

Organising Therapists' Emotional-Social Skills: Are Therapists that Different?

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Andreas Marwick

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ABSTRACT

Wampold and Imel (2015) argue that therapeutic outcomes may be more dependent on variables associated with therapists than treatment systems. An element of these therapist variables include the emotional and social skills of therapists, however, to date, little has been done to investigate the relationships between these therapy factors. One exception to this is pilot research conducted by my supervisors, their students, and myself (Harvey, Marwick, Baken, Bimler, & Dickson, 2016). This thesis aims to replicate and extend on this pilot research as to better understand therapists' emotional and social skills in practice. Using three complementary approaches including thematic analysis of therapist transcripts, a date-specific literature review, and revision of foundational research, Harvey et al.'s original pool of emotional and social skills was revised and extended. Subsequently, using a statistical method for mapping psychological constructs, therapists' emotional practices were transformed into a 'map' with three spatial dimensions, which was generally supported by comparative reliability checks including a validation study with a foreign-language sample. Finally, the nature of emotional practice was further investigated by administering a questionnaire of emotional practice items to 79 therapists. From this, eight salient practice constructs were identified. Statistical links were also found between these and both demographic data and a modified measure of the therapeutic relationship. Furthermore, using Q-analysis, a general consensus of responding was found between therapists' emotional response patterns and as a result, a tentative pathway to therapists' practice styles was developed. From these findings important research and clinical applications are apparent.

ACKNOWLEDGEMENTS

This thesis was constructed with the help of many. Thank you to my supervisors, I feel extremely privileged to have worked with you. I could not have persisted and completed this enormous undertaking without your support and guidance. Shane, your unremitting enthusiasm for my topic has been inspiring and, at times, much needed. Don, your input always conveys new insights and this thesis would be sorely lacking without you. David, your knowledge (and patience communicating such knowledge) is greatly appreciated, you are truly an expert of this methodology. Thank you to my family and friends. You brighten up my life and for that, I am grateful. Last but not least, to my participants. I cannot thank you enough for selflessly spending your valuable time. You made this research possible and its results are as much yours as they are mine. My hope is that, in some way, this research can help improve the experiences of therapy consumers.

PROLOGUE

For doctoral students the construction of a thesis is generally a daunting prospect, requiring patience, determination, and passion to achieve. Interestingly, from my perspective, the key to its completion is profoundly dependent on a single stimulating idea that sends the student down their indirect pathway to discovery. Long before my stint as a postgraduate student, unbeknown to me, this idea was already captivating my supervisors. After becoming a postgraduate student, they enlisted me to help investigate. This idea has continued to captivate me past my initial postgraduate research and is the key research question of this thesis — can we discover therapists' practice styles?

It will come as no surprise that emotional experiences are rife throughout therapy. In session, very personal thoughts, feelings, and experiences are aired, and therefore, it is understandable that the therapist's emotional and social responses in practice have some bearing on therapy process and outcome. This notion has resonated with me since beginning my clinical training. Consequently, I consciously attend to how I am feeling, and how I am portraying these feelings throughout my practice.

While a therapist's specific emotional and social responses probably differ between clients, underlying practice themes will likely remain recognisable. In other words, there is a consistency in one's practice behaviours, differing largely by when and how these behaviours are implemented. A seasoned and effective clinician I have been fortunate to observe expertly incorporates humour into his diverse clinical practice. However, how this humour is used changes between clients. In general for this clinician, humour is employed with new and unenthusiastic clients to promote interest and foster rapport. Alternatively however, for engaged yet distracted clients, humour is more likely to be used to capture attention and guide the flow of therapy. Humour for this clinician is implemented during different situations for different purposes, ultimately to benefit the client. This example demonstrates that when considering a therapist's emotional and social practice responses, it is not just a question of what to employ, but also, of how and when to implement these skills. I believe, if studied correctly, that these responses may partially identify a therapist's particular practicing style.

From my limited professional experience, I have little doubt that therapists practice in ways that reflect their unique personalities — after all, they were individuals first and psychologists second. As my instructor once told me in praise, “I saw your personality in that session,” an achievement I had strived to accomplish for some time. My colleague’s personal easy-going, quiet, and caring manner helps her to swiftly build rapport in practice, while my experienced, just, and supportive supervisor threads these factors into his practice to facilitate the therapeutic process. Our personalities are intertwined with who we are, and to practice in a way that is incongruent with our personalities would, in my mind, be noticeable and appear insincere. What we think, feel, value, and believe is reflected in our behaviour and will ultimately influence our clients for better or worse.

So why investigate therapists’ practice styles then if they largely reflect individuals’ diverse and unique personalities? Well, just as their practices are unique, they also have remarkable similarities. The colleague and supervisor previously mentioned are both meticulous and passionate about their chosen clinical fields. It is my belief that both the similarities and differences that exist between therapists at a practice level are able to be quantified. By understanding the collective and individual components of therapy, we may better understand how one’s practice style evolves and ultimately, which parts may influence client change.

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LIST OF ABBREVIATIONS

CER – Cognitive Emotional Relational	
Da – Deviation A	
Db – Deviation B	
DPCQC – Development of Psychotherapists’ Common Core Questionnaire	
ED – Emotional Difficulties	
ES – Emotional-Social	
FIS – Facilitative Interpersonal Skills	
GOPA – Group Opposite Partition Add	
HCA – Hierarchical Cluster Analysis	
HI – Healing Involvement	
Hotspot Labels	AG – Altruistic Growth
	CE – Client Empowerment
	D – Directive
	DTB – Deliberate Therapeutic Behaviours
	EC – Emotion Coaching
	ESA – Emotional Self-Awareness
	SC – Self-Confidence
	TC – Therapeutic Collaboration
MDS – Multidimensional Scaling	
NS – Non-Sorted	
NZTCI – New Zealand Translation Centre International	
ORS – Outcome Rating Scale	
PoC – Positive Collaboration	
PCA – Principal Components Analysis	
PCI – Positive Clinician Input	
SI – Stressful Involvement	
SPSS – Statistical Products and Service Solutions	
STAR-C – Scale To Assess the Therapeutic Relationship – Clinician	

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CHAPTER ONE

INTRODUCTION

“Client outcome has not tended to be taken into account in the sparse literature examining therapist emotion effects”

-de Vries (2012, p. 81)

Constructing the Question

Numerous studies have demonstrated that therapist effects – the percentage of outcome variance accounted for by the therapist — are a large and significant contributor to the psychotherapeutic result (Crits-Christoph et al., 1991; Kim, Wampold, & Bolt, 2005; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Bolt, 2006). However, despite this consensus, the majority of treatment outcome research continues to focus on treatment techniques (Wampold & Imel, 2015). Norcross and Lambert (2011) identify that 30% of the psychotherapeutic result can be attributed to the common factors of therapy (factors not specific to any therapeutic modality), while only 15% is accounted for by specific techniques (factors specific to a therapeutic modality). Therapy is fundamentally an interpersonal relationship and as the therapist applies both common factors and therapeutic techniques in practice (Sprenkle, Davis, & Lebow, 2009; Wampold & Imel, 2015), the practicing clinician is clearly an integral component of effective therapy (Blow, Sprenkle, & Davis, 2007).

Several therapist variables have been consistently associated with positive therapeutic outcomes (Blow et al., 2007). Of those investigated, therapist allegiance to treatment, empathy, collecting client feedback, cultural competence, sensitivity to clients’ unique differences (i.e. sexual orientation, religious affiliation, etc.), flexibility, therapist emotional well-being, therapist training, skill and experience, and the therapist’s contribution to the therapeutic relationship, have been variably associated with the psychotherapeutic result (Beutler et al., 2004; Blow et al, 2007; Crits-Christoph et al., 1991; Norcross & Wampold, 2011;

Wampold, 2001). Furthermore, therapist variables such as goal consensus, positive regard, and genuineness have all been tentatively associated with therapy outcomes yet currently lack empirical validation (Norcross & Wampold, 2011). Such results indicate that many potentially important therapist variables require further examination to substantiate their influence on the therapeutic outcome.

Accordingly, research focusing on master therapists – clinicians who consistently produce rapid and lasting change with clients – have largely identified several variables common among them, thus supporting the existence of key therapist variables that transcend therapeutic modality (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Eells, 1999; Jennings, D’Rozario, Goh, Sovereign, Brogger, & Skovholt, 2008; Jennings & Skovholt, 1999; Stiles, Agnew-Davies, & Hardy, 1998; Wisner & Goldfried, 1998). To account for such findings, Jennings and Skovholt (1999) propose that master therapists are proficient at applying cognitive, emotional, and relational variables in practice, each of which equally contributes to a master therapists’ therapeutic effectiveness. Nevertheless, according to those same researchers, the majority of studies in this field have focused on therapists’ cognitive variables while leaving emotional and relational factors largely neglected (Jennings & Skovholt, 1999). While investigations regarding therapists’ emotional and relational variables have increased in recent years, there is still a dearth of research in this field.

As the term suggests, the emotional-social (ES) intelligence of an individual largely encompasses what Jennings and Skovholt (1999) consider emotional and relational variables. ES intelligence is defined as the ability to efficiently manage personal and relational change through problem solving, adapting to, and/or coping with, the current situation (Bar-On, 2006; Salovey & Mayer, 1990); its functional application in practice has been termed ES competence (Saarni, 1999). While several studies have detailed generally positive results in largely lay populations as a result of high ES intelligence (Brackett, Mayer, & Warner, 2004; Brackett, Rivers, Shiffman, Lerner, & Salovey, 2006; Cote & Miners, 2006; Gohm, Corser, & Dalsky, 2005; Lopes, Brackett, Nezlek, Schutz, Sellin, & Salovey, 2004), the ES intelligence of therapists and how this factor influences therapeutic outcome has received scant attention. Of two studies identified, ES intelligence in therapists appears to a) be positively associated with therapist-rated outcomes

(Kaplowitz, Safran, & Muran, 2011), and b) moderate the relationship between personality factors and the psychotherapeutic result (Rieck & Callahan, 2013). These findings are tentative yet support the notion that emotional and relational attributes of therapists influence therapeutic outcome.

Emotional skills are endemic within social interactions. Therefore, it stands to reason that therapy, an emotionally laden interaction, is significantly influenced by those skills utilised by the therapist. Well timed social and emotional responses are likely to assist the therapist in navigating this emotional environment, enabling them to sculpt both the process and content of therapy. From this perspective, it is conceivable that ES skills do not act in isolation (Lopes et al., 2004). However, research investigating the relationship between therapists' ES skills is lacking. Due to this, we know little of their collective nature. Identifying largely co-occurring ES skills may functionally define larger therapy constructs such as trust or collaboration. Furthermore, understanding how individual ES skills relate to one another will facilitate the process of discerning therapists' practicing styles.

Combinations of therapist variables routinely employed in a similar way by multiple therapists in practice can be defined as a therapeutic style (Dolan, Arnkoff, & Glass, 1992; Geller & Berzins, 1976; Harvey et al., 2016; Spilken, Jacobs, Muller, & Knitzer, 1969). While a number of studies have investigated therapist styles (Geller & Berzins, 1976; Harvey et al., 2016; Howard, Orlinsky, & Trattner, 1970; Razin, 1971; Rice, Fey, & Kepecs, 1972), to date, no empirical research has produced reliable and valid therapeutic styles that can be generalised across clinicians. Moreover, of the limited research attempting to identify therapist styles, mixed results have been recorded linking these patterns of behaviour to client change (Beutler et al., 2004). Given that practice styles have yet to be empirically established, attempting to link styles to outcomes may be inappropriate. Clearly, the focus of future investigations must first be on the identification of consistent and applicable practice styles. After these have been reliably established, we may then begin to link these styles to outcome data, thus differentiating between effective and ineffective patterns of practicing.

To summarise, the literature suggests that a) the therapist is a key component of therapeutic outcome, b) the ES behaviours of the practicing therapist are likely to have significant implications for client outcomes, c) little is

known of the relationship between therapists' ES skills, d) due to a lack of research continuity, practicing styles have not been replicated between studies, and e) studying a therapist's therapeutic style may delineate therapeutic outcome. From these findings, my supervisors and I conducted research investigating the relationship between therapists' emotional responses (Harvey et al., 2016; Marwick, 2011). From this research, we developed an exploratory model of therapists' ES skills in practice. Furthermore, we identified that 47 therapists could be categorised into seven therapeutic styles according to the ES skills present and absent in their clinical practices. However, several substantial limitations of this research compromise the validity of this study and hamper the application of its results.

Accordingly, this thesis aims to remedy those flaws limiting Harvey et al.'s (2016) exploratory research. Furthermore, this study aims to extend on its foundational investigation at every level; from item development, through to model generation, and finally, therapist styling. Specifically, the aims of this study are: a) to update and revise Harvey et al.'s (2016) incomplete pool of ES skills, b) to integrate this new content into their exploratory model displaying the relationship between these practice interactions, c) to replicate this updated exploratory model with a foreign-language sample, d) to group ES skills into themes and style therapists across these themes according to those that they employ in their practices, and e) to tentatively link demographic data with both themes and styles. These aims were tackled over the course of four successive studies.

CHAPTER TWO

LITERATURE REVIEW

"It is just asking another what works question rather than how it works"

-Eisler (2006, p. 331)

Outcome Variability

Producing Outcome

The therapeutic modality is not the key component influencing the psychotherapeutic result. Researchers have suggested that, as numerous therapeutic modalities claim some degree of success, shared fundamental features may be responsible for their therapeutic outcomes (Blow et al., 2007; Garfield, 1997; Grencavage & Norcross, 1990; Hubble, Duncan, & Miller, 1999; Kim et al., 2005; Prochaska & Norcross, 2007; Sprenkle & Blow, 2004; Sprenkle et al., 2009). Through meta-analysis of outcome data, both Crits-Christoph and Mintz (1991) and Kim et al. (2005) report that therapeutic techniques rarely alter between treatments while therapist effects do, thus suggesting that client change may be more dependent on therapist variables than treatment variables.

From meta-analytic data, Norcross and Lambert (2011) summate the percentage of therapeutic factors responsible for client change (Figure 1). Noticeably, the greatest variance is accounted for by extra-therapeutic change (client and environmental factors that aid recovery regardless of therapy participation), followed closely by common factors (change causing variables not specific to any particular therapeutic modality, e.g. therapist warmth, therapeutic alliance, advice, modelling, feedback) (Blow & Sprenkle, 2001; Davis, Lebow, & Sprenkle, 2012; Hubble et al., 1999). The final portions of outcome variance are equally accounted for by specific techniques (factors unique to specific models of therapy) and expectancy effects (the placebo effect). Given that many researchers misconstrue the previous paragraph's findings as evidence to disregard therapeutic modality in practice (Davis et al., 2012), this representation is

significant as it clarifies the relative importance of both common factors AND specific techniques to therapeutic outcome. As the therapist implements both common factors and specific techniques in practice, the therapist is clearly a central ingredient of effective therapy (Blow et al., 2007). Despite this however, there is currently a lack of research investigating the therapist in therapy (Beutler et al., 2004; Blow et al., 2007; Garfield, 1997; Heinonen, Lindfors, Härkänen, Virtala, Jääskeläinen, & Knekt, 2014; Sullivan, Skovholt, & Jennings, 2005; Vocisano et al., 2004).

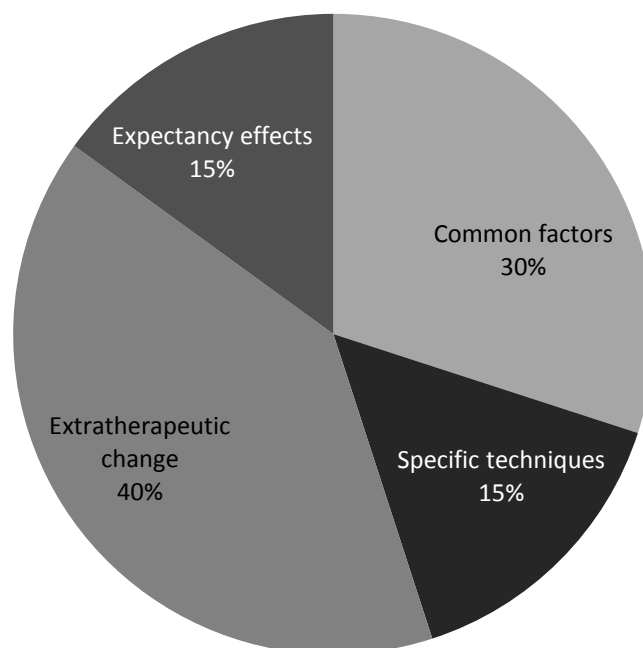


Figure 1. Percentage (%) of improvement in clinical practice as a function of therapeutic factors (adapted from Norcross & Lambert, 2011).

The Therapeutic Alliance

Arguably the most robust and empirically linked common factor to therapeutic outcomes is the therapeutic alliance (Ackerman et al., 2001; Baldwin, Wampold, & Imel, 2007; Blow et al., 2007; Hovarth & Symonds, 1991; Jenner, Woolley, & Mortimer, 2006; Martin, Garske, & Davis, 2000; Norcross & Lambert, 2011; Sullivan et al., 2005). According to Martin et al., the therapeutic alliance is broadly defined as the collaborative and affective connection between therapist and client and is regarded as essential to the process of therapy. Encompassed by the

therapeutic alliance is the therapeutic relationship — the bond between client and clinician (Lambert & Barley, 2001). According to Lambert and Barley, the therapeutic relationship is determined by an interaction between therapist variables, patient variables, and facilitative conditions (e.g. warmth, empathy, congruence), and studies have suggested that at least 12% of the psychotherapeutic result can be attributed to the therapeutic relationship alone (Lambert & Barley, 2001; Sexton & Whiston, 1994). Such findings have led Eells (1999) to assert that relationship skills and the therapeutic alliance are at the heart of therapeutic ability.

Given that the therapeutic alliance accounts for a large proportion of variance in outcome studies, and as this alliance is highly dependent on therapist variables (Blow et al., 2007), therapist effects are clearly an important source of variance in therapeutic outcome. The question remains however, how do therapist factors influence outcomes?

Explaining Outcome Variability

Two empirically informed paradigms have been proposed to explain the variance in therapeutic outcome: The Common Factors model by Sprenkle, Blow and colleagues (2004) and Wampold and colleagues' Contextual Model (2007).

In the "both/and" moderate Common Factors approach proposed by Sprenkle and Blow (2004), the client is ranked as most important to therapeutic outcome, followed by the therapist and then the model of therapy (Davis et al., 2012; Sprenkle & Blow, 2004; Sprenkle et al., 2009). Davis et al. (2012) argue that therapeutic modalities provide a vehicle through which common factors operate. They compare these treatment systems to a therapeutic road map — indicating when and how to intervene, as well as providing structure to the overall therapy process. Furthermore, Davis et al. hypothesise that models of therapy initiate or enhance the common mechanisms of change and, as a result, are relevant to therapeutic outcome. As models of therapy largely thrive or fail because of the therapist (Davis et al., 2012), and as the therapeutic modality has been proposed as necessary for common factors to operate, by this logic, common factors are also reliant on the practicing therapist. As therapist effects can be considered common

factors (Sprenkle & Blow, 2004), and as the therapist applies both common factors and the model of therapy in practice (Davis et al., 2012; Sprenkle et al., 2009), the therapist is clearly a significant factor influencing therapy outcome.

In line with Sprenkle et al. (2009), Wampold and colleagues' place the therapist, the client, and their relationship as fundamental to therapeutic outcome in their Contextual Model (Figure 2; Wampold, 2007; Wampold & Budge, 2012; Wampold & Imel, 2015; Wampold, Imel, Bhati, & Johnson Jennings, 2006). They suggest that the client and therapist must initially form a bond sufficient to facilitate engagement and garner trust. From here, the researchers propose three independent therapeutic pathways. Pathway A can be described as the real relationship between client and therapist; a potentiation of the initial bond which ultimately promotes a better quality of life through empathy, a sense of belonging, and social connection. Pathway B regards the healing properties of expectation, chiefly the placebo effect. Pathway C regards the specific ingredients of therapy models which Wampold and Imel (2015) suggest achieve beneficial results because they induce clients to perform health promoting behaviours. Considering that the therapist has been shown to be integral to the therapeutic relationship (pathway A; Lambert & Barley, 2001), expectation in therapy (pathway B; Ackerman & Hilsenroth, 2003), and the therapeutic modality (pathway C; Sprenkle et al., 2009), their contribution to the therapeutic process is clear.

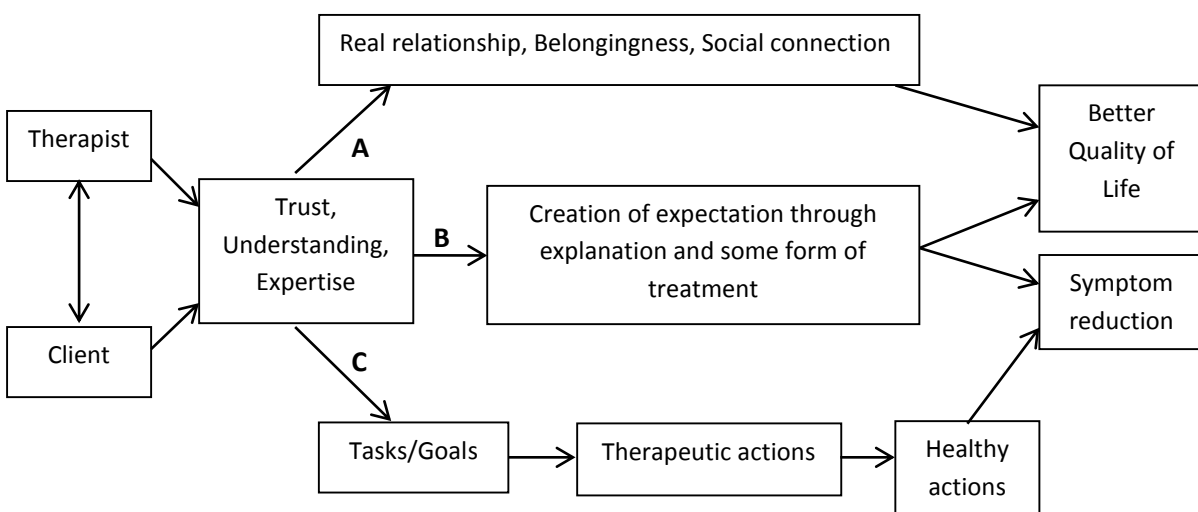


Figure 2. The Contextual Model (adapted from Wampold & Imel, 2015).

While both the Common Factors paradigm and Contextual Model remain theoretical in nature due to a lack of empirical testing, they are complementary as each implicates the client and therapist as intertwined with therapeutic change. As there is currently a dearth of research investigating therapist factors in therapy (Beutler et al., 2004; Blow et al., 2007; Garfield, 1997; Sullivan et al., 2005; Vocisano et al., 2004; Wampold & Imel, 2015), further research investigating therapist factors is needed. While the aforementioned models are informative, they do not identify the specific therapist variables associated with client change. By identifying change-causing characteristics of therapists, how therapists influence this change may also be clarified.

Therapist Variables

According to sizable reviews, a number of therapist variables have been decisively linked to the psychotherapeutic result, although these associations have generally been mild to moderate at best (Ackerman & Hilsenroth, 2003; Beutler et al., 2004; Blow et al., 2007; Crits-Christoph et al., 1991; Huppert, Bufka, Barlow, Gorman, Shear, & Woods, 2001; Kirshner, Genack, & Hauser, 1978; Norcross & Wampold, 2011; Wampold, 2001). Relevant therapist variables include therapist allegiance to treatment, honesty, respect for clients, therapist confidence, warmth, openness, empathy, collecting client feedback, cultural competence, sensitivity to clients unique differences (i.e. sexual orientation, religious affiliation, etc.), flexibility, therapist emotional well-being, therapist training, skill, and experience, as well as the therapist's contribution to the therapeutic relationship. Furthermore, more static therapist variables including gender, ethnicity, and age, have all yielded null or inconsistent literature results (Beutler et al., 2004; Blow et al., 2007; Blow, Timm, & Cox, 2008; Bowman, 1993; Cabral & Smith, 2011; Gehart & Lyle, 2001; Grayson & Meilman, 2013; Huppert et al., 2001; Korner & Goldberg, 1996; Vocisano et al., 2004; Wintersteen, Mensinger, & Diamond, 2005). While these findings are encouraging as they suggest therapists can "transcend whatever limits are potentially imposed by their age, gender, or skin colour" (Blow et al., 2008, p. 304), further research is required to investigate the numerous therapist variables

lacking sufficient empirical support to decisively associate them with therapeutic outcome.

Factors Lacking Support

Many therapist variables and common techniques deemed to contribute to the psychotherapeutic result have received inadequate empirical support in the extant literature. Goal consensus, positive regard, congruence/genuineness (Norcross & Wampold, 2011), tailoring treatment (Duncan, Miller, & Sparks, 2011), therapist optimism (Priebe & Gruyters, 1995), collaboration (Kazantzis & Kellis, 2012; Norcross & Wampold, 2011), using open ended questions (Boyd, 2003), appropriate self-disclosure (Ackerman et al., 2003; Hill & Knox, 2002), and appropriate use of humour (Bates, 2005), are just some of those variables tentatively linked to therapeutic outcomes yet lacking empirical substantiation. Given the abundance of therapist variables posited to influence therapeutic outcome and the relative lack of research afflicting this domain, dedicated ongoing investigations are required to tease out these variables' interaction with therapeutic influence.

Damaging Therapist Variables

Understandably, to improve overall clinical practice, identifying and implementing beneficial therapist variables is only one side of the therapeutic coin (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). To improve, one must also recognise and correct those behaviours found to negatively impact on the therapeutic alliance. According to a number of studies (Ackerman & Hilsenroth, 2001; Harkins & Beech, 2007; Lambert, 1983; Strupp, 1980; Williams, 2004), therapist factors including confrontation, rigidity, criticalness, hostility, coerciveness, lack of skills, inappropriate self-disclosure, over-structuring therapy, and inappropriate use of silence have all been identified as counter-therapeutic and as a result, are negatively associated with therapy outcome. As with beneficial therapist factors, there are likely an abundance of damaging therapist variables currently unexplored in the literature. Accordingly, further research is required to identify potentially damaging therapist variables in practice.

Consumers Perspectives

As past and present therapy consumers have had first-hand experiences of therapeutic change, consultation with this population is essential to tease out fundamental therapist variables. By qualitatively assessing clients' perceptions of the therapeutic alliance during separate points in therapy, Bachelor (1995) found that approximately half of the clients interviewed consistently identified therapist respect for the client and therapist competence as characteristic of a positive alliance. From these findings, Bachelor suggests that clients' perceptions of the therapist may influence the quality of the therapeutic alliance throughout therapy.

Using Multidimensional Scaling (MDS) methodology, Paulson, Truscott, and Stuart (1999) investigated the underlying relationships between retrospective experiences of helpfulness among 36 counselling consumers. Overall, nine thematic clusters were identified including *Counsellor facilitative interpersonal style*, *Counsellor interventions*, *Generating client resources*, *New perspectives*, *Client self-disclosure*, *Emotional relief*, *Gaining knowledge*, *Accessibility*, and *Client resolutions*. From these findings, Paulson et al. concluded that the concept map generated in their study was consistent with an eclectic approach to therapeutic practice. Furthermore, the authors recognise the role of the counsellor's interpersonal style and the role of the therapy relationship as key components of the counselling process. Congruent with the majority of research previously discussed, these findings point to the contribution of the therapist to the therapeutic process.

By reviewing relevant literature, Jenner et al. (2006) concluded that a good therapeutic relationship was seen, from a client's perspective, as influencing of effective treatment. As the therapeutic relationship is highly influenced by therapist characteristics, and as therapy consumers frequently associate their beneficial therapeutic change to the personal qualities of their therapists (Orlinsky, Grave, & Parks, 1994; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Strupp, Fox, & Lessler, 1969), these findings support the notion that therapist variables are key ingredients of the psychotherapeutic result. Whilst the aforementioned

findings are enlightening, as stated by Jenner et al., there is currently a lack of contemporary research investigating therapy consumers' perspectives of therapeutic change, suggesting that more research in this area would be of worth.

According to Master Therapists

As a means of identifying and understanding change causing characteristics of clinicians, some researchers have centred their focus on the practices of master therapists — practitioners who consistently produce rapid and lasting change with clients (Blatt et al., 1996; Eells, 1999; Jennings et al., 2008; Jennings & Skovholt, 1999; Stiles et al., 1998; Wisner & Goldfried, 1998). While this research is generally well received, concerns primarily related to the criteria with which 'master therapists' are selected have hampered the findings of these studies (Orlinsky, 1999). With this substantial limitation in mind, we briefly examine the literature investigating master therapists.

From interviews with ten peer-nominated US master therapists, Jennings and Skovholt (1999) identified nine cognitive, emotional, and relational characteristics that they consider contributed to their participants' efficacious practices. Overlapping concepts were also identified by Jennings et al. (2008) in their research with nine peer-nominated Singaporean master therapists. Shared characteristics between studies included the participants: *Being voracious learners; utilising a wealth of experience; attending one's own emotional wellbeing; having an awareness of how their emotional health affects the quality of their work; being emotionally receptive; possessing strong social skills; having a strong belief in a beneficial therapeutic alliance; and being experts in using their superior social skills in therapy.* Characteristics unique to their respective studies and suggested as cultural differences were *valuing client complexity and ambiguity* of Jennings and Skovholt's (1999) research and *challenges to professional development, embraces working in a multicultural context, comfortable addressing spirituality, and self-doubt* of Jennings et al.'s (2008) research.

Inspired by their original findings, Jennings and Skovholt (1999) proposed the Cognitive Emotional Relational (CER) model of master therapists. They argue that master therapists have well-developed cognitive (C), emotional (E), and relational (R) attributes at their disposal when working with clients. They state

that the CER model of master therapists is analogous to a 'three-legged expertise stool', with one unsteady leg able to compromise the stability of both other legs. They conclude stating that a significant focus in contemporary literature has been on the cognitive attributes of therapists, yet this is only one of three legs. They state that more focus must be on the emotional and relational domains of therapists so as to understand the therapist characteristics that comprise an effective clinician.

Findings consistent with the emotional and relational domains of the CER model have been recorded by a number of researchers also studying master therapists (Albert, 1997; Goldberg, 1992; Goldfried, Raue, & Castonguay, 1998). Through interviews with 12 peer-nominated expert psychiatrists, Albert found shared practice features of *flexibility, the ability to create a safe therapeutic space, the ability to forge a solid therapeutic alliance, and heightened attentiveness to personal and client difficulties*. Similarly, Goldberg's research identified that *sensitivity to a client's emotions, personal and professional growth, and the ability to forge an effective therapeutic alliance* was common among 12 master practitioners interviewed. Furthermore, Goldfried et al. found that master therapists all had a similar elevated focus during the most emotionally significant moments of therapy, thus suggesting that emotional moments in practice are important to the process of therapy (Goldfried et al., 1998). Given that many master therapists' shared elements can be linked, either directly or indirectly, to emotional or relational variables, these findings support Jennings and Skovholt's (1999) CER model of master therapists. Nevertheless, as these studies largely identify master therapists by peer-nomination with no comparison to novice therapists, it is not clear if the differences identified are particular among expert clinicians or therapists in general.

Given the above evidence, it is likely that key emotional and relational therapist variables significantly influence client change. However, most of the emotional and relational variables identified in this area of research are at a conceptual level, rather than a behavioural level. The following section explores this current gap in the literature.

Relationships Between Therapist Skills

As identified previously, numerous broad therapy concepts such as trust or collaboration have been empirically linked to the psychotherapeutic result. However, many of these concepts are inconsistently defined. Furthermore, studies investigating these constructs often fail to identify the therapist behaviours necessary to adequately practice these concepts. By identifying the vital skills that comprise these constructs, valuable therapy concepts may be translated into practice.

Research investigating the relationships between therapist skills is lacking, with even less literature exploring relationships between therapists' emotional and relational responses. Orlinsky et al.'s (1999) Development of Psychotherapists' Common Core Questionnaire (DPCCQ) and Anderson, Patterson and Weis's (as cited in Anderson et al., 2009) Facilitative Interpersonal Skills (FIS) may be the exception to this paucity of research. While both of these scales appear to compile key therapist behaviours into discrete therapy constructs, their foundational studies are currently unpublished. From the information available these scales are discussed below.

The DPCCQ is a 392-item self-assessment tool collecting a broad array of information related to therapist development (Orlinsky & Rønnestad, 2005). Included in this information are the personal and professional characteristics of therapists. Early studies have investigated the relationships between subsets of this scale's items, such as therapists' professional experiences and professional development (Orlinsky & Rønnestad, 2005), and attempts have been made to link such factors to therapeutic outcomes in short-term and long-term therapy (Heinonen, Lindfors, Laaksonen, & Knekt, 2012). Alternatively, the FIS is a measurement tool designed to assess a therapist's "ability to perceive, understand and communicate a wide range of interpersonal messages" (Anderson et al., 2009, p. 759). FIS constructs were generated from clinical and research literature investigating therapist skills that contribute to the therapeutic alliance. FIS constructs include *verbal fluency*, *emotional expression*, *persuasiveness*, *hopefulness*, *warmth*, *empathy*, *alliance-bond capacity*, and *problem focus*.

Clearly, therapist emotional and relational responses are represented in both FIS constructs as well as the DPCCQ items. However, neither the DPCCQ nor the FIS comprehensively samples therapists' emotional and relational skills in practice. Moreover, neither model has thoroughly investigated the interrelationships between their comprising emotional and relational items. Accordingly, this shortfall points to an area for future investigation.

By investigating the relationships between therapists' emotional and relational responses, we may better understand the processes of therapy. Furthermore, from such research with a comprehensive sample of therapists emotional and relational skills, sets of practice behaviours resembling key therapy constructs (e.g. trust, collaboration, etc.) may also be identified. Such findings would establish a practical pathway to these structures in therapy. Moreover, by considering the relationships between these key therapy constructs, their singular or collective nature may also be revealed. Such findings would have significant implications for research investigating these therapy constructs as well as studies exploring differences between therapists' practices. Accordingly, we now explore the emotional and relational variables of therapists in practice.

Emotional-Social Variables

Emotional-Social Intelligence

Given that therapy is fundamentally an interpersonal interaction often with high-intensity emotional exchanges (Norcross & Wampold, 2011), for a clinician to be effective it is essential that they are able to recognise, understand, express, and relate to their own and others' emotions (Bar-On, 2006; Lambert & Barley, 2001; Salovey & Mayer, 1990). According to Bar-On (2006), these factors are encompassed by what is defined as ES intelligence; a term used interchangeably with 'emotional intelligence' throughout this thesis. To be ES intelligent one must efficiently manage intrapersonal, interpersonal, and environmental change by realistically and malleably coping with the current situation, tackling difficulties, and making decisions (Bar-On, 2006; Salovey & Mayer, 1990). It has been suggested that ES intelligence is likely influential in establishing and maintaining rapport, forging strong therapeutic alliances, augmenting successful social

functioning, and reducing psychological difficulties (Ellis & Conboy, 2004; Goleman, 1995; Kaplowitz et al., 2011; Schutte et al., 2001). The functional application of ES intelligence in context has been termed emotional competence (Saarni, 1999).

Through extensive research focused on children’s emotional development, Saarni (1999) proposes eight key skills she believes comprises ES competence (Table 1). While Saarni’s skill list begins to delineate ES competence, she acknowledges the limitations of her conceptualisation, indicating that important elements may be absent and that current skills likely reflect a Western cultural bias. Succeeding Saarni’s research, ES skills continue to be identified and investigated in the extant literature, however, to date, a comprehensive list of ES skills encompassing this conceptual domain has yet to be amassed (Harvey et al., 2016).

Table 1.
Saarni’s skills and implications of emotional competence

Skill	Implication
1. Emotional self-awareness	Ability to recognise one’s own emotions
2. Identifying emotions in others	Ability to recognise emotions in others
3. Expressing and translating emotions	Ability to verbalise one’s experienced emotional states and processes
4. Empathic capacity	Involvement in others’ emotional experiences
5. Potential difference between felt and expressed emotions	Ability to realise that experienced emotions may not reflect outward expression in self and others
6. Coping with emotions	Using self-regulatory strategies to effectively manage aversive or distressing emotions
7. Understanding emotion communication	Awareness that relationships are defined by how emotions are communicated within that relationship
8. Emotional self-efficacy	Accepting one’s own emotional experience

Source: Adapted from Saarni (1999).

As this thesis investigates therapists' ES skills, it is important that these abilities are clearly defined. However, with respect to therapists, ES skills lack a clear operational definition in the literature. Anderson et al.'s (2009) similar construct FIS, appears to provide the most context appropriate definition of ES skills; the therapist's "ability to perceive, understand and communicate a wide range of interpersonal messages" (p. 759) including factors such as persuasiveness, expectation, and problem focus. Bar-On's (2006) research regarding ES intelligence, which is explored in the subsequent section, conceptualises ES skills into intrapersonal, interpersonal, stress management, adaptability, and general mood domains. Alternatively, in research linking ES skills and individuals with autism spectrum disorders, ES skills are defined as "skills essential for establishing and maintaining social interaction (e.g. understanding feelings, reactions and non-verbal cues, maintaining eye contact, recognizing emotions and facial expressions, social reciprocity, sharing social interests)" (Ramdoss, Machalicek, Rispoli, Mulloy, Lang, & O'Reilly, 2012, p. 121). Lastly, Saarni (1999) defines ES skills as "those skills needed to be self-efficacious" (p. 4), with self-efficacy considered to be the strategic application of knowledge about emotions and emotional expressiveness as to navigate through interpersonal exchanges.

With these descriptions in mind, for this project, an ES skill is defined as a therapy-related behaviour, cognition, belief, or feeling that impacts emotionally and/or socially on the relationship between client and therapist. Therefore, like FIS, it is not necessary that an ES skill makes direct reference to emotional or relational variables, just that it may have such an effect when applied in context. For clarity, take the ES skill of 'undertaking personal therapy.' The act of undertaking therapy is behavioural, however, its outcomes are likely to be both emotional and relational. Outcomes (or lack of outcomes) of undertaking personal therapy are likely to have a profound effect on a therapist's practice, possibly influencing the therapeutic alliance and the psychotherapeutic result. Furthermore, these ES skills have been labelled skills in this thesis as they reflect the notion that they can be developed (Lopes et al., 2004). While some researchers argue contrary to this point (Ackerman & Hilsenroth, 2001), considering that these

behaviours, cognitions, beliefs, or feelings have been learned, it is possible that they can also be appraised and revised.

Emotional-Social Conceptualisations

Significant research has been conducted exploring conceptualisations of ES intelligence (Joseph & Newman, 2010). From these investigations, two main ES construct models have been posited to delineate ES intelligence; a) the ability model (Mayer, Caruso, & Salovey, 1999; Salovey & Mayer, 1990), focusing on the individual's ability to process emotional information whilst navigating the social environment; and b) the mixed trait and ability model (Bar-On, 2006), an array of non-cognitive skills, characteristics, and competencies driving ES intelligent behaviour. While neither conceptualisation is without its flaws (Bradberry & Su, 2006; Joseph & Newman, 2010; Petrides & Furnham, 2001), each makes feasible contributions to better understanding ES intelligence and, for the purposes of this thesis, how individuals differ with respect to ES intelligence. The following paragraphs provide a brief overview of the ability and mixed models of ES intelligence.

According to the ability-based model proposed, investigated, and updated by Salovey, Mayer and colleagues (Mayer et al., 1999; Mayer & Geher, 1996; Mayer, Roberts, & Barsade, 2008; Salovey & Mayer, 1990), ES intelligence is a type of intelligence comprised of four mental processes: 1) perceiving emotions, 2) understanding emotions, 3) emotion facilitation, and 4) regulating emotions in the self and others. The researchers claim that emotions can be received and expressed in verbal and nonverbal ways and as a result, an emotionally adept individual will be able to regulate their own and others emotions through verbal and nonverbal mechanisms. They state that although these processes are common to everyone, people differ in their capacity to understand and express emotions, and as a result, such differences may influence their underlying ES skills which are essential in engaging in meaningful social and emotional exchanges. Consequently, an individual's ES skills will contribute to their own and others' mental health.

In contrast, the mixed ES intelligence model proposed by Bar-On (1997; 2006), conceptualises ES intelligence as a combination of ability and trait-based

aptitudes defined as a “multifactorial array of interrelated emotional and social competencies, skills and facilitators” (p. 20). These competencies, skills, and facilitators are believed to influence an individual’s capability to a) be aware of and understand one’s own and others’ emotions, b) alter one’s feelings to the changing situation, c) cope with stress and control emotions, and d) feel and express optimism and positive emotional states. Accordingly, like Saarni (1999), Bar-On (2006) lists multiple ES skills considered to comprise the aforementioned competencies, all of which likely influence an individual’s intra- and inter-personal functioning.

Given that controversy still surrounds these conceptualisations levelled either at the face and predictive validity of the ability model or theoretical underdevelopment of the mixed model (Bradberry & Su, 2006; Joseph & Newman, 2010; Petrides & Furnham, 2001), it is not surprising that caution has been recommended with respect to real-world application of either conceptualisation. Nevertheless, in lieu of this recommendation, numerous studies have been conducted investigating the interaction between ES intelligence and various variables including therapy outcomes, empathy, and rapport.

Emotional-Social Intelligence and Therapy Outcomes

Given that high ES intelligence has been empirically associated with better social functioning (Brackett et al., 2006; Lope et al., 2004), work performance and success (Cote & Miners, 2006), stress reduction (Gohm et al., 2005), and less illegal drug and alcohol use (Brackett et al., 2004) in non-therapist samples, it is conceivable that ES intelligence may influence the psychotherapeutic result also (Bar-On, 2006; Ellis & Conboy, 2004; Mayer et al., 1999). Tentative results from two pioneering studies appear to support this postulation (Kaplowitz et al., 2011; Rieck & Callahan, 2013).

Kaplowitz et al. (2011) assessed 23 psychotherapists’ ES intelligence to determine its association with therapeutic process and outcome. The findings showed high ES intelligence therapists achieved better therapist-rated outcomes and reduced rates of client drop-out than low ES intelligence therapists. However, while the researchers associated higher therapist ES intelligence with greater

levels of client compliance during assessment, non-significant relationships were observed between ES intelligence and a) client-rated outcomes and b) early therapeutic alliance ratings. Given the inaccuracy of therapist judgments (Garb, 2005; Grove, Zald, Lebow, Snitz, & Nelson, 2000), Kaplowitz et al.'s significant relationship between ES intelligence and therapist-rated outcomes rather than client-rated outcomes raises doubt as to ES intelligence's real influence on client change.

Rieck and Callahan (2013) investigated the influence of ES intelligence on therapy outcomes while controlling for personality factors among a sample of 32 trainee clinicians. They found that neuroticism positively predicted therapy outcome, with this relationship being moderated by ES intelligence. To explain this outcome, Rieck and Callahan suggest that high ES intelligence and high neuroticism provides "an effective balance of ... perspective taking ... and emotional management, resulting in positive client change" (p. 48). Given these findings, the authors assert that further research is required to substantiate their results, and suggest that ES intelligence training for therapists may result in better client outcomes.

Despite limitations afflicting both of the aforementioned studies, their results tentatively suggest that ES intelligence may have some impact on the psychotherapeutic result (Kaplowitz et al., 2011; Rieck & Callahan, 2013). Given such findings, how then might ES skills influence this change?

Empathy and Rapport

Excluding Rieck and Callahan's (2013) tentative supposition, conceptualisations outlining the overall process by which therapists' ES skills might influence client change are lacking. Empathy — the capacity to understand what another person is experiencing from within their frame of reference — has been identified as an integral component of ES intelligence (Saarni, 1999; Salovey & Mayer, 1990). Furthermore, it is a consistent predictor of psychotherapy outcome (Elliot, Bohart, Watson, & Greenberg, 2011; Moyers & Miller, 2013), and is considered vital in the development of rapport (Norfolk, Birdi, & Walsh, 2007). Accordingly, how empathy

is thought to establish rapport may also indicate one potential pathway by which ES skills effect client change.

Figure 3 below displays Norfolk et al.'s (2007) working model of empathy in establishing rapport. Put simply, the researchers delineate empathy, stating that accurate empathetic understanding results from the empathetic motivation, attention, and skills of the participating practitioner communicated to the client through both verbal and non-verbal behaviours (communication skills). Furthermore, as rapport varies between both clients and practitioners (Coulehan, Fox, Adler, Weston, Smith, & Stewart, 2001), Norfolk et al. argue that these rapport building factors (empathy and communication skills) are influenced by contextual factors including practitioner, patient, and environmental variables. Importantly, Norfolk et al.'s model identifies that rapport is more contingent on communication skills than empathic skills as the former is expressed to clients, both facilitating client disclosure (open ended questions, warmth) and determining empathy accuracy (through checking and testing client reaction), while the latter is an internal process influencing how one responds (Kirschenbaum & Jourdan, 2005; Norfolk et al., 2007; Roberts, Wass, Jones, Sarangi, & Gillett, 2003; Rogers, 1957; Ong, deHaes, Hoos, & Lammes, 1995; Suchman, Markakis, Beckman, & Frankel, 1997; Williams, 1990). In other words, a practitioner lacking communication skills despite superior empathic abilities (motivation, attention, and skills), will have client rapport more akin to a practitioner lacking empathic abilities despite the fact that some empathy will be expressed unconsciously. If accurate, this proposition highlights the importance of verbal and non-verbal abilities in practice, and reinforces the interrelated nature of cognitive, emotional, and relational characteristics of therapists.

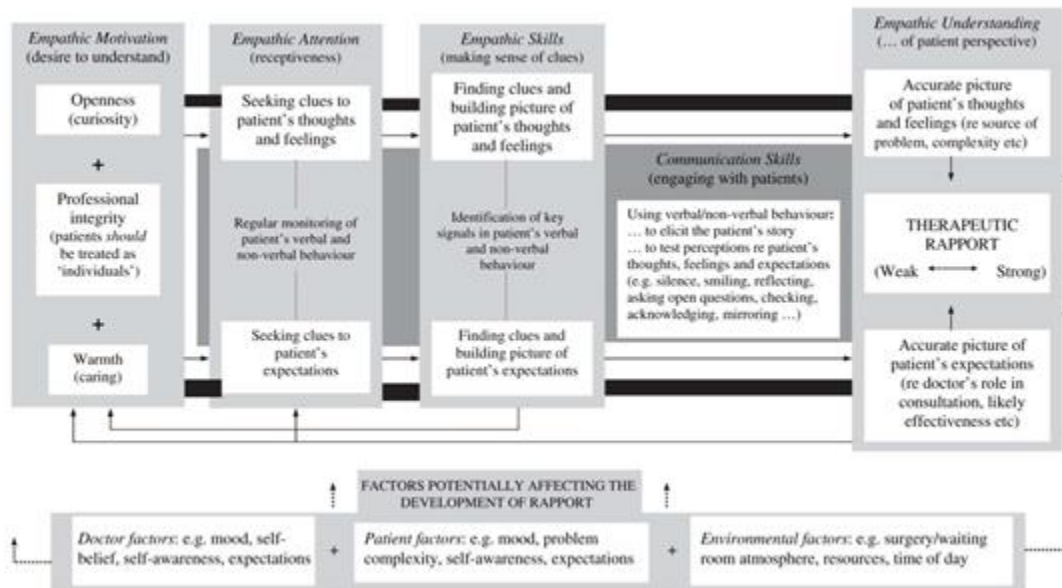


Figure 3. Developing therapeutic rapport in consultation.

Norfolk et al. (2007) have delineated the pathway to therapeutic rapport from empathy — a clear player contributing to therapeutic outcome. By doing so, they have directly identified ES skills that, if learned, will likely improve therapeutic practice. Furthermore, their conceptualisation highlights the considerable variability in client outcomes that can result from differences between relatively few ES skills. This supports previous calls to investigate the relationships between ES skills. Perhaps by understanding the relationships between these practice behaviours, we may then investigate those ES skills routinely employed in practice. Such research would emphasise key similarities and differences between therapists' practices, possibly contributing to our understanding of how these factors relate to therapeutic client change.

Therapist Profiling and Styling

Beneficial client outcomes are unlikely to result from a sole practice characteristic. Instead, the consensus points to combinations of practice patterns, when aggregated in particular ways, fostering favourable client change (Geller & Berzins, 1976; Ginot, Herron, & Sitkowski, 1986; Harvey et al., 2016; Howard et al., 1970; Lazarus, 1993; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Miller,

Benefield, & Tonigan, 1993; Razin, 1971; Rice et al., 1972; Spilken et al., 1969). Combinations of ES skills frequently used in a similar way by a therapist in practice can be defined as their idiosyncratic ES profile. Individual ES profiles may be clustered into therapeutic styles by aggregating similar ES profiles. A therapist's style is a distinguishing factor between practitioners (Dolan et al., 1992; Geller & Berzins, 1976; Spilken et al., 1969). Two therapists may adhere to the same therapeutic modality and use similar therapeutic techniques, yet produce significantly different results with the same client. Lafferty (1987) attributes a significant portion of this variation to differences in therapist styles. Furthermore, just as two clinicians may produce different outcomes with the same client, so too may two clients have different outcomes when visiting the same therapist. This highlights the notion that factors that produce success for one client may not produce the same degree of success for another client (Howard et al., 1970; Miller et al., 1993; Razin, 1971). This variation highlights that clients have differing needs in therapy, and suggests that therapists may need to adjust their practice styles to meet those needs (Blow et al., 2007; Dolan et al., 1992; Lazarus, 1993).

Discerning Styles

Comprehensively understanding therapists' styles will have significant implications for psychotherapy. However, to date, no empirical research has produced reliable and valid therapeutic styles that can be generalised across clinicians. The following paragraphs outline findings from the few studies attempting to discern these practice styles.

Several outdated pieces of research have focused on an A-B therapist "type" scale (Geller & Berzins, 1976; Howard et al., 1970; Razin, 1971). According to a review conducted by Razin, 'A' therapists were defined as problem-solvers, thought to treat schizophrenic patients more effectively than neurotic patients. Comparatively, 'B' therapists were considered to be 'black or white thinkers' and posited to treat neurotic clients more effectively than schizophrenic clients. However, the majority of these dated studies did not provide strong evidence for such relationships. While Razin concluded his review attributing the relative lack of significant findings to methodological deficits rather than flaws with the A-B

therapist “type” scale, research regarding this scale has been non-existent in recent decades.

Miller et al. (1993) investigated differences between two counsellor styles — directive-confrontational and client-centred — with 42 problem drinkers. While a single therapist behaviour (confrontational behaviour) accounted for an increase in client alcohol consumption at one year follow-up, overall, counsellor styles did not differ in overall impact on drinking behaviour. Similar research conducted with sexual offenders by Marshall, Serran, Fernandez, Mulloy, Mann, and Thornton (2003) found an inverse relationship between a confrontational therapist style and participants’ competence in coping after treatment. This change was largely attributed to therapist flexibility — the ability to readily switch between seemingly opposing styles (directive and non-directive) to meet the needs of the client. Given that research foundational to this current study (Harvey et al., 2016) identified tailoring therapy — altering one’s treatment to meet the needs of the client — as a discrete therapist practice skill, Marshall et al.’s outcome reiterates previous suggestions that a flexible therapeutic style may have significant implications for therapeutic outcomes (Lazarus, 1993).

Based on therapists’ self-descriptions of in-therapy behaviour, Rice et al. (1972) identified six therapeutic styles via factor analysis. These styles were labelled *Blank screen*, *Paternal*, *Transactional*, *Authoritarian*, *Maternal*, and *Idiosyncratic*. They found a significant distinction between the styles of experienced and inexperienced therapists. Specifically, experienced therapists described themselves as most like *Idiosyncratic* and least comparable to *Maternal*, while inexperienced therapists had the opposite pattern of responding. These findings demonstrate that therapeutic styles are able to be discerned, linked to demographic data, and change over time. However, since Rice et al.’s research, no attempts have been made to replicate the styles identified.

Also using factor analysis, Coombs, Coleman, and Jones (2002) identified three in-session therapist styles when working with clients’ expressions of emotion; *Collaborative emotional exploration*, *Educative/directive process*, and *Patient inhibition*. Subsequently, they attempted to link these styles to treatment outcome. While *Collaborative emotional exploration* and *Patient inhibition* were associated with positive client outcome, *Educative/directive process* showed a non-

significant relationship to therapy outcome. Given that no therapist style was inextricably tied to a therapy model, Coombs et al. suggest that in-session exploration of emotion is influential of therapy outcome irrespective of the therapeutic modality. Nevertheless, as there have been no attempts to replicate the findings of this exploratory study, its results are tentative at best.

Lastly, using a subset of DPCCQ items, Orlinsky and Rønnestad (2005) identified two independent second-tier factor-analytic dimensions — *Healing Involvement* (HI) and *Stressful Involvement* (SI) (Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2014). First level DPCCQ factors defining HI were *basic relational skills, accommodating, invested, and affirming*. Alternatively, first level DPCCQ factors defining SI were *frequent difficulties, avoidant coping, boredom, and anxiety*. According to Zeek et al. (2012), depending on the amount of HI and SI reported, therapists could be categorised into one of four work involvement patterns; *Effective practice* (high HI, low SI), *distressing practice* (low HI, high SI), *challenging practice* (high HI, high SI), and *disengaged practice* (low HI, low SI). Orlinsky and Rønnestad (2005) found that of 3500 therapists, 50% fit *experienced practice*, 23% experienced *challenging practice*, 17% presented as *disengaged practice*, and 10% fit *distressed practice*. The ability of the DPCCQ to style therapists' work involvement patterns has relevance for the styling literature and therapy practice.

The aforementioned research tentatively suggests that a range of therapist styles may be discerned and linked to client change. However, given the lack of studies attempting to replicate previously discerned practice styles, no clear consensus has emerged (Dolan et al., 1992). This important field of research appears to be hampered by a lack of research continuity, clarity, and direction. Ultimately, more could be done to contribute to understanding the nature of therapeutic encounters, particularly given the significant potential of this field to do so.

Summary

The key themes derived from the literature are as follows. Firstly, the majority of treatment outcome research has primarily focused on treatment techniques

despite research suggesting that therapeutic outcome may be more contingent on therapist factors. Furthermore, several key therapist variables have been empirically linked to therapeutic outcome, with virtually no research attempting to understand the relationships between variables. Despite well-founded assertions that the emotional and relational components of therapists are influential of the psychotherapeutic result, the extant literature has largely focused on the cognitive domain of therapist variables. The ES intelligence, skills, and competencies of the therapist have been tentatively linked to therapeutic outcome and it is believed that client change is the consequence of multiple interrelated therapist factors rather than isolated variables. Lastly, scant research has attempted to investigate therapists' therapeutic styles with limited continuity between styling studies largely hampering this research field.

Given these conclusions, the following considerations were conceived. Firstly, are there consistent relationships between independent ES skills and can these relationships be mapped? Furthermore, are there discernable relationships between clusters of similar ES skills? Secondly, how are these ES skills woven into practice styles? Finally, do therapists have consistent ES practice styles, can these styles be used to highlight similarities and differences between therapists, and can these ES practice styles be linked to client change? These considerations will underpin and inform our research questions, aims, and objectives.

Foundational Research

Given the above considerations, Harvey et al. (2016) a) conceptualised therapists' ES skills into a working model and b) profiled therapists according to the ES skills they apply in practice. Their research, fundamental to this current thesis, has furthered our understanding of ES skills in practice¹. The following paragraphs summarise Harvey et al.'s research.

Making use of MDS methodology, Harvey et al. (2016) organised central ES themes gathered from the relevant literature into a three dimensional conceptual model. As a result of this procedure, Harvey et al. found that ES skills could be

¹ To better understand methods used in Harvey et al.'s (2016) research, refer to the methodology sections of chapters three and four.

organised into 17 groups: *Therapists client beliefs, Tailors therapy, Emotionally aware of client, Response to connection issues, Client determination, Language use, Clarifies, Discrete behaviour, Guides, Therapists beliefs, Positive emotional connection, Structure, Current in literature, Emotionally self-aware, Open to feedback, Emotion regulation, Culturally aware, and Emotionally reflective*. These clusters were spatially dispersed throughout a conceptual map between three dimensions: X) *Emotionally aware of client* (i.e., aware of clients' emotions) to *Emotionally self-aware*, Y) *Discrete behaviour* to *Therapist collaboration with client*, and Z) *Therapist beliefs* (i.e., about client and therapy) to *Structure* (Figures 4 & 5).

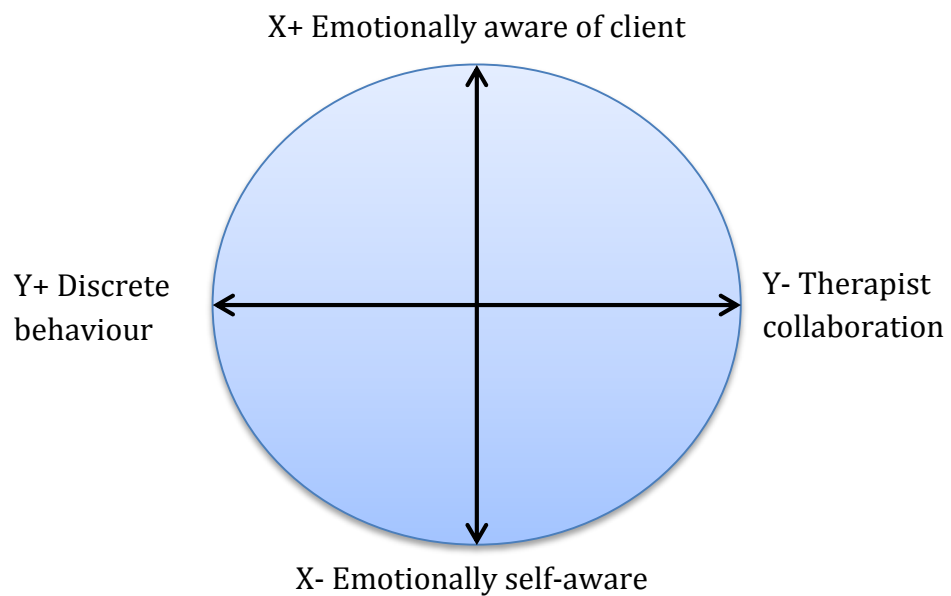


Figure 4. Representation of the three dimensional model developed in Harvey et al.'s (2015) study viewed from Z direction.

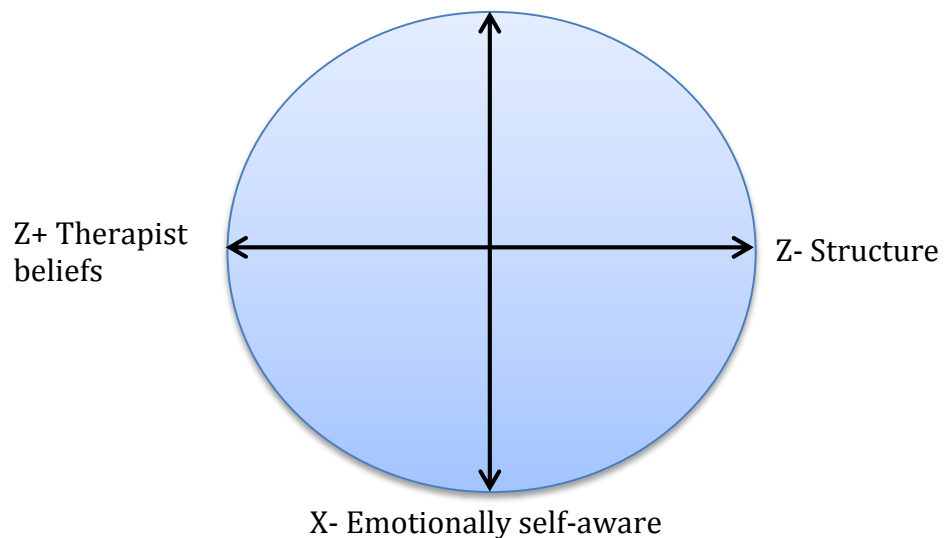


Figure 5. Representation of the three dimensional model developed in Harvey et al.'s (2015) study viewed from Y axis.

In the second study of their research, using Subjectivity Profiling methodology with 47 therapists, Harvey et al. (2016) reduced the ES skills used during their initial study into ten core themes (hotspots); *Client in context*, *Self-reflective critique*, *Therapeutic use of own experiences*, *Balanced collaboration*, *Tailoring therapy*, *Client empowerment*, *Behaviour expressions*, *Verbal easing*, *Expert role*, and *Self-secure*. Subsequently, therapists were profiled across these ten hotspots according to ratings assigned to comprising ES skills. Based on similar patterns of responding, Harvey et al. categorised therapists according to their therapeutic profiles, assigning therapists to one of seven therapeutic styles. These styles were then labelled according to the unique elements of their profiles; *Unemotional guider*, *Overt behaviours and unguiding*, *Emotion centred and unguiding*, *Client-centered and individualising*, *Moderate*, *Self-improver*, and *Professional partnership*.

Harvey et al.'s (2016) research has a number of significant limitations. Firstly, their ES skill list was incomplete, as evidenced by an observable void on the surface of their model (Figures 6 & 7; Appendix A). This limitation likely affected the clusters and hotspots identified, thus influencing the therapy styles discerned. Secondly, their ES skill list contained overlapping items as well as items with wording issues which may have influenced their results. Thirdly, no attempts were made to validate their model with a foreign-language sample as to appraise the semantic consistency of the clusters identified. Lastly, their sample size was relatively small for their profiling study, again, limiting the application of their findings. These considerations point to the limitations of Harvey et al.'s results and provide the basis for this thesis.

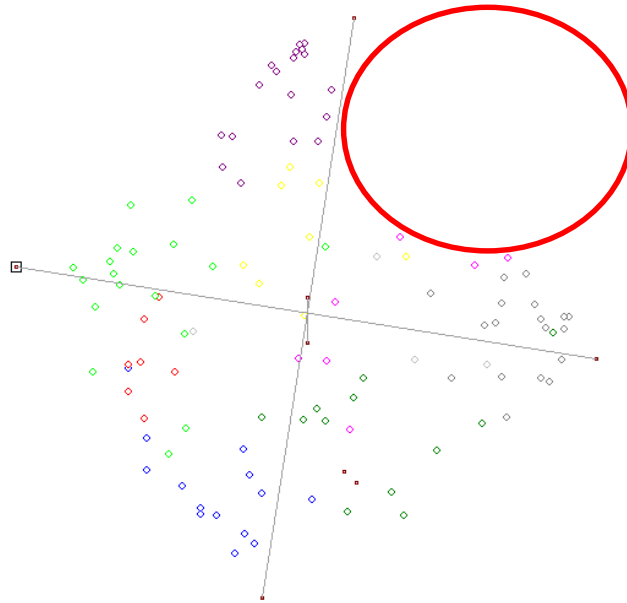


Figure 6. Harvey et al.'s (2016) Original MDS model showing individual items with emphasis on item void.

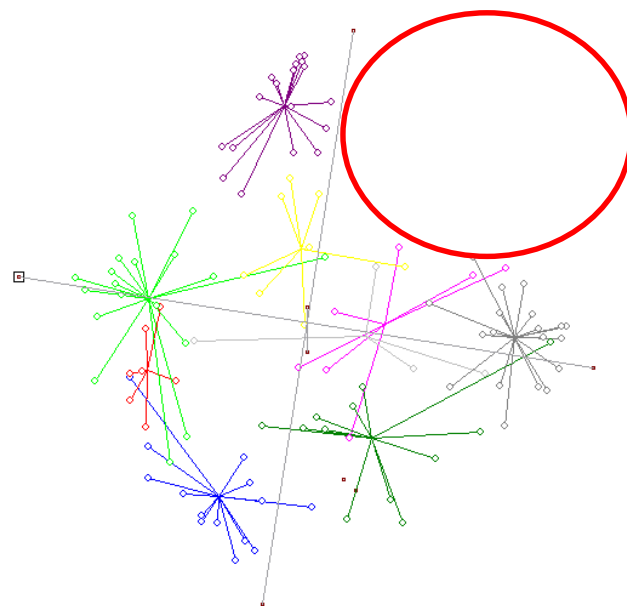


Figure 7. Harvey et al.'s (2016) Original MDS model with clusters displayed emphasising item void.

Specific Aims and Expectations

The aims of this thesis are primarily to replicate, validate, and extend exploratory research conducted by Harvey et al. (2016). Specifically, these aims are:

(a) To comprehensively summarise the ES skill domain by extending and revising the content of Harvey et al.'s (2016) original ES skills list.

(b) To create a new MDS model using the pool of ES skills generated in aim (a) and compare this with Harvey et al.'s (2016) Original model.

(c) To validate and extend this new three dimensional map with a foreign-language sample as to assess the semantic stability of ES skill relationships.

(d) To reduce our pool of ES skills into hotspots and evaluate and style therapists' emotional response patterns across the hotspots they employ in their practices.

(e) To statistically link hotspots and therapist styles with a range of demographic data including a modified measure of the therapeutic relationship.

As this thesis extends on Harvey et al.'s (2016) procedures, my predictions are largely in accordance with Harvey et al.'s findings. It is expected that new ES skills will be discernible from the literature and that overlapping or ambiguous items of Harvey et al.'s original item list may be altered or removed. It is predicted that meaningful relationships will be identified between ES skills of the item pool developed in aim (a) thus producing a new MDS model that will largely reflect Harvey et al.'s (2016) Original solution. Similar to both Harvey et al. (2012) and Rosenblatt's (2012) research, it is expected that a foreign-language population (Japanese) will organise therapists' ES skills in a similar way to a New Zealand general population. From this finding, a model combining both foreign-language and New Zealand conceptualisations will be constructed and a) create a more robust and valid MDS model and b) potentially facilitate the application of this model's results to a foreign-language population. It is predicted that the ES clusters generated will reflect those identified in Harvey et al.'s research and that meaningful therapist practice styles will emerge due to patterns of responding across these hotspots. Provided similar hotspots are identified, it is expected that the therapeutic styles generated in this research will also be recognisably similar to those identified in Harvey et al.'s (2016) research. Lastly, it is expected that statistical links will be established between demographic data and specific hotspots. Specifically, that relationships reflecting the literature findings will be identified between particular hotspots and therapist gender, age, and experience.

CHAPTER THREE

STUDY ONE

“It appears that adept therapists are able to respond to what clients offer in ways that move the therapy forward”

-Blow et al. (2007, p. 308)

Methodology

Mapping Psychological Constructs

A number of psychological studies have employed MDS, a family of multivariate methods, to investigate the cognitive models implicitly employed by individuals to make sense of a diverse range of concepts — e.g. colour, common factors, truancy, peer groups, etc. (Bimler & Kirkland, 2001; DeSteno & Salovey, 1997; Harvey, Bimler, Evans, Kirkland, & Petchel, 2012; Kirkland, Bimler, Drawneek, McKim, & Schölmerich, 2004; Harvey et al., 2016; Paulson et al., 1999; Rosenblatt, 2012; Rounds & Zevon, 1983; Shepard, 1987; Tracey, 1991). MDS enables model development by displaying perceived relationships between concepts through spatial representation (Cox & Cox, 1994; Kirkland et al., 2004; Kruskal & Wish, 1978). Typically, items are plotted in an N-dimensional Euclidean space, in which their perceived similarities to other items are directly proportional to their spatial proximity. By this process, implicit cognitive processes and cognitive maps for a range of tasks may be revealed, thus delineating underlying cognitive structures. Furthermore, as item voids (areas lacking items) can be clearly distinguished on the surface of a MDS solution, model analysis allows researchers to easily discern current gaps of knowledge thus guiding future investigation (Harvey et al., 2016; Tracey, Lichtenberg, & Goodyear, 2003).

For clarity, an MDS model is generated from a semantic matching task in which participants indicate how similar or dissimilar two concepts are perceived to be; in the case of this project and Harvey et al.’s (2016) research, these concepts are the ES skills of therapists. In this way, maps produced via MDS methodology do

not represent the application of a concept (i.e., whether an ES skill is applied in a therapist's practice), but rather, represent how people view concepts to relate. Stable and valid models produced via MDS methodology may later be used to supplement analyses (such as subjectivity profiling methodology) as to interpret these applied concepts.

Profiling

'Subjectivity Profiling' or 'Hotspot Modelling' is a procedure complementary to MDS and has been used in a number of recent studies to investigate differences between individuals and groups of individuals (Bimler & Kirkland, 2001; Harvey et al., 2012, 2015; Kirkland et al., 2004; Stewart et al., 2005). By assigning participant ranking data to items embedded in an MDS framework, model content can be clustered into key recurring themes across participants and summarised as profiles (common patterns). By organising items into clusters, MDS creates an empirical framework for interpreting subjects' personal perceptions, thereby contributing to the understanding of ambiguous content domains. Both MDS and Subjectivity Profiling are considered ideal methods for use to conceptualise and better understand ES skills.

Foundational Research

The majority of the items used in this research were originally generated in previous research conducted by Harvey et al. (2016). In their initial study, 109 specific ES skills of effective therapists thought to encompass the entire content domain were distilled from theoretical literature between the years 1970-2009 (Appendix B). Using GOPA-sorting (Group, Opposite, Partition, and Add) developed by Bimler and Kirkland (1998, 2001, 2003) and subsequent MDS analysis, the 109 items were sorted into a three dimensional semantic map based on the perceived similarities and differences among them (Appendix A). This map provided a framework to display the inter-relationships between ES skills and to develop an understanding of how these concepts relate to one another. In Harvey et al.'s latter study, alterations were made to the format of ES skills, changing these from descriptors with no individualisation (e.g. "Considers therapy an interactive

process”) to items that were personalised to the participating therapist (e.g. “I consider therapy an interactive process”). During analysis of their semantic map, Harvey et al. identified an item void on the surface of their solution thus indicating the likely limitation of a content gap in their current conceptualisation.

STUDY ONE: METHOD

Item Generation

As stated previously, in this research an ES skills is defined as a behaviour, cognition, belief, or feeling that impacts emotionally and/or socially on the relationship between client and therapist. Three approaches were used to update the pre-existing item list established and used in Harvey et al.'s (2016) research (Appendix A). These approaches included a content analysis of interview transcripts with therapists perceived to be effective, a literature search between the years 2009 and 2012, and an analysis of Harvey et al.'s semantic map. To reduce experimenter bias, approaches one and two were completed in isolation of the original item list.

Approach One: Content Analysis

Content analysis was performed on the transcripts generated from independent interviews with three New Zealand-practicing clinical psychologists who had outcome effect sizes greater than 0.7 as established by client responses on the Outcome Rating Scale (ORS; Miller & Duncan, 2004). Interviews generating these transcripts were conducted by de Vries (2012) and targeted the ES skills these therapists believed influenced their practices.

Following inductive content analysis guidelines (Elo & Kyngas, 2007; Hsieh & Shannon, 2005), each transcript was read in full, from which, statements that pertained to, or demonstrated, aspects of ES skills were identified. These statements were then categorised as to provide a means of describing the phenomena. Concepts were subsequently discerned from this categorisation process and worded to suit the format of the standard item list; that being, personalised to the participating therapist. Lastly, each item list generated from the three transcripts was aggregated with repeating and redundant items removed.

Approach Two: Literature Search

A broad literature search between the years of 2009 and 2012 was conducted to ensure that novel concepts developed in the literature after the original item list was conceived were included in this project's overall item list.

To maximise the probability that the sampling of items provided adequate coverage of ES skills in the theoretical literature, a structured approach was used partly following the guidelines for conducting meta-analyses. This involved pre-established inclusion and exclusion criteria and mirrored the article selection process of that used in formal reviews (Meline, 2006).

Databases, terms, and parameters of search. A review of Massey University's library resources identified that the databases Google Scholar and Web of Science were databases considered to easily identify the largest range of related articles for this study's topic. These databases were also used in similar research of therapeutic alliance ruptures conducted by Rosenblatt (2012). Searches were filtered by the date of publication between January 2009 and July 2012.

The identical search terms developed by the researcher were used in both databases were as follows: "master", "expert", "effective", "ability", "emotion* skill*", or "emotional intelligence", AND, "shrink", "clinician*", "psychologist*", "practitioner", "counsellor*", or "counselor*". An additional parameter used to limit searches was only peer-reviewed journals available in English.

To control for particular search terms that yielded too many articles (i.e. $N > 25$), procedures were established to produce a manageable number of results. Instances where this was necessary were largely due to the semantic quality of particular search terms and specifically, when using the search engine Google Scholar. For example, as well as generating relevant results, the search term "master practitioner*" identified literature relating to research sampling cohorts of participants holding masterate qualifications. Too few search yields were not considered problematic due to the broad nature of the initial search criteria and abundance of literature yielded from those search terms.

If more than 25 articles were identified:

1. Articles were ordered using the database's relevancy sort option.
2. Only the first 25 abstracts were reviewed for inclusion.

A maximum of 25 articles reviewed per search term was considered appropriate due to the number and variety of search terms inputted and the overlap of relevant literature identified during this approach.

Article inclusion criteria. Only abstracts that evidenced discussion of the aforementioned search terms with respect to psychology, emotion skill, or talking therapy was selected for further examination.

Approach Three: Map Analysis

An analysis of the original 109 item semantic map was undertaken to identify any possible pre-existing gaps in content. As a complete semantic map is represented by a complete sphere of items, by identifying holes on the map's surface (areas with no items), items can be constructed that are believed to fill such holes. It is important that gaps in the Original map are filled as these holes likely represent concepts that are currently lacking in the original item list (Harvey et al., 2016). As mapped items that are perceptively similar are spatially arranged to be close to one another, researchers are able to discern what item, or items, may fill an item gap on the map by analysing items surrounding the void. Furthermore, as items that are perceived as semantically opposite to one another are positioned directly opposite one another on the map, researchers are able to discern the item, or items, that are required to fill such a hole by viewing the items in the map opposite the hole and reversing their concepts (Harvey et al., 2016).

Map and dendrogram analysis also allowed for the identification of redundant items in Harvey et al.'s (2016) existing pool of ES skills. Items in close proximity to one another on the dendrogram and/or superimposed on the Original map indicated items that were statistically perceived as analogous. Statistically analogous items are also considered to be semantically similar and therefore the inclusion of both items in the pool of ES skills is unlikely to be novel. Item pairs identified by this process were semantically compared with a) one another, b) with

items proximal in the semantic model and/or dendrogram, and c) with item inclusion criteria. Following this comparison, a three-person validity panel consisting of the research team opted for the ideal ES skill of the item pair to retain. Where agreement could not be reached, neither item was removed.

STUDY ONE: RESULTS

Approach One: Content Analysis

Between 80 and 94 items were generated from each therapist transcript. On 12 occasions the same, or extremely similar, ES skills were present in each participant's transcript. These competencies regarded honesty, collaboration, gentle emotional confrontation, valuing client feedback, an awareness of personal emotions during practice, ensuring clients don't leave a session feeling worse than when they entered, appropriate mirroring, flexibility in methods, carrying emotions with them out of therapy, monitoring of their own performance, recurrent self-reflection, and a belief in emotional contagion.

Similarities were also evident between pairs of therapists. Corresponding themes were identified on seven occasions between both transcripts one and two, and transcripts one and three. ES skills common between transcripts one and two included conveying warmth, tailoring their approach, offering clients options, meeting the client where they are (e.g. emotionally, cognitively, etc.), allowing clients space, self-reflection when expected progress is not occurring, and putting themselves in their clients' shoes. Akin ES skills relating to transcripts one and three included a belief that their therapeutic style was unique, knowledge regarding the appropriate amount of empathy to use, self-disclosure when appropriate, setting emotional boundaries, a belief that their private emotional life influences their practice, awareness of their client's affect, and a belief that it can be acceptable to cry in front of clients. Furthermore, five overlapping ES skills were observed between transcripts two and three. These ES skills included a belief that they are good at building rapport, a belief that they are the expert, a belief that the relationship is therapeutic, ensuring clients feel understood, and valuing client insights.

Comparatively, one instance of direct difference was observed between transcripts one and two. This difference regarded the therapist's role within practice, with therapist one reporting that they encourage the client to control the flow of therapy and therapist two indicating that they lead therapy in their practice.

Following analysis, transcript item-lists were aggregated and redundant items removed resulting in a combined transcript item-list consisting of 182 items. Two examples of the items produced and their format are “I am persuasive,” and “I believe that I am the expert.”

Approach Two: Literature Search

The literature search yielded over 350 articles for abstract review. Of these, 25 were selected for further analysis and data generation purposes with 21 articles contributing to a 72 item list developed from this approach.

Article Representativeness

Of the 21 articles, several different fields of psychology were encompassed including clinical, psychiatric, group, couple and family, emotion and behaviour, and social. Medical, counselling, and career rehabilitation literature also contributed articles.

Practitioners working with diverse age groups, from differing theoretical backgrounds and in varied clinical settings were present in the included literature; from children to aging populations, psychoanalytic therapists to humanistic counsellors, and group therapy settings to out-patient settings.

Literature included populations sampled from a variety of OECD countries including the USA, Canada, the UK, Finland, Sweden, Norway, and Australia.

Article Review

When able, compound presentations were separated into multiple discrete concepts with phrasing from the original literature preserved. For example, “clinicians need to be flexible and ask for feedback” was separated into two separate items (Moore, 2010, p. 25). By this method multifaceted statements could be simplified into discrete concepts. Furthermore, phrases that require clinical expertise to understand were either excluded or altered as to ensure understanding among the general population while still keeping their original meaning.

Considering the presence of an original item list and the breadth of coverage included in these 21 articles within a narrow date parameter, the research team considered the number of contributing articles identified as suitable.

Approach Three: Map Analysis

One item hole on the surface of Harvey et al.'s (2016) semantic map was evident following examination. Items forming the perimeter of this void were: "I value helping others," "I strive for congruence between my values and my behaviour," "I draw on theory to help understand the client's feelings/experiences," and "I am open to feedback." Items positioned directly opposite to this gap were "I encourage clients to find their own motivation for change" and "I believe clients know what is best for themselves." These ES skills indicate that the missing item should lack emotion terminology and be a therapist-directed behaviour. Furthermore, it should be an ES skill currently absent from the item pool and have at least some theoretical underpinning. Consequently, through collaboration with a five-person validity panel consisting of emotion-focused researchers independent to the current study, "I model the appropriate way to act for my clients" was generated with the objective of filling this item void.

Item Removal

Items from the original 109 item list were reviewed to eliminate items that were considered redundant, too vague or specific, or contained jargon. As stated previously, to quantitatively supplement a qualitative approach, Harvey et al.'s (2016) Original semantic map and dendrogram were used to evaluate the perceived relationships between original items thus inferring their contribution to content. This process reduced the original item list from 109 items to 87 items.

Item Reduction

Following item generation via the aforementioned approaches, the researcher reduced both the new and original item lists over the course of four separate

iterations. Guided by Delphi exercise methodology (Michie et al., 2013), the final verification was conducted by a validation panel consisting of seven emotion-focused researchers independent to the current research project.

First Iteration

The items generated from the content analysis, literature search, and map analysis were combined to generate an initial item list consisting of over 250 items. Two types of items were immediately eliminated: a) duplicates; and b) redundant/overlapping items (e.g. “I practice in a culturally competent manner” and “I believe I am culturally competent”). This process yielded 132 items.

Second Iteration

Items were eliminated that were considered too specific, too vague, or contained language inappropriate to the general population. The goal was to find items that would not be endorsed too often or too infrequently, as such extreme items would not add value to the later subjective stages of this thesis; both over-endorsed and under-endorsed items may hinder the ability to identify patterns of responding among groups of clinicians. For example, “I follow a specific approach to treatment” was considered too vague and “I adhere to a humanistic system of therapy” was considered too specific. This resulted in 117 items remaining.

Third Iteration

The revised original item list and the newly generated item list were combined with duplicate and redundant items removed. This resulted in an item list consisting of 156 items.

Expert Consensus

Lastly, a seven-person validity panel consisting of emotion-focused researchers independent to the current study appraised the remaining combined item list and eliminated a further five items which they considered unnecessary. This resulted in a final combined item list of 151 items (Appendix C).

STUDY ONE: DISCUSSION

The aim of this study was to extend and revise an original item list created and used in Harvey et al.'s (2016) research. The results supported the general hypotheses, that novel items could be discerned via three approaches, while redundant items in the original item list could be identified and removed. Overall, 64 new items were generated and 22 items were removed from the original item list, resulting in a new combined item list of 151 items. The following discussion contrasts items generated during approaches one and three with contemporary literature, and considers the limitations of this study and its implications.

Approach One: Analysis of Exceptional Therapists' Transcripts

During approach one, items were generated after qualitatively analysing the transcripts of three New Zealand practicing therapists with noteworthy therapeutic outcome effect sizes. The initial purpose of these interviews, conducted by de Vries (2012), was to investigate how these practitioners use emotions in practice. The findings of this approach are compared and contrasted below with findings of the literature as to a) consider the coverage of ES skills identified in de Vries' therapist transcripts, b) to contemplate whether the themes identified via this approach were consistent with the general literature, and c) to tentatively consider the areas of content identified that may determine therapy effectiveness.

Literature Accordance

Overall, 12 instances of direct overlap were recorded in which the same, or extremely similar, ES skills were present in each therapist's transcript. Furthermore, seven analogous concepts were recorded between both therapists one and two and therapists one and three, while five instances of overlap were evident between therapists two and three. In contrast, one instance of discrepancy was identified between therapists one and two who diverged on the practice of directiveness in therapy. Overlap was largely observed between shared ES skills and the literature.

As expected, the competencies generated during this approach reflect major themes found by de Vries (2012) — the study for which these interviews were conducted. It would appear that each of the major themes discerned by de Vries – genuineness, tailoring therapy, positive expectations, emotional awareness, achieving objectivity, connecting with empathy, limiting empathy, balancing relationship and process, and working collaboratively – could appropriately harbour at least one shared skill discerned via this approach. While this observation is not surprising given that each study analysed identical transcripts, it is reassuring as it indicates a degree of reliability between analyses. While de Vries falls short of explicitly identifying the themes which he believes account for the interviewees' therapeutic effectiveness, his closing remarks suggest that careful consideration of actions and expressions, knowledge of emotional processes, and establishing a safe and non-judgemental therapeutic relationship, were prioritised by all participating therapists. Clearly, the identification of ES skills comprising these themes will be an important objective of the succeeding studies of this research.

Of the nine 'master therapist' characteristics Jennings and Skovholt (1999) identified, four are analogous with the shared ES skills discerned from therapists' transcripts analysed during this study. Jennings and Skovholt's characteristics that overlapped with this study's shared ES skills were: *attending to one's own emotional well-being, an emotional self-awareness, an emotional receptivity, and a strong belief in a beneficial therapeutic alliance*. As these concepts compose all of the emotional characteristics identified by Jennings and Skovholt, it is fitting that they were identified as shared ES skills during this approach.

On the other hand however, five of the nine master therapist characteristics identified by Jennings and Skovholt (1999) were not analogous with shared content identified during this approach. While several of these characteristics relate to the cognitive domain of their CER model, thus largely outside the ES scope of this research, two relational characteristics were also absent in content discerned through the analysis of the interviews. These relational characteristics regarded the possession of strong relationship skills and the application of these superior relational skills in practice. Given the ambiguous and multifaceted nature of the attributes discerned via this content analysis, it is conceivable that a

combination of skills identified during approach one reflect the above therapist characteristics. Accordingly, as Jennings and Skovholt describe strong relational expertise as “skills of listening, observing, and caring for the welfare of others” (p. 7), the items “I believe I have good communication skills,” “I seek to understand my clients,” and “I care about my clients,” discerned from therapist transcript two, reflect the facets of the above characteristics. With the exception of cognitive characteristics, the above findings demonstrate considerable overlap between the skills discerned via this approach and Jennings and Skovholt’s master therapist characteristics.

The shared skills identified during this approach were also evident in the wider empirical literature. The exceptional psychiatrist characteristics of flexibility, sensitivity to a client’s emotions, personal and professional growth, and the ability to create an effective therapeutic alliance, identified by both Albert (1997) and Goldberg (1992) were also identified in therapist transcripts analysed during this study. Similarly, empirically monitoring one’s own effectiveness and routinely seeking feedback from clients was identified in both the literature and this study as salient to effective therapeutic practice (Saggese, 2005). Lastly, collaboration, a shared ability discerned during the interviews, has consistently been asserted as a curative mechanism of multiple systems of psychotherapy (Bachelor, Laverdiere, Gamache, & Bordeleau, 2007; Kazantzis & Kellis, 2012; Orlinsky, Rønnestad, and Willutzki, 2004). The above examples demonstrate the congruence between the skills identified from analysis of the interviews and those in the literature.

A notable contrast in the directiveness of each therapist was observed between therapist transcripts one and two, with therapist one reporting they encourage the client to control the flow of therapy and therapist two indicating that they lead therapy in their practice. A similar difference was observed in Harvey et al.’s (2016) research regarding their hotspot *Expert role* defined as the therapist leading clients through therapy. One style routinely emphasised the presence of an *Expert role* whereas all other practice styles omitted this. While this finding may be a distinguishing factor between practitioners belonging to each style, as Harvey et al.’s styles consisted of a general sample of therapists, the same contrast was not expected among the three effective therapists of this approach.

This finding either disputes the notion that exceptional therapists always act in homogenous ways, indicates that the directiveness of a clinician contributes little to therapeutic effectiveness, or both. Clearly further research is required to clarify these conjectures.

Absent Emotional-Social Skills

Numerous ES skills in the literature identified as salient to effective practice were absent from the findings of this content analysis. For example, Norcross (2005) identified regular participation in personal therapy as essential in the development of an effective clinician, which was largely absent in therapist transcripts. While similarities were apparent, with therapist three reporting that they would undertake personal therapy if required, ES skills directly reflecting Norcross' assertion were lacking. This finding was not unexpected however, given the breadth of therapist characteristics in the literature and the restricted scope of the interviews analysed during this approach. The fact that no direct conflicts were observable between this approach's findings and those in the literature is of greater significance. This finding supports the premise that the interviewed therapists, whose transcripts were analysed during this approach, were of a high therapeutic calibre. However, like criticisms levelled at master therapist research (Orlinsky, 1999), as no control group of average therapists were interviewed, we are unable to determine if the ES skills found are specific to exceptional therapists or common among the majority of practitioners.

Approach Three: Analysis of Original Model

The aims of approach three were, a) the generation of content identified as lacking in Harvey et al.'s (2016) original item list, and b), the removal of ES skills considered redundant or unclear. Both of these aims were qualitative processes supplemented by the statistically derived semantic map generated and used in Harvey et al.'s research.

Adding an Item

An ES skill gap was observable in Harvey et al.'s (2016) solution (revisit Figures 6 & 7), encircled by the items "I value helping others," "I strive for congruence between my values and my behaviour," "I draw on theory to help understand the client's feelings/experiences," and "I am open to feedback." Furthermore, the ES skills "I encourage clients to find their own motivation for change" and "I believe clients know what is best for themselves" were directly opposite this item void. Consequently, through consideration of these ES skills, the item "I model the appropriate way to act for my clients" was generated with the objective of filling this item gap.

The concept of modelling was first introduced by Bandura (1969), and has relevance in psychological, educational, and organisational literature (Hendy & Raudenbush, 2000; Hoover & Giambatista, 2009; Kruger, 2013). According to Lynch, Chapman, Rosenthal, Kuo, and Linehan (2006), therapist modelling may promote client flexibility and increase client validation of personal reactions and behaviours. For this reason, this ES skill may have value in a therapist's practice. Given that this ES skill was semantically generated to occupy a void in Harvey et al.'s (2016) solution, it will be important to locate it in solutions generated in succeeding studies as to assess the success of this aim.

Removing Items

By reviewing the proximity of ES skills in Harvey et al.'s (2016) model and subsequent deliberation, a three-person validity panel consisting of the research team deemed that 22 items of Harvey et al.'s original ES skill pool were analogous and removed from the item list of this study. According to Cox and Cox (1994), as all items spatially relate to one another when displayed in a MDS solution, when items are removed, the proximity of all remaining items in the model will slightly decrease, thus resulting in more spatial distance between points in the model. However, given that a large number of new items will also be incorporated into Harvey et al.'s model in the following study, Cox and Cox's assumption would suggest that the average spatial distances between items in future MDS solutions will decrease.

Limitations

Item generation and item removal were qualitative processes, therefore, both were affected by researcher bias. To reduce this bias, validity panels were regularly consulted around decisions informing item inclusion and exclusion. When disagreements arose regarding item inclusion, compromise was sought when appropriate, otherwise the argument most supported by the validity panel was selected. Furthermore, when considering approach three, the Original solution was viewed as to quantitatively inform the item generated.

While aligned, the transcripts analysed during approach one were not generated for the purposes of this study. As noted previously, these transcripts were the product of a colleague's investigation with three exemplary New Zealand therapists seeking to understand how practitioners use emotions in practice. As a result, the possible ES skills available from these transcripts were constrained by the aims of de Vries' (2012) research. It is possible then, that the participating therapists may employ a variety of other ES skills in their practices, likely pertaining to the social domain, which were not broached during interviews. In addition, further limitations of this approach include both the small sample size and the unrepresentative sample demographic influencing the generalizability of the ES skills discerned. Nevertheless, given the presence of a pre-existing item list and the other complementary approaches employed to achieve the aims of this study, the above limitations are largely mitigated.

Several of the ES skills identified during approach two were derived from articles theoretical in nature thus lacking empirical support for their benefit in practice (Back, Bauer-Wu, Rushton, & Halifax, 2009; Betan & Binder, 2010; Bruce, Manber, Shapiro, & Constantino, 2010; Kazantzis & Kellis, 2012; Moore, 2010; Tannen & Daniels, 2010). These ES skills highlighted an important consideration; despite clear face validity, is it appropriate to include potentially valuable theoretical concepts lacking empirical grounding? As it was considered more important to produce a complete model of theoretical and proven ES skills than a limited proven-only map, inclusion of theoretical ES skills was considered acceptable. Future studies may refine this map by considering the benefit of its comprising skills when more evidence comes to light.

As discussed in a previous section, another challenge of this approach regarded the translation of psychology-specific skills into general language while maintaining item content and context. For example, through careful consideration, the ES skill termed 'compassionate silence' identified in Back et al.'s (2009) research was expanded to "I use silence to communicate my understanding." Given that the penultimate item list was reviewed by a validation panel that assessed for both redundant and unclear content, the possibility of items being misunderstood in the final ES skill pool was minimised.

Conclusions and Implications

These results support the two general hypotheses of this study. Firstly, that new and novel items contributing to Harvey et al.'s (2016) original item list could be discerned through three approaches and secondly, that redundant original items could be identified and removed.

Overlap was evident between the findings of approaches one and three and the literature. One instance of direct difference was recorded between two therapist transcripts of approach one. However, no other instances of direct ES skill contrast were distinguishable throughout the approaches of this study. Lastly, one ES skill was generated in accordance with approach three and is posited to fill an item gap observable on the surface of Harvey et al.'s (2016) Original map. Limitations of this study included the qualitative nature of content generation and removal, the use of interview transcripts conducted for different research aims, the inclusion of ES skills theorised to beneficially influence therapeutic outcomes despite a lack of empirical grounding, and the accurate conversion of psychotherapy-related jargon into general language.

In closing, the abundance of new content captured demonstrates the value of this study in updating Harvey et al.'s (2016) existing pool of ES skills. Determining the relationship between the newly generated ES skills and Harvey et al.'s original ES skills would be the next logical step in understanding therapists' ES behaviour in practice.

LINKED THOUGHTS I

Research investigating therapists' ES skills in contemporary literature is lacking. Furthermore, few studies have explored the relationships between therapists' practice behaviours. The DPCCQ (Orlinsky et al., 1999) and FIS (Anderson et al., 2009) have had some success in exploring facets of therapists' practice behaviours, however, neither has undertaken to comprehensively model therapists' ES skills in practice. Harvey et al.'s (2016) research has begun modelling therapists' ES skills in practice, however their research has been hampered by several significant limitations. One such limitation being the presence of an item void on the surface of their model.

The void evident in Harvey et al.'s (2016) solution and the 64 novel concepts discerned during study one of this research indicate that Harvey et al.'s item coverage of therapists' ES skills was likely incomplete. How these new ES skills interrelate with Harvey et al.'s original ES skills and whether the complete item pool adequately reflects the entirety of therapists' ES skills are two key questions emerging from these results.

By embedding the new content generated in the previous study into Harvey et al.'s (2016) solution and subsequent analysis, study two of this thesis will attempt to establish a) if a stable and meaningful solution can be generated, b) that the current pool of items adequately reflects the expected content domain, and ultimately, c) that the solution generated is suitable for use in the subsequent studies of this research project. It is predicted that a stable and meaningful solution that comprehensively covers the domain of therapists' ES skills will be generated from new and old content. Furthermore, it is expected that the new model generated will be largely comparable to Harvey et al.'s Original solution. If key elements still appear to be missing from the resultant solution, further item generation and item incorporation will be required before progressing onto subsequent studies of this thesis.

CHAPTER FOUR

STUDY TWO: METHOD

“Of course, it may be that emotional skills are intercorrelated, but such a conclusion awaits the findings of well-designed experiments”

-Salovey and Mayer (1990, p. 210)

Participants

A convenience sample of 25 English-speaking lay-persons was recruited to participate in this study by word of mouth and personal contact from the Auckland and Manawatu regions. There were 5 (20%) men and 20 (80%) women. 75% ($n = 19$) of participants were New Zealand European, while 12% ($n = 3$) were from the USA and 8% ($n = 2$) were from elsewhere. The age of participants were as follows: 4% ($n = 1$) were aged less than 20; 68% ($n = 17$) were aged between 21 and 30; 16% ($n = 4$) were aged between 31 and 40; and 12% ($n = 3$) were aged over 41.

Materials

An information and instruction sheet outlined the research objectives and procedure instructions (Appendix D). A demographics and consent form recorded age, nationality and gender (Appendix E). A response form derived from Kirkland and Bimler’s template for administering “GOPA” card sorts, reiterated procedure instructions and provided an area for participants to record responses (Appendix F).

A representative sample of 106 English-language items pertaining to ES interactions in therapy was taken from the 151 therapist item pool established in study one of this research (Appendix G). This item pool consisted of 43 original items, half of the remaining 87 original items used in Harvey et al.’s (2016) research, used as anchor points to situate the 64 newly generated items of study one into the Original semantic map; the rationale and process of this item

reduction is expanded in a following section. Items were typically short statements describing an ES skill therapists may use in their clinical practices. Such statements included “I can empathise without being overwhelmed,” “I reflect or communicate an understanding of the client's feelings,” “I express genuine thoughts and feelings,” and “I consistently question my own practice.” Each item was printed onto a small 35mm x 75mm thin coloured card (font Times New Roman) and was consigned a unique numerical tag as to identify it during data analysis.

Anchoring and Item Reduction Rationale

GOPA sorting methodology requires participants to mentally hold and organise a set number of items. Because of this, the difficulty of the task increases with the number of items to organise. Consequently, temporarily reducing the number of sorted items from 151 to 106 while still completing the aims of this study, is a valid and valuable asset of MDS methodology (Bimler & Kirkland, 2001; Kirkland et al., 2004). Two considerations were used to guide item reduction.

Firstly, it is important to outline the rationale regarding the incorporation of new items into a pre-established model. Young, Null, and Sarle (1978) started with a subset of items to be mapped as a set of spatial co-ordinates. Once established, these researchers fitted additional items into their framework by using inter-item comparisons to place these. This procedure limited the number of comparisons required to map a large number of stimuli once an initial framework had been established. Young et al.'s research is similar to the methodological procedures used in this current study as newly generated items were anchored into a pre-established framework without the need for participants to sort a full item set.

Secondly, determining which items of the original item list were appropriate to use as anchor points in the map was an important point for consideration. A dendrogram is a product of Hierarchical Cluster Analysis (HCA) that represents the similarities among items in the shape of a hierarchical tree diagram. The diagram progressively branches from left to right and the degree of similarity between items corresponds to the height of the intersection an item

branch shares with others; the higher the branch, the less similar two items are. Taking every second item when arranged in this format reduces the risk that items representing entire domains of content are unknowingly removed. Elimination of items by this process was considered appropriate as this method has been used in past research (Bimler & Kirkland, 2001; Kirkland et al., 2004; Harvey et al., 2016; Tracey et al., 2003). By taking every second item from the remaining 87 items of Harvey et al.'s (2016) original item list when arranged in a dendrogram (Appendix H), 43 items were distinguished as suitable anchor points because they statistically represented a diverse sample of the original item pool.

By applying the above processes to the current study, the new item set was able to be incorporated into the Original model using only half of Harvey et al.'s (2016) remaining original items. Harvey et al.'s original items that were not sorted during this study, but were still included in this projects overall item list, were labelled NS items. Because anchor items link Harvey et al.'s original item list with study one's newly generated items, NS items were still present in this study's generated model.

Procedure

Individuals who expressed interest in participating were given a data packet containing an item set, information and instruction sheet, a response form, and a demographics and consent form. As it is considered difficult to return to an unfinished GOPA procedure, consenting participants were asked to complete the entire GOPA-sorting task in one sitting.

'GOPA-sorting' is an alternative form of the commonly used group-sorting procedure (Coxon, 1999). GOPA is an acronym representing the four phases of sorting, namely; **G**roup, **O**pposite, **P**artition, and **A**dd. To complete the *Grouping* phase of this procedure, participants are required to randomise the items by shuffling the deck before organising cards into groups based on item similarity. Specifically, is the statement on item "A" similar or dissimilar to the statement on item B, C, D, E etc., and so on. Once these items have been grouped, participants are instructed to identify groups that are the most opposite to one another thus

comprising the *Opposite* phase. In the *Partitioning* phase, participants subdivide item groups into smaller subset groups of closely related items thus making a distinction between 'similar' pairs and 'very similar' pairs. In contrast, during the final *Addition* phase, participants identify which overall groups they consider the most similar, thus making distinctions between 'dissimilar' pairs and 'very dissimilar' pairs. Overall, this procedure informs us of the perceived underlying relationships between the items.

Analysis and Reliability Check

Mathematical data analyses including HCA, MDS, and reliability checks were completed by Dr David Bimler as they are beyond the scope of this thesis; nevertheless, the processes are outlined below. These processes regard the generation of a dendrogram through HCA and the objective spatial mapping of data via MDS methodology. Statistical analyses of this study utilised the IBM Statistical Products and Service Solutions (SPSS) software Version 20.

Prior to both HCA and MDS, depending on the analysis employed, co-occurrence/similarity values (equivalent terms labelled differently for HCA or MDS analysis) are established for all possible pairs of items according to the number of times two items appear in the same group during the GOPA-sorting procedure. These values represent a score between 0 and 1, with a score of 0 signifying two items that never appear in the same group and a score of 1 signifying two items that always appear in the same group (Bimler & Kirkland, 1998). Put simply, the higher the co-occurrence/similarity value, the more similar two items are perceived to be.

Hierarchical Cluster Analysis

HCA can be defined as a way of partitioning data into non-overlapping groups or clusters. The co-occurrence data generated from the GOPA-sorting procedure are initially converted into distance estimates. Distance estimates allow step-wise grouping of items into initial homogenous clusters, and subsequent merging of similar clusters into larger more heterogeneous clusters until ultimately, the

fewest possible clusters remain. This form of analysis displays the similarities and dissimilarities among items in the form of a dendrogram or tree diagram in which a single overall group progressively branches horizontally from left to right into smaller, more homogenous groups, and the height of the intersection between groups represents their perceived similarity.

Multi-Dimensional Scaling

MDS is a family of multivariate methods, with the common element that they provide details in spatial/geometrical terms (rather than in the combinatorial terms of HCA) (Cox & Cox, 1994). Such an approach enables the researcher to explore the underlying structure of a set of stimuli by analysing group judgments of similarity such as those obtained during a GOPA-sorting procedure (Kirkland et al., 2004; Kruskal & Wish, 1978).

The similarity data generated from the GOPA-sorting procedure were entered into non-metric MDS algorithms developed by Kruskal (1964), thus transforming similarity values into ordinal proximity data enabling these data to be displayed within a Euclidean space — an N -dimension real coordinate space. As the similarity values have an inverse monotonic relationship with distance, these values can be displayed in the Euclidean space with their spatial proximity to one another directly proportional to their similarity values (Kruskal & Wish, 1978). In other words, the larger the similarity value between two items, the shorter the spatial distance between those items when mapped in a Euclidean space.

Map development and verification. The algorithms produce solutions with a range of dimensionality. As each item is situated within the model according to its dimensional coordinates, the number of dimensions established is equivalent to the number of axes present in the model and therefore, the number of coordinates any item has within this space. The optimal number of dimensions is described to be the configuration of minimum stress. However, as stress will almost always decrease with additional dimensions, a balance must be sought in which stress is minimised while interpretability is maintained (Cox & Cox, 1994). Stress identifies the degree to which the model diverges from the data (Kruskal,

1964). It regards the 'badness-of-fit' between distances and perceived dissimilarities of items thus identifying a satisfactory balance between the two. The 'badness-of-fit' is determined by the following *Stress₁* function where the d_{ij} values are interpoint distances in the solution and the d^*_{ij} are transformed versions of the d_{ij} – transformed so that they have the same increasing order as the dissimilarities in the data matrix, but are otherwise as close to the d_{ij} as possible:

$$Stress1 = \sqrt{\frac{\sum_{ij} (d_{ij} - d^*_{ij})^2}{\sum_{ij} d_{ij}^2}}$$

By applying this function, the optimal number of dimensions for the model becomes apparent. By plotting stress values against dimensionality for each possible map, the ideal solution is able to be discerned as indicated by an 'elbow' on a face-value assessment called the 'elbow test' (Bimler & Kirkland, 2007). By observing the point at which the stress values reduce remarkably and then taper off, the researcher is able to deem when additional dimensions no longer substantially add to understanding (Kruskal, 1964; Kruskal & Wish, 1978). This elbow test is the counterpart of the Scree test in Factor Analysis for choosing the number of factors to retain. According to Kruskal and Wish, the ideal stress for a model is 0.10 or less.

To assess the model's stability, I measured the agreement between independent solutions. Following a 'split-half' test procedure, participants were randomly assigned to two same-sized groups with MDS applied to each group's data independently. Three tests of reliability were applied to assess the similarity between split-half solutions for both the entire item set and, more importantly, the new items independently. These comparison indices are: 1) Cophenetic correlation r between inter-point distances — a comparison of distance between every possible item pair within each map. As an r value of 1 would indicate two identical solutions, the closer the r value to 1 the better; 2) Procrustes Distance (g_1) — the total residual distance between each individual item and its counterpart when the

solutions are rescaled, rotated, and superimposed upon one another. As we would expect a Procrustes Distance value of 0.5 in a completely random solution, a value of 0.2 or less is considered optimal (Harris, 2001); 3) Canonical correlation or CANCORR — a form of multivariate analysis that progressively rotates each solution across a defined number of dimensions with subsequent comparisons between item coordinates for each dimension.

CANCORR follows a step-wise process. Firstly, both solutions are rotated independently to the optimal alignment for dimension one and then compared on the basis of the coordinates for each item to its counterpart in the other rotated solution. The closer each item is to one another with respect to the produced coordinates, the higher the correlation. Secondly, both solutions are rotated across dimension two to the optimal alignment while still maintaining the original dimension one rotation completed during phase one of this procedure. Subsequently, the coordinates of each item on both models are compared thus generating a second correlation. Both solutions continue to be iteratively rotated to optimal alignment across the remaining number of set dimensions while still maintaining the preceding dimension rotations. Upon each rotation, the coordinates of each item in each solution are compared thus producing a correlation coefficient. Due to the nature of this rotation, the initial correlation coefficient produced during dimension one rotation will always be the largest of the statistics generated during this procedure. Wilks' lambda statistic is a significance test of each correlation.

Dendrogram and map analyses. Subjective procedures such as 'eyeballing' are used to analyse the dendrogram formed via HCA and semantic map formed via MDS. Items proximal to one another are perceived to share similar attributes, and as a result, are clustered into groups based on these similarities. Additionally, due to this similarity, clusters and dimensions are classified according to the underlying shared characteristics proximal items possess. Analysis of both dendrogram and semantic map is via cluster analysis, with semantic map analysis also including neighbourhood and dimensional analyses. Neighbourhood analysis regards the comparisons of one cluster to other clusters based on proximity within the semantic map. Dimensional analysis regards the

location of item clusters within the semantic map in relation to the defined poles as to better understand their intra- and inter -cluster relationship.

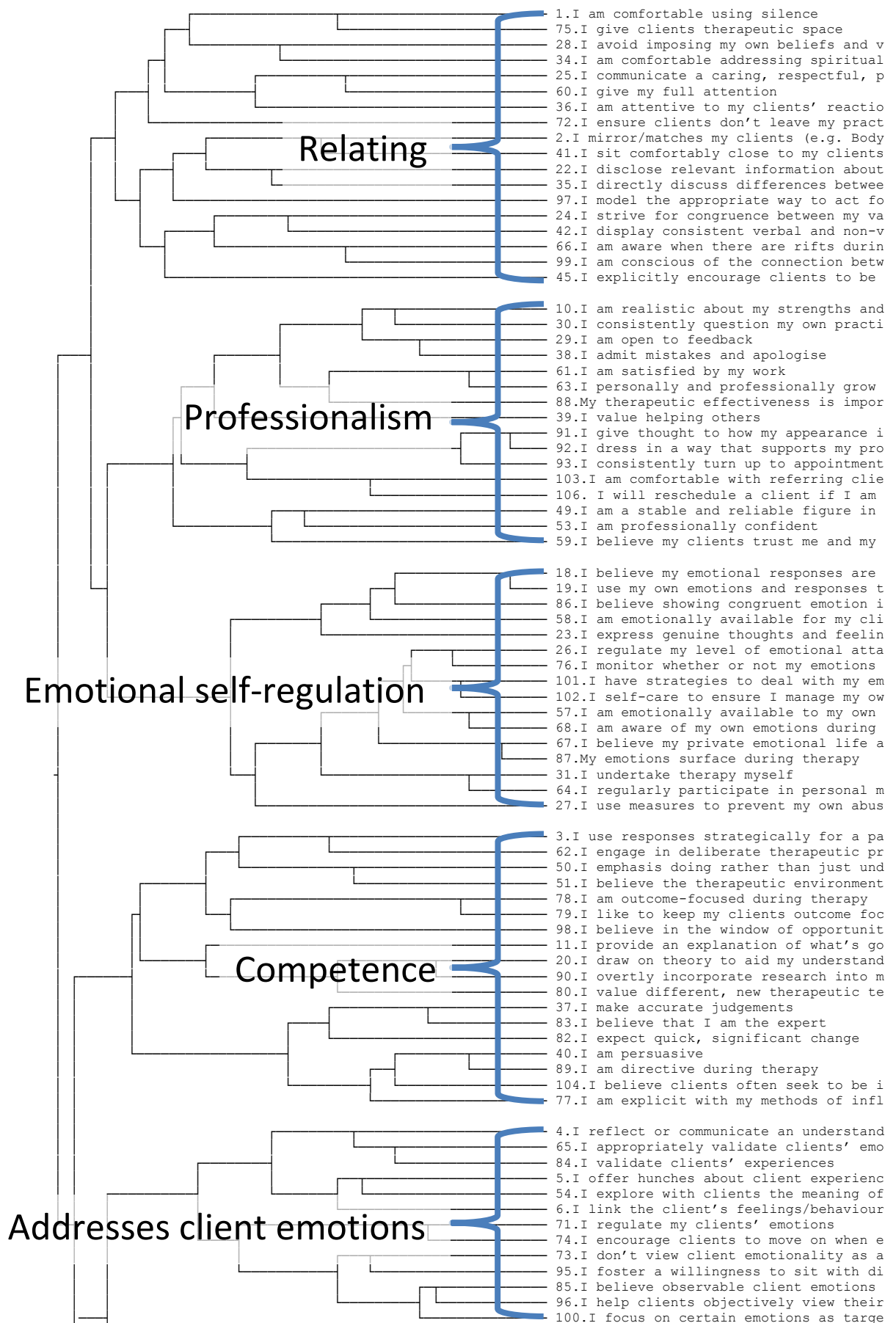
STUDY TWO: RESULTS

Hierarchical Cluster Analysis

At this point, readers are reminded of the semantic matching task used to organise the item structure and are encouraged to revisit the Mapping Psychological Constructs section of Chapter Three as to aid their understanding of the following results section.

HCA was performed prior to MDS. Both methods were utilised to interpret the data, garnering complementary information (Carter, Enyedy, Goodyear, Arcinue, & Puri, 2009). While model generation was via MDS analysis, relevant cluster determination, as appearing in the model, was informed by the HCA.

The process of HCA produces a dendrogram or hierarchical tree from participant sorts. Figure 8 below displays the dendrogram generated during this study with preliminary clustering descriptions. Given that a subset of the entire item pool was not sorted during this study (NS items), these items are not included in the dendrogram presented below. NS items have implications for subsequent MDS item clustering and will be considered in a later section. Dendrogram item text has been truncated as to fit within this document.



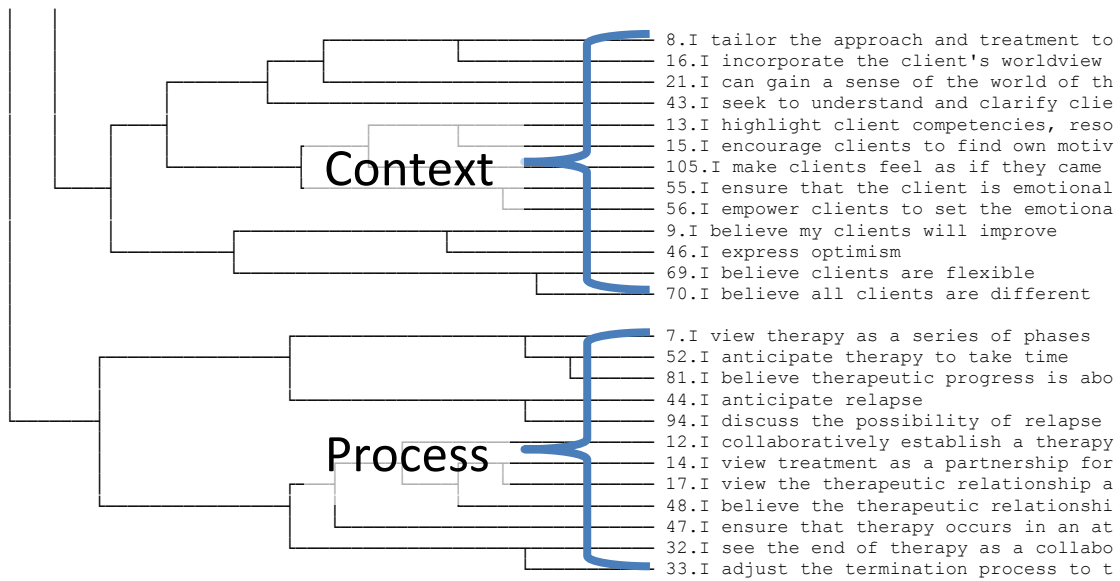


Figure 8. Dendrogram with item text truncated and preliminary cluster descriptions.

Multi-Dimensional Scaling

Reliability

Separate solutions were generated for split-half analysis. These solutions consisted of 1) 12 randomly selected GOPAs of this research and 34 randomly chosen GOPAs from Harvey et al.'s (2016) research, and 2), 13 randomly selected GOPAs of this research and 33 randomly chosen GOPAs from Harvey et al.'s research. For clarity, Harvey et al.'s GOPAs are participant sorts collected during their research and used to generate their Original map. Cophenetic correlation suggested satisfactory inter-item agreement between solutions for both the overall sample ($r = 0.77$) and the new item set in isolation ($r = 0.73$). Considering that a Procrustes Distance of 0.2 or below is considered optimal (Harris, 2001), the residual Procrustes Distance was low for both the overall item set ($g_1 = 0.062$) and the new item set in isolation ($g_1 = 0.072$). All three axes correlated significantly for both the overall item set ($R_c = 0.909$, $R_2 = 0.866$, $R_3 = 0.857$, $p < 0.0005$) and the new item set in isolation ($R_c = 0.923$, $R_2 = 0.859$, $R_3 = 0.767$, $p < 0.0005$), according to Wilks' lambda test. The above correlations indicate that enough data were collected to ensure stable locations for the items in this study's model.

Further comparisons were made between the new NZ solution and Harvey et al.'s (2016) original. Despite initial results suggesting otherwise, statistical comparisons between the original and NZ model demonstrate that the three dimensions in both models are recognisably the same. Early results indicated that the third dimension of the Canonical correlation estimate was not significant thus indicating a difference between the NZ and Original solutions. However, this discrepancy later appeared to be an artefact of the way Canonical correlations are calculated. This artefact is thought to have resulted from a limited pool of shared items between solutions thus influencing the amount of shared structure available. When rotating the two solutions to find the first Canonical correlate, the procedure may capitalise on chance and pull shared structure from succeeding dimensions. This artefact occurs again during the second Canonical correlate, pulling out more shared structure from the third dimension. As a result, there may not be any shared structure remaining to complete the third Canonical correlate thus producing a non-significant result. This supposition is supported by the split-half

analysis previously discussed showing three significantly correlated dimensions existing between each split-half solution.

Validity

As to discern the optimal dimensionality of the NZ solution, stress values were computed for each dimension: 2D, $Stress_1 = 0.371$; 3D, $Stress_1 = 0.226$; 4D, $Stress_1 = 0.174$; and 5D, $Stress_1 = 0.142$.² These values were slightly higher than that prescribed by Kruskal and Wish (1978), yet still met acceptable levels (Harvey et al., 2012, Rosenblatt, 2012). Given that the statistical advantage of increased dimensionality is offset by challenges relating to data interpretability, the three dimensional solution was pragmatically determined as ideal.

Surface Coverage

As presented below, Figure 9 displays a complementing hemispheric view of the distribution of items in the NZ solution. Imagine northern and southern hemispheres of a globe being mapped as circles, centred on the North and South Poles, respectively. The 30-degree and 60-degree lines of latitude become concentric circles, with 90-deg latitude (the pole itself) in the centre. The equator at 0-degrees becomes the outmost circle of both hemispheres. In these charts, we measure 'degrees of latitude' outward from the pole (centre of each hemisphere) to the outmost circle (the 'equator'). In Figure 9, the X axis has been oriented toward the viewer and represents the 'Pole' of each chart (90-degrees).

A complete sphere of items is represented by a relatively even distribution of items forming the shell of a sphere. Figure 9 indicates that a complete sphere of items is visible on the surface of the NZ solution. This suggests that a comprehensive pool of ES skills adequately reflecting the content domain is represented by the NZ model.

² See Figure 10 presented in the results section of the ensuing chapter for a Scree plot of these $Stress_1$ values.

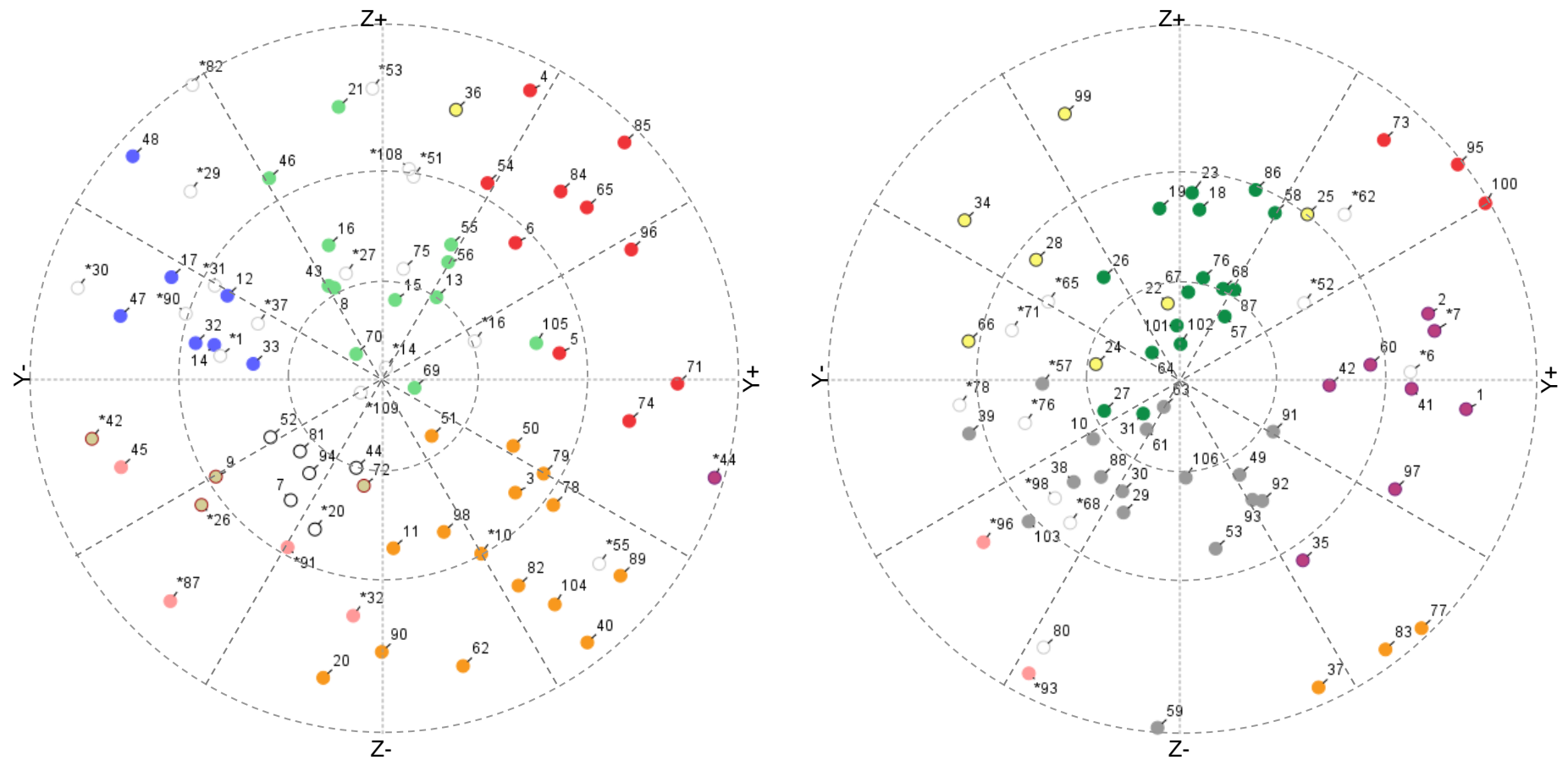


Figure 9. X- and X+ hemispheric views displaying item placement and cluster membership in the NZ model.

Note: Items beginning with * are NS items.

Light yellow = A. Interpersonal acceptance, Purple = B. Microskills, Grey = C. Reflective practice, Green = D. Emotional self-regulation, Orange = E. Strategic, Red = F. Addresses client emotions, Light green = G. Tailor, White = H. Therapy process, Blue = I. Therapeutic collaboration, Pink = J. Manages relationship, Brown = K. Optimistic about therapy.

Clusters

The items comprised in each cluster are summarised in Table 2 below.

Throughout Table 2 there are multiple items that begin with '*'. These tagged items are NS items — those items from Harvey et al.'s (2016) original item list that were absent from the set of sample items sorted during this study. Recall that NS items were not included in this study's sorting procedure as to reduce the difficulty of this sorting task and, yet, were still included in this projects overall item list (Appendix H). A similar procedure was followed in Young et al.'s (1978) work.

When arranged in a MDS solution, despite not being sorted with the new item set, NS items still maintain their relative positions due to anchor items from the original item list sorted during this study. As a result, these NS items were considered sufficiently similar (proximally and semantically) to be included in their respective clusters.

Table 2.
Cluster labels and items

Clusters	Items	Cluster themes	Proximal clusters
A. Interpersonal acceptance	22. I disclose relevant information about myself 24. I strive for congruence between my values and my behaviour 25. I communicate a caring, respectful, positive attitude 28. I avoid imposing my own beliefs and values on clients 34. I am comfortable addressing spirituality 36. I am attentive to my clients' reactions 66. I am aware when there are rifts during therapy 99. I am conscious of the connection between me and my client	Acceptance Awareness	C. Reflective practice D. Emotional self-regulation G. Tailor I. Therapeutic collaboration
B. Microskills	1. I am comfortable using silence 2. I mirror/matches my clients (e.g. Body posture, use of key words) 35. I directly discuss differences between the client and myself 41. I sit comfortably close to my clients 42. I display consistent verbal and non-verbal behaviour 60. I give my full attention 97. I model the appropriate way to act for my clients *I use encouraging responses (e.g. nodding, sounds) *I banter with clients	Discrete therapist behaviours	C. Reflective practice D. Emotional self-regulation E. Strategic F. Addresses client emotions
C. Reflective practice	10. I am realistic about my strengths and weaknesses 29. I am open to feedback 30. I consistently question my own practice 38. I admit mistakes and apologise 39. I value helping others 49. I am a stable and reliable figure in therapy 53. I am professionally confident 59. I believe my clients trust me and my clinical judgement 61. I am satisfied by my work 63. I personally and professionally grow as a result of my work 88. My therapeutic effectiveness is important to me 91. I give thought to how my appearance impacts on my client	Growth Professional boundaries Punctuality Presentation	A. Interpersonal acceptance B. Microskills D. Emotional self-regulation J. Manages relationship

	92. I dress in a way that supports my professional position		
	93. I consistently turn up to appointments on time		
	103. I am comfortable with referring clients on when required		
	106. I will reschedule a client if I am unable to competently practice		
	*I am comfortable with who I am as a person		
D.	18. I believe my emotional responses are beneficial for the client	Therapist-oriented items	A. Interpersonal acceptance
Emotional self-regulation	19. I use my own emotions and responses to relate to the client	Emotion use	B. Microskills
	23. I express genuine thoughts and feelings	Emotion regulation	C. Reflective practice
	26. I regulate my level of emotional attachment to clients	Emotional awareness	
	27. I use measures to prevent my own abuse of power		
	31. I undertake therapy myself		
	57. I am emotionally available to my own experiences		
	58. I am emotionally available for my clients' experiences		
	64. I regularly participate in personal mindfulness exercises		
	67. I believe my private emotional life affects my practice		
	68. I am aware of my own emotions during therapy		
	76. I monitor whether or not my emotions are useful during therapy		
	86. I believe showing congruent emotion is useful		
	87. My emotions surface during therapy		
	101. I have strategies to deal with my emotions that surface during therapy		
	102. I self-care to ensure I manage my own emotions		
E.	3. I use responses strategically for a particular effect or purpose	Lacking emotion	B. Microskills
Strategic	11. I provide an explanation of what's going on	Structure beliefs	H. Therapy process
	20. I draw on theory to aid my understanding of the client's feelings/experiences	Expectations	J. Manages relationship
	37. I make accurate judgements		
	40. I am persuasive		
	50. I emphasis doing rather than just understanding		
	51. I believe the therapeutic environment is a place for clients to trial different behavioural strategies		
	62. I engage in deliberate therapeutic practise		
	77. I am explicit with my methods of influencing		

	78. I am outcome-focused during therapy		
	79. I like to keep my clients outcome focused		
	82. I expect quick, significant change		
	83. I believe that I am the expert		
	89. I am directive during therapy		
	90. I overtly incorporate research into my practice to educate my clients		
	98. I believe in the window of opportunity for change		
	104. I believe clients often seek to be influenced		
F. Addresses client emotions	4. I reflect or communicate an understanding of the client's feelings	Client-oriented items	B. Microskills
	5. I offer hunches about client experiences	Emotions	G. Tailor
	6. I link the client's feelings/behaviours to past experiences	Experience	
	54. I explore with clients the meaning of their experiences		
	65. I appropriately validate clients' emotions		
	71. I regulate my clients' emotions		
	73. I don't view client emotionality as a problem		
	74. I encourage clients to move on when emotional		
	84. I validate clients' experiences		
	85. I believe observable client emotions give valuable information		
	95. I foster a willingness to sit with distress in clients		
	96. I help clients objectively view their emotions		
	100. I focus on certain emotions as target points		
G. Tailor	8. I tailor the approach and treatment to suit client's personality	Tailoring	A. Interpersonal acceptance
	13. I highlight client competencies, resources and resiliencies	Client empowerment	F. Addresses client emotions
	15. I encourage clients to find own motivation for change	Optimism	H. Therapy process
	16. I incorporate the client's worldview and theory of problem/treatment		I. Therapeutic collaboration
	21. I can gain a sense of the world of the client		
	43. I seek to understand and clarify clients' expectations		
	46. I express optimism		
	55. I ensure that the client is emotionally invested in the process of therapy		
	56. I empower clients to set the emotional pace of therapy		
	69. I believe clients are flexible		

	70. I believe all clients are different 105. I make clients feel as if they came up with their own ideas/solutions		
H. Therapy process	7. I view therapy as a series of phases 44. I anticipate relapse 52. I anticipate therapy to take time 81. I believe therapeutic progress is about small incremental changes rather than radical changes 94. I discuss the possibility of relapse with clients *I pace therapy interventions	Structure Treatment planning	E. Strategic G. Tailor I. Therapeutic collaboration J. Manages relationship K. Optimistic about therapy
I. Therapeutic collaboration	12. I collaboratively establish a therapy agreement 14. I view treatment as a partnership for change 17. I view the therapeutic relationship as a primary tool of therapy 32. I see the end of therapy as a collaborative process 33. I adjust the termination process to the nature of the therapy relationship 47. I ensure that therapy occurs in an atmosphere of mutual respect 48. I believe the therapeutic relationship is mutually influential	Therapeutic relationship Partnership	A. Interpersonal acceptance G. Tailor H. Therapy process K. Optimistic about therapy
J. Manages relationship	45. I explicitly encourage clients to be open and honest with me *I address ruptures directly *I resist settling on an explanation prematurely *I set firm ground rules *I have a detailed knowledge of my field *I systematically seek feedback	Guidance Therapist capability	C. Reflective practice E. Strategic H. Therapy process K. Optimistic about therapy
K. Optimistic about therapy	9. I believe my clients will improve 72. I ensure clients don't leave my practice feeling worse than when they entered *I believe strongly in the efficacy of my treatment *I am able to repeatedly engage with and end therapy relationships positively	Therapist confidence Beliefs of client improvement	H. Therapy process I. Therapeutic collaboration J. Manages relationship

Note. * NS items

Dimensions

MDS solutions have a number of statistically derived dimensions chosen by the researchers after establishing the optimal balance of model interpretability and stress (Scree test). However, the placement of these dimensions within each solution is not a statistical procedure but a qualitative process. Dimensions are aligned by the research team in a way that they feel best suits the data thus aiding interpretability of item relationships. In other words, while statistical dimensions can be compared between counterpart solutions using the Canonical correlations estimate, qualitative dimensions inform the reader of how the researchers perceived data to be organised in their model and thus, typically have limited overlap with other solutions. This consideration has important implications for the discussion section of this and the subsequent study of this thesis.

Each dimension is believed to represent an underlying attribute and contains two poles (Harvey et al., 2016). An item is located along a dimension according to its degree of similarity to this attribute. In the MDS solution, the dimensions are equivalent to the X, Y, and Z axes. An item's location within the solution also determines its dimensional coordinates. Items with the highest and lowest values are at the extremes of axes and can be considered the most representative examples of that pole's underlying attribute. In this way, the six poles of a three dimensional MDS solution are able to be defined thus contributing to the meaning of other, less extreme items, as well as assisting in understanding how items are perceived to relate. To achieve this aim, the eight items with values comprising the upper and lower extremes of each dimension were identified thus enabling easy within-group comparisons (Tables 3-8). Subsequently, the items' attributes, their relation to other dimensions, and their cluster were analysed for any prevailing features. It is important to note that an item with the most extreme value for a dimension may not be the best representative for that pole. Items with relatively high values relating to a pole and neutral values relating to other dimensions may be considered more pure forms of that pole's underlying attribute than items with more extreme pole-related values as well as high positive or negative values relating to other dimensions. The most representative item of each

pole was selected by the researcher and has been italicised in each table. Additionally, items tagged with an ‘*’ indicate NS items.

Dimension X. The positive pole of dimension X is characterised by items comprising the previously identified clusters *Emotional self-regulation* (D) and *Reflective practice* (C). Overall, the positive pole of dimension X contains elements of emotion, regulation, professional satisfaction, and professional growth.

Table 3.
Upper quartile of X coordinates

Item	Cluster	X-Value
<i>I self-care to ensure I manage my own emotions</i>	D	6.82
I regularly participate in personal mindfulness exercises	D	6.57
I have strategies to deal with my emotions that surface during therapy	D	6.48
I am satisfied by my work	C	6.39
I personally and professionally grow as a result of my work	C	6.29
I am emotionally available to my own experiences	D	6.08
I monitor whether or not my emotions are useful during therapy	D	5.93
I am aware of my own emotions during therapy	D	5.92

The negative pole of dimension X appears to be relatively uncharacterised by items comprising any one cluster. Items comprised by *Therapy process* (H) are present in the majority, however, the most representative item is a NS-item and does not belong to a cluster from the current study — “I ask clients to fill in the missing pieces.” Overall, the negative pole of dimension X shows the therapist valuing client experiences.

Table 4.
Lower quartile of X coordinates

Item	Cluster	X-Value
<i>I ask the client to fill in the missing pieces*</i>	-	-6.40
I believe all clients are different	G	-5.75
I anticipate relapse	H	-5.62
I believe the therapeutic environment is a place for clients to trial different behavioural strategies	E	-5.56
I reflect and seek feedback about my understanding of the client*	-	-5.55
I believe therapeutic progress is about small incremental changes rather than radical changes	H	-5.50
I modify my explanation of treatments to make it acceptable to my clients' worldviews*	-	-5.34
I anticipate therapy to take time	H	-5.02

Dimension Y. The positive pole of dimension Y is characterised primarily by items comprising *Addresses client emotions* (F), and, to a lesser extent, *Microskills* (B). This pole shows elements of client emotion, regulation, and relating.

Table 5.
Upper quartile of Y coordinates

Item	Cluster	Y-Value
I encourage clients to move on when emotional	F	6.73
<i>I regulate my clients' emotions</i>	F	6.50
I help clients objectively view their emotions	F	5.68
I use encouraging responses (e.g. nodding, sounds)*	B	5.65
I focus on certain emotions as target points	F	5.61
I am directive during therapy	E	5.06
I foster a willingness to sit with distress in clients	F	5.06
I model the appropriate way to act for my clients	B	5.04

The majority of items representing the negative pole of dimension Y do not belong to a cluster. Furthermore, the most representative item is a NS-item and only one of the eight items representing Y- was sorted by participants during this study. Overall, this pole is therapist-orientated and comprises elements of the therapeutic relationship, therapeutic confidence, and therapeutic collaboration.

Table 6.
Lower quartile of Y coordinates

Item	Cluster	Y-Value
<i>I discuss the relationship with my client*</i>	-	-6.60
I am able to repeatedly engage with and end therapy relationships positively*	K	-6.54
I seek joint solutions to difficulties*	-	-6.20
I believe strongly in the efficacy of my treatment*	K	-5.60
I am aware of the influence of my own socio-cultural background*	-	-5.37
I collaboratively establish a therapy agreement*	-	-5.35
I see the end of therapy as a collaborative process	I	-4.98
I prepare myself emotionally for sessions*	-	-4.94

Dimension Z. The positive pole of dimension Z is characterised by items not belonging to a cluster. “I can accurately recognise the client's current innermost state, experience or motivations”, an NS-item, was considered the most representative item of this pole. Z+ displays elements of insight, understanding, and empathy.

Table 7.
Upper quartile of Z coordinates

Item	Cluster	Z-Value
I can identify the impact of cultural issues on clients' problems*	-	6.23
<i>I can accurately recognise the client's current innermost state, experience or motivations*</i>	-	5.94
I seek to understand client's thoughts/feelings*	-	5.59
I believe showing congruent emotion is useful	D	5.06
I am attentive to details of client's experiences*	-	5.01
I can gain a sense of the world of the client	G	4.89
I explore with clients the meaning of their experiences	F	4.89
I don't view client emotionality as a problem	F	4.84

The negative pole of dimension Z is largely represented by items comprising *Strategic* (E), and to a lesser extent, *Manages relationship* (J). Interestingly, the most representative item of this pole belongs to *Reflective practice* (C), the only item in Table 8 not belonging to either *Strategic* or *Manages relationship*. Z- reflects elements of professional confidence, competence, and learning.

Table 8.
Lower quartile of Z coordinates

Item	Cluster	Z-Value
I expect quick, significant change	E	-6.22
I have a detailed knowledge of my field*	J	-5.86
I believe that I am the expert	E	-5.75
I overtly incorporate research into my practice to educate my clients	E	-5.73
<i>I believe my clients trust me and my clinical judgement</i>	C	-5.48
I engage in deliberate therapeutic practise	E	-5.45
I value different, new therapeutic techniques	J	-5.25
I believe clients often seek to be influenced	E	-5.22

Naming the dimensions. Poles and dimensions were assigned labels by three independent emotion-focused researchers after reviewing the items and clusters closely associated with each. Following comparison, those poles and/or dimensions assigned similar labels by two or more researchers were accepted as the title for that pole or dimension. Where no consensus was reached by this independent labelling process, the validation panel met to discuss the labels for those less obvious poles and/or dimensions.

Table 9 below displays the most salient clusters and themes relating to each pole, as well as the label assigned to each pole and dimension.

Table 9.
Pole and dimension labels with respective salient clusters

Salient clusters	Dimension Poles	Dimension
D. Emotional Self-Regulation C. Reflective practice	Emotional self-care (X+)	Client/therapist focus
H. Therapy process	Client views valued (X-)	
F. Addresses client emotions B. Microskills	Emotion coaching (Y+)	Degree of cooperative focus
No cluster	Therapeutic alliance (Y-)	
No cluster	Emotional understanding (Z+)	Understanding
E. Strategic J. Manages relationship	Therapist as expert (Z-)	

Items along dimension X were identified to transition from emotion therapist-oriented items, to emotionless client-oriented items. Accordingly, this dimension was classified as *Client/therapist focus*. Dimension Y displayed items

transitioning from only involving the therapist's actions, to items involving both the therapist and client. As a result, dimension Y was labelled *Degree of cooperative focus*. Lastly, items progressing along dimension Z were seen to move from understanding client problems in-session, to a consolidation of that understanding out of session. Consequently, dimension Z was labelled *Understanding*.

STUDY TWO: DISCUSSION

Overall, the NZ model generated during this study shows a meaningful arrangement of items positioned according to three dimensions; *Client/therapist focus (X)*, *Degree of cooperative focus (Y)*, and *Understanding (Z)*. The ES skills were grouped into 11 interpretable clusters based on perceptively similar underlying themes. As the primary aim of this study was to embed the new ES skills generated during study one into the Original solution established in Harvey et al.'s (2016) research, the findings of this study support the general expectations: a) that novel content could be meaningfully incorporated into an existing MDS framework thus updating a working model of therapists' ES practices in therapy; b) that this solution would be representative of the content domain; and c), that the updated NZ model would remain analogous to Harvey et al.'s Original. Given that the succeeding study of this research will determine the most representative MDS solution for use in study four of this thesis, to avoid redundancy, the ensuing discussion will largely be limited to appraising the consistency and validity of the NZ solution. Accordingly, the following discussion compares the NZ model and its identified dimensions and clusters with the foundational and extant literature. Subsequently, the limitations of this study are considered.

Surface Coverage

The NZ solution has excellent surface coverage with no item voids observable. Given that an item gap was present on the surface of Harvey et al.'s (2016) Original solution, the new content generated during study one appears to have filled this hole. Unexpectedly however, the item "I model the appropriate way to act for my clients", intentionally generated during study one to fill this item void, does not appear to have achieved its intended result. Interestingly, "I model the appropriate way to act for my clients" as well as items originally forming the perimeter of this void in Harvey et al.'s solution, are largely dispersed between neighbouring clusters in the NZ model. This observation suggests that the new content embedded during study two has largely differentiated original perimeter items, exposing their differences rather than their similarities. Overall, given that no item

void is present on the surface of the NZ solution, this result is encouraging as it demonstrates that, at least according to this sample, a comprehensive representation of ES skills are encompassed in this research's entire item pool.

Dimensions

The results suggest that relatively few dimensions are underlying the organisation of therapists' ES skills in clinical practice.

Client/therapist focus (X) (i.e. the orientation of ES skills) was considered the most prominent theme linking *Emotional self-care* (X+) with *Client views valued* (X-). This finding suggests that participants' cognitively organised ES skills on the basis of item perspective, either client or therapist focused. This dimension points to the difference between a) the ES skills therapists employ in-therapy to understand their clients (client-focus) and b) the introspective ES skills the therapist utilises out-of-therapy to manage their professional practice (therapist-focus).

Degree of cooperative focus (Y) suggests that participants classified ES skills according to each item's perceived cooperation. In other words, items were positioned on dimension Y according to their independent or joint nature. Organising items in this manner may reduce comprehension time and quickly distinguish items that are clearly unrelated.

Lastly, as the relevant ES skills demonstrate elements of knowledge structures, *Understanding* (Z) is thought to link *Emotional understanding* (Z+) and *Therapist as expert* (Z-). This finding suggests that participants of this model organise ES skills according to the understanding the therapist has of their clients as well as their therapeutic capability.

While Harvey et al. (2016) did not label the dimensions of their model, they identified that items were organised between continuums: X) *Emotionally aware of client* (i.e., aware of clients' emotions) to *Emotionally self-aware*, Y) *Discrete behaviour* to *Therapist collaboration with client*, and Z) *Therapist beliefs* (i.e., about client and therapy) to *Structure*. While the poles of *Emotional self-care* (X+) and *Therapeutic alliance* (Y-) in this study's solution align with their counterpart poles

in Harvey et al.'s, the four remaining poles of each solution appear dissimilar. While this finding may initially call in to question the overall overlap between solutions, it is important to remember that integrating axes into MDS models does not influence the positioning of items in any way. Dimensions were situated in each solution at the discretion of each research team as to enhance the viewer's understanding of item positioning relative to one another (Harvey et al., 2012; Harvey et al., 2016; Rosenblatt, 2012). While this may initially appear to limit axes comparisons between separate maps, the reliability estimates of Cophenetic correlation, Procruste Distance, and Canonical correlations provide the necessary item placement comparisons between solutions. What is significant is that the Canonical correlation reliability estimate between solutions identified that three mutually-recognisable dimensions were present between the NZ solution and Original solution, thus indicating that participants cognitively organised items between three akin dimensions. For a more subjective contrast of solutions, comparisons between items groupings may yield greater insights.

Clusters

Links to Foundational Literature

Given the overlap between methodology and items, comparisons were possible between the 11 clusters discerned during this study and the 19 clusters and ten hotspots identified in studies one and two of Harvey et al.'s (2016) research, respectively. Clusters and hotspots were compared largely by item composition, with grouping labels guiding initial comparisons.

Overall, as displayed in Table 10, there was a general overlap of item groupings between this and Harvey et al.'s (2016) study. As the NZ solution is a merging of both Harvey et al.'s and this study's data sets, identified overlap between solutions and their respective item groupings must be interpreted with caution. This study's clusters *Reflective practice*, *Emotional self-regulation*, *Strategic*, *Addresses client emotions*, and *Therapy process* were found to be largely comprised of new content (over half their item composition was generated in study one of this research). As these clusters remain thematically similar to Harvey

et al.'s item groupings, this observation indicates that the anchoring methodology employed during this procedure was well-founded and supports the overall stability of the model discerned during this study.

Table 10.
Comparison of item groupings between this study and Harvey et al.'s (2016)

Current study	Harvey et al. (2016)	
Clusters	Clusters	Hotspots
Interpersonal acceptance	Positive emotional connection Culturally aware	Therapeutic use of own experiences Self-secure
Microskills	Discrete behavior Language use	Verbal easing Behavioral expressions
Reflective practice*	Open to feedback	Self-reflective critique
Emotional self-regulation*	Emotionally reflective Emotion regulation Emotionally self-aware	-
Strategic*	Response to connection issues Current in literature Guides Therapists beliefs Therapists client beliefs	Expert role
Addresses client emotions*	Emotionally aware of client	Feeling in context
Tailor	Tailors therapy	Tailoring therapy Client empowerment
Therapy process*	Structure	
Therapeutic collaboration	Therapy collaboration	Balanced collaboration
Manages relationship	Clarifies Client determination	-
Optimistic about therapy	-	-

Note. Clusters tagged with an '*' largely consist of items generated during study one of this thesis.

Most item groupings of Harvey et al.'s (2016) study contained far fewer items than the clusters of this study. This factor largely accounts for the overlap of numerous Harvey et al. item groupings to single clusters of this study. While it may be argued that fewer items in each cluster provides an overall clearer cluster theme, this reasoning must also be weighed against the total number of potential

clusters to be discerned, A balance is sought in which each cluster remains meaningful whilst the total number of clusters leaves the interpretability of the model intact. With the NZ solution displaying 151 items, 11 clusters was deemed an appropriate balance of cluster and model interpretability.

Links to Extant Literature

While not identical, several of this solution's clusters show congruence with discrete literature concepts. Perceptively related clusters *Interpersonal acceptance* and *Microskills*, both reflect aspects of Anderson et al.'s (2009) FIS, defined as an individual's ability to perceive, understand, and communicate a wide range of interpersonal messages. Elman, Illfelder-Kaye, and Robiner's (2005) fundamental components of professionalism – a sense of professional identity, a developed commitment to reliably fulfilling responsibilities, being self-aware, and practicing self-care - supported by an extensive body of medical and psychological literature (Ducheny, Allezhauser, Crandell, & Schneider, 1997; Friedman & Kaslow, 1986; Rønnestad & Skovholdt, 2001; Skovholt, Rønnestad, & Jennings, 1997; VanZandt, 1990), shows striking a chord with *Reflective practice*. Elements of both *Emotional self-regulation* and *Addressing client emotions* have been identified as common among the practices of master therapists (de Vries, 2012; Greenberg & Pascual-Leone, 2006; Goldfried et al., 1998; Harrison & Westwood, 2009; Jennings et al., 2008; Jennings & Skovholt, 1999), while *Optimistic about therapy* resembles Harrison and Westwood's (2009) initial elements of active optimism - the ability to maintain faith in (a) the self as good enough, (b) the therapeutic change process, and (c) the world as a place of beauty and potential. Lastly, *Tailor, Manages relationship*, and *Therapeutic collaboration* each have elements considered important for establishing rapport with clients and essential in the development of a concrete therapeutic alliance (Bachelor et al., 2007; Kazantzis & Kellis, 2012; Norcross & Wampold, 2011; Orlinsky et al., 2004). These findings indicate that participants of this study grouped items in a meaningful way thus supporting the validity of the NZ solution.

Clusters Absent in the Literature

The concept of therapist strategy in practice, as represented in cluster *Strategic*, appears to be neglected in contemporary literature; this is despite the potential value such a concept may embody. In this research, therapist strategy is thought to regard the active decisions made by the therapist prior to, during, and post therapy, as well as the rationale guiding such decision-making. Furthermore, this construct encompasses concepts of therapist learning to inform decision-making, as well as therapist problem-solving. From this definition, it can be argued that cluster *Strategic* represents a 'processing hub' in the NZ solution; in which knowledge, beliefs, skills, and contextual information are interpreted to produce deliberate therapist responses. Clearly, therapist strategy is a complex process that would be challenging to research and this may indicate why therapist strategy is largely absent in the literature.

In contrast to therapist strategy, the term therapy process is common in the literature. Being ubiquitous, therapy process is often implicitly understood and therefore tends to lack a clear operational definition. Through deduction of the contexts in which it is cited as well as anecdotal experience, therapy process is temporal in nature and encompasses all in-session intrapersonal and interpersonal interactions. Cluster *Therapy process* appears to capture concepts of treatment planning and therapy structure, yet clearly falls short of encompassing all therapy process themes. Perhaps the ES skills of *Strategic* and/or *Therapy process* begin to provide some clear and observable behaviours that, taken together, reflect aspects of these important therapy constructs.

Alternatively, it must be considered that these clusters may represent an artefact of the anchoring methodology implemented during this study. *Strategic* and *Therapy process* are largely comprised of new content. Perhaps the absence of these clusters in the literature demonstrates that ES skills comprising these clusters do not tie together as meaningfully as other clusters identified. Given this, it will be important to review the composition of *Strategic* and *Therapy process* in the succeeding study as to better consider the above suppositions.

Absent Literature Concepts

A number of prominent literature constructs were not represented as discrete clusters discerned during this study. For example, of Saarni's (1999) eight emotional skills proposed to comprise emotional competence (revisit Table 1), both *Potential difference between felt and expressed emotions* and *Understanding emotion communication* were not recognised as clusters in this study. The above example demonstrates a notable consideration; that it is implausible to expect complex and/or specific literature constructs to be discerned as discrete clusters via MDS methodology. This is because the specific foundational elements required to establish these constructs may not be available in the item list — i.e. the foundational elements may be too specific to contribute meaningfully to the ES skills list of this study. Moreover, even if these foundational elements were available, it is improbable that a general New Zealand sample will arrange items in such a way that distinguishes all of Saarni's complex emotional competence skills. This is because a general New Zealand sample will most likely lack the required knowledge to organise ES skills into such constructs.

The above example highlights an important consideration of this methodology; that the solution constructed reflects the implicit cognitive structures of the particular sample group completing the sorting procedure. For example, a sample group of mathematicians will likely organise math problems in a way that is different to a sample of high school students. Similarly, a sample group of professional artists will probably organise tertiary colours in a way that is different to a sample group of mechanics. This study consisted of a general sample, while Harvey et al.'s (2016) sample group partially consisted of clinical psychologists — the intended participant demographic of this thesis. As the NZ solution was found to be analogous to Harvey et al.'s Original solution, we can have confidence that, with respect to ES skills, the organisation structures of a general sample and a clinical psychologist sample is largely equivalent. This consistency suggests that a clinical psychologist sample are also unlikely to discern all of Saarni's (1999) nine emotional skills posited to comprise emotional competence.

Saarni's (1999) six remaining emotional skills did not form distinct groups, but rather, were encompassed by the clusters *Emotional self-regulation* and *Addresses client emotions*. The compression of Saarni's skills into two clusters of this study is the likely consequence of grouping perspective; at which dendrogram branch the researcher decides to group items — i.e. the optimum balance between cluster interpretability and size. By viewing the dendrogram of the NZ solution, we can see that reducing both *Emotional self-regulation* and *Addresses client emotions* into multiple smaller clusters, will result in several of Saarni's emotional skills emerging as discrete clusters. Subsequently however, these clusters will then likely be overshadowed by the total number of clusters now comprising the NZ solution. This example reflects the argument previously proposed accounting for Harvey et al.'s (2016) item groupings containing fewer items than the clusters of this study.

Inter-Cluster Relationships

As well as inter-item relationships, MDS solutions also display the perceived relationships between clusters. In other words, using the NZ solution, we are able to identify therapy constructs that are perceptively similar and dissimilar to other constructs. For example, from the NZ solution we can see that cluster *Reflective practice* is proximal to clusters *Interpersonal acceptance*, *Microskills*, *Emotional self-regulation*, and *Manages relationship*. Such an observation suggests that a therapist's reflective practice may be more influenced by these proximal clusters than distal clusters and/or influence those proximal clusters more than distal clusters also. Given that reflection is largely an internal thought process (Bradbury, Frost, Kilminster, & Zukas, 2012), a cluster like *Emotional self-regulation* being influential of reflective practice makes sense; especially when you consider the bearing heightened emotional states have on our tendency to reflect. In contrast to this logic however, is the cluster *Microskills* which embodies notably overt therapist behaviours, and yet is also proximal to *Reflective practice*. Perhaps this organisation points to a unidirectional pathway of reflective practice, from identifying the need for reflective practice (*Emotional self-regulation*), to the overt practice behaviours that are influenced by such reflection (*Microskills*).

From such an example, we can see the hypothesis-generating value of investigating inter-cluster relationships. Save for Orlinsky and Rønnestad's (2005) research, few other studies have empirically investigated such construct relationships with respect to therapist practice behaviours. Furthermore, virtually no other research has attempted to investigate the relationships between therapist practice constructs comprised of therapists' emotional and relational skills (Harvey et al., 2016). By representing both intra- and inter-cluster relationships, the MDS solutions of this thesis have notable implications for clinical practice and research. These implications will be considered in an ensuing chapter.

Limitations

Clustering Non-Sorted Items

As NS items were not sorted by participants and therefore not grouped during HCA analysis, these items were absent from the major formation procedure determining clusters for the NZ solution. Because of this, NS items were only incorporated into pre-existing clusters at the discretion of the research team after 'eyeballing' the solution for proximal cluster-less items. Through this process, with the exception of largely NS item composed clusters, NS items had little impact on gross cluster structures. While it is possible that NS items may have had very little effect on initial HCA item grouping, it is also possible that, with all content sorted, the composition of current clusters would be considerably changed. Like dimensional placement, it is important to clarify that this limitation would have no effect on item placement in the model, only for the clusters identified. As the subsequent study of this research aims to establish a new solution with the entire item pool thus including all ES skills in cluster generation, the above limitation is considered acceptable at this stage.

Eyeballing

'Eyeballing' is a qualitative technique informed by quantitative methods which has been used in a number of similar MDS studies (Harvey et al., 2012, 2015;

Rosenblatt, 2012). Specifically, it regards the semantic comparison of proximal items as to determine cluster inclusion or exclusion eligibility. This procedure may be considered a limitation as interpretations may be confounded by researcher bias. Nevertheless, through consultation with the aforementioned validity panels regarding the appropriateness of cluster composition, this bias was minimised. Furthermore, as the final study of this thesis employs a statistical procedure that derives item-groupings (hotspots) from participants' responses, the ability to compare 'eyeballing' judgements from this study with statistically derived hotspots from the latter study further mitigates this limitation.

Sorting Criteria

During a GOPA sorting procedure, participants employ a variety of mental processes to distinguish similarities and dissimilarities between items. Clearly, judgements made based on underlying item themes would be of greater value than those based on superficial item content. Nevertheless, while we are unable to empirically substantiate the level of cognitive consideration employed by participants for each item pair, superficial item clustering was evident in at least two of this study's clusters. For example, almost all of the items comprising *Therapy process* and *Therapeutic collaboration* referenced the word 'therapy', a likely reason these clusters were identified as perceptively similar by both the dendrogram and cluster positioning within the NZ solution. Furthermore, with the exception of *Emotional self-regulation* (1/3 of its items contain the word 'therapy'), virtually no other clusters contain items referencing the term 'therapy', indicating that these items were almost exclusively sorted together. Given that almost all items comprising *Emotional self-regulation* reference the term 'emotion' (including those items referencing the term 'therapy'), and as items referencing the term 'therapy' were spread between three clusters, these observations indicate that a classification system, albeit superficial, existed for the majority of participants when concerning these items.

The Partitioning and Addition phases of the GOPA procedure are intended to increase participant cognitive consideration thus mitigating this potential

limitation. Furthermore, as items will be translated and organised by a foreign-language sample in the subsequent study of this thesis (thus sorting ES skills with a different sentence structure), this potential limitation of GOPA sorting methodology is further reduced for this overall research.

Demographic Variables

Given the relatively small sample size ($n = 25$) and lack of demographic diversity, the findings of this study have limited generalizability. Nevertheless, as adequate reliability estimates have been established comparing this study's solution with Harvey et al.'s (2016) Original, and, given that their Original solution is composed of both a New Zealand general sample and a New Zealand clinical psychologist sample, the above limitation is considered acceptable in the context of this study's aims.

Conclusions and Implications

In summary, these results support the three general hypotheses of this study: a) that Harvey et al.'s (2016) Original solution will be meaningfully updated with new content generated during study one of this research, and that the resultant NZ solution will b) comprehensively represent the content domain, and c), be statistically similar to Harvey et al.'s Original. Largely equivalent statistical dimensions and clusters of the NZ and Original solutions demonstrate the stability of both solutions. Furthermore, excluding two ambiguous clusters, overlap was generally observed between the clusters of the NZ model and the literature. While not compromising the integrity of this study, limitations included the consequences of NS items and researcher bias on cluster determination, superficial sorting criteria influencing item grouping, and the lack of demographic diversity affecting the generalizability of the results.

In closing, the NZ solution tentatively provides insight into how a New Zealand general sample cognitively organise therapists' ES skills in practice. While a number of implications are apparent from this solution, as another model will be

generated in the succeeding study of this thesis, to avoid redundancy, discussion of these implications will ensue in the subsequent study. Given that the NZ solution appears stable and valid, it is appropriate for use as a comparison model in the next study of this thesis, when a similar procedure will be completed by a sample of foreign-language participants.

LINKED THOUGHTS II

Overall, the findings of the previous chapter highlighted that new content could be reliably and meaningfully incorporated into Harvey et al.'s (2016) solution. Importantly, the void present in their Original model was not evident on the surface of the NZ solution. This complete sphere of items indicates sufficient coverage of the content domain. While the NZ solution appears to be a stable and meaningful representation of therapists' ES skills, given that the entire item pool was not used during the sampling procedure, replication of this model using the entire item pool would be an important next step to achieve the aims of the larger project.

As a consequence of this reasoning, and like both Harvey et al.'s (2012) and Rosenblatt's (2012) research, it was considered important to map therapists' ES skills with a foreign-language sample — in this case, a Japanese sample. Harvey et al.'s (2016) Original model and the NZ model of this research were generated with New Zealand English-language samples. Therefore, the current organisation of ES skills in these models may reflect specific words (e.g. therapy, emotion, etc.) and/or item phrases (e.g. "I am", "I can", "I use", etc.), rather than item semantics. Given that the grammatical and sentence structures of the Japanese and English languages differ (Dalrymple, 2001), while the semantic understanding of emotion terms has been found to remain consistent between these languages (Moore, Romney Hsia, & Rusch, 1999), items correctly translated between languages should maintain their semantic meaning, whilst, with all likelihood, be grammatically and structurally dissimilar. It is thought that by having a foreign-language sample sort the entire ES skill pool and subsequently merging NZ and foreign-language data sets (if deemed statistically appropriate), the resultant solution will represent a more thoughtful cognitive organisation structure than solutions representing either sample in isolation.

Obviously, cultural differences between New Zealand and foreign-language samples will be of consideration. However, as the current ES skill pool was generated from English-language sources (research and interview transcripts) and therefore, will not contain Japanese culture-specific skills, this method is considered suitable to validate the predominantly New Zealand organisation of ES

skills currently limiting this research. Such reasoning is supported by Rosenblatt's (2012) research who noted little difference between New Zealand and Japanese conceptualisations of therapy rupture behaviours. Furthermore, as Lopes et al. (2004) found largely universal understanding of emotional skills between culturally distinct groups, albeit a German student sample, it is believed that any English-language cultural-specific skills will not markedly influence the sorting of ES skills conducted by a foreign-language sample. Nevertheless, if marked differences are identified between NZ and foreign-language samples, the reason for these differences will require careful consideration.

As a result, the third study of this thesis aims to tentatively consider whether a foreign-language sample conceptualises therapists' ES skills in a similar way to New Zealand populations. If found to overlap, like Rosenblatt's (2012) research, we may combine foreign-language and NZ data sets as to form a more robust Combined model. A Combined model will likely have several implications for future research and therapeutic practice in English-language countries. Furthermore, if found to overlap, aspects of this model may be deemed applicable to foreign-language samples, particularly Japanese populations, as well as support the assertion that a number of ES skills may be universally understood (Lopes et al., 2004). Aside from providing the robust foundation required for the final study of this thesis, such research would ultimately contribute to our current knowledge of ES skills on an international scale.

CHAPTER FIVE

STUDY THREE: METHOD

“Basic emotional competencies are important in all cultures”

-Lopes et al. (2004, p. 1024)

Participants

A convenience sample of 45 Japanese lay-persons from throughout New Zealand was recruited to participate in this study. Participants were recruited primarily via the Japanese Associations of Auckland, Wellington, Palmerston North, Hawkes Bay, and Canterbury through the dissemination of a Japanese language recruitment email on the researcher’s behalf (Appendix I). Subsequently, personal associates of the researcher who met participation criteria were contacted. There were 7 (16%) men and 38 (84%) women. The age of participants were as follows: 11% ($n = 5$) of participants were aged between 21 and 30; 33% ($n = 15$) of participants were aged between 31 and 40; 36% ($n = 16$) of participants were aged between 41 and 50; and 20% ($n = 9$) of participants were aged over 50.

Materials

All documentation used in study three of this research was originally written in English and subsequently translated to Japanese. The entire item-list was translated by the New Zealand Translation Centre International (NZTCI) and, to ensure consistency, this translation was subsequently reviewed by an accredited Japanese translator external to the NZTCI. While items were translated by the NZTCI, the information and instruction sheet, demographics and consent form, response sheet, and the advertisement email were all translated by the aforementioned accredited Japanese translator. Furthermore, a final review of the item list was conducted by a Japanese clinical psychologist fluent in both English

and Japanese to ensure further consistency and validity between English and Japanese lists.

A Japanese translated information and instruction sheet outlined the research objectives and procedure instructions (Appendix J). A Japanese translated demographics and consent form recorded gender and age and indicated that completion of the form implied informed consent of participation (Appendix K). A Japanese translated response form, derived from Kirkland and Bimler's template for administering "GOPA" card sorts, reiterated procedure instructions and provided an area for participants to record responses (Appendix L).

The entire 151 Japanese translated items pertaining to ES interactions in therapy established in study one of this research was used during this study (Appendix M) but no participant sorted all the items. Six different item sets consisting of either 75 or 76 items each were sorted by participants. The item numbers of the six different sets were as follows: (set 1) item numbers 1-75, (set 2) item numbers 26-100, (set 3) item numbers 51-125, (set 4) item numbers 76-151, (set 5) item numbers 101-151 and 1-25, and (set 6) item numbers 126-151 and 1-50. The rationale for partitioning the entire item list is discussed in the following section. As described in study two, items were typically short descriptions of an ES skill clinicians may use in their practices. Such statements (in English) included "I can empathise without being overwhelmed," "I reflect or communicate an understanding of the client's feelings," "I express genuine thoughts and feelings," and "I consistently question my own practice." Each item was printed onto a small 35mm x 75mm thin coloured card (font MS Mincho) and was consigned a unique numerical tag as to identify it during data analysis.

Item Partitioning Rationale

As GOPA sorting methodology can be a lengthy and tedious task, reducing the number of items to be sorted by each participant while still completing the aims of this study was an important consideration to increase participation. By partitioning the full item-list into staggered sets for sorting and aggregating these

data during analysis, similarity values could be inferred between item-pairs as to meet the aims of this research.

Procedure

With the exception that all procedure instructions were translated from English to Japanese, the procedure of this study is identical to the procedure of study two of this thesis.

Analysis and Reliability Check

As above, with the exception of the following paragraph, the analysis of the data obtained during this study was exactly the same as the analysis section of study two of this thesis.

Given the partitioning of item sets, similarity data could be inferred for item-pairs sorted by different subsets of participants. This process provided a similarity value between 0 and 1 for both sorted and inferred item-pairs, with a value of 0 indicating two items that were never grouped together, and a value of 1 distinguishing two items always sorted into the same group. As the number of participants fluctuated between item sets, item-pairs could be given a 'reliability weight' depending on how many participants had encountered both items and had the opportunity to sort them into a group. Those item-pairs that were sorted more often had a greater reliability and therefore, more weight was given to their values during HCA and MDS analysis.

STUDY THREE: RESULTS

At this point, readers are reminded of the semantic matching task used to organise the item structure and are encouraged to revisit the Mapping Psychological Constructs section of Chapter Three and the Linked Thoughts II section of Chapter Four as to aid their understanding of the following results section.

Like study two, both HCA and MDS methods were utilised to interpret the data, garnering dissimilar yet complementary information (Carter et al., 2009). While model generation was via MDS analysis, relevant cluster determination as appearing in the model was largely informed by HCA. As both studies two and three utilised the same pool of items, two distinct solutions were able to be generated from these data via MDS; a Japanese solution and a Combined solution merging both study two NZ and study three Japanese data sets. Given that the remaining study of this research project will analyse data using either the NZ solution, Japanese solution, or the Combined solution, it is important to assess the statistical and clinical advantages and disadvantages of each solution available before proceeding with cluster determination.

Multi-Dimensional Scaling

Japanese Solution

Overall, by viewing the reliability weights established between item pairs, it was found that the Japanese solution produced during this study showed adequate local structure and inadequate global structure. In other words, relationships between items, as viewed by the dendrogram, were suitable, while the item placement and dimensionality of the solution were less stable. This limitation is thought to have occurred due to uneven participant responding across item sets in which certain item pairs had lesser reliability weights than counterpart item pairs, ultimately compromising the overall structure of the Japanese solution. As a result, the Japanese solution was a less than ideal map to analyse in isolation. Fortunately however, making use of MDS methodology, Japanese data still meaningfully contributed to the aims of this study as well as the overall thesis. This

methodological flaw is discussed further in the limitations section of the succeeding discussion.

Solution Comparison

Three indices of comparison were utilised to compare the NZ solution generated during the previous study, the Japanese solution generated during this study, and a combination of the two solutions. The intention was to determine a) whether the NZ and Japanese solutions from each study were suitably correlated to justify the generation of a Combined solution, and b) determine the most clinically and statistically suitable solution for use with a largely New Zealand sample demographic participating in the subsequent study of this research.

Combined solution. Analysis identified that enough common ground was present to combine the NZ solution and Japanese solution. While the Canonical correlation coefficients showed only two of three mutually recognisable dimensions between the data sets ($R_c = 0.663$, $R_2 = 0.321$, $R_3 = 0.100$; two significant at $p < 0.05$), given that this dimensional difference was considered by the research team to be an artefact of deficient global structure in the Japanese solution, it was considered that with the addition of NZ data, the global structure of the Japanese data would be bolstered, ultimately producing a robust overall model. For this reason, it was considered acceptable to merge data sets and analyse the resultant solution as to test the aforementioned expectation.

Accordingly, to assess the stability of the Combined solution, split half analysis was conducted. Two separate Combined solutions were generated from 1) 23 Japanese and 12 New Zealand sorts and 2) 22 Japanese and 13 New Zealand sorts. These two solutions were subsequently compared generating the following comparison statistics: Cophenetic correlation $r = 0.57$;³ Procrustes Distance $g_1 = 0.120$;⁴ and Canonical correlation $R_c = 0.820$, $R_2 = 0.805$, $R_3 = 0.647$, all significant

³ Cophenetic correlation r between inter-point distances, the closer the r value to 1 the better.

⁴ Procrustes Distance (g_1), the difference in distance between individual items in each map when solutions are rescaled and rotated to optimal alignment; a value of 0.2 or less is considered optimal (Harris, 2001).

at $p < 0.0005$.⁵ As presumed above, these statistics indicate that, with the addition of the NZ data, deficient global structure in the Japanese solution did not affect the structure of the Combined solution. In fact, given the good reliability statistics presented above, including overlapping dimensionality, we can be confident that the complete Combined solution is internally consistent and the most statistically robust solution of the three generated throughout this research project.

Further comparisons were conducted between the Combined solution and both the NZ and Japanese solutions. Table 11 displays the Procrustes Distance and Canonical correlation estimates between the Combined solution and both the NZ and Japanese models. The results demonstrate the following: a) that three mutually-recognisable dimensions are present between the Combined solution and both the NZ solution and Japanese solution and b), that the Combined solution is statistically more similar to the NZ solution than Japanese solution. This result is encouraging as it indicates that not only is the Combined solution more statistically robust than the other solutions, but also shares more global and local structure with the NZ solution than the Japanese solution thus increasing its applicability with the succeeding study's sample demographic.

Table 11.
Statistical comparison of Combined solution with NZ and Japanese solutions

Combined solution vs.	Procrustes Distance	Canonical correlation
NZ solution	0.083	0.965, 0.943, 0.524*
Japanese solution	0.246	0.853, 0.346, 0.271**

*all significant at $p < 0.0005$, **all significant at $p < 0.005$.

Validity. As with study two, $Stress_1$ values were assessed to identify the optimal number of dimensions for each solution. Figure 10 below displays the change in $Stress_1$ values across dimensionality for each solution. The results demonstrate further similarities between maps given that three dimensions appear to be the optimum balance between validity and interpretability for each solution.

⁵ Canonical Correlation, a form of multivariate analysis, that progressively rotates each solution across three dimensions with subsequent comparisons between item coordinates for each dimension.

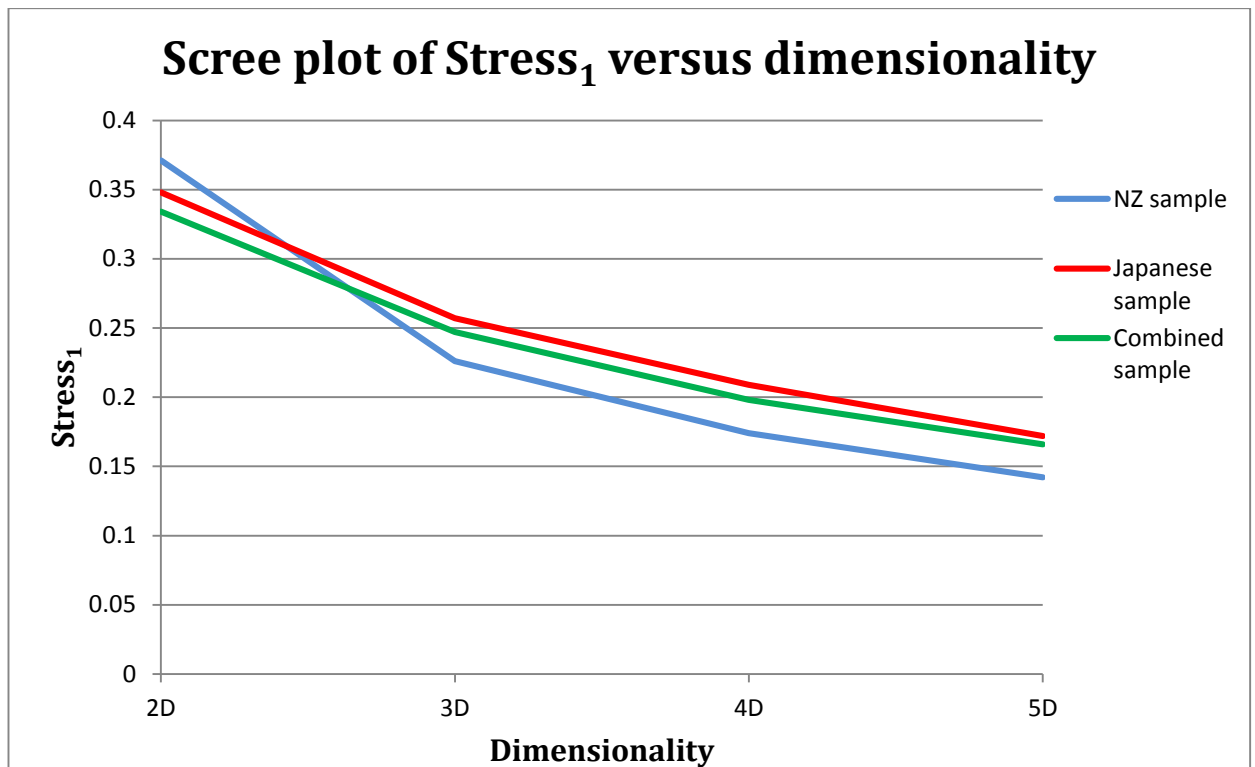


Figure 10. Scree plot of $Stress_1$ versus dimensionality for New Zealand, Japanese, and Combined samples.

Whilst a solution's statistical reliability is essential, analysis of item locations, clustering, and dimensionality is of considerable importance when deciding on the optimal solution to use in the succeeding study. As to ensure that item grouping and dimensionality of the Combined solution was meaningful to a NZ population, a NZ validation panel consisting of two senior clinical psychologists and three emotion-focused researchers examined the item clusters and dimensionality of the Combined solution (presented in subsequent section). Several minor recommendations were made and this validation panel determined that the clusters and dimensions of the Combined solution had satisfactory face validity.

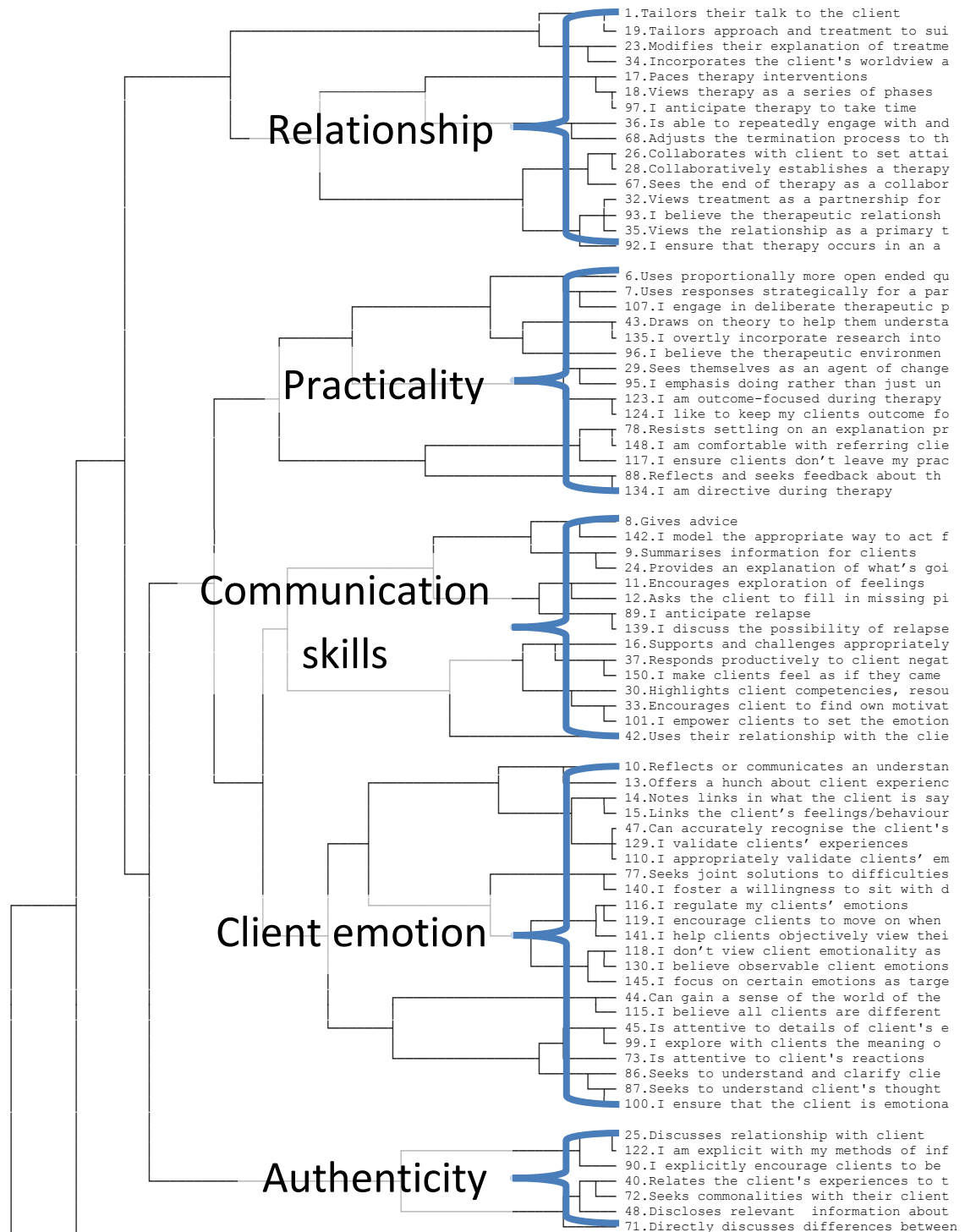
As the NZ solution was generated from a sort procedure using only a portion of the total item pool as well as less total number of participants, its possible advantage of a full New Zealand sample cohort is greatly offset by the statistical reliability shown by the Combined solution as well as the more

thoughtful cognitive organisation the Combined solution is believed to represent. Furthermore, as the Combined solution shows greater statistical similarity to the NZ solution than the Japanese solution and, given the face validity of dimensions and clusters as determined by a six-person validity panel consisting of the research team and three New Zealand clinical psychologists independent to the current project, the likelihood of cultural nuances influencing the results of the succeeding study were largely reduced. For the above reasons, the Combined solution was selected for use in the following study of this overall research project.

Combined Solution

Dendrogram

Figure 11 below displays the dendrogram generated from the combined NZ and Japanese data sets with preliminary clustering descriptions. Item text has been truncated as to fit within this document.



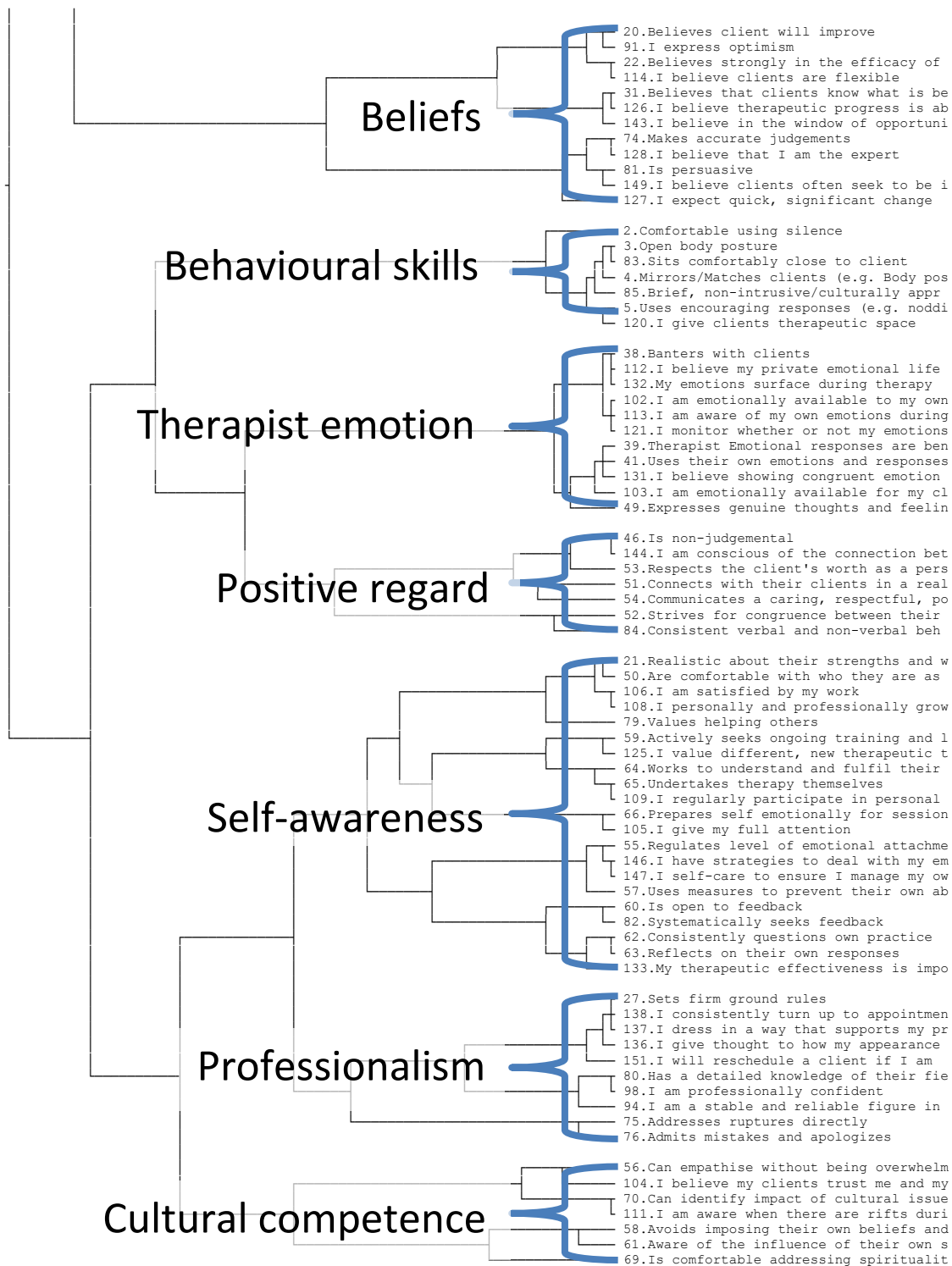


Figure 11. Combined sample dendrogram with item text truncated and preliminary cluster descriptions.

Surface Coverage

As presented below, Figure 12 displays complementing hemispheric views of the distribution of items in the Combined solution. The solution is sliced down the middle and flattened with the X-axis oriented toward the viewer. Two concentric circles are visible which represent 30 degree and 60 degree projections respectively from the centre to the outmost circle. The exterior circle lining the figure represents a zero on the X-axis.

Like the NZ solution, an even distribution of items is visible on the surface of the Combined solution with no item voids observable. This indicates that a comprehensive pool of ES skills adequately reflecting the content domain is represented by the Combined model.

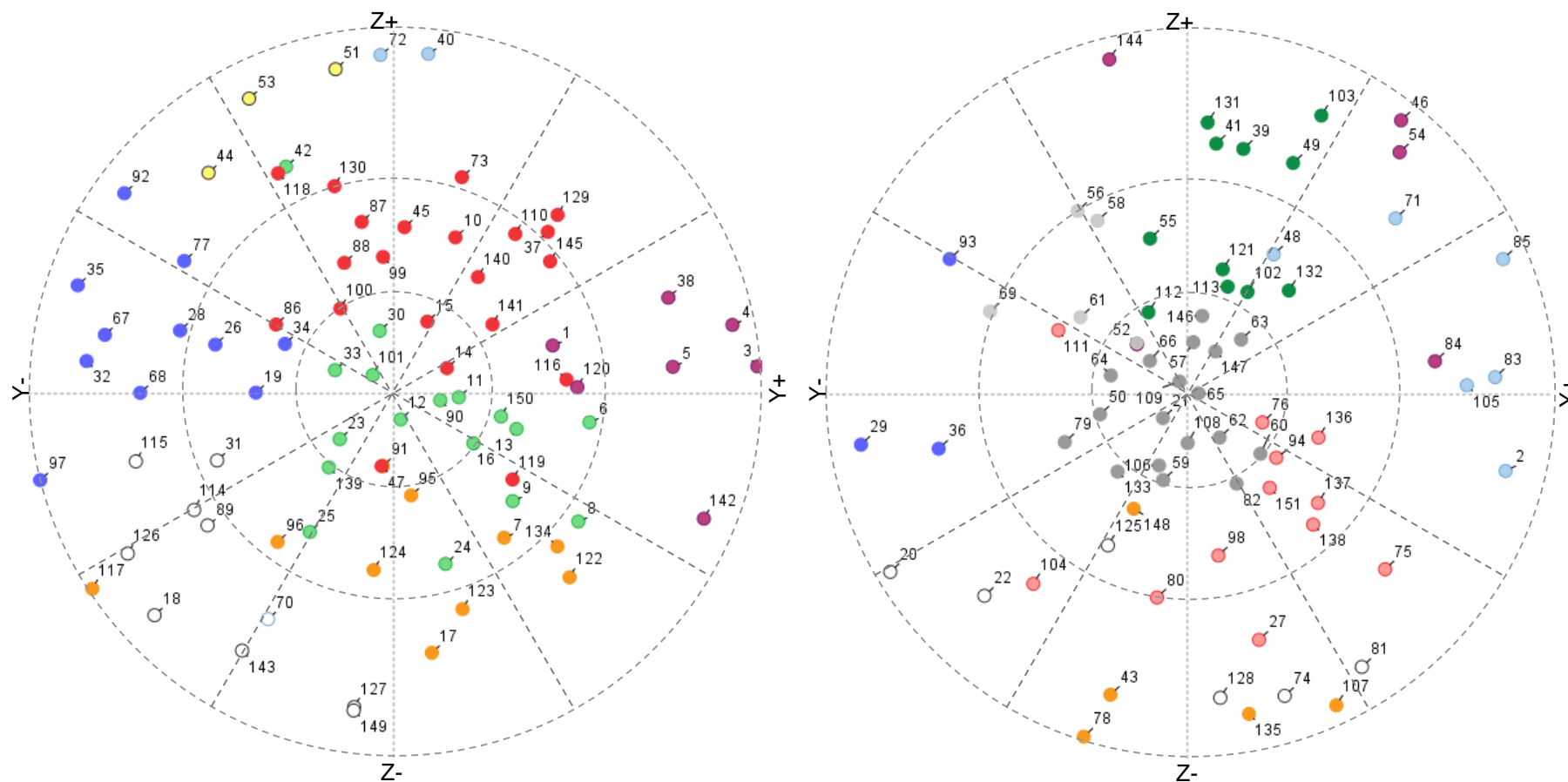


Figure 12. X- and X+ hemispheric views displaying item placement and cluster membership in the combined model.

Note. Blue = A. Therapeutic collaboration and tailoring, Orange = B. Practical, Light green = C. Communication behaviours, Red = D. Emotion coach, Light blue = E. Commonalities, White = F. Beliefs, Purple = G. Behavioural skills, Dark green = H. Therapist emotion, Yellow = I. Positive connection, Dark grey = J. Therapist self-care and improvement, Pink = K. Professional behaviour, Light grey = L. Cultural competence.

Clusters

The items comprised in each cluster, cluster themes, and proximal clusters are summarised in Table 12 below. Gross item grouping was primarily informed by HCA followed by more specific item assignment after 'eyeballing' the Combined map. The clusters' labels resulted from a qualitative aggregation of the underlying themes pertaining to the items they encompass.

Table 12.
Cluster items, themes and locations

Cluster	Items	Cluster themes	Proximal clusters
A. Therapeutic collaboration and tailoring	19. I tailor my approach and treatment to suit my client's personality 26. I collaborate with my client to set attainable/acceptable goals 28. I collaboratively establish a therapy agreement 29. I see myself as an agent of change in the relationship 32. I view treatment as a partnership for change 34. I incorporate the client's worldview and theory of problem/treatment 35. I view the relationship as a primary tool of therapy 36. I am able to repeatedly engage with and end therapy relationships positively 42. I use my relationship with the client to increase client motivation 67. I see the end of therapy as a collaborative process 68. I adjust the termination process to the nature of the therapy relationship 77. I seek joint solutions to difficulties 92. I ensure that therapy occurs in an atmosphere of mutual respect 93. I believe the therapeutic relationship is mutually influential 97. I anticipate therapy to take time	Collaboration Time during therapy Tailoring	F. Beliefs I. Positive connection L. Cultural competence
B. Practical	7. I use responses strategically for a particular effect or purpose 17. I pace therapy interventions 43. I draw on theory to help me understand the client's feelings/experiences 70. I can identify the impact of cultural issues on clients' problems 78. I resist settling on an explanation prematurely 91. I express optimism 95. I emphasis doing rather than just understanding 96. I believe the therapeutic environment is a place for clients to trial different behavioural strategies	Practicality Professional practise Directive Therapist-oriented	C. Communication behaviours F. Beliefs K. Therapist self-care and improvement

	107. I engage in deliberate therapeutic practise		
	117. I ensure clients don't leave my practice feeling worse than when they entered		
	122. I am explicit with my methods of influencing		
	123. I am outcome-focused during therapy		
	124. I like to keep my clients outcome focused		
	134. I am directive during therapy		
	135. I overtly incorporate research into my practice to educate my clients		
	148. I am comfortable with referring clients on when required		
C.	6. I use proportionally more open ended questions (than closed)	Techniques	B. Practical
Communication	8. I give advice	Communication	D. Emotion coach
behaviours	9. I summarise the information for clients	Microskills	G. Behavioural skills
	11. I encourage exploration of feelings		
	12. I ask the client to fill in the missing pieces		
	13. I offer a hunch about client experiences		
	16. I support and challenge appropriately		
	23. I modify my explanation of treatments to make it acceptable to client's worldview		
	24. I provide an explanation of what's going on		
	25. I discuss the relationship with my client		
	30. I highlight client competencies, resources and resiliencies		
	33. I encourage clients to find their own motivation for change		
	90. I explicitly encourage clients to be open and honest with me		
	101. I empower clients to set the emotional pace of therapy		
	139. I discuss the possibility of relapse with clients		
	150. I make clients feel as if they came up with their own ideas/solutions		

D. Emotion coach	10. I reflect or communicate an understanding of the client's feelings 14. I note links in what the client is saying (e.g. Recurring themes, discrepancies) 15. I link the client's feelings/behaviours to past experiences 37. I respond productively to client negativity 45. I am attentive to details of client's experiences 47. I can accurately recognise the client's current innermost state, experience or motivations 73. I am attentive to client's reactions 86. I seek to understand and clarify client expectations 87. I seek to understand client's thoughts/feelings 88. I reflect and seek feedback about my understanding of the client 99. I explore with clients the meaning of their experiences 100. I ensure that the client is emotionally invested in the process of therapy 110. I appropriately validate clients' emotions 116. I regulate my clients' emotions 118. I don't view client emotionality as a problem 119. I encourage clients to move on when emotional 129. I validate clients' experiences 130. I believe observable client emotions give valuable information 140. I foster a willingness to sit with distress in clients 141. I help clients objectively view their emotions 145. I focus on certain emotions as target points	Understanding Validation Regulation	C. Communication behaviours E. Commonalities G. Behavioural skills I. Positive connection
E. Commonalities	2. I am comfortable using silence 40. I relate my client's experiences to their own life and experiences 48. I disclose relevant information about myself 71. I directly discuss differences between myself and my client 72. I seek commonalities with my clients 83. I sit comfortably close to my clients 85. I use a brief, non-intrusive/culturally appropriate touch 105. I give my full attention	Honesty Relating	D. Emotion coach H. Therapist emotion I. Positive connection

F. Beliefs	18. I view therapy as a series of phases 20. I believe my client will improve 22. I believe strongly in the efficacy of my treatment 31. I believe that clients know what is best for themselves 74. I make accurate judgements 81. I am persuasive 89. I anticipate relapse 104. I believe my clients trust me and my clinical judgement 114. I believe clients are flexible 115. I believe all clients are different 125. I value different, new therapeutic techniques 126. I believe therapeutic progress is about small incremental changes rather than radical changes 127. I expect quick, significant change 128. I believe that I am the expert 143. I believe in the window of opportunity for change 149. I believe clients often seek to be influenced	Therapy-related beliefs Optimism Client change	A. Therapeutic collaboration and tailoring B. Practical L. Cultural competence
G. Behavioural skills	1. I tailor my talk to the client 3. I display open body posture 4. I mirror/match my clients (e.g. Body posture, use of key words) 5. I use encouraging responses (e.g. nodding, sounds) 38. I banter with clients 46. I am non-judgemental 54. I communicate a caring, respectful, positive attitude 84. I display consistent verbal and non-verbal behaviour 120. I give clients therapeutic space 142. I model the appropriate way to act for my clients 144. I am conscious of the connection between me and my clients	Behavioural Micro-skills Relating	C. Communication behaviours D. Emotion coach I. Positive connection K. Professional behaviour
H. Therapist emotion	39. My emotional responses are beneficial for clients 41. I use my own emotions and responses to relate to the client 49. I express genuine thoughts and feelings 55. I regulate my level of emotional attachment to my clients 102. I am emotionally available to my own experiences	Emotion Therapist-oriented	E. Commonalities I. Positive connection J. Therapist self-care and improvement L. Cultural competence

	103. I am emotionally available for my clients' experiences		
	112. I believe my private emotional life affects my practice		
	113. I am aware of my own emotions during therapy		
	121. I monitor whether or not my emotions are useful during therapy		
	131. I believe showing congruent emotion is useful		
	132. My emotions surface during therapy		
I.	44. I can gain a sense of the world of the client	Respect	A. Therapeutic collaboration and tailoring
Positive connection	51. I connect with my clients in a real way	Awareness	D. Emotion coach
	53. I respect the client's worth as a person	Genuineness	E. Commonalities
			G. Behavioural skills
			H. Therapist emotion
			L. Cultural competence
J.	21. I am realistic about my strengths and weaknesses	Professionalism	H. Therapist emotion
Therapist self-care and improvement	50. I am comfortable with who I am as a person	Competency	K. Professional behaviour
	57. I use measures to prevent my own abuse of power	Growth	L. Cultural competence
	59. I actively seek ongoing training and learning opportunities	Self-awareness	
	60. I am open to feedback	Values	
	62. I consistently question my own practice	Therapist-oriented	
	63. I reflect on my own responses	Regulation	
	64. I work to understand and fulfil my emotional and physical needs		
	65. I undertake therapy myself		
	66. I prepare myself emotionally for sessions		
	79. I value helping others		
	82. I systematically seek feedback		
	106. I am satisfied by my work		
	108. I personally and professionally grow as a result of my work		
	109. I regularly participate in personal mindfulness exercises		
	133. My therapeutic effectiveness is important to me		
	146. I have strategies to deal with my emotions that surface during therapy		
	147. I self-care to ensure I manage my own emotions		

K. Professional behaviour	27. I set firm ground rules 75. I address ruptures directly 76. I admits mistakes and apologise 80. I have a detailed knowledge of my field 94. I am a stable and reliable figure in therapy 98. I am professionally confident 136. I give thought to how my appearance impacts on my client 137. I dress in a way that supports my professional position 138. I consistently turn up to appointments on time 151. I will reschedule a client if I am unable to competently practice 111. I am aware when there are rifts during therapy	Professionalism Competence	B. Practical G. Behavioural skills J. Therapist self-care and improvement
L. Cultural competence	52. I strive for congruence between my values and my behaviour 56. I can empathise without being overwhelmed 58. I avoid imposing my own beliefs and values on clients 61. I am aware of the influence of my own socio-cultural background 69. I am comfortable addressing spirituality	Confidence Competence Culture/spiritual	A. Therapeutic collaboration and tailoring F. Beliefs H. Therapist emotion I. Positive connection J. Therapist self-care and improvement

Dimensions

Each dimension is believed to represent an underlying attribute and contains two poles. Tables 13-18 display the eight items with values closest to each pole. Recall from study two, that an item with the most extreme value for a pole may not best represent that pole. Items with relatively high values relating to a pole and neutral values relating to other dimensions may be considered more representative forms of that pole's underlying attribute than items with extreme pole-related values as well as high positive or negative values relating to other dimensions. The most representative item of each pole has been italicised in each table.

Dimension X. The positive pole of dimension X is characterised entirely by items comprising the cluster *Therapist self-care and improvement* (J) of the MDS solution. Overall, the positive pole of dimension X is therapist-oriented and contains elements of self-reflection and self-care.

Table 13.
Upper quartile of X coordinates

Item	Cluster	X-Value
<i>I undertake therapy myself</i>	J	6.89
I actively seek ongoing training and learning opportunities	J	6.84
I regularly participate in personal mindfulness exercises	J	6.61
I consistently question my own practice	J	6.59
I prepare myself emotionally for sessions	J	6.58
I personally and professionally grow as a result of my work	J	6.51
I work to understand and fulfil my emotional and physical needs	J	6.40
I reflect on my own responses	J	6.38

The negative pole of dimension X appears to be largely characterised by items comprising cluster *Communication behaviours* (C). Overall, the negative pole of dimension X is client-oriented with qualities of understanding and clarification.

Table 14.
Lower quartile of X coordinates

Item	Cluster	X-Value
<i>I ask the client to fill in the missing pieces</i>	C	-6.63
I encourage exploration of feelings	C	-6.41
I note links in what the client is saying (e.g. Recurring themes, discrepancies)	C	-5.95
I encourage clients to find their own motivation for change	C	-5.81
I highlight client competencies, resources and resiliencies	C	-5.77
I link the client's feelings/behaviours to past experiences	D	-5.76
I modify my explanation of treatments to make it acceptable to client's worldview	C	-5.69
I empower clients to set the emotional pace of therapy	C	-5.62

Dimension Y. The positive pole of dimension Y is characterised entirely by items comprising cluster *Therapy Collaboration (A)*. Overall, the positive pole of dimension Y shows elements of collaboration between client and therapist.

Table 15.
Upper quartile of Y coordinates

Item	Cluster	Z-Value
I see the end of therapy as a collaborative process	A	6.42
I seek joint solutions to difficulties	A	6.36
I view treatment as a partnership for change	A	6.21
<i>I view the relationship as a primary tool of therapy</i>	A	5.99
I collaboratively establish a therapy agreement	A	5.63
I adjust the termination process to the nature of the therapy relationship	A	5.61
I believe the therapeutic relationship is mutually influential	A	5.56
I anticipate therapy to take time	A	5.48

The negative pole of dimension Y is characterised primarily by items comprising the cluster *Behavioural skills (G)*. Overall, the negative pole of dimension Y regards behavioural skills as well as an intention to influence.

Table 16.
Lower quartile of Y coordinates

Item	Cluster	Z-Value
I display open body posture	G	-6.61
I use encouraging responses (e.g. nodding, sounds)	G	-6.15
I give advice	C	-6.06
I sit comfortably close to my clients	G	-5.71
I address ruptures directly	K	-5.54
<i>I am comfortable using silence</i>	G	-5.49
I am persuasive	F	-5.32
I am explicit with my methods of influencing	B	-5.18

Dimension Z. The positive pole of dimension Z is characterised by items comprising a range of clusters. Most relevant of these clusters are *Positive connection* (I), *Commonalities* (E), and *Therapist emotion* (H). Overall, the positive pole of dimension Z comprises items important in making connections with clients.

Table 17.
Upper quartile of Z coordinates

Item	Cluster	Y-Value
I relate my client's experiences to their own life and experiences	E	6.75
<i>I am non-judgemental</i>	I	6.30
I seek commonalities with my clients	E	6.22
I connect with my clients in a real way	I	5.66
I express genuine thoughts and feelings	H	5.61
My emotional responses are beneficial for clients	H	5.34
I use my own emotions and responses to relate to the client	H	5.32
I use a brief, non-intrusive/culturally appropriate touch	G	5.11

The majority of items representing the negative pole of dimension Z belong to cluster *Beliefs* (F). Furthermore, one item was present from each of the clusters *Professional behaviour* (K), *Practical* (B), and *Cultural competence* (L). Overall, this pole is largely therapist-oriented and regards therapist beliefs in practice.

Table 18.
Lower quartile of Z coordinates

Item	Cluster	Y-Value
I expect quick, significant change	F	-7.37
<i>I believe in the window of opportunity for change</i>	F	-6.37
I believe strongly in the efficacy of my treatment	F	-6.22
I view therapy as a series of phases	F	-6.07
I believe clients often seek to be influenced	F	-5.82
I have a detailed knowledge of my field	K	-5.72
<i>I resist settling on an explanation prematurely</i>	B	-5.62
I can identify the impact of cultural issues on clients' problems	L	-5.61

Naming the dimensions. As presented below, Table 19 displays the most salient clusters relating to each pole, the label assigned to each pole, and the attribute each dimension is thought to regard. These poles and dimensions were labelled by the same process outlined in study two.

Table 19.
Pole and dimension labels with respective salient clusters

Salient clusters	Dimensional poles	Dimension
J. Therapist self-care and improvement	Therapist-focused reflective practice (X+)	Reflective practice
C. Communication behaviours	Client-focused reflective practice (X-)	
A. Therapeutic collaboration and tailoring	Collaboration (Y+)	Degree of cooperative focus
G. Behavioural skills	Behavioural skills (Y-)	
E. Commonalities	Real connection (Z+)	Tailored-general
F. Beliefs	Belief in therapy (Z-)	

Items along dimension X were identified to regard reflective practice as well as a transition from therapist-oriented items, to client-oriented items. Accordingly, this dimension was classified as *Reflective practice*. Items progressing along dimension Y were seen to move from only involving the therapist's actions, to items involving both the therapist and client. Consequently, dimension Y was labelled *Degree of cooperative focus*. Lastly, dimension Z showed items transitioning from general beliefs about therapy, to therapist tailoring skills. As a result, dimension Z was labelled *Tailored-general*.

STUDY THREE: DISCUSSION

The aims of study three were five-fold. Firstly, to translate and sort the entire pool of ES skills used in study two of this research with a foreign-language sample; secondly, to generate a Japanese solution from these data; thirdly, to compare Japanese and NZ solutions as to identify differences in semantic and/or cultural understanding; fourthly, to generate a Combined solution from data collected during this study and the previous study; and lastly, to identify the most suitable solution for use in the succeeding study of this research. While not all aims were successful, the findings of this study support the general hypotheses: a) that a non-random Japanese solution was able to be generated based on translated English-language derived ES skills sorted by a Japanese sample; b) that a stable and valid Combined solution could be generated from combined data sets; and c), that the Combined solution would be identified as the most suitable solution for use in the succeeding study. The following discussion compares the Combined solution of this study with both the NZ solution of the previous study as well as the Original solution of Harvey et al.'s (2016) research. Subsequently, the implications of this solution are considered with its limitations acknowledged.

Surface Coverage

Like the NZ model, the Combined model shows representative surface coverage with an even distribution of items and no significant item voids observable. This result indicates that the intended content domain is adequately represented in this research's entire item pool.

Dimensions

As expected, the results indicate that a general sample of Japanese-language participants cognitively organised English-derived ES skills across three dimensions that are akin to a New Zealand general population. Tentatively, this finding suggests that therapists' practice interactions may be organised in a stable way across foreign-languages. Clearly, future studies independently replicating

this finding and assessing diverse populations' organisation of therapists' ES skills are required to substantiate this supposition. Nevertheless, the above finding supports the merging of Japanese and New Zealand data sets to produce a more robust Combined solution.

The data of the Combined solution appears to fit best between the axes labelled *Reflective practice* (X), *Degree of cooperative focus* (Y), and *Tailored-general* (Z). *Reflective practice* suggests that individuals structure items according to the focus of the therapist's appraisals — i.e., reflecting on personal (X+) or client (X-) information in practice. This finding is supported by MDS research conducted by Darcy, Lee, and Tracey (2004) regarding counsellor multicultural competence. They constructed a three-dimensional solution from participant sorts and defined one of these dimensions as *Focus on self* and *Focus on other* thus indicating the counsellor's focus in therapy. While not identical, the orientation of the therapist's appraisals has also been noted in both NZ and Original solutions. This consistent dimensional theme, which is also supported in the literature (Darcy et al., 2004), suggests that individuals routinely employ an orientation-based classification system when appraising general therapist behaviour — i.e. that these appraisals may not be restricted to just therapist ES skills or multicultural competence.

Degree of cooperative focus is analogous to its counterpart dimension in both the NZ and Original solutions. These dimensions consistently indicate that participants classify therapist ES skills between specific therapist skills and collaborative practice interactions. Hence, with respect to this dimension, items appear to be cognitively organised according to the individual or dual nature of therapist ES skills. Again, like dimension X, this consistent dimensional theme suggests that individuals routinely employ this classification structure when appraising therapist ES skills.

Tailored-general suggests that items are classified according to their specificity. At one extreme, items reflect a tailored connection to clients (Z+), while at the other extreme (Z-), they reflect general beliefs about therapy. This dimension showed little resemblance to those identified in either the NZ or Original solutions. As statistical results indicate three mutually recognisable dimensions between the NZ and Combined solutions, the aforementioned lack of

resemblance can be considered to reflect differences in qualitative axis placement rather than genuine sorting differences between sample groups. Making sense of *Tailored-general*, this dimension may reflect a transition from mostly static therapy beliefs to factors more likely to fluctuate with client presentation. Following this logic, participants may appraise therapists' ES skills according to their potential degree of fluctuation, a relatively complex consideration.

The dimensions *Degree of cooperative focus* and *Tailored-general* have not been identified in the limited research attempting to map therapist behaviour. Tracey et al. (2003) found the dimensions *Hot versus cool processing* (or feeling vs. thinking) and *Therapeutic activity* resulting from a sorting procedure of therapeutic common factors. Alternatively, Barak and LaCrosse (1975) identified support for the hypothesised counsellor behaviour dimensions *Expertness*, *Attractiveness*, and *Trustworthiness* after participants rated therapists' practice sessions across 36 bipolar scales. This lack of literature conformity is not surprising given the limited MDS research conducted on this subject as well as the challenging and highly subjective nature of MDS output interpretation (Jaworska & Chupetlovska-Anastasova, 2009).

Nevertheless, the statistical dimensions of the Combined solution are analogous to previous solutions. Furthermore, two of three qualitative dimensions positioned by the research team are also in accordance with previous solutions. These results are encouraging as they indicate uniform and meaningful organisation of ES skills across differing populations. This finding validates the merging of data sets to form a more robust Combined solution for application in the final study of this thesis.

Clusters

Links to NZ and Original Models

Considerable overlap was present between the methodology and items of this study and those of both the previous study and Harvey et al.'s (2016) research. As a result, comparisons were made between the 12 clusters of the Combined solution, 11 clusters of the NZ solution, and 19 clusters and ten hotspots identified

in studies one and two of Harvey et al.'s research, respectively. Like study two, clusters and hotspots were compared largely by item composition, with grouping labels guiding initial comparisons.

Again, as displayed in Table 20, there was a general overlap of clusters between combined and NZ solutions as well as those item groupings discerned in Harvey et al.'s (2016) research. This finding a) supports the notion that participants of each study grouped ES skills in similar ways, b) supports the merging of NZ and Japanese data sets to produce a more reliable Combined solution, and c) verifies the overall stability of the Combined solution.

Table 20.
Comparison of item groupings between NZ and Combined solutions of this research as well as those from Harvey et al.'s (2016)

Study three: Combined solution clusters	Study two: NZ solution clusters	Harvey et al. (2016)	
		Clusters	Hotspots
Therapeutic collaboration and tailoring	Therapeutic collaboration	Therapy collaboration	Balanced collaboration
Practical	Tailor	Tailors therapy	Tailoring therapy
Communication behaviours	Strategic	-	-
Emotion coach	-	Language use	Client empowerment
Commonalities	Addresses client emotions	Clarifies	
Beliefs	-	Client determination	
Behavioural skills	Optimistic about therapy	Emotionally aware of client	Feeling in context
Therapist emotion	Therapy process	-	Therapeutic use of own experiences
Positive connection	Microskills	Therapists beliefs	-
Therapist self-care and improvement	Emotional self-regulation	Therapists client beliefs	
Professional behaviour	Reflective practice	Structure	
Cultural competence	Manages relationship	Discrete behavior	Behavioral expressions
	Interpersonal acceptance	Emotionally Reflective	Verbal easing
		Emotion regulation	
		Emotionally self-aware	
		Positive emotional connection	
		Open to feedback	Self-reflective critique
		Guides	Expert role
		Current in literature	
		Response to connection issues	
		Culturally aware	Self-secure

Note. The positions of NZ solution clusters and Harvey et al.'s (2016) item groupings are dependent on similarities with clusters of the Combined solution.

Cluster *Therapy process* of the NZ solution did not remain as a discrete cluster in the Combined solution. By monitoring the ES skills previously belonging to *Therapy Process*, it was identified that these items were largely encompassed by Combined solution cluster *Beliefs*. In contrast however, NZ solution cluster *Strategic* — a cluster consisting mostly of items generated during study one of this thesis and lacking acknowledgement in contemporary literature — remained largely unified in the Combined solution, with ten of its 17 items belonging to cluster *Practical*. Moreover, three remaining *Strategic* items not captured by cluster *Practical* of the Combined solution, were present in the cluster *Beliefs* of the Combined solution. As cluster *Beliefs* and cluster *Practical* are extremely proximal to one another in the Combined solution, this observation indicates that the composing items of cluster *Strategic* have largely remained in close proximity after being sorted by a disparate sample group. This result suggests that the ES skills comprising cluster *Strategic* have been meaningfully organised. This finding supports the argument that a distinct construct relating to therapeutic strategy may currently be unexplored in the literature. Clearly, further research exploring this supposition is warranted.

Links to Other Research

General literature. Like clusters of the NZ solution, elements of Combined solution clusters are represented in the extant literature. Both *Communication behaviours* and *Behavioural skills* have routinely been touted as important to therapeutic rapport in the medical and psychological literature (Mast, 2007; Norfolk et al., 2007; Roberts et al., 2003; Sharpley, Jeffery, & McMahan, 2006). The clusters *Emotion coach* and *Therapist emotion* reflect several of Saarni's (1999) and de Vries' (2012) emotional skills. Furthermore, *Emotion coach* is virtually analogous to the literature construct emotion coaching – coaching others to identify, accept, and positively transform emotions (Gottman, 2001; Greenberg, 2004, 2011; Katz, Maliken, & Stettler, 2012; Lunkenheimer, Shields, & Cortina, 2007; Ramsden & Hubbard, 2002). *Therapeutic collaboration and tailoring* strikes accord with research regarding the therapeutic relationship (Ackerman et al.,

2001; Bachelor et al., 2007; Kazantzis & Kellis, 2012; Norcross & Wampold, 2011; Orlinsky et al., 2004). The two key concepts comprising *Therapist self-care and improvement* are clearly acknowledged as a) salient to master therapists' practices (Harrison & Westwood, 2009; Jennings et al., 2008; Jennings & Skovholt, 1999) and b), along with *Professional behaviour*, fundamental components of professionalism (Elman et al., 2005). *Positive connection* largely reflects the Rogerian client-centred concept of unconditional positive regard (Farber & Doolin, 2011; Norcross & Wampold, 2011), and *Commonalities* can be linked to research regarding the therapeutic use of self-disclosure in practice (Ackerman et al., 2001; Hill & Knox, 2002; Watkins, 1990). Lastly, *Cultural competence*, key to working with differing cultural and spiritual groups (Jennings et al., 2008; Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003; Smith, Rodriguez, & Bernal, 2011; Worthington, Hook, Davis, & McDaniel, 2011), along with facets of cluster *Beliefs* (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004; Wampold, 2001), have both been identified as important to psychotherapeutic outcomes.

Existing framework. Of Anderson, Patterson, and Weis' eight FIS constructs (as cited in Anderson et al., 2009, and operationally defined in Uhlin, 2011), seven show overlap with six Combined solution clusters. This overlap is displayed below (Table 21).

Table 21
Comparison of Combined solution clusters and FIS constructs

Combined solution clusters	Anderson, Patterson, and Weis' FIS constructs (as defined by Uhlin, 2011)
Therapeutic collaboration and tailoring	Alliance-bond capacity
Communication behaviours	Verbal fluency
Emotion coach	Emotional expressiveness Persuasiveness Empathy
Beliefs	Hopefulness and positive expectations
Positive connection	Warmth, acceptance, and understanding
Cultural competence	

Note. FIS construct Problem-focus did not overlap with Combined solution clusters. Combined solution clusters Practical, Commonalities, Behavioural skills, Therapist emotion, Therapist self-care and improvement, and Professional behaviour did not overlap with FIS constructs.

Of interest in Table 21 was overlap between *Emotion coach* and *Persuasiveness*, as well as *Beliefs* and *Hopefulness and positive expectations*. Cluster *Emotion coach* appeared to best capture FIS construct *Persuasiveness* despite the seemingly representative item “I am persuasive” belonging to cluster *Beliefs* instead of cluster *Emotion Coach* in the Combined solution. Given that scoring criteria for the FIS construct *Persuasiveness* includes the ability to logically explain one’s particular belief, it is understandable that the item “I am persuasive” was clustered with belief-related ES skills. Alternatively, perhaps the item “I am persuasive” was perceived by this study’s cohort to represent a therapist’s belief about their practice, rather than their actual ability to be persuasive. This comparison also suggests that participants view the ES skills of *Emotion coaching* as persuasive.

FIS construct *Hopefulness and positive expectations* is most captured by cluster *Beliefs*, while the cluster *Beliefs* does not appear to be restricted to one such theme — i.e. it includes a number of general beliefs about therapy (e.g. “I am persuasive”, “I view therapy as a series of phases”, etc.). Moreover, the item “I express optimism” which appears representative of *Hopefulness and positive expectations* was contained in cluster *Practical*, separate from other optimism related items contained in the neighbouring cluster *Beliefs*. Conceivably the item “I express optimism” was grouped with the ES skills of *Practical* as it is perceived to have a pragmatic purpose in therapy — i.e. that optimism is intentionally expressed to serve a therapeutic purpose.

Several of the Combined solution clusters did not overlap with FIS constructs and may reflect the scope of the FIS scale. According to Anderson et al. (2009), the FIS scale is designed as an in-session tool to assess therapist behaviour. Therefore, in-session therapist behaviours that are difficult to observe (*Practical* and internal aspects of *Therapist emotion*) as well as out-of-session therapist behaviour (*Therapist self-care and improvement* and *Professional behaviour*) may not be applicable to this measure. Nevertheless, such reasoning does not account for why cluster *Behavioural skills* was not a discrete FIS construct and may indicate a valuable element currently lacking in the FIS conceptualisation.

Cluster absent in the literature. As discussed previously, the cluster *Practical* is virtually absent in the literature and has remained essentially distinct during two separate sorting procedures. Recall that *Practical* is determined to consist of themes including therapeutic strategy, professional practice, and therapist directiveness. This observation suggests that *Practical* may be an important therapist construct currently missing in the literature thus warranting future investigation.

Overall, the above associations between clusters of the Combined solution and the literature (including FIS constructs), validates the clusters of the Combined solution. Furthermore, these results suggest that the ES skills of this research were organised by a foreign-language sample in way that is meaningful to English-speakers. Such results support previous findings that certain ES skills may be understood universally (Lopes et al., 2004) and that this model is appropriate for use in the succeeding study of this project.

Inter-Cluster Relationships

Like the NZ solution, the Combined solution displays the perceived relationships between clusters. Recall that perceptively similar clusters are located near one another while perceptively dissimilar clusters are distal to one another in the MDS solution. By considering the interrelationships between clusters, we may hypothesise how and why those cluster are perceived to relate. The following paragraphs consider several examples of interesting inter-cluster relationships identified in the Combined solution.

From their proximity in the Combined solution we can see that cluster *Positive connection* is perceptively similar to clusters *Therapeutic collaboration and tailoring*, *Cultural competence*, and *Behavioural skills*. This link suggests that to achieve *Positive connection* in practice (along with ES skills related to *Positive connection*), behavioural skills, collaboration skills, tailoring skills, and openness to cultural differences will also be important. As a positive connection between the client and the therapist is a hallmark of a strong therapeutic bond, behavioural skills, collaboration, and tailoring one's practice may also be fundamental to

achieving a working alliance, with the literature supporting this supposition (Ackerman & Hilsenroth, 2003).

Cluster *Cultural competence* is proximal to clusters *Therapeutic collaboration and tailoring*, *Beliefs*, *Therapist emotion*, *Positive connection*, and *Therapist self-care and improvement*. Intuitively, practicing in a culturally competent manner requires the therapist to be collaborative, adaptable, non-judgemental, and reflective, with the literature supporting these associations (Sue, 1998). Less explicit but also important to cultural competence are one's beliefs. Sue (2001) states that cultural competence requires an individual to understand how their cultural upbringing informs their attitudes, values, and beliefs. This notion suggests that beliefs and cultural competence are interdependent, and that specific therapist beliefs (one or many) may directly impact a practitioner's cultural competence for better or worse. Future research would be well placed to identify the specific beliefs that are positively and negatively associated with cultural competence as to better understand pathways to culturally competent practice.

Less clear however, is the perceived association between *Cultural competence* and *Therapist emotion*. It can be argued that this link may reflect the cultural values pertaining to emotional expression. Ekman (1993) coins this 'display rules', "culture-specific prescriptions about who can show which emotions, to whom, and when" (p. 384). Perhaps to practice in a culturally competent manner, one must either a) be aware of, and regulate, their emotional responses to maintain cultural propriety, or b) explicitly acknowledge cultural differences in emotional expression ('display rules') as to not offend others. Interestingly however, *Emotion coach* (working with client emotions) did not neighbour cluster *Cultural competence*, but instead, was separated by cluster *Positive connection*. Perhaps, *Positive connection* mediates the relationship between these two constructs, with one needing to have formed an interpersonal bond before they can begin to effectively address client emotions.

Limitations

Irregular Participant Responding

The staggered approach to data collection was a limitation impacting the results of this study. Given that participant responses to data sets were not uniform despite a representative distribution of data packets, an uneven spread of sorting data was acquired. This uneven spread in the context of the staggered item sets limited the available pool of similarity comparisons between several groups of items. In turn, this reduced the inter-cluster and dimensional stability of the Japanese solution and accounts for its deficient global structure. Nevertheless, by combining NZ and Japanese data sets, the less reliable item-pairs of the Japanese solution were bolstered in the Combined solution. By this process, the above limitation was mitigated and ultimately resulted in a meaningful and robust Combined solution.

Japanese Translation

All practical components of this study were translated from English to Japanese as to ensure comprehension by this study's cohort demographic. Despite certified translators performing this task, given that I do not speak Japanese and as the budget of this thesis did not allow for independent back-translation, mistranslation of items was a potential limitation of this study. To mitigate this risk within the confines of a limited budget, translators were encouraged to contact me to clarify any item meaning. Furthermore, to check for interpretation errors, a Japanese clinical psychologist colleague compared both the English and Japanese versions of the item list as to ensure interpretability and consistency.

Japanese Culture

No attempt was made to identify ES skills unique to the Japanese culture. While Japanese-specific ES skills may have affected the validity and stability of the Combined solution, such a group of ES skills may also have indicated where New Zealand and Japanese therapists differ markedly in clinical practice. Furthermore, this study intentionally followed an etic research design — research conducted by

an individual outside the cultural group being studied — as to validate an English-derived model with a foreign-language sample. While an etic design has its benefits (i.e. observation from the perspective of an observer), an emic research approach — research conducted by an individual within the cultural group being studied — may yield insights previously overlooked due to cultural differences. Again, future research that includes Japanese-specific ES skills and conducted from an emic approach would be well placed to better understand Japanese conceptualisations of therapists' ES skills.

Demographic

While appropriate for a NZ population, the Combined solution currently lacks applicability with differing ethnic and cultural groups. Replicating this study's procedure with varying demographic groups and comparing the resultant solution with the Combined solution should clarify the applicability of this solution.

Implications

Overall, these findings are significant. They demonstrate that the cognitive organisation of English-derived ES skills are stable among a New Zealand and foreign-language population, thus suggesting that a) a number of ES skills may be universally understood, and b) that aspects of this solution may be applicable to cultural groups outside New Zealand, in particular Japanese populations. Furthermore, due to general cluster overlap with the literature, they suggest that the groupings of ES skills are meaningful thus validating the Combined solution. Ultimately, these findings indicate that the use of the Combined solution to discern therapists' therapeutic styles, the subsequent and final study of this thesis, is appropriate. The potential implications of these results are as follows.

Professional Practice, Supervision, and Training

In their research regarding the affective responses of trainee therapists, Kimerling, Zeiss, and Zeiss (2000) highlight the need for emotionally reflective training and

supervision throughout one's clinical career. As the Combined model was intended to be a reflection of potential therapist interactions in clinical practice, this model has important training, supervision, and practice implications.

By creating a collective working model of how therapeutic skills and strategies are inter-related, these implicit judgements are made explicit. Through use of this working model, it is hoped that therapists and clinical supervisors will have a heightened awareness of their own and others' personal actions and beliefs in therapy. Such recurrent reflective practice, either independently or during supervision, will help identify personal strengths and potential deficiencies, thus facilitating professional growth and ultimately, therapeutic competence. In this way, the Combined model provides the necessary empirical framework to both understand and further advance therapists' ES skills in practice.

Multicultural Competency

Given the ever increasing cultural diversity of Western nations and the push to globalise psychotherapy (Leong & Ponterotto, 2003; Leung, 2003), the need for culturally informed models of clinical practice are essential. The Combined model indicates a shared understanding of English-derived ES skills between New Zealand and Japanese populations thus supporting Lopes et al.'s (2004) notion of universally understood ES skills.

Future research attempting to identify culture-specific ES skills would be of significant value. By using these ES skills to generate MDS models with both native-language samples and foreign-language samples, several culture-specific models may be generated. Such culture-specific solutions would offer a method of empirical comparison between both clinicians and therapy consumers of different cultures thus enabling a) the effective culture-specific training of clinicians and b), the employment of specific ES skills targeted to specific populations, both of which would ultimately improve therapist competence and client outcomes. Alternatively, from this research, universally understood ES skills may be gathered and used to generate a largely universal framework. This framework would represent key ES skills that are understood by all peoples, thus transcending

cultural boundaries. Application of such a framework may enable clinicians to practice with some degree of competence within the limitations of their cultural scope. The identification of culture-specific models and/or a universal conceptualisation is currently a distant and hopeful ambition. However, at the very least, this study has indicated that with future research it may be feasible to extend Harvey et al.'s (2016) Original mono-cultural solution to a framework with applications for foreign-language populations. This research represents an important step toward developing a tool improving therapists' cultural competence in practice.

Research Applications

As seen in Harvey et al.'s (2016) Original solution, item voids on the surface of MDS models are suggestive of an incomplete and unrepresentative item set. The ability to visually detect such content gaps allows researchers to remedy such deficiencies early on in research, thus potentially salvaging costly long-term investigations. Furthermore, item clusters discerned via MDS methodology may be compared to the extant literature as to identify potential gaps of knowledge thus guiding future investigation — i.e. cluster *Practical* of the Combined solution.

Currently, theoretical definitions have been posited for a number of key psychological constructs considered pertinent for effective clinical practice. However, for a number of these constructs, like collaboration in therapy (Kazantzis & Kellis, 2012), they currently lack a clinically utilisable operational definition significantly hampering research and training applicability. While the present model is by no means omniscient, this framework and the clusters it encompasses is a much needed step linking theoretical concepts to objective practices. By using this framework to consistently define sets of ES skills deemed to represent therapy influencing factors, the operational definitions of these factors may also be established. Operationally defining clinical constructs such as collaboration or emotion coaching will facilitate cross-study comparisons between equivalent research and potentially clarify how these factors' influence client change. Subsequently, following empirical investigation, these clearly defined ES skills may

be used in training programmes to communicate exactly what collaboration or emotion coaching looks like in practice.

Conclusion

In summary, the primary aims of this study were accomplished with the majority of hypotheses supported. Specifically, that a foreign-language sample would meaningfully organise English-derived ES skills in a way analogous to an NZ population, and that foreign-language data could be combined with NZ data to procure a more robust overall solution. Due to a lack of global structure, the generation of a stable standalone Japanese solution for comparison with the NZ solution was not achieved. While this outcome is unfortunate, given that it does not affect the succeeding study of this research, the overall integrity of this thesis remains intact.

Overall, the Combined solution shows gross consistency with foundational solutions and its dimensionality and clusters are largely congruent with both the foundational and extant literature. Limitations of this study include uneven participant responding, the Japanese translation of materials, and the demographic limitations of the Combined solution. The Combined solution has important potential implications for: Professional practice, supervision and training; multicultural competency; and research applications. Given that the stability and validity of the Combined model has been supported, following Harvey et al.'s (2016) procedure, the succeeding and final study of this thesis will use the Combined solution to examine therapists' reported practice styles in therapy.

LINKED THOUGHTS III

While not all of the previous chapter's intended outcomes were achieved, the combination of two data sets to produce a more reliable and valid model of therapists' ES skills for use in the succeeding study was accomplished. Like prior research conducted by both myself and my colleagues (Harvey et al., 2012; Harvey et al., 2016), the production of a stable and meaningful solution paves the path to what I consider the most interesting component of this thesis — the profiling and styling of therapists.

Previous research investigating therapist practice styles have been varied and numerous. Some studies have grouped therapists' based on interactional style and explored the effectiveness of each style with client groups — i.e. “problem solving” therapists vs. “black and white thinking” therapists (Geller & Berzins, 1976; Howard et al., 1970; Razin, 1971). Others have investigated single specific therapist styles and their impact on particular client groups, such as a confrontational style with problem drinkers (Miller et al., 1993) or a directive approach taken with sexual offenders (Marshall et al., 2003). Alternatively, researchers have used factor analysis with data from self-report measures of therapist behaviours to determine interactional styles. Such studies have investigated therapist styles with respect to clients' expressions of emotion (Coombs et al., 2002) as well as therapist work involvement patterns (Orlinsky & Rønnestad, 2005). Findings from the above studies generally support the notion that therapists' interactional styles have some bearing on the therapeutic process. However, as there has been minimal continuity among studies in this domain, valid, reliable, and generalizable therapist styles remain relatively indistinct. By investigating therapist practice styles, how ES skills influence the process of therapy may also be exposed.

The final study of this overall project aims to use the previous chapter's Combined solution as an objective lens for interpreting therapists' subjective responses. Specifically, the aims are as follows: a) to empirically reduce the total item pool to several core themes (also known as hotspots); b) to profile therapists based on patterns of responding across these hotspots; c) to aggregate similar ideographic therapist profiles into common therapeutic styles; and d) to make

meaningful statistical comparisons between relevant demographic data and both hotspots and therapeutic styles. Not only will this study be a continuation of Harvey et al.'s (2016) identified therapist styles, but it will also use the stable and meaningful Combined model as a foundation to discern therapist styles.

CHAPTER SIX

STUDY FOUR: METHOD

“Counsellors need first a level of self-awareness in terms of attitudes, beliefs, and interpersonal style in order to know when adjustments are needed”

-Whiston and Coker (2000, p. 243)

Participants

The sample group of 79 participants were recruited to participate via email, word of mouth, phone or personal contact. There were 17 (22%) men, 61 (77%) women and 1 unreported (1%). 87% ($n = 69$) of participants were from New Zealand, while 11% ($n = 9$) were from elsewhere and 1% ($n = 1$) were unknown. Participants were generally older, with 17% ($n = 13$) of participants aged less than 31, 23% ($n = 18$) of participants aged between 31 and 40, 24% ($n = 19$) of participants aged between 41 and 50, 35% ($n = 28$) of participants aged over 50, and the age of 1% ($n = 1$) of participants was unknown. 75% ($n = 59$) of participants were psychologists, 5% ($n = 4$) were counsellors, 19% ($n = 15$) were from a number of heterogeneous professions and grouped together in the other professionals category, and 1% ($n = 1$) were unknown; participants belonging to the other professionals group consisted of general nurses, psychiatric nurses, social workers, addictions professionals, a psychiatrist, and a psychotherapist all working with clients on an individual basis in a talking therapy capacity. Participants' years of experience were skewed with 56% ($n = 44$) having less than 11 years of experience, 19% ($n = 15$) having between 11 and 20 years of experience, 18% ($n = 14$) having between 21 and 30 years of experience, and 8% ($n = 6$) having greater than 30 years of experience. 29% ($n = 23$) of participants worked in a general government setting, 31% ($n = 24$) worked in a general private setting, 18% ($n = 14$) worked in a child or adolescent setting, 6% ($n = 5$) worked in an addictions setting, and 17% ($n = 13$) worked in other settings.

Materials

Emotional-Social Skills

A representative sample of 71 English-language items pertaining to therapists' ES interactions in therapy was taken from the 151 item pool used in studies two and three of this thesis (Appendix N). Items were selected by 'eyeballing' a modified dendrogram as well as the Combined solution as to ensure a diverse range of items representative of the entire item pool were sampled; the rationale and process of this item reduction is expanded in a following section. Participants indicated how true the items were of their practices ranging from "not true at all" to "very true". Items were designed to be perceived as what a participant felt they actually did in their practice rather than what they believed they should do. This way, it was hoped to gain a sample of responses pertaining to the ES skills actually used in practice rather than what a therapist believes should be done in practice. Each item was assigned a unique numerical tag as to identify it during data analysis. Items were presented in electronic form via email.

Item reduction rationale. As in Harvey et al.'s (2016) research, given the relatively small number of potential participants, reducing participation time by lessening the total number of items was an essential requirement to attract participation. As the data gathered during this study can be analysed using either the Combined solution or the NZ solution, it was decided that the selected items should be relevant to both solutions; a relatively easy task given the similarities between models. By excluding items not sorted during study two (NS items) and visually arranging the remaining 106 items by dendrogram relating to the Combined solution, a diverse range of items relevant to both solutions was clearly accessible (Appendix O). Given that roughly half the item pool is needed for viable analysis via this methodology (Harvey et al., 2016), 71 of the 106 items displayed in the modified dendrogram were selected for use in this study. By removing every third item when arranged in the modified dendrogram, a diverse range of ES skills meeting the aims of this study were obtained for use (Appendix N). This item reduction methodology was deemed appropriate given its use in prior research (Bimler & Kirkland, 2001; Kirkland et al., 2004; Harvey et al., 2016).

Scale to Assess the Therapeutic Relationship

The therapeutic relationship was assessed by a modified version of the Scale to Assess the Therapeutic Relationship - Clinician (STAR-C; McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007), a scale initially generated for use with therapists practicing in an adult outpatient setting. The scale consists of 12 items rated on a 5-point Likert scale ranging from 0 “never” to 4 “always”. Items comprise three subscales: Positive Collaboration (PoC), reflecting good rapport, trust, and shared treatment goals; Emotional Difficulties (ED), reflecting problems in the therapeutic relationship; and Positive Clinician Input (PCI), the extent to which a clinician perceives themselves to encourage, support, and understand the client. Scale scores may be aggregated to determine a total score, higher scores denoting a better relationship. Test-retest reliability ($r = 0.68$) was good and internal consistency ($\alpha > 0.65$) acceptable (McGuire-Snieckus et al., 2007). Modifications approved by the measure’s developers included altering the term ‘patient’ in each item to ‘client’ and pluralising these nouns as to generalise item meanings (e.g. client to clients). Alternate versions of this measure include the STAR-P, a patient version (McGuire-Snieckus et al., 2007), and the D-STAR, a German translated version (Loos et al., 2012).

Procedures

The procedure was administered via email for quick and easy access to local and distant potential participants. Participants were sent an email consisting of an instructions page, a demographics form, a questionnaire composed of the 12-item modified STAR-C survey, and 71 statements all previously discussed (Appendix P). After reading the instructions page and completing the demographics form, participants completed the modified STAR-C questionnaire, selecting how frequently each item occurs in their therapeutic practices, ranging from “never” to “always.” Subsequently, participants read each statement and selected one of five options available to them regarding how true that statement was of their practice. The options available were “very true”, “mainly true”, “unsure”, “slightly true” and “not true at all.” Upon processing all items, participants were instructed to return

the completed email from which data were recorded and stored electronically. Completion of this procedure took approximately 15 minutes.

Analysis: Hotspot Modelling, Subjectivity Profiling, and Q-analysis

Data were coded and entered by hand into a Microsoft Excel spreadsheet. This dataset was then exported to SPSS software version 20 for analysis. Principal Components Analysis (PCA) and Factor Analysis were applied to the data as a means of distinguishing factors and assessing loadings through Scree Test analysis. After discerning a suitable number of factors, response data were submitted to a data-reduction method known as 'Subjectivity Profiling' or 'Hotspot Modelling'. The goal of this procedure is to group a small number of co-varying items within the Combined solution according to the scores attributed to them by participants. Each group of interrelated items is established as relating to a specific and separate theme or domain otherwise known as a hotspot. Where a cluster is an aggregation of perceptively-related items, a hotspot is an abstract point on the Combined solution that is physically located within its group of interrelated items. The proximity of each item to a hotspot's location denotes how well that item defines that hotspot's content. By summing the scores given by participants to each item, and depending on the weight of that item due to its proximity to the hotspot, a score is produced describing the extent to which that hotspot is present or absent in a therapist's practice. A core meaning for each hotspot is abstracted via researcher judgement by reviewing the items encompassed by that hotspot with a greater focus on items most proximal to that hotspot — i.e. items with the highest weights. This method is not unlike other methods such as Preference Mapping (Carroll, 1972) and Concept Mapping (Trochim, 1989).

Subsequent to hotspot identification and defining, each participant's responses to individual items were re-entered into an Excel spreadsheet that standardised the values to *z* scores, then obtained a weighted average score for each hotspot to condense them to a profile. Individual participant's responses can be presented as idiographic summaries across the set of identified hotspots thus eliciting that individual's specific profile of responding. Ultimately, the goal was to

divide the sample into collections of participants who responded in similar patterns (i.e. therapeutic styles) and to distinguish the response pattern that differentiated each group of participants; a procedure facilitated by hotspot modelling as the 'noise' in the responses at the level of individual items is smeared out when partitioning. However, after viewing the collective spread of participants' ideographic profiles, styling therapists according to these hotspots was deemed inappropriate.

Alternatively, Q-analysis could be applied to the data, in which participants' response patterns were analysed between respondents across items. This procedure is in contrast to conventional PCA where the units of analysis are the items, not the participants. Initially, the data matrix is transposed, reflected in a 45-degree diagonal so that each respondent is now a column and each row is now an item (previously each column was an item and each row was a participant). By applying PCA to this transposed matrix, according to the change in Eigenvalues across factors (Scree Test), the total number of individual viewpoints could be reduced to a limited number of factors representing shared response patterns. These factors account for a proportion of the variance observed between participants' response styles, with the initial factor accounting for the most variance. The output of this analysis includes a loading indicating a participant's similarity to each factor. Furthermore, peripheral items can be identified for each response pattern, thus indicating that response pattern's underlying themes. Subsequently, these response patterns can be associated with both demographic and STAR-C data.

STUDY FOUR: RESULTS

STAR-C

Table 22 displays this sample's mean scores, standard deviation, and range for the STAR-C scale and subscales. Furthermore, as a means for comparison, the maximum score has been included in Table 22 also.

Table 22.

Means, stanDARD deviations (SD) and ranges of Scale to Assess the Therapeutic Relationship (STAR-C) scores

STAR-C scale and subscales	Mean	(SD)	Range	Maximum
PoC	18.0	(1.8)	14-23	24
ED	9.6	(1.4)	6-12	12
PCI	10.4	(1.0)	8-12	12
STAR-C	38.0	(3.2)	31-46	48

Note. PoC = Positive collaboration, ED = Emotional difficulties, PCI = Positive clinician input, STAR-C = Scale to assess the therapeutic relationship – clinician.

One-way between subjects ANOVAs were conducted to compare demographic variables with STAR-C scale and subscale scores. When excluding unknown cases, there was a significant effect of profession on the subscales PoC ($F(2, 71) = 4.94, p = 0.004$) and ED ($F(2, 73) = 3.785, p = 0.027$) as well as the overall STAR-C ($F(2, 70) = 6.118, p = 0.004$). No other demographic data were statistically associated with the STAR-C scale or subscale scores.

Post hoc comparisons using the Tukey HSD test, which compensates for multiple comparisons, indicated that counsellors scored significantly higher on the PoC subscale ($M = 20.5, SD = 2.7$) than either psychologists ($M = 17.9, SD = 1.4$) or other professionals ($M = 17.3, SD = 2.2$). Again, counsellors also scored higher on the ED subscale ($M = 11.3, SD = 1.5$) than either psychologists ($M = 9.5, SD = 1.4$) or other professionals ($M = 9.3, SD = 1.1$). These scores contributed to counsellors' significantly higher overall score on the STAR-C ($M = 42.8, SD = 4.7$), compared with both psychologists ($M = 37.7, SD = 2.9$) and other professionals ($M = 36.9, SD = 3.0$). For all of the above comparisons, psychologists and other professionals did not differ significantly.

Hotspots and Interpretation

Eight regions of the most prominent or regularly co-occurring items formed the greatest approximation of response patterns (hotspots). Table 23 identifies the seven items most relevant to the eight hotspots discerned. The items' order in the list represents how proximal that item was to the cluster's core thus indicating which items contributed most to a hotspot's interpretation. A three-person validity panel consisting of the research team labelled each hotspot.

Table 23.
Commonly reported item groups representing their described hotspots

Hotspot label and description	Hotspot items
Deliberate therapeutic behaviours (DTB) Therapist behaviours intended to be therapeutic.	I model the appropriate way to act for my clients I dress in a way that supports my professional position I engage in deliberate therapeutic practice I give my full attention I am a stable and reliable figure in therapy I give thought to how my appearance impacts on my client I display consistent verbal and non-verbal behaviour
Emotion coaching (EC) The therapist recognising emotion, seeing the opportunity of emotion, learning from emotion, and empathising.	I reflect or communicate an understanding of the client's feelings I am attentive to my clients' reactions I validate clients' experiences I appropriately validate clients' emotions I believe observable client emotions give valuable information I don't view client emotionality as a problem I highlight client competencies, resources and resiliencies
Emotional self-awareness (ESA) The therapist having an emotional awareness in and out of practice.	I regulate my level of emotional attachment to clients I monitor whether or not my emotions are useful during therapy I am aware of my own emotions during therapy I believe my private emotional life affects my practice I use measures to prevent my own abuse of power I strive for congruence between my values and my behaviour I self-care to ensure I manage my own emotions.
Altruistic growth (AG) The therapist questioning their practice.	I am comfortable with referring clients on when required My therapeutic effectiveness is important to me I am satisfied by my work I personally and professionally grow as a result of my work I am a stable and reliable figure in therapy I value different, new therapeutic techniques I consistently question my own practice

<p>Directive (D) The therapist guiding the flow of therapy.</p>	<p>I am directive during therapy I encourage clients to move on when emotional I offer hunches about client experiences I am explicit with my methods of influencing I regulate my clients' emotions I dress in a way that supports my professional position I mirror/matches my clients (e.g. Body posture, use of key words)</p>
<p>Self-confidence (SC) The therapist having confidence in their therapeutic abilities.</p>	<p>I expect quick, significant change I believe that I am the expert I believe clients often seek to be influenced I make accurate judgements I draw on theory to aid my understanding of the client's feelings/experiences I am professionally confident I engage in deliberate therapeutic practice</p>
<p>Client empowerment (CE) The therapist's desire to encourage the client.</p>	<p>I encourage clients to find own motivation for change I discuss the possibility of relapse with clients I explicitly encourage clients to be open and honest with me I highlight client competencies, resources and resiliencies I emphasis doing rather than just understanding I incorporate the client's worldview and theory of problem/treatment I seek to understand and clarify clients' expectations</p>
<p>Therapeutic collaboration (TC) The ability to collaborate with clients throughout therapy.</p>	<p>I view the therapeutic relationship as a primary tool of therapy I view treatment as a partnership for change I ensure that therapy occurs in an atmosphere of mutual respect I see the end of therapy as a collaborative process I believe all clients are different I adjust the termination process to the nature of the therapy relationship I anticipate therapy to take time</p>

With the exception of *Altruistic growth*, *Self-confidence*, and *Directive*, the hotspots of this study largely reflected the clusters of the Combined solution. Hotspots *Therapeutic collaboration*, *Emotion coaching*, *Client empowerment*, *Emotional self-awareness*, and *Deliberate therapeutic behaviours* were generally consistent with clusters of the Combined solution. Furthermore, *Therapeutic collaboration* and *Client empowerment* of this study were largely comprised of the same items as Harvey et al.'s (2016) hotspots *Balanced collaboration* and *Client*

empowerment, respectively. Lastly, overlapping themes were evident between *Emotion coaching* and *Directive* of this study and Harvey et al.'s hotspots *Feelings in context* and *Expert role*, respectively.

The following sections largely regard the variation of hotspot scores with demographic data. For this reason, it is important to clarify what a hotspot score actually represents. Hotspot values are relative to the rest of a participant's responses. A positive value on a single hotspot signifies the presence of that particular parameter. In other words, that a particular hotspot was present to a greater degree than a participant's baseline of responding. In contrast, a negative value on a single hotspot reflects the absence of that particular parameter with the behaviours being conspicuous by their absence. An assigned value of zero for a hotspot demonstrates that that parameter was unnoticed.

Hotspots by STAR-C Scale and Subscales

Table 24 displays the correlation coefficients comparing hotspot scores and STAR-C scale and subscale scores. No significant correlations were identified between variables.

Table 24.
Pearson's (r) Correlations between hotspot scores and scores on the Scale to Assess the Therapeutic Relationship (STAR-C) scale and subscales

Hotspot	PoC	ED	PCI	STAR-C
DTB	0.11	0.19	0.04	0.18
EC	0.18	0.06	0.19	0.19
ESA	0.04	-0.05	0.16	0.04
AG	-0.09	-0.04	0.09	-0.04
D	.10	0.06	-0.10	0.06
SC	-0.18	-0.09	-0.21	-0.20
CE	-0.13	-0.03	0.02	-0.07
TC	0.03	0.05	-0.02	0.01

Note. None of the comparisons were significant. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration, PoC = Positive collaboration, ED = Emotional difficulties, PCI = Positive clinician input, STAR-C = Scale to assess the therapeutic relationship – clinician.

Hotspots by Demographic Data

Gender. As shown below, Table 25 displays one-way between subjects ANOVA results comparing gender and hotspot scores. The Levene's test indicated unequal variance on the analysis for *Emotion coaching* ($F = 5.56, p = .021$). Furthermore, the Kolmogorov-Smirnov test indicated that the distribution of female participant for *Emotion coaching* was significantly non-normal ($D(61) = 0.12, p < .05$). As a result, the non-parametric Mann-Whitney test was used instead to compare gender groups for the hotspot *Emotion coaching*. However, as the Mann-Whitney test also assumes homogeneity of variance, significant findings should be interpreted with caution (Field, 2009).

Table 25.
Summary of analyses of variance results comparing hotspot scores by gender

Hotspots		Sum of Squares	df	Mean Square	F
DTB	Between Groups	0.60	1	0.60	0.82
	Within Groups	55.60	76	0.73	
	Total	56.20	77		
ESA	Between Groups	10.80	1	10.80	5.93*
	Within Groups	138.38	76	1.82	
	Total	149.18	77		
AG	Between Groups	0.14	1	0.14	0.34
	Within Groups	32.12	76	0.42	
	Total	32.26	77		
D	Between Groups	2.91	1	2.91	2.40
	Within Groups	92.22	76	1.21	
	Total	95.13	77		
SC	Between Groups	19.77	1	19.77	10.67**
	Within Groups	140.85	76	1.85	
	Total	160.62	77		
CE	Between Groups	0.10	1	0.10	0.16
	Within Groups	46.29	76	0.61	
	Total	46.39	77		
TC	Between Groups	0.05	1	0.05	0.17
	Within Groups	22.82	76	0.30	
	Total	22.87	77		

Note. DTB = Deliberate therapeutic behaviours, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

* $p < .05$. ** $p < .01$.

Emotional self-awareness and *Self-confidence* differed significantly with respect to gender. Particularly, male therapists tended to score negatively for *Emotional self-awareness* ($M = -0.38$, $SD = 1.44$), while female therapists tended to score positively ($M = 0.52$, $SD = 1.32$). Alternatively, for *Self-confidence*, female clinicians tended to score more negatively ($M = -3.24$, $SD = 1.36$) than male clinicians ($M = -2.02$, $SD = 1.38$). Furthermore, the Mann-Whitney test indicated

that female participants ($M = 1.68$, $Mdn = 1.77$, $SD = 0.71$) tended to score more positively than male participants ($M = 1.51$, $Mdn = 1.44$, $SD = 0.66$) for *Emotion coaching*, $U = 374.50$, $z = -1.74$, $p < .01$.

Age. Table 26 displays one-way between subjects ANOVA results comparing the effect age had on hotspot scores. The Levene's test indicated unequal variance on the analysis for *Client empowerment* ($F = 2.81$, $p = .45$). Furthermore, the Kolmogorov-Smirnov test indicated that the distribution of 31-40 year old participants for *Client empowerment* was significantly non-normal ($D(18) = 0.23$, $p < .05$). As a result, the non-parametric Kruskal-Wallis test was used instead to compare age groups for the hotspot *Client empowerment*. As the Kruskal-Wallis test also assumes homogeneity of variance, significant findings should be interpreted with caution (Field, 2009).

Table 26.
Summary of analyses of variance results comparing hotspot scores by age

Hotspots		Sum of Squares	df	Mean Square	F
DTB	Between Groups	5.77	3	1.92	5.08**
	Within Groups	50.43	39 ^a	0.68	
	Total	56.20	42		
EC	Between Groups	3.15	3	1.05	2.61 [†]
	Within Groups	29.71	74	0.40	
	Total	32.86	77		
ESA	Between Groups	20.00	3	6.67	3.82*
	Within Groups	129.18	74	1.75	
	Total	149.18	77		
AG	Between Groups	0.74	3	0.25	0.58
	Within Groups	31.52	74	0.43	
	Total	32.26	77		
D	Between Groups	9.30	3	3.10	2.67 [†]
	Within Groups	85.83	74	1.16	
	Total	95.13	77		
SC	Between Groups	13.02	3	4.34	2.18
	Within Groups	147.60	74	2.00	
	Total	160.62	77		
TC	Between Groups	0.56	3	0.19	0.62
	Within Groups	22.31	74	0.30	
	Total	22.87	77		

Note. ^aLevene's test indicated unequal variance on analysis for DTB ($F = 2.75, p = .49$). Accordingly, the Welch robust test of equality of means was applied and within groups degrees of freedom was reduced to 39 for DTB. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, TC = Therapeutic collaboration.

[†] $p < .10$. * $p < .05$. ** $p < .01$.

Post hoc comparisons using the Tukey HSD test indicated that, for *Emotional self-awareness*, participants aged less than 31 scored negatively ($M = -$

0.68, $SD = 1.10$), while participants aged over 50 scored positively ($M = 0.80$, $SD = 1.41$). Both *Emotion coaching* ($p = .058$) and *Directive* ($p = .098$) were bordering ANOVA significance and post hoc comparisons using the Tukey HSD test indicated that participants aged less than 31 had significantly less positive scores ($M = 1.28$, $SD = 0.70$) than participants aged 31 to 41 for *Emotion coaching* ($M = 1.92$, $SD = 0.54$), and significantly less negative scores ($M = -1.54$, $SD = 1.21$) when compared with participants aged over 50 for *Directive* ($M = -2.55$, $SD = 0.92$). The assumption of homogeneity of variance was violated for *Deliberate therapeutic behaviours*; therefore, Welch F -ratio is reported (Field, 2009). This analysis indicated that there was a significant effect of age on *Deliberate therapeutic behaviours* ($F(3, 39) = 5.08$, $p = .005$). Accordingly, Games-Howell post hoc test was used to determine the relationship between age and *Deliberate therapeutic behaviours* (Field, 2009). As with previous comparisons, participants aged less than 31 ($M = -0.29$, $SD = 0.41$) had significantly less negative scores than participants aged over 50 for *Deliberate therapeutic behaviours* ($M = -1.06$, $SD = 0.89$). The Kruskal-Wallis test indicated that no significant relationship was present between age groups for *Client empowerment*, $H(3) = 2.79$, $p = .426$.

Profession. Table 27 displays one-way between subjects ANOVA results comparing the effect profession had on hotspot scores.

Table 27.
Summary of analyses of variance results comparing hotspot scores by profession

Hotspots		Sum of Squares	df	Mean Square	F
DTB	Between Groups	5.45	2	2.72	4.02*
	Within Groups	50.76	75	0.68	
	Total	56.20	77		
EC	Between Groups	0.42	2	0.21	0.49
	Within Groups	32.43	75	0.43	
	Total	32.86	77		
ESA	Between Groups	10.76	2	5.38	2.92†
	Within Groups	138.42	75	1.85	
	Total	149.18	77		
AG	Between Groups	1.09	2	0.55	1.31
	Within Groups	31.17	75	0.42	
	Total	32.26	77		
D	Between Groups	5.00	2	2.50	2.08
	Within Groups	90.13	75	1.20	
	Total	95.13	77		
SC	Between Groups	8.60	2	4.30	2.12
	Within Groups	152.01	75	2.03	
	Total	160.62	77		
CE	Between Groups	1.24	2	0.62	1.03
	Within Groups	45.14	75	0.60	
	Total	46.39	77		
TC	Between Groups	0.31	2	0.16	0.52
	Within Groups	22.56	75	0.30	
	Total	22.87	77		

Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

† $p < .10$. * $p < .05$.

Post hoc comparisons using the Tukey HSD test indicated that psychologists ($M = -0.61$, $SD = 0.75$) scored less negatively than other professionals ($M = -1.20$, $SD = 1.02$) for *Deliberate therapeutic behaviours*. Furthermore, borderline

significant results ($p = 0.068$) indicated that psychologists scored less positively ($M = 0.12, SD = 1.36$) than other professionals ($M = 1.01, SD = 1.46$) for *Emotional self-awareness*.

Experience. Table 28 displays one-way between subjects ANOVA results comparing the relationship between experience and hotspot scores. The Levene's test indicated unequal variance on the analysis for *Client empowerment* ($F = 2.97, p = .037$). Furthermore, the Kolmogorov-Smirnov test indicated that the distributions of 1-10 year experienced participants for *Deliberate therapeutic behaviours* ($D(44) = 0.15, p < .05$) and *Client empowerment* ($D(44) = 0.15, p < .05$) were significantly non-normal. As a result, the non-parametric Kruskal-Wallis test was used instead to compare experience groups for the hotspots *Deliberate therapeutic behaviours* and *Client empowerment*. As the Kruskal-Wallis test also assumes homogeneity of variance, any significant findings arising from the comparison between experience and *Client empowerment* should be interpreted with caution (Field, 2009).

Table 28.
Summary of analyses of variance results comparing hotspot scores by experience

Hotspots		Sum of Squares	df	Mean Square	F
EC	Between Groups	1.93	3	0.64	1.81
	Within Groups	33.00	21 ^a	0.44	
	Total	34.94	24		
ESA	Between Groups	17.54	3	5.85	3.32*
	Within Groups	132.10	75	1.76	
	Total	149.65	78		
AG	Between Groups	0.41	3	0.14	0.32
	Within Groups	32.04	75	0.43	
	Total	32.44	78		
D	Between Groups	5.56	3	1.85	1.53
	Within Groups	90.71	75	1.21	
	Total	96.26	78		
SC	Between Groups	11.12	3	3.71	1.85
	Within Groups	150.47	75	2.01	
	Total	161.59	78		
TC	Between Groups	0.54	3	0.18	0.60
	Within Groups	22.34	75	0.30	
	Total	22.88	78		

Note. ^aLevene's test indicated unequal variance on analysis for EC ($F = 3.37, p = .023$). Accordingly, the Welch robust test of equality of means was applied and within groups degrees of freedom was reduced to 21. EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, TC = Therapeutic collaboration.

* $p < .05$.

Post-hoc comparisons using the Tukey HSD test indicated that participants with 1-10 years of experience ($M = -0.05, SD = 1.22$) had significantly lower scores than participants with 11-20 years of experience for *Emotional self-awareness* ($M = 1.16, SD = 1.30$). The Kruskal-Wallis test indicated that a significant relationship was present between experience groups for *Deliberate therapeutic behaviour*, $H(3) = 11.35, p < .05$. Mann-Whitney tests were used to follow-up on pairwise

comparisons with a bonferroni correction applied to the comparisons so all the effects are reported at 0.017 significance level (Field, 2009). Participants with 1-10 years of experience ($M = -0.51$, $Mdn = -0.37$, $SD = 0.78$) had significantly less negative scores than participants with 11-20 years of experience ($M = -1.07$, $Mdn = -.108$, $SD = 0.74$) for *Deliberate therapeutic behaviour*. Furthermore, the Kruskal-Wallis test indicated that no significant relationship was identified between experience groups for *Client empowerment*, $H(3) = 2.22$, $p = .528$.

Setting. Table 29 displays one-way between subjects ANOVA results comparing the relationship between work setting and hotspot scores.

Table 29.
Summary of analyses of variance results comparing hotspot scores by setting

Hotspots		Sum of Squares	df	Mean Square	F
DTB	Between Groups	5.49	4	1.37	2.00
	Within Groups	50.73	74	0.69	
	Total	56.22	78		
EC	Between Groups	3.48	4	0.87	2.05 [†]
	Within Groups	31.45	74	0.43	
	Total	34.94	78		
ESA	Between Groups	26.73	4	6.68	4.02 ^{**}
	Within Groups	122.92	74	1.66	
	Total	149.65	78		
AG	Between Groups	0.19	4	0.05	0.13
	Within Groups	32.25	20	0.44	
	Total	32.44	24		
D	Between Groups	3.51	4	0.88	0.70
	Within Groups	92.75	74	1.25	
	Total	96.26	78		
SC	Between Groups	29.09	4	7.27	4.06 ^{**}
	Within Groups	132.50	74	1.79	
	Total	161.59	78		
CE	Between Groups	1.36	4	0.34	0.55
	Within Groups	45.35	74	0.61	
	Total	46.71	78		
TC	Between Groups	0.56	4	0.14	0.46
	Within Groups	22.32	74	0.30	
	Total	22.88	78		

Note. ^aLevene's test indicated unequal variance on analysis for AG ($F = 3.230$, $p = .017$). As a result, the Welch robust test of equality of means was applied and within groups degrees of freedom was reduced to 20. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

[†] $p < .10$. * $p < .05$. ** $p < .01$.

Post hoc comparisons using the Tukey HSD test indicated that: a) participants working in private practice scored positively ($M = 1.13, SD = 1.37$) while participants working in other settings scored negatively ($M = -0.40, SD = 1.47$) for *Emotional self-awareness*; b) participants working in private practice ($M = -3.84, SD = 1.31$) scored more negatively than participants working in other settings ($M = -2.20, SD = 1.62$) for *Self-confidence*; and c) that borderline significant results ($p = 0.098$) indicate that participants working in mental health scored less positively ($M = 1.49, SD = 0.72$) than participants working in private practice ($M = 1.97, SD = 0.56$) for *Emotion coaching*.

Styling

The diversity of participant responding across hotspots was analysed (Figure 13). Recall that a positive value on a single hotspot signifies the presence of that particular parameter, whereas a negative value on a single hot spot reflects the absence of that particular parameter. An assigned value of zero for a hotspot demonstrates that that parameter was unnoticed.

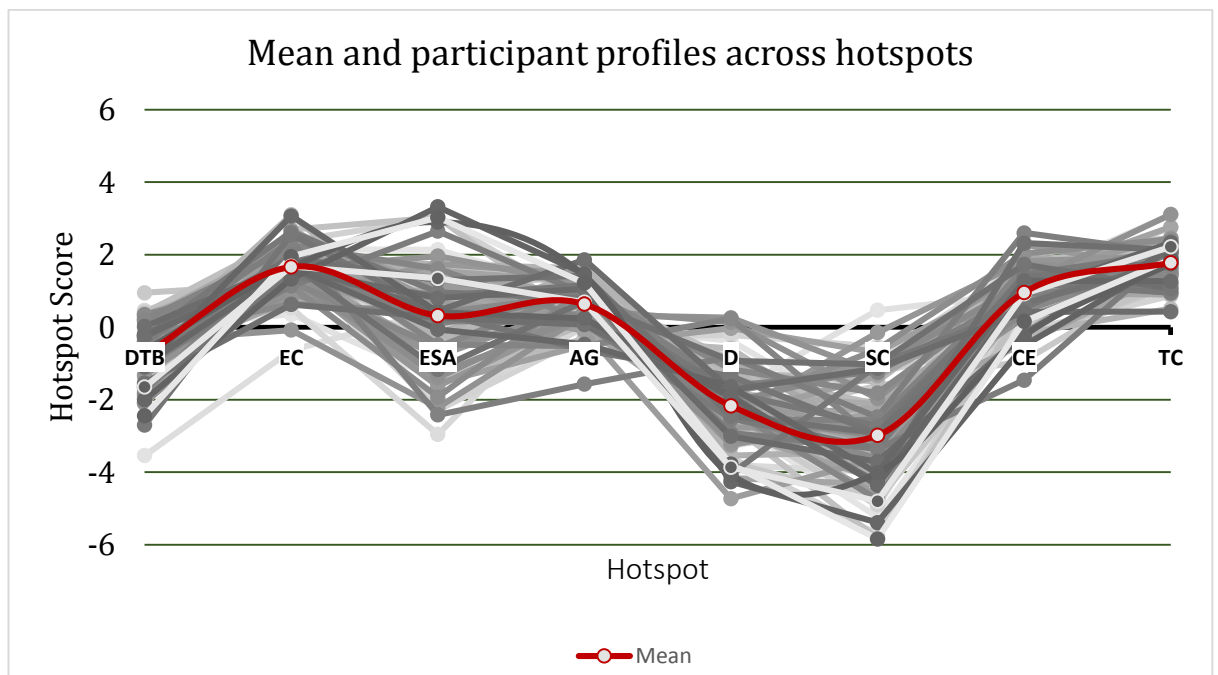


Figure 13. All ideographic participant profiles plotted according to hotspot scores with mean profile score emphasised.

Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

As we can see from Figure 13, for hotspots *Deliberate therapeutic behaviours* ($SD = 0.85$), *Emotion coaching* ($SD = 0.67$), *Altruistic growth* ($SD = 0.65$), *Client empowerment* ($SD = 0.77$), and *Therapeutic collaboration* ($SD = 0.54$), participants' ratings were remarkably uniform. Score variation was most evident for hotspots *Emotional self-awareness* ($SD = 1.39$), *Directive* ($SD = 1.11$), and *Self-confidence* ($SD = 1.44$), however, in comparison to Harvey et al.'s (2016) hotspot results, variation across this study's hotspots was relatively small. Simply put, according to this sample group and the items that were ranked, participant response patterns were dominated by a general consensus. Counter to initial intentions, this result suggests that conducting a styling analysis akin to that used in Harvey et al.'s (2016) research would be of little value. Styles produced via this method would all be of similar shape, varying largely in their degrees of amplitude.

Response Patterns

Accordingly, as to explain the above consensus, Q-analysis was applied to the data. Figure 14 displays the scree plot of Eigenvalues against factors for Q-analysis. Accordingly, three factors were retained with factor one accounting for 43.9% of the common variance, factor two accounting for 5.5% of the common variance, and factor three accounting for 3.0% of the common variance.

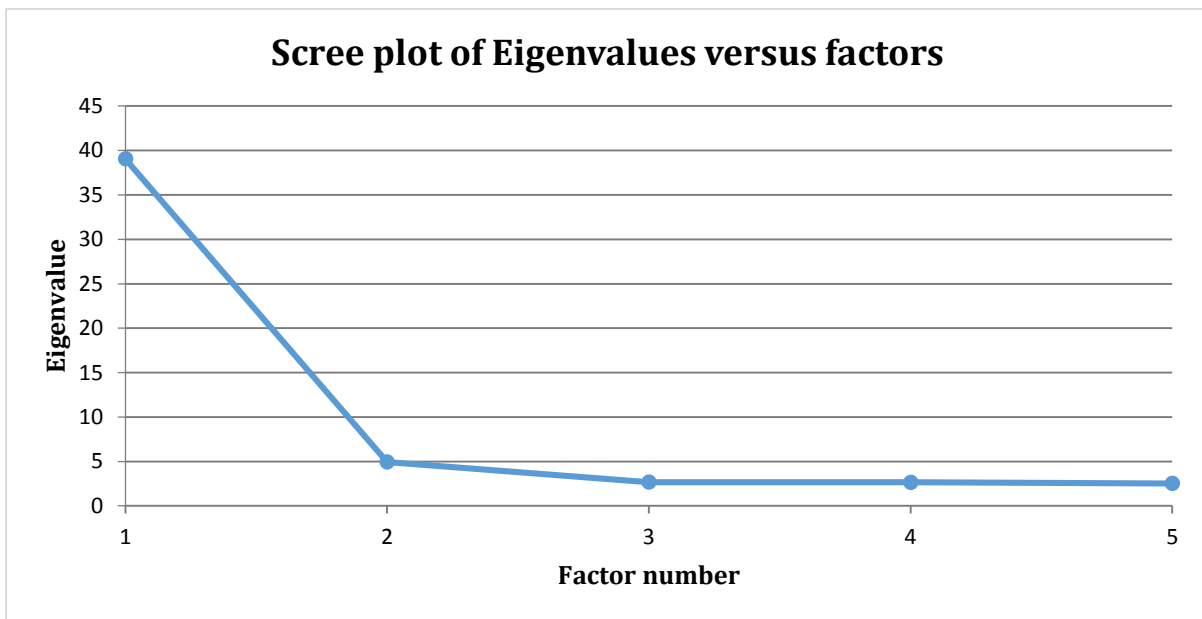


Figure 14. Scree plot of Eigenvalues versus factors for Q-analysis across five factors.

G-factor

Factor one was labelled *G-factor* due to its resemblance to the like-termed general-factor construct in cognitive ability research (Rindermann, 2007). In this research, the *G-factor* indicates how well each participant approaches the group consensus. Possible overall factor loadings fluctuate between 1 and -1, with the former indicating a perfect adherence to the *G-factor* response profile, and the latter value indicating a completely inverted response profile. Participant overall factor loadings for *G-factor* had a mean of 0.65 ($SD = 0.11$), ranging between 0.36 and 0.84 thus indicating a clear consensus among participants' response patterns.

As well as identifying each participant's loading on a factor from Q-analysis, SPSS can reconstruct each factor itself as a new column added to the data table.

Each new factor has a 'score' for each item and represents a prototypical, idealised participant, whose responses can be analysed in the same way as the actual participants. By viewing these prototypical participant scores, we can see how a participant perfectly conforming to *G-factor* would have scored across items and hotspots. Figure 15 below displays the hypothetical hotspot scores for a participant with a *G-factor* loading of 1, superimposed on the previous figure.

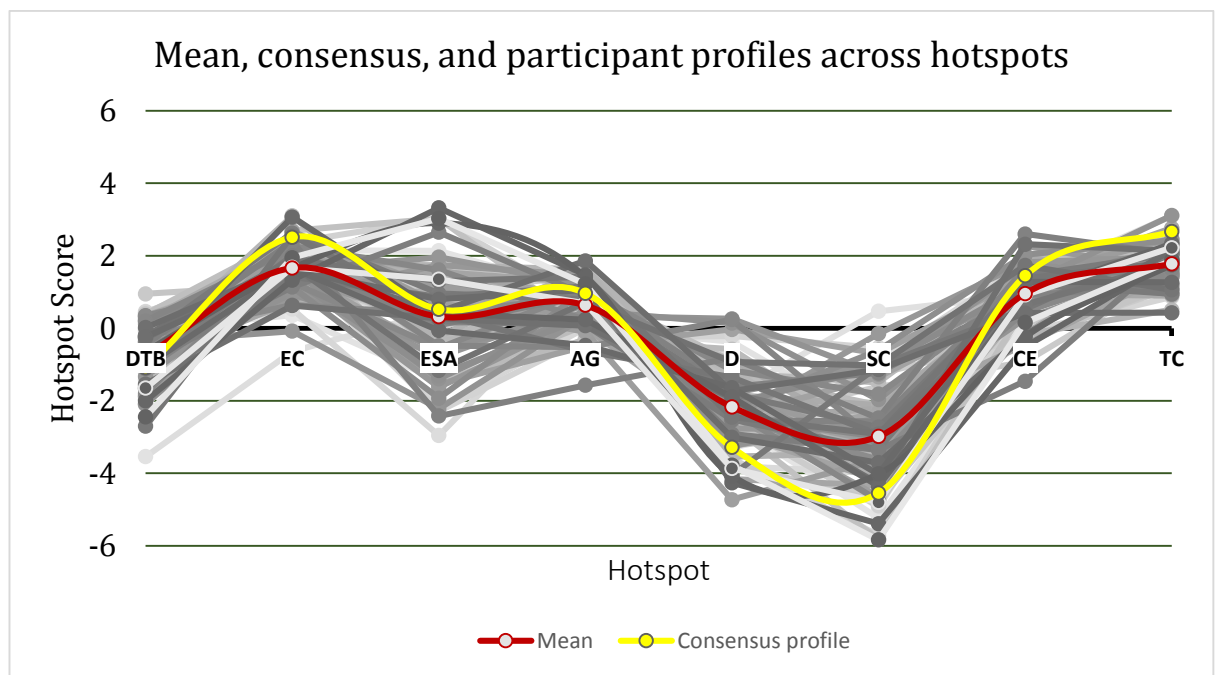


Figure 15. All ideographic participant profiles plotted according to hotspot scores with mean profile and consensus profile emphasised.

Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

Figure 15 above also displays the differences between the consensus profile and the mean score profile across hotspots. According to mean scores, participants scoring closer to the consensus profile would have more negative scores across *Deliberate therapeutic behaviours*, *Directive*, and *Self-confidence*, and more positive scores across *Emotion coaching*, *Client empowerment*, and *Therapeutic collaboration*.

Divergent Response Patterns

Recall that Q-analysis identified three factors as accounting for a substantial proportion of participant response pattern variance. While *G-factor* identifies where therapists converge, factor two and factor three tell us where therapists diverge. Accordingly, factor two was labelled *Deviation A* (Da) and factor three was labelled *Deviation B* (Db). Da and Db account for the variance observed after controlling for *G-factor*. In other words, Da and Db response patterns are modulations superimposed on the group consensus, the response pattern that everyone generally conforms to. Variations away from *G-factor* can partially be explained by Da and Db. Overall factor loadings for Da range from -0.43 to 0.54 around a mean of 0.00 ($SD = 0.24$), while loadings for Db range from -0.39 to 0.41 also around a mean of 0.00 ($SD = 0.18$).

Across hotspots. Given that Da and Db response patterns are never present in isolation (*G-factor* is always dominant to varying degrees), Figures 16-18 display hypothetical hybrids of *G-factor* merged with either positive or negative Da or Db response patterns. So where positive Da or Db response patterns are concerned, this profile represents *G-factor* modulated with 50% of Da or Db, respectively. Alternatively, negative Da or Db response patterns represent *G-factor* modulated by negative 50% of Da or Db, respectively.

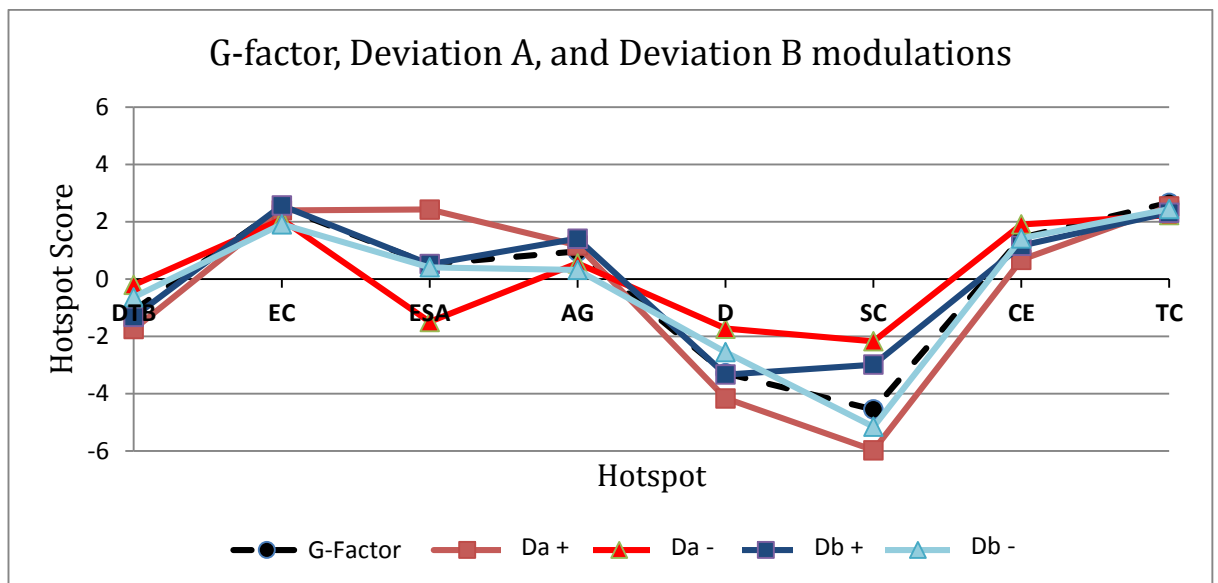


Figure 16. G-factor, positive and negative Da and Db modulations across hotspots.
Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

As evidenced by Figure 16, Da diverges more from *G-factor* than Db across all hotspots of this study. Furthermore, the above figure shows that for the hotspots *Emotional self-awareness*, *Directive*, and *Self-confidence*, positive forms of Da and Db as well as negative forms of Da and Db, are largely conflicting, thus counteracting one another. This result indicates that participants with equivalent positive or negative forms of Da and Db will remain close to *G-factor* in practicing style across hotspots of this study.

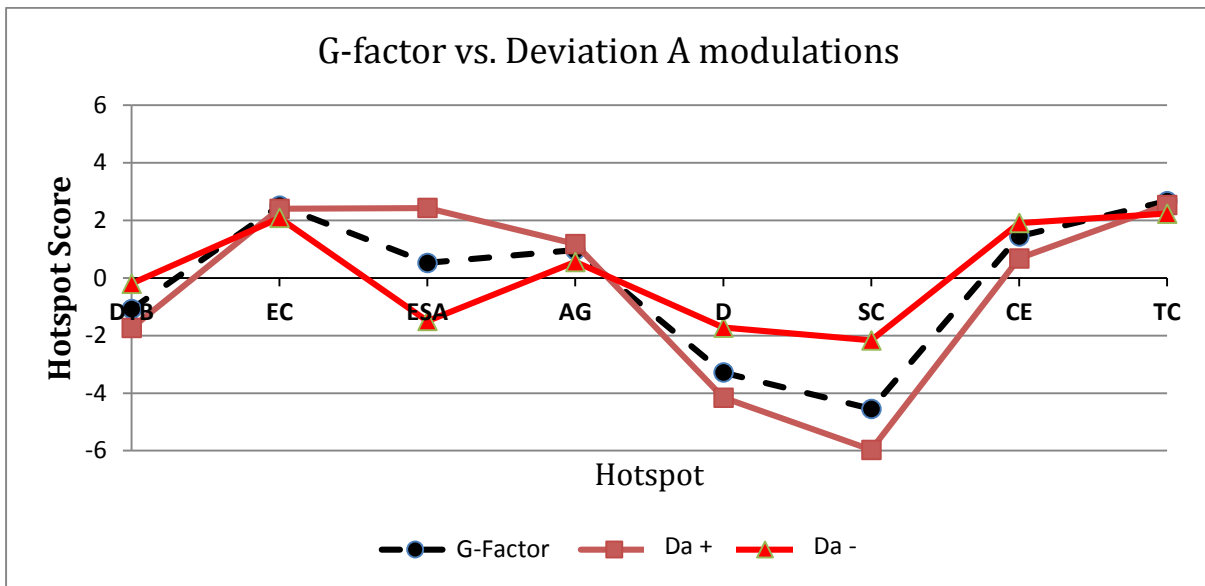


Figure 17. G-factor and positive and negative Da modulations across hotspots.

Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

Figure 17 displays Da-specific divergence from *G-factor*. From this figure we can see that divergence is largely localised around hotspots *Emotional self-awareness*, *Directive*, and *Self-confidence*, with *Deliberate therapeutic behaviours* and *Client empowerment* showing minor divergence.

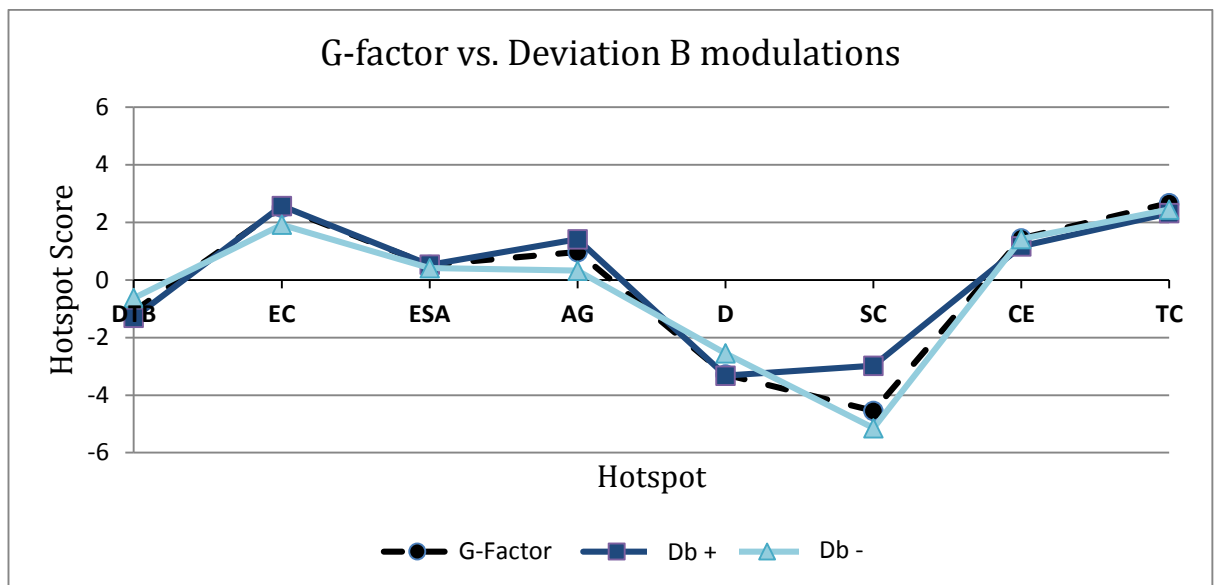


Figure 18. G-factor and positive and negative Db modulations across hotspots.

Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

Figure 18 displays Db-specific divergence from *G-factor*. From this figure we can see that divergence is largely localised around hotspots *Altruistic growth* and *Self-confidence*, with *Emotion coaching* and *Directive* showing minor divergence.

Given that *G-factor* represents a lack of Da or Db, an observant reader might notice that for certain hotspots, unequal inverse differences exist between positive and negative forms of Da and Db. For example, see hotspot *Self-confidence* in Figure 16. Remember that in an effort to account for ‘noise’ in any given data set, an item’s contribution to a hotspot’s score is weighted and therefore non-linear. Equal ratings for separate items may not contribute equally to a given hotspot. Furthermore, equal differences between ratings for the same item may not translate equivalently into hotspot scores – i.e. for a specific hotspot, a positive item score may have a higher contribution than a negative item score, or vice versa. This nonlinear relationship explains the aforementioned disproportional differences.

Extreme Items

Items were able to be ranked according to their prototypal scores for each response pattern. In other words, items were ranked as if they had been scored by a participant perfectly conforming to each response pattern. By viewing items ranked in this way, we are able to identify the most extreme items for each response pattern thus gauging the practice themes that each response pattern best captures. Table 30 below displays the most extreme items of each response pattern as well as their associated hotspots.

Table 30.
Six most extreme items, including their hotspots, for each factor

Factor	Form	Items	Hotspot	Theme
G-factor	Positive	I ensure that therapy occurs in an atmosphere of mutual respect	TC	Collaborative Feedback
		My therapeutic effectiveness is important to me	AG	
		I view treatment as a partnership for change	TC	
	Negative	I encourage clients to move on when emotional	D	Confidence Progress-oriented
		I expect quick, significant change	SC	
		I believe that I am the expert	SC	
Da	Positive	I undertake therapy myself	-	Reflective practice
		I believe my private emotional life affects my practice	ESA	
		I directly discuss differences between the client and myself	-	
	Negative	I believe that I am the expert	SC	Confidence Progress-oriented
		I encourage clients to move on when emotional	D	
		I like to keep my clients outcome focused	-	
Db	Positive	I use measures to prevent my own abuse of power	ESA	Professional Awareness
		I believe clients often seek to be influenced	SC	
		I monitor whether or not my emotions are useful during therapy	ESA	
	Negative	I dress in a way that supports my professional position	DTB	Professional Appearance-oriented
		I model the appropriate way to act for my clients	DTB	
		I give thought to how my appearance impacts on my client	DTB	

Note. DTB = Deliberate therapeutic behaviours, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, TC = Therapeutic collaboration.

Response Patterns by Hotspots

A correlational analysis was conducted to identify statistical associations between hotspots and response patterns. Table 31 displays correlation coefficients between hotspot scores and response patterns.

Table 31.
Pearson's (r) correlations between hotspot scores and response patterns

	DTB	EC	ESA	AG	D	SC	CE	TC
G-factor	0.16	.233*	0.147	0.178	-.276*	-.359**	0.146	.273*
Da	-.504**	0.116	.768**	.260*	-.597**	-.718**	-.434**	0.151
Db	-0.145	0.157	0.011	.326**	-0.11	.340**	-0.088	-0.104

Note. DTB = Deliberate therapeutic behaviours, EC = Emotion coaching, ESA = Emotional self-awareness, AG = Altruistic growth, D = Directive, SC = Self-confidence, CE = Client empowerment, TC = Therapeutic collaboration.

* $p < .05$, ** $p < .001$.

Findings indicate a small positive correlation between *G-factor* and both *Emotion coaching* and *Therapeutic collaboration*. Furthermore, a small negative correlation was evident between *G-factor* and *Directive*, while a moderate negative correlation was evident between *G-factor* and *Self-confidence*. A large positive association was identified between *Da* and *Emotional self-awareness*, and a small positive correlation was found between *Da* and *Altruistic growth*. Alternatively, large negative correlations were evident between *Da* and *Deliberate therapeutic behaviours*, *Directive*, and *Self-confidence*. A moderate negative association was found between *Da* and *Client empowerment*. Lastly, moderate positive correlations were identified between *Db* and both *Altruistic growth* and *Self-confidence*.

Response Patterns by STAR-C Scale and Subscales

A simple linear regression was calculated to predict PCI scores based on loadings of *G-factor*. A significant regression equation was found ($F(1, 75) = 12.24, p = .001$), with an R^2 of .140. Participants' predicted PCI score is equal to $8.14 + 3.45 (G\text{-factor})$. Similarly, a simple linear regression was calculated to predict STAR-C

scores based on *G-factor*. A significant regression equation was found ($F(1, 72) = 8.73, p < 0.01$), with an R^2 of .108. Participants' predicted STAR-C score is equal to $31.80 + 9.46$ (*G-factor*). These results indicate that people hewing more to the general consensus scored higher on the STAR-C and PCI subscale. As the STAR-C is intended to measure the therapeutic relationship, this result suggests that *G-factor* may have some relationship to the therapeutic relationship also. No other relationships were identified between response patterns and STAR-C scale and subscale scores.

Response Patterns by Demographic Data

Gender. Table 32 displays one-way between subjects ANOVA results comparing the effect gender had on Da and Db scores. As the Kolmogorov-Smirnov test indicated that the distribution of female participants for *G-factor* was significantly non-normal ($D(61) = 0.12, p < .05$), gender differences for *G-factor* were assessed using the non-parametric Mann-Whitney test rather than the ANOVA (Field, 2009).

Table 32.
Summary of analyses of variance results comparing styles by gender

Style		Sum of Squares	df	Mean Square	F
Da	Between Groups	0.24	1	0.24	4.23*
	Within Groups	4.33	76	0.06	
	Total	4.57	77		
Db	Between Groups	0.03	1	0.03	0.83
	Within Groups	2.52	21 ^a	0.03	
	Total	2.54	22		

Note. ^aLevene's test indicated unequal variance on the analysis for the Db ($F = 4.07, p = .047$), so the Welch robust test of equality of means was applied and within groups degrees of freedom was reduced to 21.

* $p < .05$.

Male participants' pattern of responding conformed less to the positive dimension of Da ($M = -0.11, SD = 0.25$, respectively) than female participants ($M =$

0.03, $SD = 0.23$, respectively). The Mann-Whitney test indicated that female participants ($M = 0.67$, $Mdn = 0.68$, $SD = 0.11$) conformed significantly more to the positive dimension of *G-factor* than male participants ($M = 0.59$, $Mdn = 0.58$, $SD = 0.12$), $U = 316.50$, $z = -2.45$, $p < .05$. No relationship was evident between gender and Db.

Age. Table 33 displays one-way between subjects ANOVA results comparing the effect age had on *G-factor*, Da, and Db.

Table 33.
Summary of analyses of variance results comparing styles by age

Style		Sum of Squares	df	Mean Square	F
G-factor	Between Groups	0.07	3	0.02	1.79
	Within Groups	0.93	74	0.01	
	Total	1.00	77		
Da	Between Groups	0.75	3	0.25	4.88**
	Within Groups	3.81	74	0.05	
	Total	4.57	77		
Db	Between Groups	0.47	3	0.16	5.56**
	Within Groups	2.08	74	0.03	
	Total	2.542	77		

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

Post hoc comparisons using the Tukey HSD test indicated significant differences between participants aged less than 31 ($M = -0.20$, $SD = 1.53$) and both 31-40 year old participants ($M = 0.02$, $SD = 0.17$) and participants aged over 50 ($M = 0.09$, $SD = 0.25$) for Da. Furthermore, also for Da, a borderline significant result ($p = .080$) was identified between participants aged less than 31 and 41-50 year old participants ($M = 0.00$, $SD = 0.27$). No significant differences were observed between other age groups for Da. Significant differences were identified between participants aged less than 31 ($M = -0.13$, $SD = 0.11$) and both 41-50 year old participants ($M = 0.08$, $SD = 0.19$) and participants aged over 50 ($M = 0.05$, $SD = 0.17$) for Db. Furthermore, a borderline significant difference ($p = .070$) was observed between 31-40 year old participants ($M = -0.06$, $SD = 0.18$) and 41-50

year old participants ($M = 0.08$, $SD = 0.19$) for Db. No significant differences were observed between other age groups for Db.

Profession. Table 34 displays one-way between subjects ANOVA results comparing the effect of profession on *G-factor*, Da, and Db.

Table 34.
Summary of analyses of variance results comparing styles by profession

Style		Sum of Squares	df	Mean Square	F
G-factor	Between Groups	0.02	2	0.01	0.73
	Within Groups	0.98	75	0.01	
	Total	1.00	77		
Da	Between Groups	0.42	2	0.21	3.81*
	Within Groups	4.15	75	0.06	
	Total	4.57	77		
Db	Between Groups	0.06	2	0.03	0.91
	Within Groups	2.48	75	0.03	
	Total	2.54	77		

Note. * $p < .05$.

Post hoc comparisons using the Tukey HSD test indicated a borderline significant difference ($p = .061$) between psychologists ($M = -0.04$, $SD = 0.23$) and other professionals ($M = 0.12$, $SD = 0.27$) for Da. No significant differences were observed between other professionals groups for Da.

Experience. Table 35 displays one-way between subjects ANOVA results comparing the effect of experience on Da and Db. The Kolmogorov-Smirnov test indicated that the distribution of participants with 1-10 years of experience for *G-factor* was significantly non-normal ($D(44) = 0.14$, $p < .05$). As a result, the non-parametric Kruskal-Wallis test was used instead to compare experience groups for *G-factor* (Field, 2009).

Table 35.
Summary of analyses of variance results comparing styles by experience

Style		Sum of Squares	df	Mean Square	F
Da	Between Groups	0.73	3	0.25	4.79**
	Within Groups	3.83	75	0.05	
	Total	4.57	78		
Db	Between Groups	0.41	3	0.14	4.80**
	Within Groups	2.14	75	0.03	
	Total	2.55	78		

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

Post hoc comparisons using the Tukey HSD test indicated significant differences between participants with 1-10 years of experience ($M = -0.07$, $SD = 0.21$) and a) participants with 11-20 years of experience ($M = 0.14$, $SD = 0.24$) and b) participants with more than 30 years of experience ($M = 0.19$, $SD = 0.22$) for Da. No significant differences were observed between other experience groups for Da. Significant differences were observed between participants with over 30 years of experience ($M = 0.19$, $SD = 0.22$) and a) participants with 1-10 years of experience ($M = -0.03$, $SD = 0.16$) and b) participants with 11-20 years of experience ($M = -0.07$, $SD = 0.18$) for Db. Furthermore, a borderline significant result ($p = .078$) was obtained between participants with 11-20 years of experience ($M = -0.07$, $SD = 0.18$) and participants with 21-30 years of experience ($M = 0.09$, $SD = 0.22$) for Db. No significant differences were observed between other experience conditions for Db. The Kruskal-Wallis test indicated that a significant relationship was present between experience groups for *G-factor*, $H(3) = 7.39$, $p < .10$. Mann-Whitney tests were used to follow-up on pairwise comparisons with a bonferroni correction applied to the comparisons so all the effects are reported at 0.017 significance level (Field, 2009). No significant differences were found between experience conditions for *G-factor*.

Setting. Table 36 displays one-way between subjects ANOVA results comparing the effect of work setting on *G-factor*, Da, and Db.

Table 36.
Summary of analyses of variance results comparing styles by setting

Style		Sum of Squares	df	Mean Square	F
G-factor	Between Groups	0.13	4	0.03	2.84*
	Within Groups	0.87	74	0.01	
	Total	1.00	78		
Da	Between Groups	0.53	4	0.13	2.42†
	Within Groups	4.04	74	0.06	
	Total	4.57	78		
Db	Between Groups	0.09	4	0.02	0.69
	Within Groups	2.46	74	0.03	
	Total	2.55	78		

Note. † $p < 0.10$. * $p < .05$.

Post hoc comparisons using the Tukey HSD test indicated significant differences between participants working in private practice ($M = 0.70$, $SD = 0.10$) and participants working in other settings ($M = 0.58$, $SD = 0.14$) for *G-factor*. No significant differences were observed between other work setting conditions for *G-factor*. A borderline significant difference ($p = .063$) was observed between participants working in private practice ($M = 0.11$, $SD = 0.23$) and participants working in a child or family setting ($M = -0.10$, $SD = 0.23$) for Da. No significant differences were observed between other work setting conditions for Da.

STUDY FOUR: DISCUSSION

Overall, the results of this study were not as expected. While responses to ES skills could be reduced to eight hotspots salient to therapists' practices, due to a general consensus, therapist styling across these hotspots was not considered an appropriate method to meet the aims of this study and the overall thesis. Alternatively, by applying Q-analysis, this consensus was identified and labelled *G-factor*, with statistical associations identified between it and a modified measure of the therapeutic relationship. Furthermore, two divergent response patterns were identified after controlling for this consensus, with both age and experience, among other demographic variables, associated with each divergent response pattern. The following discussion outlines the hotspots identified and explores the presence and absence of these hotspots in the mean and consensus profiles. Furthermore, *G-factor*, *Da*, and *Db* are explored, with statistical associations unpacked. Lastly, the implications of these findings are considered with this study's limitations acknowledged.

Hotspots

With the omission of *Altruistic growth*, *Self-confidence*, and *Directive*, all other hotspots identified in this study are consistent with clusters of the Combined solution. This comparison indicates that a) the themes linking *Altruistic growth's* ES skills, *Self-confidence's* ES skills, and *Directive's* ES skills were encompassed by other, more recognisable, themes during study three; and b), that these thematic links were statistically established following the application of ranking data during this study.

Four of Harvey et al.'s (2016) ten hotspots overlapped with hotspots of this study; specifically, *Therapeutic collaboration*, *Client empowerment*, *Emotion coaching*, and *Directive*. However, Harvey et al.'s hotspots *Self-reflective critique*, *Therapeutic use of own experiences*, *Tailoring therapy*, *Behavioural expressions*, *Verbal easing*, and *Self-secure* were not captured in this study's hotspots. It is considered that this disparity may reflect differences in a) items rated during procedures, b) sample size and demographic composition, and c), MDS solutions

used during analysis. The identified hotspots of this study are considered in detail below.

Mean and Consensus Profiles

Neutral Hotspots

Rich information is discerned from neutral hotspot scores across mean and consensus profiles (revisit Figures 13 and 14). While exceptions do exist, a mean neutral score tends to indicate a division in participant response patterns, with hotspot scores differing in valence rather than amplitude. In other words, neutral hotspot scores represent a fluctuation between valences thus indicating that certain participants see these behaviours as present in their practices, while others view them as absent. While the spread of hotspot scores are also of import, polar differences allow us to identify practice behaviours that differ remarkably between therapists and consider why, hopefully yielding insights into the evolution of practicing styles.

In this research, neutral hotspots were defined as those with mean scores within one point of the neutral line. These neutral hotspots included *Deliberate therapeutic behaviours*, *Emotional self-awareness*, and *Altruistic growth*. As a borderline neutral score was observed for *Client empowerment* ($M = 0.96$) across the mean profile, and a clear positive score across the consensus profile ($M = 1.45$), for the purposes of analysis, this hotspot was considered positive rather than neutral. As typical with neutral hotspot scores, participants' ideographic profiles fluctuated considerably between planes thus resulting in a largely mean neutral value. This result suggests that these hotspots and their comprising items may be largely discriminating.

Deliberate therapeutic behaviours. Despite a relatively neutral average score, participants of this sample tended to agree that *Deliberate therapeutic behaviours* was absent in their practices, with older therapists, more experienced, and other professionals (cf. psychologists) having larger negative scores than their colleagues. These results suggest that with age and experience, participants become less deliberately therapeutic, possibly coming to place greater trust in the

intrinsic therapy process. Alternatively, this result may demonstrate the transition of deliberate behaviours into a therapist's personal style as described by Landström, Rudebeck, and Mattsson (2006). Lastly, as an individual's discipline appears to influence their use of *Deliberate therapeutic behaviours* in practice, it may be that one's practicing style arises from differences in either pre-training characteristics, professional development, client group, or a combination of all three.

Research conducted by Sharpley and colleagues (Sharpley, Halat, Rabinowicz, Weiland, & Stafford, 2001; Sharpley et al., 2006; Sharpley & Sagris, 1995) have investigated the impact of therapist discrete behaviours on rapport. Specifically, they found that counsellor eye contact, posture, forward lean, and facial responses were influential of the client-counsellor bond. Furthermore, Sharpley et al. (2006) also identified an inverse relationship between hypothetical interest expressed by the counsellor — interest that may be interpreted as ambiguous as it is not expressed emotionally — and rapport. As Sharpley et al. (2006) assert the importance of training counsellors to develop discrete non-verbal behaviours in practice, these behaviours can be considered learnt and at least initially, actively applied in practice. These findings call into question the general hotspot scores indicating an absence of *Deliberate therapeutic behaviours* in this study. Perhaps, as stated previously, a general absence of *Deliberate therapeutic behaviours* scores reflect the non-deliberate application of these behaviours in practice by an experienced clinicians, a lack of contemporary training encouraging the development of these behaviours in one's practice, or that participants of this sample were answering honestly and do not practice these behaviours.

Emotional self-awareness. Given that emotional self-awareness is a key component of two ES intelligence models (Bar-On, 1997, Salovey & Mayer, 1990), is labelled by Saarni (1999) as a discrete ES skill, has consistently been identified as a common characteristic among master therapists (Albert, 1997; Jennings & Skovholt, 1999; Jennings et al., 2008), and is associated with better therapist emotion recognition in others (Machado, Beutler, & Greenberg, 1999), it is clearly a desirable therapist ability. However, despite this, scores for *Emotional self-*

awareness are not uniformly positive across participants of this study. Statistical findings suggest that participants' reported *Emotional self-awareness* differed significantly with respect to gender, age, profession, experience, and work setting. The following paragraphs explore these interactions.

Female participants of this study reported greater *Emotional self-awareness* scores than their male counterparts. While this finding is consistent with the extant literature (Barrett, Lane, Sechrest, & Schwartz, 2000; Ciarrochi, Hynes, & Crittenden, 2005; Lane, Sechrest, & Riedel, 1998), according to Barrett et al., a cause for this gender-based difference has yet to be identified. Barrett et al. hypothesise that because complex emotional knowledge is more accessible to, or efficiently used by, women (Ciarrochi et al., 2005; Tulving & Pearlstone, 1966), their ability to recall emotional experiences is heightened thus leading to greater emotional awareness. However, to date, their supposition lacks empirical backing. Nevertheless, given that Ciarrochi et al. (2005) found a positive effect of motivation on emotional awareness for both genders, they suggest that this ability can be developed thus demonstrating implications for clinical training.

In line with expectations, younger and less experienced therapists of this sample endorsed less items indicating emotional self-awareness than their older counterparts. These findings are generally supported in contemporary literature (John & Gross; 2004; Machado et al., 1999; Rønnestad & Skovholt, 2003), and indicate that both personal and professional experiences influence one's personal emotional awareness. However, despite this general consensus, the specific experiences thought to influence one's emotional awareness have yet to be determined. Anecdotes provided by Rønnestad and Skovholt suggest that emotion-related life events, including child raising, marriage, divorce, and death, likely have some influence on therapist development and thus therapeutic practice; however, to date, this supposition has not been empirically investigated. By exploring the interaction between emotional awareness and personal and professional experiences, we may better understand emotional development throughout the lifespan, an endeavour with significant implications for clinical research and training.

Finally, psychologists endorsed less items indicating emotional self-awareness than other professionals. Furthermore, participants working in other settings endorsed less items indicating emotional self-awareness than those working in private practice. As both the undefined practitioner subgroup and the undefined work setting subgroup are relatively heterogeneous with low participant numbers, inferences drawn from the above statistical findings must be interpreted with caution. Tentatively, these results suggest that *Emotional self-awareness* may fluctuate with profession as well as constraints imposed by work setting.

Altruistic growth. *Altruistic growth* is identified as containing two related themes. Theme one regards a therapist doing what is best for their clients even if that means referring that client to another clinician. Theme two reflects a therapist growing personally and professionally as a result of their practice. A concept akin to *Altruistic growth* appears to be lacking in the extant literature. Furthermore, despite therapy being largely an altruistic profession, the concept of therapist altruism itself in therapeutic practice has received little research attention.

Participants' item scores for *Altruistic growth* spanned positive and negative valences resulting in a mean neutral score. Interestingly, no statistical differences were identified across demographic groups for *Altruistic growth*. This result suggests that either the spread of *Altruistic growth* values was not sufficient to identify statistical differences, or that participant age, gender, years of experience, or profession has little association with what a participant reports doing when regarding *Altruistic growth* items. When we consider that the ES skills of *Altruistic growth* largely regard doing what is best for the client and growing professionally, it is unclear how this hotspot has not received a unanimous positive score. Perhaps participants do not always do what is best for the client and/or themselves and thus, responded honestly to the items of this hotspot. Alternatively, given that this hotspot consists of two themes, perhaps participants' scores were conflicting across each theme, thus resulting in an overall neutral value. Evidently, further research investigating this potentially salient practice behaviour would be of value.

Positive Hotspots

General positive scores were observed for *Emotion coaching*, *Client empowerment*, and *Therapeutic collaboration* across the mean and consensus profiles. Given that Harvey et al.'s (2016) akin hotspots *Feelings in context*, *Client empowerment*, and *Balanced collaboration* also scored positively across the majority of their participant styles, the reliability of this sample's scores across these hotspots is supported. Furthermore, as each of these constructs has previously been associated with effective clinical practice (Coombs et al., 2002; Farber & Doolin, 2011; Greenberg, 2004; Kazantzis & Kellis, 2012; Norcross & Wampold, 2011), these findings indicate that the majority of this sample's participants report that they apply a number of empirically supported therapy behaviours in practice.

Emotion coaching. Before the concept of emotion coaching debuted in psychology literature, it was being investigated as a research tool in the field of child development. It is hypothesised that parents have differing organised sets of beliefs and feelings about their own and their child's emotions, and that emotion coaching is one of these parental emotional philosophies (Gottman, Katz, & Hooven, 1996; Katz et al., 2012). This premise has largely endured with respect to the therapist-client dynamic in therapeutic practice — i.e. that therapists have differing emotional beliefs in practice, and emotion coaching behaviours reflect one of these emotional philosophies. According to Gottman et al., after modifying the context from a parent-child dynamic to a therapist-client dynamic, emotion coaching is defined as: a) an awareness of the client's emotion, b) viewing the client's emotion as an opportunity for connecting and/or learning, c) helping the client identify and label the emotion, d) empathising and validating the client's emotion, and e) helping to consider solutions to manage future emotions. Given that the ES skills comprising the hotspot *Emotion coaching* wholly reflect the aforementioned components of Gottman et al.'s definition, this hotspot was labelled accordingly.

As well as a high mean positive score, *Emotion coaching* items were scored almost unanimously positive across participants of this sample. This finding suggests that almost all participants of this sample hold an emotional philosophy viewing emotion-related intervention as present in their practices, differing largely

with respect to amplitude. Statistical findings suggest that *Emotion coaching* fluctuated with therapist age and work setting, with younger participants as well as those working in government funded adult mental health settings (cf. private practice) having less positive *Emotion coaching* scores than their counterparts. These results suggest that emotional philosophies — particularly an emotion coaching philosophy — develop with age and fluctuate according to work settings (e.g. client age, client gender, presenting problems, management policy, etc.).

Empirical research investigating therapist temporal development is currently lacking (Skovholt & Rønnestad, 2003), with even less attention paid to emotion coaching changes across the life-span. Nevertheless, considering that age-related changes are likely to be connected to lived experiences (Rønnestad & Skovholt, 2003; Safran & Muran, 2000), it is viable to assume that life events promoting an individual to consider their own, and others', emotions (e.g. aging, schooling, parenting, marriage, death, etc.) may also result in appraisals of their personal emotional philosophies. Perhaps these lived experiences account for the age-related statistical differences observed across *Emotion coaching* scores. Clearly, further research investigating emotional philosophies, emotion coaching, and life experiences would be of value.

Client empowerment. As reported previously, a mean borderline positive score was recorded for *Client empowerment* across participants of this sample. Given that the literature construct client empowerment has been linked to therapy adherence (Simpson, Bell, Knox, & Mitchell, 2005), client resilience (Padesky & Mooney, 2012), and greater client self-determination (Cowger, 1994), *Client empowerment's* mean positive score indicates that this sample's participants report that they employ a set of behaviours empirically endorsed as conducive to the therapy process. As *Client empowerment* is favourably viewed and valued in the literature, it may be that this general literature support has also been largely translated to therapists' practices (or reported practices). Such reasoning may partially explain the absence of significant differences observed between demographic groups for this hotspot; in other words, that most therapists report practicing *Client empowerment* items. Nevertheless, as negative scores were observed for a minority of participants for this hotspot, it would be important to

evaluate why these participants differed from the norm, and how an absence of *Client empowerment* ES skills influenced their therapeutic results.

Therapeutic collaboration. While *Therapy collaboration* was unanimously scored positively across participants of this study, no statistical differences were observed between demographic groups for this hotspot. Given that therapy collaboration is consistently linked to efficacious practice (Bachelor et al., 2007; Kazantzis & Kellis, 2012; Orlinsky et al., 2004), the therapeutic alliance (Ackerman et al., 2001; Tryon & Winograd, 2011) and is a fundamental component of many contemporary therapy modalities (Prochaska & Norcross, 2007), the unanimous positive score and absence of statistical differences may reflect a professional consensus that therapy collaboration is a necessary condition of efficacious practice. This supposition is supported by Orlinsky, Willutzki, Meyerberg, Cierpka, Buchheim, and Ambühl (1996), who found that of 2400 relatively diverse therapists, 88%-97% rated their typical client manner as accepting, committed, friendly, and warm. While these researchers did not specifically investigate therapy collaboration, their findings indicate that shared characteristics are present among the majority of therapy practitioners, and it is conceivable that therapy collaboration is one of these shared capacities. The implications of these shared practice features are discussed in a subsequent section.

Negative Hotspots

Negative scores across the mean profile were observed for *Directive* and *Self-confidence*. These scores indicate that participants of this sample generally shunned these hotspots in their practices.

Directive. Almost all participants of this study scored negatively for the hotspot *Directive*. This result largely reflects scores associated to the similar hotspot *Expert role* in Harvey et al.'s (2016) research. Furthermore, borderline significant results suggest that *Directive* differs with age, perhaps decreasing across the lifespan. However, longitudinal research investigating therapist directiveness is lacking in the extant literature.

While there is general support in the literature that *Directiveness* can be counter-therapeutic thus validating this samples' largely negative mean score (Bischoff & Tracey, 1995; Karno & Longabaugh, 2005a; Lafferty, 1987; Lafferty, Beutler, & Cargo, 1989; Svartberg & Stiles, 1991), a growing body of evidence indicates that therapist directiveness may play an important role in contemporary practice, especially with particular client groups (Bachelor, 1995; Beutler, Harwood, Michelson, Song, & Holman, 2011; Karno & Longabaugh, 2004, 2005b; Marshall, 2005; Norcross & Hill, 2002). In fact, researchers have associated therapy structure, a component of therapist directiveness (Lafferty, 1987), with the therapeutic alliance (Ackerman & Hilsenroth, 2001; Eaton, Abeles, & Gutfreund, 1993; Price & Jones, 1998). Specifically, Price and Jones demonstrate that weaker alliances are associated with both under- and over-structuring therapy among largely US samples. While these findings may not be applicable to a New Zealand sample, they indicate that clinicians' practices may benefit from appraising their directiveness on a client by client basis. Clearly, further research investigating therapist directiveness in practice would be of value, particularly among New Zealand clinicians. Moreover, it would be interesting to investigate how seemingly opposing constructs of directiveness and collaboration are implemented and balanced by the therapist in practice.

Self-confidence. Despite a positive relationship between therapist confidence and the psychotherapeutic result (Ackerman & Hilsenroth, 2003; Frank, 1982; Johnson & Caldwell, 2011; Littauer, Sexton, & Wynn, 2005; McGuff, Gitlin, & Enderlin, 1996; Saunders, 1999), the hotspot *Self-confidence* was almost unanimously scored negatively across participants of this study. In particular, female therapists and therapists working in private practice (cf. other settings) scored more negatively than their counterparts. Three factors likely account for this stark contrast in findings.

Firstly, the ES skills defining *Self-confidence* may not reflect the literature field's classification of therapist confidence. Johnson and Caldwell (2011) define therapist confidence as "assuredness and freedom from doubt in oneself and one's abilities... represent(ing) one's perception of self" (p. 311). While several prominent ES skills of *Self-confidence* reflect this conviction (e.g. I believe that I am

the expert, I make accurate judgements, and I am professionally confident), other prominent items are less congruent (e.g. I expect quick, significant change and I believe clients often seek to be influenced), and ultimately appear to fuse therapist confidence with therapy-related beliefs. Given this reasoning, it may be that if participants of this study were to rate their confidence as a therapist, their ratings may not align with their scores for this hotspot.

Secondly, research linking therapist confidence to the psychotherapeutic result tends to measure perceived therapist confidence from the client's perspective, whereas this study identified therapist confidence from the clinician's perspective. Perhaps there is a distinction between how confident one feels and how confident they are perceived to be. Given that Joo, Bae, and Orlinsky (2005) states that therapists' self-perceptions may influence how their clients experience the therapeutic process, a therapist's perception of their confidence likely has substantial implications for their therapeutic practice. Consequently, further research investigating differences between therapist and client perceptions of therapy behaviours would be of substantial value.

Lastly, cultural differences between sample groups will likely have some bearing on the differences observed between findings. Of the following cited research regarding therapist confidence, only Littauer et al.'s (2005) sample group hailed from outside the US (Ackerman & Hilsenroth, 2003; Frank, 1982; Johnson & Caldwell, 2011; Littauer et al., 2005; McGuff et al., 1996; Saunders, 1999), thus geographically limiting the application of most therapist confidence research. Considering that Jennings et al. (2008) identified several differences between shared characteristics of Singaporean and US master therapists, this finding supports previous postulations that country and/or cultural differences likely influence one's practice (Bae, Joo, & Orlinsky, 2003; Joo et al., 2005). As the majority of this study's sample are from New Zealand, they most likely affiliate with a culture historically valuing trait modesty (Cosgrove & Bruce, 2005). This cultural trait may have significant implications for how New Zealand therapists view themselves and how New Zealand clients view their therapists. These perceptions are likely to influence a therapist's practice and may partially account for unanimous negative scores for *Self-confidence* among this study's sample.

Clearly, the above considerations would be important to explore as to better understand how culture influences one's expression of self-confidence.

G-factor

The identification of a general consensus in this study is significant. It highlights that, according to this sample and these particular ES skills, little variation is present between participant responses across several basic points. This finding does not suggest that therapists do not vary, both divergent response patterns indicate that they do, just that their differences are dominated by a basic conformity. This finding was in contrast to Harvey et al. (2016), who found that their sample fit to one of seven distinct therapeutic styles. This disparity may partly be due to differences between items, participants, sample sizes, MDS models used for analysis, and/or all of the above. Such a difference highlights the need to replicate this study as to assess the permanence of this basic conformity across participants and time.

G-factor is positively associated with *Emotion coaching* and *Therapy collaboration*, while negatively associated with *Directive* and *Self-confidence*. The most and least endorsed ES skills of this consensus imitate the aforementioned associations. Significant differences were observed between *G-factor* values and both gender and work setting. Specifically, male therapists and therapists practicing in other settings were found to hew less closely to the general consensus than female therapists and therapists working in private practice, respectively. Both male practitioners and therapists working in other settings were minority conditions of their demographic groups. Given that the consensus is largely comprised of majority response patterns, it is understandable that minority subgroups were significantly less associated with this consensus. This finding indicates that a general agreement exists between practitioners and suggests that this agreement varies marginally with the majority of those sampled. Replicating this consensus with a larger sample would enable us to test its stability across various demographic groups and conditions.

Interestingly, *G-factor* scores could be used to statistically predict both the overall modified STAR-C and PCI subscale scores. The modified STAR-C is intended to assess the therapeutic relationship and this association suggests that the consensus profile includes endorsed ES skills important in developing this relationship. Given that collaboration in therapy has been positively associated with the therapeutic alliance (Ackerman et al., 2001; Tryon & Winograd, 2011), large positive *Therapeutic collaboration* scores across the consensus profile are consistent with the above inference. Furthermore, items included in the PCI subscale also reflect ES skills largely comprising *Emotion coaching*. Considering that *Emotion coaching* scores are largely positive across the consensus profile, this congruence further supports the aforementioned statistical associations. As a number of substantial limitations are associated with the modified STAR-C, it is important that the aforementioned inferences are considered with care. Nevertheless, these findings indicate that statistical associations are possible between this consensus and empirical measures and suggest that these associations may reveal key facets of this agreement. Clearly, these findings point to a possible direction future research may take.

Taken at face-value, this consensus makes sense. Like common factors that transcend therapy modalities (Sprenkle et al., 2009), there are likely therapist behaviours that are almost universally practiced irrespective of demographic variables or theoretical orientation. In other words, this finding suggests that the majority of therapists, for any number of indistinct reasons, agree on certain practice behaviours and, to an extent, therapy philosophies. However, empirical research investigating globally practiced therapy behaviours is lacking. Orlinsky et al. (1996) identified that 2400 otherwise diverse therapists routinely employed several similar practice behaviours, however, their study appears to be unique. The identification of this consensus may be an initial step toward exploring these agreements. Hotspots with large consensus profile scores indicate points of general agreement between participants of this sample. Perhaps this sample's convergence points also reflect a consensus held by local therapist populations. So how might we explain this consensus?

Synthesising prior paragraphs related to those largely unanimous hotspots would appear to show that those hotspots are either strongly supported in the literature or may reflect specific cultural values. Following this reasoning, clear positive and negative hotspots across the consensus profile may reflect a shared understanding of acceptable and unacceptable practice behaviours, resulting from a a) cultural ethos (e.g. individual vs. collectivistic values, desirable characteristics, etc.), and b) professional culture (e.g. legal, ethical, research consensus, etc.), both of which also likely influence one another. This theoretical pathway has been presented below and will be expanded in a following section (Figure 19).

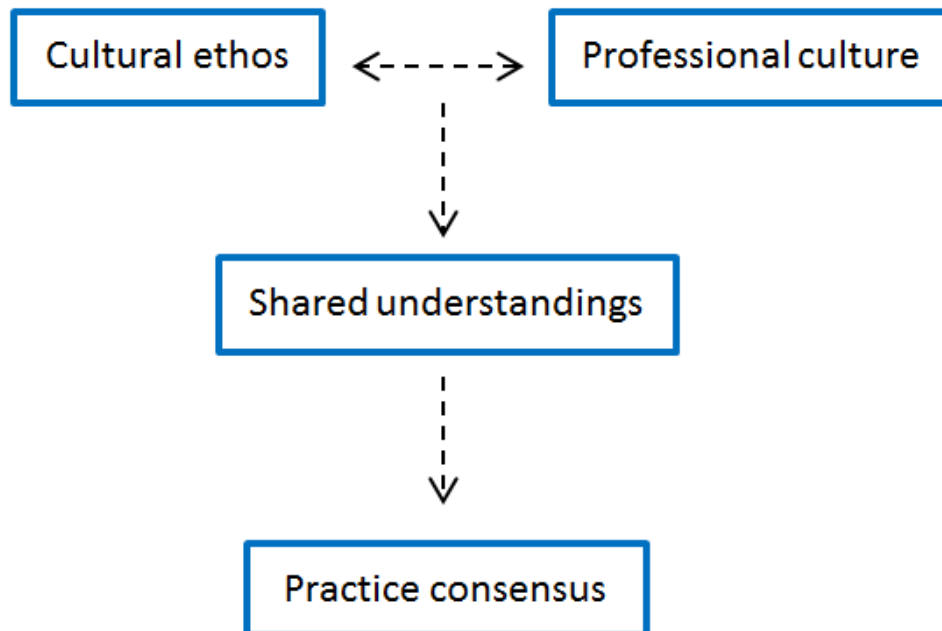


Figure 19. Proposed theoretical pathway to practice consensus.

Divergent Findings

Within the analytical context, Da and Db are modulations superimposed on the *G-factor* consensus. Participants diverging from one another according to Da and Db loadings are still largely in agreement according to a basic conformity. Da and Db styles are the responding differences we observe when partially controlling for the group consensus — i.e. factoring this conformity out. Furthermore, like *G-factor*, Da and Db loadings can range from -1 to 1; in other words, depending on their

loadings, participants can either conform or diverge from Da and Db response patterns.

Deviation A and Deviation B

From the perspective of *G-factor*, the positive form of Da scored more negatively for *Deliberate therapeutic behaviours*, *Directive*, *Self-confidence*, and *Client empowerment*, and more positively for *Emotional self-awareness*. For the negative form of Da, the above hotspot trends were largely reversed by similar amplitude. Da differed significantly according to gender, age, experience, profession, and setting. Specifically, female participants, older participants, more experienced participants, participants not defined as psychologists or counsellors, and those working in private practice were more associated with the positive form of Da. Alternatively, male participants, younger participants, less experienced participants, psychologists, and those working in a child and family setting were more associated with the negative form of Da.

In contrast to Da modulations, less variation was observed among Db loadings across hotspots. From the perspective of *G-factor*, a more positive score was observed for *Altruistic growth* and a less negative score was observed for *Self-confidence* for the positive form of Db. Furthermore, while the negative form of Db showed the inverse response pattern for the aforementioned hotspots, a less positive score for *Emotion coaching* and a less negative score for *Directive* was observed for the negative form of Db, while little/no change from *G-factor* was observed for the positive form of Db across these same hotspots. Db loadings differed significantly according to both age and experience. Specifically, the older and/or more experienced a participant, the more they conformed to the positive form of Db.

Deviating from G-factor

Divergent styles appear to fluctuate with demographic variables, chiefly age and experience, while one's conformity to a group consensus does not. However, employing hotspots to view these deviations may be unsuitable, ultimately limiting

interpretability. From the perspective of hotspots, Da and Db appear to counteract one another. For example, as one conforms to Da their *Self-confidence* score decreases, whereas conforming to Db increases one's *Self-confidence* score. As both Da and Db are positively associated with age and experience, surely these variables cannot have opposing effects for the same hotspot. This contradiction indicates that real deviations from *G-factor* may be better captured according to other ES skills not comprised by hotspots. One particular method of identifying these areas of divergence would be to view those most and least endorsed ES skills associated with each style.

Positively endorsed items of Da indicate both intra- and inter-personal emotional awareness qualities of one's practice (e.g. reflective practice, undertaking personal therapy, etc.). Conversely, negatively endorsed items suggest that the therapist assumes more of an expert role in practice (e.g. encourage clients to move on when emotional, belief of being the expert, etc.). From these data, it would suggest that Da largely captures the therapist's practice focus, with introspective therapists conforming to positive Da, and externally focused therapists associated with negative Da. Alternatively, participants hewing to a positive pattern of responding for Db appear to value more implicit aspects of professionalism (e.g. preventing own abuse of power, monitoring personal emotions, etc.), whereas those adhering to a negative pattern of responding tend to value more explicit signifiers of professionalism (e.g. appearance, modelling, etc.). These themes suggest that as a therapist ages and becomes more experienced, they transition from observable/face-value professionalism to intrinsic/process-related professionalism. From this analysis, we can see that demographic variables influence a therapist's practice focus for Da and perception of professionalism for Db.

Practice Styles

This study provides evidence suggesting how one's practice style may be formed according to ES skills. These data would suggest that one's ES practice style is largely influenced by a) a general consensus relating largely to the therapeutic

relationship, and b) bidirectional divergence from this consensus associated predominantly with therapist practice focus and professionalism. Hypothesised pathways leading to this consensus include both cultural ethos and professional culture. Alternatively, proposed pathways diverging from this consensus largely reflect those demographic differences previously identified. Accordingly, Figure 20 below displays the proposed partial pathway to therapists' ES practice styles.

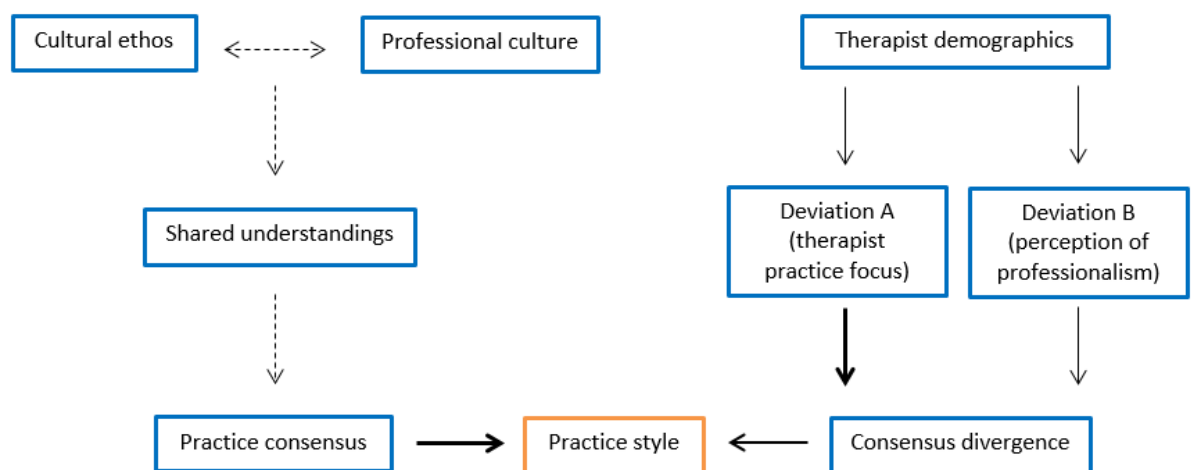


Figure 20. Proposed partial pathway to therapists' ES practice styles.

There is little doubt that this pathway is incomplete. There are likely to be numerous variables influencing both consensus and divergent responding that are missing from this model. Furthermore, it is possible that the position and/or unidirectional influence of variables in the current conceptualisation are incorrect. However, taken with its obvious limitations, this model is novel and contributes to a currently neglected literature field. It provides a key initial step toward understanding the development of therapists' practice styles. By investigating the general consensus we may better understand practice similarities between practitioners. Moreover, investigating consensus divergences in a number of different directions may a) illuminate how and why therapists diverge and b) enable one to predict a therapist's developmental trajectory. At the very least, this model may encourage others to consider, or possibly even help answer, Orlinsky et al.'s (1999) question "Do psychotherapists at different points in their careers

develop along divergent paths, or does a common pattern of development apply to most therapists?" (p. 132).

Limitations

Subjectivity

As the nature of responding was subjective, this has multiple implications for the results of this study. Subjectivity, as opposed to objectivity, can create distortions in data from such effects as social desirability (biased responses so that they are more consistent with the norms of peers) or fluctuations in responses due to the time the participant was assessed and the current mood of that participant. Furthermore, possibly due to a lack of insight, there may be an incongruence between what participants say they do and what they actually do. Efforts were made to prevent this source of error by such methods as anonymous responding and the rewording of the items so that there was less ambiguity in the statements. Furthermore, as this study made use of MDS methodology and the Combined model, through a process of 'smearing out' participant ratings (Bimler & Kirkland, 2001; Harvey et al., 2016; Kirkland & Bimler, 1996), distortions imposed by subjective data were reduced. 'Smearing out' involves averaging participant weighted ratings across several proximal items in the Combined solution, subsequently using this overall average rank in analysis. By this process, participants' subjective reports are observed through an objective lens thus reducing the error inherent in subjective responding (Kirkland & Bimler, 1996). However, as subjectivity can never be completely erased, this presents an opportunity for future research.

By objectively scoring practicing therapists and subsequently comparing these results to their responses on a similar ranking task, we may better understand the relationship between what a therapist reports doing and what they actually do. Such research would have implications for therapist-focused studies relying on self-report data.

Item Error

While attempts were made to ensure that the items rated during this study were interpreted consistently across participants, it is impossible to completely control for this factor. Such item error can include poorly worded items, careless participant responding, data entry errors, and culture and/or age specific items. Fortunately however, use of the Combined model as an objective framework and hotspot modelling methodology significantly mitigate this potential limitation.

When presented in the Combined solution, items tending to be consistently interpreted in a similar way across participants spread along the surface of the solution. More ambiguous items however, tend to be located toward the interior of the model as they are consistently prescribed to differing groups during the sorting task. In this study, we are able to identify these inconsistently sorted items and exclude them from the data analysis. Furthermore, hotspot modelling methodology allows the researcher to omit approximately 10% of the rated items (provided an even distribution of items within the model) with relatively little influence on the results of the study (Bimler & Kirkland, 2001). These factors further control for item errors that may influence this study's findings.

Sample Cohort

Although this study's sample size was adequate in forming hotspots and organising profiles, it would have been beneficial to have more participants as to increase the power of our findings. Furthermore, this study's sample consisted largely of New Zealand therapists. Conceivably, the hotspots and response patterns of this study may not be applicable outside of a New Zealand context. Consequently, a goal of future research should be the replication of this study with a larger and more diverse sample as to validate the response patterns identified and begin the generalisation of results. Moreover, the collection of further supplementary information (e.g. confidence ratings, therapeutic outcome, therapeutic modality, etc.) which could later be linked to hotspots, consensus styles, and practice styles would likely yield greater insights into how one's therapeutic style is formed.

STAR-C

In an attempt to tentatively link hotspots and therapist styles to outcome data, the STAR-C was completed by each participant as to gauge their average therapeutic relationship across clients. As well as obvious limitations imposed by a social desirability bias, further limitations imposed by this measure include its intended sample demographic and the alteration of items. Firstly, this measure was designed for therapists working in an adult outpatient setting, thus suggesting that its use with therapists working in other settings (e.g. child and family, acute, addictions, health, etc.) may not be appropriate. Furthermore, as the format of STAR-C items were modified from specific clients to clients in general for the purposes of this study, the reliability and validity of this measure is likely compromised. These limitations indicate that any inferences drawn from linking STAR-C data with hotspots or therapist styles must be interpreted with caution. Nevertheless, as the collection of STAR-C data did not substantially alter the procedure of data collection, its potential value did not compromise the integrity of this study's primary purpose.

Implications and Future Research

This study is a step toward identifying those interrelated ES skills that are salient to therapists' practices. By better understanding how and why these ES skills are linked, we may gain further insights into the development of practice styles. First in Harvey et al.'s (2016) study, and now in this study, hotspot generation has begun to examine these ES skill links. The development of hotspots contributes an empirical evaluation and measurement tool to investigate future interactions in therapy. Using these relevant ES constructs, researchers will be able to discern how interrelated ES skills change longitudinally, across client presentations, and/or life and professional experiences.

Firstly however, further research is necessary to replicate and validate the consensus and divergent response patterns identified in this study. Subsequently, by investigating those more contentious hotspots where little agreement is found, we may begin to establish a range of therapist practice styles clearly depicting

where therapists diverge. After validation, these practice styles may then be compared and contrasted with one another, consensus and divergent response patterns, client presentations, and therapeutic models, to better understand how these practice styles a) develop, and b) contribute and/or detract from therapeutic practice. Finally, research may begin to associate these therapeutic styles with outcome data, thus identifying effective and ineffective sets of ES behaviours. By doing so, it may be found that favoured profiles exist for particular disorders, contexts, or clients. From these findings, it may be possible to develop a client-therapist matching scale with real world implications for therapeutic outcome. Alternatively, by comparing valid and consistent profiles to those of master therapists, researchers may better differentiate between average and adept therapists. From this, objective measures may be designed to a) screen for candidate potential during therapist training intakes, b) indicate areas for professional development across one's career, and c), accurately tailor training programs to meet the needs of their trainees. While there is much to be gained from studying therapists' ES skills in therapy, this field is still in its infancy with substantial research still required before real world gains manifest.

Conclusion

This study aimed to identify and highlight therapists' practice differences. Paradoxically, it largely did the opposite, highlighting those similarities that exist between therapists. Specifically, this study found that the ES skills of therapists can be organised into eight clusters of functioning. Interestingly, three of these hotspots were largely unnoticed from participants' responses (neutral), while the remaining five were almost unanimously present or absent across this sample. From these findings, a general consensus of responding, as well as two divergent response patterns, were distinguished. Accordingly, a theoretical pathway to therapists' practice styles was developed thus facilitating future research. Confounds of this study include the subjective nature of participant responses, item errors, the small sample size, and the use of the modified STAR-C as a measure of the therapeutic relationship.

Future research would be well placed to first replicate this study using a larger sample size as to validate the general findings. Subsequent to this, exploring cultural and professional influences of the general consensus would be of value. Additionally, exploring divergent response patterns across ES skills may indicate where, how, and why therapists diverge as well as enable the identification of several consistent and valid therapist profiles. By associating these practice styles with outcome data we may begin to ascertain how particular styles may be best matched to context and clients. Findings such as these may herald the coming of client-therapist matching and the incorporation of effective profile components into training programs for therapists. This research has taken a step towards understanding the development of therapist practice styles. Nevertheless, due to a lack of research in this field, more work is still required to manifest the many potential gains conceivable from researching therapists' ES skills.

CHAPTER SEVEN

CONCLUSION

In brief, the primary aim of this thesis was to replicate and extend on Harvey et al.'s (2016) research at every level. This aim was largely achieved over the course of four separate studies. Via content analysis of three exemplary therapist transcripts, a date-limited literature search, and analysis of Harvey et al.'s Original model, 64 novel ES skills were added to the foundational item pool while 22 original items were deemed redundant and removed. By employing MDS methodology with a 25 person general sample, this new content was meaningfully embedded into Harvey et al.'s Original solution, producing a reliable standalone model statistically similar to the foundational solution. While an aim of study three was not achieved due to methodological limitations, data from a Japanese population were combined with New Zealand data to produce a more reliable and valid solution applicable for use as a framework to better understand the ES skills New Zealand therapists' employ in practice. Lastly, a general consensus of responding was discerned across eight salient kernels of practice interactions. These findings lead to the development of an exploratory model proposing a pathway to the development of therapists' practice styles.

The Combined solution of this thesis has important implications for clinical practice and future research. It provides a framework to conceptualise therapist behaviours in practice, allowing practitioners to easily identify their practice strengths as well as those requiring development. For research, this solution may be used to identify potentially important constructs currently lacking investigation in contemporary literature as well as providing a comprehensive set of behaviours defining ambiguous literature concepts thus aiding equivalent comparisons across studies. Lastly, while I would be hesitant to apply this solution to other cultures, tentative evidence suggests that this model may have some relevance to a Japanese population. Further research aimed at developing and comparing MDS solutions with different cultural groups may expose important differences between the

practices of culturally dissimilar therapists. Such findings may identify culture-salient competencies thus revealing culturally competent practice.

The general consensus and divergent response patterns identified in the final study of this research support prior research identifying that shared practice features may exist among the majority of clinicians (Orlinsky et al., 1996). This theoretical model serves to conceptualise the development of therapists' practice styles. As suggested previously, this pathway may a) illuminate how and why therapists diverge and b) enable one to predict a therapist's developmental trajectory.

While both this thesis and Harvey et al.'s (2016) research have explored a relative gap in the current literature, we cannot overlook the fact that both studies have been conducted by the same research team. All data have been scrutinised and interpreted by these researchers and as a result, this continuity has likely had some influence on the results. It is important that, at this point, independent research teams carry this project forward, largely replicating the methodology as to test the validity and reliability of the Combined solution, hotspots, and response patterns. It is my firm belief that dedicated research of this subject can and will improve our understanding of the therapists' role in therapy outcomes. Such research will improve therapists' practices, and ultimately, result in better therapy for all consumers.

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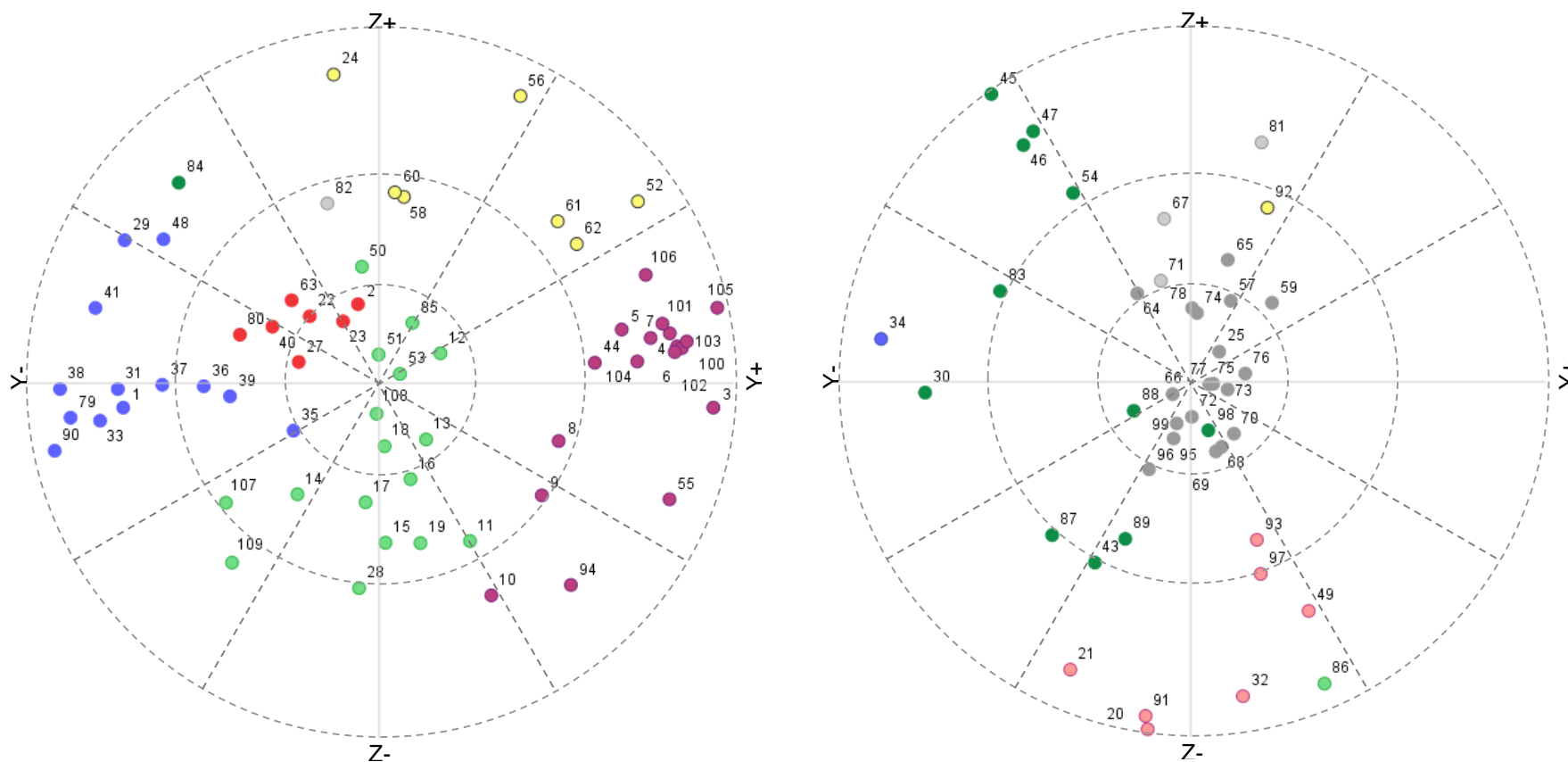
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APPENDICES

APPENDIX A - Harvey et al.'s (2016) Original MDS model



Split-hemisphere display of Harvey et al.'s (2016) Original MDS solution, showing X+ and X- hemispheres projected onto the plane.

APPENDIX B – Harvey et al.'s (2016) original item list

1. Considers therapy an interactive process
2. Tailors their talk to the client
3. Comfortable using silence
4. Open body posture
5. Mirrors/Matches clients (e.g. Body posture, use of key words)
6. Appropriate eye contact
7. Uses encouraging responses (e.g. nodding, sounds)
8. Uses proportionally more open ended questions (than closed)
9. Uses responses strategically for a particular effect or purpose
10. Gives advice
11. Summarises information for clients
12. Reflects or communicates an understanding of the client's feelings
13. Encourages exploration of feelings
14. Asks the client to fill in missing pieces
15. Offers a hunch about client experiences
16. Notes links in what the client is saying (e.g. Recurring themes, discrepancies)
17. Offers interpretations of the client's feelings/experiences
18. Links the client's feelings/behaviours to past experiences
19. Supports and challenges appropriately
20. Paces therapy interventions
21. Views therapy as a series of phases
22. Tailors approach and treatment to suit client's personality
23. Adjusts level of formality to suit client
24. Believes client will improve
25. Realistic about their strengths and weaknesses
26. Believes strongly in the efficacy of the treatment
27. Modifies their explanation of treatments to make it acceptable to client's worldview
28. Provides an explanation of what's going on
29. Attempts to create understandings based on a shared frame of reference between themselves and their client
30. Discusses relationship with client
31. Collaborates with client to set attainable/acceptable goals
32. Sets firm ground rules
33. Collaboratively establishes a therapy agreement
34. Sees themselves as an agent of change in the relationship
35. Highlights client competencies, resources and resiliencies
36. Believes that clients know what is best for themselves
37. Believes that clients should determine the timing and direction of therapy
38. Views treatment as a partnership for change
39. Encourages client to find own motivation for change
40. Incorporates the client's worldview and theory of problem/treatment
41. Views the relationship as a primary tool of therapy

42. Is able to repeatedly engage with and end therapy relationships positively
43. Responds productively to client negativity
44. Banters with clients
45. Therapist Emotional responses are beneficial for client
46. Relates the client's experiences to their own life and experiences
47. Uses their own emotions and responses to relate to the client
48. Uses their relationship with the client to increase client motivation
49. Draws on theory to help them understand the client's feelings/experiences
50. Can gain a sense of the world of the client
51. Is attentive to details of client's experiences
52. Is non-judgemental
53. Can accurately recognise the client's current innermost state, experience or motivations
54. Discloses relevant information about themselves
55. Sensitive and skilled in the use of language, imagery and metaphor
56. Expresses genuine thoughts and feelings
57. Are comfortable with who they are as a person
58. Connects with their clients in a real way
59. Strives for congruence between their values and their behaviour
60. Respects the client's worth as a person
61. Communicates a caring, respectful, positive attitude
62. Communicates unconditional warmth
63. Adjusts how they relate (according to the needs of the client)
64. Regulates level of emotional attachment to client
65. Can empathise without being overwhelmed
66. Uses measures to prevent their own abuse of power
67. Avoids imposing their own beliefs and values on clients
68. Actively seeks consultation and supervision
69. Actively seeks ongoing training and learning opportunities
70. Is open to feedback
71. Aware of the influence of their own socio-cultural background
72. Consistently questions own practice
73. Reflects on their own responses
74. Works to understand and fulfil their emotional and physical needs
75. Undertakes therapy themselves
76. Prepares self emotionally for sessions
77. Monitors self for signs of depletion and stagnation
78. Can find satisfaction from different aspects of success
79. Sees the end of therapy as a collaborative process
80. Adjusts the termination process to the nature of the therapy relationship
81. Is comfortable addressing spirituality
82. Can identify impact of cultural issues on clients' problems
83. Directly discusses differences between themselves and the client
84. Seeks commonalities with their clients
85. Is attentive to client's reactions
86. Makes accurate judgements
87. Addresses ruptures directly

88. Admits mistakes and apologizes
89. Openly discusses difficulties
90. Seeks joint solutions to difficulties
91. Resists settling on an explanation prematurely
92. Values helping others
93. Has a detailed knowledge of their field
94. Is persuasive
95. Persistent and believable when seeking honest feedback
96. Systematically seeks feedback
97. Detailed forethought and planning
98. Monitors their performance
99. Reflects on what they could do better
100. Nods
101. Sits comfortably close to client
102. Smiles
103. Leans forward
104. Uses expressive tone and gestures
105. Consistent verbal and non-verbal behaviour
106. Brief, non-intrusive/culturally appropriate touch
107. Seeks to understand and clarify client expectations
108. Seeks to understand client's thoughts/feelings
109. Reflects and seeks feedback about their understanding of the client

APPENDIX C – Combined item list

1. I tailor my talk to the client
2. I am comfortable using silence
3. I display open body posture
4. I mirror/match my clients (e.g. Body posture, use of key words)
5. I use encouraging responses (e.g. nodding, sounds)
6. I use proportionally more open ended questions (than closed)
7. I uses responses strategically for a particular effect or purpose
8. I give advice
9. I summarise the information for clients
10. I reflect or communicate an understanding of the client's feelings
11. I encourage exploration of feelings
12. I ask the client to fill in the missing pieces
13. I offer a hunch about client experiences
14. I note links in what the client is saying (e.g. Recurring themes, discrepancies)
15. I link the client's feelings/behaviours to past experiences
16. I support and challenge appropriately
17. I pace therapy interventions
18. I view therapy as a series of phases
19. I tailor my approach and treatment to suit my client's personality
20. I believe my client will improve
21. I am realistic about my strengths and weaknesses
22. I believe strongly in the efficacy of my treatment
23. I modify my explanation of treatments to make it acceptable to client's worldview
24. I provide an explanation of what's going on
25. I discuss the relationship with my client
26. I collaborate with my client to set attainable/acceptable goals
27. I set firm ground rules
28. I collaboratively establish a therapy agreement
29. I see myself as an agent of change in the relationship
30. I highlight client competencies, resources and resiliencies
31. I believe that clients know what is best for themselves
32. I view treatment as a partnership for change
33. I encourage clients to find their own motivation for change
34. I incorporate the client's worldview and theory of problem/treatment
35. I view the relationship as a primary tool of therapy
36. I am able to repeatedly engage with and end therapy relationships positively
37. I respond productively to client negativity
38. I banter with clients
39. My emotional responses are beneficial for clients
40. I relate my client's experiences to their own life and experiences
41. I use my own emotions and responses to relate to the client
42. I use my relationship with the client to increase client motivation

43. I draw on theory to help them understand the client's feelings/experiences
44. I can gain a sense of the world of the client
45. I am attentive to details of client's experiences
46. I am non-judgemental
47. I can accurately recognise the client's current innermost state, experience or motivations
48. I disclose relevant information about myself
49. I express genuine thoughts and feelings
50. I am comfortable with who I am as a person
51. I connect with my clients in a real way
52. I strive for congruence between my values and my behaviour
53. I respect the client's worth as a person
54. I communicate a caring, respectful, positive attitude
55. I regulate my level of emotional attachment to my clients
56. I can empathise without being overwhelmed
57. I use measures to prevent my own abuse of power
58. I avoid imposing my own beliefs and values on clients
59. I actively seek ongoing training and learning opportunities
60. I am open to feedback
61. I am aware of the influence of my own socio-cultural background
62. I consistently question my own practice
63. I reflect on my own responses
64. I work to understand and fulfil my emotional and physical needs
65. I undertake therapy myself
66. I prepare myself emotionally for sessions
67. I see the end of therapy as a collaborative process
68. I adjust the termination process to the nature of the therapy relationship
69. I am comfortable addressing spirituality
70. I can identify the impact of cultural issues on clients' problems
71. I directly discuss differences between myself and my client
72. I seek commonalities with my clients
73. I am attentive to client's reactions
74. I make accurate judgements
75. I address ruptures directly
76. I admits mistakes and apologise
77. I seek joint solutions to difficulties
78. I resist settling on an explanation prematurely
79. I value helping others
80. I have a detailed knowledge of my field
81. I am persuasive
82. I systematically seek feedback
83. I sit comfortably close to my clients
84. I use consistent verbal and non-verbal behaviour
85. I use a brief, non-intrusive/culturally appropriate touch
86. I seek to understand and clarify client expectations
87. I seek to understand client's thoughts/feelings
88. I reflect and seek feedback about my understanding of the client

89. I anticipate relapse
90. I explicitly encourage clients to be open and honest with me
91. I express optimism
92. I ensure that therapy occurs in an atmosphere of mutual respect
93. I believe the therapeutic relationship is mutually influential
94. I am a stable and reliable figure in therapy
95. I emphasis doing rather than just understanding
96. I believe the therapeutic environment is a place for clients to trial different behavioural strategies
97. I anticipate therapy to take time
98. I am professionally confident
99. I explore with clients the meaning of their experiences
100. I ensure that the client is emotionally invested in the process of therapy
101. I empower clients to set the emotional pace of therapy
102. I am emotionally available to my own experiences
103. I am emotionally available for my clients' experiences
104. I believe my clients trust me and my clinical judgement
105. I give my full attention
106. I am satisfied by my work
107. I engage in deliberate therapeutic practise
108. I personally and professionally grow as a result of my work
109. I regularly participate in personal mindfulness exercises
110. I appropriately validate clients' emotions
111. I am aware when there are rifts during therapy
112. I believe my private emotional life affects my practice
113. I am aware of my own emotions during therapy
114. I believe clients are flexible
115. I believe all clients are different
116. I regulate my clients' emotions
117. I ensure clients don't leave my practice feeling worse than when they entered
118. I don't view client emotionality as a problem
119. I encourage clients to move on when emotional
120. I give clients therapeutic space
121. I monitor whether or not my emotions are useful during therapy
122. I am explicit with my methods of influencing
123. I am outcome-focused during therapy
124. I like to keep my clients outcome focused
125. I value different, new therapeutic techniques
126. I believe therapeutic progress is about small incremental changes rather than radical changes
127. I expect quick, significant change
128. I believe that I am the expert
129. I validate clients' experiences
130. I believe observable client emotions give valuable information
131. I believe showing congruent emotion is useful
132. My emotions surface during therapy

133. My therapeutic effectiveness is important to me
134. I am directive during therapy
135. I overtly incorporate research into my practice to educate my clients
136. I give thought to how my appearance impacts on my client
137. I dress in a way that supports my professional position
138. I consistently turn up to appointments on time
139. I discuss the possibility of relapse with clients
140. I foster a willingness to sit with distress in clients
141. I help clients objectively view their emotions
142. I model the appropriate way to act for my clients
143. I believe in the window of opportunity for change
144. I am conscious of the connection between my client and I
145. I focus on certain emotions as target points
146. I have strategies to deal with my emotions that surface during therapy
147. I self-care to ensure I manage my own emotions
148. I am comfortable with referring clients on when required
149. I believe clients often seek to be influenced
150. I make clients feel as if they came up with their own ideas/solutions
151. I will reschedule a client if I am unable to competently practice

APPENDIX D – Study two research objectives and procedure instructions

Validating the mapping and profiling of therapists’ social and emotional competencies

Instruction Sheet

About this Task

We use the acronym, GOPA to describe the four phases involved: **G** = Group, **O** = Opposite, **P** = Partition, **A** = Add. The entire exercise will take about 60 minutes (please spend about 5 minutes working through these guidelines).

Getting Started

In front of you, there should be a deck of item cards (please shuffle these before starting), a record sheet for entering your responses, a pen or pencil, and these instructions.

Start by looking over the record sheet to identify the location of each phase’s response section. You can read over the summary notes on the record sheet now to get a feel for what each step asks you to do.

Find a large flat surface to work at. It is easiest if you have about a meter of counter space on which to spread out the cards and groupings.

About the Items

Each item represents a social-emotional behaviour or philosophy that therapists may value when working with clients. Occasionally, there are items with jargon (words that are unfamiliar) and, as a result, a list of words and definitions are provided at the end of this instruction sheet. However, if you still don’t understand or if the list doesn’t contain the appropriate word please don’t hesitate to look the word up yourself or consult the researcher.

Phase One – Grouping

Take the shuffled card-item deck. Read the top card’s statement and place it at top left of your working space so you can still see what it says. Then read the second item and decide whether the second item belongs in the same general group as the first item or whether it should be placed into a new group. A “group” consists of those items you think

are similar, belonging to the same concept group. If you think it belongs within the same concept group then place the second item immediately below the first one (concept groups run down, as columns). However, if you think the second item is unrelated and would belong in a new concept group, then start a new column by placing that item beside the first one, to the right. Any reasonable type of relationship is acceptable when deciding about a concept group's membership. You only need to justify concept group relationship criteria to yourself.

Now, go ahead and place all the items into various concept groups. As soon as you set out a few items this will begin to make sense. Try to make up between 5 and 15 concept groups but with no more than 14 members in each one. A concept group can have just one item member if there are no apparent relations.

Record your answers. When you are satisfied these concept groups make sense (and you may have to move the items around to firm these up) then print the numbers from each concept group onto the lines provided on the response page. For this task, each concept group's item numbers will be printed onto a separate row. The top line has an example with a 6-item concept group, namely: 7, 22, 1 (Do, please, print neatly.)

!!!!!! IMPORTANT!!!!!!

KEEP THESE GROUPS TOGETHER

TO USE IN THE FOLLOWING PHASES

Phase Two – Partitioning (sub-dividing)

Using the groups from phase one, for any concept group with 3 or more members it may be possible to find sub-groups within each whole concept group. (Concept groups with only 1 or 2 members do not have subgroups.) Do keep concept groups intact; **do not** move individual items between concept groups.

One way to do this is to rearrange items within each concept group so subgroup members are kept together, leaving a small gap between them. In some cases there will be no subgroups because a concept group is made up of very similar items. However, in most cases there will be some slight differences and it's these differences we want to know about.

Record. When sub-concept groups have been formed use brackets on the recording form to show what they are. For all concept groups that do have sub-groups, rewrite all item numbers on exactly the same line as in phase one but this time use brackets to indicate how sub-groups are formed. Our example shows the use of brackets.

Phase Three – Opposites:

This time, look over the whole concept groups and form in your mind a common theme for each one: what makes the items in each concept group stick together. Remember, for this phase we are focusing upon whole concept groups and not separate items.

When scanning these concept groups look for those that seem to be “opposites”, at the extreme from each another. We find that in any item set there are generally two or three sets of quite different concept groups.

Record. When you find a pair of opposites, enter onto the response form spaces provided any one item number selected from each of those two groups. (The reason for entering only one item number is straightforward, because the whole concept groups have been described in phase one above then any one item number from a single concept group will stand for the whole group.)

There is space to provide for up to six sets of concept group opposites. Try to find at least two.

Phase Four – Adding

This time we are asking you to merge similar concept groups together. Go right back to the original concept groups created in phase one, above. Survey these whole concept groups again (as was done in phase 2). This time though the idea is to join concept groups up, one pair at a time. Find the two most similar concept groups. Then physically shift a whole concept group’s items onto another one every time a merger occurs. This way it is clear which item- groups have been joined up. It is possible to add onto a previous merger. But once a merger has occurred it cannot be undone. Several concept groups will not join up because they are so different from each another. In general though at least 3 concept group mergers may be found.

Record. For recording purposes, as each merger occurs indicate on the response page spaces provided a single pair of item numbers, selecting any one item number to represent each concept group being joined together.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University’s Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O’Neill, Director (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz.

APPENDIX E – Study two demographics response sheet

Demographic Data

Gender: Male/ Female

Age: _____

Nationality: _____

Do you consent to participate in this research? Yes/No

Phase three – Opposites

Look over the phase 1 groups to find which are the most different. Record these “opposites” by entering any one item number from each group on the spaces below. Try to find at least two sets of opposites. Use your own judgment. Leave the item groups intact. Do NOT move items around.

Opposite set 1: ____, ____# Opposite set 2: ____, ____# Opposite set 3: ____,
____#

Opposite set 4: ____, ____# Opposite set 5: ____, ____# Opposite set 6: ____,
____#

Phase four – Adding

This time join together the most similar groups in phase 1. Physically place these similar Phase 1 item groups together and enter any one item number from each joining group onto the spaces below. Only some groups will join up, many will not. Try to make at least two merges. If there are more than three, continue showing item pairs.

merger a) ____, ____# merger b) ____, ____# merger c) ____,
____#

merger d) ____, ____# merger e) ____, ____# merger f) ____,
____#

Thank You for Your Time 😊

*Please contact the researcher on [REDACTED] or [REDACTED] you have any queries. If posting the results, please send to:
Andreas Marwick*

[REDACTED]
[REDACTED]

Manukau, 2014

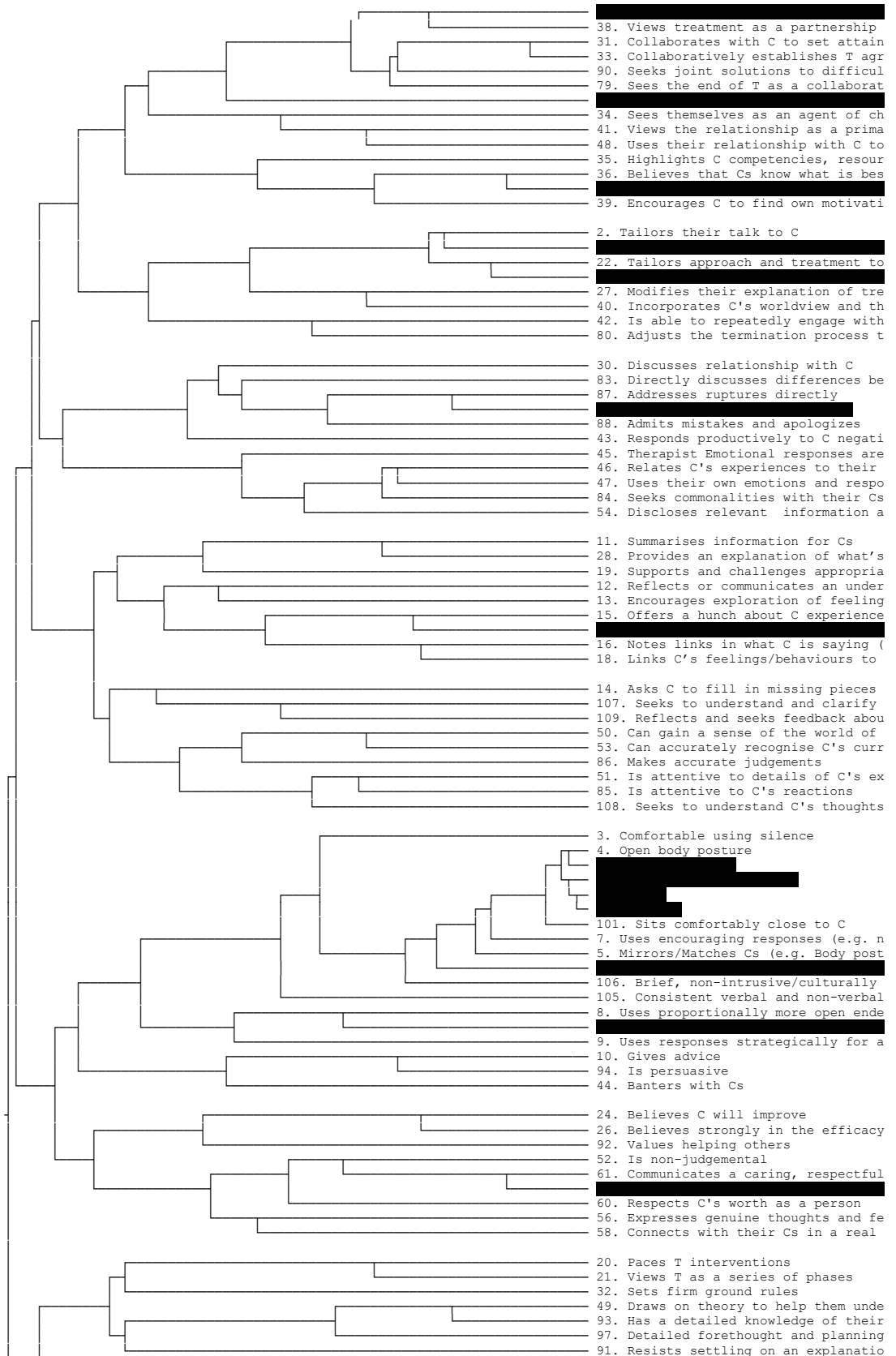
APPENDIX G – Study two 106 item list

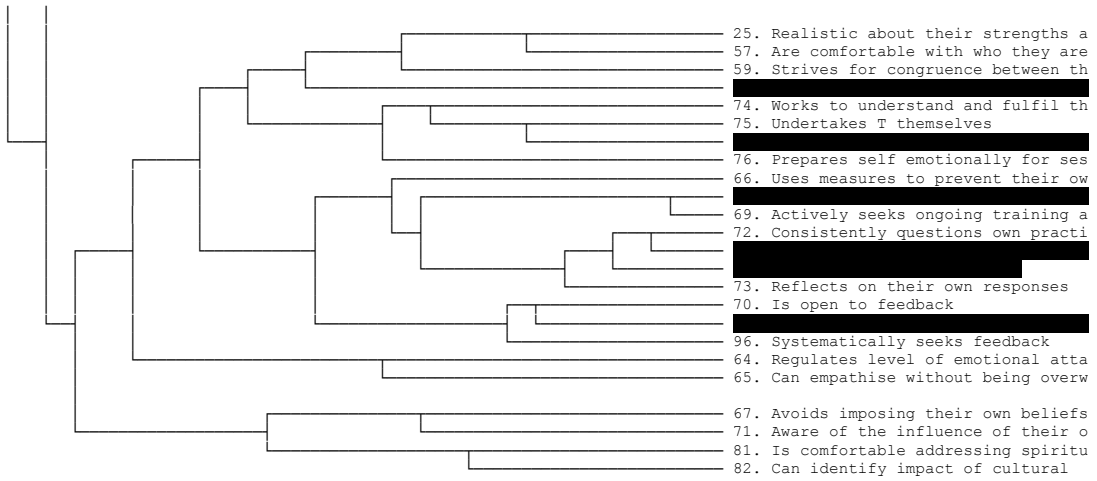
1. I am comfortable using silence
2. I mirror/matches my clients (e.g. Body posture, use of key words)
3. I use responses strategically for a particular effect or purpose
4. I reflect or communicate an understanding of the client's feelings
5. I offer hunches about client experiences
6. I link the client's feelings/behaviours to past experiences
7. I view therapy as a series of phases
8. I tailor the approach and treatment to suit client's personality
9. I believe my clients will improve
10. I am realistic about my strengths and weaknesses
11. I provide an explanation of what's going on
12. I collaboratively establish a therapy agreement
13. I highlight client competencies, resources and resiliencies
14. I view treatment as a partnership for change
15. I encourage clients to find own motivation for change
16. I incorporate the client's worldview and theory of problem/treatment
17. I view the therapeutic relationship as a primary tool of therapy
18. I believe my emotional responses are beneficial for the client
19. I use my own emotions and responses to relate to the client
20. I draw on theory to aid my understanding of the client's feelings/experiences
21. I can gain a sense of the world of the client
22. I disclose relevant information about myself
23. I express genuine thoughts and feelings
24. I strive for congruence between my values and my behaviour
25. I communicate a caring, respectful, positive attitude
26. I regulate my level of emotional attachment to clients
27. I use measures to prevent my own abuse of power
28. I avoid imposing my own beliefs and values on clients
29. I am open to feedback
30. I consistently question my own practice
31. I undertake therapy myself
32. I see the end of therapy as a collaborative process
33. I adjust the termination process to the nature of the therapy relationship
34. I am comfortable addressing spirituality
35. I directly discuss differences between the client and myself
36. I am attentive to my clients' reactions
37. I make accurate judgements
38. I admit mistakes and apologise
39. I value helping others
40. I am persuasive
41. I sit comfortably close to my clients
42. I display consistent verbal and non-verbal behaviour
43. I seek to understand and clarify clients' expectations

44. I anticipate relapse
45. I explicitly encourage clients to be open and honest with me
46. I express optimism
47. I ensure that therapy occurs in an atmosphere of mutual respect
48. I believe the therapeutic relationship is mutually influential
49. I am a stable and reliable figure in therapy
50. I emphasis doing rather than just understanding
51. I believe the therapeutic environment is a place for clients to trial different behavioural strategies
52. I anticipate therapy to take time
53. I am professionally confident
54. I explore with clients the meaning of their experiences
55. I ensure that the client is emotionally invested in the process of therapy
56. I empower clients to set the emotional pace of therapy
57. I am emotionally available to my own experiences
58. I am emotionally available for my clients' experiences
59. I believe my clients trust me and my clinical judgement
60. I give my full attention
61. I am satisfied by my work
62. I engage in deliberate therapeutic practise
63. I personally and professionally grow as a result of my work
64. I regularly participate in personal mindfulness exercises
65. I appropriately validate clients' emotions
66. I am aware when there are rifts during therapy
67. I believe my private emotional life affects my practice
68. I am aware of my own emotions during therapy
69. I believe clients are flexible
70. I believe all clients are different
71. I regulate my clients' emotions
72. I ensure clients don't leave my practice feeling worse than when they entered
73. I don't view client emotionality as a problem
74. I encourage clients to move on when emotional
75. I give clients therapeutic space
76. I monitor whether or not my emotions are useful during therapy
77. I am explicit with my methods of influencing
78. I am outcome-focused during therapy
79. I like to keep my clients outcome focused
80. I value different, new therapeutic techniques
81. I believe therapeutic progress is about small incremental changes rather than radical changes
82. I expect quick, significant change
83. I believe that I am the expert
84. I validate clients' experiences
85. I believe observable client emotions give valuable information
86. I believe showing congruent emotion is useful
87. My emotions surface during therapy

- 88. My therapeutic effectiveness is important to me
- 89. I am directive during therapy
- 90. I overtly incorporate research into my practice to educate my clients
- 91. I give thought to how my appearance impacts on my client
- 92. I dress in a way that supports my professional position
- 93. I consistently turn up to appointments on time
- 94. I discuss the possibility of relapse with clients
- 95. I foster a willingness to sit with distress in clients
- 96. I help clients objectively view their emotions
- 97. I model the appropriate way to act for my clients
- 98. I believe in the window of opportunity for change
- 99. I am conscious of the connection between me and my client
- 100. I focus on certain emotions as target points
- 101. I have strategies to deal with my emotions that surface during therapy
- 103. I self-care to ensure I manage my own emotions
- 104. I am comfortable with referring clients on when required
- 105. I believe clients often seek to be influenced
- 106. I make clients feel as if they came up with their own ideas/solutions
- 107. I will reschedule a client if I am unable to competently practice

APPENDIX H - Harvey et al. (2016) original dendrogram with items removed





APPENDIX I - Recruitment email to Japanese associations in New Zealand

こんにちは。

この度は、ニュージーランド在住の日本人の皆様、私がマッセイ大学で博士論文の一環として行っている調査研究へのご協力をお願い申し上げたく、このお手紙をさし上げております。

セラピスト（カウンセラー）はクライアント（相談者）への接し方次第で、より高いカウンセリング効果をあげることができるのではないかと考えられています。しかし、ではセラピストにはどのような接し方のスキル（技能）が必要とされるのかという点は、殆ど研究されておられません。

私ども研究班はこの度、求められる接し方のスキルについて幅広く洗い出しを致しました。そこで皆様のご協力を賜り、体系化を図りたいと考えた次第です。今回、特に日本人の皆様をお願いをさし上げましたのは、そのスキルの体系化において、文化的差異がどのような影響をもたらすかについて調べるのが目的です。

この調査にご参加いただく上で、カウンセリング分野についての経験は必要ではありません。また、18歳以上の方であれば、どなたでもご参加いただけます。

皆様のご協力を賜り、最終的には、セラピストがカウンセリングの際に用いる接し方のスキルについて体系化したモデルを作り上げたいと考えております。

私はこの調査にご賛同いただける日本人の大人の方で、カードを分類するタスク（60分から90分ほどの作業です）にご協力いただける方を、少なくとも40人必要としております。タスクを完了した参加者の皆様には、「ニューワールド」で使用できる商品券（20ドル相当）を御礼としてさし上げます。また、関心をお持ちの参加者の方には、調査結果の要約をお送り致します。

このタスクは、クライアントがセラピストについてどう思うかについて、日本人の大人の方の感じ方と、ニュージーランドの大人の方の感じ方を比較する、大変重要なタスクです。また、セラピストの様々なスキルを「似ている／似ていない」という観点から分類していただくタスクですので、興味深い頭の体操とさせていただければ幸いです。

この調査への参加について関心を持っていただけた皆様には、封書で、参加に際しての詳細を記したインフォメーションシート、およびカードを分類する際のインストラクションを含む、すべての必要な情報をお渡し致します。また、参加してみたいがもっと情報が必要という方がおられれば、喜んでお電話さしあげ、ご説明させていただきたく存じます。さらに、参加者募集のためにもしご協力いただける方がおられましたら、大変幸甚に存じます。

よろしくお願い致します。深く感謝申し上げます。

アンドレアス・マーウィック
マッセイ大学（パーマストンノース校）心理学博士課程生

電子メールもしくは携帯電話にご連絡ください：

電子メール 

携帯電話 

(Re-translation into English from Japanese translation)

Hello,

I am writing this letter to ask Japanese people living in New Zealand to take part in a study that I am conducting as part of my doctorate thesis at Massey University.

It is believed that therapists can achieve improved counselling outcomes by applying appropriate skills for interacting with clients. However, there is very little research looking at what interaction skills therapists are required to possess.

We are a research unit and have identified a range of interaction skills necessary. We hope you could help us, so that we will be able to organise them. We are asking Japanese people to help us in particular, so that we can see how language differences impact upon organisation of these skills.

To participate in this research, no experience in the area of counselling is required. Any person of the age 18 or above can participate in it.

With your participation, it is our ultimate goal to generate a model organising the interaction skills that therapists use in practice.

I need at least 40 Japanese adults who agree to participate in this research and do a card-sorting task, which takes 60 to 90 minutes. All participants who complete the task will receive a \$20 voucher redeemable at New World, as a token of our appreciation. Additionally, I will send a summary of the results to participants if they are interested.

This is a very important task as it helps to compare how Japanese adults understand therapist behaviour and how New Zealand adults understand therapist behaviour. Participants will be requested to group various skills of therapists according to how similar or different they think they are. I hope they will find this task an interesting brain-teaser.

Any person interested in participating in this research will receive an envelope of all relevant information including a detailed information sheet about their involvement and instructions for completing the card sort. If any person willing to participate should require further information, I would be very happy to explain over the phone in English. I would also appreciate any assistance you could offer with approaching participants.

Thank you very much in advance. Your help will be very much appreciated.

Andreas Marwick
Doctorate in Psychology student
Massey University
Palmerston North

Please contact me on either:

Email:

████████████████████

Mobile Phone:

██████████

APPENDIX J - Study three research objectives and procedure instructions**セラピストの社交面および情緒面における能力の
マッピングとプロファイリングの有効性について検証する
インストラクションシート****このタスクについて**

このタスクでは、一連の文言について、それらを類似しているかどうかに基づいて分類していただきます。それぞれの文言は、セラピストがクライアントとのセッションの際に重視すると思われる、社交上＝情緒上の行動や哲学を表しています。当研究の結果により、セラピストがセッションの際に利用するそれらの社交上＝情緒上のスキルについて、人々はどのように思うのか、一つのモデルパターンが導きだされることでしょうか。このタスクに取り組む際には、全体で約 60 分必要となります（5 分ほどお取りになっていただき、以下のガイドラインをお読みくださいますよう）。

スタートの前に

目の前に、積み重ねられたアイテムカードが一山（あらかじめよく混ぜておいてください）、回答を記入するためのレスポンスシート、ペンもしくは鉛筆、そして当インストラクションシートをご用意ください。

まずはレスポンスシートをご覧ください、それぞれの文言について回答を記入する場所をご確認ください。ここでレスポンスシートの各タスクのまとめについてご一読いただき、それぞれの段階で何をすることが求められているのか、ざっと把握していただいで結構です。

作業のために大きくて平らな場所をご利用ください。カウンターテーブルに 1 メートル幅ほどの空間があれば、その上でアイテムカードやそれをグループにしたものを拡げられるので、作業がやり易いでしょう。

第一段階：グルーピング

あらかじめ混ぜておいたアイテムカードの山を見てください。一番上のカードの文言を読み、文言の面を見えるように上向きにして、作業台の左上の端に置いてください。続いて第二のカードを読み、それが最初のアイテムカードと同じグループに属するものか、あるいは新たな別のグループに属するべきか、ご判断ください。「グループ」とは、類似しているアイテムカードの集まりで、共通のコンセプトを持つものです。第二のカードが最初のカードと同じコンセプトグループに属すると思った場合は、そのカードを最初のカードの真下に置いてください（即ちコンセプト毎のグループは柱状に縦並びとなります）。あるいは、第二のカードが最初のカードとは関係がなく、新たなコンセプトのグループに属するものであると思った場

合は、そのカードを最初のカードの右隣に置き、新しい柱の最初の一枚にしてください。新たなカードをコンセプト毎のグループに加えるかどうかを判断する際、そのカードとコンセプトとのつながりが説明のつくものであれば、どのようなつながりであっても構いません。コンセプト毎のグループを作る際の判断基準は、ご自身にとって説明できるものであれば、それで結構です。

それでは、全てのアイテムカードを、コンセプトグループ毎に並べてください。アイテムカードを何枚か並べてゆくと、意味がおわかりになることでしょう。コンセプトグループは全部で5つから15まで、但し各グループのアイテムカードの枚数は最も多くても14枚までとしてください。もし、他に類似するアイテムカードがないようであれば、アイテムカードたった1枚のみのコンセプトグループもあり得ます。

では回答の記入です。意味の通るコンセプトグループが出来上がったと満足されましたら（しっかり意味が通るようにするためにアイテムカードを動かしても構いません）、レスポンスシートの回答欄に、各コンセプトグループのアイテムカードの番号を記入してください。このタスクでは、それぞれのコンセプトグループのアイテムカードの番号は、別々の行に記入してください。例として回答欄の最初の行に、6枚のアイテムカードのコンセプトグループを記しておきます（7、22、1...と続くものです。丁寧に読み易い字でご記入ください）。

!!!!!! 重要 !!!!!!

コンセプトグループをそのまま動かさないでください。

後の段階でも利用します。

第二段階：パーティショニング（コンセプトグループ内での細分化）

第一段階で作成したコンセプトグループで、3枚以上のアイテムカードのあるグループは、その中でさらにサブグループに分類することが可能かもしれません（アイテムカードが1枚あるいは2枚のみのコンセプトグループは、サブグループを持ちません）。各コンセプトグループはそのままに、コンセプトグループ間でアイテムカードを動かすことはしないでください。

一つの方法として、各コンセプトグループの中でアイテムカードを動かし、サブグループとなるカード同士を並べ、サブグループ毎に少し空間を空けてみてください。場合によっては、大変類似したアイテムカードばかりのコンセプトグループであれば、サブグループが無い場合もあります。しかし多くの場合は、若干の差異はあるものです。当研究ではその差異について知ることが目的です。

では回答の記入です。サブグループが出来たら、カッコを使ってレスポンスシートに記入し、サブグループがわかるようにしてください。サブグループが出来た全てのコンセプトグループで、第一段階で書いたのと同じ高さの行に、全てのアイテムカードの番号を記入し、但し今回はカッコを使ってどのようなサブグループが出来たかがわかるようにしてください。例としてカッコを使った記入例を示してあります。

第三段階：オポジット（対立グループ）

今度はコンセプトグループ全体を見渡し、コンセプトグループ毎の「共通テーマ」を考えてみてください。即ち、各コンセプトグループのアイテムカードを一つにまとめているテーマです。この段階では個々のアイテムカードではなく、コンセプトグループ全体に焦点を置いていることをお忘れなきよう。

コンセプトグループ全体を見渡しつつ、お互いに真逆であるコンセプトグループ同士（即ち「オポジット（対立グループ）」）を探してください。どのようなアイテムカードの集合でも、一般的に、大変相反したコンセプトグループが2つ3つあるものです。

では回答の記入です。オポジットが一組見つかったら、レスポンスシートの回答欄に、両方のコンセプトグループから一つずつアイテムカードの番号を自由に選び、記入してください（アイテムカードの番号をそれぞれ一つ記入していただければよい理由は単純明快、第一段階で全てのコンセプトグループは記入済みであるので、各コンセプトグループから一つのアイテムカードの番号を選べば、どの番号でもそのコンセプトグループ全体を示すことになるからです）。オポジットは最多で6組まで記入していただけるよう回答欄が設けられています。少なくとも2組のオポジットを見つけてください。

第四段階：アディング（合体）

今度は類似のコンセプトグループを一つに合体していただきます。第一段階で作成済みのコンセプトグループに戻ってください。（第二段階と同様に）コンセプトグループ全体を見渡してください。しかし今回は、コンセプトグループ同士を、一回に一組、つなげてみるという趣旨です。最も類似したコンセプトグループ一組を見つけてください。そして一方をもう一方の所に移動し、合体させてください。これでどのコンセプトグループが一つになったかはっきりとわかるでしょう。合体済みのコンセプトグループに、さらに加えて合体させることも可能です。但し、一回合体したら、元に戻すことはできません。コンセプトグループによっては、他とあまりにも違っているため、合体できないものもあるでしょう。しかし一般的に、コンセプトグループの合体は、少なくとも3件見つかることがあります。

では回答の記入です。合体毎に、レスポンスシートの回答欄に、合体した各コンセプトグループのアイテムカードの番号からどれでも一つずつ選び、組にして記入してください。

当プロジェクトはピアレビュー（研究者同士による審査）による審査課程を受け、低リスクであると判断されました。従って当プロジェクトは、「（マッセイ）大学の倫理委員会」によるレビューは受けておりません。もし、当リサーチの実行に関してもいかなるご心配をお持ちになり、リサーチ担当者以外のスタッフにその旨を述べたいとご希望される場合は、ジョン・オニール教授（リサーチ倫理）にご連絡ください。電話番号：06 350 5249、電子メール：

humanethics@massey.ac.nz

第三段階：オポジット

第一段階のグループを見渡し、最も相反するグループ同士を見つけてください。各グループからどれでも一つずつアイテムカードの番号を選び、「オポジット」として以下の回答欄に記入してください。少なくとも2組のオポジットを見つけてください。ご自身の判断をご利用ください。各コンセプトグループはそのままに、コンセプトグループ間でアイテムカードを移動させてはいけません。

オポジット 1: ____, ____# オポジット 2: ____, ____# オポジット 3: ____, ____#

オポジット 4: ____, ____# オポジット 5: ____, ____# オポジット 6: ____, ____#

第四段階：アディング

第一段階のグループで、最も類似したグループ同士を一つにしましょう。類似したグループを動かして合体させ、合体した各グループからどれでも一つずつアイテムカードの番号を選んでペアを作り、以下の回答欄に記入してください。合体するのは一部のグループのみで、多くのグループは合体しません。少なくとも2組、合体するものを見つけてください。3組以上あれば、続けてそのペアを記入してください。

合体 a) ____, ____# 合体 b) ____, ____# 合体 c) ____, ____#

合体 d) ____, ____# 合体 e) ____, ____# 合体 f) ____, ____#

結果は以下の住所にご送付願います：

郵便番号 4410

パーマストンノース

ファウンテンコート 1 番

アンドレアス・マーウィック

Andreas Marwick

アイテムカードと当レスポンスシート、人口統計用フォームを合わせてご返送ください。また、ご返信いただいた封筒を当リサーチ担当者が受け取り次第、20ドルのスーパーマーケット用商品券をお送りさせていただきますよう、住所を明記していただいた返信用封筒をご同封いただければ幸いに存じます。

お時間をとっていただき、ありがとうございました。☺

もしご質問等あれば、当リサーチ担当者までご連絡ください。電話番号：0211147944、もしくは nz_andreas@hotmail.com まで。

APPENDIX M – Study three item list

1. 患者に対する話し方を調整している
2. 沈黙を活用することに違和感がない
3. オープンな姿勢を体位で示すようにしている
4. 患者をミラーリングしている/患者に合わせている（姿勢や重要な語句など）
5. 相談者（クライアント）を励まし、促すような仕草を返す（うなづく、ふんふんと応える、等）
6. 比率的に見て、自由回答形式の質問の方が（イエスノー形式よりも）多い
7. 特定の効果を引き出したり目的を達成するために、戦略的に回答を利用している
8. アドバイスを与えている
9. 患者の情報をまとめるようにしている
10. 患者の気持ちについて熟考したり、理解した内容を伝えたりしている
11. 感情を深く掘り下げることを奨励している
12. 患者に足りない部分を補って説明してもらおうよう求めている
13. 患者が体験したことについて、直感で推測できることを提案してみる
14. 患者の発言の因果関係など（反復されるテーマや食い違いなど）を記憶に留めておく
15. 患者の感情/行動と過去の体験の関連性を見出す
16. 支援と問題提起を適切に行っている
17. 治療の介入ペースを一定に調整している
18. 治療を一連の段階と捉えている
19. 自分の接し方や治療方法を患者の性格に合わせてカスタマイズしている
20. 患者はよくなると信じている
21. 自分の長所と短所を現実的に捉えている
22. 自分の治療は効き目があると強く信じている
23. 治療の説明に手を加えて、患者の世界観で受け入れられるようにする
24. どのようなことを行っているか、説明している
25. 相談者（クライアント）に対し、自分はセラピストとしてどのような姿勢で相談者に接するかについて説明する
26. 患者と協力して、達成可能な/許容できる目標を設定している
27. しっかりした基本原則を定めている
28. セラピー（カウンセリング）について、相談者（クライアント）と一緒に考え、合意を取り付けておく
29. 自分は関係を変えるための媒体の役割を果たしていると考えている
30. 患者の能力、資質、回復力を強調する
31. 患者は自分にとって何が一番かを知っていると確信している
32. 治療を変化を起こすためのパートナーシップと見なしている
33. 患者には、変わるための動機を自分で見つけることを奨励する
34. 患者の世界観を問題/治療の理論に取り入れている
35. 患者との関係を治療の主なツールであると見なしている
36. 治療関係に繰り返し関与し、前向きに治療関係を終えることができる
37. 患者の否定的な傾向にも生産的に対処できる
38. 患者と冗談を言い合う
39. 自分の感情的な反応は患者の益になっている
40. 患者の経験を患者独自の人生およびその他の体験と関連付けて考えている

41. 自分自身の感情や反応を用いて患者に共感している
42. 患者との関係を患者が意欲を高めるのに用いている
43. 理論を活用して、患者の感情/経験の理解に役立っている
44. 患者の世界観について理解を深めることができる
45. 患者の体験について詳細まで注意を払っている
46. 批判しない態度で接している
47. 患者の心の内面、体験、意欲を正確に認識できる
48. 自分に関する関連性のある情報は開示している
49. 偽りのない考えや気持ちを表明している
50. 人間としての自分に満足している
51. 患者とは誠実につながっている
52. 自分の価値観と行動が一致するように努力している
53. 患者の人間としての価値を尊重している
54. 思いやり、敬意、前向きな態度を伝えている
55. 患者に対する感情的な愛着を規制している
56. 打ちのめされずに感情移入することができる
57. 自分の権力を乱用しないための対策を用意している
58. 自分の信念や価値観を患者に押し付けないようにしている
59. 継続的なトレーニングや学習の機会を積極的に探している
60. フィードバックをオープンに受け入れている
61. 自分の社会文化的背景の影響を認識している
62. 自分の診療に常に疑問を投げかけるようにしている
63. 自分自身の反応を振り返っている
64. 自分の感情的・身体的ニーズを理解し、満たすように努めている
65. 自分でもセラピーを受けている
66. セッションに備えて、自分の感情的準備をする
67. セラピーの最後を、協力的プロセスと捉えている
68. セラピー終了プロセスをセラピー関係の性質に合わせて調整している
69. 霊的な概念に問題なく対応できる
70. 患者の問題に対する文化的な問題の影響を見分けることができる
71. 自分自身と患者の違いについて直接話し合っている
72. 患者との共通性を探す
73. 患者の反応に注意を払っている
74. 正確な判断を下している
75. 決裂には直接対応している
76. 過ちを認め、謝罪している
77. 困難な問題に対して共同で解決方法を求めている
78. 時期尚早に理詰めで解決しないようにしている
79. 人を助けることに価値を見出している
80. 自分の分野について詳しい知識がある
81. 自分は説得力がある
82. 自分は体系的にフィードバックを求めている
83. 患者から遠すぎず近すぎず、快適な距離を取って座るようにしている
84. 常に言語行動と非言語行動を一貫させている
85. 患者に負担をかけない、文化的に適切な方法で軽く触れている
86. 患者の期待を理解し、明確にしようと努めている

87. 患者の考えや気持ちを理解しようと努めている
88. 患者に対する自分の理解を振り返り、フィードバックを求めている
89. 再発・ぶり返しはあるものと想定している
90. 患者には、心を開き、正直になるようにはっきりと奨励している
91. 楽観主義を示している
92. 治療が、相互尊重の雰囲気で行われるようにしている
93. 治療関係は相互に影響を与え合うものだと思信している
94. 自分はセラピーにおいて、安定した信頼できる人物である
95. 理解するだけでなく、行動に移すことを強調している
96. 治療的な環境は、患者がさまざまな行動戦略を試せる場所であると確信している
97. セラピーは時間がかかるものと想定している
98. 自分の専門知識に自信を持っている
99. 患者の体験の意味合いを患者と一緒に探っている
100. 患者が治療の過程で感情レベルで治療に関与できるように配慮している
101. 患者が治療で感情的ペースをコントロールできるように力を貸している
102. 自分自身の体験に感情的に対応できる状態である
103. 患者の体験に感情的に対応できる状態である
104. 患者は自分や自分の臨床判断を信じてくれていると思う
105. 細心の注意を払って治療にあたっている
106. 自分の仕事に満足している
107. 意図的な治療行為を実践している
108. 自分は仕事を通じて個人的にも職業的にも成長している
109. 定期的に個人的なマインドフルネスの訓練に参加している
110. 患者の感情の有効性を認め、評価している
111. 治療の途中で亀裂が生じた場合、認識できる
112. 自分のプライベートな感情的側面は、自分の治療行為に影響を与えらると思う
113. 治療中の自分自身の感情に気付いている
114. 患者は臨機応変であると思う
115. すべての患者は異なるものだと思う
116. 患者の感情を規制するようにしている
117. 患者が治療を受け始めたときよりも悪化したと感じて治療を終えることがないようになっている
118. 患者の情動性を問題とは見なしていない
119. 感情的になった患者には、気持ちを切り替えるよう勧めている
120. 患者が治療で必要とする精神的余裕を与えている
121. 治療の際に自分の感情が役に立つかどうかをモニタリングしている
122. 相手に影響を与える方法について明確に説明している
123. 治療の際は結果を重視する
124. 患者に結果を重視してもらいたいと思う
125. さまざまな新しい治療方法を尊重している
126. 治療における進歩は、急激な変化ではなく、小さな変化の積み重ねであると信じている
127. 自分は速効の有意な変化を期待する
128. 患者ではなく、自分こそが治療のエキスパートであると思う
129. 患者の体験が有効であることを認めている
130. 観察できる患者の感情から、貴重な情報が得られると信じている

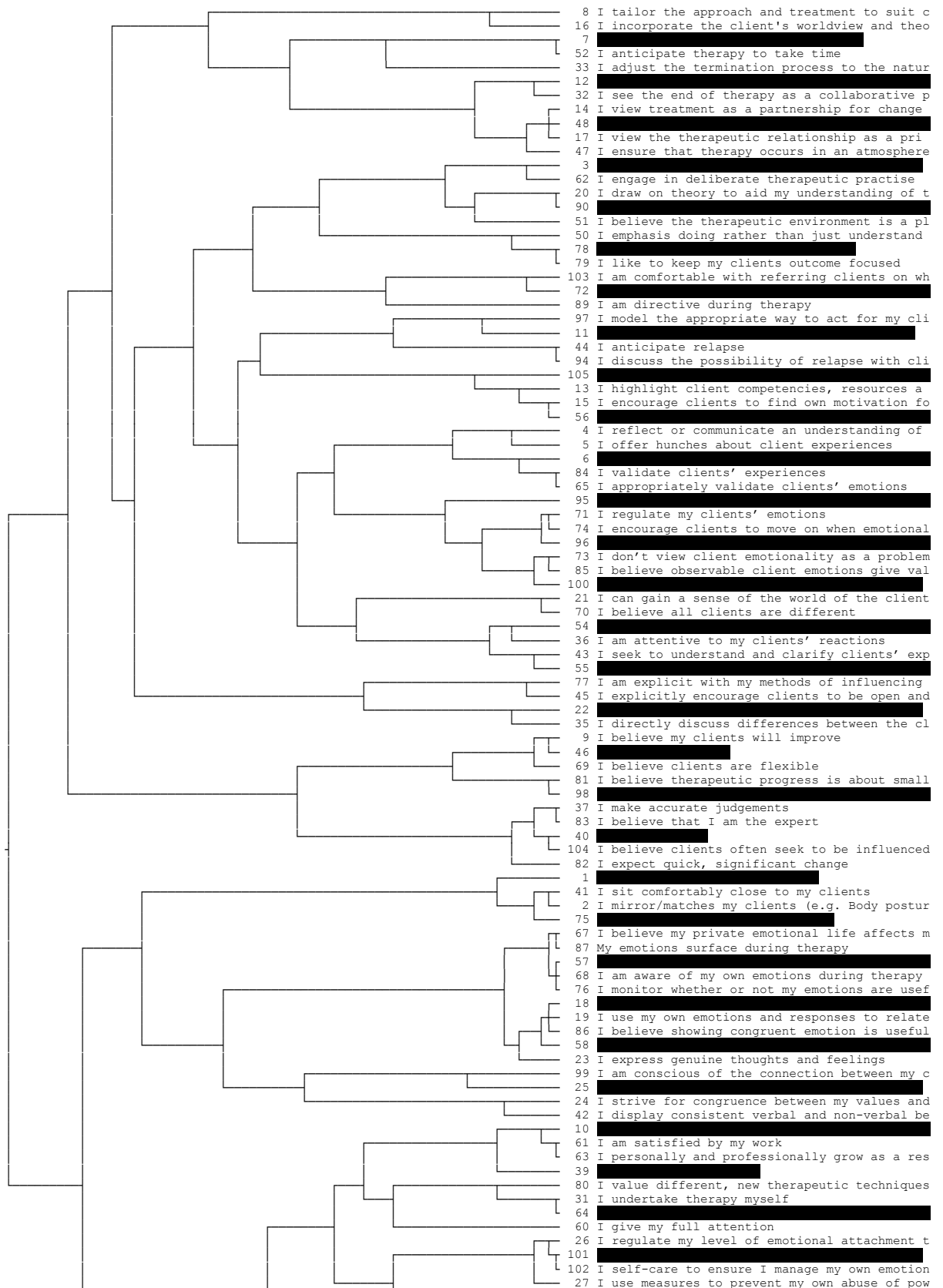
131. 感情が一致していることを示すことは役に立つと思う
132. 治療の間に自分の感情が表面に出る
133. 自分の治療の有効性は、自分にとって重要なことだ
134. 治療の間に指示を出す方だ
135. 患者に学習してもらうために、研究を公然と自分の治療に取り入れている
136. 自分の外観が患者にどのような影響を与えるかを考えている
137. 自分の専門家としての立場を裏付けるような服装をしている
138. 予約の時間を常に厳守している
139. 再発・ぶり返しの可能性を患者と話し合う
140. 相談者（クライアント）に対し、「自分の中の苦しみと向き合ってみよう」という気持ちを育んでいる
141. 患者が自分の感情を客観的に見つめられるように助けている
142. 適切な対応の仕方について患者に見本を示している
143. 変化のチャンスが訪れることがあると信じる
144. 患者と自分の間のつながりを意識している
145. 特定の感情を標的ポイントとして重視している
146. 治療の間に表面化した自分の感情に対する対応戦略がある
147. 自分自身の感情を管理できるように、自分をケアしている
148. 必要であれば他の専門家に患者を紹介することに抵抗を感じない
149. 患者は影響を受けたいと思っていることがよくあると思う
150. 患者が自分自身でアイデア/解決策を思いついたと感じるように仕向けている
151. 自分の治療能力を十分に発揮できなかった場合は、患者の予約を変更する_

APPENDIX N – Study four item list

1. I mirror/match my clients (e.g. Body posture, use of key words)
2. I reflect or communicate an understanding of the client's feelings
3. I offer hunches about client experiences
4. I tailor the approach and treatment to suit client's personality
5. I believe my clients will improve
6. I highlight client competencies, resources and resiliencies
7. I view treatment as a partnership for change
8. I encourage clients to find own motivation for change
9. I incorporate the client's worldview and theory of problem/treatment
10. I view the therapeutic relationship as a primary tool of therapy
11. I use my own emotions and responses to relate to the client
12. I draw on theory to aid my understanding of the client's feelings/experiences
13. I can gain a sense of the world of the client
14. I express genuine thoughts and feelings
15. I strive for congruence between my values and my behaviour
16. I regulate my level of emotional attachment to clients
17. I use measures to prevent my own abuse of power
18. I consistently question my own practice
19. I undertake therapy myself
20. I see the end of therapy as a collaborative process
21. I adjust the termination process to the nature of the therapy relationship
22. I am comfortable addressing spirituality
23. I directly discuss differences between the client and myself
24. I am attentive to my clients' reactions
25. I make accurate judgements
26. I sit comfortably close to my clients
27. I display consistent verbal and non-verbal behaviour
28. I seek to understand and clarify clients' expectations
29. I anticipate relapse
30. I explicitly encourage clients to be open and honest with me
31. I ensure that therapy occurs in an atmosphere of mutual respect
32. I am a stable and reliable figure in therapy
33. I emphasis doing rather than just understanding
34. I believe the therapeutic environment is a place for clients to trial different behavioural strategies
35. I anticipate therapy to take time
36. I am professionally confident
37. I believe my clients trust me and my clinical judgement
38. I give my full attention
39. I am satisfied by my work
40. I engage in deliberate therapeutic practise
41. I personally and professionally grow as a result of my work
42. I appropriately validate clients' emotions
43. I am aware when there are rifts during therapy

44. I believe my private emotional life affects my practice
45. I am aware of my own emotions during therapy
46. I believe clients are flexible
47. I believe all clients are different
48. I regulate my clients' emotions
49. I don't view client emotionality as a problem
50. I encourage clients to move on when emotional
51. I monitor whether or not my emotions are useful during therapy
52. I am explicit with my methods of influencing
53. I like to keep my clients outcome focused
54. I value different, new therapeutic techniques
55. I believe therapeutic progress is about small incremental changes rather than radical changes
56. I expect quick, significant change
57. I believe that I am the expert
58. I validate clients' experiences
59. I believe observable client emotions give valuable information
60. I believe showing congruent emotion is useful
61. My emotions surface during therapy
62. My therapeutic effectiveness is important to me
63. I am directive during therapy
64. I give thought to how my appearance impacts on my client
65. I dress in a way that supports my professional position
66. I discuss the possibility of relapse with clients
67. I model the appropriate way to act for my clients
68. I am conscious of the connection between my client and I
69. I self-care to ensure I manage my own emotions
70. I am comfortable with referring clients on when required
71. I believe clients often seek to be influenced

APPENDIX O – Study four modified dendrogram with items removed



	29	[REDACTED]
	30	I consistently question my own practice
	88	My therapeutic effectiveness is important to
	93	[REDACTED]
	92	I dress in a way that supports my professiona
	91	I give thought to how my appearance impacts o
	106	[REDACTED]
	53	I am professionally confident
	49	I am a stable and reliable figure in therapy
	38	[REDACTED]
	59	I believe my clients trust me and my clinical
	66	I am aware when there are rifts during thera
	28	[REDACTED]
	34	I am comfortable addressing spirituality

APPENDIX P – Study four participant email

You can help us understand therapist behaviours in practice!

The majority of psychological research on therapies focuses on specific techniques. However, little has been done to investigate the emotional and social qualities of the therapist delivering therapy. This study hopes to extend exploration of this important research domain.

You will be given a questionnaire of common emotional-social skills. We want you to identify the degree to which these skills play a part in your practice. Your responses will help us to identify the key emotional-social practices used by clinicians and enable us to categorise practitioners based on their patterns of responding. The entire procedure will only take about 15 minutes.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researchers are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researchers, please contact Professor John O'Neill, Director (Research Ethics), telephone +64 06 350 5249, e-mail humanethics@massey.ac.nz.

If you have any queries or concerns regarding this research, please don't hesitate to contact the researcher at psychologistsort@gmail.com.

If you wish to participate, you can either:

Download this form, complete it on your computer, save it, and return it via email (you may have difficulty filling out this form if you attempt to edit it online in your browser)

Or

Print it, fill it out manually, scan it, and return it via email.

You are welcome to withdraw from this study at any time. Completing this document implies informed consent.

Thank you and we value your participation!

Part 1:

Please complete the following demographic information by typing over the space provided:

Gender	_____
Age	_____
Country	_____
Profession	_____
Years of therapeutic experience	_____
Predominant therapeutic setting	_____

Your name is not required for this study. However, if you are interested in receiving our overall results, please include your email address in the space provided below. It will never be used for any other purpose, nor will this information be made available to anyone else.

E-mail (optional) _____

Part 2: Replace the tick box '☐' with an 'x' to indicate your selection

Please select how frequently the following statements occur in your therapeutic practice:

	Question	Never	Rarely	Sometimes	Often	Always
1	I get along well with my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	My clients and I share a good rapport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	I listen to my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	I feel that my clients reject me as a clinician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	I believe my clients and I share a good relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I feel inferior to my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	My clients and I share similar expectations regarding their progress in treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I feel that I am supportive of my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	It is difficult for me to empathize with or relate to my clients' problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	My clients and I are open with one another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	I am able to take my clients' perspectives when working with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	My clients and I share a trusting relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part 3: Replace the tick box '☐' with an 'x' to indicate your selection**Please select how true the following statements are of your therapeutic practice:**

	Question	Not true at all	Slightly true	Not sure	Mainly true	Very true
1	I mirror/match my clients (e.g. Body posture, use of key words)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	I reflect or communicate an understanding of the client's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	I offer hunches about client experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	I tailor my approach and treatment to suit the client's personality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	I believe my clients will improve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I highlight client competencies, resources and resiliencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	I view treatment as a partnership for change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I encourage clients to find their own motivation for change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	I incorporate the client's worldview and theory of problem into treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	I view the therapeutic relationship as a primary tool of therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	I use my own emotions and responses to relate to the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	I draw on theory to aid my understanding of the client's feelings/experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	I can gain a sense of the client's world	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	I express genuine thoughts and feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15	I strive for congruence between my values and my behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	I regulate my level of emotional attachment to clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not true at all	Slightly true	Not sure	Mainly true	Very true
17	I use measures to prevent my own abuse of power	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	I consistently question my own practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	I undertake therapy myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	I see the end of therapy as a collaborative process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	I adjust the termination process to the nature of the therapy relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	I am comfortable addressing spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	I directly discuss differences between the client and myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	I am attentive to my clients' reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	I make accurate judgements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	I sit comfortably close to my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	I display consistent verbal and non-verbal behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	I seek to understand and clarify clients' expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	I anticipate relapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	I explicitly encourage clients to be open and honest with me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	I ensure that therapy occurs in an atmosphere of mutual respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	I am a stable and reliable figure in therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	I emphasize doing rather than just understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34	I believe the therapeutic environment is a place for clients to trial different behavioural strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35	I anticipate therapy to take time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	I am professionally confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37	I believe my clients trust me and my clinical judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not true at all	Slightly true	Not sure	Mainly true	Very true
38	I give my full attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39	I am satisfied by my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40	I engage in deliberate therapeutic practise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41	I personally and professionally grow as a result of my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42	I appropriately validate clients' emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43	I am aware when there are rifts during therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44	I believe my private emotional life affects my practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45	I am aware of my own emotions during therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46	I believe clients are flexible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47	I believe all clients are different	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48	I regulate my clients' emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49	I don't view client emotionality as a problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50	I encourage clients to move on when emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51	I monitor whether or not my emotions are useful during therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52	I am explicit with my methods of influencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53	I like to keep my clients outcome focused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54	I value different, new therapeutic techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55	I believe therapeutic progress is about small incremental changes rather than radical changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

56	I expect quick, significant change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57	I believe that I am the expert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58	I validate clients' experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not true at all	Slightly true	Not sure	Mainly true	Very true
59	I believe observable client emotions give valuable information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60	I believe showing congruent emotion is useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61	My emotions surface during therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62	My therapeutic effectiveness is important to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63	I am directive during therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64	I give thought to how my appearance impacts on my client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65	I dress in a way that supports my professional position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66	I discuss the possibility of relapse with clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67	I model the appropriate way to act for my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68	I am conscious of the connection between me and my clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69	I self-care to ensure I manage my own emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70	I am comfortable with referring clients on when required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71	I believe clients often seek to be influenced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**APPENDIX Q - Harvey, Marwick, Baken, Bimler, and Dickson (2016)
supplementary article**

Profiling the social-emotional skills of therapists

Abstract

Objective: Greenberg (2002) proposed that emotional skills are central to the therapy process and that skillful use by therapists of client emotion is an essential catalyst to client change. However, the contribution of emotion to the therapy process and how therapists' emotional skills are incorporated into psychological practice is still unclear. With intense emotional interactions occurring in therapeutic encounters careful research is required to investigate therapists' emotional practices with clients.

Method: Using a statistical method for mapping psychological constructs, therapists' emotional practices were transformed into a 'map' with three spatial dimensions, which was supported by comparative reliability checks. The nature of emotional practice was further investigated by administering a Q-Sort of emotional practice items to 47 therapists.

Results: Ten highly applicable clusters of emotional behavior across seven profile patterns with therapists were identified. Tentative links were drawn between demographic data and both clusters and therapist profiles.

Conclusions: These findings suggest therapists' emotional practices can be organized into meaningful clusters and that therapists can be profiled according to their responses across these clusters. Furthermore, gaps identified in the model suggest possible 'blind spots' in the literature. The implications of these findings are significant.

Keywords: emotion, emotional skill, emotional practice, therapist variables, multidimensional scaling, profiling

Introduction

Clients on helpful therapy:

“The counsellors that helped me the most had their own lives together, and it showed”
“At the end of every session I could tell by her body language that she was very engaged by what I was saying, and I felt beautifully listened to, which turned out to be a really crucial part of the healing” (from Jenner, Woolley, & Mortimer, 2006)

Therapy by nature involves both emotions and social interactions. As practitioners, we have observed emotions such as distress motivating clients to attend therapy. We have also noticed clients responding emotionally to the process of therapy. Therapy is also a social process involving two or more people and social behaviors are used in this setting to influence, express and respond to emotions. Increasingly, researchers have found that therapeutic outcome is influenced by more than just the techniques used by therapists (Crits-Christoph, & Mintz, 1991; Luborsky, McClellan, Woody, O’Brien, & Auerbach, 1985; Shapiro & Firth, 1987; Shapiro, Firth-Cozens, & Stiles, 1989; Wampold & Brown, 2005). In addition to therapeutic techniques, variance in outcome can be attributed to variables such as expectancy effects, attributes of the client, what the therapist does outside therapy, and common factors (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Horvath, & Symond, 1991, Lambert & Barley 2001). Common factors include social and emotional factors such as empathy, warmth and therapeutic relationship, and these constructs have been shown to correlate significantly with client outcome (Lambert and Barley, 2001). It therefore seems logical that the success of implementing psychological strategies relies on the presence of common factors to develop and sustain rapport through which the therapeutic process can occur.

As a complex interpersonal event, therapy affords many opportunities to guide clients’ emotions directly and indirectly, the success of which is likely to be reliant on the social and emotional skills of therapists (Ellis, & Conboy, 2004). Indeed, Jenner, Woolley, and Mortimer (2006) found clients repeatedly attributed deep emotional change not to therapeutic techniques or theories used, but to the social and emotional qualities of their therapists. However, research aimed at operationalizing and organizing these qualities is still in its infancy. Sharpley and colleagues investigated the relationship between a variety of therapist behaviors and therapist-client rapport (Sharpley, 1997; Sharpley & Anastasia, 1995a; Sharpley & Anastasia, 1995b; Sharpley, Fairnie, Tabary-Collins, Bates, & Lee, 2000; Sharpley & Heyne, 1993; Sharpley,

Jeffrey, & McMahan, 2006; Sharpley, Munro, & Elly, 2005). To do this, they singled out a number of discrete social and emotional skills hypothesized to affect rapport. Examples of skills included the interruption (or not) of silence and the body posture of the therapist (e.g., leaning towards the client). This work provided useful analysis of individual social and emotional skills; but stopped short of investigating the interrelationship between different practice behaviors. Furthermore, questions remain around the therapeutic influence combinations of these behaviors may have with clients. Such questions provision a clear rationale for the development of a model guiding the selection of social and emotional behaviors for investigation.

Social-emotional skills

The ability to understand and manage emotions in one's self and others involves a sophisticated set of measurable skills known as 'emotional intelligence' (Bar-On, 1997; Mayer, Caruso, & Salovey, 1999). Salovey and Mayer (1990) suggests that emotional intelligence involves four abilities; emotional awareness, emotional facilitation of thought, emotional understanding, and emotional management. 'Emotional competence' includes the four abilities mentioned in Salovey and Mayer's definition of emotional intelligence, but adds social abilities related to emotional expression, empathy, relationships and self-efficacy (Saarni, 1999). The aptitudes associated with both form an integral part in successful social functioning, problem solving, and preventing psychological difficulties (Saarni, 1999). Emotional intelligence and competencies carry the unfortunate connotation that these worthwhile attributes omit the contextual nature of emotion and are innate to a practitioner. However, we believe that such skills can be developed and are interested in establishing the range of discrete social-emotional behaviors evident in therapeutic practice. For this reason, we prefer to use the term social-emotional skills; in that it implies these same qualities can be learned through instruction, practice and everyday experiences, are contextually based, and are therefore directly transferrable to practice. Given the widely accepted benefits of social-emotional skills, it would seem desirable for therapists to understand and cultivate the development of these in their practice. Given the similarities with common factors, it is not surprising that some studies have suggested that social-emotional skills might impact on therapeutic outcomes (Kaplowitz et al., 2011; Rieck & Callahan, 2013).

Current models

There is a paucity of research investigating the underlying relationships between therapists' practice behaviors. The exception to this has been work carried out by Orlinsky et al. (1999) and Anderson, Patterson and Weis (as cited in Anderson et al., 2009). Orlinsky et al.'s (1999) Development of Psychotherapists' Common Core Questionnaire (DPCCQ) is a measure aimed at collecting therapists' personal and professional characteristics. Using factor analysis, they identified primary skill clusters such as basic relational skills, accommodating, investment, affirming, frequent difficulties, avoidant coping, boredom and anxiety (Orlinsky & Rønnestad, 2005). Second-tier structures included healing involvement and stressful involvement were also identified. Instead of therapists' characteristics, Anderson and colleagues developed the concept of Facilitative Interpersonal Skills (FIS), which they defined as a "person's ability to perceive, understand, and communicate a wide range of interpersonal messages, as well as a person's ability to persuade others with personal problems to apply suggested solutions to their problems and abandon maladaptive patterns" (Anderson et al, 2009, p. 759). Their approach was to investigate therapists' relational practice behaviors concepts aligned to the FIS model such as verbal fluency, hopefulness, warmth, persuasiveness, emotional expression, alliance bonding capacity, and problem focus. Initial results by Anderson and colleagues (2009) were promising; suggesting FIS accounted for some variation in client outcomes between therapists.

Orlinsky et al. (1999) and Anderson et al.'s (2009) work identifies the important influence therapists' interpersonal styles could potentially exert on client outcome. However, neither the DPCCQ nor the FIS has comprehensively sampled the domain of therapists' social-emotional skills nor mapped the nature of their inter-relationships. Furthermore, the nature of therapists' social-emotional skills and its relationship to interpersonal styles remains unclear. Moreover, the degree of utility assigned to different social-emotional skills or even how therapists' exhibit styles of social-emotional practice remains largely unknown. These social-emotional therapist skills require further clarification before being linked into a larger unified model, after which associations to client outcomes can be investigated.

This research

Two studies are presented in this paper. The aim of Study 1 is to collect and organize social-emotional skills identified in the literature into a theoretical map so that

interrelationships between social-emotional skills can be viewed and used to understand clusters of social-emotional practice. This will be undertaken using multidimensional scaling, which is a family of multivariate methods that enable researchers to use participant judgments of similarities between items to display perceived relationships between items in spatial representation (Cox & Cox, 1994; Kirkland, Bimler, Drawneek, McKim, & Schölmerich, 2004; Kruskal & Wish, 1978). Using this process, the interrelationships between items thought to encompass a content domain are able to be visually evaluated. Gaps in knowledge are depicted as voids in the solution and are able to guide future investigation. The purpose for Study 2 is to investigate therapists' self-reported use of these social-emotional skills and to evaluate patterns of social-emotional practice. This will be achieved using subjectivity profiling to cluster the behaviors into key recurring themes across participants. These can then be summarized as profiles (common patterns of behaviors).

Study 1: Method

Participants

Thirty four therapists consisting of 22 females, 11 males and 1 unrecorded, were recruited to sort items for MDS analysis. Recruitment of therapists was conducted via snowballing of active therapists known to the research team. The use of convenience samples is considered appropriate with this methodology given the nature of the semantic exercise and opportunistic samples with different demographics have not produced significantly different outcomes (e.g., Harvey, Bimler, Evans, Kirkland, & Pechtel, 2012; Kirkland et al., 2004). This sample size was based on Bimler and Kirkland (1998) and Coxon (1999), who report stable map structures appear after 30 sorts. The ethnicity of this sample included two Māori (Māori are the indigenous people of Aotearoa/New Zealand), 20 New Zealand European or Pākehā (Pākehā is the indigenous term for NZ Europeans), five Europeans, two Chinese, and five unidentified. A convenience sample of 33 non-therapist informants to establish reliability was also recruited to the study. The non-therapist sample consisted of 20 females, 11 male, and 2 unknown; One Māori, 29 Pākehā, and 3 Europeans.

Measures

For the map construction phase of Study 1, a comprehensive pool of specific social-emotional interaction observations ('items') was developed after a) searching the literature extensively for beneficial social-emotional practices of therapists using computerized bibliographic databases, and b) manually searching for references of previous relevant papers. Searches were conducted through Discover, which contains the databases PsycINFO, Mental Measurements Yearbook, Business Source Complete, ERIC and Health Databases on EbscoHost. A comprehensive search of the literature on social-emotional interactions of effective therapists was conducted from 1970 through to present. Keywords (where * indicates truncation) entered as search terms into the subject term search included (therap* OR psycholog* OR counsel* OR practition* OR psychotherap* OR Psychiat*) AND (master therap* OR exemplar therap* OR therap* variable* OR therap* effect* OR supershrink*) AND (emot* OR emot* intelligence OR emot* competenc* OR emot* skill*) AND (therap* variability OR therap* effect* OR therap* outcome* OR outcome* OR excellen* OR effective* OR therap* success). These keywords identified 1,302 papers. A member of the research team read through headings and abstracts and conducted associated reference searches. When it was

unclear from the title and abstract whether the report detailed therapists' beneficial social-emotional practices, an inspection was made of the full report. Of the 351 papers identified through this initial review process, 38 reports were identified that contained specific information referring to therapists' social-emotional practices that could be sourced. These papers were read in full and 181 descriptions of social-emotional practices were extracted and arranged according to themes. Descriptors were independently rephrased as items by the authors and differences in wording and item inclusion were resolved through discussion. Whenever descriptors were judged to represent the same behavior, these were combined into a single item, resulting in a total set of 167 items. It was noted that the majority of items sampled from the literature appeared to be derived from researchers' and/or therapists' perspectives.

Coxon's observation (1999, p.12) that "...sets of around 100 [items] are fairly common, [and] sets of 40 or so are most common" was taken as a guideline. Though a process of refinement, central themes were distilled down from 167 to 109 therapist items by the identification of nearly-synonymous items and the removal of redundancies by three of the authors. Each item was printed onto a small 75mm x 35mm (1.5 x 3.0 inches) thin colored card with an accompanying number. Items were typically short pithy statements such as: "Encourages exploration of feelings", "Addresses ruptures directly", "Sits comfortably close to client", "Reflects on what they could do better" or "Is persuasive". They were intended to be neither so broad as to be answered by general affective response rather than by observations, nor to be so fine-grained as to miss the emotional practice altogether. Estimates of similarities among the items were obtained by having participating experts sort them into groups according to perceived meaning. These similarities were summarized as a three-dimensional map representing the dimensional organization underlying the items. Several steps were taken to evaluate reliability. The map was first replicated using data from non-therapists. Second, a combined map was generated and then compared back to their original source maps. Finally, a split-half analysis of the combined map was conducted.

Procedure

Judgments of semantic similarity among the items were elicited with the 'GOPA-sorting' procedure (Coxon, 1999). The deck of item cards is shuffled into a random order and participants are asked to arrange them into groups (**G**) of relatively similar items, i.e. closely-related behaviors. Having recorded these groups, participants are

asked to identify which are the most opposite or dissimilar (**O**). The partition phase (**P**) asks participants to impose a higher similarity threshold and subdivide each group of cards into smaller subsets. The final addition phase (**A**) asks participants to relax the similarity threshold and combine item groups into larger, looser groups (Bimler & Kirkland, 2002; 2003).

Analysis and Reliability Check

The data were converted into numerical similarity values, for analysis with MDS. The value for any pair of items is essentially the fraction of the participants' grouping arrangements in which those two items were grouped together. A pair that were never placed in the same group by anyone, even at the end of the A phase, receive a similarity value of 0. Conversely, a pair that was always grouped together, even in the finer subgroups created in the P phase, receive the maximum value of 1.

MDS converts the participants' judgments into a three-dimensional geometric space in which each item becomes a single point, located so as to represent the relationships between them. Items perceived as highly similar are shown as clustering closely, while dissimilar items appear in distant geographic locations. The goodness-of-fit between distances and perceived similarities is measured by an index called '*Stress*₁', which is minimized iteratively by moving the points to their final locations (Kruskal & Wish, 1978).

The emergence of a geometrical, dimension-based model of a conceptual domain from MDS is no guarantee that all or any of its dimensions are meaningful. Thus, we prefer to confirm the model's stability by measuring the agreement between independent maps. Here, separate solutions for the therapist and non-therapist data were compared, followed by a 'split-half' test in which the GOPA participants were assigned randomly to two same-size groups and MDS applied to each group's data in isolation. Three indices of agreement were applied in each of these comparisons. (1) We calculated the Cophenetic correlation r between corresponding inter-point distances. This value indicates the overall correlation between maps by measuring and comparing the distances between items within each map: The higher the correlation, the greater the agreement. (2) The second index is "Procrustes Distance", (g_1), which compares individual points rather than pairs. This index is the normalized sum of residual or inter-item distances between corresponding points in two maps, after they have been reflected and rotated to bring each point in one map as close as possible to its counterpart in the

other. The smaller the value of g_1 , the greater the agreement. (3) Canonical correlation or CANCECORR, a form of multiple analysis of variance, calculates the number of independent dimensions in one model that have recognizable, statistically-significant counterparts in the second model. Canonical correlation maximizes correlation (R_c) by selecting a pair of linear combinations from two datasets. Further extractions are conducted sequentially, (providing correlations R_2, R_3, \dots, R_p), up to the dimensionality of the solution, with each pair of linear combinations being orthogonal to the previous ones (Harris, 2001). Loosely speaking, both solutions are rotated to new axes so as to maximize the correlations between the coordinates of corresponding points along the first axis, then the second, and so on. Wilks' lambda statistic is a significance test of each correlation.

Study 1: Results

The reliability of the three-dimensional map created was evaluated first. Given data were collected from therapist and non-therapist samples, two solutions were generated and compared both separately and in combination. Cophenetic correlation suggested the two solutions are not identical, though similar ($r = 0.69$). The combined map is closer to the therapist-only map ($r = 0.93$) than to the non-therapist-only map ($r = 0.81$), which may mean that the non-therapist informants have 'noisier' responses. An implication of this is if therapists agreed more amongst themselves, their responses are likely to dominate the combined map. The residual Procrustes Distance between the therapist and non-therapist map was correspondingly low ($g_1 = 0.059$). Across the therapist and non-therapists map, all three axes correlated significantly ($R_c = 0.919$, $R_2 = 0.870$, $R_3 = 0.535$, $p < 0.0001$), according to Wilks' lambda test. All three axes had a recognizable counterpart in the other solution. It appears that the social-emotional behaviors of therapists are perceived in a stable way across both therapist and non-therapist samples. It is worth noting that the divergence between separate solutions for non-therapist and therapist samples was not larger than the divergence between the two randomized half-samples discussed in the following paragraph, suggesting there is no evidence that divergence is anything other than random. For three-dimensional solutions, $Stress_1$ values (goodness-of-fit) were 0.205 for the combined data, and 0.216, 0.225 for both of the separate maps. This is considered acceptable by typical standards of interpretation (Kruskal & Wish, 1978). Decreasing the dimensions to 2 increased the $Stress_1$ to 0.290; increasing to four dimensions reduces $Stress_1$ to 0.158; and a fifth dimension brings a smaller incremental improvement (to 0.125). We decided to work with three dimensions as providing an optimal and interpretable solution.

Internal consistency of the combined solution was evaluated using split half analysis. Data from 67 participants were split into two halves using odd and even numbers and analyzed separately. The cophenetic correlation between odd and even solutions was moderate to high ($r = 0.66$). Moreover, the cophenetic correlation was high between odd and combined solutions ($r = 0.90$) and also, between even and combined solutions ($r = 0.75$). This suggests an adequate sample size was recruited for their consensus model to stabilize, and that the model would not change significantly with more subjects. In other words, therapist sample was representative of the wider population, and the solution is general. Thus the combined therapist-and non-therapist

map was chosen as the preferred solution due to its high correlation across all three dimensions and low residual distances.

A perspective view of the three-dimensional map with item location is shown in Figure 1. The map has been split into two hemispheres (D1+ and D1- halves) to ease interpretation. The 109 items are projected onto the surface of a hollow sphere and each half is flattened with the Stereographic projection to see the distributions of items (as an atlas might present the North and South hemispheres). The D1 axes are at the center of the circle and the outer circle represents the 'equator' where $D1 = 0$, where the two hemispheres meet. The center and middle circles equate to 30° and 60° angles respectively away from the D1 axes. Notable themes corresponding to item clusters have been identified on this map.

The symbols represent the items' membership of clusters with identifiable social-emotional themes (identified below), such as therapy collaboration, tailoring, rupture repair, emotional connection, summarises/links, understand, microskills, positive regard, structure, professionally self-aware, seeks feedback/improvement, emotional boundaries, and cultural competence. Examining the items clustering on the three dimensional map at the limits of the three dimensions enables interpretation of those dimensions along the following continuums: d1) *emotionally aware of client* (i.e., aware of clients' emotions) to *emotionally self-aware*, d2) *discrete behaviors* to *therapist collaboration with client*, and d3) *therapist's beliefs* (i.e., about client and therapy) to *structure*.

Using this method of three-dimensional mapping, when the conceptual domain is sampled comprehensively, the map representation is like a sphere with items generally placed at regular intervals around the surface. A "hole" or void indicates the absence of a content domain. We found an even coverage was generally the case in Figure 1; however, the sampling of the concourse by items wasn't evenly spread. Instead, some local concentrations/clusters were evident in the split-hemisphere view and a void is present to the right of the -D1 hemisphere, i.e. stretching between the -D1 and +D2 poles. A hierarchical cluster analysis was conducted to identify recurring themes and groupings and the items that comprise them more clearly (see Appendix A). Hierarchical clustering represents similarities among items are represented in the form of a tree diagram or dendrogram, and the degree of similarity between items relates to the height of the connection an item "branch" shares with others. The existence of 'holes' or discontinuities among items – any unevenness in their distribution across the domain – contribute to this clustering.

Discussion/link

The arrangements of data suggest most content domains were represented and the maps were considered stable. Whilst a void was identified on the surface of the combined model thus indicating a potential content domain not yet covered, exploration of this possible gap is currently beyond the scope of the present research. As there is a distinct possibility that therapists' behaviors exist which have yet to be identified in the extant literature, the capacity to visualize content 'voids' is one of the important reasons to apply this exploratory MDS analysis to therapists' "working models" of therapy. Future research could focus on exploration of social-emotional practices that may be missing from the extant literature via use of working models to guide their investigations. First however, additional research is required to distil what is currently known as essential elements of emotional practice and how they are represented in practice. By using the combined model identified during Study 1 to interpret therapists' responses regarding their practices, elucidation of both salient social-emotional practices and therapists' practice styles may be determined.

Despite the considerable knowledge to be gained from understanding therapists' styles, to date, no empirical research has produced reliable and valid therapeutic styles that can be generalized across clinicians. Attempts have been made in personality research, however, these findings have been questionable with no clear consensus achieved (Dolan, Arnkoff, & Glass, 1993). The purpose of Study 2 is to investigate essential social-emotional practice elements and to profile how these are expressed across clinicians.

Study 2: Method

Participants

The participants in the second study consisted of 47 therapists or counsellors recruited by email, word of mouth, phone and personal contact. There were 15 (31.9%) men and 32 (68.1%) women. Pākehā/European New Zealanders made up 74.5% (n = 35) of participants, while 10.6% (n = 5) were from the USA and 14.9% (n = 7) were from elsewhere. Participants were distributed relatively evenly based on age with 31.9% (n = 15) of participants aged less than 41, 27.7% (n = 13) of participants aged between 41 and 50, and 40.4% (n = 19) of participants aged over 50. Cognitive Behavioral Therapy was the therapeutic approach indicated by 36.2% (n = 17) of participants, while 44.7% (n = 21) of participants associated themselves with an Eclectic approach and 19.1% (n = 9) of participants followed an approach not otherwise classified. Participants' years of experience were skewed with 47.9% (n = 23) having less than 11 years of experience, 27.1% (n = 13) having between 11 and 20 years of experience, and 25% (n = 12) having over 20 years of experience. Lastly, responses were collected by email administration from 32 (68.1%) participants and manually in person from 15 (31.9%).

Materials

A representative sample of 51 English-language social-emotional practice items were selected from the 109 item pool established in Study 1. Selected items were personalized in the first person due to the target sample being therapists (e.g. from *Considers therapy an interactive process* to *I consider therapy an interactive process*). Item selection was supplemented by analysis of the dendrogram thus ensuring that eliminated items were redundant or unrepresentative.

Item reduction rationale. The number of items was reduced through information from the dendrogram (Appendix A) to minimize the burden on participants. A dendrogram is way of summarizing similarities among items which represents them as a tree diagram which progressively branches off a line and the degree of similarity between items corresponds to the height of the intersection an item branch shares with others. There were eight items that the dendrogram and 3D map showed were very closely linked to the 'microskills' domain and it was judged that the domain could be represented by a single item and so the other seven items were excluded. For the remaining 102 items every second item in the dendrogram was taken for use in this study. Taking every second item when arranged in this format reduces the risk that

items representing entire domains of content are unknowingly removed. Elimination of items by this process was considered appropriate as this method has been used in past research (Bimler & Kirkland, 2001; Kirkland et al., 2003).

Procedures

To access local potential participants a two-phase Q-sorting procedure was administered via an in-person approach, while a rating procedure was used to access distant potential participants. The method used by participants was not considered as a large enough factor to affect the results, but it was recorded for comparison during analysis.

In the email formatted approach to data collection, participants were sent an email consisting of an instructions page, a demographics form and a questionnaire composed of the 51 statements previously discussed. Participants read each statement in the questionnaire and selected one of five options available to them regarding how true that statement was to their practice. The options available were “very true”, “mainly true”, “unsure”, “slightly true” and “not true at all”. Upon completion of all items, participants were instructed to return the completed email from which data were recorded and stored electronically.

During the in-person data collection procedure, participants read through an instructions page before filling out a demographic form and entering the testing phase of this study. In the testing phase, participants were instructed to sort one item at a time into one of three piles available (“more true”, “less true” or “unsure”) depending on how true that item’s statement was of their practice. They continued doing this until all 51 items were sorted. Upon completion of this phase, participants were shown the items again, one at a time, and were instructed to reorganize them into one of three more available piles. The piles available for selection were dependent on which pile the item was initially placed in. Specifically, if organized into the pile of “more true” during phase one of sorting, participants had the option of placing that item into the piles of “very true”, “mainly true” and “unsure”. Conversely, if participants placed the item into the “less true” pile during phase one sorting, than they would have the option of placing that item into the piles “slightly true”, “not at all true” and “unsure”. Additionally, if placed in the “unsure” pile during phase one sorting, participants had the option of placing that item into the piles “mainly true”, “unsure” and “slightly true” during phase two. Participants were able to review and change their responses at any time during phases one and two of sorting and no constraints were placed on the number of cards

each pile was required to have. Upon completion of phase two, data were recorded and stored electronically.

These rating and ranking self-descriptions were submitted to a data-reduction method known as “subjectivity profiling” or “hotspot modelling.” The goal of this procedure is to classify a small number of interrelated items, analogous to factor analysis but informed by the three-dimensional combined model established in Study 1 (e.g., Harvey, et al., 2012; Bimler, Evans, Kirkland, & Pechtel, 2012; Kirkland et al., 2004). Each group of interrelated items is established as relating to a specific and separate theme or domain otherwise known as a “hotspot”. This hotspot becomes an abstract point on the model and is located within its neighborhood of interrelated items. The proximity of each item to a hotspot’s location denotes how well that item defines that hotspot’s content. By summing the values given by participants to each item – weighting those values according to each item’s proximity to the hotspot – a score is produced describing the extent to which that hotspot plays a role in a therapist’s practice. A core meaning for each hotspot is abstracted via researcher judgment primarily based on reviewing the items encompassed by that hotspot with a greater focus on items most proximal to that hotspot, i.e., items with the highest weights. An iterative algorithm progressively adjusts the hotspots’ locations. This method is not unlike other methods such as Preference Mapping (Carroll, 1972) and Concept Mapping (Trochim, 1989).

A preliminary factor analysis of the responses provided possible candidates for hotspots. Scree Test analysis and the Monte Carlo PCA for Parallel Analysis estimated the complexity of the variance across participants, i.e. the approximate number of profile clusters they required.

Subsequent to hotspot generation, individual responses can be presented as idiographic summaries across the set of identified hotspots thus eliciting that individual’s specific profile of responding. Ultimately, the goal was to divide the sample into collections of participants who described themselves in a similar pattern and to characterize the response pattern that differentiates each collection. Hotspot modelling facilitates this partitioning, by smearing out any ‘noise’ in the responses at the level of individual items.

The process involved entering each participant’s responses to the item sorts into a spreadsheet that ipsatized or standardized the values to z -scores, then obtained several weighted averages to condense them to a profile. Agglomerative hierarchical cluster

analysis was applied to the profiles, using Ward's (1963) method and Squared Euclidean distance to assess proximity, to determine the number of clusters for *k*-means analysis. Hierarchical cluster analysis was run on combined participant responses and dendrograms with resultant agglomeration schedules examined.

Using *k*-means clustering, summary profiles (the mean profile of all profiles in that cluster) were created from these 47 profiles and subsequently each participant profile was categorized according to the summary profile that it most resembled. *K*-means cluster analysis assigns cluster membership by maximizing the differences between cluster centroids while minimizing within cluster variance.

Study 2: Results

Hotspots

Ten regions of the most prominent or similarly-rated items formed the optimal approximation of response patterns (hotspots): within each neighborhood, items might be endorsed or rejected, but tended to behave in parallel. Themes based on the items most relevant to the ten hotspots are presented in Table 1. The items' order in the list dictates how proximal that item was to the cluster's core thus indicating which items contributed most to a hotspot's interpretation. Differences were observed based on item format (either "I" statements or descriptions). Non-italicized items were those changed for use in this current study. Italicized items on the other hand, were not used in this study and although they remain unchanged, still represent the most proximal items to the hotspot's location.

With the exception of *feeling in context*, *therapeutic use of own experiences* and *verbal easing*, the general recovery of neighborhoods interested as *self-reflective critique* (i.e. *open to feedback and current in literature*), *balanced collaboration*, *tailoring therapy* (i.e. *individualizing therapy*), *client empowerment*, *behavioral expressions*, *expert role*, and *self-secure* were consistent with the clusters emerging from MDS and HCA in Study 1. Table 2 also below visually displays dendrogram clusters, MDS clusters and hotspot.

Table 1.
Hotspots

Hotspot description	Hotspot items
<p>Feeling in context. The ability to make meaning of client experience.</p>	<p>I note links in what the client is saying (e.g. Recurring themes, discrepancies), <i>Encourages exploration of feelings, Links the client's feelings/experience, Offers interpretations of the client's feelings/experiences</i>, I seek to understand the client's thoughts/feelings.</p>
<p>Self-reflective critique. The desire to learn and improve.</p>	<p>I systematically seek feedback, <i>Persistent and believable when seeking honest feedback, Actively seeks ongoing training and learning opportunities</i>, I monitor my performance, <i>Reflects on what they could do better.</i></p>
<p>Therapeutic use of own experiences. The therapist using their own emotional experiences to relate to their client.</p>	<p>I use my own emotions and responses to relate to the client, <i>Relates the client's experiences to their own life and experiences</i>, I disclose relevant information about myself, I believe my emotional responses are beneficial for the client, <i>Believes client will improve.</i> [numbers of items?]</p>
<p>Balanced collaboration. The ability to collaborate with clients throughout therapy.</p>	<p>I seek joint solutions to difficulties, <i>Sees the end of therapy as a collaborative process, Collaboratively establishes a therapy agreement</i>, I consider therapy an interactive process, I collaborate with my client to set attainable/acceptable goals.</p>
<p>Tailoring therapy. The therapist tailoring their approach to suit the client.</p>	<p>I modify my explanation of treatments to make it acceptable to client's worldview, <i>Incorporates the client's worldview and theory of problem/treatment</i>, I tailor my approach and treatment to suit client's personality, <i>Adjusts how they relate (according to the needs of the client), Adjusts level of formality to suit client.</i></p>

Client empowerment.	I ask the client to fill in missing pieces, <i>Seeks to understand and clarify client expectations, Offers interpretations of the client's feeling/experiences</i> , I highlight client's competencies, resources and resiliencies, I reflect and seek feedback about my understanding of the client.
The therapist's desire to encourage the client.	
Behavioral expressions.	<i>Nods</i> , I use appropriate eye contact, <i>Leans forward, Smiles, Open body postures.</i>
The use of discrete behaviors in therapy.	
Verbal easing.	I banter with clients, I communicate unconditional warmth, <i>Communicates a caring, respectful, positive attitude, Mirrors/Matches clients (e.g. Body posture, use of key words)</i> , I am non-judgmental.
The ability to verbally communicate with warmth.	
Expert role.	I give advice, <i>Is persuasive, Summarises information for clients, Makes accurate judgments</i> , I set firm ground rules.
The therapist leading clients through therapy.	
Self-secure.	<i>Values helping others, Is comfortable addressing spirituality</i> , I can empathise without being overwhelmed, I express genuine thoughts and feelings, <i>Avoids imposing their own beliefs and values on clients.</i>
The therapist's strong sense of self.	

Note. All items not used in this specific study are italicized in this table.

Table 2.
Comparison of dendrogram, clusters, and hotspots.

Dendrogram	Multidimensional Scaling Map Clusters	Hotspots
Therapy collaboration (1)	Therapy collaboration	Feeling in context
Believes in client (2)	Therapists client beliefs	Self-reflective critique
Tailors therapy (3)	Tailors therapy	Therapeutic use of own experiences
Disengagement skills (4)	Emotionally aware of client	Balanced collaboration
Rupture repair (5)	Response to connection issues	Tailoring therapy
Involves real self (6)	Client determination	Client empowerment
Summarizes/Links (7)	Language use	Behavioral expressions
Understands (8)	Clarifies	Verbal easing
Microskills (9)	Discrete behavior	Expert role
Directive (10)	Guides	Self-secure
Believes in therapy (11)	Therapists beliefs	
Positive regard (12)	Positive emotional connection	
Structure (13)	Structure	
Knowledge (14)	Current in literature	
Professionally self-aware (15)	Emotionally self-aware	
Seeks feedback or improvement (16)	Open to feedback	
Emotion regulation (17)	Emotion regulation	
Culturally competence (18)	Culturally aware	
	Emotionally Reflective	

Profiles

Hierarchical clustering of the 47 participants' profiles, scoring across 10 hotspots, pointed to seven clusters of comparable profiles in the data set, as the point in the agglomeration schedule where the trade-off between within-cluster and between-cluster variance was optimal. The "elbow test" within Factor Analysis supported this number. Subsequently, to aid in assigning participants to these seven clusters, *k*-means analysis was applied with $k = 7$, using that stage of agglomerative HCA as 'seeds' for the *k*-means iteration. Therapists were distributed across clusters as follows: Of the overall percentages, cluster 1 accounted for 15%, cluster 2 for 19%, cluster 3 for 19%, cluster 4 for 11%, cluster 5 for 19%, cluster 6 for 11% and cluster 7 for 6%.

The trends in each profile are a combination of the weighted values assigned to each item by participants of a respective cluster, summarized across ten hotspots. A high positive value on a single hotspot signifies the presence of that particular parameter, whereas a high negative value on a single hot spot reflects the absence of that particular parameter. An assigned value of zero for a hotspot demonstrates that that parameter was unnoticed. See Appendices B and C for demographic data associated with each profile and a brief outline of each profile, respectively.

The summary profiles are plotted in Figures 2 to 8. For convenience, similar shaped profiles are grouped together. Profiles are representations of respondent's priorities around emotional and social philosophies and behaviors. Certain hotspots are consistently negative or positive throughout yet the profiles vary on the magnitude of these values. Such consistencies evident are the negative values associated with *therapeutic use of own experiences* and *expert role*, and the positive values associated with *balanced collaboration*, *tailoring therapy*, *client empowerment* and *behavioral expressions*. Additionally, all values on *behavioral expressions* except those from Profile 7 were within 2 points of one another signifying that this emotional behavior was relatively stable across all profiles. Differences between profiles are considered below, along with a detailed demographic description of therapists associated with each cluster.

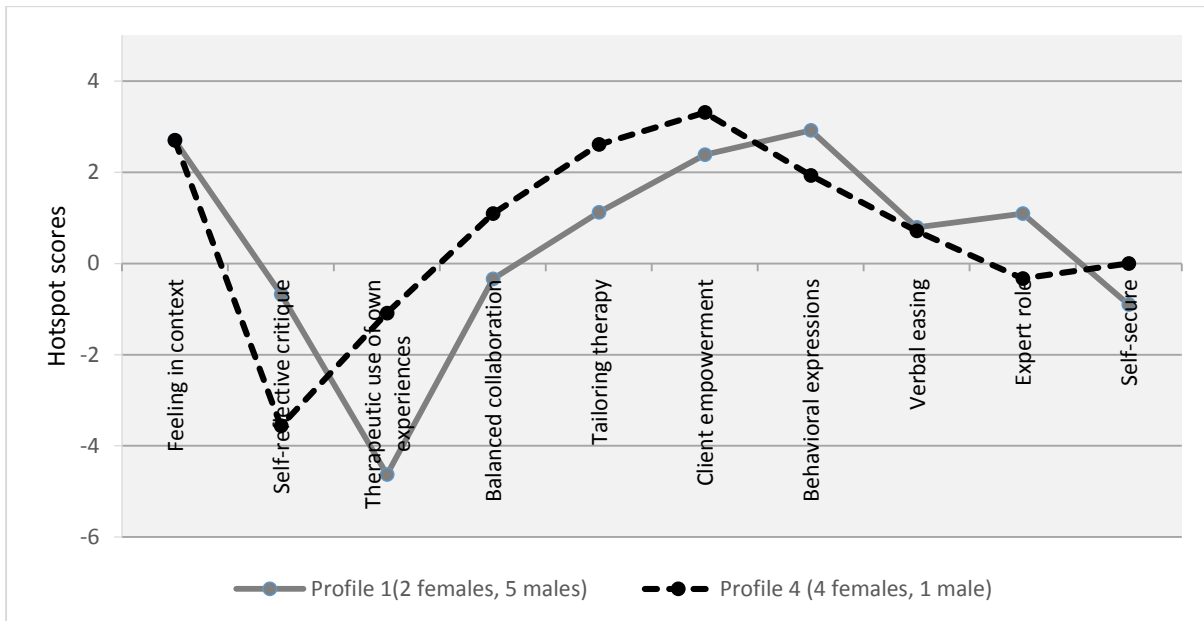


Figure 2. Profiles 1 and 4 with their respective hotspot scores reported by 15% and 10% of participants, respectively.

Profile 1 involved 15% ($n = 7$) of therapists who preferred *feeling in context*, *clarification*, *expert role* and *behavioral expressions*. Profile 1 had the largest negative value of *therapeutic use of own experiences*, suggesting the absence of this practice and the only profile to demonstrate the presence of *expert role* behavior. Profile 1 contained the highest number of males (33% of the overall sample), the largest proportion of participants aged over 50 ($n = 4$), and an even distribution of therapeutic models and years of experience. Similar to Profile 1, Profile 4 (11% of participants; $n = 5$) emphasized high positive values for *feeling in context* and a low negative value for *therapeutic use of own experiences*. This profile additionally reflected high positive values in *tailoring therapy* and *client empowerment* and the highest negative value in *self-reflective critique*. Low positive values were noted for *balanced collaboration* and *verbal easing*. Four participants were females and one male in this profile, and were evenly distributed across age groups, theoretical models, and years of experience.

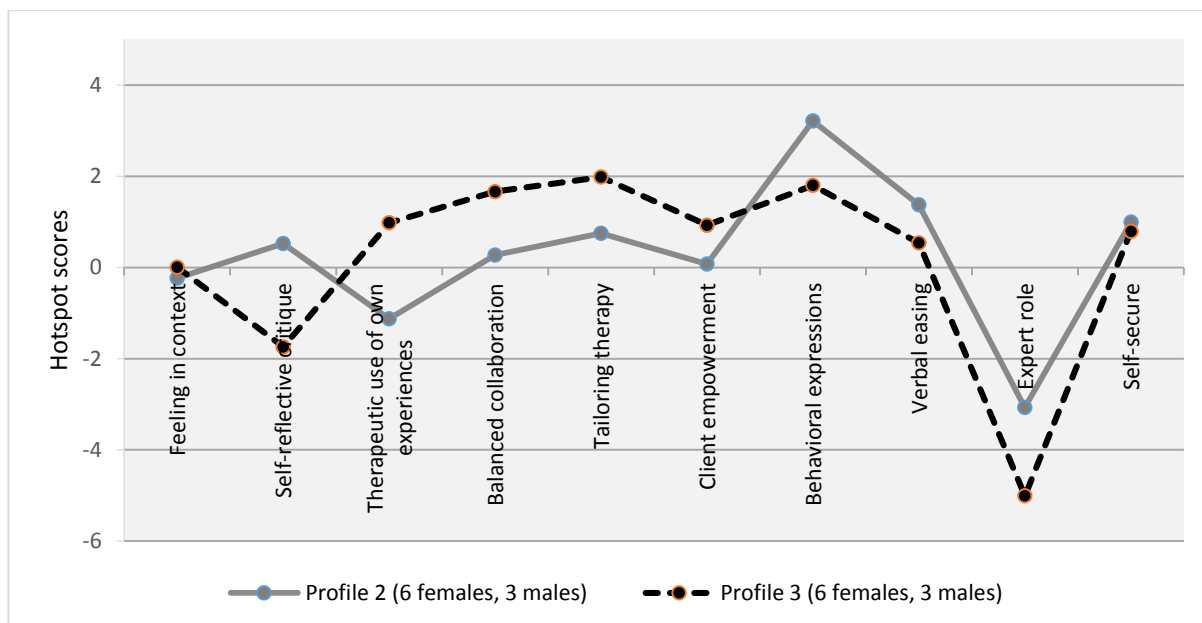


Figure 3. Profiles 2 and 3 with their respective hotspot scores each reported by 19% of participants.

Profiles 2 and 3 were characterized by large negative *expert role* values and this was particularly evident in Profile 3, which had the largest negative value on this compared to other profiles. Profile 2 on the other hand, had the largest positive value of *behavioral expressions*. These two profiles were similar on *balanced collaboration*, *tailoring therapy*, *client empowerment*, *verbal easing*, *self-secure* and *feeling in context*. The main divergence between Profiles 2 and 3 were with *therapeutic use of own experiences* and *self-reflective critique*: *Therapeutic use of own experiences* was negative for Profile 2 positive for Profile 3. *Self-reflective critique* was zero for Profile 2 negative for Profile 3. Profiles 2 and 3 were similar demographically: Each accounted for 19% of participants ($n = 9$), had six females and three males, and age groups were evenly distributed. Moreover, each profile had four participants who were eclectic in practice (and the remainder were mixed) and most had less than 10 years' experience ($n = 5$).

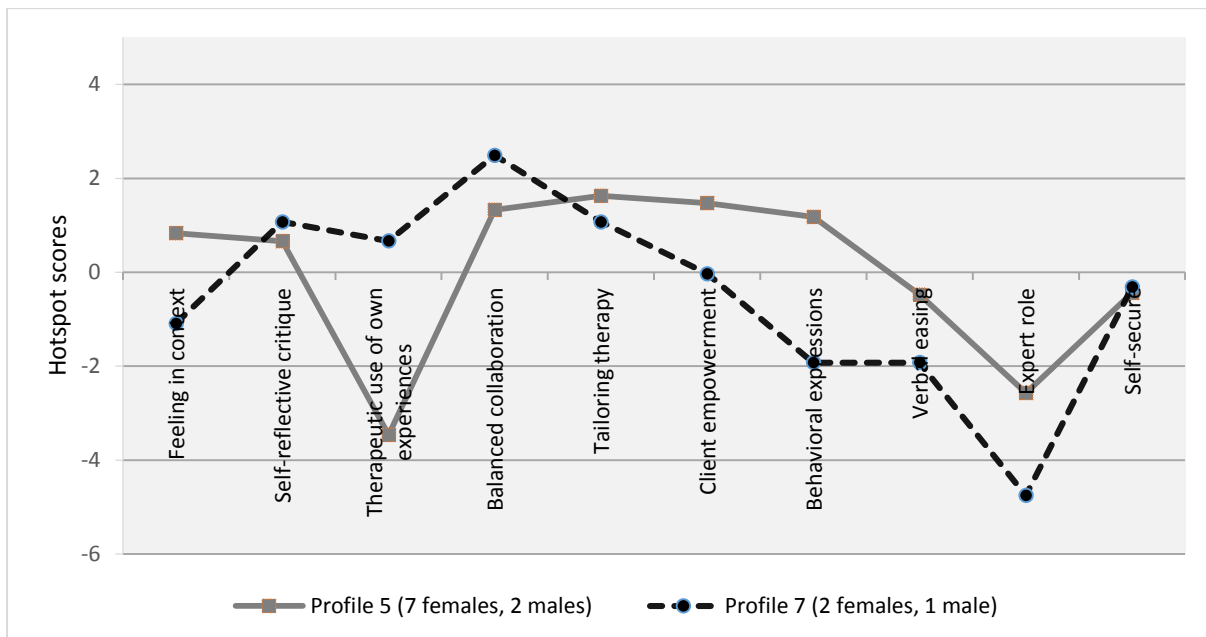


Figure 4. Profiles 5 and 7 with their respective hotspot scores reported by 19% and 6% of participants, respectively.

The positive values on Profile 5 were low for *feeling in context* and *self-reflective critique* and high on *balanced collaboration*, *tailoring therapy*, *client empowerment* and *behavioral expressions*. Correspondingly, high negative values existed for *therapeutic use of own experiences* and *expert role*. It contained 19% of participants overall ($n = 9$), seven females and two males, the majority were aged between 41 and 50 ($n = 5$) and primarily used CBT ($n = 7$; 41% of all CBT participants). When regarding years of experience, both less than 11 years and between 11 and 20 years groups had four participants each and more than 20 years only had one participant. Profile 7 only contained 3 participants, two females and one male. It contained the highest positive value on *balanced collaboration* and the most negative values on *feeling in context*, *client empowerment*, *behavioral expressions* and *verbal easing*. This profile 7 also displayed low positive scores on *self-reflective critique*, *therapeutic use of own experiences* and *tailoring therapy* and a high negative score on *expert role*.

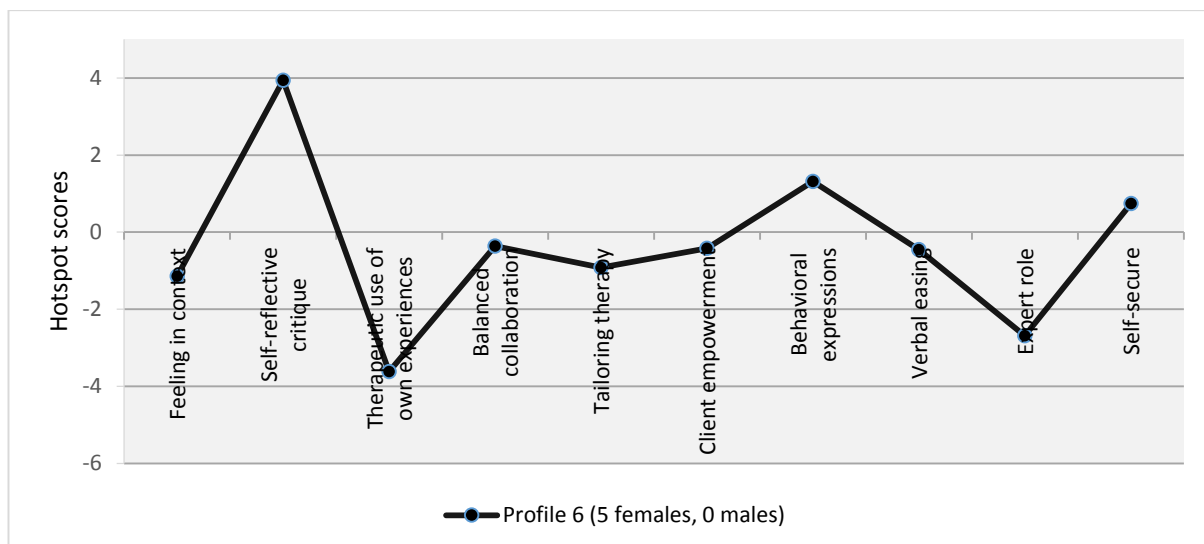


Figure 5. Profile 6 with its respective hotspot scores reported by 11% of participants.

Profile 6 was strong on *self-reflective critique* and was the only profile to score negatively for *tailoring therapy*. High negative scores existed on the *therapeutic use of own experiences* and *expert role* hotspots. This profile contained 11% of participants ($n = 5$), all of whom were females. There was an even distribution of participants across age groups and almost all were eclectic in practice ($n = 4$). Four had less than 11 years' experience.

Discussion

Hotspots

With the omission of the hotspots *feeling in context*, *therapeutic use of own experiences* and *verbal easing*, all other hotspots identified were consistent with HCA and MDS clusters discerned during the initial study of this research. The similarity of hotspot results between these two studies lends support to the construct validity of the hotspots identified.

Both the hotspots *feeling in context* and *client empowerment* represent similar emotional interactions of therapists and this similarity was reflected in the results. For instance, each profile's *feeling in context* score was approximately one point lower than each profile's score for *client empowerment*. This result is meaningful as it demonstrates that all participants consistently perceived these two hotspots in the same way thus indicating that, for the items representing these two hotspots at least, there was little ambiguity in the item statements.

Self-reflective critique was the greatest fluctuating hotspot (range = 7.4), with four profiles (1, 2, 3 and 4) displaying this behavior as absent in practice and three profiles (5, 6 and 7) displaying this behavior as present in practice. Given that several researchers identified that personal and professional growth (similar to self-reflective critique) was a characteristic of master therapists (Albert, 1997; Goldberg, 1992; Jennings & Skovholt, 1999), we postulate that *self-reflective critique* is the highest correlating hotspot with those of master therapists. As our sample size is too small and we have no outcome data to substantiate our postulation, further research is required to evaluate the relationship between *self-reflective critique* and master therapists.

Profile scores for the hotspots *therapeutic use of own experiences*, *verbal easing* and *self-secure* were inconsistent with the expectations of the authors given the largely unanimous empirical support regarding their beneficial influence for both the therapeutic relationship and therapy outcomes (Albert, 1997; Bar-On, 2005; Goldberg, 1992; Goldfried et al., 1998; Jennings & Skovholt, 1999; Lambert & Barley, 2001; Norfolk, Birdi, & Walsh, 2007; Salovey & Mayer, 1990). *Therapeutic use of own experiences* was consistently absent in almost all profiles and only low values were associated with *verbal easing* and *self-secure*. These unexpected findings may be the result of real shortcomings of the participating therapists' practices or distortions imposed by small profile sample sizes, demographic effects or hotspot item ambiguity. Clearly, further empirical research is required to substantiate these findings.

Balanced collaboration, defined as the therapist viewing therapy as a joint enterprise, was consistently identified as present in therapists' practices. Given this hotspot's distinct resemblance to the therapeutic alliance, a key component of many contemporary therapy modalities (Prochaska & Norcross, 2010), and the largely CBT or eclectic demographic sample of this study, the above results are fitting. While two majority eclectic profiles (1 and 6) presented with low negative scores on *balanced collaboration*, both had small, gender dominated samples which may account for the values assigned to this hotspot. Ultimately, this finding suggests that *balanced collaboration* is a salient characteristic to our samples' practices and demonstrates their adherence to more contemporary collaborative models of intervention in which decisions are made with, rather than for, clients.

Tailoring therapy, a concept which has consistently been empirically associated with positive client outcomes (Dolan et al., 1993; Prochaska & Norcross, 2010), was largely identified as positive across profiles, with this hotspot unnoticed in profile 6. Given that Profile 6 comprised only female participants, this sample bias may account for, or influence, the negative value associated with tailoring therapy. Evidently, further research would be beneficial in validating the findings of this hotspot.

With the exception of Profile 7, all profiles attributed a moderate to high positive value to the hotspot *behavioral expressions*. This finding is consistent with the literature which commonly identifies warming behaviors as essential in rapport building thus augmenting a strong therapeutic relationship (Lambert & Barley, 2001; Norfolk et al., 2007).

All but one profile (Profile 1) associated *expert role* with a negative value, thus suggesting that most therapists do not take a direct role in leading their client, rather viewing therapy as a collaborative partnership. Accordingly, almost every profile that had a negative result on *expert role* had a positive value associated with *balanced collaboration*; the exception to this was Profile 6, which had a negative value associated with *balanced collaboration* and *expert role*. Further supporting the aforementioned inverse relationship, Profile 1, the only profile to have a positive value on *expert role*, had a negative value on *balanced collaboration*. As guiding in therapy appears to be highly dependent on the type of clients being seen, mixed results regarding its influence on therapeutic outcome is evident in the literature (Crits-Christoph & Mintz, 1991; Prochaska & Norcross, 2010; Swanson & Hoskyn, 1998). Consequently, our findings are neither consistent nor inconsistent with the literature and it may be the case that the

score given by our participants to this hotspot is directly influenced by their therapeutic setting. This supposition may be tested in future research by recording the therapeutic setting of participants.

Profiles

Given the exploratory nature of this research, to date, no other empirical studies have been conducted profiling therapists' social-emotional competencies. Consequently, comparisons between this study's seven identified profiles and the literature were limited. Nevertheless, by eyeballing the data differences between profile trends were evident.

Considerable similarities and differences were evident between clusters. This finding supports the notion that therapists do not all have the same social-emotional therapeutic styles. However, it does show that there are consistencies between groups of individuals and that these styles can be identified and analyzed.

There was some tentative evidence of demographic differences in the distributions of social-emotional profiles. A majority of males was seen in Profile 1 (71%) perhaps accounting for the irregular score it represented on *expert role* and the highest negative score observed in *therapeutic use of own experiences*. Conversely, a majority of females was observed in every other profile with Profile 6 containing only females. As Profile 6 represented only females, this may account for the extreme positive value attributed to *self-reflective critique* by this profile. Country was evenly distributed throughout all profiles as was the age of participants. Profile 5 represented a noteworthy majority of CBT participants (78%) perhaps accounting for the lack of extreme values associated with this profile. Profile 6 contained the highest majority of participants who engaged in eclectic approaches (80%) and the highest majority of individuals with the least years of experience (80%) both possibly accounting for the high positive value associated with *self-reflective critique*. Other than those values, all other models of practice and years of experience were evenly distributed among all profiles. Lastly, Profile 3 represented the largest majority of participants responding by email (89%) thus suggesting that the high negative value associated with *expert role* may be accounted for by this method of responding. However, Profile 3 was very similar to Profile 2 and as Profile 2 did not have this bias in response method, we can assume that a bias regarding the method of responding did not influence results. Among all other profiles, the method by which participants responded was distributed evenly.

Regardless of these findings, due to the low sample sizes of most profiles, demographic data must be interpreted with caution.

Implications and future research

This study is a step toward the evaluation and measurement of social and emotional interactions in therapy. Nevertheless, further research is required to establish the stability of hotspots and therapists' emotional and social profiles over time, across different therapeutic models, with clients, and to assess the convergent and divergent validation of the themes identified in this study. Once these themes have been validated more research is needed to assess the emotional and social influence that each hotspot and profile may have on clients and whether any favored profiles existed for particular disorders, situations or clients. Research in this domain could be done by matching profiles to outcome measures thus identifying the varying effectiveness of each style working with differing clients, disorders and situations. By identifying what emotional and social styles work best for certain contexts, client-therapist matching could become a real and achievable goal significantly improving client outcome. The implications carry over into therapeutic practices also. The degree of effectiveness found to be associated with hotspots such as tailoring therapy for instance, could highlight the importance of accommodating for client uniqueness in manualized therapies and fidelity regimes. Furthermore, by profiling master therapists and subsequent comparison to validated profiles, researchers may elucidate differences between average and adept therapists thus indicating where certain groups of therapists are lacking and explaining variances in outcomes. A finding such as this could herald the development of objective measures designed to screen for candidate potential during therapist training intakes, the incorporation of training programs during therapeutic training and to indicate areas that qualified practitioners could improve on. Nevertheless, despite the significant potential associated with profiling therapists' social-emotional skills in therapy, this field is still in its infancy with substantial research still required before observable beneficial gains become evident.

Limitations

Several limitations of this study may have influenced the outcomes and/or applicability of findings. Firstly, this study used two procedures to collect data with an uneven distribution between sample methods. While there was no indication that the method of

data collection influenced the results obtained, it would have been more appropriate to obtain a sample from only one method source. This would increase our confidence that findings were a true representation of practice patterns rather than a byproduct of the method used to collect data. Secondly, although the sample size was adequate in forming hotspots and organizing profiles, it would have been beneficial to have at least 10 participants associated with each profile as to increase the power of our findings. Given that this study was exploratory in nature, the small sample size was justified, yet future research should aim to replicate this study with a larger sample size as to validate the profiles and begin the generalization of results. Lastly, attempts were made to minimize distortions in the results due to subjective responding. These included anonymity of participation, reduced item ambiguity and the use of the conceptual model to ‘smear out’ inherent noise by viewing participant responses through an objective lens (Kirkland & Bimler, 1996). Nevertheless, as subjectivity can never be completely erased, traces of subjectivity may still linger despite efforts to control it.

Conclusion

Overall, the findings of this research support the notion that consistencies exist between therapists’ social and emotional skills and that these skills may be grouped and themed accordingly. Furthermore, the results support the authors’ initial suppositions, that a) therapists’ emotional interactions are interrelated and contribute to the general therapy emotional climate and b), that therapist responses are able to be grouped into similar emotional response patterns. Tentative evidence from this study suggest gender, age, therapeutic model adhered to and years of experience influenced therapeutic practice. Nevertheless, given the small sample size due to the exploratory nature of this investigation, we suggest further research investigates the influences of such demographics on therapeutic profiles. Replication of this study to validate the profiles identified followed by research evaluating the effectiveness of each profile may herald the coming of client-therapist matching and the incorporation of effective profiles into training programs for therapists.

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