occurs, you have the right to withdraw from the research.

What is involved?
Once you have agreed to participate in the study you will answer some demographic questions and then complete a 75-item questionnaire addressing social-emotional interactions within practice and self-perceived emotional awareness. After completing the questionnaire you will view a 20 minute segment of a filmed therapy session that has the therapists' voice removed. When viewing the filmed therapy session you will be asked to identify emotion displayed by the client. The questionnaire will take you approximately 15-minutes to complete and the time it takes you to watch and respond to the filmed segment will depend on the frequency of your responding.
Therapists who are randomly assigned to the training group will then engage with the Subtle Expression Training Tool (SETT), developed by Dr Paul Ekman. Instructions on how to access this training will be sent to you before you commence the research. The therapists in the training group will complete four sessions of the SETT within a two-week period. Each SETT session takes approximately 30-minutes to complete. Those therapists who are randomly assigned to the no training group are not to engage in any emotion training during this time. After the two-week period therapists will progress onto the final phase of the research.
The final phase of the research is similar to the first phase. You will login to the website once more, complete the same 75-item questionnaire, and finally watch and respond to the 20-minute filmed therapy session segment.

What will happen to the collected data?

The website will collect your responses into a database. These data will be stored securely on a computer with a password and login access. All data will be destroyed after a 10-year period.

To anonymise your data it will be labeled with a participant number. Only three people other than the researcher will see your anonymous responses. This includes a website programmer, cultural advisor, and statistician. The website programmer may see your responses if they require access to the participant data file to fix any unforeseen website issues. A cultural advisor will be consulted if cultural aspects emerge, and a statistician will assist with analysis of the data. All of these individuals have signed confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

A summary of the project findings will be available by indicating that you wish to receive this during the online process. This will be sent to you as soon as it is available. Note that if you request the project results it will be given as a group result and be sent via email.

Participant's Rights You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Project Contacts
If you have any further questions please contact the researcher or main supervisor.

Researcher	Main Supervisor
Amanda Johnsen	Dr. Shane Harvey
School of Psychology	School of Psychology
Massey University, Turitea Campus	Massey University, Turitea Campus
Palmerston North	Palmerston North
Phone: 021 022 84200	Phone: (06) 356 9099 ext. 84967
Email: emotional.practice@gmail.com	Email: s.t.harvey@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/65. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone (06) 356 9099 ext. 84459, email humanethicsoutha@massey.ac.nz.

[Continue](#) [Print](#)

Understanding the Link Between Emotional Awareness, Therapy, and Training. Logout

Consent Form

- I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the information sheet

Yes
 No

I wish to have my questionnaire data stored with my consent form in a research archive

Yes
 No

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Understanding the Link Between Emotional Awareness, Therapy, and Training. Logout

Confidentiality Agreement

- I agree to keep confidential all information concerning the project "Understanding the Link Between Emotional Awareness, Therapy, and Training."
- I will not retain or copy any information involving the project.

I agree to these confidentiality terms

Yes

[Continue](#) [Print](#)

Understanding the Link Between Emotional Awareness, Therapy, and Training. Logout

Request For Results

I would like to be sent the group results from this research via email

Please Note: If you select Yes the group results from this research will be sent via email to the email address you have previously supplied. If you would like these results sent to another address please email the researcher. Thank you.

Yes
 No

[Continue](#) [Print](#)

Demographic Data

Gender

Ethnicity

- European
 Maori
 Asian
 Pacific Peoples
 Middle Eastern/Latin American/African
 Other

Location (city and country)

Age

Years of Experience as a Practitioner (including internship if applicable)

Professional Registration

- Counsellor
 Psychologist
 Psychotherapist

Therapeutic Approach (please note only one approach, your foremost approach)

Please enter only one

Continue

Print

Therapist Social Emotional Interactions Questionnaire Revised

Instructions

You are now going to move onto answering the questionnaire. Please select the appropriate response to each item concerning **how true it is to your practice**.

Questionnaire Answers

1: I mirror/match my clients (e.g. Body posture, use of key words)

- Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

2: I reflect or communicate an understanding of the client's feelings

- Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

3: I offer hunches about client experiences

Very True Mainly True Unsure Slightly True Not at all True

4: I tailor the approach and treatment to suit client's personality

Very True Mainly True Unsure Slightly True Not at all True

5: I believe my clients will improve

Very True Mainly True Unsure Slightly True Not at all True

6: I highlight client competencies, resources and resiliencies

Very True Mainly True Unsure Slightly True Not at all True

7: I view treatment as a partnership for change

Very True Mainly True Unsure Slightly True Not at all True

8: I encourage clients to find own motivation for change

Very True Mainly True Unsure Slightly True Not at all True

9: I incorporate the client's worldview and theory of problem/treatment

Very True Mainly True Unsure Slightly True Not at all True

10: I view the therapeutic relationship as a primary tool of therapy

Very True Mainly True Unsure Slightly True Not at all True

11: I use my own emotions and responses to relate to the client

Very True Mainly True Unsure Slightly True Not at all True

12: I draw on theory to aid my understanding of the client's feelings/experiences

Very True Mainly True Unsure Slightly True Not at all True

13: I can gain a sense of the world of the client

Very True Mainly True Unsure Slightly True Not at all True

14: I express genuine thoughts and feelings

Very True Mainly True Unsure Slightly True Not at all True

15: I strive for congruence between my values and my behaviour

Very True Mainly True Unsure Slightly True Not at all True

16: I regulate my level of emotional attachment to clients

Very True Mainly True Unsure Slightly True Not at all True

17: I use measures to prevent my own abuse of power

Very True Mainly True Unsure Slightly True Not at all True

18: I consistently question my own practice

Very True Mainly True Unsure Slightly True Not at all True

19: I undertake therapy myself

Very True Mainly True Unsure Slightly True Not at all True

20: I see the end of therapy as a collaborative process

Very True Mainly True Unsure Slightly True Not at all True

21: I adjust the termination process to the nature of the therapy relationship

Very True Mainly True Unsure Slightly True Not at all True

22: I am comfortable addressing spirituality

Very True Mainly True Unsure Slightly True Not at all True

23: I directly discuss differences between the client and myself

Very True Mainly True Unsure Slightly True Not at all True

24: I am attentive to my clients' reactions

Very True Mainly True Unsure Slightly True Not at all True

25: I make accurate judgements

Very True Mainly True Unsure Slightly True Not at all True

26: I sit comfortably close to my clients

Very True Mainly True Unsure Slightly True Not at all True

27: I display consistent verbal and non-verbal behaviour

Very True Mainly True Unsure Slightly True Not at all True

28: I seek to understand and clarify clients' expectations

Very True Mainly True Unsure Slightly True Not at all True

29: I anticipate relapse

Very True Mainly True Unsure Slightly True Not at all True

30: I explicitly encourage clients to be open and honest with me

Very True Mainly True Unsure Slightly True Not at all True

31: I ensure that therapy occurs in an atmosphere of mutual respect

Very True Mainly True Unsure Slightly True Not at all True

32: I am a stable and reliable figure in therapy

Very True Mainly True Unsure Slightly True Not at all True

33: I emphasis doing rather than just understanding

Very True Mainly True Unsure Slightly True Not at all True

34: I believe the therapeutic environment is a place for clients to trial different behavioural strategies

Very True Mainly True Unsure Slightly True Not at all True

35: I anticipate therapy to take time

Very True Mainly True Unsure Slightly True Not at all True

36: I am professionally confident

Very True Mainly True Unsure Slightly True Not at all True

37: I believe my clients trust me and my clinical judgement

Very True Mainly True Unsure Slightly True Not at all True

38: I give my full attention

Very True Mainly True Unsure Slightly True Not at all True

39: I am satisfied by my work

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

40: I engage in deliberate therapeutic practise

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

41: I personally and professionally grow as a result of my work

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

42: I appropriately validate clients' emotions

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

43: I am aware when there are rifts during therapy

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

44: I believe my private emotional life affects my practice

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

45: I am aware of my own emotions during therapy

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

46: I believe clients are flexible

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

47: I believe all clients are different

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

48: I regulate my clients' emotions

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

49: I don't view client emotionality as a problem

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

50: I encourage clients to move on when emotional

Very True
 Mainly True
 Unsure
 Slightly True
 Not at all True

51: I monitor whether or not my emotions are useful during therapy

Very True Mainly True Unsure Slightly True Not at all True

52: I am explicit with my methods of influencing

Very True Mainly True Unsure Slightly True Not at all True

53: I like to keep my clients outcome focused

Very True Mainly True Unsure Slightly True Not at all True

54: I value different, new therapeutic techniques

Very True Mainly True Unsure Slightly True Not at all True

55: I believe therapeutic progress is about small incremental changes rather than radical changes

Very True Mainly True Unsure Slightly True Not at all True

56: I expect quick, significant change

Very True Mainly True Unsure Slightly True Not at all True

57: I believe that I am the expert

Very True Mainly True Unsure Slightly True Not at all True

58: I validate clients' experiences

Very True Mainly True Unsure Slightly True Not at all True

59: I believe observable client emotions give valuable information

Very True Mainly True Unsure Slightly True Not at all True

60: I believe showing congruent emotion is useful

Very True Mainly True Unsure Slightly True Not at all True

61: My emotions surface during therapy

Very True Mainly True Unsure Slightly True Not at all True

62: My therapeutic effectiveness is important to me

Very True Mainly True Unsure Slightly True Not at all True

63: I am directive during therapy

Very True Mainly True Unsure Slightly True Not at all True

64: I give thought to how my appearance impacts on my client

Very True Mainly True Unsure Slightly True Not at all True

65: I dress in a way that supports my professional position

Very True Mainly True Unsure Slightly True Not at all True

66: I discuss the possibility of relapse with clients

Very True Mainly True Unsure Slightly True Not at all True

67: I model the appropriate way to act for my clients

Very True Mainly True Unsure Slightly True Not at all True

68: I am conscious of the connection between my client and I

Very True Mainly True Unsure Slightly True Not at all True

69: I self-care to ensure I manage my own emotions

Very True Mainly True Unsure Slightly True Not at all True

70: I am comfortable with referring clients on when required

Very True Mainly True Unsure Slightly True Not at all True

71: I believe clients often seek to be influenced

Very True Mainly True Unsure Slightly True Not at all True

72: I am aware of others' emotions

Very True Mainly True Unsure Slightly True Not at all True

73: I can recognize the emotions of others

Very True Mainly True Unsure Slightly True Not at all True

74: I empathize with others' emotions

Very True Mainly True Unsure Slightly True Not at all True

75: I am able to understand others' feelings

Very True Mainly True Unsure Slightly True Not at all True

[Continue](#)

Video Instructions

You are about to watch and respond to the Emotional Practice Film Stimulus. Before you continue please re-familiarise yourself with the specific instructions that have been sent to you. Please also ensure the researcher is aware of the date in which you are completing this phase of the research (Part 1).

As a reminder you need to watch the film without any interruption, as you are unable to cease viewing for an extended period. Please also be aware that the therapist's voice has been edited out of the video clip therefore expect the audio to cut in and out.

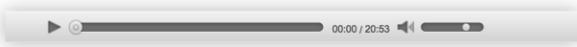
You are asked to pause the film whenever you identify an emotion displayed by the client. A master list of emotion is then provided for you to choose an emotion from, which includes the following options: anger, contempt, disgust, fear, happiness, sadness, or surprise.

When you have completed the Emotional Practice Film Stimulus you will then complete Part 2 of the research. This will involve either no emotion training for a two week period or engagement with the Subtle Expression Training Tool developed by Dr. Paul Ekman four times within a two week period. The final part of the research (Part 3) will require you to again login to this website, complete the questionnaire, watch and respond to the Emotional Practice Film Stimulus.

If you wish to get in touch with the researcher for any reason please do so by emailing me at emotional.practice@gmail.com or phone me on 021 022 84200.

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Video



As a reminder, the master list of emotion is:

Anger, Contempt, Disgust, Fear, Happiness, Sadness, Surprise

Video

From this master list of emotion, what emotion is displayed by the client?

Please select one option:

- Anger
- Contempt
- Disgust
- Fear
- Happiness
- Sadness
- Surprise

[Save](#)

Appendix C: Written Permission to Recruit from the Clinic

Amanda Johnsen
School of Psychology
Massey University
Private Bag 11-222
Palmerston North 4442

19th May 2014

Clinic Director
Turitea Psychology Clinic
Bernard Chambers B
Library Road
Massey University
Palmerston North

Dear Clinic Director,

I am a doctoral student training in the clinical psychology programme at Massey University, Palmerston North.

For my doctoral research I am motivated to gain an understanding of therapists' emotional practice as well as investigate whether emotional training can enhance therapists' emotional competencies. Implications for practice may arise from such investigation, especially since there is limited research within this area.

I intend to find out whether an emotion awareness training intervention influences therapists' therapeutic and self-reported emotional practice. I will also investigate whether a relationship exists between therapists' therapeutic and self-reported emotional practice.

Using a two stage written consent process, I propose filming four therapy sessions with different clients and their therapist. Following the therapy session, I will ask each client about key emotional moments within the session. I will then take three 20-minute portions from any one of the filmed therapy sessions where emotional instances occur. Ultimately, one of these film segments will be used as a stimulus to measure therapists' ability to identify client emotion. The therapists will also be asked to note their response if they were the therapist at particular points within the filmed segment.

To access participants from around New Zealand, the procedure will be hosted on a secure website where a login and password are required for access. The participants' ability to detect emotion in this therapy film will be recorded and scored, and their self-reported responses at particular points throughout the film analysed. The therapist participants will also be given a questionnaire addressing social-emotional interactions and self-perceived emotional awareness.

I am writing to request permission to display advertisements in your clinic to recruit clients, and to hand deliver advertisements to the therapists working in your clinic. I have added a copy of each of these advertisements to this letter for your information.

I look forward to hearing from you.

Kind regards,

Amanda Johnsen

Appendix D: Clinic Advertisement for Clients



Invitation to Participate in Research

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

Dear Clients,

I would like to invite you to be involved in an exciting research study. The study is an investigation of therapists' awareness of emotion in practice.

Who can participate?

Clients being seen by a practicing therapist at the Turitea Psychology Clinic are invited to participate. Participating clients need to be proficient in English, over the age of 16 years old, attending therapy by themselves, and be paying privately.

What is involved?

If you consent to participating, your scheduled therapy session with your therapist will be filmed. I will call you approximately a week before your scheduled therapy session to ask you for verbal consent to be involved in the research. Following this, your written consent will be sought at either one or two stages of this research. These stages are described in more detail next.

You will first be asked by a therapist independent to the research to provide written consent to having your therapy session with your therapist filmed. Your regular therapy session will then proceed. At the end of your filmed therapy session I will ask you about key emotional moments during the session. This will take 15-minutes of your time.

From those who have been filmed, three 20-minute segments will be selected from any one of the four the filmed therapy sessions. Your therapist's voice will be edited out of segments, and your voice will be neutralised if you happen to mention someone. Your consent will be sought again if one of the segments chosen is from your filmed therapy session. If your film is chosen, you will review the 20-minute segment with your therapist and myself before being asked to provide written consent to the segment being viewed by a facial coder. A facial coder will review the three segments, and will ultimately select one to be fully facially coded. I will notify you whether or not your segment is or is not the final one selected. If your filmed session is not chosen, it will be destroyed. The segment chosen will be shown to therapists through a secure online portal. Therapists observing the segment will be asked to identify emotion and answer questions about what they would do at particular times if they were the therapist.

A facial coder, website programmer, technical staff member, and cultural advisor will be the only individuals other than the researcher and therapist participants who see the videoed therapy session segment. All individuals will be required to sign confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

If you are interested participating in this research, please contact Amanda Johnsen at emotional.practice@gmail.com, or on 02102284200. I will send you an information sheet, which has further information.

Thank you for taking the time to consider this invitation.

Amanda Johnsen

Appendix E: Clinic Advertisement for Therapists



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKĒNGA TANGATA

Invitation to Participate in Research

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

Dear Therapists,

I would like to invite you to be involved in an exciting research study. The study is an investigation of therapists' awareness of emotion in practice.

Who can participate?

Practicing therapists including clinical psychologists, psychotherapists, and intern psychologists working at the Turitea Psychology Clinic are invited to participate. Therapists are required to be proficient in English. The client the therapist is seeing needs to be proficient in English, over the age of 16 years old, attending therapy by himself or herself, and be paying privately.

What is involved?

If you consent to participating, your scheduled therapy session with your client will be filmed. Your written consent will be sought at either one or two stages of this research. These stages are described in more detail next.

I will first ask you to provide written consent to having your therapy session with your client filmed. This will happen before you enter the therapy room with your client. From those therapy sessions that have been filmed, three 20-minute segments will be selected from any one of the filmed therapy sessions. If your client mentions another person during the segment, their voice will be neutralised in such a way to retain their tone of voice. Your voice will be edited out of the film. Your consent will be sought again if one of the segments chosen is from your filmed therapy session. If your film is chosen, you will review the 20-minute segment with your client and myself before being asked to provide written consent to the segment being viewed by a facial coder. A facial coder will review the three segments, and will ultimately select one to be fully facially coded. I will notify you whether or not your segment is the final one selected. If your filmed session is not chosen, it will be destroyed. The segment chosen will be shown to therapists through a secure online portal. Therapists observing the film will be asked to identify emotion and answer questions about what they would do at particular times if they were the therapist.

A facial coder, website programmer, technical staff member, and cultural advisor will be the only individuals other than the researcher and therapist participants who see the videoed therapy session segment. All individuals will be required to sign confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

If you are interested participating in this research, please contact Amanda Johnsen at emotional.practice@gmail.com, or on 02102284200. I will send you an information sheet, which has further information.

Thank you for taking the time to consider this invitation.

Amanda Johnsen

Te Kūmenga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7366 <http://psychology.massey.ac.nz>

Appendix F: Client Information Sheet



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TE KURA PŪKENGĀ TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

INFORMATION SHEET – FILMED CLIENT

Who is doing this research?

My name is Amanda Johnsen and I am a student at Massey University, Palmerston North. I am conducting this research project as a requirement for the completion of a Doctorate in Clinical Psychology. My main supervisor is Dr. Shane Harvey, along with co-supervisors Dr. Don Baken and Dr. Peter Cannon.

Project Description and Invitation

This study is an investigation of therapists' awareness of emotion in practice. I intend to find out whether an emotion training intervention influences therapists' therapeutic and self-reported emotional practice. I also intend to investigate whether a relationship exists between therapists' therapeutic and self-reported emotional practice.

I am seeking consent from you to have your therapy session with your therapist filmed.

Who can participate?

Privately paying clients seeing a therapist at the Turitea Psychology Clinic by themselves whom are over the age of 16 years old and proficient in English can participate. Written consent will also be sought from the therapist who is seeing you. Only four clients and their therapists are able to participate.

It is possible that you may become uncomfortable during participation. If this occurs, you have the right to terminate the recording.

As compensation for your time given to the research, the cost of your therapy session will be paid for.

What is involved?

Three segments approximately 20-minutes in length will be taken from any of the four filmed therapy sessions with different clients and their therapists. The three segments will be taken from emotional moments in the filmed therapy sessions. The segments chosen will not contain any identifying information of others. If you mention another person, the content will be neutralised so to retain the tone of your voice. Your therapists' voice will be edited out of the film segment. If one of the three segments is extracted from your filmed therapy session, you will review the segment with your therapist and the researcher before a facial coder views it. The facial coder will select one segment from the three that contains the most expressed emotion. The final segment selected will then be facially emotionally coded.

I have given this information to you before I call to ask for your verbal consent to be involved in the research. If you provide verbal consent, your written consent will be requested before your therapy session with your therapist is filmed. There will be two stages to the written consent process for the individuals who have a segment, or segments, from their therapy session selected. There will be one written consent process for the filmed therapy sessions, or sessions, not selected. First, written consent will be sought from you by a therapist independent to the research. This will occur in your therapy room before your therapist enters. The independent therapist is included to verify you are aware of what will happen and that you have given your consent. The second stage will involve you and your therapist reviewing the segment before being asked by the researcher to provide written consent to the segment being viewed by a facial coder. The researcher will notify you whether or not your segment is the final segment selected to be used in the research.

Your therapy session will be filmed at a scheduled date and time suiting you and your therapist. The filming equipment will be set up before the therapy session begins. The camera will be focused on you. Your therapist will turn on the video recorder when they enter the room and your normal therapy session will take place. When your therapy session ends, your therapist will turn off the video camera and leave the room to allow the researcher to ask you about the therapy session. The researcher will ask you to identify key emotional moments in your therapy session. Answering these questions should take no more than 15-minutes. Once this is complete, you will be able to

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leave. You will also be asked what your preferred method is for the researcher to seek additional written consent if your segment is selected to be viewed by a facial coder. Therefore, the total time required from you to participate in this research is expected to be approximately 15-minutes if a segment from your film is not chosen, or 45-minutes if a segment is chosen from your film. This approximated time does not take into account the length of your normal therapy session.

The final film segment will be used as a stimulus to measure therapists' ability to identify and respond to client emotion. The therapist participants will be asked to identify emotion in the film segment and note their response to the client if they were the therapist in the session. In addition, the therapist participants will be given a 77-item questionnaire addressing social-emotional interactions within practice and self-perceived emotional awareness. The therapist participants' ability to detect emotion in this therapy film will be recorded and scored, as well as their questionnaire and self-reported response at particular points throughout the film analysed. To access therapist participants from around New Zealand, the procedure will be hosted on a secure website where a login and password is required for access.

What will happen to the collected data?

The filmed therapy session will be immediately removed from the video camera and stored securely on a computer requiring login access. If a segment from your filmed therapy session is not chosen, it will be destroyed. If your filmed session is chosen, only the segment taken will be stored securely on a computer requiring login access. The full filmed therapy session will be destroyed. Upon selecting the final segment, the other two segments will be destroyed. After a 10-year period, the final chosen film segment will be destroyed.

As mentioned previously, a facial coder will view your filmed segment if it is one of the three 20-minute segments initially selected. The facial coder will watch the three segments and select which segment out of the three contains the most expressed emotion. For the final film segment selected, four people other than the researcher and therapist participants will view it. This includes a facial coder who will analyse the emotion expressions in the film segment, a website programmer who will view the segment while building the website, a technical member who will edit the film, and a cultural advisor who will be consulted if cultural aspects emerge. All of these individuals will be required to sign confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

A summary of project findings will be available by indicating to the researcher that you wish to receive this. If you wish to receive results from the research, you will have the opportunity to complete a "Request for Group Results from the Research" upon consenting to participating in the research. The results of the research will be sent to you as soon as it is available. Note that if you request the results, it will be given as a group result and be sent via email.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*

Project Contacts

If you have any further questions please contact the researcher or main supervisor.

Researcher	Main Supervisor
Amanda Johnsen	Dr. Shane Harvey
School of Psychology	School of Psychology
Massey University, Turitea Campus	Massey University, Turitea Campus
Palmerston North	Palmerston North
Phone: 021 022 84200	Phone: (06) 3569099 Ext. 81742
Email: emotional.practice@gmail.com	Email: s.t.harvey@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/65. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicssoutha@massey.ac.nz.

Appendix G: Therapist Information Sheet



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TE KURA PŪKĒNGA TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

INFORMATION SHEET – FILMED THERAPIST

Who is doing this research?

My name is Amanda Johnsen and I am a student at Massey University, Palmerston North. I am conducting this research project as a requirement for the completion of a Doctorate in Clinical Psychology. My main supervisor is Dr. Shane Harvey, along with co-supervisors Dr. Don Baken and Dr. Peter Cannon.

Project Description and Invitation

This study is an investigation of therapists' awareness of emotion in practice. I intend to find out whether an emotion training intervention influences therapists' therapeutic and self-reported emotional practice. I also intend to investigate whether a relationship exists between therapists' therapeutic and self-reported emotional practice.

I am seeking consent from you to have your client's therapy session with you filmed.

Who can participate?

Therapists including clinical psychologists, psychotherapists, and intern psychologists currently practicing at the Turitea Psychology Clinic can participate. Therapists need to be proficient in English. Written consent will also be sought from the client who is seeing you. Only four clients and their therapists are able to participate.

It is possible that you may become uncomfortable during participation. If this occurs, you have the right to terminate the recording.

As compensation for your time given to the research, you will be provided with access to the Subtle Expression Training Tool (SETT) developed by Dr. Paul Ekman for your own professional development.

What is involved?

Three segments approximately 20-minutes in length will be taken from any of the four filmed therapy sessions with different clients and their therapists. The three segments will be taken from emotional moments in the filmed therapy sessions. The segments chosen will not contain any identifying information of others. If your client mentions another person, the content will be neutralised so to retain the tone of their voice. Your voice will be edited out of the film segment. If one of the three segments is extracted from your filmed therapy session, you will review the segment with your client and the researcher before a facial coder views it. The facial coder will select one segment from the three that contains the most expressed emotion. The final segment selected will then be facially emotionally coded.

I will call your client approximately a week before the scheduled therapy session to request their verbal consent to be involved in the research. Prior to the therapy session commencing, you and your client will be asked to provide written consent. There will be two stages to the written consent process for the individuals who have a segment, or segments, from their therapy session selected. There will be one written consent process for the filmed therapy session, or sessions, not selected. First, written consent will be sought from your client by a therapist independent from the research before you enter the therapy room with your client. The independent therapist is included to verify the client is aware of what will happen and that they have given consent. The researcher will request your written consent. The second stage will involve you and your client reviewing the segment before being asked to provide written consent to the segment being viewed by a facial coder. The researcher will notify you whether or not your segment is the final segment selected to be used in the research.

Your therapy session will be filmed at a scheduled date and time suiting you and your client. The filming equipment will be set up before the therapy session begins. The camera will be focused on your client. You will turn on the video recorder as soon as you enter the room. The therapy session will run its usual length. When the therapy session ends, you will turn off the video recorder and leave the room to allow the researcher to ask the client about the therapy session. Your client will be asked to identify key emotional moments in the therapy session. Answering these questions should take no more than 15-minutes. Once this is complete, the client will be able to leave. You will be

Te Kūnenga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

asked what your preferred method is for the researcher to seek additional written consent if your segment is selected to be viewed by a facial coder. Therefore, the total time required from you to be involved in this research is expected to be approximately 30-minutes if your film is chosen, or five minutes if no segment is chosen from your film. This approximated time does not take into account the length of the therapy session.

The final film segment will be used as a stimulus to measure therapists' ability to identify and respond to client emotion. The therapist participants will be asked to identify emotion in the film segment and note their response to the client if they were the therapist in the session. In addition, the therapist participants will be given a 77-item questionnaire addressing social-emotional interactions within practice and self-perceived emotional awareness. The therapist participants' ability to detect emotion in this therapy film will be recorded and scored, as well as their questionnaire and self-reported response at particular points throughout the film analysed. To access therapist participants from around New Zealand, the procedure will be hosted on a secure website where a login and password is required for access.

What will happen to the collected data?

The filmed therapy session will be immediately removed from the video camera and stored securely on a computer requiring login access. If a segment from your filmed therapy session is not chosen, it will be destroyed. If your filmed session is chosen, only the segment taken will be stored securely on a computer requiring login access. The full filmed therapy session will be destroyed. Upon selecting the final segment, the other two segments will be destroyed. After a 10-year period, the chosen film segment will be destroyed.

As mentioned previously, a facial coder will view your filmed segment if it is one of the three 20-minute segments initially selected. The facial coder will watch the three segments and select which segment out of the three contains the most expressed emotion. For the final film segment selected, four people other than the researcher and therapist participants will view it. This includes a facial coder who will analyse the emotion expressions in the film segment, a website programmer who will view the segment while building the website, a technical member who will edit the film, and a cultural advisor who will be consulted if cultural aspects emerge. All of these individuals will be required to sign confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

A summary of project findings will be available by indicating to the researcher that you wish to receive this. If you wish to receive results from the research, you will have the opportunity to complete a "Request for Group Results from the Research" upon consenting to participating in the research. The results of the research will be sent to you as soon as it is available. Note that if you request the results, it will be given as a group result and be sent via email.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*

Project Contacts

If you have any further questions please contact the researcher or main supervisor.

Researcher	Main Supervisor
Amanda Johnsen	Dr. Shane Harvey
School of Psychology	School of Psychology
Massey University, Turitea Campus	Massey University, Turitea Campus
Palmerston North	Palmerston North
Phone: 021 022 84200	Phone: (06) 3569099 Ext. 81742
Email: emotional.practice@gmail.com	Email: s.t.harvey@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/65. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

Appendix H: Independent Therapist Information Sheet



MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

INFORMATION SHEET – INDEPENDENT THERAPIST

Who is doing this research?

My name is Amanda Johnsen and I am a student at Massey University, Palmerston North. I am conducting this research project as a requirement for the completion of a Doctorate in Clinical Psychology. My main supervisor is Dr. Shane Harvey, along with co-supervisors Dr. Don Baken and Dr. Peter Cannon.

Project Description and Invitation

This study is an investigation of therapists' awareness of emotion in practice. I intend to find out whether an emotion training intervention influences therapists' therapeutic and self-reported emotional practice. I also intend to investigate whether a relationship exists between therapists' therapeutic and self-reported emotional practice.

You are invited to participate.

Who can participate?

A therapist working in the Turitea Psychology Clinic who is proficient in English and independent to the research can participate. Only one therapist is required.

What is involved?

With written consent, four real life therapy sessions involving a client and their therapist will be filmed at scheduled dates and times suiting the client and their therapist. Three segments approximately 20-minutes in length will be taken from any of the four filmed therapy sessions. The 20-minute segments chosen will not contain any identifying information of others. If the client mentions another person, the content will be neutralised so to retain the tone of voice. The therapists' voice will be edited out of the film segment. Each filmed client and therapist pair filmed in the three 20-minute segments will review the segment with the researcher before a facial coder views it. The facial coder will select one segment from the three that contains the most expressed emotion. The final segment selected will then be facially emotionally coded.

There will be two stages to the written consent process for the individuals who have a segment, or segments, from their therapy session selected. There will be one written consent process for the filmed therapy session/s not selected. You will be involved in the first stage of the written consent process. Before the therapy sessions commence, you will seek written consent from the client in their allocated therapy room. This will occur before the client's therapist enters the therapy room. You are required to verify the client is aware of what will happen and that they have given consent. The second stage will involve the client and their therapist reviewing the segment chosen before being asked by the researcher to provide written consent to the segment being viewed by a facial coder. The researcher will notify the client and therapist if their segment is the final segment selected by the facial coder, and ultimately used in the research.

The final film segment will be used as a stimulus to measure therapists' ability to identify and respond to client emotion. To access therapist participants from around New Zealand, the procedure will be hosted on a secure website where a login and password is required for access. The therapist participants will be asked to identify emotion in the film segment and note their response to the client if they were the therapist in the session. In addition, the therapist participants will be given a 77-item questionnaire addressing social-emotional interactions within

practice and self-perceived emotional awareness. The therapist participants' ability to detect emotion in this therapy film will be recoded and scored, as well as their questionnaire and self-reported response at particular points throughout the film analysed.

What will happen to the collected data?

The filmed therapy session will be immediately removed from the video camera and stored securely with a password on a computer requiring login access. The therapy sessions where no segment is chosen will be destroyed. The filmed therapy sessions chosen will only have the segment stored securely on a computer requiring login access. The full filmed therapy session will be destroyed. Upon selecting the final segment, the other two segments will be destroyed. After a 10-year period, this film segment will be destroyed.

As mentioned previously, a facial coder will view the filmed segment if it is one of the three 20-minute segments initially selected. The facial coder will watch the three segments and select which segment out of the three contains the most expressed emotion. For the final film segment selected, four people other than the researcher and therapist participants will view it. This includes a facial coder who will analyse the emotion expressions in the film segment, a website programmer who will view the segment while building the website, a technical member who will edit the film, and a cultural advisor who will be consulted if cultural aspects emerge. All of these individuals will be required to sign confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

A summary of project findings will be available by indicating to the researcher that you wish to receive this. If you wish to receive results from the research, you will have the opportunity to complete a "Request for Group Results from the Research" upon consenting to participating in the research. The results of the research will be sent to you as soon as it is available. Note that if you request the results, it will be given as a group result and be sent via email.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*

Project Contacts

If you have any further questions please contact the researcher or main supervisor.

Researcher	Main Supervisor
Amanda Johnsen	Dr. Shane Harvey
School of Psychology	School of Psychology
Massey University, Turitea Campus	Massey University, Turitea Campus
Palmerston North	Palmerston North
Phone: 021 022 84200	Phone: (06) 3569099 Ext. 81742
Email: emotional.practice@gmail.com	Email: s.t.harvey@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/65. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

Appendix I: Participant Consent Form – Therapist



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKĒNGA TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

PARTICIPANT CONSENT FORM – FILMED THERAPIST; INITIAL CONSENT

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the therapy session being sound recorded.

I agree/do not agree to the therapy session being image recorded.

I wish/do not wish to have the filming stored with my consent form in a research archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

Full Name - printed

Te Kūmanga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

Appendix J: Participant Consent Form – Independent Therapist



MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

PARTICIPANT CONSENT FORM – INDEPENDENT THERAPIST

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I wish/do not wish to have the filming of the therapy session stored with my consent form in a research archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

Te Kōwhiri
ki Pākehua

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7960 <http://psychology.massey.ac.nz>

Appendix K: Independent Therapist Confidentiality Agreement



Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

CONFIDENTIALITY AGREEMENT – INDEPENDENT THERAPIST

I (Full Name - printed)

agree to keep confidential all information concerning the project "Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies".

I will not retain or copy any information involving the project.

Signature: **Date:**

Appendix L: Participant Consent Form – Client



MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PUKENGA TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

PARTICIPANT CONSENT FORM – FILMED CLIENT; INITIAL CONSENT

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the therapy session being sound recorded.

I agree/do not agree to the therapy session being image recorded.

I wish/do not wish to have the filming stored with my consent form in a research archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

Full Name - printed

Te Kūnenga
ki Pārehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

Appendix M: Request for Research Results



Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

REQUEST FOR GROUP RESULTS FROM THE RESEARCH

Please indicate your preference by circling the appropriate statement below:

(Note: The results will be sent via email)

1. I would like to be sent the group results from this research

or,

2. I do not want to receive the group results from this research

Please provide your email address if you selected option 1 above.

Email Address:

Appendix N: Reviewed Consent Form – Client



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TE KURA PUKENGA TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

PARTICIPANT CONSENT FORM – FILMED CLIENT; REVIEWED CONSENT

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the filmed therapy session segment being used in the research.

I wish/do not wish to have the film segment stored with my consent form in a research archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

Full Name - printed

Te Kūnenga
ki Pārehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand. T 06 356 9099 extn 85071 F 06 355 7968 <http://psychology.massey.ac.nz>

Appendix O: Reviewed Consent Form – Therapists



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

PARTICIPANT CONSENT FORM – FILMED THERAPIST; REVIEWED CONSENT

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the filmed therapy session segment being used in the research.

I wish/do not wish to have the film segment stored with my consent form in a research archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

Full Name - printed

Te Kōwhiri
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7968 <http://psychology.massey.ac.nz>

Appendix P: Release of Transcript Form



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TE KURA PUKENGA TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to review and amend the filmed therapy session I was involved in.

I agree to the chosen segment from the original therapy session being used for the research. I acknowledge this film will be used as an emotion measure, and the findings will be presented in reports and publications arising from the research.

Signature:

Date:

Full Name - printed

Te Kōwhiri
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9009 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

Appendix Q: Interview Schedule



Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

INTERVIEW QUESTIONS/SCHEDULE

- Were there any key emotional moments during the therapy session for you today?
- Are you able to describe these moments to me?
- What made them key emotional moments for you?
- What would be the best way for me to get in contact with you to seek additional consent should your filmed therapy session be chosen? If it is chosen, a 20-minute segment will be extracted from it. You will need to come and view the segment before being asked to provide written consent to it being used in the research.

Appendix R: Confidentiality Agreement – FACS Coders



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TE KURA PŪKENGĀ TANGATA

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

CONFIDENTIALITY AGREEMENT – FACIAL CODER

I (Full Name - printed)

agree to keep confidential all information concerning the project "Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies".

I will not retain or copy any information involving the project.

Signature: _____

Date: _____

Te Kunenga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 350 5673 <http://psychology.massey.ac.nz>

Appendix S: Confidentiality Agreement – Website Programmer



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Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

CONFIDENTIALITY AGREEMENT – WEBSITE PROGRAMMER

I (Full Name - printed)

agree to keep confidential all information concerning the project "Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies".

I will not retain or copy any information involving the project.

Signature: _____ **Date:** _____

Appendix T: Confidentiality Agreement – Technical Support



Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

CONFIDENTIALITY AGREEMENT – TECHNICAL STAFF

I (Full Name - printed)

agree to keep confidential all information concerning the project "Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies".

I will not retain or copy any information involving the project.

Signature:

.....

Date:

.....

Appendix U: Invitation and Brief Advertising

Dear X,

I am a student member of the New Zealand College of Clinical Psychologists and the New Zealand Psychological Society. My doctoral research is investigating therapists' awareness of emotion in practice. Would you please share the research invitation I have added below to the members of your association/society?

Kind regards,

Amanda Johnsen

Hello everyone,

My name is Amanda Johnsen and I am a student at Massey University, Palmerston North. I am conducting an online study investigating whether training in emotion recognition can improve therapists' awareness of emotion in practice. If you are a **practicing counsellor, psychologist, or psychotherapist, are proficient in English, and have not completed any emotion recognition training**, I invite you to participate (see the attached advertisement). If you choose to participate you will be randomly assigned to a training or no training group where the Subtle Expression Training Tool developed by Dr. Paul Ekman will be utilised. This training will be provided at no cost to you and will be available to the participants in both the training and no training group.

If you are interested in participating and/or have any questions please contact me at emotional.practice@gmail.com.

Thank you for your time.

Kind regards,

Amanda Johnsen



Appendix V: Therapist Advertisement



MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKĒNGA TANGATA

Invitation to Participate in Research

Understanding the Link Between Emotional Awareness, Therapy, and Training

Dear Therapists,

I would like to invite you to be involved in this research study, which is an investigation of therapists' awareness of emotion in practice.

Who can participate?

Practicing therapists including counsellors, psychologists, or psychotherapists are invited to participate. Therapists are required to be proficient in English and to have not previously completed any emotion recognition training.

What is involved?

The study is administered through a secure website that needs to be accessed using a computer/laptop. Your consent will be sought at the beginning of the research process and will be followed with a confidentiality agreement. You will complete an emotional practice questionnaire, which takes approximately 15-minutes, and watch and respond to a filmed therapy session segment approximately 20-minutes long. While watching the film segment you will be asked to identify emotion displayed by the client. The time it takes you to watch and respond to the filmed therapy session segment will depend on the frequency of your responses.

Participating therapists will be randomly assigned to either a training or no training group. The training group will engage with the Subtle Expression Training Tool (SETT) developed by Dr. Paul Ekman, which is provided at no cost to you, while the no training group will be able to partake in any activity provided it is not emotion training. The training group will be required to complete four SETT sessions within two weeks, with each SETT session taking approximately 30-minutes to complete. The no training group will have a two week delay before the final research step. The final step involves all participants completing the questionnaire again and watching the film once more.

Note: participants in the no training group will be given free access to the SETT upon completion of the research.

If you are interested in participating in this research please contact Amanda Johnsen at emotional.practice@gmail.com.

Thank you for taking the time to consider this invitation.

Amanda Johnsen

Te Kūnenga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tangata
Private Bag 11222, Palmerston North 4442, New Zealand T 06 356 9099 extn 85071 F 06 355 7966 <http://psychology.massey.ac.nz>

Appendix W: Therapist Information Sheet



MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

INFORMATION SHEET

Who is doing this research?

My name is Amanda Johnsen and I am a student at Massey University, Palmerston North. I am conducting this research project as a requirement for the completion of a Doctorate in Clinical Psychology. My main supervisor is Dr. Shane Harvey, along with co-supervisors Dr. Don Baken and Dr. Peter Cannon.

Project Description and Invitation

This study is an investigation of therapists' awareness of emotion in practice. I also intend to investigate whether an emotion training intervention influences therapists' self-reported emotional practice.

You are invited to participate.

Who can participate?

Therapists who are currently in practice and have not previously completed any emotion recognition training can participate. Therapists are required to be proficient in English and either be a counsellor, psychologist, or psychotherapist. Only 50 therapists are able to participate in the research. Of these 50 participants 25 will be randomly assigned to a training group. The other 25 participants will be randomly assigned to a control group who will receive no training during the study. However, participants receiving no training will be given free access to the training on completion of the research phases.

It is possible that you may become uncomfortable during participation. If this occurs, you have the right to withdraw from the research.

What is involved?

Once you have agreed to participate in the study you will answer some demographic questions and then complete a 75-item questionnaire addressing social-emotional interactions within practice and self-perceived emotional awareness. After completing the questionnaire you will view a 20 minute segment of a filmed therapy session that has the therapists' voice removed. When viewing the filmed therapy session you will be asked to identify emotion displayed by the client. The questionnaire will take you approximately 15-minutes to complete and the time it takes you to watch and respond to the filmed segment will depend on the frequency of your responding.

Therapists who are randomly assigned to the training group will then engage with the Subtle Expression Training Tool (SETT), developed by Dr Paul Ekman. Instructions on how to access this training will be sent to you before you commence the research. The therapists in the training group will complete four sessions of the SETT within a two-week period. Each SETT session takes approximately 30-minutes to complete. Those therapists who are randomly assigned to the no training group are not to engage in any emotion training during this time. After the two-week period therapists will progress onto the final phase of the research.

The final phase of the research is similar to the first phase. You will login to the website once more, complete the same 75-item questionnaire, and finally watch and respond to the 20-minute filmed therapy session segment.

What will happen to the collected data?

The website will collect your responses into a database. These data will be stored securely on a computer with a password and login access. All data will be destroyed after a 10-year period.

To anonymise your data it will be labeled with a participant number. Only three people other than the researcher will see your anonymous responses. This includes a website programmer, cultural advisor, and statistician. The website programmer may see your responses if they require access to the participant data file to fix any unforeseen website issues. A cultural advisor will be consulted if cultural aspects emerge, and a statistician will assist with analysis of the data. All of these individuals have signed confidentiality agreements to ensure the material stays confidential and will only be used for the current research.

A summary of the project findings will be available by indicating that you wish to receive this during the online process. This will be sent to you as soon as it is available. Note that if you request the project results it will be given as a group result and be sent via email.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*

Project Contacts

If you have any further questions please contact the researcher or main supervisor.

Researcher	Main Supervisor
Amanda Johnsen	Dr. Shane Harvey
School of Psychology	School of Psychology
Massey University, Turitea Campus	Massey University, Turitea Campus
Palmerston North	Palmerston North
Phone: 021 022 84200	Phone: (06) 356 9099 ext. 84967
Email: emotional.practice@gmail.com	Email: s.t.harvey@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 13/65. If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone (06) 356 9099 ext. 84459, email humanethicsoutha@massey.ac.nz.

Appendix X: Therapist Social-Emotional Interactions Questionnaire-Revised

1

Therapist Social Emotional Interactions Questionnaire Revised

Instructions:

You are now going to move onto answering the questionnaire. Please select the appropriate response to each item concerning how true it is to your practice.

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
1. I mirror/match my clients (e.g. Body posture, use of key words)					
2. I reflect or communicate an understanding of the client's feelings					
3. I offer hunches about client experiences					
4. I tailor the approach and treatment to suit client's personality					
5. I believe my clients will improve					
6. I highlight client competencies, resources and resiliencies					
7. I view treatment as a partnership for change					
8. I encourage clients to find own motivation for change					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
9. I incorporate the client's worldview and theory of problem/treatment					
10. I view the therapeutic relationship as a primary tool of therapy					
11. I use my own emotions and responses to relate to the client					
12. I draw on theory to aid my understanding of the client's feelings/experiences					
13. I can gain a sense of the world of the client					
14. I express genuine thoughts and feelings					
15. I strive for congruence between my values and my behaviour					
16. I regulate my level of emotional attachment to clients					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
17. I use measures to prevent my own abuse of power					
18. I consistently question my own practice					
19. I undertake therapy myself					
20. I see the end of therapy as a collaborative process					
21. I adjust the termination process to the nature of the therapy relationship					
22. I am comfortable addressing spirituality					
23. I directly discuss differences between the client and myself					
24. I am attentive to my clients' reactions					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
25. I make accurate judgements					
26. I sit comfortably close to my clients					
27. I display consistent verbal and non-verbal behaviour					
28. I seek to understand and clarify clients' expectations					
29. I anticipate relapse					
30. I explicitly encourage clients to be open and honest with me					
31. I ensure that therapy occurs in an atmosphere of mutual respect					
32. I am a stable and reliable figure in therapy					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
33. I emphasis doing rather than just understanding					
34. I believe the therapeutic environment is a place for clients to trial different behavioural strategies					
35. I anticipate therapy to take time					
36. I am professionally confident					
37. I believe my clients trust me and my clinical judgement					
38. I give my full attention					
39. I am satisfied by my work					
40. I engage in deliberate therapeutic practise					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
41. I personally and professionally grow as a result of my work					
42. I appropriately validate clients' emotions					
43. I am aware when there are rifts during therapy					
44. I believe my private emotional life affects my practice					
45. I am aware of my own emotions during therapy					
46. I believe clients are flexible					
47. I believe all clients are different					
48. I regulate my clients' emotions					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
49. I don't view client emotionality as a problem					
50. I encourage clients to move on when emotional					
51. I monitor whether or not my emotions are useful during therapy					
52. I am explicit with my methods of influencing					
53. I like to keep my clients outcome focused					
54. I value different, new therapeutic techniques					
55. I believe therapeutic progress is about small incremental changes rather than radical changes					
56. I expect quick, significant change					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
57. I believe that I am the expert					
58. I validate clients' experiences					
59. I believe observable client emotions give valuable information					
60. I believe showing congruent emotion is useful					
61. My emotions surface during therapy					
62. My therapeutic effectiveness is important to me					
63. I am directive during therapy					
64. I give thought to how my appearance impacts on my client					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
65. I dress in a way that supports my professional position					
66. I discuss the possibility of relapse with clients					
67. I model the appropriate way to act for my clients					
68. I am conscious of the connection between my client and I					
69. I self-care to ensure I manage my own emotions					
70. I am comfortable with referring clients on when required					
71. I believe clients often seek to be influenced					
72. I am aware of others' emotions					

Item List	Very True	Mainly True	Unsure	Slightly True	Not at all True
73. I can recognize the emotions of others					
74. I empathize with others' emotions					
75. I am able to understand others' feelings					

Appendix Y: Instructions – Training Group



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TE KURA HINENGARO TANGATA

1

Understanding the Link Between Emotional Awareness, Therapy, and Training

Instructions – Training Group

Please carefully read through these instructions before commencing the research and get in touch if you have any questions.

Please also make sure the researcher has been informed what date you have aside to complete Part 1 and fill in the gaps below for your own record.

Date to complete Part 1: _____

Date to complete Part 3 (2-weeks after Part 1): _____

There are three parts to the research process:

Part	Approximated Time to Complete	Description of the Part
Part 1.	20-minutes Dependent on your responding	Login to the website and read the information sheet, complete the consent form, confidentiality agreement, request for results option, demographic data section, and the Therapist Social-Emotional Interactions Questionnaire Revised Watch and respond to the Emotional Practice Film Stimulus online
Part 2.	Approximately 2-hours of training within a 2-week period	Online training – you are required to complete the training 4 times within a 2-week period Each time you complete a set of training please email the researcher the date it was completed and the score you achieved
Part 3.	15-minutes Dependent on your responding	Login to the website and complete the Therapist Social-Emotional Interactions Questionnaire Revised Watch and respond to the Emotional Practice Film Stimulus online

It is important to complete the parts in the order specified above.

A brief checklist is provided on the next page for your convenience, and detailed instructions for each part follow the checklist.

Brief Checklist

- Read the instructions provided.

Part 1.

- Inform the researcher when you are going to complete Part 1 of the research.
- Login to the website.
- Read the information sheet.
- Complete the:
 - Consent form
 - Confidentiality agreement
 - Request for results option
 - Demographic data section
 - Therapist Social-Emotional Interactions Questionnaire Revised
- Read the video instructions.
- Watch and respond to the Emotional Practice Film Stimulus.
 - *The master list of emotions* provided as options for you to select from is: anger, contempt, disgust, fear, happiness, sadness, or surprise.
- Log off and exit the website.

Part 2.

- Complete four sets of the Subtle Expression Training Tool (SETT) within a two week period, and email the researcher the date and score achieved each time.

Part 3.

- Inform the researcher when you are completing Part 2 of the research, which needs to be two weeks after Part 1.
- Login to the website.
- Complete the Therapist Social-Emotional Interactions Questionnaire Revised.
- Read the video instructions.
- Watch and respond to the Emotional Practice Film Stimulus.
 - *The master list of emotions* provided as options for you to select from is: anger, contempt, disgust, fear, happiness, sadness, or surprise.
- Log off and exit the website.

Note: if you wish to get in touch with the researcher (Amanda Johnsen) at any point please do so by emailing me at emotional.practice@gmail.com or by phoning me on 02102284200.

Part 1.

Note: if applicable I will send you an email reminder regarding when to complete Part 1.

Step 1. Search <http://emotionalpractice.co.nz/> in your address bar.
 Step 2. You will be prompted for the email address you used to make initial contact and a password. I will email you the password for your account.

Step 3: Complete the pages presented. This will include a: consent form, confidentiality agreement, request for results option, demographic data section, and the Therapist Social-Emotional Interactions Questionnaire Revised.

Press "Continue" on the bottom left hand corner to move on to the next page. You also have the option to print the page by pressing "Print" on the bottom right corner.

Please read the instructions below before continuing onto Step 4.

Step 4: Now you will move onto watching and responding to the **Emotional Practice Film Stimulus.**

You are able to play the film when you wish. However, once the film begins, you are unable to cease viewing the film for an extended period. Therefore **you need to watch the film without any interruption. The film segment is approximately 20-minutes in length, but the time it takes you to watch and respond will depend on the frequency of your responses.**

Please be aware that the therapist's voice has been edited out of the video clip therefore expect the audio to cut in and out.

You are required to pause the film whenever you identify emotion displayed by the client.

Step 5: On pausing the film when you identify emotion a pop-up will appear of a master list of emotion. You need to select the emotion option that most closely captures the emotion you identified and click "Save". The emotions provided as options are: Anger, Contempt, Disgust, Fear, Happiness, Sadness, and Surprise.

Step 6: Watch and respond to the film right until the end.

Step 7: When you are finished, log off and exit the page.

***Press "Continue" when you are ready to watch and respond to the Emotional Practice Film Stimulus ***

Part 2. Training

After completing Part 1 you are required to complete the **Subtle Expression Training Tool (SETT)** developed by Dr. Paul Ekman four times within two weeks. Each week I will send you an email reminder regarding the completion of the training.

Note: please review the system requirements for training at: <http://www.paulekman.com/technical-requirements/>

To login to and access the SETT training follow the steps below:

- Step 1: Go to: <http://www.paulekman.com/product/subtle-facial-expressions-training-tool/>
- Step 2: Click "Add to Cart."
- Step 3: Click "View Cart" and check that you have one quantity of the Subtle Facial Expressions Training Tool in your cart.
- Step 4: Enter this code in the "Coupon" field: **XXX** and click "Apply Coupon."
- Step 5: Confirm the total is \$0 and click "Proceed to Checkout."
- Step 6: Enter your information into the relevant fields including a password of your choice for your account.
Please enter a valid email address; you will receive system notifications to this address.
- Step 7: Read the Terms and Conditions of the training then click "I've Read and Accept the Terms & Conditions."
- Step 8: Click "Place Order."
- Step 9: From the Order Received page you should be logged in. If you are not logged in then please login at the top right of the page using your username or email address and password.
Click "Account" at the top right of the webpage.
- Step 10: Under the "My Trainings" section click "Start Training" at the bottom of the Subtle Facial Expression Training Tool description.

If you have any questions specifically regarding the Subtle Expression Training Tool the Paul Ekman Group will be happy to help. They can be contacted at <https://www.paulekman.com/contact-us/>

- Step 11: Read the "Introduction" sections, pressing "Next" on the right hand side to move to the next slide.
- Step 12: Read the "Learn" section. Press "Next" on the right hand side to move to the next slide and to begin the training.

During the "Learn" and "Practice" session please keep the presentation speed set at "NORMAL"

- Step 13: Complete the "Learn" session for all of the seven emotions. Start at Surprise and move clockwise (i.e., Surprise, Fear, Happy, Anger, Disgust, Sadness, and Contempt). Press the play button to see the first slide of the subtle expression. There will be commentary provided after each image shown. Listen and

watch each presentation of the emotion once only. Click the arrow to move to the next slide of the learning phase.

Step 14: When you reach the end of the presented facial expressions, click "No" on the left hand side when it asks whether you would like to see the expressions again.

Step 15: After completing the "Learn" session move onto completing the "Practice" session by pressing "Next" on the right hand side.

Press the play button when you are ready to watch each facial expression flash on the screen and select which emotion you believe was presented (the options are listed on the left of the screen).

If you make an incorrect response, press the repeat icon presented below the presented facial expressions to allow yourself another try.

Leave the presentation speed set as "NORMAL" and do not use the flash or audio buttons presented below the image

Upon completing the "Practice" session, you will be provided with a score.

Please make a note of this score and the date you did this session, and email it to me at emotional.practice@gmail.com. Each time you complete a set of the Subtle Expression Training Tool you need to email me the date you did the training and your score. There is a recording sheet provided at the end of these instructions that you can use to record this data for your own reference.

Step 16: Exit out of the training and log off the website.

Four times within a two week period you need to login to the Paul Ekman Group website, start at Step 9 and go through all remaining steps until Step 16.

Part 3.

Please complete Part 3 two weeks after Part 1

Note: I will send you an email reminder a couple of days before you need to complete Part 3.

Complete the Therapist Social Emotional Interactions Questionnaire Revised and watch and respond to the Emotional Practice Film Stimulus once more. The relevant instructions are repeated below.

- Step 1. Search <http://emotionalpractice.co.nz/> in your address bar.
- Step 2. You will be prompted for your email and password. Enter your email and the password previously sent to you.
- Step 3: Complete the **Therapist Social-Emotional Interactions Questionnaire Revised**.
- Step 4: After completing the questionnaire you will move onto watching and responding to the **Emotional Practice Film Stimulus**. Please read the instructions and Steps 5-7 below before continuing.

You are able to play the film when you wish. However, once the film begins, you are unable to cease viewing the film for an extended period. Therefore, **you need to watch the film without any interruption. The film segment is approximately 20-minutes in length, but the time it takes you to watch and respond will depend on the frequency of your responses.**

Please be aware that the therapist's voice has been edited out of the video clip therefore expect the audio to cut in and out.

You are required to pause the film whenever you identify emotion displayed by the client.

- Step 5: On pausing the film when you identify emotion a pop-up will appear of a master list of emotion. You need to select the emotion option that most closely captures the emotion you identified and click "Save". The emotions provided as options are: Anger, Contempt, Disgust, Fear, Happiness, Sadness, and Surprise.
- Step 6: Watch and respond to the film right until the end.
- Step 7: When you are finished, log off and exit the page.

*****Press "Continue" when you are ready to watch and respond to the Emotional Practice Film Stimulus *****

After completing Parts 1, 2, and 3, you have completed the research process.

Thank you for taking the time to participate in this research. Your time and contribution is greatly appreciated! I hope you enjoyed taking part and found it interesting.

Remember that you can access the Subtle Expression Training Tool anytime you wish using the login and password you have set up. The user license is for up to one year.

To do so go to the Paul Ekman Group's website (<http://www.paulekman.com/>), click "Login" at the top right and use your username or email address and password. Click "Account" and under "My Trainings" click "Start Training".

If you wish to get in touch with myself for any reason please do so by emailing me at emotional.practice@gmail.com, or by phoning me on 02102284200.

Thank you once again,

Amanda Johnsen

Does Emotional Awareness Inform Emotional Practice? An Investigation into Therapists' Emotional Competencies

Subtle Expression Training Tool (SETT) Dates of Completion and Scores

Date of Completion of SETT session **One**: _____

SETT Score **One**: _____

Date of Completion of SETT session **Two**: _____

SETT Score **Two**: _____

Date of Completion of SETT session **Three**: _____

SETT Score **Three**: _____

Date of Completion of SETT session **Four**: _____

SETT Score **Four**: _____



Appendix Z: Instructions – No-training Group



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1

Understanding the Link Between Emotional Awareness, Therapy, and Training

Instructions – No Training Group

Please carefully read through these instructions before commencing the research and get in touch if you have any questions.

Please also make sure the researcher has been informed what date you have aside to complete Part 1 and fill in the gaps below for your own record.

Date to complete Part 1: _____

Date to complete Part 3 (2-weeks after Part 1): _____

There are three parts to the research process:

Part	Approximated Time to Complete	Description of the Part
Part 1.	20-minutes Dependent on your responding	Login to the website and read the information sheet, complete the consent form, confidentiality agreement, request for results option, demographic data section, and the Therapist Social-Emotional Interactions Questionnaire Revised Watch and respond to the Emotional Practice Film Stimulus online
Part 2.	A 2-week period with no emotion training	No form of emotion training for a <i>2-week period</i>
Part 3.	15-minutes Dependent on your responding	Login to the website and complete the Therapist Social-Emotional Interactions Questionnaire Revised Watch and respond to the Emotional Practice Film Stimulus online

It is important to complete the parts in the order specified above.

A brief checklist is provided on the next page for your convenience, and detailed instructions for each part follow the checklist.

Brief Checklist

- Read the instructions provided.

Part 1.

- Inform the researcher when you are going to complete Part 1 of the research.
- Login to the website.
- Read the information sheet.
- Complete the:
 - Consent form
 - Confidentiality agreement
 - Request for results option
 - Demographic data section
 - Therapist Social-Emotional Interactions Questionnaire Revised
- Read the video instructions.
- Watch and respond to the Emotional Practice Film Stimulus.
 - *The master list of emotions* provided as options for you to select from is: anger, contempt, disgust, fear, happiness, sadness, or surprise.
- Log off and exit the website.

Part 2.

- A 2-week period of no emotion training.

Part 3.

- Inform the researcher when you are completing Part 2 of the research, which needs to be two weeks after Part 1.
- Login to the website.
- Complete the Therapist Social-Emotional Interactions Questionnaire Revised.
- Read the video instructions.
- Watch and respond to the Emotional Practice Film Stimulus.
 - *The master list of emotions* provided as options for you to select from is: anger, contempt, disgust, fear, happiness, sadness, or surprise.
- Log off and exit the website.

Note: if you wish to get in touch with the researcher (Amanda Johnsen) at any point please do so by emailing me at emotional.practice@gmail.com or by phoning me on 02102284200.

Part 1.

Note: if applicable I will send you an email reminder regarding when to complete Part 1.

- Step 1: Search <http://emotionalpractice.co.nz/> in your address bar.
- Step 2: You will be prompted for the email address you used to make initial contact and a password. I will email you the password for your account.
- Step 3: Complete the pages presented. This will include a: consent form, confidentiality agreement, request for results option, demographic data section, and the Therapist Social-Emotional Interactions Questionnaire Revised.
- Press "Continue" on the bottom left hand corner to move on to the next page. You also have the option to print the page by pressing "Print" on the bottom right corner.

Please read the instructions below before continuing onto Step 4.

- Step 4: Now you will move onto watching and responding to the Emotional Practice Film Stimulus.

You are able to play the film when you wish. However, once the film begins, you are unable to cease viewing the film for an extended period. Therefore, **you need to watch the film without any interruption. The film segment is approximately 20-minutes in length, but the time it takes you to watch and respond will depend on the frequency of your responses.**

Please be aware that the therapist's voice has been edited out of the video clip consequently the sound will cut in and out.

You are required to pause the film whenever you identify emotion displayed by the client.

- Step 5: On pausing the film when you identify emotion a pop-up will appear of a master list of emotion. You need to select the emotion option that most closely captures the emotion you identified and click "Save". The emotions provided as options are: Anger, Contempt, Disgust, Fear, Happiness, Sadness, and Surprise.
- Step 6: Watch and respond to the film right until the end.
- Step 7: When you are finished, log off and exit the page.

***Press "Continue" when you are ready to watch and respond to the Emotional Practice Film Stimulus ***

Part 2. No Training

After completing Part 1 you need to have a period of no emotion training for 2-weeks before completing Part 3.

Please note that although you have been randomly assigned into the no training group, you will receive access to the Subtle Expression Training Tool (SETT) developed by Dr. Paul Ekman after completing Part 3.

Part 3.

Please complete Part 3 two weeks after Part 1

Note: I will send you an email reminder a couple of days before you need to complete Part 3.

Complete the Therapist Social Emotional Interactions Questionnaire Revised and watch and respond to the Emotional Practice Film Stimulus once more. The relevant instructions are repeated below.

- Step 1. Search <http://emotionalpractice.co.nz/> in your address bar.
- Step 2. You will be prompted for your email and password. Enter your email and the password previously sent to you.
- Step 3: Complete the **Therapist Social-Emotional Interactions Questionnaire Revised**.
- Step 4: After completing the questionnaire you will move onto watching and responding to the **Emotional Practice Film Stimulus**. Please read the instructions and Steps 5-7 below before continuing.

You are able to play the film when you wish. However, once the film begins, you are unable to cease viewing the film for an extended period. Therefore, **you need to watch the film without any interruption. The film segment is approximately 20-minutes in length, but the time it takes you to watch and respond will depend on the frequency of your responses.**

Please be aware that the therapist's voice has been edited out of the video clip therefore expect the audio to cut in and out.

You are required to pause the film whenever you identify emotion displayed by the client.

- Step 5: On pausing the film when you identify emotion a pop-up will appear of a master list of emotion. You need to select the emotion option that most closely captures the emotion you identified and click "Save". The emotions provided as options are: Anger, Contempt, Disgust, Fear, Happiness, Sadness, and Surprise.
- Step 6: Watch and respond to the film right until the end.
- Step 7: When you are finished, log off and exit the page.

*****Press "Continue" when you are ready to watch and respond to the Emotional Practice Film Stimulus *****

After completing Parts 1, 2, and 3, you have completed the research process.

Send me an email and I will provide you with the information you need to access the Subtle Expression Training Tool (SETT) developed by Dr. Paul Ekman. The user license is for up to one year.

Thank you for taking the time to participate in this research. Your time and contribution is greatly appreciated! I hope you enjoyed taking part and found it interesting.

If you wish to get in touch with myself for any reason please do so by emailing me at emotional.practice@gmail.com, or by phoning me on 02102284200.

Thank you once again,

Amanda Johnsen

Appendix AA: Instructions for Accessing the SETT



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TE KURA HINENGARE TANGATA

1

Understanding the Link Between Emotional Awareness, Therapy, and Training

Instructions to Access the Subtle Expression Training Tool (SETT) – No Training Group

Note: please review the system requirements for training at:
<http://www.paulekman.com/technical-requirements/>

To login to and access the SETT training follow the steps below:

- Step 1: Go to: <http://www.paulekman.com/product/subtle-facial-expressions-training-tool/>
- Step 2: Click "Add to Cart."
- Step 3: Click "View Cart" and check that you have one quantity of Subtle Facial Expressions Training Tool in your cart.
- Step 4: Enter this code in the "Coupon" field: **XXX** and click "Apply Coupon."
- Step 5: Confirm the total is \$0 and click "Proceed to Checkout."
- Step 6: Enter your information into the relevant fields including a password of your choice for your account.
Please enter a valid email address; you will receive system notifications to this address.
- Step 7: Read the Terms and Conditions of the training then click "I've Read and Accept the Terms & Conditions."
- Step 8: Click "Place Order."
- Step 9: From the Order Received page, you should be logged in. If you are not logged in then please login at the top right of the page using your username or email address and password.
Click "Account" at the top right of the webpage.
- Step 10: Under the "My Trainings" section click "Start Training" at the bottom of the Subtle Facial Expression Training Tool description.
- Step 12: You can return to the Subtle Expression Training Tool at any time. To do so go to the Paul Ekman Group's website (<http://www.paulekman.com/>), click "Login" and enter your username or email address and password. Click "Account" and under "My Trainings" click "Start Training."

Remember that you can access the Subtle Expression Training Tool anytime you wish using the login and password you have set up. The user license is for up to one year.

If you have any questions specifically regarding the Subtle Expression Training Tool the Paul Ekman Group will be happy to help. They can be contacted at <https://www.paulekman.com/contact-us/>

If you wish to get in touch with myself for any reason please do so by emailing me at emotional.practice@gmail.com, or by phoning me on 02102284200.

Thank you once again,

Amanda Johnsen