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**IN SEARCH OF THE MASTER THERAPIST:  
EMOTIONAL COMPETENCE AND CLIENT OUTCOME**

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**Abstract**

Psychotherapy for clients is an interpersonal, often emotional, process facilitated under guidance from their therapist. Whilst the literature offers some tantalising clues as to which therapist-emotional qualities are beneficial for establishing good working relationships, which tend to lead to positive client change, little is known about which specific emotional skills successful therapists use to achieve this process. The purpose of the present study was to gain insight into how excellent therapists use their emotion in therapy to help clients achieve positive outcomes. Three therapists with high client outcome ratings engaged in semi-structured interviews, and resulting transcripts were analysed using interpretative phenomenological analysis. Participants spoke of genuine congruence in warmth and caring characteristics; sensitivity to client needs; harbouring positive expectations of their therapeutic methods and clients; possessing strong self-reflective and emotion regulation skills; often experiencing strong empathy but moderating their empathic expression; balancing the client relationship and therapeutic process; working collaboratively with their clients; and prioritising client emotional needs over their own. Implications, study limitations and future directions for research are discussed.

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## CHAPTER ONE: INTRODUCTION

*"Happiness is when what you think, what you say,  
and what you do are in harmony"*

Mohandas Ghandi

The aim of psychological therapy is unquestionably to strive to assist clients in achieving a degree of change that leads to positive outcomes. The professional and ethical responsibility that accompanies delivery of psychotherapeutic services is to ensure that when clients engage such services, they encounter professionals whose commitment, ability, and knowledge are focused towards working with the client to achieve the best possible results (New Zealand Psychologists Board, 2011). The search for evidence of what makes therapy successful is a complicated process, as many differing and interacting variables are involved in the processes that lead to therapeutic outcomes (Lambert & Ogles, 2004; Orlinsky, Rønnestad, & Willutzki, 2004). Human beings are incredibly diverse creatures, and diversity brought to therapy by client and therapist personalities, cultures, values, lived experiences, and expectations mean that an algorithm of optimal therapist behaviours or methods generalisable to all clients is unlikely to ever eventuate. To complicate matters, many differing theoretical approaches to psychotherapy exist, most of which stress different priorities, aims, methods, and roles for clients and therapists during the process of therapy (Lambert & Ogles, 2004).

However, there appear to be some common features in many therapies that tend to be beneficial for most if not all clients. Therapy is an interpersonal process which requires much communication between therapist and client. Because therapy often requires clients to share negative emotional experiences with the therapist (Lambert & Ogles, 2004), there may be characteristics in certain therapists that facilitate this process, allowing clients to connect and develop a sense of trust and confidence in their ability to help (Martin, Garske, & Davis, 2000). If such characteristics can be identified, understood, and shared with the professional body of



therapists, perhaps the general effectiveness of therapy could be raised. The following literature review examines some of these features, directing close attention to characteristics present in therapists considered to be particularly effective.

This paper reviews the following literature from within the perspective of Western cultures, and recognises that this perspective may not be applicable to persons from other cultures. Therefore, whenever research is cited throughout this paper, the reader should keep in mind that unless specifically identified, the theories and research cited has originated from, been conducted within, and broadly relates to, Western cultures.

### **Aims of this Study**

The aims of the present study were to explore and illuminate how successful therapists use their emotions within therapy to contribute to positive client outcomes. The empirical association between the therapeutic relationship and client outcomes (Beutler et al., 2004; Martin, Garske, & Davis, 2000) highlights the need for a thorough understanding of how therapist variables affect the therapeutic relationship, as therapist variables tends to predict outcome better than do client variables (Baldwin, Wampold, & Imel, 2007).

Emotional functioning is considered to be an important facet of the quality of interpersonal relationships and social competency (Saarni, 1999), two factors which affect the establishment of the therapeutic relationship (Reynolds Welfel & Patterson, 2005; Slattery & Park, 2011; Teyber & Holmes McClure, 2011). By illuminating how successful therapists use, or do not use, their emotions in therapy, it is hoped a contribution to the growing literature on successful therapist characteristics can be made.

## CHAPTER TWO: LITERATURE REVIEW

Therapy is a relational process, where specific instances of therapist behaviour and interaction with a client may be beneficial for one client, and detrimental for another, or even be temporally specific in that such interactions could be deemed negative only when the timing is considered inappropriate. The search for the active ingredients in what makes therapy successful for clients continues, and is of necessity usually aggregated across therapist and client samples in order to derive a degree of generalisability of the findings. Such aggregation often masks specific actions or interactions that lead to success. Qualitative research has steadily grown in popularity within psychology, and may be well positioned to illuminate specific areas of psychological practice that quantitative research tends to neglect due to a lack of generalisability.

### **The General Efficacy of Psychotherapy**

Over the last three decades, researchers have established that most different forms of psychotherapy result in reported benefits for many clients, and that these benefits tend to be enduring (Lambert & Ogles, 2004). On average, people who seek and complete a course of psychotherapy can expect to be 80% better off than those with similar problems who do not enlist professional help (Lambert & Barley, 2002). While specific theoretical therapeutic techniques have been shown to assist clients in achieving positive benefits, large effects that are common across various treatments have also been identified. Many of these common effects are attributable to skills or abilities that therapists contribute to their interactions with clients (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Cristoph & Mintz, 1991; Wampold & Brown, 2005), including expectations of improvement, specific techniques, and the ability to form a constructive and helpful therapeutic relationship with clients (Ackerman & Hilsenroth, 2003; Lambert & Ogles, 2004; Martin, Garsky, & Davis, 2000). Therapist variables are particularly interesting because they may represent a subset of personality and social-interactional skills that can be useful in establishing effective working relationships with most clients, rather than being specifically useful in working with particular client groups,

personalities, or issue domains. In other words, some therapist variables may be beneficial at the basic level of human interaction in a manner that could be generalisable across differing theoretical approaches, and effective with the vast majority of clients. Understanding what these variables are, how they operate, and how - or if - they can be taught to other therapists may have the potential to assist the profession in delivering the best possible service to clients seeking assistance.

Because some therapists appear to consistently obtain better results than others (Lambert & Ogles, 2004), it would be of considerable value to the professional field to identify which particular characteristics or skills these therapists possess that make them more successful in helping clients achieve beneficial outcomes. One of the most consistently identified factors linked to positive client outcomes has been the relationship between the therapist and the client that develops during therapy (Lambert & Ogles, 2004), explored in the following section.

### **The Therapeutic Relationship**

While some research has been directed at quantifying aspects of therapist behaviours or characteristics considered conducive to the relationship between the therapist and the client, research interest in discrete therapist factors has not received the attention that randomised clinical trials and therapeutic models have attracted (Beutler et al., 2004). The therapist-client relationship, also called the therapeutic alliance, the therapeutic relationship, the working relationship, the real relationship, or client-therapist rapport, has been positively correlated with desirable client outcomes (Beutler et al., 2004; Crits-Cristoph, Connolly Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Horvath & Symonds, 1991; Lambert & Ogles, 2004; Martin, Garske, & Davis, 2000).

Therapist behaviours and characteristics with the potential of influencing the therapeutic alliance include specific behaviours such as: patterns of eye-contact (Sharpley & Anastasia, 1995a); facial emotional micro-expression (Merten, 2005), leaning forward toward the client (Sharpley & Anastasia, 1995b); the use of silence (Sharpley, 1997; Sharpley, Munro, & Elly, 2005); communicative control (Sharpley, Jeffrey, & McMahan, 2006); immediacy (a focus on the present within the alliance; Hill et al., 2008); and verbal

response modes (Sharpley, Fairnie, Tabary-Collins, Bates, & Lee, 2000). While each study that examines a particular therapist variable potentially contributes a small insight into effective therapy processes (Reynolds Welfel & Patterson, 2005), one of the greatest difficulties in researching process variables like those described above is that such variables are notoriously difficult to manipulate (Wampold, Hollon, & Hill, 2011). Evidencing causality requires experimental manipulation, and the therapeutic alliance and therapist-to-client responses are not practically or ethically open to satisfactory manipulation (Wampold, Hollon, & Hill, 2011). The intricacies of interpersonal interaction within therapy are extremely context-dependant. Certain behaviours, questions, or statements made by therapists towards a client can be helpful during specific phases of therapy, and ineffective or even harmful during others. Much interpersonal communication is non-verbal (Schore, 2003), and presumably therapists monitor these non-verbal cues in clients in order to ascertain which strategies to employ at any given time.

Nevertheless, the quality of the therapeutic relationship has consistently shown a positive correlation with outcomes for clients (Beutler et al., 2004; Martin, Garske, & Davis, 2000), albeit with marked differences in effect size between studies, most likely reflecting inconsistent study design, variable conceptualisation, and measures used (Lambert & Ogles, 2004). The next section explores some of the literature that examines the role of therapist variables in establishing therapeutic relationships and achieving positive client outcomes.

### **Therapist Variables**

Therapist variables potentially contribute to processes in therapy that lead to desirable client outcomes. Research examining the effect of therapist variables on client outcomes has implicated that these variables can differ substantially between therapists (e.g., Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Lambert & Ogles, 2004; Kraus, Castonguay, Boswell, Nordberg, & Hayes 2011; Luborski, McClellan, Woody, O'Brien, & Auerbach, 1985; Shapiro, Firth-Cozens, & Stiles, 1989). Therapist variables may even account for more variance in client outcomes than treatment effects (Lambert & Ogles, 2004). For instance, the therapeutic relationship is

thought to account for around 30 percent in outcome variance, whilst therapeutic techniques have been linked to around 15 percent of outcome variance (Asay & Lambert, 1999). In other words, when differing modes of treatment are contrasted with differences between therapists, therapist variables appear to have a greater impact on beneficial client outcomes through the therapeutic alliance than specific therapeutic treatment types.

Differences between therapists based on client outcome scores can be good predictors of treatment outcomes with future clients, and these effects can be independent of therapist experience, clinic location, or the type of treatment provided by each therapist, as demonstrated in a study by Blatt, Sanislow, Zuroff, and Pilkonis, (1996). Such variability may be due to characteristics therapists bring to therapy that appear to influence therapeutic outcomes for clients (Blatt, et al., 1996; Jennings, Goh, Skovholt, Hansou, & Banerjee-Stevens, 2003; Wampold & Brown, 2005). Blatt et al. comment that these variables may assist therapists to establish particularly helpful therapeutic alliances conducive to successful treatment outcomes. They also comment that future research should attempt to explore these interpersonal dimensions in detail. However, the Blatt, et al., (1996) study only examined client outcomes for the treatment of depression, and thus was unable to comment on the general efficacy of therapists across client problem domains. Recent research indicates that individual therapist success may not be consistent between differing client domains (Kraus, Castonguay, Boswell, Nordberg, and Hayes, 2011).

The recent survey study by Kraus et al. (2011) contrasted individual therapist effectiveness with client outcomes in naturalistic practice settings, creating an estimate of the prevalence of effective and non-effective therapists. It is worth noting the difference between effectiveness studies and efficacy studies at this point. Effectiveness studies most often concern the degree of change facilitated through therapy with actual clients in naturalistic settings, whilst efficacy studies are usually conducted using randomised clinical trials where clients are assigned to intervention and control groups in order to determine differences in treatment effects (Kendall, Holmbeck, & Verduin, 2004; Seligman, 1995).

Kraus et al., (2011) examined archival datasets of 6960 adult outpatient clients and 696 therapists. Client outcomes were assessed using the Treatment Outcome Package (TOP; Kraus, Seligman & Jordan, 2005, cited in Kraus et al., 2011, p. 269), which tracks client change on 12 domains: Sexual Functioning; Work Functioning; Social Functioning; Violence; Panic/Anxiety; Substance Abuse; Psychosis; Quality of Life; Sleep; Suicidality; Depression; and Mania. Client change was assessed by the authors using the Reliable Change Index (RCI; Jacobson & Truax, 1991, cited in Kraus et al., 2011). An *effective therapist* label was assigned to those whose average client showed reliable improvements, *unclassifiable/ineffective therapist* labelled those whose clients showed no reliable improvement, and *harmful therapist* designated participants whose clients showed reliable deterioration. The study compared the dataset to that of other published TOP data by Kraus et al., (2005, cited in Kraus et al., 2011) and found similar distributions of improvement, no change, and worsening client outcome data.

The results indicated that while up 96% of therapists showed competency in at least one of the 12 TOP domains, none showed competence in all domains, and only one therapist showed effectiveness in 11 of the 12 domains. On average, between 11% and 38% of clients across the differing domains ended treatment in a deteriorated condition compared to when they started. The authors also found that individual therapist effectiveness was inconsistent between different client disorders, where therapist competencies were most common across 3 - 7 of the 12 TOP domains. For each domain the authors found high percentages of therapists whose average client improved reliably, with the exception of the Mania scale, where little change was observed for most clients. Considering mean therapist ratings across the TOP domains, 42.7% of the therapists rated as effective, and 37.4% of the clients showed reliable improvement through therapy.

Some tentative conclusions can be made about therapist effectiveness from the Kraus et al., (2011) study. Most therapists showed competencies in some areas, and a lack of competencies in others. Individual therapist variables or characteristics may have increased effectiveness in specific

domains of therapy, but this did not appear to generalise to effectiveness in other domains. The results imply that all the therapists in the study may be able to raise their effectiveness by specialising in the specific domains for which they evidenced strong positive treatment effects. The figures suggest great variability between therapists in their general effectiveness of assisting clients to attain positive change. The authors noted that if rigorous effectiveness measures could reliably identify areas of competence or incompetence for individual therapists, therapists could then be directed towards domains that allow them to use their strengths in order to maximise desirable client outcomes across the field of professional therapy. Such direction in domain specificity may show potential in raising the general effectiveness of psychotherapy considerably. The findings of the Kraus et al. study suggest that if these results were generalisable to all therapists, the general effectiveness of psychotherapy could be well below popular estimates (e.g., Lambert & Barley, 2002).

Several limitations were notable in the Kraus et al., (2011) study. The authors stated that, unlike the therapists in their sample, many therapists do not track and evaluate client outcome measurements, which in itself tends to aid reflexive practise and can lead to increased therapeutic effectiveness. Because they sampled therapists who reported and tracked client outcome statistics, the study sample may have underestimated the prevalence of harmful or non-effective therapists working in practice, and overestimated the prevalence of effective therapists. Additionally, the 12 domains tracked by the TOP fall short of the myriad domains clients present with in therapy. The authors noted this fact and added that this may have resulted in lower average effectiveness measures for therapists whose strengths lay outside of the TOP domains. On the other hand, some of the therapists in the sample may have had low effectiveness in domains not included in the 12 TOP domains.

Furthermore, it is unlikely that all clients entered therapy due to deficits in all 12 TOP domains, meaning 'no change' conditions would have been artificially inflated for domains not targeted in therapy, or for domains in which clients possessed no deficits. Some domains that may not have been a focus of therapy may have shown deterioration due to clients experiencing

difficulties outside of therapy, artificially raising the level of deterioration witnessed and attributing undue cause to the therapist.

Lastly, it is likely that more than 10 client-outcome results per therapist should be used to ascertain a reliable estimate of therapist effectiveness, as for instance it has been argued that at least 60 client-outcome results are needed in order to deliver reliable therapeutic alliance figures (Crits-Cristoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011).

Nevertheless, the Kraus et al. study demonstrated that between-therapist variability occurs in naturalistic settings, and highlights that future studies should examine the cause of such variability.

There is some evidence that therapist experience as indicated by age may facilitate more desirable outcomes in clients (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). Although this result is contrary to much research that indicates therapist age has no predictive value in client outcomes (see Beutler et al., 2004 for a review), the effect appears to reflect gains made in interpersonal functioning skills through clinical experience gathered by therapists over time.

The Anderson et al., (2009) study examined the relationship between therapist Facilitative Interpersonal Skills (FIS) and client outcomes using the Outcome Questionnaire-45 (OQ-45; Lambert et al., 2004) in a sample of 25 therapists whose caseloads ranged between 13 and 141 clients. The study assessed FIS by presenting each participating therapist with eight video segments of challenging interpersonal actor-client interactions, and requesting a video clip recording of participants responding to the segments as if they were performing therapy. Each therapist's recording was then rated by two practicing clinicians who scored participant responses using a 5-point Likert-type scale on ten FIS ratings, including emotion expression, warmth, hopefulness, and empathy. Rater scores were summed and a mean score was derived for each participant to indicate their FIS rating.

The authors also included the Social Skills Inventory (SSI) for each participant, but found that only FIS accounted for outcome variance between therapists. Whilst participant age was found to relate to therapist effects, the authors found that FIS tended to improve with experience, and when age effects were adjusted for FIS, outcome variance was no longer



predicted by age alone. It may be that with experience, therapists who achieve at least a minimum level of successful outcomes for their clients learn to hone their FIS in a manner most useful to achieving beneficial outcomes with future clients. Perhaps FIS represent skills that therapists may or may not possess early in their careers, but tend to develop through experience with clients. If this is the case, teaching FIS to inexperienced or ineffective therapists may present a relatively simple and robust way to improve therapeutic effectiveness for newly qualified therapists.

More specifically, the Anderson et al., (2009) study included a variety of therapist emotion variables in their measure of FIS, providing a tentative indication that through experience, therapists may be able to develop the effectiveness of their emotional functioning, resulting in a positive impact on client outcomes. If this is the case, it may be possible that more detailed information on how such 'superior' emotion functioning is achieved could be used to teach less experienced or less successful therapists how to improve their client outcomes.

The Anderson et al. (2009) study used a sample of 25 therapists, and their statistical methods required outliers to be discounted. The authors commented that one outlier therapist was identified as performing consistently more poorly by achieving more negative outcomes than other participants, and recommended future studies also examine variables in therapists that lead to negative outcomes for clients. It may be that therapists who under-perform do not show many gains in FIS facilitated through their experience because they possess an interpersonal style that prevents them from interacting in a non-defensive manner with clients. Therapist defensiveness can lead clients to conclude that the therapist misunderstands them and is failing to engage with them in a manner that addresses their needs (Hardy, Cahill, & Barkham, 2007). Some tentative evidence for this process could also be concluded from the Kraus et al., (2011) study, which showed most therapists to have weak or negative efficacy in at least three domains of client problems, while showing good or excellent efficacy in other domains. The Kraus et al. study did not attempt to investigate why some therapists showed good or poor efficacy in specific domains, but it is possible that personal experiences or personality variables

were involved, if the discrepancies could not be attributed to inadequate sample sizes for each domain. Similar future studies linking specific therapist variables to domain-specific outcomes could prove valuable in directing therapists toward domains that complement their strengths. Additionally, future studies comparing effective with ineffective therapists could provide further insight into how variance in specific therapist variables is related to negative or positive effects on client outcomes.

In a review of 25 quantitative and qualitative studies reporting on the positive effects of therapist personal attributes and therapy activities on the therapeutic relationship, Ackerman and Hilsenroth (2003) compiled a list of helpful variables and corresponding techniques reflecting their practical application, listed below in Table 1.

**Table 1:**  
**Therapist attributes and techniques positively**  
**influencing the therapeutic alliance**

<b>Personal Attributes</b>	<b>Technique</b>
Flexible	Exploration
Experienced	Depth
Honest	Reflection
Respectful	Supportive
Trustworthy	Notes past therapy success
Confident	Accurate interpretation
Interested	Facilitates expression of affect
Alert	Active
Friendly	Affirming
Warm	Understanding
Open	Attends to patient's experience

*Source: Ackerman & Hilsenroth, (2003, p28).*

Ackerman & Hilsenroth, (2003) found that theoretical orientation did not predict the strength of the therapeutic alliance, commenting that the

interpersonal connection between therapist and client is likely a common therapeutic factor within differing theoretical approaches. If that is the case, then results from the Ackerman and Hilsenroth study may be useful for improving the therapeutic alliance in most, if not all, different approaches to therapy. The authors also noted that therapist contributing factors to the development and maintenance of the therapeutic alliance overlap to a significant degree with factors considered to be involved with repairing ruptures to the alliance. This suggests that the above therapist variables may be positive contributors to the entire structure of alliance fluctuations throughout the therapeutic process, useful in initiating, maintaining, and repairing the therapeutic alliance.

Ackerman & Hilsenroth, (2003) comment that future studies should include close examination of the role of client variables in the therapeutic relationship, a claim supported by Duncan (2010). However, others have contended that therapist variables are more relevant to the therapeutic relationship than client variables (e.g., Teyber & McClure, 2000; Wampold & Brown, 2005). While both therapist and client variables probably do contribute to the strength of the therapeutic alliance, only therapist variables are open to manipulation or improvement through research and training. Specific client needs may or may not be met through certain therapist personal characteristics, but most of the characteristics included in Ackerman and Hilsenroth's review tend to help therapists adjust their interpersonal interactions to the needs of their clients. Before they enter therapy, clients cannot be trained to improve the personal characteristics likely to facilitate good outcomes. This process arguably occurs to some degree within therapy, and therefore therapist variable research is much more likely to deliver results useful in improving the general effectiveness of psychotherapy for most, if not all, clients.

Essentially, therapist interactions and contributions to outcomes with clients are probably a mix of their academic theoretical background in theory and personal characteristics. Assuming that the majority of therapists possess the ability to apply theoretically sound methods of therapy in an academic setting, then the failure to assist clients in achieving satisfactory therapeutic outcomes in practice may, at least in part, be attributable to interpersonal

variables operating within the therapist/client dyad. The therapist is ethically and professionally responsible for achieving the best possible quality of therapeutic alliance, as some clients can be expected to arrive in therapy with a degree of deficit in interpersonal functioning. When therapy fails, it may be the emotional aspects of therapist functioning that cause ruptures in the therapeutic relationship, or subsequent failures to repair such ruptures. Indeed, therapist variability in the therapeutic alliance appears to predict therapy outcomes, whilst client variability does not (Baldwin, Wampold, & Imel, 2007).

The success of therapy through the formation of a useful therapeutic alliance is most likely at least partly reliant on the emotional well-being of the therapist (Beutler et al., 2004; Jennings and Skovholt 1999). McCarthy and Frieze (1999) examined the positive effect of therapist emotional well-being on 131 clients (all college students, mixed diagnoses, mixed treatments) who rated the quality of therapy they received, and found a strong positive association between therapist emotional well-being and client satisfaction with the therapy they delivered. Other studies have found positive effects on outcomes associated with therapist emotional well-being in relation to several measures, including: global severity of client distress post-treatment; global severity of client stress at 7-month follow-up; composite therapist/client rating of treatment benefit; and post-treatment client self-esteem scores (see Beutler et al., 2004, for a comprehensive review).

Research on impairment and distress in therapists has netted some alarming conclusions. Impairment and other issues are varied among therapists, and include distress affecting therapists to the degree they considered themselves ineffective with clients (Pope, Tabachnick & Keith-Spiegel, 1987), depressive episodes (Pope, 1994), elevated incidence of childhood emotional trauma when contrasted with non-therapist professional groups (Elliott & Guy, 1993), substance-abuse problems (Thoreson, Miller, & Krauskopf, 1989), sexual contact with clients (Borys & Pope, 1989), personal relationship problems (Thoreson, Miller, & Krauskopf, 1989), and high suicide rates (Ukens, 1995). The prevalence of impairment

among psychologists has been estimated to be as high as 15 percent (Lalotas & Grayson, 1985).

In a qualitative study that sought to access therapists' own experiences of emotional difficulties with some clients, de Oliveira and Vandenberghe (2009) interviewed four clinical psychologists about their emotions within therapy, where the therapists attributed difficulties in dealing with emotionally salient issues to personal problems and biases. Personal life problems, issues with assumed responsibility, using avoidance tactics, and attaching a personal element to client hostility were other topics raised by the therapists, and the researchers conclude these could potentially be useful topics for attention in training and supervision (de Oliveira & Vandenberghe, 2009).

Other research investigating factors associated with therapist burnout has identified several variables, including low distress/emotionality tolerance by therapists in themselves and clients, inflexibility in the application of therapeutic models, intolerance of ambiguity of emotional and therapeutic control (Emery, Wade, & McLean, 2009), negative client perceptions of the therapist and therapy, and increased use of negative social coercion strategies by the therapist (McCarthy & Frieze, 1999). Emery, Wade, and McLean (2009) concluded that high levels of personal resources (recreation, self-care, social support, and rational/cognitive coping) appeared to provide a protective mediating effect on burnout. Similarly, Jenaro, Flores, and Arias (2007) found that several personality variables provided an ameliorating effect on burnout in a sample of 211 child protection workers and in-home caregivers, including positive coping strategies, high self efficacy, and a sense of personal accomplishment.

Another study examining occupational hazards in a sample of 208 psychotherapists showed that the three highest reported career-sustaining behaviours were maintaining a sense of humour, taking an interest in client issues, and using leisure activities to bolster vitality (Kramen-Kahn & Hansen, 1998). It is interesting to note the similarities of the above therapist factors and behaviours when compared with those identified by master therapists below. Deficiencies in characteristics tentatively attributable to master therapists appear to increase the chance of burnout,

stress, and work dissatisfaction. While it remains unclear exactly how emotional skills interact with, cause, moderate, or mediate such variables, therapist emotional functioning appears to be important to both therapist well-being and achieving positive outcomes for clients. Oliveira & Vandenberghe, (2009) comment that their study highlights a relationship between therapists' personal emotional coping mechanisms and their ability to repair ruptures in the therapeutic relationship. Indeed, emotional competence and strong relationship skills appear to be common factors in successful therapists (Anderson et al., 2009; Jennings & Skovholt, 1999).

### **Master Therapist Qualities**

How can the profession ensure that psychological therapy is delivered in a manner most likely to lead to benefits for clients seeking its services? Most theoretical orientations tend to be beneficial, and most therapists probably possess qualities which enable them to be reasonably effective in therapy (Beutler et al., 2004). However, it is unclear which specific therapist variables contribute to positive client outcomes, especially within the realm of therapist emotion and emotion-related skills. Beutler et al. have commented that their review of the literature up to 2004 indicates a strong variability of therapist emotional well-being, which may be "a hidden moderator of many contradictory or inconsistent therapy findings" (p. 277). They added that their meta-analysis showed a consistent positive relationship between therapist well-being and positive client outcomes, and expressed their surprise that up to 2004, research on therapist emotional well-being has waned. It appears that, with the current trend of renewed interest in emotion processes and theory, research in this area has become more popular (e.g., Angus & Kagan, 2007; Baldwin, Wampold, & Imel, 2007; Emery, Wade, & McLean, 2009; Gilbert, 2007; Greenberg, 2007, 2008, 2011; Jenaro, Flores, & Arias, 2007; Merten, 2005; de Oliveira, & Vandenberghe, 2009)

One method that may be able to expand psychology's knowledge base about the characteristics of successful therapists in order to raise general effectiveness is to carefully examine which of their characteristics and behaviours help clients reach favourable outcomes (Wampold, Hollon, & Hill, 2011). Some researchers have contributed to this knowledgebase by

interviewing exceptionally effective therapists (e.g., Jennings & Skovholt, 1999; Levitt & Williams, 2010) or by investigating which qualities of therapists in general contribute to desirable client outcomes (e.g., Ackerman & Hilsenroth, 2003; Wampold & Brown, 2005). Research on therapist personality variables that influence the quality of the therapeutic relationship has often focused on student or novice therapists, most likely because they represent a convenient sample for researchers. This may be problematic as such research is not a representative sample of therapists working in the naturalistic field of practice.

By selecting therapists who are deemed to be exceptionally effective in assisting clients reach favourable outcomes, a more accurate understanding of effective variables assisting this process may be achievable. Jennings and Skovholt (1999) conducted a study in which they interviewed therapists identified to be of exceptional skill in order to compile a set of master therapist characteristics. The authors emphasised that previous research into therapist effectiveness had mostly failed to identify therapist characteristics that contribute to client success, and the aim of their study was to explicate such characteristics.

The study was conducted in a major metropolitan area in the Midwest of the United States of America. The researchers used a purposeful snowballing sampling approach to select participants, where therapists were asked to nominate others who they considered to be master therapists. The criteria for master therapist nominees were on the basis of the term itself and the considerations that the nominator would be consider engaging the nominee's services if referring friends, family or themselves. The criteria for inclusion was that each participant had to have received at least four nominations from other therapists. From a pool of 103, 10 therapists were selected. Participants' demographics included seven women and three men; six PhD psychologists, three master's level social workers, and one psychiatrist; age ranged from 50 to 72 years; experience ranged from 21 to 42 years; all participants were European American and worked full-time in private practice; theoretical orientations were psychodynamic ( $n=4$ ), family systems ( $n=2$ ), integrative ( $n=2$ ), and existential-humanistic ( $n=2$ ).

Each participant collaborated in two 90-minute semi-structured interviews, comprising 16 open-ended questions focusing on personal characteristics. Themes and categories were identified using inductive analysis, and aggregated into three domains, illustrated in Table 2.

**Table 2:**  
**Characteristics of Master Therapists**

<b>Domain</b>	<b>Category</b>	<b>Implication</b>
Cognitive	1. Expert therapists are voracious learners.	Enthusiastically seek professional development.
	2. Accumulated experiences have become a major resource for master therapists.	Draw on experience to improve self and professional services.
	3. Expert therapists value cognitive complexity and the ambiguity of the human condition.	Recognising and valuing the complexity of human experiences.
Emotional	4. Master therapists appear to have emotional receptivity, defined as being self-aware, reflective, non-defensive, and open to feedback.	A constant striving for reflexivity on self, others, and professionalism.
	5. Master therapists seem to be mentally healthy and mature individuals who attend to their own emotional well-being.	Congruency, authenticity, and honesty in personal and professional lives.
	6. Master therapists are aware of how their emotional health affects the quality of their work.	A recognition that private issues can potentially compromise professionalism.
Relational	7. Master therapists possess strong relationship skills.	Strong social skills, compassion, and sensitivity.
	8. Master therapists believe that the foundation for therapeutic change is a strong working alliance.	Positive expectations and respect for client autonomy.
	9. Master therapists appear to be experts at using their exceptional relationship skills in therapy.	Providing safety, support, appropriate challenges, and an ability to stay engaged during extreme client emotion.

*Source: Adapted from Jennings and Skovholt (1999, pp.6-8).*



The following discussion of the results from Jennings and Skovholt's (1999) study is limited to the emotional and relational domains for their relevance to the present study.

The first emotional domain focused on self-reflective practises. Participants discussed achieving self-reflection through peer consultation, supervision, personal therapy, and receiving feedback from clients. One therapist raised the subject of accepting criticism without becoming defensive - a process that led to critical self-reflection which allowed the therapist to accept that gaps existed in their service delivery, accept responsibility for such gaps, and modify their practises accordingly. Although not highlighted in this particular domain by the authors, the therapist's readiness to accept criticism reflects a degree of humility that most likely allowed the therapist to use this experience in a constructive, self-improving manner.

The second emotional domain centered on the emotional and mental well-being of the therapist. Participants described congruence between personal and professional lives, and cited congruence, authenticity, and honesty as personal characteristics they possessed. One participant reported that genuineness was presenting a congruent image to clients of who they are in their personal and professional lives. The therapist embodied the values used to engage with and advocate to their client in therapy. Jennings and Skovholt commented that participants appeared to possess a balance of humility and confidence, a balance that allowed participants to appraise their importance in the world without a sense of self-centeredness or grandiosity. This balance is probably useful in allowing therapists to accept criticism in a manner most likely to lead to self-reflection, which in turn formulated strategies for preventing similar future failures, without a degree of overly critical self-appraisal which could lead to a collapse in self-perceived efficacy beyond the domain being criticised.

The third emotional domain identified was closely related to the concept introduced by the second domain, and involved an awareness of how emotional well-being and life experience had the potential to affect performance in therapy. The self-reflection, recognition of, and resolution to issues encountered by participants in their personal lives appeared to be important in providing good therapeutic service to clients. Unresolved

personal issues for the therapist could lead to impaired performance with clients raising similar issues in therapy. One participant acknowledged that therapists are not immune to encountering difficulties in their private lives, and attached importance to therapists' own ability to address these issues in order to resist transferring their unresolved issue to clients. This participant made the distinction between learning the skills required to address psychological issues, and applying them to one's own private experiences.

The first relational domain focused on relationship skills inherent in the participants. Jennings and Skovholt highlighted that many participants raised the subject of learning relationship skills such as listening, observing, and empathic care for others' well-being within their family of origin. One participant discussed an early experience which could have presented a psychological issue had the individual been unaware of the dynamics which contributed to this facet of their personal characteristic. Taken in conjunction with the third emotional domain, it appears that past therapist personal experience had the potential be transformed into adaptive strengths within therapy. Another participant spoke of how personal suffering affected their interactions with clients. It appeared therapists were not immune to experiencing negative emotions due to difficult circumstances in their private lives, but such emotions did not affect their self-perceived ability to extend their sensitivity to client needs in therapy. Jennings and Skovholt commented that participants reported personal suffering to be a factor that increased their abilities to empathise and extend compassion towards clients. Perhaps the self-reflective characteristic of master therapists allowed them to contextualise their own issues without contaminating their performance in therapy. This suggests that the element of congruence in therapists may focus more on positive aspects of the self rather than negative experiences or emotion. Participants appeared to be able to transform negative intrapersonal emotion into heightened sensitivity to client distress, suggesting strong elements of coping, awareness, and an ability to process and regulate intrapersonal emotion.

The second relational domain related to participants' beliefs in the working alliance as being critical in facilitating therapeutic change. Common themes identified by the authors included a positive expectation of client change, and respect for client self-determination. The ability to facilitate change in others was attributed to the ability to connect with others by the participants. This finding is supported by some of the literature regarding the importance of the therapeutic relationship in facilitating positive client outcomes (Beutler et al., 2004; Crits-Cristoph et al., 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

The third relational domain focused on master therapists' ability to use their relationship skills within the therapeutic process. The authors commented that these skills allowed participants to provide a safe and supportive environment from which participants could challenge and address major client issues. Additionally, participants reported that they were not averse to strong client emotions, and were able to stay connected with clients during these times. Interestingly, the subject of therapist emotional well-being also arose in this domain. It may be crucial for therapists to have resolved personal issues in order to respond to client needs, at least within domains which bear significance on the therapists' difficulties (Jenaro, Flores, & Arias, 2007; Laliotis & Grayson, 1985; McCarthy & Frieze, 1999).

Several conclusions can be made about emotional characteristics of master therapists from Jennings and Skovholt's (1999) study. First, master therapists are self-reflective, non-defensive, congruent between private and work-lives, and recognisant of how their emotional health affects their work. Second, master therapists possess exceptional relationship skills which they use effectively in practice to provide a safe, supportive working relationship within which they challenge and address client issues. Third, there appears to be substantial convergence between emotional and relational characteristics of master therapists. Perhaps because emotion is a major component involved in interpersonal relationships, establishing distinct frameworks in these two domains will remain problematic.

Several limitations were apparent in the Jennings and Skovholt study. While the snowball selection process of master therapists had also been used by other authors (e.g., Goldfried & Raue, 1998), the process was

dependent on the implicit assumption that therapists are able to recognise exceptional performances by other therapists. This process is not able to separate myriad reasons why some therapists may admire and nominate others, such as respect or admiration for the therapist rather than their effectiveness, affiliation towards other therapists who operate under similar theoretical paradigms or work within the same organisation, personal friendships with nominees, and a bias in modality of treatment where some therapists may practise effectively only within a very limited scope of client-presented problems (e.g., Orlinsky, 1999). Without specifically tracking client-outcomes through assessing differences in well-being between commencement and conclusion of therapy, effective client outcomes cannot be ascertained empirically (Kraus et al., 2011; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Orlinsky, 1999), making the selection of master therapists through snowballing a subjective process. Another variable with the potential to confound the selection process is that many therapists have difficulty predicting treatment outcomes for their clients (Hannan et al., 2005), and this difficulty may extend to predicting how well other therapists perform.

A recent study by Levitt and Williams (2010) used a different approach to selecting exceptional therapists in order to investigate how they facilitate client change in therapy. Their study recruited 14 'eminent' therapists who met at least one of the following inclusion criteria: holding a senior position in a psychology-oriented association; having authored over 100 papers discussing psychotherapy; being the recipient of awards for contributions to practice or research; or being the founder of a new approach to psychotherapy. The authors conducted interviews with each participant, focusing on their understanding of the processes involved in facilitating client change in their practice. Grounded theory analysis was used to organise the resulting data into subcategories, clusters, and categories of recurrent themes. The authors discussed two clusters relevant to the therapeutic relationship and the change process in their 2010 article, and a brief summary restricted to categories relevant to therapists' use of emotional skills follows.

Levitt and Williams (2010) found that eminent therapists talked of facilitating client motivation and commitment to the process of change by engaging in emotional exploration. Emotional exploration was driven by fostering curiosity, informed by therapists' monitoring unspoken client emotion, and facilitated by assisting clients in fostering an inward focus which assisted their self-understanding. Participants considered that therapist empathy, honesty, and validation were essential in providing an environment most likely to assist clients in exploring their emotions. The display of therapist empathy was considered crucial, although only when expressed in a genuine and honest manner as opposed to being used as an instrumental tool. Appropriate empathy was seen as useful in validating client experience, which in turn was deemed to assist clients engage in reflexive tasks, especially through providing the security of a genuinely honest and empathic, therapeutic relationship within which anxious or vulnerable emotion themes could safely be explored.

Appropriate therapist disclosure was considered helpful in building a real and intimate relationship, with client or therapist safety needs and boundary issues governing the use of disclosure. A trustworthy and emotionally open relationship with the client was deemed important in creating an environment in which clients could take risks conducive to change within therapy. Appropriate therapist disclosure was considered to add to therapist authenticity, and important in fostering the level of trust necessary for clients to be honest and open about their experiences, feelings, and thoughts.

The participants in the Levitt and Williams (2010) study also talked of the importance to understand, acknowledge, respect, review, and work with client goals. This assisted the formation of mutual goals, which guided the direction of therapy and fostered commitment to change for the client. It was deemed the therapist's responsibility to explore progress impediments and adjust their therapeutic practises to meet client capacities. This would require therapists to adopt a primary focus on fitting therapeutic methods to meet client needs and expectations, when such needs and expectations were considered appropriately useful to work towards. Attunement to clients was considered an important facet of this process, including

interpersonal sensitivity through tuning into client needs on a moment-to-moment basis. Additionally, participants would de-emphasise technique when the establishment of a genuine relationship was paramount.

Levitt and Williams commented that their study had mainly recruited white male therapists despite attempts to obtain a more diverse sample, although they added that when contrasted within the study, the content of the minority therapists' views suggested they were representative of the majority of participants' views. While the authors' inclusion criteria certainly resulted in a sample of eminent or esteemed therapists, no direct empirical evidence of beneficial client outcome was required for inclusion. One could certainly infer that therapists meeting criteria such as receiving awards in the field of practice or research, holding a senior position in an association, having published many articles, or founding a new psychotherapeutic approach would probably also perform well in assisting clients achieve desirable outcomes, but without direct evidence such a causal relationship remains inferred. Again, without specifically tracking before-and after-therapy client-outcome to assess a degree of change, effective client outcomes cannot be ascertained empirically (Kraus et al., 2011; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Orlinsky, 1999).

An earlier study by Blatt, Sanislow, Zuroff, & Pilkonis (1996) examined therapists' contributions to positive client outcomes, and found that those most effective tended to rely on psychotherapy rather than pharmacotherapy (or a combination), which the authors concluded showed that the most effective therapists, including psychiatrists, had a "psychological rather than a biological orientation" towards their clients (p. 1280). This may reflect that these effective therapists more readily accepted the challenge of working with clients to corroborate strategic solutions to presenting problems rather than be inclined to dismiss their clients' issues as treatable through pharmacotherapy. The difference in effectiveness may be due to more effective therapists focusing on the presenting problems' underlying causation, while less effective therapists had a stronger focus on addressing the symptoms.

## **Emotion**

From the literature reviewed thus far, therapist emotion appears to emerge as a variable that, at least in some way, is involved in the establishment and maintenance of the therapeutic relationship, and may also be related to client therapeutic outcomes. While it is not clear how therapist emotion moderates or mediates client outcomes, this may in part be due to the interaction of therapist and client emotional characteristics, and partly due to the fact that emotion has not yet been defined in a unified and consistent manner in psychological research and theory literature. Studies investigating therapist personality or emotion have typically been difficult to conduct and interpret due to the variety of - often overlapping - personality dimensions that tend to be non-specific and ill designed to investigate the effects therapist personalities exert on client outcomes (Beutler et al., 2004).

The conceptualisation of emotion has provided psychology with a formidable challenge. Because emotions occur as internal processes that tend to be subjective and can vary with culture, context, and individual differences, measurement and classification has proven to be a difficult prospect to accomplish (Mesquita, Feldman Barrett, & Smith, 2010). Empirical research into emotion today is still plagued with issues relating to the measurement of internal, subjective experiences (Kalat & Shiota, 2007), and a general consensus on how emotion should be defined in the psychological literature has not yet been achieved (Izard, 2007; Fox, 2008).

To complicate matters, there is also little agreement on how, and if, cognition and emotion should be considered as either separate or interrelated concepts. For instance, the distinction between emotions and cognitive representations of emotions (emotional schemas) has often been overlooked, resulting in confusing evaluations of emotion theories forwarding primary or discrete emotion models (Izard, 2007). On the other hand, emotion and cognition may be so intertwined that discussing one without involving the other may lead to serious errors in conceptualisation and understanding (Davidson, Scherer, & Goldsmith, 2003; Mesquita, Feldman Barrett, & Smith, 2010).

Within the psychological literature of emotion, most theorists appear to approach the field of emotion through the lens provided by their preferred theoretical school of thought. Cognitive approaches tend to stress the importance of cognition in the processes of emotion (e.g., Lazarus, 1991), emotion-focussed approaches tend to stress the effects emotion has on cognition (e.g., Greenberg, 2011), developmental approaches lean towards the influence of early experience on emotional functioning (e.g., Shaver, Mikulincer, & Chun, 2008), social approaches tend to emphasise the effects of interpersonal social interactions on emotional functioning (e.g., Lawler & Thye, 2006), and motivational approaches often focus on motivation in the use and generation of emotions (e.g., Reeve, 2009). The range of perspectives with which theorists incorporate emotion into differing frameworks leads to both parallel and separate advances in knowledge (Rottenberg & Johnson, 2007), and potentially reflects the difficulties encountered by researchers and theorists in the task of establishing commonalities in how emotions affect individuals in their daily lives in a practical sense. A remarkable phenomenon, considering the majority of human beings lead an active, emotion-rich life where emotions surface, motivate, and affect our experience on a daily basis.

The subjectivity with which human beings experience emotions, combined with a wide range of individual differences in language, culture, and verbalisation skills which tend to impose restrictions on how internal experiences are verbalised, means the empirical standardisation of emotions remains an elusive prospect at this point in time for psychology. That is not to say that the literature is without value, as many different and contentious stances in past psychological literature have proven to each contribute valuable aspects to more integrated and sophisticated concepts. It is possible that some time in the future we will see an integration of emotion theories which will likely draw useful concepts from each of the different theories currently available.

Nevertheless, for now emotions can be seen as adaptive processes that contribute meaning and depth to the human experience, can facilitate or impede interpersonal connections, and convey important information concerning our values, morals, and needs (Fox, 2008; Leahy, Trich, &



Napolitano, 2011). Emotions are generally thought to involve cognitive, somatic, sensory, autonomic, motivational, and behavioural processes that assist humans in adapting to their environment (Fox, 2008; Hatfield, Rapson, & Le, 2009; Reeve, 2009; Rottenberg & Johnson, 2007; Wilkinson, 2010).

However, emotions can become problematic when individuals experience difficulty or inability to cope with emotions through over- or under-regulation. Over-regulation of emotion may assist coping in the short-term for some circumstances, but tends to interfere with emotion processing, which can lead to maladaptive behaviour in context or similar situations in the future (Leahy, Trich, & Napolitano, 2011). Under-regulation of emotion can lead to excessively intense emotions which tend to be experienced as overwhelming and intolerable, which can also lead to maladaptive behaviour within the context or in future (Leahy, Trich, & Napolitano, 2011). The maladaptive regulation of emotion tends to be a common feature in most types of psychopathology (Rottenberg & Johnson, 2007; Schore, 2003).

Emotion regulation can be thought of as a *homeostatic thermostat*, where any adaptive or maladaptive coping strategy leads to a reduction in the intensity of an unwanted emotion (Leahy, Trich, & Napolitano, 2011). Maladaptive coping strategies tend to be temporary solutions and can intensify unwanted emotions later, or become problematic behaviours in themselves, such as bingeing, blaming, substance abuse, and avoidance (Greenberg, 2008; Leahy, Trich, & Napolitano, 2011). Adaptive emotion regulation depends on the individual and the context in which it occurs, but tends to facilitate the coping process and leads to adaptive behaviours that assist problem solving, coping, tolerating, and/or learning from intense emotions and can affirm values, goals (Leahy, Trich, & Napolitano, 2011), and self-efficacy (Saarni, 1999).

One concept that attempts to capture and qualify how individuals use and/or experience emotions is emotional intelligence (EI). The next section briefly explores how emotional intelligence is conceptualised, highlights some of the current issues plaguing measures of EI, and forwards some of the theoretical convergence within this field.

## **Emotional Intelligence**

Over the last 20 years, two distinct methods have been developed to measure emotional intelligence (EI), and much debate has occurred on whether the trait approach or the ability approach is superior in measuring what is theoretically thought to define emotional intelligence (see Stough, Saklofske, & Parker, 2009; Zeidner, Matthews, & Roberts, 2009, for comprehensive reviews). Trait approaches tend to view EI as a facet of personality, while ability approaches tend to view EI as applied skills (Zeidner, Matthews, & Roberts, 2009).

Perhaps the most prominent instrument measuring EI ability is the Mayer-Salovey-Caruso Emotional Intelligence test (MSCEIT; Mayer, Salovey, & Caruso, 2002), a four-branch model of EI (Mayer, Salovey, 1997; Mayer, Salovey, & Caruso, 2008). The model suggests the following four skills comprise emotional intelligence: emotion management in order to attain goals; understanding emotions and verbal/visual emotion communication; using emotion to supplement thought; and correctly perceiving emotions in self and others. The MSCEIT is forwarded as an ability-focused measure of EI (Mayer, Salovey, & Caruso, 2002), and is considered by some as the only valid established standardised test of EI ability (Fiori & Antonakis, 2010).

Defining emotional intelligence as a set of constructs that accurately predict emotional functioning and well-being has proven to be a complex task. First of all, there is a prominent lack of consensus on what emotional intelligence is, how it is measured, or even if it is an ability that is different from other well-established personality constructs (Stough, Saklofske, & Parker, 2009). Secondly, although widely considered to be a superior measure of ability EI, the MSCEIT has been shown to be a poor predictor of subjective emotional well-being (Zeidner & Olnick-Shemesh, 2010), shows inconsistencies in construct validity (Keele & Bell, 2008; Locke, 2005; Petrides, 2009), and has been criticised for its majority-consensus scoring procedures (Brody, 2004; Keele & Bell, 2009; MacCann, Roberts, Matthews, & Zeidner, 2004). More generally, existing measures of EI fail to consistently distinguish high EI from immoral behaviour (Waterhouse, 2006), or psychopathological behaviour (Hare, 1999).

Overall, a theoretical agreement does exist about the skills that are involved in EI: "Perceiving, understanding, regulating, and communicating emotions are all commonly seen as central" (Roberts et al., 2007; Scherer, 2007, cited in Zeidner, Matthews, & Roberts, 2009, p. 342). It is the application of such theoretical skills that has made EI a difficult construct to measure when using tests similar to intelligence quotient tests (e.g., Brody, 2004). This may in part be due to the disagreement that still exists within the literature, as Zeidner, Matthews, and Roberts (2009, p. 342) point out: "At the present time it is unclear if EI concerns explicit or implicit knowledge of emotion, cognitive or noncognitive functioning, a biological ability or an environmental adaptation process, or a distinct ability or a host of separate but related abilities". For now, the term 'emotional competence' may be more representative of emotional skills used appropriately in context, in light of the current difficulties in defining behaviours or thought processes as emotionally intelligent without accounting for the naturalistic context in which they occur, as different contexts render different behaviours appropriate or inappropriate (Saarni, 1999).

One recent pilot study was identified that used the MSCEIT to assess if EI in therapists was related to client outcome results, finding that higher therapist EI was related to higher therapist-rated client outcome benefits and increased client compliance during assessment, although no relationship between therapist EI and the early working alliance was detected (Kaplowitz, Safran, & Muran, 2011). However, therapist-rated outcomes have previously been identified as poor predictors of client-rated outcomes (Hannan et al., 2005), and the validity and reliability of the MSCEIT has attracted much criticism (Brody, 2004; Keele & Bell, 2008, 2009; Locke, 2005; MacCann, Roberts, Matthews, & Zeidner, 2004; Petrides, 2009; Zeidner & Olnick-Shemesh, 2010). With such flaws apparent in the measures used to assess client outcomes and therapist EI, the Kaplowitz, Safran, & Muran (2011) study was unlikely to have shown a valid relationship between its variables.

For the moment, therapist EI appears to remain an elusive prospect, most likely because no measures have been developed that specifically address the unique relationship and emotional dynamics that operate within the

therapeutic dyad (e.g., Beutler et al, 2004). Therapy includes emotional interpersonal features of adult/adult relationships such as empathy and respect for autonomy and life experience, while it also includes interpersonal features of caregiver/child relationships such as unconditional positive regard, a commitment to assist and scaffold the other in achieving tasks currently beyond their ability. Professional therapists commit to focusing on client issues without reciprocating by raising their own problems in therapy. Therapists investigate deeper meaning in client narratives rather than accepting statements at face value and perhaps becoming defensive, hostile, or withdrawing, as other individuals in the client's life may have done. Yet therapists approach clients with respect and openness, and value diversity, life experience, and client autonomy. Therapist EI in their role as a professional may be different to their EI within their own lives. For example, perhaps a therapist who possesses narcissistic traits in their private relationships can adopt a professional role in therapy and place their client's needs before their own, purely because of the business relationship they enter with the client. If one were to assess the EI of such a therapist in their professional role, the results could be markedly different to an EI assessment of their interactions in personal relationships. Clearly, much is yet to be learned about emotional intelligence and the competencies involved, including how the literature defines the terminology, settles on whether skills, attributes, characteristics, abilities, or a mixture are involved and provides a more cohesive conceptual framework of which variables are involved in each term's definition.

Emotional competence has been forwarded as the functional application of emotional intelligence (Saarni, 1999). The next section examines Saarni's conceptual framework of emotional competence in order to highlight major skills or attributes thought to be involved in emotionally competent human behaviour.

### **Emotional Competence**

The term emotional competence has typically been used as an umbrella term that encompasses a host of skills and attributes regarding how an individual may experience, process, and use emotions. The following section summarises emotional competence as defined in

Dr. Carolyn Saarni's (1999) book titled "The development of emotional competence". Saarni is a developmental psychologist who has conducted extensive research with children on the development of emotions and emotion skills over the last three decades.

Emotional competence can be seen as a term that articulates how people interact with their changing environments with "emotion-related capacities and abilities" in a manner that results in positive, desirable, or beneficial outcomes (Saarni, 1999, p. 4). Saarni (1999) forwards eight skills of emotional competence that she considers central to the concept (Table 3), although she adds that other skills may also be involved.

**Table 3:**  
**Skills Embedded in Emotional Competence**

Skill	Implication
1 Self-awareness of emotion states	Ability to recognise and identify one's own emotions
2 Awareness of others' emotions	Recognising emotions in others
3 Verbal expression of emotion	Ability to verbalise emotional states and processes
4 Empathic capacity	Involvement in other's emotional experiences
5 Awareness of potential differences between felt and expressed emotions	Realisation of possible discrepancies between intra and inter-personal emotional states
6 Adaptation and coping through self-regulatory strategies	Coping with negative emotion by using regulating strategies
7 Awareness of the importance of emotional communications within relationships to the nature of the relationship	Knowledge that emotion communication is relational to the significance of relationships
8 Emotional self-efficacy	A relative harmony between expressed and ideological emotion experiences

*Source: Adapted from Saarni (1999).*

Saarni comments that the above eight skills represent the wisdom of emotional competence, reflecting that one's emotional competence is dependent on how one's use of emotional skills is congruent relative to one's values, and those of the larger community or culture. The

management of one's own emotions is crucial in negotiating interpersonal interactions (Saarni, 1999). Saarni's model of emotional competence is explored in greater detail below.

#### *Self awareness of emotion states*

Saarni (1999) states that a sense of self precludes awareness of one's own emotions. In other words, a cognitive conceptualisation of the self experiencing emotion is required before one can be said to be self-aware about emotional processes. Saarni adds that other important factors include an understanding of the differing contexts in which different emotions may or may not be appropriate or warranted, an understanding of one's own drives and needs in the generation of emotions, insight and differentiation about one's own emotion intensity and duration, an awareness of one's own ability to experience conflicting or multiple emotions, and an awareness that one's emotions may sometimes occur unconsciously. At a very basic level, therapists should be aware of their emotions in order to separate emotions originating from their private lives and emotions that occur within therapy as a response to client narratives. Therapists who aim to provide an environment that is non-judgemental, warm, friendly, and empathic probably need a strong self-awareness of their emotional reactions to client narratives before they are able to make the necessary adjustments to consistently uphold such an environment.

#### *Awareness of others' emotions*

Saarni's (1999) explanation of the awareness of emotion in others centres on the relationship between one's ability to infer emotional states in others and the abilities of identifying one's own emotional states, experiencing empathy for others, and understanding the causes and consequences of emotion. She further breaks down this skill into subcategories of understanding facial expressions, being aware of how differing situations elicit differing emotions, knowledge of how others' inner states may be similar or different to one's own, using individual personality differences in understanding emotion in others, and the ability to include relationship contexts in the inference of emotions. Therapists need to identify emotions in their clients in order to better understand how clients have experienced, or are experiencing, the issues at hand. Clients may not be aware of their

emotional expression, or their narratives may not match their emotions, and these instances provide important clues to the intrapersonal functioning of the client.

#### *Verbal expression of emotion*

Two important abilities are achieved through the communication of emotion through language: Communication of emotions through time and space, and being able to conceptualise about and elaborate on emotional experiences (Saarni, 1999). Saarni includes imagery and symbolism under the rubric of emotion communication. She breaks this skill down into the following components: As children begin to use language they are able to represent emotional processes cognitively. This allows individuals to affect social relations through language use, as children are increasingly able to hold more sophisticated concepts of emotion, facilitating their understanding of self and other's emotional experiences (Saarni, 1999). Saarni also discusses emotion scripts, which she defines as schemes that allow individuals to predict meaningful sequences of experience involving emotion. Such scripts are grounded in social and private experiences, values, and norms (Saarni, 1999), and essentially serve to predict sequences of events and outcomes for individuals. This last concept highlights that previous experience may be an important facet of interpersonal emotion communication, and that self reflection and self-awareness is important for therapists to maintain a degree of flexibility and openness to clients' experiences (e.g., Jennings & Skovholt, 1999).

#### *Empathic capacity*

Empathy plays a central role in the promotion of social bonds and the facilitation of pro-social behaviours, according to Saarni (1999). She distinguishes empathy and sympathy as *feeling with others*, and *feeling for others*, respectively (p. 162). Saarni also considers that empathy may be in part driven by a measure of self-interest (such as a drive to promote closer relationships). She suggests empathy and moral dispositions are closely related, and that empathy tends to be a skill that is developed in early life by exposure. In other words, early experiences of receiving empathy tends to facilitate individuals in developing the skill in a manner that leads to altruistic deployment of empathy towards others. The important role of

therapist empathy has been well established (e.g., Ackerman & Hilsenroth, 2003; Jennings & Skovholt, 1999; Levitt and Williams, 2010), especially in relation to the establishment of a trusting, safe therapeutic relationship.

*Awareness of potential differences between felt and expressed emotions*

The manner in which individuals express emotion is not always congruent with how emotion is experienced internally. Saarni (1999) comments that most people can relate to times when their emotion expression differs from felt emotion in order to avoid the emotion expression having undesirable consequences for the self or others, which she labels *emotional dissemblance*. Saarni suggests emotional dissemblance involves a range of other skills, such as knowledge of the appropriateness or acceptability of displaying certain emotions in certain contexts, the ability to control or modify one's expression (physical and verbal) of emotion, and the motivation inspired through inter- and intra- personal consequences. Saarni suggests cognitive representations of emotions are central to understanding one's own dissemblance, including representations of the self and strategies to moderate emotion states. Therapist control over emotional expression is likely to be facilitative to maintaining a strong therapeutic relationship by minimising unnecessary relationship ruptures during intense emotional expression by clients. Indeed, negative emotional expression, attaching a personal element to client hostility, and the use of negative coercive strategies have been associated with ineffective therapy and therapist burnout (Emery, Wade, & McLean, 2009; McCarthy & Frieze, 1999).

*Adaptation and coping through self-regulatory strategies*

Saarni (1999) considers the coping strategies involved in successfully adapting to negative aspects of emotion and environments that cause distress to involve a combination of cognitive appraisal processes and self-regulatory skills. She also notes the influence of early experience on an individual's resilience to traumatic events, where early high quality of care tends to facilitate competence in coping strategies in later life. Saarni tentatively connects such exhibited resilience, especially in the self-regulation of emotion, with the attachment style that the individual has developed through early caregiver/child dyadic experience. Learning new



coping strategies are likely to be an integral aspect of successful therapy, and successful therapists tend to be well-versed in the practise of cognitive reappraisal and self-regulation strategies (Jenaro, Flores, & Arias, 2007; Emery, Wade, & McLean, 2009). Attachment styles and their relevance to therapists is discussed in the next section.

*Awareness of the importance of emotional communications within relationships to the nature of the relationship*

Saarni (1999) suggests that this skill represents an integration of all skills listed previously. The communication of emotion within relationships varies immensely between differing relationships, and Saarni concludes that it is emotional communication that largely defines the structure and nature of relationships between people. Saarni forwards three aspects of relationship dynamics important to this skill: 1) interpersonal consequences for the self and other due to the communication of emotion; 2) the manner in which the quality of the relationship is maintained or altered; 3) how power is applied and negotiated within the relationship. In other words, people have differing relationships with others. Different 'engagement' rules of emotionally salient interactions apply, depending upon whom one is interacting with. Saarni considers that knowledge of such differences, and the use of appropriate emotion interactional patterns according to their suitability to the dyadic relationship at hand, is one attribute of the emotionally competent individual. Through the studies examined earlier in this chapter (e.g., Emery, Wade, & McLean, 2009, Jennings & Skovholt, 1999; Levitt & Williams, 2010), it has become clear that good therapists talk of knowing the importance of emotional communications to the nature of the therapeutic relationship they have with their clients.

*Emotional self-efficacy*

Central to this skill is that one's emotional experiences tend to be aligned with one's sense of moral justification such as values and beliefs, and an acceptance of one's emotional experiences in line with the actions taken (Saarni, 1999). Saarni adds that insight into how one's own personality interacts with emotional experience may be involved in one deemed emotionally self-efficacious, as well as a tolerance for emotionally ambiguous experiences, and the ability to reflect upon oneself with a certain

degree of irony. Self reflection, a strong self awareness of values and beliefs, and congruence in personality and behaviour tend to be characteristics of good therapists, as well as insight into how previous personal experiences can affect emotions in client/therapist dyads (Jennings & Skovholt, 1999; Levitt & Williams, 2010).

The next section briefly explores attachment theory, which has developed over approximately the last 70 years, to forward a relatively simple model of differing patterns in emotional functioning.

### **Emotion Skills: An Attachment Perspective**

This final section of the literature review briefly examines the increasing contribution of attachment theory literature to psychology's knowledge of the development of emotional skills and their relative stability in adulthood (e.g., Gilbert & Leahy, 2007; Leahy, Tirsch, & Napolitano, 2011; Liotti, 2007; Reeve, 2009; Saarni, 1999; Schore, 2003, 2009; Shaver, Mikulincer, & Chun, 2008; Sroufe, Egeland, Carlson, & Collins, 2005; Teyber & Holmes McClure, 2011; Wachtel, 2011; Wilkinson, 2010). Because attachment styles have been shown to be relatively stable between childhood and adulthood (e.g., Hazan & Shaver, 1987; Mikulincer & Shaver, 2007), exploring the skills or abilities that parents use to develop secure attachment in their children may provide some insight into the etiology of emotional competence

Attachment theory provides a framework for the development of emotion regulation and personality through the early caregiver-infant relationship (Bowlby, 1958, 1969). Emotion regulation is the maintenance, elimination, or change of emotional experience and/or expression through cognitive, behavioural, physiological, emotional, or attentional strategies (Ochsner & Gross, 2005).

Sensitive, attuned care-giving leads infants to establish a secure attachment with their caregiver, allowing the infant to use the caregiver as a secure base from which the world around them can be explored and learnt about (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Davila & Levy, 2006; Karen, 1998; Kennedy & Kennedy, 2004; Schore, 2003).

Insecure attachment can result when a breakdown or an absence of attuned and sensitive interaction between the infant and the caregiver occurs, and

the infant is not able to use the caregiver as a secure base from which to explore the world (Ainsworth, Blehar, Waters, & Wall, 1978; Cicchetti & Lynch, 1995; Karen, 1998; Ladnier & Massanari, 2000). Insecure attachment has been organised into three separate patterns: Avoidant-attached children tend to avoid or dismiss their caregivers while experiencing distress; Anxious-attached children tend to cling to their caregivers under stress, but may show angry or resistant behaviours and emotions while doing so (Ainsworth, Blehar, Waters, & Wall, 1978; Chae, Ogle, & Goodman, 2009); and Disorganised-attached children show a lack of consistent strategies for obtaining soothing or regulation from their caregivers whilst distressed (Main & Solomon, 1990). Securely attached children, on the other hand, seek caregiver proximity under stress, are usually easily soothed or regulated by their caregiver, and show superior affect self-regulation strategies (Ainsworth, Blehar, Waters, & Wall, 1978; Chae, Ogle, & Goodman, 2009).

In infancy, emotion regulation is a process strongly reliant upon the external influences of the parent in moderating the emotional arousal displayed by infants (Gottman, Katz, & Hooven, 1997; Schore, 2003, 2009). To regulate their infants' emotions, parents intervene in various ways such as soothing, comforting, and meeting the infant's physiological demands (Gottman, Katz, & Hooven, 1997; Thompson & Meyer, 2007). As the infant develops an experiential history of such interventions, social expectations of having her or his needs met are formed - expectations which assist the infant's self-regulation of emotions (Thompson & Goodman, 2010), probably through the development of heuristic expectations based on previous experience that allow the infant to anticipate external regulation, thereby indirectly down-regulating arousal.

A neurobiological explanation of the development of secure attachment is offered by Schore (2003, 2009): The capacity of the caregiver to regulate infant arousal in an attuned manner, a manner that synchronises external regulation with expressed or implicit infant arousal, allows the infant's developing neural brain networks to neurologically record these experiences, serving as foundations for more complex future neural networks (Schore, 2003, 2009). The sequential progression of maturation

from limbic circuitries to the orbitofrontal cortex enters a critical maturation period at about nine months of age, integrating cortical and sub-cortical information about external and internal environments (Schore, 2003). This integration of information serves to accommodate emotional and attentional states with adaptive bodily responses (Critchley, Elliott, Mathias, & Dolan, 2000). If the parental attunement and emotional availability to infant states is 'good enough', secure attachment in the infant tends to develop, which regulates arousal and expands coping mechanisms (Schore, 2003, 2009). Examined in light of Schore's explanation, the self-regulation of emotional states and the resources employed to cope with and process emotional experiences may be largely developmentally learned skills that integrate somatic and psychological states of the self in the context of how the primary caregiver responds to verify, counter, or accommodate such states.

Additionally, in early childhood the development of language abilities increasingly allows for cognitive representations of emotion. Parents who coach self-regulatory strategies for children such as cognitive reframing, problem-focused coping, and shifting attention, assist their children to develop the capacity to regulate themselves (Gottman, Katz, & Hooven, 1997; Miller & Sperry, 1987). The parental encouragement of such strategies contributes to children's self-efficacy about managing their own emotional states (Thompson & Goodman, 2010), and tends to lead to emotional coherency in later life (Oppenheim & Koren-Karie, 2009). Such emotional self-efficacy and coherence tends to be typical of securely attached children (Karen, 1998) and adults (Mikulincer & Shaver, 2007).

Securely attached children and adults appear to possess a more integrative, flexible, and resourceful set of emotion characteristics that allow them to cope with and process emotions in ways more likely to lead to socially and personally desirable outcomes. Secure attachment in childhood appears to represent a foundation for adult emotional intelligence and emotional competence, as attachment styles tend to persist into adulthood (Hazan & Shaver, 1987; Mikulincer & Shaver, 2007). Adults classified as avoidant tend to down-regulate, deactivate, or inhibit attachment-related behaviours and emotions (Edelstein & Shaver, 2004). Anxious adults tend to show

preoccupation with attachment figures' (usually intimate partners) emotional availability and responsiveness (Mikulincer, Gillath, & Shaver, 2002). In adulthood, the disorganised attachment category tends to be labelled as *unresolved/disorganised* with respect to loss and trauma (Allen, 2001), and sometimes absorbed into avoidant and anxious categories (e.g., Bakermans-Kranenburg & van Ijzendoorn, 2009). The most prominent attachment style instrument, the Adult Attachment Interview (AAI) classifies attachment into the above dimensions, and corresponds well with infant attachment classifications (Hesse, 1999; Main & Goldwyn, 1994, cited in Allen, 2001).

Secure attachment style has increasingly been linked to emotional and social competencies such as awareness of emotions, empathy, and the expression of positive affect and values in children, adolescents, and adults (e.g., Ben-Ari & Lavee, 2005; Colle & Del Giudice, 2011; Davila, Bradbury, & Fincham, 1998; Hamarta, Deniz, & Saltali, 2009; Laible, 2007; Rogers Kobak & Sceery, 1988; Roisman, Collins, Sroufe, & Egeland, 2005; Sroufe, 2005). While representing a wider construct than emotional functioning, established measures of attachment style such as the Adult Attachment Interview (AAI) may prove to be good predictors of emotional competence.

Some research has examined the role of therapist attachment style in the establishment and maintenance of the collaborative relationship. The premise underlying such research is that securely attached therapists should possess an affinity for sensitive caregiving roles which assists in the creation of a working alliance with clients, while insecurely attached therapists may disrupt or complicate the process of alliance-formation due to unresolved needs and/or relationship insecurities (Mikulincer & Shaver, 2007). Indeed, it appears that securely attached therapists report stronger working alliances than insecurely attached therapists (Black, Hardy, Turpin, & Parry, 2005), although therapist-reported relationship quality may not be a robust indicator (e.g., Hannan et al., 2005), significant differences in the alliance relationship were apparent in self-reports between securely and insecurely attached therapists. Across multiple sessions of therapy, a secure attachment style in therapists tends to be associated with stronger client ratings of the therapeutic alliance than client ratings of the

therapeutic alliance with insecurely attached therapists (Rozov, 2002, cited in Mikulincer & Shaver, 2007; Diener & Munroe, 2011; Sauer, Lopez, & Gormley, 2003), although one study found only a negative association between insecurely attached therapists and the quality of the alliance (Dinger, Strack, Sachsse, & Schauenburg, 2009).

For most individuals, a developmental history of exposure to empathic, attuned caregivers tends to have positive effects on personality development in manner that suggests such individuals become adults who have a tendency to exhibit such behaviours themselves. Such individuals may be biologically, cognitively, and emotionally well-placed to offer the kinds of services that professional psychology intends to deliver. If this is the case, then secure attachment may be the dominant attachment style of master therapists. Future research directed at linking therapist attachment style and client outcomes may be able to further link emotional regulation patterns and personality variables important in providing successful therapy to clients.

### **Summary**

There appears to be a relationship between the emotional characteristics of therapists and the outcomes of therapy for clients. For one, successful therapists appear to exhibit emotional strengths not apparent in therapists who suffer from burnout. Secondly, a common thread in the emotional functioning of effective therapists who build a strong therapeutic alliance with clients and assist them in achieving favourable outcomes appears to be emerging. Broadly speaking, effective therapists appear to be interested in and open to client experience without becoming defensive or inappropriately directive, are warm, friendly, authentic, compassionate, empathic, reflective, self aware, and recognise that their own emotions can impact on their professional role.

The ability to interpret and comprehend one's own and others' emotions and use emotions in adaptive, contextually appropriate ways has been termed emotional competence (Saarni, 1999). Aside from the significant effects emotions have on social functioning, stress management, and psychological well-being, emotions are considered to play an important role in the creation and maintenance of the therapeutic alliance (Crits-Cristoph &

Mintz, 1991). The quality of the therapeutic alliance is one of the most widely accepted variables relating to therapeutic change (Andrews, 2000; Lambert, 1992), but Beutler et al. (2004) comment that while therapist and client traits can be notoriously difficult to separate because each has an effect on the other that may change their response, it seems clear that therapist traits interact with client traits in a manner that can be beneficial to patient response to treatment. For now, the role of therapist emotion and how it may or may not contribute to client outcomes through its effects on therapeutic relationship remains unclear.

The current project was aimed at investigating the opinions and experiences on the use of emotion within therapy from the perspective of therapists who attain high frequencies of positive client outcome ratings. The themes and categories that emerged may prove useful in delineating and defining how good therapists use emotion, and whether such emotion skills might be able to be learned by less successful therapists.

### CHAPTER THREE: METHODOLOGY

*"One of the greatest joys known to man is to take a flight into ignorance in search of knowledge"*

Robert Lynd

Research into human emotions has resulted in the generation of many differing theories, including what entails function or dysfunction, many differing attempts at categorising emotions, and documenting commonalities or differences between individuals, groups, and cultures. The disparity that plagues this field of research is at least partially ascribable to the difficulty of attempting to study a variable as contextually dependant as emotion (Mesquita, Feldman Barrett, & Smith, 2010).

Western psychology has traditionally embraced essentialism as the dominant method of exploration and investigation into psychological phenomenon. The essence of essentialism is in the identification and categorisation of variables of interest, which can then be explored in detail. This detail serves as a foundation from which inferences are drawn about how these variables generalise to other individuals or groups to explain functioning in naturalistic settings. Such methods have difficulty accounting for the contextual variables that can influence the variable of interest because they must be set aside in order to build a detailed essentialist perspective of the variable in question, which is why such contextual variables have typically been assigned the label of 'confounding variables'.

Emotion is both an interpersonal and intrapersonal phenomenon, where meaning, significance, and behaviour is heavily influenced by myriad contextual variables (Mesquita, Feldman Barrett, & Smith, 2010), and experienced in potentially differing subjective ways. Factors such as present and past relationships with others, experiential history of the individual, differences in culture, socio-historic trends, ethnicities, individual temperament, and gender, as well as the presence of neurological injury and differing developmental experiences and pathways, all contribute to how emotion is experienced by individuals. Because myriad variables can



influence how emotion is both experienced and verbally reported, research investigating the phenomenon may benefit from adopting a strong sensitivity to idiographic experience.

Due to the complex nature of client/therapist interactions, coding specific instances of behaviour intensity and frequency in order to generalise to how therapists should use such behaviours, may miss or at least minimise the partly unconscious processes that occur in the therapist as a response to unique client needs. The quantification of overt behaviours that probably stem from implicit processes allows researchers to ascertain that, on average, therapists engage a particular behaviour a certain percentage of the time, at different stages of therapy, with particular clients. However, the detailed responses of the therapist to particular client needs or emotional states as they arise tend to be lost in aggregated data. When knowledge regarding difficult-to-quantify response-modes of therapists is sought, qualitative research allows the development of a clearer framework about how therapists attune to their clients in a manner that makes them successful in fostering a therapeutic process that facilitates beneficial outcomes (e.g., Jennings & Skovholt, 1999; Levitt and Williams, 2010; Oliveira & Vandenberghe, 2009). If research can formulate a framework regarding the qualities and characteristics particularly successful therapists possess, such knowledge could be used to educate intern and practicing therapists in order to raise the effectiveness of their services.

In the quest for quantifying therapist behaviours that are relevant to achieving positive client outcomes, it may be useful to acknowledge the wider scope. Both clients and therapists each bring a host of variables to therapy (Beutler et al., 2004). To derive decisive statements about the contribution of each separate variable on therapeutic outcomes, experiments must be conducted that control each of the variables not being measured by the experiment in question. Given that many of these variables remain elusive, are based on theory, or are at present unknown and thus impossible to control, a baseline of therapist emotional competencies to which other variables may be added could be beneficial. The present study represents an attempt to create a preliminary concept of

what therapists whose clients consistently report favourable outcomes consider important about using emotions competently in therapy.

While it was tempting to include the MSCEIT in the current research project to assess therapist emotional intelligence as a facet of emotional competence, the lack of factor stability and the fact that the scoring criteria are consensus-based meant this instrument may not address the characteristics this current project is hoping to investigate. Additionally, the AAI would have been valuable in linking the use of emotion with attachment status of the participants in the present research project, in order to examine if similarities in attachment co-exist with similarities in the use of emotion. However, the AAI is a highly specialised, licensed instrument that requires extensive training to use (e.g., Hesse, 1999; Main & Goldwyn, 1994, cited in Allen, 2001), making inclusion of the AAI untenable for the current project.

#### *Qualitative Methods*

Most qualitative approaches share significant overlaps in methodology, such as focusing on lived participant experience (data driven); sensitivity to contextual factors included in raw data, a degree of self reflection of the researcher regarding motivation and preconceived alignments with existing theory, and a critical stance towards traditional positivist methodology regarding the production of knowledge. Differing methods were explored in order to ascertain which method best suited the purposes of the current study.

Grounded theory analysis argues theory should arise from the data because existing theory of the phenomenon under study is lacking, or researchers aim to challenge existing theories (Payne, 2007). The focus of the current study was more geared towards exploring participant experience, rather than a fresh attempt to create a new theoretical framework, meaning a more participant-experience focused method was preferred. Narrative research focuses on participant experience over theory generation, being concerned with how individuals construct meaning from their experiences through creating stories that describe their identity within the researched subject (Murray, 2008). However, the emergence of themes or categories is not a priority in narrative research (Murray, 2008), and the current

research project aimed to categorise participant experiences into common themes, meaning narrative accounts were deemed too immersive and identity-focused. Furthermore, being psychologists, the participants in the current study were grounded within the same theory that was contrasted with their experience, making the interpretation process necessary to link participant experience with academic theory redundant. Also considered was discourse analysis, a social constructionist approach that aims to adopt a critical stance towards objectivity, suggesting that language in itself defines to some extent the assumptions individuals hold about the objectivity or reality of the world around them (Coyle, 2007; Willig, 2008a). The focus on linguistic phenomena and the metaphorical interpretations of participant experiences provides a framework which is critical at levels beyond the purpose of the current study. The current study was not intended to question the validity of knowledge at such a deep level, partly because it intended to broadly stay within the dominant forms of epistemology within psychology, as the participants, the researchers, and the intended audience are all expected to be familiar with the language common to psychological literature.

The present study aimed to forward how practitioners use emotion in their practice in order to contrast emergent themes with existing literature, hopefully providing a modest insight into successful therapist emotional functioning, which may prove to be of some use for practitioners, students, and other consumers of psychological literature. For these reasons, Interpretative Phenomenological Analysis was considered the method of choice for this study.

Interpretative Phenomenological Analysis (IPA) is pertinent when analysing participant experience and data are collected with small, homogenous samples using semi-structured interviews (Eatough & Smith, 2008; Rapley, 2011; Smith & Eatough, 2007; Smith & Osborn, 2008; Willig, 2008). Analysis focuses on holistic meanings and interconnecting themes are linked back to the original data source (Giorgi & Giorgi, 2003; Eatough & Smith, 2008; Smith & Osborn, 2003). Dissemination of IPA findings makes use of the narrative, the semantics embedded within the dialogue, and balances contextual descriptions with conceptual frameworks (Eatough and Smith,

2008). Researchers may link analysed themes with existing literature and theory to discover how well theory corresponds to meaning arising from lived experiences (Smith & Osborn, 2008).

### **Participants**

A purposive sampling method was utilised for this research project. Therapists in New Zealand tracking their performance with the Outcome Ratings Scale (ORS; e.g., Bringham, Watson, Miller, & Duncan, 2006; Miller, Duncan, Brown, Sorrell, & Chalk, 2006) using the Administration, Scoring, Interpretation and data Storage Tool Excel spreadsheet programme (ASIST; Elliott, 2011), were mailed an advertisement, inviting those with an ASIST Normative Comparison Score of .7 or higher to participate in this study. Respondents were mailed an introduction letter (see Appendix C). Three therapists who met the inclusion criteria responded to the advertisement. No therapists who responded were excluded from this study.

The three therapists who met inclusion criteria were interviewed by the author, who met each participant at their place of work to conduct the interviews. Interview duration ranged between 1 hour 40 minutes and 1 hour 50 minutes.

Participant demographics were as follows: All identified as New Zealand European, mean age was 43 years; 2 females and 1 male participated; all were employed as Clinical Psychologists; mean years of clinical experience was 7; mean years of tertiary education was 9; favoured theoretical approaches to therapy were listed as follows: Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Therapy (CBT), Neuro-linguistic Programming, Solution-focused Therapy, and Mindfulness Therapy.

### **Measures**

#### *The semi-structured interview*

Interview guidelines were developed in order to direct interview discussions towards the use of emotion by therapists within therapy. Initial questions were developed by the researcher, based on a review of the literature. Questions were checked and discussed with the researcher's two supervisors and three senior therapists known to the researcher. Six pilot interviews were conducted, with four informants selected from a

convenience sample of therapists. On the basis of the pilot interviews, five original questions were eliminated and three were added. The final interview guide comprised 26 guideline questions and seven demographic questions (see Appendix A). Not all 26 guideline questions were asked in each interview. If sufficient discussion on topics preceded the relevant questions, the questions were not posed later. On this basis, between four and six differing questions were considered redundant in each interview as the content had naturally arisen.

### *Demographics*

Demographic questions were ethnicity, age, sex, occupation title, years experience in therapy, years of tertiary education, and favoured theoretical approach to therapy (see Appendix A).

### *Audio recordings*

Each interview was audio-recorded on a Panasonic Digital Voice Recorder. The resulting Windows Media Audio (WMA) files were transferred and stored on a password-protected laptop until the analyses were completed, whereupon the WMA files were deleted.

### *Follow-ups*

Follow-ups with participants were conducted post-analysis for error-correction, to ensure anonymity, and to lend a degree of validity to the researcher's interpretation. For this purpose, each participant was sent by email a copy of the researcher's analysis of their contribution (see e.g., Eatough & Smith, 2008; Willig, 2008), and asked to verify the validity of the analysis, and whether they were comfortable with their anonymity being preserved on the basis of excerpts of their texts being used in the final document.

## **Procedures**

### *Advertisement*

An advertisement was distributed by a third party to approximately 50 nationwide managers holding an ASIST licence (see Appendix D).

### *Letter of introduction*

A participant information pamphlet describing the study and providing technical, confidentiality, and ethics details was distributed to candidates

who had expressed interest in participating (see Appendix B). Because the aim of the study was to investigate participants' subjective experiences about their use of emotion in practise, no literature summary was provided in the participant information sheet. The omission of this material was necessary in order to access accounts of personal experience from the participants that were minimally influenced by the researcher's expectations or theoretical framework. From the potential pool of approximately 50 licence holders across New Zealand, three therapists responded and were each sent an interview guide (see Appendix C).

### *Interviews*

Each participant engaged in one semi-structured interview (see Appendix A), each lasting approximately 100 minutes. Each interview was followed by a short debrief, allowing discussion of any issues raised during the interview. None of the participants reported that any issues had surfaced for them as a result of the interview.

The role of the researcher in these semi-structured interviews was to encourage the participants' exploration of the subject of interest with minimal explicit prompting (Smith & Eatough, 2007). Open questions led the topics of the interview, and the participants determined how their experience was brought into focus. The researcher kept reflective notes during the interviews to assist the analyses.

### *Data analysis*

IPA follows differing levels of analysis, although maintaining a flexible approach is central to IPA methodology in order to provide adaptability to differing research aims (Smith & Eatough, 2007). The following procedures, consistent with IPA methods, were followed.

The interview audio-recordings were transcribed verbatim by the researcher, who next listened to each audio-recording to check the accuracy of each transcript, then re-read each transcript to attain a thorough familiarity with each participant's account (Eatough & Smith, 2008; Giorgi & Giorgi, 2003; Smith & Eatough, 2007; Smith & Osborn, 2003; Storey, 2007).

Each transcription was reproduced in column-format, with comments about relevant psychological concepts and abstractions inserted in columns adjacent to the relevant lines of the transcript (Smith & Eatough, 2007). This process allowed the researcher to identify significant statements, recurring content, specific themes, and patterns, which were labelled as subordinate themes, and organised into clusters (Smith & Eatough, 2007). Care was taken to preserve the connection between the participant's account and the researcher-identified themes, primarily through consistent checking and re-reading transcript sections to ascertain congruence was present (Smith & Eatough, 2007).

A phenomenological approach was used (e.g., Giorgi & Giorgi, 2003). This involved interpreting subordinate units of meaning and documenting these as language which is explicitly psychologically relevant to the research question at hand. The aim was to interpret participant experiences as contextual clarifications explaining the phenomenon under investigation (Giorgi & Giorgi, 2003). Analysis of each transcript continued until no new themes or categories emerged (Willig, 2008b).

Subordinate themes of related meaning were grouped and assigned superordinate theme labels (Smith & Eatough, 2007). The researcher continued to check validity of superordinate labels by linking such labels with participant statements. Seven of the subordinate themes were discarded at this point because they did not fit within the context of the aim of the study. Three themes were discarded because the researcher considered the links with the relevant participant account weak in retrospect (e.g., see Smith & Eatough, 2007; Storey, 2007).

#### *Follow-ups*

Each participant was sent a copy of the case-analysis of their transcript. This allowed each participant the opportunity to correct errors made in the interpretation process by the researcher, as well as to provide participants the opportunity to retract statements if they considered such statements had the potential to compromise their anonymity. One participant retracted one statement, one participant corrected two errors, and one participant did not respond to the follow-up requests.

## CHAPTER FOUR: RESULTS/DISCUSSION

*“The greatest compliment that was ever paid me was when one asked me what I thought, and attended to my answer”*

Henry David Thoreau

Each participant’s table of superordinate themes was cross-analysed with the others for common themes. Four master themes emerged, each reflecting superordinate or subordinate themes found in all the participants’ analyses. The master themes are listed in Table 4, each accompanied by excerpts from each participant in order to illustrate their relevance to the theme. Each of the master themes is then explained in greater detail in the following section of this chapter.

The following transcript notations were used in the quoted extracts below:

- ... Significant pause or omitted material.
- [text] Explanatory material added by researcher

**Table 4:**  
**Master themes across participants**

Theme	Page
<b>1 Therapist Characteristics</b>	
<i>Genuineness</i>	
Anne: “How do I, as me... talk to people in a human way... And connect on a human level...”	1
Bill: “...we model in therapy what we do in real life”	10
Celia: “...you’ve got to bring your own personality to it. People see it if you’re not being genuine”	2
<i>Sensitively Tailored Therapy</i>	
Anne: “Does this seem to be working for them and...maybe even checking that out... Does what they say about the process seem to fit with my sense of it...”	4



Theme	Page
<p>Bill: "...it's our job to meet them where they are, and move with them to where they want to get to"</p>	5
<p>Celia: "...the main goal of [my theoretical approach] is promoting psychological flexibility for my clients and so in doing that I need to demonstrate that I'm psychologically flexible as well, in terms of what I'm doing with them, so it's kind of modelling the way that you want them to be too"</p>	2
<p><i>Positive Expectations</i></p>	
<p>Anne: "People are pretty amazing"</p>	7
<p>Bill: "I need to monitor where I'm at, and make sure that I go into a session positive and optimistic, which is going to help them be positive and optimistic"</p>	13
<p>Celia: "...using an approach that you really believe in and actually use some of those therapeutic tools in your own life as well, you're much more likely to get clients on board with something that you believe in..."</p>	1
<p><b>2 Reflective Practice</b></p>	
<p><i>Emotional Awareness</i></p>	
<p>Anne: "[I use my own emotion in practice] to see whether something feels alright or not. I do think I get probably quite a reliable sense if something is... different from how I might usually be with a client, with their doing something that's radically different... And to respond to... my feeling about them and what that might tell... me about... their feelings about me</p>	4
<p>Bill: "... awareness of my own emotions... is giving me the message about where I'm at... Its information which I can then use and make decisions based on. If I didn't have that awareness I wouldn't be able to know where I'm at, where the session's at, where the relationship's at"</p>	12
<p>Celia: "Sometimes you'll have a really strong emotional reaction to something that a client says, and I think it's important not to kind of push that away, but to think about, okay what is that telling me about what's going on for this client at the moment, and what's going on in terms of our therapeutic relationship"</p>	3

Theme	Page
<i>Achieving Objectivity</i>	
Anne: "I use a lot of up and down the corridor reflections as well. Pop into somebody else's room"	9
Bill: "I have... regular formal supervision which I can take my clients to, my cases, metaphorically. But within our team we also have this great sort of open door policy, where... we can wander down the corridor and have a 5 or 10 minute conversation about a client that we're struggling with"	9
Celia: "...we use supervision... to also talk about what's going on for us personally in therapy... acknowledging it and managing it and feeling like you have colleagues that you can talk to about it and taking it to supervision"	8
<b>3 Empathy and Fostering Relationships</b>	
<i>Connecting with Empathy</i>	
Anne: "... you need some empathy... to try and tune in with other people's experience"	5
Bill: "... you go there for two reasons; one is to get the information about how they feel, and how it is for them, so you can understand that; and secondly so that they understand that you understand"	4
Celia: "...in that first session the initial focus would be... making them feel like they've been empathised with, they've been understood"	1
<i>Limiting Empathy</i>	
Anne: "...it doesn't seem – appropriate – to collude with people, keeping it going and keeping it going when they feel really bad about it, and it's not [useful] – they're not feeling any better in the world, and they're not doing anything any differently"	8
Bill: "[Therapist emotion] is always useful if it's congruent. How long you stay there is a different thing ... if I stay in that state for too long then maybe it's not so useful"	17
Celia: "I think there is a fine line in terms of you want to convey empathy but you don't want to get into a situation where you actually become the client's best friend, and you're sort of empathising with each other's struggles"	2

Theme	Page
<b>4 Focusing on Outcomes</b>	
<i>Balancing Relationship and Process</i>	
Anne: "I'm quite... pragmatic really, in working with people and, you know acknowledging feelings but also looking at some quite solution focussed [strategies], so looking at some practical steps"	4
Bill: "I have this image in my head of going in there and out a little bit... you know, connecting and disconnecting. The ability to come in, connect with the client, and then just step back out and do the work of the psychologist... this is what works for me"	7
Celia: "We like to think that it's all about collaborating with the client and supporting them in doing what they want to do, and yes, you are doing that but in the process of that you are influencing them in some way"	15
<i>Working Collaboratively</i>	
Anne: "I think it is important to feel that empathy, some empathy for the person and understand where they're coming from, and then look at where they want to go, rather than staying where they are"	7
Bill: "... we're the professionals, it's our job to meet them where they are, and move with them to where they want to get to. Whatever way works"	5
Celia: "...if you do actually do that [being very directive] for people you find it tends to kind of promote defensiveness, it's better to do it in a more subtle way normally, and get them to kind of think of 'what can I do differently' and then subtly kind of manoeuvre them in a direction of more adaptive ways coping as opposed to less adaptive ways of coping"	15

## Theme One: Therapist Characteristics

### *Genuineness*

Participants clearly brought positive aspects of themselves into their role as therapists. They cared for other people both inside and outside of therapy, possessed warm and approachable demeanours, and respected other individuals.

"I think that I'm genuine, usually reasonably kind of warm and open and respond to people" (Anne, page 1).

"How do I, as me... talk to people in a human way... And connect on a human level..." (Anne, page 2).

"I'm reasonably congruent – I'm not clever enough to pretend to be what I'm not. I couldn't be a spy, for example... I'm just not clever enough to play a game long term. You get what you get, and people know that... this is me, I'm here with you as me, as me who cares about you and is wanting to make a difference" (Bill, page 8).

"...you've got to be friendly and approachable and compassionate" (Celia, page 2).

The participants were open and interested in the questions, enthusiastic about discussing the material, and all showed concern that the interview was successfully addressing the questions the researcher was asking. Thus they modelled the characteristics they spoke of using in therapy during the interviews.

Warm and compassionate therapists tend to genuinely reflect these qualities in therapy, while such qualities would be impossible to act out consistently if they were incongruent with the therapist's personal characteristics (Reynolds Welfel & Patterson, 2005). Participants were aware that clients would be able to detect incongruence if they were not genuine.

"Something somebody said to me recently... they were offered the service a number of times, and they said 'no' – they thought they'd be seeing a head-shrink. I said 'what do you think now, having seen me', and they said 'you're just like me'" (Anne, page 11).

"...if I was to pretend to be somebody or something else, that wouldn't be helpful" (Bill, page 8).

"...we model in therapy what we do in real life" (Bill, page 10).

"...at the end of the day... you've got to bring your own personality to it. People see it if you're not being genuine. I think being genuine in therapy is pretty important" (Celia, page 2).

Genuine therapists display congruence in how they respond to clients within and between session and are more likely to foster a sense of predictability and trustworthiness for their clients (Reynolds Welfel & Patterson, 2005). The participants were well aware of this benefit and all expressed the utility of congruence and genuineness in forming a therapeutic relationship and fostering an environment where clients could feel like they could talk about personal and difficult issues.

"[Communicating] that I am trustworthy and reliable and professional and that I'm a safe person that they can talk to about things, and that we can work together, collaboratively... which I think is genuine" (Anne, page 16).

"...this whole thing of caring starts right back as far as [being offered] coffee when they come in the door, and simple things like – I'll be here, if our appointment is at 9.00, I'll be here at 9.00. It happens in all those things – it's not just around the interaction stuff, [it] comes into the [tidy] dress stuff, names, remembering people's names properly. Not having to look through files while you're with the client, trying to remember who they are, what their case was. Those are all sending messages to the client" (Bill, page 11).

"I think I'm reasonably good at forming relationships with people, and making people at ease... getting a relationship to a place where people can feel as though they can say stuff" (Bill, page 1).

"I think it's very important to bring your own personality into the session rather than sort of do it in the way that you think it should necessarily be done based on how you've seen other people do it because, if you lose yourself in using a particular approach it's not going to be convincing to the client" (Celia, page 1).

"...for me the top priority is that I go away from that session feeling like I've got rapport with them and they want to keep coming back and see me. Because you can gather all the information in the world but if the client doesn't want to come back and see you again then you're not going to be particularly useful" (Celia, page 1).

While being genuine in bringing positive aspects of their personality characteristics into therapy, the participants closely monitored their own emotional processes, especially negative emotion. Participants did not express all the attitudes, thoughts, and emotions that arose for them in therapy, but tended to match their way of being with the client with what they considered useful or beneficial at that particular time. It appeared as if genuineness was tempered through self-awareness and self-reflection to ensure that therapist expressions were beneficial to clients.

"I guess its monitoring isn't it – being aware of what's going on so that we don't... automatically express frustration, irritation, anger" (Anne, page 9).

"... like many guys, I feel a little uncomfortable when people get upset [in and out of therapy]... I don't steer away from it... I think it's important... to stay there, to validate the experience... and it is okay to be upset in this place. This is an absolutely fine place to be to do that... [But] there's no point staying there any longer than what's useful" (Bill, page 7).

"So depending on what's going on with the client interpersonally, that might change how you are interpersonally with them in the session. If you have a client with a frontal lobe dysfunction who is quite disinhibited in social situations, you probably don't want to be overly warm and friendly and compassionate because what you are wanting to model is having some boundaries in terms of your interpersonal relationships and maybe actually pulling back on the level of what you're doing at the moment, in terms of divulging things about yourself and things like that. So in that situation you might use extremely limited self-disclosure, whereas in other situations you might feel more able to self-disclose because you are conscious of the fact that you're modelling, you are wanting to

model something that's quite different to what they're doing at the moment" (Celia, page 11).

Anne discussed one occasion where her professional ethics guided her to not overextend herself in helping her client outside of work-hours. She experienced a degree of discomfort in being unable to fully respond to a client's needs, even although such needs were beyond what she should ethically and professionally deliver. This highlights that therapist genuineness is likely to be a process that requires an element of self-awareness and reflection.

"Some kind of edginess – yeah, just feeling bad about saying 'No, I can't do that'... It was the right professional decision – [but] it felt bad on a human level" (Anne, page 15).

For Bill, a sense of frustration with a client was a source of information which he would evaluate introspectively. Bill would exert purposeful effort in transforming this negative response into more useful information about the dynamics within therapy, again showing that therapist genuineness probably requires a degree of mindfulness as well as allowing aspects of one's personality to surface.

"if you're feeling frustrated with the client and stuff, that just means that you're off base really – you've lost the connection with them and you're more on about your own agenda rather than their agenda" (Bill, page 17).

"Well it's information, but yeah you do look to fight it and change it, because it's not useful, it's not useful to be frustrated with a client – it's information that we're not making the progress we want to make, or [that] I'm not connected to my client here. That's useful information and therefore... what do I need to do to get back to a state where it's going to be useful" (Bill, page 17).

Celia also talked of monitoring her emotional reactions to derive information, highlighting the necessity of allowing emotions to be experienced but not automatically expressed to the client.

"Sometimes you'll have a really strong emotional reaction to something that a client says, and I think it's important not to kind of push that away, but to think about, okay what is that telling me about what's going on for this client at the moment, and what's going on in terms of our therapeutic relationship" (Celia, page 3).

"...sometimes [your own emotion] it's telling you something important and actually saying that maybe what the client said is not something that's okay, maybe that is something that you need to target in therapy..." (Celia, page 3).

An element of incongruence was apparent in how participants talked of expressing felt emotion to clients. Gelso (2011) termed this necessary

element of therapist incongruence *the humanistic paradox*, commenting that while the therapist should be genuine and congruent, he or she must prioritise the needs of the client and not disclose all felt emotions arising in therapy. On a similar note, Greenberg (2002) recommends that therapists self-disclose emotion with discipline, self-awareness, and remain focused on assisting clients achieve therapeutic objectives rather than their own needs (see also Greenberg, 2007). The participants all talked of prioritising their clients' needs when experiencing emotion that they may not have considered useful to express. Rather, such emotion would typically be reflected on in terms of the dynamics between the therapist and the client. The participants spoke of explicating their emotion or associated thoughts in a tempered manner to ascertain if their understanding of the situation was accurate.

"Does this seem to be working for them and...maybe even checking that out... Does what they say about the process seem to fit with my sense of it..." (Anne, page 4).

"I think it's also... about monitoring body language, monitoring facial expressions, tone... what's happening [for the client]. So you can respond to that, so you can back out of stuff. I do a bit of that because I'm quite directive in the way I work. And I can be quite confrontational, a little bit, but gently confrontational, like I'm not afraid to say things. But then it's really important to be reading the person so you can then add softness or back out a little bit" (Bill, page 3).

"...if you feel like you're not in control of [your own emotional reactions] or able to regulate that, then it becomes something that you need to take to supervision and find some ways of managing so that doesn't have a negative effect on the client" (Celia, page 12).

It appeared that the participants resolved the humanistic paradox by processing what they considered unhelpful emotional reactions through self-reflection and supervision. An element of congruence was still apparent as the participants appeared to explicate the facets they considered useful to the therapeutic process.

#### *Sensitively Tailored Therapy*

All three participants talked of being flexible in assessing client needs and understanding of their experiences. They spoke of monitoring and discussing client knowledge and perspectives on issues that brought them to therapy, including client expectations of how therapy was able to assist them achieve the goals they were expecting. This assisted participants in

developing an understanding of their client in order to formulate a treatment plan that adapted the therapeutic process to their needs.

"I'm genuine, usually reasonably kind of warm and open and respond to people and try and kind of... suss out where they're starting from" (Anne, page 1).

"...how do they understand how the problem formed? How do they understand what this problem is?... I need to know that, and take that into consideration as I work with [them]" (Bill, page 5).

"When somebody's upset about something it tells me that it's important to them, that it's an unpleasant thing for them. That's information for me. So this is hard. It provides information" (Bill, page 7).

"...before I come into sessions I do... a session plan, but oftentimes... not always but oftentimes I end up doing stuff that's quite different to my plan. Based on where the client's at when they come in. It's important to be able to do that" (Celia, page 2).

Therapists need to understand such client perspectives and characteristics in order to sensitively formulate treatment plans that aim to address issues clients bring to therapy (Lebow, 2006; Reynolds Welfel & Patterson, 2005). When therapists ask relevant questions and actively listen to clients, they communicate attunement, which tends to foster trust and credibility, allows the client to perceive the therapist is intending to work with them collaboratively, is open to client opinion and insight about their experiences and issues, and tends to foster client perceptions of self efficacy (Teyber & Holmes McClure, 2011). Attunement validates client experience and is thought to facilitate client change through increasing client self reflection on emotion and thought processes, fostering flexibility in self-and-others perspective taking, ultimately resulting in gains in self regulation of behaviour and emotion (Allen, Fonagy, & Bateman, 2008). Additionally, attunement is considered an interpersonal emotional regulation strategy achieved through the therapist's responsiveness to client affect which communicates acceptance and validation of client experience (Greenberg, 2007), a process considered to include non-verbal interpersonal communications such as facial expressions, body language, and similarities in affect expression (Schore, 2003). When therapists display sensitivity in tailoring the treatment process to the needs of the client, the client is likely to perceive the therapist's validation, understanding, and commitment to resolving the problem they have brought to therapy. In turn the client may



feel more motivated, empowered, and commit to engaging in the processes likely to lead to positive outcomes.

Sensitivity included not pushing clients to work at a pace that was beyond their capacity, but at the same time ensuring clients moved towards positive outcomes wherever possible. Establishing rapport preceded working towards therapeutic change. While all participants considered themselves outcome-focused, each spoke of first fostering rapport, leading to a collaborative relationship, and then focusing on working towards positive therapeutic change for their clients. Each participant discussed strategies in gently pushing towards useful and constructive change.

“I do really try and listen to people, but if we keep going over the same ground, then I do talk to them about maybe this isn't actually helpful. Because I think it kind of really revs people up... and then look at where they want to go, rather than staying where they are” (Anne, page 7).

“So [I] gently lead towards [positive outcome]- it really comes down to is it helpful, and if it's not helpful then I will gently move them towards the fact that actually probably, this isn't going to help you achieve the outcome you want” (Bill, page 12).

“Sometimes you do end up going off on a tangent and that's important... because there are other things that come up between sessions in client's lives, and sometimes you do need to diverge from what you've been talking about and actually focus on something else for a little while. And then... hopefully come back to it [the process of change]” (Celia, page 7).

### *Positive Expectations*

Participants spoke of harbouring positive expectations both of the therapeutic techniques they used and the clients they encountered in therapy. They spoke of therapy with passion, and it was clear each participant believed in the efficacy of their preferred therapeutic methods. Modelling such positive expectations is likely to foster optimism in clients, providing hope and motivation for achieving desirable change.

“I've had some experiences recently with couples where I do... a better job at... talking about how are we going to [achieve positive outcomes]... I do... that more than I used to, thinking about it” (Anne, page 11).

“I think being outcome focused... is really important... It keeps the client outcome focused as well, it brings about expectancy of positive change, which is really important” (Bill, page 1).

“I think the particular therapeutic approach that I use makes me successful because it's one that I'm quite passionate about and I believe it really works well for my clients. ...using an approach that you really believe in and actually use some of those therapeutic tools in your own life as well, you're much more likely

to get clients on board with something that you believe in, rather than just using something that you think 'oh yep, it's been shown to be effective' but maybe isn't such a good fit for you as a therapist" (Celia, page 1).

Optimistic individuals tend to use more planning and problem-focused coping during controllable events and display greater flexibility and acceptance in uncontrollable events (Scheier & Carver, 1992). It is likely that raising client optimism to any extent will facilitate some of these positive benefits in therapy (Arnkoff, Glass, & Shapiro, 2002).

"...when you're in therapy you have to be optimistic about outcome, because if you're not, you're not going to try, you're not going to come back next session, you're not going to do your homework" (Bill, page 11).

Bill talked of explicating research on the efficacy of treatment and providing examples of other clients who have experienced positive gains.

"I'm using a technique at the moment where I've actually got a graph – I've got instructions for the technique and I've actually put a graph of the outcomes on the bottom of a piece of paper [that] I've cut it out of a research paper, and they can see, over a 6 month period, what – on average – this does to depression and happiness scores. So they take that home with them, and they can see, hey if I do this... I'm going to be along that line" (Bill, page 11).

"I'll talk about other people I've seen – [I will say] 'I just finished with somebody recently who, two months ago they were feeling exactly like you were, we did these simple techniques and now they're fantastic, they're feeling great and I discharged them yesterday'" (Bill, page 11).

Participants approached clients with positive attitudes that reflected their beliefs in client resilience, potential, and value as human beings. Therapist acceptance is likely to foster trust in clients, and allows them to accept that they are worthwhile human beings who deserve respect from their therapist. Positive attitudes towards clients were expressed in several different ways, included normalising client problems by pointing out that all people struggle with issues at some time in their life, accepting behaviours and thoughts as valid experiences in need of understanding, and promoting self-compassion.

"I think people are pretty forgiving and pretty flexible" (Anne, page 2).

"...some people have an amazing propensity for happiness, don't they? You know, to see good in situations – I think people can lose that temporarily, but then regaining that sense of appreciation for stuff... getting on with what they've got really, enjoying what they have (Anne, page 7).

"...they're not dysfunctional for having these problems... human beings experience difficulties in relationships at different stages. Variations in connectedness and everything else" (Anne, page 10).

"I suppose part of this is around unconditional positive regard... there's no sort of negative interpretation about this is a naughty client coming in and playing up in session, it's a real experience, which needs to be understood and worked with to achieve the outcome they want" (Bill, page 16).

"...being compassionate towards them but also encouraging them to be compassionate towards themselves. Cos I think a lot of clients are really hard on themselves. And they sort of beat themselves up about the way that they're feeling or the things that they're doing, and sometimes that can be a useful thing, but I think normally that kind of passion of beating yourself up is not very useful. It tends to promote feelings of guilt which you know then tend to lead to, kind of maladaptive ways of managing it" (Celia, page 4).

"...I always talk about suffering being a normal part of life, part of the human condition" (Celia, page 14).

Therapist positive attitude is likely to foster a sense of hope, motivation, and commitment to future change in the client, knowing their therapist accepts them for who they are, and is committed to helping them make positive changes. Reeve (2009) broadly refers to this positive attitude as an *autonomy-supportive motivational style*, and includes the following four manners of relating to others as essential components: Nurturing inner motivational resources through identifying and fostering interests, preferences, and needs; using informational language to focus on problem-solving rather than criticising or blaming; providing explanatory rationales through explicating the value or utility of the suggested behaviours or thoughts; and acknowledges/accepts negative affect and works to resolve the underlying cause. Therapists with an autonomy-supportive motivational style tend to foster "motivation, engagement, development, learning, performance, and psychological well-being" in their clients (Reeve, 2009, p. 152). All three participants in the current study spoke of engaging their clients in ways reflecting Reeve's autonomy-supportive motivational style, especially through normalising suffering and relationship difficulties, adopting a non-judgemental approach to client issues, and working with clients to develop shared goals for therapeutic outcomes.

## Theme Two: Reflective Practice

### *Emotional Awareness*

Participants spoke of the utility of being aware of their own emotions arising within sessions through reflecting on the process. Their emotional reaction to session dynamics could motivate participants to reflect on how the client was feeling about the therapist, how the therapist was responding to the client, or how therapy was progressing in a more general sense.

“[I use my own emotion in practice] to see whether something feels alright or not. I do think I get probably quite a reliable sense if something is... different from how I might usually be with a client, with their doing something that’s radically different... And to respond to... my feeling about them and what that might tell... me about... their feelings about me” (Anne, page 4).

“...awareness of my own emotions...is giving me the message about where I’m at... It’s information which I can then use and make decisions based on. If I didn’t have that awareness I wouldn’t be able to know where I’m at, where the session’s at, where the relationship’s at” (Bill, page 12).

“...in terms of how I use emotion in therapy it’s more about being mindful of my own emotions and my own reactions to the client as well and what that says about how therapy is going or where we’re going. Sometimes you’ll have a really strong emotional reaction to something that a client says, and I think it’s important not to kind of push that away, but to think about, okay what is that telling me about what’s going on for this client at the moment, and what’s going on in terms of our therapeutic relationship” (Celia, page 3).

Accurate emotional awareness requires a thorough therapist understanding of their own emotional process as well as that of the client, being similar to what Gottman, Katz, & Hooven (1997) termed *meta emotion*, which incorporates identifying emotions by employing cognitive resources. This process is also found in Saarni’s (1999) concept of emotional competence, both in the self awareness of emotional states, and in the awareness of emotions in others. It appears the participants were able to ‘read’ their emergent emotions, gaining important information about their clients, therein displaying a cognitive response to a generated emotion. Attending to an emotional reaction by purposefully selecting less provocative aspects of the eliciting situation tends to down-regulate emotion intensity in the process of achieving a primary objective (Zelazo & Cunningham, 2007), in this case through the participants searching for insight into how clients perceive their therapist.

Mindfulness has been posited as facilitating a more objective and detached perspective on thoughts, sensations, and feelings for therapists, potentially

resulting in a delay between perception and response (Bischof et al., 2006), which may lead to more reflective response to situations in therapy (Hick, 2008). Perhaps through prioritising client welfare and need over their own, participants could more easily down-regulate negative emergent emotions through purposefully focusing attention towards consciously considering therapeutic goals.

In session, specific emotions such as frustration, or even a failure to experience expected emotions such as empathy, tended to initiate a reflective process which motivated participants to locate the source of the disconnection or relationship rupture.

“I can think of an example recently where I thought I was having some difficulty connecting, and... I... wasn't getting much empathy for the person I was seeing. So maybe in those deficit situations I'm much more alert than if... I feel relaxed, the person seems reasonably relaxed, they're talking openly... and they're able to talk about their feelings and I... can respond to what they're saying. Like [when] I feel in tune with them then I wouldn't be thinking about what [emotionally] I'm doing or how I'm doing it” (Anne, page 4).

“[Self reflection is prompted by] the sense that I'm not getting anywhere. And... that's very subjective – you need to check with the person that you're not getting anywhere, and they might agree, so [then] you definitely need to do some thinking about what could be helpful” (Anne, page 8).

“...if you're feeling frustrated with the client and stuff, that just means that you're off base really – you've lost the connection with them and you're more on about your own agenda rather than their agenda” (Bill, page 17).

“...sometimes it's telling you something important and actually saying that maybe what the client said is not something that's okay, maybe that is something that you need to target in therapy, or maybe it's just simply that you were really empathising with them, and being with them there in the moment, that actually it was perfectly okay and actually quite nice that you felt that at the same time” (Celia, page 3).

While frustration occasionally surfaced for participants, it was not directly expressed to clients. Instead, they would use the emotion to self reflect on the cause, then action change by either becoming more client-experience focused through grounding themselves in client experience and generating empathy, or by assessing what they could change to be more useful to the client in achieving therapeutic goals. The researcher concluded that this displayed participants' ability to identify and regulate their own emotional processes by consciously switching to more productive and useful emotions such as empathy, or by cognitively regulating their own emotion by focussing on task-oriented goals. Participants' self-awareness and efficacy

in regulating their own emotions appeared to lead to a moderation of emotional expression, in terms of usefulness to the therapeutic process. Indeed, participants spoke of the need to regulate their emotion and process emotional experiences to ensure client welfare and benefit were optimised.

"... but deeper emotional or personal things, you kind of think, is this a useful thing to talk about? Probably not" (Anne, page 9).

"...it's ok [for a therapist] to be hugely sad, and it's ok to be anything, I think. But it's what you actually show of those feelings" (Anne, page 11).

"[In therapy, my emotions] do come to the surface sometimes. I think I generally have – in life, I have reasonably steady emotions. Like I don't have particularly high highs or particularly low lows. My emotions are generally pretty lukewarm" (Bill, page 7).

"I need to monitor where I'm at, and make sure that I go into a session positive and optimistic, which is going to help them be positive and optimistic" (Bill, page 13).

"...if you feel like you're not in control of [your own emotional reactions] or able to regulate that, then it becomes something that you need to take to supervision and find some ways of managing so that doesn't have a negative effect on the client" (Celia, page 12).

"...being aware of when you go into a session, where you're at emotionally – if you're not aware of that and you've had some personal stuff going on, and you haven't had a chance to think about how that might get triggered or what you're going to do with it, then there is a chance that you end up breaking down with the client" (Celia, page 9).

While participants talked of the importance of self awareness about their own emotional processes, occasionally they harboured emotions that originated outside of the session at hand. They did not consider such emotions problematic, provided they had a strong awareness of why such emotion was present, and believed that such emotion would not compromise the utility of their service to the client. The process of self reflection allowed them to consider if these emotions were useful in facilitating rapport or helping their client achieve therapeutic gains.

"I can think of another example – I'm getting an emotional response to this from my own experience. Is it useful to me to reflect on this from my own experience for the person, and what would I gain from this? Is it useful? Maybe not, actually... that's the in-session reflection as well" (Anne, page 9).

"... sometimes it's just about another client, sometimes it's about stressors within the work-place, so it's not necessarily about my personal life. But stuff outside, emotions outside the session coming into the session are a problem" (Bill, page 4).

"Well it's information, but yeah you do look to fight it and change it, because it's not useful, it's not useful to be frustrated with a client – it's information that we're not making the progress we want to make, or [that] I'm not connected to my client here. That's useful information and therefore... what do I need to do to get back to a state where it's going to be useful" (Bill, page 17).

"...being aware of when you go into a session, where you're at emotionally – if you're not aware of that and you've had some personal stuff going on, and you haven't had a chance to think about how that might get triggered or what you're going to do with it, then there is a chance that you end up breaking down with the client" (Celia, page 9).

### *Achieving Objectivity*

The participants appeared to be well aware of how aspects of themselves or their personal lives had the propensity to affect who they were as therapists. Again their priority lay with clients, ensuring that they only brought such aspects into therapy that they considered useful and beneficial. Participants spoke of the need to use supervision or personal therapy if they felt they could not process or resolve such issues successfully. Each participant spoke of personal experiences or characteristics that impacted on aspects of their professional role as a therapist. Regardless of the experience, the participants' priority remained with their clients' wellbeing, signalling they considered client needs above their own in therapy.

"...for example, when my parents died, it wasn't a particularly easy time, but... maybe I was more attuned to people's emotions, being more emotional myself. Not necessarily a bad thing, because it probably depends on how distracted [your] thinking is, or... whether you can... focus in on somebody else – so it could go either way" (Anne, page 14).

"I like to be a little jokey at times, a little cheeky. I'm a youngest child. So I'm used to being a little cheeky and getting away with it" (Bill, page 2).

"... like many guys, I feel a little uncomfortable when people get upset [in and out of therapy]... I don't steer away from it... I think it's important... to stay there, to validate the experience... and it is okay to be upset in this place – this is an absolutely fine place to be to do that... [But] there's no point staying there any longer than what's useful" (Bill, page 7).

" [If] you're actually noticing that when you've got a client who's in a similar situation possibly to what's going on for you personally, that you're getting tearful or you're experiencing some of the emotions that they're experiencing. I think it's just being mindful about where that takes you. Sometimes that's not such a bad thing because it allows you to empathise, but if you feel like you're not in control of that or able to regulate that, then it becomes something that you need to take to supervision and find some ways of managing so that doesn't have a negative effect on the client" (Celia, page 12).

Achieving objectivity about intrapersonal emotional states was a quality all participants valued. They all spoke of being fallible, of not always performing at their best in therapy. Knowing when one makes mistakes or could have performed better is essential to learning from such mistakes, and adapting future behaviour in a beneficial manner (Baumeister, Zell, & Tice, 2007). Participants were realistic and objective about their own practises and abilities, and as such are probably more likely to strengthen their practice when sensing room for improvement. The participants appeared to hold objective perspectives about themselves as fallible individuals, accepting that they sometimes made mistakes, did not always perform at their best, and recognised areas they would like to improve on.

"I think all of our history goes into that [skills used to tune into clients], which has some good bits and some bad bits... some strengths and weaknesses" (Anne, page 5).

"None of us get this communication stuff right the whole time. It is a work in progress for everybody" (Anne, page 10).

"... sometimes if you're feeling frustrated with the client... that just means that you're off base really... you've lost the connection with them and you're more on about your own agenda rather than their agenda" (Bill, page 17).

"...it's a philosophy of what I like to do when I'm on my game... But I'm not always on my game" (Bill, page 6).

"A lot of therapists would... argue that I take too much responsibility on myself for [client] change. Maybe that's something I'll learn to do better in future" (Bill, page 9).

"...there is invariably always things that you feel like you can do better... sometimes that is affected by the clinician's own emotional frame, where they're at themselves emotionally" (Celia, page 7).

"Because of things that have happened outside of their control in their personal life... for example if your husband left you or your wife left you a day before you see a client who's going through a marriage break-up it's probably not a very good idea if you're feeling emotionally very upset yourself to see that client that day. And so it's important to, you know that's what we use supervision for is to also talk about what's going on for us personally in therapy, and you know sometimes that means clinicians need to get some personal therapy outside of the supervision for themselves to be able to work through that stuff. Because at the end of the day we're all human... it's unrealistic to think we're going to go through life without having our own stressors and personal things going on" (Celia, page 8).

Peer discussion surfaced as a helpful tool in achieving objectivity about themselves, and all participants actively engaged in it. Because therapy tends to be conducted in private with clients, therapists often practise in



isolation which probably makes achieving objective views about one's practise or emotional reactions to clients difficult when ambiguity is present. It is likely that peer discussion provides an informal network of objective opinion which allows therapists to reflect on their own processes in a manner complementary to self reflection. This process is likely to identify areas of practice or emotional reactions that are of little benefit or even harm to either the practitioner or the client. Additionally, peer discussion can support and validate clinicians when ambiguous situations or emotions have surfaced within therapy.

"I use a lot of up and down the corridor reflections as well. Pop into somebody else's room" (Anne, page 8).

"...within our team we also have this great sort of open door policy, where... we can wander down the corridor and have a 5 or 10 minute conversation about a client that we're struggling with" (Bill, page 9).

"...we use peer supervision heaps. In fact we have a peer supervision group which is a group of us who are all about the same level of our training, we just get together and discuss... Bounce off each other- and a lot of it is about some of the struggles with being a clinical psychologist – it's not necessary like client focussed, it's just about what's going on with us. Any burnout issues that might be going on. I think that's really important" (Celia, page 13).

Formal supervision provided a formal supplement to peer discussion for the participants, and was considered especially useful when encountering more complex issues in therapy. The participants also used supervision to obtain more objective perspectives on personal emotions they might be experiencing in their private lives, or in response to some clients.

"I've been doing quite a bit of it lately [discussing clients in supervision]– I've probably had some more complex situations to deals with" (Anne, page 8).

"I... have regular formal supervision which I can take my clients to, my cases, metaphorically" (Bill, page 9).

"[Discussing strategies on an occasion where one client became emotionally dependent on him] Obviously talked about it in supervision" (Bill, page 15).

"...we use supervision... to also talk about what's going on for us personally in therapy... acknowledging it and managing it and feeling like you have colleagues that you can talk to about it and taking it to supervision" (Celia, page 8).

"...very important to take that sort of stuff [client emotional dependence] to supervision because I think the more ears and eyes you can have on the situation the better in some ways" (Celia, page 10).

### **Theme Three: Empathy and Fostering Relationships**

#### *Connecting with Empathy*

Empathy emerged as probably the single most significant emotional tool participants discussed in forging emotional connections with clients.

Therapist experience and display of empathy functions to communicate to the client that they are understood and validates their experience, as empathic attunement is one of the foundational meaningful human interactions present in significant dyadic interaction (Slattery & Park, 2011; Wilkinson, 2010).

“...you need some empathy... to try and tune in with other people’s experience” (Anne, page 5).

“With the nature of my work there are times when I get – I do get sad, I do get tearful at times. It’s not a common occurrence... I think it would be wrong in my work if I didn’t, because some of our situations are very, very sad, and if you can’t connect with that, then... you’re not connecting with where the client is” (Bill, page 7).

“...in that first session the initial focus would be, you know, making them feel like they’ve been empathised with, they’ve been understood” (Celia, page 1).

Participants talked of the necessity of feeling empathy in response to issues raised by clients, both as a means for understanding the client’s situation, but also to monitor that they were tuning into client experience appropriately. Not only does accurate empathic response from therapist to client foster therapist credibility, but clients tend to engage more readily with their therapist, and invest more effort in the exploration and treatment processes (Angus & Kagan, 2007; Slattery & Park, 2011).

The participants considered that their display of empathy was important for clients to perceive as it showed clients that they were understood, and that the therapist felt genuine compassion for their situation. Feeling understood, validated, and cared for are important aspects of socioaffective needs for individuals who have experienced negative emotional events (Rime, 2007). Participants appeared to use both feeling and displaying empathy as a means to validate client experience for themselves and clients respectively.

“I think it is important to feel that empathy, some empathy for the person and understand where they’re coming from...” (Anne, page 7).

"... you go there for two reasons; one is to get the information about how they feel, and how it is for them, so you can understand that; and secondly so that they understand that you understand" (Page 4)." (Bill, page 4).

"Sometimes you'll have a really strong emotional reaction to something that a client says, and I think it's important not to kind of push that away, but to think about, okay what is that telling me about what's going on for this client at the moment, and what's going on in terms of our therapeutic relationship" (Celia, page 3).

The participants ensured that their expressions of empathy conveyed a message of understanding to their clients to validating their experience.

"...it's... like validating but not ramping it up" (Anne, page 18).

"If the emotion is congruent with their emotion, and with the situation, it is useful... It means that you're there with the client. And they know you're with them" (Bill, page 17).

"...at times... I've had the odd tear, my eyes would well up, with clients... just to reflect 'hey, that's pretty hard, even I'm really feeling that emotion now'. So it is just putting out there what you're feeling" (Bill, page 17).

"...there have been times when I've felt quite strong emotion for the pain...that they've been going through in that particular circumstance and I will... reflect that back to them and say 'gosh, I'm just noticing that just listening to your story I'm really feeling so sad for you right now that you've had to go through this situation'. So I think it can be quite therapeutic in that way" (Celia, page 3).

A clear indicator of how participants used empathy to connect emotionally was evidenced in how they responded when sensing a lack of rapport with a client. Participants would ground themselves in the client's experience, allowing them to reconnect on a personal level.

"[When struggling to establish rapport] I wasn't feeling much... it... felt like bouncing off... Not connecting...it became... task-focused... That was the first time [I saw the client]... last time it was better. It's... recognising why it's probably happening. I think [it was] high levels of anxiety on the part of the client...[Next time I met with the client] It was better. Perhaps still a bit on the task-focused side of things, but I think just that kind of acknowledgement... about where this is coming from. How it might feel for her too" (Anne, page 18).

"And so what I do in those situations is, once I've realised that the session isn't going well, that the response I'm getting from the client isn't... there, they're not responding to the things I'm suggesting or just not feeling there's the connection with them. I reconnect with them and their situation... it's very quick, [I] very quickly put myself in their position, in the context of why they've come" (Bill, page 4).

"[If struggling to establish rapport] going back to the basics of matching, understanding their model of the world, spending more time off topic, allowing them to wander... So I take my hands off the steering wheel a little bit more at times... Allowing them time to do their stuff more than to do the stuff that I have in mind for us to work on in session" (Bill, page 16).

"[If a client expressed no benefits were apparent from therapy] sometimes reflecting the sense that actually I'm feeling a little bit lost in these sessions too, like 'I'm not quite sure where to go with you right now either'. Like I think it's okay to acknowledge because you do get to the points with some clients where you think, 'gosh, we've tried everything and nothing seems to be useful' and I think sometimes it can be useful to put yourself in the boat with them" (Celia, page 15).

The participants spoke of voluntarily reverting to empathy when they considered they were losing rapport with the client. The ability to reconnect using voluntary evoking of emotions suggests the participants had a strong mastery of their emotional awareness and processes. The process is similar to Rothbart and Bates' (2006) definition of *effortful control*, using cognitive resources such as executive functioning to inhibit or activate emotional responses to wilfully direct behaviour to achieve goals. Effortful control can be used to wilfully move from automatic thoughts and actions to more contextually adaptive thoughts and actions (Eisenberg, Hofer, & Vaughan, 2007), is associated with lower self-reported psychological distress in adults (Eisenberg et al., 1997), and considered to be linked to effortful emotion self-regulation (Eisenberg, Hofer, & Vaughan, 2007). Personal psychological distress can lead to intense empathic arousal to distress in others, which tends to evoke self-care focused behaviours and decrease commitment to the care of others (Eisenberg, Wentzel, & Harris, 1998). The participants' talked of connecting with empathy where cognitive or emotional awareness of a rupture or disconnection surfaced suggesting that participants may at times rely on effortful control to remedy therapeutic relationship fractures. Interestingly, participants did not appear to use empathy instrumentally or incongruently, which has been suggested as being unhelpful or even harmful to the therapeutic relationship (Levitt & Williams, 2010), but rather reflected on client experience, thereby 'placing themselves in their client's shoes', resulting in genuine empathy for the situation and plight of their client, preserving, strengthening, or repairing the therapeutic relationship.

#### *Limiting Empathy*

Participants considered that there were limits to how much empathy they should express in order to be useful to the client. Each participant spoke of not exacerbating negative client emotion by extending empathy beyond the utility of validating client experience. They spoke of exercising restraint

when expressing empathy to clients, although this varied in response to client need. The concepts of therapeutic usefulness and client welfare remained central.

"...it's ok [for a therapist] to be hugely sad, and it's ok to be anything, I think. But it's what you actually show of those feelings" (Anne, page 11).

"So you've empathised – they've heard that you understand, that this is upsetting. And, you know, 'would you like some tissues'... and then start trying to understand what it is that led to that– what was it that you were thinking about, or that you were talking about that brought that about? So that's sort of like the moving back, the moving to more objective. So we've got the information, I've empathised, I have – I'm don't just say the words. I honestly do empathise. And then – I mean – as it starts to naturally peter down, you know, you don't start moving off when they're still very, very upset" (Bill, page 10).

"...it's almost impossible to say 'this is the limit' [to emotionally connect with clients] because that differs depending on the client" (Celia, page 11).

"But if you notice that's happening all the time [mirroring client emotion to build a therapeutic relationship], sometimes it can get to the point where it's not therapeutic anymore and you actually need to change your way of being, to start modelling a new way of being to them" (Celia, page 12).

Participants spoke of how the expression of empathy focused on showing compassion for the client, without reaching the intensity that personal distress was apparent in the therapist. It is possible that participants' effortful control facilitated appropriate (non-over-aroused) empathic responses to client distress, ensuring they were not personally distressed to the point where self-care or a lapse in client concern resulted. Again, client welfare and therapeutic usefulness was of primary concern for participants. Participants talked of regulating their expression of empathy in terms of intensity and duration. This ensured clients did not feel an obligation to sympathise with their therapist, and that therapists did not unnecessarily extend the duration of negative client emotion.

"I don't know... about... too much, too little... You know maybe when... it's too much... if your client is comforting you... I've never been in that situation" (Anne, page 3).

"...my view of emotions is that they're information. And so once you've got the information, and you've empathised and they know that you understand, the sooner you can move on to solving whatever's causing the emotion the better. So, without shutting down emotions... if somebody's upset and they're crying, I don't sort of 20 seconds later go stop that, we need to move on... But I won't do stuff to purposefully maintain that. I will allow it to peter out" (Bill, page 10).

“Although there is a place for, at times, maybe shedding tears with the client in empathy of their situation... but you don't want to be a bawling mess on the floor with your client – that's not therapeutic either. You don't want your client feeling like they have to rescue you” (Celia, page 9).

Participants did speak of experiencing emotional contagion after work at times, including the possibility of expressing distress once the client had left their office. It is likely that effortful control could vary with transient personal and psychological stressors, and perhaps emotional contagion and therapist burnout reflect such variance. Therapist denial or unawareness of personal and psychological stressors affecting their performance does appear to be associated with burnout and emotional problems (Lalotiotis & Grayson, 1985). Effortful control may be an indirect factor providing resilience to such issues.

As far as the expression of appropriate empathy was concerned, all participants talked of continuing to empathise if clients showed high levels of distress, but also of moving to more outcome-focused processes once client distress was waning. The shift from affective validation to more cognitive task-focused processes is likely to perform emotion regulatory functions as attention shifts from experiencing affect-laden emotional signals to cognition-demanding tasks.

#### **Theme Four: Focusing on Outcomes**

##### *Balancing Relationship and Process*

While each of the participants described themselves as being strongly outcome-focused, all talked of the necessity of establishing rapport and a therapeutic relationship as the primary objective in therapy. They tended to monitor that rapport endured to a degree that a collaborative, therapeutic relationship was maintained when focusing on outcomes.

“I think it is important to feel that empathy, some empathy for the person and understand where they're coming from, and then look at where they want to go, rather than staying where they are” (Anne, page7).

“...it's like the leading...metaphor: if you find you're dragging... you're out of the rapport. And you've got to slow down, and you've got to come back, and you've almost got to let them start walking themselves. And it might be in a slightly different direction from where you want them to go. But you've got to like walk together again for a little while. And then you can gently start to lead them back to where you – it's their direction, alright, cos they've set the goal, so you're not leading them to your goal, but leading them in your path to get to that goal...

Their path might well be fine... let them try their treatment plan if it's different from yours. And if that doesn't work then say 'hey, how about we try mine, how about we try this'" (Bill, page 16).

"...we're the professionals, it's our job to meet them where they are, and move with them to where they want to get to. Whatever way works" (Bill, page 5).

"We like to think that it's all about collaborating with the client and supporting them in doing what they want to do, and yes, you are doing that but in the process of that you are influencing them in some way, absolutely. And that's what psychology is about at the end of the day" (Celia, page 15).

Participants talked of variability in the ease with which rapport was established or sustained with different clients, such as in cases where age differences or a focus on process may have a negative effect on rapport. This highlights that therapists who on average obtain good client outcomes are likely to be flexible and adapt their methods and interactions to suit client needs and expectations. The participants talked of differing strategies suiting differing clients, and of adjusting their role in a sensitive manner that allowed for some flexibility depending on client needs or expectations.

"[In matching client needs] That's the line, I guess – that's why it's so hard to put into words – you know, where you position yourself. It's a constant interchange isn't it" (Anne, page 13).

"Sometimes I'll say something which might be confrontational, or it might be challenging, and if I see I get a really negative reaction I'll just go 'well that's just my impression anyway'. So, yeah really downplaying the statement or 'that's what I was thinking, what do you think?'. You know, so you've suddenly taken it from 'I'm the expert giving this to this statement' to the backing right of and saying 'hey this is just a possibility, what do you think?'" (Bill, page 3).

"[If sensing his connection with his client was lost] I just step back into their shoes, which takes a second. I go 'shoot, this person's important, they're here with need', and just really connect into their [experience]– and the relationship quickly recovers and the session's back on track" (Bill, page 4).

"...a lot of the clients that I work with are older than me so I think when you have a younger therapist working with an older client it can take a little bit longer to build that rapport, initially" (Celia, page 2).

"...you do have to - with some clients - spend more time building rapport and creating the sort of relationship that you want to have" (Celia, page 3).

### *Working Collaboratively*

Participants spoke of fostering an environment where their clients felt validated, accepted, safe, and able to work collaboratively with the therapist.

"[Communicating] that I am trustworthy and reliable and professional and that I'm a safe person that they can talk to about things, and that we can work together, collaboratively... which I think is genuine" (Anne, page 16).

"[As a client] you also have to feel cared for by the therapist, and you have to feel as though this person actually cares. So you can then open up, and be honest, respect and listen to what they say" (Bill, page 11).

"...in that first session the initial focus would be, you know, making them feel like they've been empathised with, they've been understood. And, really getting them wanting to come back, and if I don't get everything else covered that I want to cover in the initial assessment that's okay" (Celia, page 1).

"... if I don't get everything else covered that I want to cover in the initial assessment that's okay. As long as that's the case, well we've established that they're safe" (Celia, page 1).

Participants considered that this environment allowed clients to experiment with new strategies and attitudes, using the therapist as a guide in forming new ideas and attitudes that would allow them to make positive changes in their lives.

"We're trying to create an environment where people feel like it's ok to come and talk about stuff, and do some things differently" (Anne, page 16).

"I work with people who are grieving a lot of the time... either for changes in their life, or changes in a special person's life. So, you know, there's sometimes no easy fix for that. There's some things we can do to reduce it...it's totally okay for them to come in and be really upset again, but then for us to sort of work on... this is great, this is fine, this is an absolutely safe place to do that, but you don't want to be doing that all the time, so what are some things that you can learn to do that allow you to not be there long term... Are you actually holding it together out there in the world, and this is your place to let it go, in which case that's okay as well" (Bill, page 16).

"...the relationship, it makes them comfortable and then it allows me to do a variety of things within the context, and I can get away with those things because the relationship's good" (Bill, page 1).

"...the therapeutic relationship is a really good opportunity to practise new ways of being in a safe place, in a safe environment, and so you have to think of it as kind of like experimenting at times, in session, experimenting with new ways of being" (Celia, page 11).

"... you always have to be conscious of the fact that as a therapist you are modelling ways of being with people – with the client – and so you have to be conscious of 'is the way that I'm modelling to be with other people, is that one that I want them to take outside of this session, or is it one that I don't think is that useful for them'" (Celia, page 11).

Participants took responsibility for fostering the relationship, allowing clients to focus on the tasks of making changes in behaviours or thought patterns. Because these therapists foster an environment of positive regard, trust,



and safety, clients are probably more comfortable trying new strategies, can experiment without suffering anticipated negative interpersonal consequences, and begin to build self-efficacy and confidence in changes they have made.

### **Discussion**

Although not included as a master or superordinate theme, perhaps the most recurring subject evidenced throughout all interviews is that participant therapists considered client safety, welfare, and positive change most important in their work. Participants on occasion discussed experiencing negative emotion in their private life with the propensity to contaminate their professional role as therapists, and in these cases their primary concern appeared to be ensuring their emotional state did not interfere with their delivery of effective and beneficial services to their clients. It was unclear whether this priority was a facet of participants' dedication to their professional role, or due to their personal characteristic of caring for other people, although within the context of each interview, the researcher concluded that prioritising client needs was likely a mixture of the two variables.

It appears that the participants met all criteria of being deemed emotionally competent, at the very least in their role of being a therapist. Revisiting Saarni's (1999) framework of emotional competence, the participants discussed their use of emotion in a manner that encompassed all eight skills, as follows:

1) Self awareness of emotion states was reflected in theme two through participants' mindfulness of their own emotions both in and out of therapy, and their varied methods in achieving objectivity about their emotion awareness.

2) Awareness of others' emotions was reflected in all four themes, as participants talked of monitoring client emotion for information, sometimes using their own emotional responses to understand client emotion, adjusting their levels of empathy to benefit current client emotional states, and balancing the alliance with outcome process.

- 3) Verbal expression of emotion was evident in all themes as participants spoke of thinking and reflecting on their own emotional processes and of different emotions they had experienced.
- 4) Empathic capacity was apparent in theme three as participants spoke of the importance of experiencing and showing empathy when appropriate to their clients; furthermore, participants talked of regulating their expression of empathy to the best interest of their clients in the therapeutic context.
- 5) Awareness of potential differences between felt and expressed emotions was evident in themes two and three where participants talked of experiencing certain emotions in therapy, such as frustration, that they would avoid expressing to clients because they considered it unhelpful. Participants also talked of verbally raising the subject of incongruence between felt and expressed emotion with their clients when they identified such incongruence.
- 6) Adaptation and coping through self-regulatory strategies was seen in themes two and four, where participants spoke of focusing on outcome processes or re-focusing on their client's experience when unhelpful emotions arose. A conscious shift in attention appeared to be a central feature in regulating unhelpful emotions for the participants.
- 7) Awareness of the importance of emotional communications within relationships to the nature of the relationship was evidenced in all themes as participants discussed being aware of the potential impacts of their emotional communications on their clients. They spoke of using positivity and compassion to foster strong rapport and build collaborative relationships, monitored the expression of their own emotional communication by limiting negative affect and ensuring appropriate empathy was expressed.
- 8) Emotional self-efficacy was again evident in all themes as participants talked of genuine expressions of positive personal characteristics, spoke of being aware and comfortable with the majority of their felt and expressed emotions, and considered it important to model to, and foster such qualities in, their clients.

According to Saarni's (1999) criteria, all of the participants in the present study qualified to be labelled as emotionally competent. It should be noted that Saarni's definition of emotional competence is directed at people in general, and it may be that the professional role of being a therapist either facilitates emotionally competent behaviours and skills by prioritising another's needs over one's own, or perhaps most therapists embody emotionally competent skills because of personality characteristics that draw them to such work. However, the literature on therapist burnout reviewed in chapter two does suggest that not all therapists embody emotionally competent skills, suggesting the utility in future studies of comparing successful therapist skills with those of therapists who achieve less successful client outcomes.

The dynamics of the therapeutic relationship between therapist and client are in some ways similar to adult dyadic relationships, but in many ways this relationship is unique. Adult friendships tend to be reciprocal, where both individuals support one another, and derive support from the presence and verbal interaction within the dyad. In therapy, the therapist does not (or at least should not) look to meet their own interpersonal needs for affirmation, validation, support, or emotional regulation. The therapist places client needs before their own, and is able to monitor, assess, confirm, and hopefully meet these needs. This implies that the interpersonal emotion heuristics within the therapeutic relationship are different to perhaps any other interpersonal dyadic relationships. If this is the case, then there may be a need to develop a unique model of emotional competence for therapists in their professional role.

In light of other studies reviewed in chapter two, the present study results appear to reiterate much of the findings on therapist emotion variables. The present study elaborated on therapists' use of mindful empathy and its role in fostering the therapeutic relationship, and the implication that congruence does not automatically extend to all facets of the therapists' emotional activity, but is also regulated by the participants in a manner most likely to lead to the expression of positive and useful emotions to clients. This finding was similar to Levitt and Williams' (2010) conclusion about eminent therapists' use of empathy, where empathy was only

considered useful if expressed genuinely. The present study showed that when participants perceived a lack of appropriate empathic response to their client, they would resolve the issue by grounding themselves in client experience, which led to the generation of a genuine empathic response.

The present study found that participants highly valued self reflection and supervision to augment objectivity, mirroring findings by Jennings and Skovholt (1999). Genuineness encompassed congruence, authenticity and honesty, and reflected that participants believed in the importance of engaging clients with congruent aspects of their individual personalities. Participants in the present study also discussed aspects of their private lives in relation to their identity as a therapist, highlighting their awareness of how emotional well-being and life experience was a facet of their congruent professional identity, as Jennings and Skovholt found in their third emotional domain.

In the present study, participants spoke of the importance of the therapeutic alliance to facilitating therapeutic change through connecting with clients, including positive expectations of methods and clients, and respect for clients and for their autonomy through sensitive tailoring of therapy reflecting similar values to those found by Jennings and Skovholt (1999) and Levitt and Williams (2010).

As reflected in both Jennings and Skovholt's (1999) and Levitt and Williams' (2010) studies, the present study found that a safe and supportive environment for clients was considered paramount to facilitating the challenging and/or addressing of major client issues, and participants also spoke of the importance of allowing clients space and safety to experience strong emotions if they arose during therapy. The present study found that participants considered genuineness, attunement to client needs, and the display of genuine empathy were important to developing a safe and secure environment in which clients could discuss and work on issues, a finding almost identical to that of Levitt and Williams.

The present study showed that participants considered that the working relationship with their clients needed to be sensitively tailored to suit client needs and expectations, resulting in the formulation of mutually agreed therapeutic goals, a finding closely resembling Levitt and Williams' (2010)

finding of eminent therapists' focus on client needs and goals in the formation of a plan of therapy, and Blatt, Sanislow, Zuroff, & Pilkonis' (1996) finding that more effective therapists tended to focus on the underlying causation of issues rather than explicitly focusing on symptoms. Similarly, the formation of a therapeutic relationship was considered a precursor to the application of therapeutic process technique, highlighting the primary importance of the therapeutic relationship, as also reflected in Jennings and Skovholt's (1999) study.

Many of the variables that Ackerman and Hilsenroth (2003) found in their meta-analysis on helpful variables and techniques were also apparent in the present study. Participants spoke of flexibility and openness in attending to client experience and tailoring therapy. Respect and interest was present in how participants talked of valuing client opinion, expectation, and, autonomy. Warmth was considered important in facilitating good therapeutic relationships and in the expression of genuine empathy. Trustworthiness arose in participants' talking of being genuine and explicating the process of therapy to their clients. Confidence was reflected in how participants strongly believed in their therapeutic methods, the positive expectations with which they approached their clients, and indirectly, in how participants achieved reflective objectivity through peer discussion, supervision, and checking interpretations with clients to ensure accuracy.

### **Implications**

The present study confirmed much of what the literature review showed about personality and emotional variables of successful therapists. These three therapists who achieved excellent client outcome results demonstrated through a discussion of their knowledge about their use of emotion in therapy that they believe it is important to be genuine, tailor therapy to client needs, hold and reflect positive expectations of clients and therapeutic methods, be emotionally self aware as well as correctly identifying client emotions and strive for objectivity in such awareness through peer discussion, supervision, and checking with clients, feel and display appropriate empathy, balance the therapeutic process with the

therapeutic relationship, and work collaboratively with clients towards positive change. While many of these skills are commonly thought of as relatively static personality variables, recent tentative evidence suggests that such skills could be learned through training procedures.

Gains in emotional competence can potentially be facilitated in adulthood, leading to positive increases in functioning of emotional regulation and understanding, gains in psychological and physical well-being, as well as increasing positive aspects of social relationships (Kotsou, Nelis, Gregoire, & Mikolajczak, 2011; Nelis et al., 2011). Nelis and her colleagues conducted two controlled experimental studies with undergraduate students, finding that 18 hours of emotional competence training sessions (broadly focusing on understanding, identifying, managing, and expressing emotions in self and other, as well as enhancing positive emotions) resulted in lasting (at six months) gains in the aforementioned skills. If it is indeed possible to increase emotional competence in adult students, then such a programme could be invaluable in academic training programmes for students intending to enter the mental health helping professions, or even for professionals already working in this field. The present study could potentially contribute its findings in directing which areas should be focused on in the training of new therapists.

It appears that historically, exemplar therapists have been selected based on a myriad of qualifiers, including that they are respected by many colleagues, have created new therapeutic approaches, have published over 100 papers on psychotherapy, or would be the therapist of choice for other therapists seeking assistance. Despite the differing inclusion criteria, it appears the emotional skills and functioning of such therapists broadly fall in agreement between these studies and the present one. One particular strength in the present study was in basing inclusion criteria on client outcomes, as the resulting therapist demographics reflected a less restricted sample of participants than other studies have done. For instance, Jennings and Skovholt's (1999) participants were aged between 50 to 72 years, while the current study's mean age of participants was 43 years. Participants in the current study had practised therapy for an average of 7 years, while Jennings and Skovholt's participants had at least 21 years' experience,

similar to Levitt and Williams' (2010) study where participants had at least 20 years' experience. By restricting participant intakes to only include senior professionals and highly experienced therapists, studies may risk blurring effective emotional skills with therapist variables perhaps gained through sheer experience or gains made in emotional functioning as a result of engaging in extended practice. It would be disheartening indeed for younger therapists to learn that the best, or perhaps the only sure, way to become an effective therapist is to have upwards of 20 years' experience. Hopefully the practice of studying master therapist variables will increasingly adopt the practise of the current study and examine positive client outcomes as a qualifier for determining excellent therapists.

### **Limitations**

The results of this study are not generalisable to all therapists. In any study with a small sample of participants, results cannot be assumed to apply to others in the field. However, this was not the purpose of the present study, and finding commonalities between the three participants working in similar positions with similar theoretical orientations may have provided some useful insights into the facets of emotional competence within this field in light of the similarities found when compared with similar studies.

Because only therapists who responded to the advertisement were included in this study, a self-selection bias was present. For instance, it may be possible that certain extrovert tendencies are common between therapists who forward themselves for research such as the present study, and that such tendencies also impact on the use of emotion in interpersonal communication and building therapeutic relationships. Future studies assessing therapists' use of emotion in therapy may control for such unidentified personality variables by including the administration of established personality tests.

All participants did have proven track records using the ASIST programme, but in the course of discussing the use of this programme with other therapists it became apparent that some psychologists only used the ORS with clients they thought had not benefitted from therapy to the full extent; a process which artificially lowered their ASIST scores. Since inclusion

criteria included ASIST Normative Comparison Scores of .7 or higher, some effective therapists may have been excluded from participating in the study.

Focusing on one measure of client outcome may have placed too much reliance on the validity and reliability of that measure. In future research, multiple measures of client outcome may provide more empirical outcome data, such as using the ASIST (Elliott, 2011) Normative Comparison Scores in conjunction with the Outcome Questionnaire-45 (OQ-45; Lambert et al., 2004). However, limiting participant inclusion criteria to professionals using one specific outcome measure meant that only a select pool of potential participants was available, an issue that would be magnified if more client outcome measures were required for inclusion.

Furthermore, a qualitative project such as the present study would have benefitted from multiple analyses by co-researchers in order to obtain a degree of consensus on how the themes emerged from the data. As the researcher was essentially working in isolation, with the only verification being a participant check on the case-study analysis of their individual contribution, it was difficult to ascertain if an objective perspective had been reached in the final report.

### **Directions for Future Research**

This study used client outcomes as the criteria for selecting successful therapists, a method increasingly lauded as important for ensuring that research examining the effectiveness of therapist variables focus on variables likely to lead to positive client outcomes (e.g., Kraus et al., 2011; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Orlinsky, 1999). While client outcomes have long been taken into account when investigating the effectiveness and efficacy of therapeutic techniques, intervention formulations, and myriad therapist effects outside of the domain of emotion (Lambert & Ogles, 2004), client outcome has not tended to be taken into account in the sparse research literature examining therapist emotion effects. Future studies should ensure that in defining successful therapist emotion characteristics, client outcomes are taken into account.

Increasingly sophisticated technologies are now allowing researchers to begin to examine the functional and developmental aspects of neurobiological processes involved in emotion in greater detail. This



integrative field of research has often looked to attachment theory as a paradigm that provides theoretical support for its findings (Chae, Ogle, & Goodman, 2009; Schore, 2003, 2009; Shaver, Mikulincer, & Chun, 2008; Siegel, 1999; Wilkinson, 2010). Space limitations for this paper meant this field could not be addressed to the level of detail it probably deserves. Future studies investigating therapist attachment style and client outcomes may assist researchers in identifying emotional characteristics of successful therapists.

The interview questions for this study focused broadly on emotions, which meant responses tended towards non-specific use of emotion. In future, perhaps a series of studies each investigating specific aspects of emotion, such as empathy or positive expectations, might yield the level of detail required to assert how individual emotions are experienced and expressed with a variety of clients.

Lastly, the present study could have benefitted from the presence of a control group with which to contrast the current findings. Future studies could include a sample of therapists whose clients report low benefits or negative outcomes as a result of therapy, providing an illuminating contrast to highlight which emotional skills are unique to exceptional therapists.

### **Conclusion**

The tentative conclusion of the present study is that the participants appeared to meet all of Saarni's (1999) eight criteria for emotional competence, confirmed previously postulated emotional and relational characteristics of master therapists (Jennings & Skovholt, 1999), spoke of using similar emotional skills as Levitt and Williams' (2010) eminent therapists in facilitating client change, and embodied the emotion-related attributes and techniques that positively influence the therapeutic alliance (Ackerman & Hilsenroth, 2003).

Some additional detail of how the participants used emotion in therapy was apparent, similar to Levitt and Williams' (2010) findings. While participants did use their own emotion in therapy, they strongly regulated their emotional expression to clients. The utility of expressed emotion to client benefit tended to be carefully considered, and centered on positive expectations and appropriate empathy. None of the participants spoke of

expressing negative emotion such as anger or disappointment to their clients. Participants spoke of experiencing a broader range of emotions internally than they expressed, and focused on the importance of processing and coping in various different ways with emotions considered unhelpful to their clients.

It was clear that participants considered the establishment of a safe and non-judgemental therapeutic relationship important in allowing clients the safety and freedom required to discuss difficult issues and practise new ways of being. The participants considered client needs and expectations paramount, and ensured the process of therapy was individually tailored to each client.

If there was one common thread present throughout the interviews in the present study, it was that these excellent therapists carefully considered whether the actions and decisions they made within therapy held benefits with the potential to facilitate positive change for their clients. They possessed solid knowledge of emotional processes, and were able to use their knowledge to explore both the client's and their own emotions in order to facilitate their understanding of client issues and needs. Participants possessed the emotional skills required to ensure that their client's safety, welfare, and benefits to positive change were prioritised throughout the process of therapy.

## REFERENCES

- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting on the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Erlbaum.
- Allen, J. G. (2001). *Traumatic relationships and serious mental disorders*. Great Britain: John Wiley & Sons, Ltd.
- Allen, J., Fonagy, P., & Bateman, A. (2008). *Mentalizing in clinical practice*. Arlington, VA: American Psychiatric Publishing.
- Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A., (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*, 755—768.
- Andrews, H. B. (2000). The myth of the scientist-practitioner: A reply to R. King (1998) and N. King and Ollendick (1998). *Australian Psychologist, 35*, 60-63.
- Angus, L., & Kagan, F. (2007). Empathic relational bonds and personal agency in psychotherapy: Implications for psychotherapy supervision, practice, and research. *Psychotherapy: Theory, Research, Practice, Training, 4*, 371-377.
- Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 335-356). Oxford, United Kingdom: Oxford University Press.
- Asay, T. P., & Lambert, M. J. (1999). The empirical case for common factors in therapy: Quantitative findings. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-55). Washington, DC: American Psychological Association.

- Bakermans-Kranenburg, M. J., & van Ijzendoorn, M. H. (2009). The first 10,000 Adult Attachment Interviews: Distribution of adult attachment representations in clinical and non-clinical groups. *Attachment and Human Development, 11*, 223-263.
- Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability within the alliance. *Journal of Consulting and Clinical Psychology, 75*, 842-852.
- Baumeister, R. F., Zell, A. L., & Tice, D. M. (2007). How emotions facilitate and impair self-regulation. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 408-426). United States of America: Guilford Press.
- Ben-Ari, A., & Lavee, Y. (2005). Dyadic characteristics of individual attributes: Attachment, neuroticism, and their relation to marital quality and closeness. *American Journal of Orthopsychiatry, 75*, 621–631.
- Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 227–306). New York, NY: Wiley.
- Bischof, S., Lau, M., Shapiro, S., Carlson, L., Anderson, N., & Carmody, J. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice, 11*, 230-241.
- Black, S., Hardy, G., Turpin, G., & Parry, G. (2005). Self-reported attachment styles and therapeutic orientation of therapists and their relationship with reported general alliance quality and problems in therapy. *Psychology and Psychotherapy, 78*, 363-377.
- Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analysis of data from the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 64*, 1276-1284.

- Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of attitudes and practices. *Professional Psychology: Research and Practice, 20*, 283-293.
- Bowlby, J. (1958). The nature of a child's tie to his mother. *International Journal of Psycho-Analysis, 39*, 350-373.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York, NY: Basic Books.
- Bringhurst, D. L., Watson, C. W., Miller, S. D. & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: A replication study of a brief clinical measure. *Journal of Brief Therapy, 5*, 23-30.
- Brody, N. (2004). What cognitive intelligence is and what Emotional Intelligence is not. *Psychological Inquiry, 15*, 234–238.
- Chae, Y., Ogle, C., & Goodman, G. S. (2009). Remembering negative childhood experiences: An attachment theory perspective. In J.A. Quas and R. Fivush (Eds.), *Emotion and memory in development: Biological, cognitive, and social considerations* (pp. 3-27). New York: Oxford University Press.
- Cicchetti, D., & Lynch, M. (1995). Failures in the expectable environment and their impact on individual development: The case of child maltreatment. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology* (pp. 32-71). New York: Wiley.
- Colle, L., & Del Giudice, M. (2011). Patterns of attachment and emotional competence in middle childhood. *Social Development, 20*, 51-72.
- Critchley, H., Elliott, R., Mathias, C. J., & Dolan, R. J. (2000). Neural activity relating to generation and representation of galvanic skin conductance responses: A functional magnetic resonance imaging study. *Journal of Neuroscience, 20*, 3033-3040.
- Crits-Cristoph, P., Connolly Gibbons, M. B., Hamilton, J., Ring-Kurtz, S., & Gallop, R. (2011). The dependability of alliance assessments: The alliance outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology, 79*, 267-278.

- Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of Consulting and Clinical Psychology, 59*, 20–26.
- Davidson, R. J., Scherer, K. R., & Goldsmith, H. H. (2003). *Handbook of affective sciences*. New York, NY: Oxford University Press.
- Davila, J., Bradbury, T. N., & Fincham, F. (1998). Negative affectivity as a mediator of the association between adult attachment and marital satisfaction. *Personal Relationships, 5*, 467–484.
- Davila, J., & Levy, K. N. (2006). Introduction to the special section on attachment theory and psychotherapy. *Journal of Consulting and Clinical Psychology, 74*, 989-993.
- Diener, M. J., & Munroe, J. M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review, *Psychotherapy, 48*, 327-248.
- Dinger, U., Strack, M., Sachsse, T., & Schauenburg, H. (2009). Therapists' attachment, patients' interpersonal problems and alliance development over time in inpatient psychotherapy. *Psychotherapy Theory, Research, Practice, Training, 46*, 277-290.
- Duncan, B. L. (2010). *On Becoming a better therapist*. Washington, DC: American Psychological Association.
- Eatough, V., & Smith, J. A. (2008). Interpretive Phenomenological Analysis. In C. Willig and W. Stainton-Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (pp. 179-194). London: Sage Publications.
- Eisenberg, N., Guthrie, I. K., Fabes, R. A., Reiser, M., Murphy, B. C., Holgren, R., Maszk, P., & Losoya, S. (1997). The relations of regulation and emotionality to resiliency and competent social functioning in elementary school children. *Child Development, 68*, 295-311.

- Eisenberg, N., Hofer, C., & Vaughan, J. (2007). Effortful control and its socioemotional consequences. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 287-306). United States of America: Guilford Press.
- Eisenberg, N., Wentzel, M., & Harris, J. D. (1998). The role of emotionality and regulation in empathy-related responding. *School Psychology Review, 27*, 506-521.
- Elliott, D. (2011). ASIST Outcome Management Software. Retrieved on 30-10-2011 from <http://www.clientvoiceinnovations.com/index.html>
- Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice, 24*, 83-90.
- Emery, S., Wade, T. D., & McLean, S. (2009). Associations among therapist beliefs, personal resources and burnout in clinical psychologists. *Behaviour Change, 26*, 83-96.
- Fiori, M., & Antonakis, J. (2010). The ability model of emotional intelligence: Searching for valid measures. *Personality and Individual Differences, 50*, 329-334.
- Fox, E. (2008). *Emotion science*. London: Palgrave Macmillan.
- Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change*. Washington DC: American Psychological Association.
- Gilbert, P. (2007). Evolved minds and compassion in the therapeutic relationship. In P. Gilbert and R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioural psychotherapies* (pp. 106-142). East Sussex, United Kingdom: Routledge.
- Gilbert, P., & Leahy, R. L. (2007). Introduction and overview: Basic issues in the therapeutic relationship. In P. Gilbert and R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioural psychotherapies* (pp. 3-23). East Sussex, United Kingdom: Routledge.

- Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P.M. Camic, J.E. Rhodes, and L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 234-273). Washington, DC: American Psychological Association.
- Goldfried, M. R., & Raue, P. J. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioural and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66*, 803-810.
- Greenberg, L. S. (2007). Emotion in the therapeutic relationship in emotion-focused therapy. In P. Gilbert & R.L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 43-62). East Sussex, Great Britain: Routledge.
- Greenberg, L. S. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology, 49*, 49-59.
- Greenberg, L. S. (2011). Emotion-focused therapy. Washington, DC: American Psychological Association.
- Hamarta, E., Deniz, M. E., & Saltali, N. (2009). Attachment styles as a predictor of emotional intelligence. *Educational Sciences: Theory & Practice, 9*, 213-229.
- Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., et al. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*, 155-163.
- Hardy, G., Cahill, J., & Barkham, M. (2007). Active ingredients of the therapeutic relationship that promote client change: A research perspective. In P. Gilbert & R.L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 24-42). East Sussex, Great Britain: Routledge.
- Hare, R. D. (1999). *Without conscience: The disturbing world of the psychopaths among us*. New York, NY: Guilford Press.



- Hatfield, E., Rapson, R. L., & Le, Y.L. (2009). Emotional contagion and empathy. In J. Decety and W. Ickes (Eds.), *The social neuroscience of empathy*. United States of America: MIT Press.
- Hazan, C., & Shaver, P. R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *59*, 270-280.
- Hesse, E. (1999). The Adult Attachment Interview: Historical and current perspectives. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of attachment* (pp. 395-433). New York, NY: Guilford.
- Hick, S. F. (2008). Cultivating therapeutic relationships: The role of mindfulness. In S.F. Hick and T. Bien (Eds.), *Mindfulness and the therapeutic relationship*. United States of America: Guilford Press.
- Hill, C. E., Sim, W., Spangler, P., Stahl, J., Sullivan, C., & Teyber, E. (2008). Therapist immediacy in brief psychotherapy therapy: Case Study II. *Psychotherapy: Theory, Research, Practice, Training*, *45*, 298-315.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139-149.
- Izard, C. E. (2007). Basic emotions, natural kinds, emotion schemas, and a new paradigm. *Perspectives in Psychological Science*, *2*, 260-280.
- Jenaro, C., Flores, N., & Arias, B. (2007). Burnout and coping in human service practitioners. *Professional Psychology: Research and Practice*, *38* (1), 80-87.
- Jennings, L., Goh, M., Skovholt, T. M., Hansou, M., & Banerjee-Stevens, D. (2003). Multiple factors in the development of the expert counselor and therapist. *Journal of Career Development*, *30*, 59-72.
- Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology*, *46*, 3-11.
- Kalat, J. W., & Shiota, M. N. (2007). *Emotion*. Canada: Thomson Wadsworth.

- Kaplowitz, M. J., Safran, J. D., & Muran, C. J. (2011). Impact of therapist emotional intelligence on psychotherapy. *Journal of Nervous and Mental Disease, 199*, 74-84.
- Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. New York: Oxford University Press.
- Keele, S. M., & Bell, R. C. (2008). The factorial validity of emotional intelligence. An unresolved issue. *Personality and Individual Differences, 44*, 487–500.
- Keele, S. M., & Bell, R. C. (2009). Consensus scoring, correct responses and reliability of the MSCEIT V2. *Personality and Individual Differences, 42*, 740-747.
- Kendall, P. C., Holmbeck, G., & Verduin, T. (2004). Methodology, design, and evaluation in psychotherapy research. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 16-43). New York, NY: Wiley.
- Kennedy, J. H., & Kennedy, C. E. (2004). Attachment theory: Implications for school psychology. *Psychology in the schools, 41*, 247-259.
- Kotsou, I., Nelis, D., Gregoire, J., & Mikolajczak, M. (2011). Emotional plasticity: Conditions and effects of improving emotional competence in adulthood. *Journal of Applied Psychology, 96*, 827-839.
- Kramen-Kahn, B., & Hansen, N.D. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. *Professional Psychology: Research and Practice, 29*, 130-134.
- Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S, & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*, 267-276.
- Ladnier, R. D., & Massanari, A. E. (2000). Treating ADHD as attachment deficit hyperactivity disorder. In T. M. Levy (Ed.), *Handbook of Attachment Interventions*. San Diego, California: Academic Press.
- Laible, D. (2007). Attachment with parents and peers in late adolescence: Links with emotional competence and social behavior. *Personality and Individual Differences, 43*, 1185-1197.

- Lalotis, D. A., & Grayson, J. H. (1985). Psychologist heal thyself: What is available for the impaired psychologist? *American Psychologist, 40*, 84-96.
- Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J.C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 17-32). New York, NY: Oxford.
- Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., et al. (2004). Administration and Scoring Manual for the Outcome Questionnaire - 45. Orem, UT: American Professional Credentialing Services.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 139-193). New York, NY: Wiley.
- Lawler, E. J., & Thye, S. R. (2006). Social exchange theory of emotions. In J.E. Stets and J.H. Turner (Eds.), *Handbook of the sociology of emotions* (pp. 295-320). United States of America: Springer Science.
- Lazarus, R. S., (1991). *Emotion and adaptation*. New York, NY: Oxford University Press.
- Leahy, R. L., Trich, D., & Napolitano, L. A. (2011). *Emotion regulation in psychotherapy*. New York, NY: Guilford Press.
- Lebow, J. (2006). *Research for the psychotherapist: From experience to practice*. New York, NY: Routledge Taylor & Francis Group.
- Levitt, H. M., & Williams, D. C. (2010). Facilitating client change: Principles based upon the experience of eminent psychotherapists. *Psychotherapy Research, 20*, 337-352.
- Liotti, G. (2007). Internal working models of attachment in the therapeutic relationship. In P. Gilbert and R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioural psychotherapies* (pp. 143-161). East Sussex, United Kingdom: Routledge.

- Locke, E. A. (2005). Why emotional intelligence is an invalid concept. *Journal of Organizational Behavior, 26*, 425-431.
- Luborsky, L., McClellan, T., Woody, G., O'Brien, C., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42*, 602–611.
- MacCann, C., Roberts, R. D., Matthews, G., & Zeidner, M. (2004). Consensus scoring and empirical option weighting of performance-based emotional intelligence (EI) tests. *Personality and Individual Differences, 26*, 645-662.
- Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M.T. Greenberg and D. Cicchetti (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 121-160). Chicago, IL: University of Chicago Press.
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.
- Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. Sluyter (Eds.), *Emotional development and emotional intelligence: Educational implications* (pp. 3–31). New York, NY: Basic Books.
- Mayer, J. D., Salovey, P., & Caruso, D. R. (2002). *Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) user's manual*. Toronto, Ontario, Canada: Multi-Health Systems.
- Mayer, J. D., Salovey, P., & Caruso, D. R. (2008). Emotional intelligence: New ability or eclectic traits? *American Psychologist, 63*, 503-517.
- McCarthy, W. C., & Frieze, I. H. (1999). Negative aspects of therapy: Clients' perceptions of therapists' social influence, burnout, and quality of care. *Journal of Social Issues, 55*, 33-50.
- Merten, J. (2005). Facial microbehavior and the emotional quality of the therapeutic relationship. *Psychotherapy Research, 15*, 325-333.

- Mikulincer, M., Gillath, O., & Shaver, P. R. (2002). Activation of the attachment system in adulthood: Threat-related primes increase the accessibility of mental representations of attachment figures. *Journal of Personality and Social Psychology, 83*, 881-895.
- Mikulincer, M., & Shaver, P. R. (2007). *Attachment in Adulthood: Structure, dynamics, and change*. New York, NY: Guilford Press.
- Miller, P. J., & Sperry, L. (1987). The socialisation of anger and aggression. *Merrill-Palmer Quarterly, 33*, 1-31.
- Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of brief Therapy, 5*, 5-22.
- Nelis, D., Kotsou, I., Quoidbach, I., Hansenne, M., Weytens, F., Dupuis, P., Mikolajczak, M. (2011). Increasing emotional competence improves psychological and physical well-being, social relationships, and employability. *Emotion, 11*, 354-366.
- New Zealand Psychologists Board (2011). *Core competencies for the practice of psychology in New Zealand*. Wellington, New Zealand: Author. Retrieved on 14-12-2011 from [http://www.psychologistsboard.org.nz/cms\\_show\\_download.php?id=41](http://www.psychologistsboard.org.nz/cms_show_download.php?id=41)
- Ochsner, K. N., & Gross, J. J. (2005). The cognitive control of emotion. *Trends in Cognitive Sciences, 9*, 242-249.
- de Oliveira, J. A., & Vandenberghe, L. (2009). Upsetting experiences for the therapist in-session: How they can be dealt with and what they are good for. *Journal of Psychotherapy Integration, 19*, 231-245.
- Oppenheim, D. & Koren-Karie, N. (2009). Mother-child emotion dialogues: A window into the psychological secure base. In J.A. Quas and R. Fivush (Eds.), *Emotion and memory in development: Biological, cognitive, and social considerations* (pp. 142-165). New York, NY: Oxford University Press.

- Orlinsky, D. E. (1999). The master therapist: Ideal character or clinical fiction? Comments and questions on Jennings and Skovholt's "The cognitive, emotional, and relational characteristics of master therapists". *Journal of Consulting Psychology, 46*, 12-15.
- Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 307-389). New York, NY: Wiley.
- Petrides, K. V. (2009). Psychometric properties of the trait emotional intelligence questionnaire (TEIQue). In C. Stough, D. H. Saklofske, & J. D. A. Parker (Eds.), *Current advances in the assessment of emotional intelligence* (pp. 85–101). New York, NY: Springer.
- Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42*, 993-1006.
- Rapley, T. (2011). Some pragmatics of data analysis. In D. Silverman (Ed.), *Qualitative research* (3<sup>rd</sup> ed.), (pp. 273-290). London, United Kingdom: SAGE Publications Ltd.
- Reeve, J. (2009). *Understanding motivation and emotion* (5<sup>th</sup> ed.). United States of America: John Wiley and Sons, Inc.
- Reynolds Welfel, E., & Patterson, L. E. (2005). *The counseling process: A multitheoretical integrative approach* (6<sup>th</sup> ed.), United States of America: Thomson Brooks/Cole.
- Rogers Kobak, R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representations of self and others. *Child Development, 59*, 135-146.
- Roisman, G. I., Collins, W. A., Sroufe, L. A., & Egeland, B. (2005). Predictors of young adults' relationships of and behavior in their current romantic relationship: Prospective tests of the prototype hypothesis. *Attachment & Human Development, 7*, 105-121.

- Rothbart, M. K., & Bates, J. E. (2006). Temperament. In W. Damon and N. Eisenberg (Eds.), *Handbook of child psychology: Volume 3. Social, emotional, and personality development* (6<sup>th</sup> ed.), (pp. 99-166). New York, NY: Wiley.
- Rottenberg, J., & Johnson, S. L. (2007). Introduction: Bridging affective and clinical science. In J. Rottenberg and S. L. Johnson (Eds.), *Emotion and psychopathology: Bridging affective and clinical science* (pp. 3-9). Washington, DC: American Psychological Association.
- Saarni, C. (1999). *The development of emotional competence*. United States of America: The Guilford Press.
- Sauer, E. M., Lopez, F. G., & Gormley, B. (2003). Respective contributions of therapist and client adult attachment orientations to the development of the early working alliance: A preliminary growth modeling study. *Psychotherapy Research, 13*, 371-382.
- Scheier, M. F., & Carver, C. S. (1992). Effects of optimism on psychological and physical well-being: Theoretical overview and empirical update. *Cognitive Therapy and Research, 16*, 201-228.
- Schore, A. N. (2003). *Affect Regulation and the Repair of the Self*. United States of America: W.W. Norton & Company.
- Schore, A. N. (2009). *The Neurobiology of Childhood Trauma and Attachment*. Australian Childhood Foundation conference, held at Darling Harbour Conference Centre, Sydney on 17-03-2009.
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: the Consumer Reports study. *American Psychologist, 30*, 965-974.
- Shapiro, D. A., Firth-Cozens, J., & Stiles, W. B. (1989). The question of therapists' differential effectiveness: A Sheffield Psychotherapy Project addendum. *British Journal of Psychiatry, 154*, 383-385.
- Sharpley, C. F. (1997). The influence of silence upon client-perceived rapport. *Counselling Psychology Quarterly, 10*, 237-245.
- Sharpley, C. F., & Anastasia, S. (1995a). Does eye contact increase counsellor-client rapport? *Counselling Psychology Quarterly, 8*, 145-152.

- Sharpley, C. F., & Anastasia, S. (1995b). When does counsellor forward lean influence client perceived rapport? *British Journal of Guidance & Counselling, 23*, 387-393.
- Sharpley, C. F., Fairnie, E., Tabary-Collins, E., Bates, R., & Lee, P. (2000). The use of counsellor verbal response modes and client-perceived rapport. *Counselling Psychology Quarterly, 13*, 99-116.
- Sharpley, C. F., Jeffrey, A. M., & McMaha, T. (2006). Counsellor facial expression and client-perceived rapport. *Counselling Psychology Quarterly, 19*, 343-356.
- Sharpley, C. F., Munro, D. M., & Elly, M. J. (2005). Silence and rapport during initial interviews. *Counselling Psychology Quarterly, 18*, 149-159.
- Shaver, P. R., Mikulincer, M., & Chun, D. S. (2008). Adult attachment theory, emotion regulation, and prosocial behavior. In M. Vandekerckhove, C. von Scheve, S. Ismer, S. Jung, and S. Kronast (Eds.), *Regulating emotions: Culture, social necessity, and biological inheritance* (pp. 121-145). Oxford, United Kingdom: Blackwell Publishing Ltd.
- Slattery, J. M., & Park, C. L. (2011). *Empathic counseling: Meaning, context, ethics, and skill*. United States of America: Brooks/Cole, Cengage Learning.
- Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons and A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 35-50). London, United Kingdom: Sage.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51-80). London, United Kingdom: Sage.
- Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development, 7*, 349-367.



- Sroufe, L. A., Egeland, B., Carlson, E. A., & Collins, W. A. (2005). *The Development of the person: The Minnesota study of risk and adaptation from birth to adulthood*. New York, NY: Guilford Press.
- Stough, C., Saklofske, D. H., & Parker, J.D.A., (2009). *Assessing emotional intelligence: Theory, research, and applications*. New York, NY: Springer.
- Teyber, E., & McClure, F. (2000). Therapist variables. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change* (pp. 62–87). New York, NY: John Wiley and Sons.
- Teyber, E., & Holmes McClure, F. (2011). *Interpersonal process in therapy* (6<sup>th</sup> ed.). United States of America: Brooks/Cole, Cengage Learning.
- Thompson, R. A., & Goodman, M. (2010). Development of emotion regulation: More than meets the eye. In A. M. Kring and D. M. Sloan (Eds.), *Emotion regulation and psychopathology: A transdiagnostic approach to etiology and treatment* (pp. 38-58). New York, NY: Guilford Press.
- Thompson, R. A., & Meyer, S. (2007). Socialization of emotion regulation in the family. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 249-268). New York, NY: Guilford Press.
- Thoreson, R. W., Miller, M., & Krauskopf, C. J. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology: Research and Practice*, 20, 153-158.
- Ukens, C. (1995). The tragic truth. *Drug Topics*, 139, 66-74.
- Wachtel, P. L. (2011). *Therapeutic communication: Knowing what to say when* (2<sup>nd</sup> ed.). New York, NY: Guilford Press.
- Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, 73, 914-923.

- Wampold, B. E., Hollon, S.D., & Hill, C. E. (2011). Unresolved questions and future directions in psychotherapy research. In J. C. Norcross, G. R. Vandenbos, and D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (pp. 333-356). Washington, DC: American Psychological Association.
- Waterhouse, L. (2006). Inadequate evidence for multiple intelligences, Mozart effect, and emotional intelligence theories. *Educational Psychologist, 41*, 247-255.
- Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2<sup>nd</sup> ed.). Berkshire, United Kingdom: McGraw-Hill.
- Wilkinson, M. (2010). *Changing minds in therapy: Emotion, attachment, trauma, & neurobiology*. United States of America: W.W. Norton & Company.
- Zeidner, M., Matthews, G., & Roberts, R.D. (2009). *What We Know about Emotional Intelligence: How it Affects Learning, Work, Relationships, and our Mental Health*. Cambridge, Massachusetts: The MIT Press.
- Zeidner, M., & Olnick-Shemesh, D. (2010). Emotional intelligence and subjective well-being revisited. *Personality and Individual Differences, 48*, 431-435.
- Zelazo, P. D., & Cunningham, W. A. (2007). Executive function: Mechanisms underlying emotion regulation. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 135-158). United States of America: Guilford Press.

## APPENDICES

### Appendix A: Interview Guide

In this interview, please be explicit about your practises, as my position is one that acknowledges you as the expert who will direct the line of enquiry along the path that you consider most important to your strategic, cognitive, and behavioural uses of emotions within therapy.

Because you have been identified as a therapist who is successful in assisting the majority of their clients achieve positive outcomes, the information this questionnaire seeks from you is how (and if) you use your own or your client's emotions to achieve this success. During the course of the interview, please remember that the information we seek centres on your instrumental behavioural and cognitive use of emotion as an explicitly used tool to achieve positive outcomes. Please do state details that you may consider obvious, or that could be considered essential for all therapists to use.

- Were you previously aware of your high performance on the Outcome Rating Scale?
- What makes you successful with clients? What do you do that helps?
- What do you do that differs from other therapists? That in your opinion improves client outcomes?
- How do you use your own and client's emotions in your practice? What role does emotion have in your practice?
- How do you identify emotions in your clients? And in yourself?
- Do you regulate your own or your clients' emotions during sessions? How? Please give examples. Describe what happened, what you did emotionally, and what outcomes resulted.
- Are there emotions that you foster in yourself to work more effectively? How do you decide which emotions to foster? How does this improve your practice?
- Do client emotions ever warrant regulatory intervention in therapy? How do you regulate them? How do you assist them to regulate themselves?
- What client emotions lead to positive outcomes? How do you facilitate these? Are there emotional chains in the process of therapy that you consider typical or beneficial?
- Do you use self-reflection to improve your skill as a therapist? How? What prompts self-reflection? How does the process work?
- Are there any emotions expressed by clients that you could say were common in therapy? Do you focus on such emotions?
- How is awareness of your own emotions related to emotional competence in therapy? What about awareness of emotions in others?
- Do you set emotional boundaries in practice? How?
- Is emotional connectedness with clients useful? How?
- How is emotional contagion exhibited in therapy? What about clients? Do you use emotional contagion in therapy? How?

- How do other aspects of your [emotional] life affect your practice? How do emotions in practice affect your private life?
- Are there any emotional characteristics that you foster in clients to facilitate positive outcomes? How? Are there any emotions that you consider are typically related to negative outcomes?
- Do you believe you have influencing skills on others? Can you describe the nature of these skills?
- To what degree is empathy involved in your practice?

**Specific instances in therapists' experience: Please consider the following situations, and briefly describe a personal experience with a client that most closely resembles the situation described.**

- A client criticises your professional conduct or your abilities as a therapist to help them
- A client who has become overly emotionally dependent on you
- A client with whom you struggle to establish rapport
- A client who becomes emotional in every session
- When you become emotional as a client describes an event

**Guideline questions for the above experiences:**

- How did you know a problem manifested?
- What did you do to address the issue: at the time of the incident? In the next session? In supervision? With future clients?

**Demographics**

- Ethnicity
- Age
- Gender
- Occupation Title
- Years experience in therapy
- Years of tertiary education
- Favoured theoretical approach to therapy

## **Appendix B: Participant Information Sheet**

### **In Search of the Master Therapist: Emotional Competence and Client Outcome**

My name is Ivor de Vries. I am a student at Massey University where I am enrolled in a Masters degree with the School of Psychology. I am conducting research on emotional skills therapists use in practice and hope to contribute to the growing body of knowledge concerning the influence of emotions upon human interactions, especially in the field of the helping professions.

The subjective manner in which emotion can be experienced has traditionally made it a difficult subject for empirical research. Using qualitative methods, this project hopes to document commonalities in emotion skills that excellent therapists identify as important in aiding positive client outcomes. By purposefully targeting information shared by therapists whose clients most often report positive outcomes, it is hoped this project will provide a valuable contribution to the sparse existing literature about what emotional skills master therapists use for client benefit. This information will be used to inform a large international study on master therapist practises, which is expected to deliver results relevant to the education, training, and development of students, practitioners, academics, researchers, and supervisors in the field of psychology.

**If your ASIST normative comparison score is equal to or higher than .7, then your effectiveness suggests that you are a master therapist and we want you to participate in this project. Your insight and experience will be invaluable to this research.**

The project involves one semi-structured interview that will aim to investigate how you strategically and behaviourally use emotions in the process of therapy to facilitate positive client outcomes. The interview will be conducted using Skype, although a face-to-face interview option is available if you are based in the lower North Island. The interview is expected to last approximately 1.5 hours. About a month after the interview, you will be contacted by email and given an opportunity to comment on the condensed, analysed report of your interview. This process should take about thirty minutes.

There are no risks or harmful effects expected to result from your participation this study. Your anonymity and confidentiality will be protected. Only you, the researcher, and the researcher's supervisors will have access to the audio and written record of your interview and the questionnaire data. Any data that could indicate your identity will be held in a secure location at Massey University, and removed once your interview has been transcribed. Demographic data will only be reported in aggregated form.

Participation in this study is entirely voluntary. You can withdraw from the study at any time and are not required to provide reasons for doing so. This study is an independent research project being conducted under the auspices of the School of Psychology at Massey University. Your employment with an institution that may or may not be associated with Massey University should in no way influence your decision about whether or not you participate in this study.

The completed thesis will be made available to you electronically on request, and held as a public document in Massey University Library from the time of completion, which is expected to be March 2012.

If you decide to participate in this study, please contact the researcher or his academic supervisors at the appropriate email address below, and include both

your ASIST Normative Comparison Score, and your ASIST figure of the Percentage of Clients who Reach Benchmark Score. These two ASIST statistics can be found by checking the purple tab at the bottom of the main page labelled "Therapist Change Scores". A table at the top left of the page displays the two relevant statistics; "Percentage of Clients reaching Benchmark Score", and "Normative Comparison (All Clients)". These figures will be used for selection criteria only, and not disclosed to anyone outside of the research team. If you are in the lower North Island and prefer to participate in a face-to-face interview, please note this in your email. Your agreement to participate will indicate your consent to participate under the terms listed above. You will be contacted to arrange a time for the interview within three weeks of your response.

For further information about this research project, including ethical queries, please contact:

Ivor De Vries (the researcher) by email at: [cateandive@paradise.net.nz](mailto:cateandive@paradise.net.nz)

OR Dr. Shane Harvey (University supervisor) by email at [S.T.Harvey@massey.ac.nz](mailto:S.T.Harvey@massey.ac.nz)

OR Dr. Don Baken (University supervisor) by email at [D.M.Baken@massey.ac.nz](mailto:D.M.Baken@massey.ac.nz)

OR for additional ethics queries, please contact:

The Secretary  
MUHEC: Southern A & B  
Research Ethics Office  
Sir Geoffrey Peren Building (PN221)  
Massey University  
Private Bag 11 222  
Palmerston North 4442  
Ph: 64 6 350 5573

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT (0800 2787 7678)

Email: [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)

Ivor de Vries

*This study has received National Ethics Advisory Committee approval through an Expedited Review of Observational Studies Application on the 21<sup>st</sup> of June 2011, for the period of 21/06/2011 to 21/06/2013. The reference number is MEC/11/048.*

## **Appendix C: Interview Guide for Participants**

### **In Search of the Master Therapist: Emotional competence and Client Outcome**

Thank you for your consent to participate in this study. The purpose of the interview is to collect information about how you, as a successful therapist, strategically use emotions in the process of therapy with clients to help them achieve positive outcomes. In particular, the information we are seeking is what it is that you do or don't do with emotions in therapy to assist your clients in achieving therapeutic goals.

The importance of the therapeutic relationship on facilitating positive client outcomes is now well established. Personal and emotional variables that therapists bring to therapy are thought to affect this relationship, but there is a lack of consensus in the literature as to which variables are necessary to achieve this purpose. Part of the hindrance has been the lack of agreement as to how variables such as emotion, emotional competence, and emotional intelligence should be conceptualised, measured, or reported. The dominance of theory rather than clinical practice or empirical evidence in the field of emotions has ensured emotion remains a largely elusive construct in practical applications of psychotherapy.

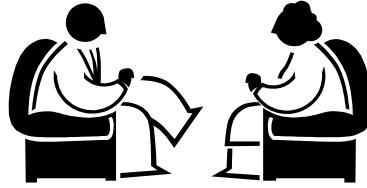
Intuitively, therapists need to be highly competent at using emotions in order to facilitate clients to work towards resolving the issues which have brought them to therapy. Client issues often involve emotional functioning, and more often the consequences of the issues brought to therapy have at least some kind of emotional effect on the client. It is up to the therapist to provide an emotional environment that is safe, constructive, and free from personal judgement. To achieve such an environment, therapists probably use a set of emotional skills and social interactional behaviours that correspond with their interpersonal interactions outside of the therapists' office. However, it is unclear if these emotional skills represent personality variables brought to therapy by the therapist, if such skills can be taught to any therapist for use within therapy, or if there is congruence between therapist emotional skills at work and their private lives.

The current research project is taking the position that we need to expand our practical knowledge regarding how emotions are used by therapists to assist clients in achieving therapeutic goals. We hope insight will be gained by using a 'bottom up' approach, where no assumptions are made about how emotion is or is not used by therapists, but information is sought from those that have proven their performance in practice. For this reason, please be explicit about your practises, as our position in this interview is one that acknowledges you as the expert who will direct the line of enquiry along the path that you consider most important to the strategic, cognitive, and behavioural uses of emotions within therapy that assist clients in achieving positive therapeutic outcomes.

During the course of the interview, please remember that the information we seek centres on your instrumental behavioural and strategic cognitive use of emotion as a tool employed to achieve positive outcomes. Please do state details that you may consider obvious, or that could be considered essential for all therapists to use. The intention of the information gathered in the interviews is that we will create an overview of commonalities between good therapists, to create an understanding of how you use emotion in your practice. This understanding may then be used in an international study aiming to create a 'best practice' guideline which could potentially be useful in future to inform psychology students and professionals about strategies and behaviours important to facilitating positive client outcomes.

## Appendix D: Participant Advertisement

### Emotional Competencies in Therapy and Client Outcome



What emotional skills do good therapists use, and how do these skills help clients? Interested? So are we! The answers are elusive, but we expect our study to make a substantial contribution on this subject, which will be used to inform an international project documenting a range of skills and behaviours exhibited by master therapists.

If your ASIST Normative Comparison Score is equal to or higher than .7, then your efficacy suggests that you may be a master therapist, and we want to access your knowledge in an interview using Skype.

Please note that your contribution will not exceed three hours of your time.

For further information please contact:

Ivor de Vries (the researcher) at:

[cateandive@paradise.net.nz](mailto:cateandive@paradise.net.nz)

Ivor de Vries

*This study has received National Ethics Advisory Committee approval through an Expedited Review of Observational Studies Application on the 21<sup>st</sup> of June 2011, for the period of 21/06/2011 to 21/06/2013. The reference number is MEC/11/048.*



**GLOSSARY OF ACRONYMS**

AAI:	Adult Attachment Interview
ASIST:	Administration, Scoring, Interpretation and data Storage Tool
EI:	Emotional Intelligence
FIS:	Facilitative Interpersonal Skills
MSCEIT:	Mayer-Salovey-Caruso Emotional Intelligence test
OQ-45:	Outcome Questionnaire-45
ORS:	Outcome Ratings Scale
RCI:	Reliable Change Index
SSI:	Social Skills Inventory
TOP:	Treatment Outcome Package
WMA file:	Windows Media Audio file