

Master therapists' construction of the therapy relationship.

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Qualitative research methods were used to elicit master therapists' statements regarding their use and understanding of the therapy relationship. The master therapists were identified and recruited in a previous study (Jennings & Skovholt, 1999) through a procedure used to create a sample of information-rich cases. The result of the analysis is a Model of Relationship Stances. The Safe Relationship Domain is composed of three categories of therapist actions: Responding, Collaborating, and Joining. The Challenging Relationship Domain also is composed of three categories of therapist actions: Using Self, Engaging, and Objectivity. The domains and categories are conceptualized as relationship stances utilized by the master therapists to meet individual client needs.

The long war among theoretical orientations in counseling and psychotherapy has come to a truce. Numerous studies have found that most approaches can produce positive change, but a consistent superiority of one approach has not been found. Instead, much of what is effective in psychotherapy is due to pantheoretical or common factors, those shared by many schools of psychotherapy (Asay & Lambert, 1999).

Although the most important pantheoretical variable appears to be the client (Tallman & Bohart, 1999), the therapist is another promising variable. There is now strong evidence for the therapist effect on client outcome. Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) found that significant therapy success was determined most by a helpful relationship with the therapist. In research studies, the contribution by the therapist surpassed all but the contribution by the client (Teyber & McClure, 2000). In an exhaustive review of the research, Wampold (2001) affirmed the neglected but critical therapist effect:

We have seen that the particular treatment that the therapist delivers does not affect outcomes. Moreover, adherence to the treatment protocol does not account for the variability in outcomes. Nevertheless, therapists within treatment account for a large proportion of the variance. Clearly, the person of the therapist is a crucial factor in the success of therapy. (pp. 20-21)

A highly effective therapist does seem to make a difference. We know this implicitly as people and consumers when we actively search for a really good practitioner: a doctor, dentist, attorney, or therapist. We know that some are better than others. Yet, this notion of exploring the therapist variable has been less of a focus in contemporary research.

Reviewing the research that pointed out the critical importance of the therapist and the therapeutic relationship, Teyber and McClure (2000) emphasized focusing future research on factors that enhance the therapist-client relationship. The authors stated, "In many studies, what therapists say and do in the therapy hour that promotes a good working alliance has proven to be the most important contributor to change and positive treatment outcome" (p. 70). Therefore, the present research investigated the working alliance as constructed by a sample of those considered the "best of the best" by their professional colleagues, a group of master therapists.

METHODOLOGY

We used a qualitative interview method to investigate therapist contributions to the therapy relationship because in-depth interviews with practicing therapists can provide data for variables that have yet to be identified in the research literature. When the purpose of a study is to describe clinically relevant therapist modes of perceiving and acting, a discovery-oriented approach is deemed most suitable (Marshall & Rossman, 1999). We were interested in what master therapists could tell us about their construction and use of the therapy relationship. In the pursuit of this research question, information-rich informants provided the kind of data this investigation sought.

Respondents

Recruitment. A sample of information-rich cases, a master therapist group, was described in Jennings and Skovholt's (1999) study of the personal characteristics of master therapists. In their study, peer nomination was combined with snowball sampling to find participants. Anastasi and Urbina (1997) supported the psychometric quality of peer nomination, concluding that it is a reliable technique that has been used in a variety of settings. They stated, "When checked against a variety of practical criteria dependent on interpersonal relations, such ratings [peer nomination] usually have been found to have good concurrent and predictive validity" (p. 468).

First, three senior and respected psychotherapists were each asked to nominate three psychotherapists whom they considered to be master therapists based on a list of written criteria. The criteria were as follows:

1. This person is considered to be a "master therapist."
2. This person is most frequently thought of when referring a close family member or dear friend to a psychotherapist considered to be the "best of the best."
3. Because of this person's superior skills as a psychotherapist, one would have full confidence in seeing this psychotherapist for one's own personal psychotherapy. Therefore, this psychotherapist might be considered a "therapist's therapist."

The therapists who received nominations were contacted and asked to nominate three therapists according to the same criteria. This snowball sampling was continued until a select few therapists were repeatedly nominated. A total of 103 psychotherapists were nominated. Seeking a balance between depth and breadth of data, Jennings and Skovholt (1999) decided that four or more nominations was a useful cutoff point, creating a master therapist group of 10 therapists.

In the present study, the 10 master therapists were initially contacted through a letter. A week after the letters were sent out, the first author phoned the therapists and scheduled interviews. All 10 therapists agreed to participate.

An interview-follow-up format was used in the present study. This design enables the respondents to participate in the analysis as derived from the initial interviews. In this way, a "validity through dialogue" (Skovholt & Ronnestad, 1995, p. 147) is established.

Respondent characteristics. The master therapist group (i.e., 7 women and 3 men) included 1 psychiatrist; 3 master's level social workers, one of whom is also a master's level psychologist; and 6 Ph.D. psychologists. Their age range was 53 to 75 years, with an average age of 62 years. The years of therapist experience ranged from 24 to 44 years, with an average of 32.5 years. Theoretical orientations of the therapists were psychodynamic ($n = 4$), integrative ($n = 2$), family systems ($n = 2$), existential ($n = 1$), and Gestalt and client-centered ($n = 1$). All of the therapists were Caucasian.

Trends evident in therapists' descriptions of their clients indicated that, early in their careers, these therapists worked with a wider range of clients. Now they were more selective in their clientele. Some clients were other practicing therapists. Generally, these therapists saw clients who were functioning well in some areas of life but not so well in other areas. Diagnostically, depression and anxiety were the most frequently mentioned disorders. This group of therapists generally did not see clients who had an active addiction or were psychotic.

Instrument

The first author developed an initial set of questions after a review of the literature on therapy

relationships, particularly the therapy alliance (Bachelor, 1991; Bordin, 1979, 1994; Gaston & Marmar, 1994; Henry & Strupp, 1994; Horvath, 1994; Horvath & Greenberg, 1994; Luborsky, 1994; Marziali, 1984). The second author reviewed and amended the initial set of questions. The first author then further refined the questions by conducting two pilot studies. The content of the questions reflects concern with clinical relevance while also incorporating aspects of alliance theory. Table 1 shows the correspondence of interview questions with alliance concepts.

Procedure and Data Analysis

The face-to-face interviews occurred over a 2-month period. The audiotaped interviews averaged 90 minutes. At the beginning of the interview, the purpose of the study was explained, and an informed consent form was obtained from each respondent. One of the respondents had to be reinterviewed because of an audiotape error. The interviewer checked the verbatim transcriptions for accuracy.

An inductive analysis procedure described by Patton (2002) and Jennings and Skovholt (1999) was utilized in this study. The data analysis proceeded inductively from the smallest unit, concepts, to themes, then to categories, then to the largest unit, domains. A concept comes from analysis of a small part of the transcript, such as a sentence or a paragraph answer supplied by a respondent. All the concepts then are examined and ordered for the purpose of identifying themes. Themes are identified by organizing a variety of concepts to make a coherent whole. Next, themes are examined for the purpose of identifying categories. Categories organize a variety of themes. Finally, the categories are examined for the purpose of identifying domains. Domains, the largest organizing unit, house similar categories. The analysis involved a back-and-forth process in which-

both the meaning of parts of the text and global meaning of the text are continually modified through an analysis of both. One arrives at a better understanding of the parts through analysis of the global meaning, and one arrives at a better analysis of the global meaning through analysis of parts. (Skovholt & Ronnestad, 1995, p. 148)

The third author, an experienced qualitative researcher, served as the auditor. As a validity check, the auditor and the first author separately coded portions of three transcripts from the study for concepts. These researchers compared and discussed concepts derived from the two analyses until they obtained agreement. The first author then completed the identification of concepts, resulting in 567 concepts. Each concept then was written on one side of a card, with the corresponding quote placed on the other side.

As another data source and using the same procedure described above, transcripts from Jennings and Skovholt's (1999) study of the same master therapists were analyzed for concepts. We analyzed only the portions of the Jennings and Skovholt transcripts in which the respondents were specifically discussing aspects of the therapy relationship. This analysis resulted in 185 concepts; the total number of concepts from both analyses was 752.

The first author then grouped concepts into themes by sorting the concepts into similar groupings until distinct themes seemed evident. As emphasized by Patton (2002) and described in Jennings and Skovholt (1999), "at this stage of the analysis ... important examples, themes, patterns, and natural variation in the data" (p. 5) are sought out and uncovered for the purpose of identifying themes and categories (i.e., composites of themes) from the data. The preliminary grouping of concepts resulted in 44 themes within four general categories.

Follow-up face-to-face interviews were conducted approximately 6 months after the last initial interview was completed. The follow-up interview focused on respondents giving their reactions to the initial formulation of the themes. Only 9 out of the 10 respondents were interviewed in the follow-up interview because, sadly, one of the therapists died before the follow-up interviews were completed. Themes and categories from the preliminary analyses were presented to the respondents during a 60-minute interview. This interview also was audiotaped and focused on (a) respondents' agreement or disagreement with the themes and categories as formulated, (b) respondents' comments about the results as reflective of their therapy experience, and (c) respondents' comments about aspects of the therapy relationship that were not reflected in the results.

After we conducted a second analysis of the data that incorporated feedback from the master therapists, we reduced the number of themes from 44 to 18. This reduction focused on retaining and consolidating the strongest themes as endorsed by the respondents. Themes that 7 out of 9 (67%) respondents agreed with were retained. Then we organized the themes to create categories. With the categories created, the themes were eliminated as a separate organizing structure. Six categories within two domains constitute the final formulation.

RESULTS

Derived from the qualitative interviews, the categories and domains are presented and described. The three categories within the Safe Relationship Domain are Responding, Collaborating, and Joining. The three categories within the Challenging Relationship Domain are Using Self, Engaging, and Objectivity. For ease of reading, we incorporate the themes into the text and offer the quotations that best represent the themes, categories, and domains.

The Safe Relationship Domain

Responding. The first category within the Safe Relationship Domain was labeled Responding. By "responding," we mean that the master therapists evidenced a heightened responsiveness to their clients. We found three themes in this category: being sensitive to clients at the beginning of therapy, using therapy techniques to suit client needs, and being nondefensive in hearing client complaints.

The master therapists described the importance that they placed on the beginning of the therapy relationship. Particular importance was placed on the initial contact, even if this contact was a phone call. The therapists emphasized careful listening and responding to the cues that the client was presenting. One master therapist told of foregoing intake formalities to respond to a client's immediate needs:

When I do an intake, my first thing is. "Why are you here? What is it that brought you into therapy?" Sometimes I won't even do an intake until the second session because they are so full of what it is they are upset about.

At times, the client had not been sensitively responded to in previous therapy encounters. For example, one master therapist described an empowering approach to clients in the initial meeting:

It is truly listening and being interested and feeding back to them from the beginning what you are hearing. Because I have heard more clients come in saying that they felt hurt or disrespected if people are too curt with them--like they're not interested.... So what I say to them when they come in here is that ... "Do you feel understood and respected?" So to me, that's the most important.... Its like, right from the beginning, engage them in the process as an equal and a consumer ... when you give them that, it's like they've got some power.

Another manifestation of heightened sensitivity of master therapists is their wise and judicious use of therapy techniques to meet individual client needs. One master therapist used the analogy of doing research with the client:

The contract is one way to start, but then we proceed as we experience each other. What I usually say is, "This is something we are going to do together. It is a kind of research, and we are both going to work on it together." They [the clients] have the final authority.

Another master therapist discussed her facility with a variety of therapy techniques, which were applied according to client need:

I may use more than one approach. So I may use psychodynamic and nondirective [approaches] and then with someone [else] a different

way. But if the need appears very clearly--let us say for behavioral therapy then I am very proficient with that also.

An aspect of the master therapists' heightened sensitivity is their ability to hear and respond to clients' complaints. Master therapists' ability to respond to client concerns, even at times to elicit client expressions of such concerns, seems to be a reflection of their experience and maturity as therapists. As one master therapist stated,

I wrote a paper about this about 10 years ago. It said, and I still believe, an apology is one of the best therapeutic tools there is. And I think that so many of our clients who get screwed around by the system, they are so astonished by an apology that it begins to put the relationship back where it belongs.

One master therapist discussed her willingness to admit mistakes as a departure from how she was trained to respond to client complaints. Her training had taught her that client complaints were primarily about the client:

The first thing is to really listen to what the person is saying to you in terms of how they are feeling about the rupture. Sometimes the rupture has to do with something that you actually did. I think very often in the past, the training has been, and emphasis has been, that [relationship problems are] about the client and about transference issues and to turn it back to the client.

Collaborating. The second category within the Safe Relationship Domain was called Collaborating. By "collaborating," we mean that master therapists actively collaborate with the client. We found three themes in this category: gearing the therapy agreement to the client's understanding of the problem, mutually resolving impasses in the relationship, and working with clients to form a meaningful therapy termination.

One master therapist described the process of forming the therapy agreement in terms of writing a job description for the therapist:

I do want to stay with what the client presents. I won't hesitate to point out patterns and invite somebody to go to that broader level, but I don't want to enlarge the job description. If somebody comes and says, "I want to hire you to help me with my boss," I don't want to start saying, "Yes, and we'll work on all this other stuff, too."

Another master therapist described establishing the therapy agreement as a cooperative process:

It's probably not as formal as a therapy contract, as in some settings where they actually require contracts. I don't do this that formally. I usually ask what they are looking for and what their expectations are and give them some feedback of what I believe I can deliver. I try to convey that it is basically a cooperative process--so it isn't me establishing the terms and trying to deliver.

When facing a lack of progress in therapy, master therapists would openly discuss the difficulty and seek joint solutions. Master therapists described clients not following through on therapy tasks as an expected aspect of the process. The master therapists typically addressed the resistance directly, aligned themselves with the client in approaching the resistance, and viewed the resistance as an opportunity to learn about the client's difficulty in making needed changes. One master therapist said,

I view resistance as a normal part of the process, I'm likely to find some way to explain it like, "You're here with a purpose in mind of addressing certain kinds of problems, and I see you

defeating yourself or digging in your heels and not doing the things that would be most helpful to us in pursuing this problem." So I name what I see in the way of resistance and then inquire what the person thinks about that or feels about that or what they know about the way they are not doing what they need to do. But I would be reluctant to issue any kind of ultimatum about "you have to do this or else--we're not going to do this kind of work," because I think the process of understanding a resistance is really a big chunk of the therapy. If you get through that, you're near the end of the tunnel.

Meaningful termination of therapy is seen as an extension and fulfillment of the therapy contract. Meaningful termination is defined as the following: (a) The termination is a mutual decision, and (b) the termination process is sensitive to the nature and stage of the therapy relationship. One master therapist discussed tying discussions of terminating with the client to the nature of the relationship:

Out of the nature of the work comes the nature of the closing. If we've met for three times, we might stop and we might terminate in the same session that the idea of termination comes up. If we've been meeting for three years, we'll probably be talking about it [over time]. We'll probably be tapering off for a while and then talking about ending. It will be one of the background topics.

Another master therapist described arriving at the termination phase of therapy as an intuitive, yet mutual, process:

Most of the time, what I find is that when it occurs to me that we're ready to end, it's also occurring to them.... When they do bring it up, I'll ask them, "When did you first think about this?" They'll go back to almost exactly the same time that I was thinking about it. In that sense, I do think we arrive there pretty close together. What usually happens is that we talk about how many more times we need to racer. They'll give me some idea [of their idea] about that.

Joining. The third category within the Safe Relationship Domain was named Joining. By "joining," we mean that master therapists seek a strong, deep therapy relationship with clients. This category comprises three themes: the centrality of the relationship to the therapeutic enterprise, the great value of a relationship that can withstand ruptures, and how profound healing occurs within a strong therapy relationship.

Master therapists' descriptions of the importance of the relationship ranged from the relationship being the therapy to the relationship as necessary for therapy. As one master therapist described it, "I guess my response is--the relationship is the whole thing. This person's investment in our relationship gets to be one of the biggest motivations for pursuing difficult work, for being reliable, for facing pain." One master therapist talked of the therapeutic relationship as the primary tool in therapy:

I guess I believe, and that I have always maintained this, that the primary tool that I use is the relationship. I have a lot of knowledge, I have a lot of skills, but they're wasted if the relationship isn't there. For me, it's the critical dynamic, and everything I'm doing is actually through that relationship.

The master therapists also expressed the view that strains and ruptures in the therapy relationship are an expected occurrence. The desired outcome from working through relationship ruptures is a stronger, deeper relationship. The in-therapy experience of repairing a relationship provides a blueprint for the client repairing other non-therapy relationships. For example, one master therapist explained the importance of working through ruptures with clients:

What I would say to clients is that a therapy relationship is like all other relationships. Even though sometimes we wouldn't want it to be, it is, and how we repair the rupture in our relationship can also help with ruptures occurring in other relationships. This

could be a place where that could happen and serve as a model for that in other experiences.

Ruptures that arose from clients reenacting prior negative relationship patterns typically were discussed by the master therapists as transference reactions. One master therapist discussed working through ruptures in the context of a client having not resolved ruptures in previous therapy relationships:

I just need to be willing to go there with somebody and explore the feelings of a falling-apart relationship and understand what that means in the context of their life history. If I don't chicken out, perhaps they won't chicken out, and we can sort through this together. ... When somebody comes and tells me about how the last six therapists failed them and they heard I was the best, I know that I too will fail, and the task will be whether or not I can work that out.

For the master therapists, client healing occurs because a strong therapy relationship provides a safe environment. Health and healing are seen as natural occurrences that antagonistic environments have thwarted. A strong, healthy, deep relationship provides an environment in which the natural process of healing takes place. For example, one master therapist described how clients may come, through the therapy relationship, to change their experience of themselves:

Often the people that come in to see you have never felt cared about, have never felt respected, doubt their own judgment, so that by your listening and your attentiveness, you begin the process of respecting them.... As they begin to trust you and begin to open up and look at their past history, they begin to see the pieces in their history that have not been helpful or have damaged them, and they can begin to see in a different way. You provide a different way of seeing without blaming ... and you help them to learn to repair themselves in a relationship of respect.

One master therapist described psychological healing as analogous to physical healing:

I think of an old medical school image of how I would facilitate the healing of a wound by stitching it up and covering it up. But another kind of answer would be to let it granulate in and heal from the depth up, and that is more my version of how therapy works. You got an open, gaping wound for a long time. [It] heals from the inside out in the context of this relationship where it is safe and supportive and noninjurious.

Another master therapist described therapeutic healing as occurring because the client has the opportunity to find new symbolic value in his or her experience through the relationship:

How does psychotherapy heal? ... I think that one of the things it does is that it's a way in which people can symbolize their experience, put into symbolic form something that has not been put into symbolic form, just by talking about it.... I think that [the symbolization] bridges the gulf of isolation and alienation that a person may feel from life--the traumas and the dehumanizing experiences or the injustices that they've experienced. It sort of reestablishes that kind of bridge back to humanity, reestablishes that sense of being in the human community. I think that all of this seems to build with reestablishing that kind of link. It has to do with having the opportunity to trust, to feel self-esteem, and to be part of a relationship.

The Challenging Relationship Domain

Using self The first category within the Challenging Relationship Domain was named Using Self

Being seen. The first category within the Challenging Relationship Domain was named being seen. By "using self," we mean that master therapists describe a great awareness of their "selves" as an agent of change in the relationship. There were two themes under this category: the use of self as an agent of change in the relationship, and the importance of self-care and congruency in their professional and personal lives.

A distinguishing characteristic of master therapists was their use of themselves as agents of change in the relationship. One master therapist described the importance of therapist awareness of his or her own power in the relationship:

We can't just do therapy intellectually. That therapy is a relationship, that therapy is about feelings and about history, and recognizing the power of our own psychological and emotional stuff in the process of therapy, we need to recognize the power of that.

Another master therapist emphasized accepting and using one's emotions, such as fear, therapeutically:

The issue isn't whether you're afraid or not, it's whether you recognize the fear and accept it and use it therapeutically, because the trick is to use yourself therapeutically. Use as many aspects of yourself as you can as a therapeutic agent.

In addition, master therapists used core metaphors to convey their role in therapy. When describing their essential activities as therapists, the master therapists frequently employed a metaphor. A range of metaphors was used, with "guide" being mentioned most frequently. One master therapist stated,

One of the metaphors I often use with my clients is the metaphor of "the wilderness guide," and the way I put that is they can hire me as a guide, because I know a lot about survival in the wilderness--my own, and I've traveled through a lot of wildernesses. I've got a compass; I can start a fire in the rain. I know how to make it through, but this is a new wilderness to me. Haven't been in this particular wilderness before, and so I can't quite predict what we're going to encounter.

Other metaphors included "good mother," "good parent," "helper," and "artist." Lastly, from a master therapist who used a detective metaphor:

There are two kinds of therapists as there are two kinds of detectives. There is Sherlock Holmes, and there is Columbo. And Sherlock Holmes is very keen-minded, cuts to the chase, and does it. And Columbo, who fumbles. I'm a Columbo. I frame the first interview as, "We are going to 'muck' around; we're going to have to get to know each other and what we can or cannot do here."

Engaging. The second category within the Challenging Relationship Domain was labeled Engaging. By "engaging," we mean that master therapists intensely engage the client throughout the therapy relationship. We found four themes in this category: engaging clients in change by working with client motivation, pacing the therapy, expecting clients to progress, and maintaining the conditions for change.

Master therapists expertly make use of the relationship to increase client motivation. They described working with client motivation in a variety of ways. For example, if the client came to

therapy because it was court-mandated, the therapist would attempt to form an alliance with the client to establish an intrinsic, rather than extrinsic, reason for the therapy. If the alliance could not be established, the therapy would not continue. One master therapist described building a therapy relationship to affect client motivation:

I know that I have to build a relationship in which I have leverage, then to use that leverage to help certain things happen. Sometimes the leverage is about becoming very important in

somebody's life. Sometimes the leverage is my approval. Sometimes the leverage is my caring. It can take a lot of different manifestations, but I'm very aware that I'm building a relationship to create that leverage.

A master therapist discussed increasing a client's motivation this way: "I can say that I view it as my job to heighten the motivation and that I try to do that by getting them to invest in their growth." Another stated, "Recognizing that what they've done in the past hasn't worked, [I] try to seal those doors off, to heighten sometimes the anxiety that helps them move toward the change they have to make. So I do heighten motivation."

Master therapists try to skillfully pace therapy interventions. They described pacing interventions to enable clients to make changes at a rate that they can manage. For example, one master therapist told of skillfully responding to clients, wishes for too rapid change with patience and understanding. Another master therapist suggested introducing a wider perspective on the client's therapy issues, but only when the client is ready to hear:

The issue isn't one of trying to "shoehorn" them into your way of seeing, the issue is trying to help them see how maybe what they are struggling with reflects other things they may want to consider. It is to reframe the whole issue as you see it, but you have to do that at a pace in which they can hear it. You can't just lay it on them.

Master therapists described a precision and grace in becoming more active in therapy exactly when it is needed to move the therapy forward. Being more active may include therapists being more verbally challenging, taking a more didactic approach, or setting limits. The circumstances that may give rise to the therapist becoming more active include questionable client behavior or the therapist perceiving that the client would benefit from a carefully applied push. One master therapist illuminated a more lecturing stance with a client with whom she had a values conflict:

I am very passionate about protecting the young and helpless, and if I see clients not doing that, then I have to say. "You know, you need a lecture from a mother's peak, and I am delivering it. You don't do this with kids." So I will take my stand. I won't throw a client out on that account, but I do make it clear that is not my value system.

Another master therapist told of setting firm ground rules for behavior in couples therapy. The ground rules for behavior also establish a therapeutic contract:

What I generally do with couples who are verbally abusing each other is to say, "Stop this. You've got to stop that." The situation that comes to mind is one in which the wife would get into these temper outbursts, and she would degrade her husband, and he would get weepy and feel so injured and often sulk. Then she wouldn't respect him for being such a wimp. I said to her, "You've got to stop that." It was early in therapy. They had had a lot of therapy with someone else on that very topic. And I said, "Well, listen, I'm not even going to do therapy on this. It's preliminary in therapy." "Well," she said, "I have a right to my feelings, and I get angry." So we had to dialogue about that, and I specifically said. "I'm not going to do therapy with you unless you agree with me. I'm not asking you for perfection; I'm asking you to establish a standard. It's off-limits. It's out of bounds. It's a foul ball. You have no right to do it. If you can agree to that, we can start there."

Another master therapist communicated applying a therapeutic kick to a client:

We were talking about some self-hypnosis or some meditation time. He said, "You know, any time we have done that here, it's really helped and made me feel a lot better. But when I try and do it at home, I don't feel like I did at home." I said to

none, I don't know, I just don't follow through on it." I said to him at that point, "Now this is where I feel like I need to give you a kick in the butt. This is about you taking care of yourself, and what you're telling me is you don't take care of yourself. So I want to give you a kick in the butt." So that's an example of my response. ... I leaned on my relationship with him, in essence, and said, "I expect you to follow through on this."

Objectivity. The third category within the Challenging Relationship Domain was called Objectivity. By "objectivity," we mean that master therapists remained objective within the powerful pulling forces of therapy. We found three themes in this category: master therapists have a perspective based on extensive experience, they maintain an objective stance in the therapy relationship, and they view therapy in a series of phases.

Master therapists view their task as attending to the context of the client's experience. Earlier, master therapists described the importance of being present in the relationship with clients. Here, they described the necessity to be somewhat outside the relationship to increase client awareness of relationship patterns in their lives. One master therapist described an important therapist task:

Sometimes my task [is] to be attentive to a larger range of their experience than they are identified with and to bring that in. It's present in them, but it isn't getting much priority in their self-system. I catch that and reinforce it in some way, but I am catching something that is present in their experience. I'm not putting something in their experience that is not there.

One master therapist recounted asking clients to fill in missing pieces. In this example, the therapist is not so much pointing out a larger perspective that is known but is more sensing that there is more than what the client has so far disclosed:

I may say ... "I need to know more about ta-da ta-da ta-da, which I want you to tell me more about next time so that I have a fuller picture, because there are missing pieces here." I do that a lot, and I think this is true across the board with clients.

Master therapists also bring clients' outside relationships into the therapy relationship, which is another means to increase clients' awareness of relationship patterns. One master therapist's example: "If they are talking about something that is happening, I'll ask them, 'Do you find that happening here?' Then we can move closer to the interpersonal relationship between us."

Master therapists view therapy as a series of phases. As a rule, master therapists described the phases as a beginning, a middle, and a termination. Within these three phases of the relationship, the master therapists conceived the nature and tasks differently. Thematically, master therapists located clients within a temporal framework with expectations for tasks and progress according to the phase. However, they also were mindful of individual complexity and variations in moving through phases.

Several master therapists described distinct parts of the beginning phase of therapy. An example:

At the beginning, if there is a good, positive connection, there is often some idolizing that goes on by the client, as they would do with their parents. For the first period of time, the positive idolizing is OK because it really helps you get into what's going on, and they trust you a lot.

Another master therapist described the beginning phase as more of an introduction:

I think there's sort of an introductory phase, a getting to know all the manifestations of a problem or of how a person is constructed-- whether it's family of origin, or defense structure, what their strengths are, or what's all current. So I think there is sort of a generalized introductory phase.

The middle phase of therapy often was described by the master therapists as the working phase. The nature, or content, of the phase varies to some extent according to the master therapist's theoretical orientation. Overall, master therapists told of less rigidity of form and more authenticity. As one master therapist described the middle phase,

If that phase [beginning] plays out successfully, then I think we move into the next phase, which is more trusting, less game playing ... to see now whether or not it's OK not to be so guarded, in which the client can be thoughtless or angry or be embarrassed and let me in on it. I can be more exploratory. I can be a little more spontaneous. I can make a mistake because I'm not being so careful. At that level, there is something more authentic happening. At that level, what happens between us counts for a lot more.

Another master therapist said of the middle phase,

There are different levels of intimacy that come, phases of intimacy, and some of those places involve increasing conflict where we are more able to identify the difference--where I am not the same thing, the one they prayed for, and they are not the perfect client that I saw a glimmer of. We begin to engage our differentness, and we begin to experience conflict and some contesting and that kind of apprehension with each other.

Another master therapist illuminated the middle phase of therapy for both individual and couples work:

I think the longest phase is the midphase, and I think of that as the working-through phase. Helping people to start identifying more of their feelings and also feelings that they may feel ashamed of, looking at their part in the relationship issues, looking at areas where they may be blocked or stuck, areas of conflict. I think about that as being midphase, if you are doing couples work, it might be the phase where you teach them skills--things like identifying feelings, being able to share them with each other, being able to ask for what they need--those kinds of things where I think it is the working part of the relationship.

The master therapists discussed a variety of ways of ending therapy. They appeared to be sensitive to clients' needs in terminating from therapy. The master therapists expressed specifically what is expected of the client and of the therapy in the termination phase. One master therapist talked of planning for termination "well in advance":

I believe in planning for termination well in advance. It doesn't always turn out that way as sometimes the patients have their own agendas going ... to set a date somewhere out there in advance, weeks or months depending on the intensity of the therapy. And between now and the termination time, that will be a major subject of our conversations, and it's important that they be paying attention to their feelings and fantasies and dreams in relation to the termination.

Finally, one master therapist said that the end phase of therapy comes from experiencing a change in how each party in the relationship experiences the other:

At that point, there is a deeper commitment to work together where our differentness becomes a richness in what's happening here. My differentness from what they thought [I was] becomes an asset to them, and their differentness becomes a pleasure to me.

DISCUSSION

Throughout the interview process the master therapists verbally demonstrated their

Throughout the interview process, the master therapists verbally demonstrated their astute awareness of the therapy relationship, and their understanding led us to develop a Model of Relationship Stances. The six categories identified in the present study may be conceived as

relationship stances employed by master therapists. Norcross (1993) described relationship stances as forms of the therapy relationship, chosen by therapists, to meet individual client needs. Norcross compared choosing a relationship stance to choosing a clinical technique to match a client's presenting problem. He said, "It is widely acknowledged that psychotherapists ... attempt to adjust their interpersonal style and stimulus value to meet the needs of the unique client and the singular circumstance" (p. 402). We propose a Model of Relationship Stances grouping the relationship stances into two domains. Each of the domains, the Safe Relationship Domain and the Challenging Relationship Domain, describes a complementary aspect of the therapy relationship.

The Safe Relationship Domain

The master therapists' relationship stances within the Safe Relationship Domain (i.e., the categories of Responding, Collaborating, and Joining) have these elements in common: The client and his or her needs are the central focus, the therapist constructs the relationship to be a secure base from which the client may express feelings and explore new behaviors, and the client is able to feel the empathy and concern of another human being who is worthy of the client's trust. For many clients, the relationship stances of the Safe Relationship Domain may contain the essential ingredients for the client to make necessary changes. In the responsive stance, which is aligned with the Responding category, the master therapist is warm and receptive, listens, and offers unconditional positive regard. The client-centered approach (Rogers, 1957) is seen as the theoretical framework that is most descriptive of the responsive stance. A master therapist using the collaborative stance, which is aligned with the Collaborating category, emphasizes the client's partnership in the therapy alliance. Here, the therapist supports and encourages the client's involvement in setting the therapy agenda. The master therapist using the joining stance, which is aligned with the Joining category, creates the relationship as a cocoon-like haven in which the client may heal. The therapist offers the conditions of trust necessary for the client to enter into such a relationship.

The Challenging Relationship Domain

The master therapists described a different set of relationship stances within the Challenging Relationship Domain (i.e., the categories of Using Self Engaging, and Objectivity). "Challenge" is considered the quality of requiring the full use of one's abilities, energy, or resources (American Heritage Dictionary, 1992). The Challenging Relationship Domain describes more active relationship stances by the master therapists, relationship stances that overtly bring forth from clients behaviors that approach clients' therapy goals. In the self stance, which is aligned with the Using Self category, the master therapist emphasizes the therapist's role in the relationship of trust. The therapist, intentionally making use of his or her personality and personal resources to authentically relate to the client, does not lose the self in the relationship. The engaging stance, which is aligned with the Engaging category, emphasizes the master therapist's responsibility to move the therapy forward and the therapist's increased activity in guiding and directing the therapy. A description of the team approach in cognitive therapy illustrates this stance:

The cognitive therapist implies that there is a team approach to the solution of a patient's problem: that is, a therapeutic alliance where the patient supplies raw data ... while the therapist provides structure and expertise on how to solve the problems.... The therapist fosters the attitude "two heads are better than one" in approaching personal difficulties. When the patient is so entangled in symptoms that he is unable to join in problem solving, the therapist may have to assume a leading role. (Beck, Emery, & Greenberg, 1985, p. 175)

In the objective stance, which is aligned with the Objectivity category, the master therapist provides interpretations and information and evaluates progress. Goldfried and Safran (1986) described the therapist's role of offering clients a more objective perspective on themselves and their world as a general clinical strategy common to all therapy orientations.

Correlates to Model of Master Therapists' Stances

In this section, we will explore existing research that shares similarities with the Model of Relationship Stances presented above. Because the therapeutic relationship consistently accounts

relationship stances presented above. Because the therapeutic relationship consistently accounts for more therapy outcome variance than technical interventions do (e.g., Krupnick et al., 1996), it is surprising that a prescriptive approach to the therapy relationship has not been the subject of more research activity. As Norcross (1993) stated, "Although many experienced clinicians may intuitively try to tailor their relational stance to individual clients, there are few published attempts to systematize the process" (p. 402). Various researchers recently undertook a concerted effort to examine the efficacy of relationship stances on therapeutic outcome. Findings from the Task Force on Empirically Supported Therapy Relationships (Norcross, 2002) have made a significant contribution to our understanding of the impact relationship stances have on positive therapy outcomes. Norcross (2001) summarized the findings of the task force by stating that the "therapy relationship is crucial to outcome ... can be improved by certain therapist contributions, and ... can be effectively tailored to the individual patient" (p. 354). As an example, Beutler, Rocco, Moleiro, and Talebi (2001) noted that, for clients displaying high levels of resistance, the optimal therapist stance appears to be nondirective although a more directive therapist stance is beneficial for clients with low levels of resistance.

Another example of the need for differing therapist stances was offered by Prochaska and Norcross (2001) who prescribed relationship stances based on client readiness for change. In the early stages of change, the authors suggested a nurturing parent role. Then, to help the client delve deeper and gain insight into his or her problems, the authors suggested the therapist take on a Socratic teacher role. Each of the five stages of readiness for change requires that the therapist adapt his or her stance to best facilitate client movement.

In addition, the present findings of master therapists' relationship stances are similar to Clarkson's (1994) theory of five types, or modes, of therapy relationships: (a) the working alliance, (b) the transferential/countertransferential relationship, (c) the reparative/developmentally needed relationship, (d) the I/you relationship, and (e) the transpersonal relationship. A primary aim of Clarkson's descriptions of relationship modes appears to be to connect the various modes of relationship with different therapy orientations. Clarkson's theory is offered here because it is similar to the present findings of relationship stances: The therapy relationship may take different forms, as intentionally constructed by the master therapist, in response to different client therapy needs.

The model of Adaptive Counseling and Therapy (ACT) is another model similar in several respects to the findings of relationship stances noted in this study (Howard, Nance, & Myers, 1986). ACT is a system of prescribing relationship styles to task-readiness levels of clients and has been used with humanistic, cognitive-behavioral, and psychodynamic psychotherapies (Nance & Associates, 1995). ACT posits two dimensions of therapist activity, supportive and directive, that correspond to the Safe and Challenging Relationship domains. In ACT, the two dimensions evolve into four therapist styles; whereas the present findings derive six relationship stances from two domains.

The ACT model has developed an assessment of client characteristics that is prescriptive of a preferred therapist style. The present findings, having no client database, do not match relationship stances with client characteristics. However, it appears from the interviews that a therapist stance may be chosen and applied according to the master therapist's assessment of client need. The proposed Model of Relationship Stances derived from the master therapists' interviews was not developed using the ACT. The many similarities support the construct validity of each of these models.

Limitations

The intent of this study was to describe how master therapists construct the therapy relationship. The study was exploratory and preliminary, and as such, it carries several limitations. The study sample was primarily White, middle-aged, and private practitioners. They were, therefore, not representative of therapists more generally, nor of master or expert therapists in various work settings, nor of therapists' diverse backgrounds. The method of the study allowed for a "feedback loop" through the use of a second interview with the therapists to reflect on the initial formulation of themes and categories. Additionally, an auditor was extensively involved in the formulation and reformulation of the results. These are forms of triangulation that are encouraged to improve validity in qualitative studies. However, the internal validity of the study could have been augmented through other forms of triangulation (Hill, Thompson, & Williams, 1997). For instance, collecting data from clients regarding the relationship stances that they experience with their therapists would have increased the validity of these formulations.

Implications and Recommendations

The study of relationship stances may have implications for training. As evidenced in the literature review, there is a wealth of information available about the therapy relationship, generally, and a developing knowledge of therapist contributions to the relationship, specifically. A curriculum focusing on this literature, highlighting the efficacy of the therapy relationship in predicting good therapy outcomes, could be offered to mental health counseling students.

In mental health clinical training, students could learn about flexible strategies for relationship stances in response to client variables. An important component of such learning would be the student's self-awareness regarding one's own relationship capacity. One's relationship capacity is not a static sum; nevertheless, students could begin to explore the following questions: "Can I work with a hostile client, a dependent client, or an involuntary client?" "What would be my relationship stance toward clients with [various] characteristics?" Such questions may open avenues of self-exploration of one's strengths and limitations.

Future mental health counseling research may incorporate a strategy of studying relationship stances, working-alliance measures, and therapy outcome. General measures of therapist relationship skills--for instance, therapist capacity for relationship (Luborsky et al., 1985)--and measures of therapist social adjustment (Dunkle & Friedlander, 1996) have been found to correlate with alliance measures. However, these measures lack specificity and do not tell us why some therapists are more effective than others in forming therapy relationships. Therapist relationship stances may be operationalized and studied for their association with variables such as client relationship expectations.

In addition, we recommend that future studies continue to make use of information-rich informants. A strategy of exploratory, qualitative research is a recognized means to discover new variables,

with information-rich informants an excellent source for identifying the most salient variables (Patton, 2002). A quote from a quantitative study comparing master therapists' interpersonal interventions illustrates the value of research with information-rich informants: "How do we as psychologists define the 'state of the art?' Is it by the treatment manuals included in clinical trials or is it by what master therapists, who have been nominated by those who wrote the manuals, actually do in clinical practice?" (Goldfried, Raue, & Castonquay, 1998, p. 809). Research with information-rich informants, such as in Goldfried et al.'s study, supports the notion that information-rich informants provide different data than other sources. Also, at higher levels of professional attainment, there is, ideally, a distilling of the best practice techniques.

CONCLUSION

This study was conducted with a view similar to Teyber and McClure (2000), who said, "In many studies, what therapists say and do in the therapy hour that promotes a good therapy alliance has proven to be the most important contributor to change and positive treatment outcome" (p. 70). Using a sample of master therapists, we have explored their construction of the working alliance. The master therapists' belief that effective therapy involves safety and challenge, which we conceptualized as the Safe Relationship Domain and the Challenging Relationship Domain, resonates with the classic statement that an ideal climate for human development involves an optimal balance of support and challenge. In addition, within each of the domains, we have suggested that master therapists use relationship stances. Within the Safe Relationship Domain, the therapist is attuned to the client's needs (i.e., the responsive stance), is attentive to the client's participation in therapy (i.e., the collaborative stance), and is receptive to the client's deepest concerns (i.e., the joining stance). Within the Challenging Relationship Domain, the self stance has the therapist employ his or her personality to effect client change, the engaging stance has the therapist employ a more directive role, and the objective stance has the therapist reframe the client's experience in a larger context. Perhaps master therapists are those who can use their talents as a gifted artist would--in a creative way where therapeutic tools such as timing, intensity, and relationship stances are applied optimally.

Table 1

Correspondence of Interview Questions with Alliance Concepts

Alliance Concept	Interview Question
Therapist-client agreement on the tasks of therapy	* How do you establish agreement with clients as to the tasks of therapy? * How do you work with clients when

Therapist-client agreement
as to the goals of therapy

How do you work with clients when
they are not following through on
their therapy tasks?
* Do you have a set way of estab-
lishing the respective roles of
therapist and client, and how do
you go about doing this?
* How do you proceed to work with
clients when their goals for
therapy do not match the needs they
seem to have?
* Describe in what ways you acknow-
ledge clients' success in reaching
their goals.
* How do you establish an alliance
with clients as to the goals of

Therapist-client emotional bonds

therapy when a third party ...?
* Describe the importance in your
work with clients of establishing a
positive therapy relationship.
* Describe how a novice therapist
may acquire the skills necessary to
form a good therapy relationship.
* How do you go about repairing a
therapy relationship that has
become problematic?

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