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The Personal and Professional Characteristics of Master Therapists and Matched Controls

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The Personal and Professional Characteristics of Master Therapists and Matched Controls

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OF MASTER THERAPISTS AND MATCHED CONTROLS

Barbara A. Granville

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The dissertation is fulfilling the requirements for a degree

from the Muskie School of Public Policy

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Abstract

This dissertation is an attempt to replicate the results of a study conducted by Len Jennings (1996) which provided the data underlying the "cognitive, emotional, and relational" (CER) model of therapist excellence. As outlined in Jennings' (1996) research protocol, data were gathered through semi-structured interviews with ten master therapists chosen through a snowball sampling technique. Unlike the original study, this dissertation includes a matched control group intended to provide insight about the generalizability of the categories/domains of CER. There were two specific research questions. (1) Would the results of this replication study be similar to Jennings' findings? (2) Are there significant differences between master therapists and their matched controls in any of the domains or categories outlined in CER? The answer to the first question is yes, the importance of each domain/category described in CER was mentioned by at least one research subject. The answer to the second question is no:

there were no significant differences found between groups. The importance of this study is the potential contribution to the development of the CER model, which could provide a structure for further research in the area of therapist effects on clinical outcome. The potential contribution of this study to the field of public policy is incremental progress towards a replicable model of therapist excellence which, if developed, would lead to more effective and accountable mental health care.

CHAPTER 1: LITERATURE REVIEW

This dissertation is an attempt to replicate the results of a study conducted by Jennings (1996) which provided the data underlying the "cognitive, emotional, and relational" (CER) model of therapist excellence. As outlined in Jennings' (1996) research protocol, data were gathered through semi-structured interviews with ten master therapists. In addition, unlike the original study, this dissertation includes a matched control group intended to provide insight about the generalizability of the CER model. The master therapists were recruited using the snowball sampling technique, and the matched controls through targeted sampling of professional databases. The resulting transcripts were systematically analyzed using the CER model.

There are two specific research questions. (1) Would the results of this replication study be similar to Jennings' findings? (2) Are there significant differences between master therapists and their matched controls in any of the domains or categories outlined in the CER model?

The importance of this study is the potential contribution to the development of the CER model, which could provide a structure for further research in the area of therapist effects on clinical outcome.

The potential contribution of this study to the field of public policy is a replicable model of therapist excellence, leading to more effective and accountable mental health care. Future research efforts could incorporate client outcome measures and use CER to explore the

personal and professional characteristics of therapists who demonstrate exceptional performance.

Dissertation Structure

Chapter 1 summarizes the literature; the first section clarifies the term "master therapist" and outlines the research in that area, with particular emphasis on findings emerging from the original study conducted by Jennings (1996). The second section reviews the literature related to variability in therapist outcomes, and the third section describes the theoretical basis for research in the area.

Chapter 2 discusses research methodology and provides detailed descriptions of the subject selection process, a discussion of the data collection and analysis, and the bases for conclusions.

Chapter 3 describes the results of the study, including both quantitative and qualitative analyses of the data. This chapter also proposes some changes to the CER model intended to provide concrete guidance about goal setting to clinicians seeking to improve.

Chapter 4 consists of a discussion about the findings and some final conclusions. It touches on convergence of study findings with current research, describes some of the limitations of the study, and posits some suggestions for future research in the area of therapist excellence.

Definitions

As used in this dissertation, the term "master therapist" refers to research subjects who meet the criteria developed by Jennings (1996). The words psychotherapist, therapist, counselor, clinician, and practitioner are used interchangeably, and may refer to any licensed professional

in the mental health field, including psychologists, social workers, counselors, and psychiatrists. Similarly, the words psychotherapy, therapy, and counseling are synonymous, as are the terms patient and client.

Master Therapist Research

Research on master therapists is an offshoot of attempts to understand and map the developmental process of counselors. In 1985, Tom Skovholt and colleague Helge Rønnestad conducted a cross-sectional, longitudinal, qualitative study of 100 clinicians at various points in their careers. The end result was a six-phase model describing the transition from lay helper to senior professional (Skovholt & Rønnestad , 2003). The master therapist research emerged from Skovholt's interest in extraordinary professional development (Skovholt & Jennings, 2004; p. xv), which led one of his doctoral students, Kevin Harrington (1988), to study the personal characteristics of 201 psychologists certified by the American Board of Professional Psychology. Using quantitative techniques, he discovered that based on responses to the Adjective Checklist (ACL), subjects were very similar to one another as well as to helping professionals in other disciplines (Harrington, 1988).

Skovholt later became the dissertation advisor for another student, Len Jennings, who wanted to explore the concept of master therapist using qualitative methods. In what proved to be an initial study, Jennings (1996) outlined the basic components of the CER model of therapist excellence (Jennings & Skovholt, 1999). The 10 master therapists Jennings identified all agreed to participate in two additional dissertation studies (Mullenback, 2000; Sullivan, 2002). Both were replications of Jennings' (1996) study and used the CER model as the basis for analysis. The first was by Mullenbach (2000) and explored the emotional domain; the second, by Sullivan (2002), explored the relational domain (Sullivan, Skovholt, & Jennings, 2005). In

addition, a third study used the transcripts from Jennings' (1996) original study to identify the nine ethical values of master therapists (Jennings, Sovereign, Bottorff*, et al*., 2005). Those findings were synthesized and published in the book *Master Therapists: Exploring Expertise in Therapy and Counseling* (Jennings & Skovholt, 2004) which won the Association for Counselor Education and Supervision Publication of the Year award.

Variability in Therapist Outcomes

There is significant variation among therapists on client outcome measures such as average degree of improvement (Anderson, Ogles, Patterson, et al., 2009; Luborsky, McLellan, Diguer, et al., 1997; Okiishi, Lambert, Nielsen, et al., 2003). That variation tends to be consistent, *i.e.*, clients who share a therapist tend to have similar experiences and outcomes (Crits-Christoph, Baranackie, Kurcias, et al., 1991; Luborsky, McLellan, Diguer, et al., 1997; Wampold & Brown, 2005).

In a two studies (Okiishi *et a*l., 2003; Okiishi, Lambert, Eggett, et al., 2006), a research team collected data from 71 therapists and 7,628 clients over a six-year period at a university counseling center and concluded:

> A client seen by one of the "best" therapists can expect to be feeling significantly better after a few weeks of treatment. A client seen by one of the "worst" therapists can expect to feel about the same, if not worse, than when they started treatment, and this after almost three times as much treatment as those seeing the more efficient therapists (Okiishi et al., 2003, p. 370).

The seven most effective therapists outperformed the seven least effective by a substantial amount; client recovery rate (remission of symptoms to normal range) was 22.40 percent versus 10.61 percent (Okiishi *et al*., 2006, p. 1167); improvement rate was 21.54

percentversus 17.37percent (Okiishi *et al*., 2006, p. 1167); and deterioration rate was 5.20 percent versus 10.56 percent (Okiishi *et al*., 2006, p. 1167).

Those differences persist in spite of attempts to eliminate them. In one study, researchers (Luborsky *et al*., 1997) found that efforts to homogenize caseload and therapist skill level had little effect; the range of client improvement for the sample of 22 clinicians still varied from less than 0 percent(clients got worse) to 80 percent. In addition, there is There is some evidence that therapist effects are present even when the primary intervention is psychotropic medication (McKay, Emel, & Wampold, 2006; Wampold & Brown, 2005):

> In a pharmacotherapy trial, it was found that an antidepressant was more effective than a placebo, accounting for 3% of the variability in outcome; however, the psychiatrist, providing weekly clinical management, accounted for 9% of the variability in outcomes—indeed, the more effective psychiatrists had better outcomes administering placebos than the poorer psychiatrists had administering the antidepressant (Wampold, 2009b, p. 640, citing McKay, Emel, & Wampold, 2006).

Given the quantity of efficiency studies, why did it take so long to discover that treatment effects were overstated, and therapist effects overlooked? (1) In a randomized clinical trial, any effect which is not treatment related or placebo is considered a nonspecific factor (Wampold & Bolt, 2006). (2) Most research designs fail to specify the therapist as an explanatory variable, resulting in erroneously large treatment effects (Crits-Christoph & Mintz, 1991) and/or omit therapists with outcome measures significantly higher or lower than average

(Wampold & Bolt, 2006). (3) From approximately 1940 to 1994, attempts to identify the characteristics of effective therapists led to inconsistent and contradictory results (Beutler, Machado, & Neufeldt, 1994; Beutler, Malik, Alimohamed, *et al*., 2004; Parloff, Waskow, & Wolfe, 1978).

How Psychotherapy Works

Based on a series of well-regarded studies (Lambert & Ogles, 2004; Lipsey & Wilson, 1993; Grissom, 1996; Smith & Glass, 1977; Wampold, 2001; Westen, Novotny, & Thompson-Brenner, 2004; Seligman, 2005), it can be said with some confidence that the therapeutic practices in widespread clinical use are effective. For example, in one of the first significant meta-analyses in the field of outcome research, Smith and Glass (1977) analyzed 400 studies and concluded: "On the average, the typical therapy client is better off than 75% of untreated individuals" (p. 752). Two decades later, a meta-meta-analysis by Grissom (1996) of 46 meta-analyses estimated that a randomly selected subject had a 70% better chance of improvement in comparison to one in the control group, and 66% better chance than one treated only by placebo.

Client Outcome Research: Common Factors

In 1936, Rosenweig hypothesized that all psychotherapeutic approaches have underlying components—common factors—which affect outcome to a greater degree than theoretical orientation. The first empirical study supporting his claim was published in 1975. Following a review of comparative studies, Luborsky, Singer, and Luborsky (1975) concluded that there were no significant differences in outcomes between treatment modalities.

The most comprehensive analysis in support of the common factors model of psychotherapeutic effectiveness to date is the work of Bruce Wampold (2001). In *The Great Psychotherapy Debate*, Wampold (2001) presented a coherent, extensive series of arguments in support of alternative paradigms such as the common factors model, and recommended that researchers concentrate their efforts in understudied areas such as therapist effects. With a research team, Wampold analyzed the results of 227 studies published between 1970 and 1995, and found no differences between treatments (Wampold, Mondin, Moody, et al., 1997); he has estimated that technique accounts for (at most) 8 percent of variance in client outcome (Wampold, 2001).

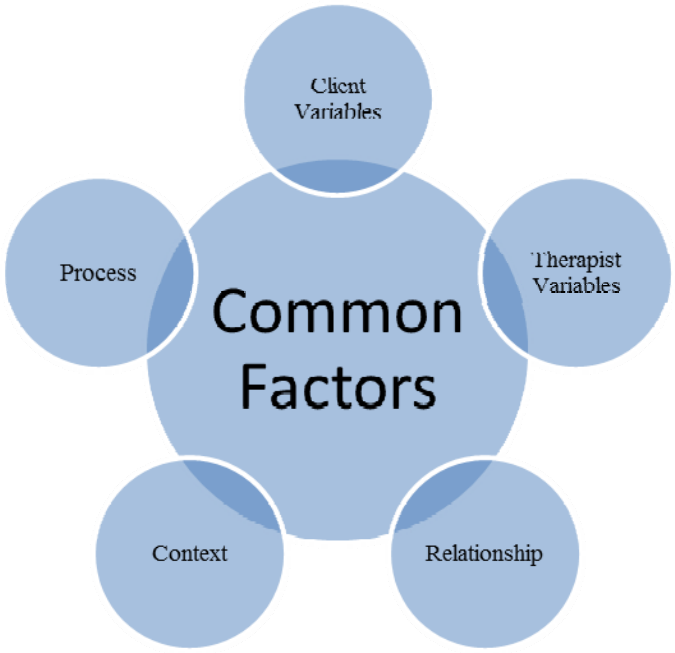
In 2002, *Clinical Psychology: Science and Practice* published an issue that looked at the common factors model from a variety of different viewpoints. It contained a new article by Luborsky who, with a different research team than in 1975, conducted a meta-meta-analysis of comparative clinical trials and reported (again) that differences between treatments were not significant (2002). Others in the field have noted, "It has proven to be the most replicated finding in the literature" (Duncan, Miller and Sparks, 2004, p. 32).

What are common factors?

The conventional understanding of a common factor is any variable that is present, regardless of treatment modality or theoretical orientation. To think about the concept, it helps to consider the basic mechanics of psychotherapy. (For illustration, see Figure 1: Common Factors.) First there is the client, who presents for treatment with a constellation of an infinite set of variables (demographic, diagnosis, expectations, and personal history). Second, there is

the psychotherapist, who can assess signs and symptoms, provide a diagnosis, and has been trained in specific techniques, but who also represents an infinite set of variables (demographic, degree of allegiance to a particular theoretical orientation, clinical experience, and personal history). Third is the relationship between the two, be it warm or chilly, easy or awkward, hierarchical or collaborative. Fourth, there is the context, or the manner in which the psychotherapist uses technique: for example, highly structured sessions versus a non-directive approach. Some contextual differences are dependent on the psychotherapist's personality and personal characteristics, including extra-therapeutic values and beliefs; others are organizational mandates unrelated to ethical practice. Fifth, there are trans-theoretical models which focus process, such as the generic model of psychotherapy (Orlinksy, 2009), the five stages of grief (Kübler-Ross, 1969), or five stages of change (Prochaska, Norcross, & DiClemente, 1994).

Figure 1: Common Factors



In part due to the large number of potential variables (most of which lack standardized operational definitions), the common factors research lacks coherence. Grencavage and Norcross (1990) analyzed 50 publications, found 89 different proposed common factors, and reported:

> There is little apparent agreement or empirical research on therapeutic commonalities. Without such accord, however, it is difficult to discuss them intelligibly or apply them clinically (p. 373).

Based on the number of studies in the literature over the past decade, a few common factors have been popular research topics (in particular, client variables and relationship) (Beutler *et al*., 1994; Beutler et al., 2004). Others, including therapist variables, have been largely neglected (Beutler *et al*., 1994; Beutler *et al*., 2004).

Therapist Effects

Almost five decades before confirmatory empirical evidence was published, Rozenzweig (1936) presciently suggested that therapist effects might be as (or more) important than treatment effects. His hunch was later confirmed by multiple studies (Crits-Christoph & Mintz, 1991; Crits-Christoph et al., 1991; Wampold, 2001; Wampold & Brown, 2005).

The range of estimates for the percentage contribution of therapist effects to client outcome varies. The first study reported that on average, 8.6 percent of outcome variance was attributable to therapist effects (p. 86), but the range among studies was wide, from 0 percent to 48.7 percent, (and from 0 percent to 72.9 percent for individual variables) (Crits-Christoph *et*

al., 1991, p. 86). The second study found a narrower range, from 0 percent to 39.5 percent (Crits-Christoph & Mintz, 1991). One explanation of the difference was that research methodology had improved over time, *e.g*. older studies showed greater variance (Crits - Cristoph & Mintz, 1991). Nevertheless, reanalysis of outcome studies continue to find therapist effects not detected earlier (Beutler et al., 2004; Wampold, 2001; Wampold & Brown, 2005).

In *The Great Psychotherapy Debate*, Wampold (2001) confirmed the finding that individual therapist effects represented over 70 percent of outcome variance. In a real world setting, using data from a managed care company, PacifiCare Behavioral Health, Wampold and Brown (2005) analyzed the outcomes of 6,146 clients treated by almost 600 clinicians, and found that when initial level of symptom severity was taken into account, approximately 5 percent of the variation in outcomes was due to therapists (p. 914). The top 25 percent of therapists achieved pre-post effect sizes which were twice the size of the bottom 25 percent of therapists, and their clients consistently did better than expected (p. 919).

In summary, there is a great deal of evidence to support the hypothesis that therapist effects (differences in client outcomes between individual psychotherapists) are greater than treatment effects (differences in client outcomes between treatment modalities) (Crits-Christoph & Mintz, 1991; Crits-Christoph, Baranackie, Kurcias, *et al*., 1991; Wampold, 2001; Wampold & Brown, 2005). In addition, when found at all, treatment effects tend to be small (Beutler, *et al*., 2004; Lambert & Ogles, 2004; Wampold, Mondin, Moody, *et al*., 1997; Wampold, 2001). Those findings suggest that there are therapist characteristics associated with

better patient outcomes, yet there is no accepted model that outlines what those characteristics might be.

One typology which shows promise for standardized use in future research efforts focused on therapist effects is Cognitive, Emotional, Relational (CER), which clearly describes the personal and professional characteristics of psychotherapists identified as exceptional through a peer nomination process (Skovholt & Jennings, 2004). What differentiates CER from most other models of therapist excellence is that Skovholt and Jennings (2004) clearly illustrate each category/domain using specific quotations from subjects. That specificity provides the basis for researchers to develop operational definitions for each concept in the CER model. As the operational definitions suggested by CER are concrete, they can be tested for replicability and reliability, which raises the possibility of creating a research tool which would allow for greater generalization of results across studies of therapist effects.

CHAPTER 2: RESEARCH DESIGN

Selection of Subjects

There are two categories of subjects for this study. The first is master therapists, selected according to the process and criteria used in the study, "The Cognitive, Emotional, and Relational Characteristics of Master Therapists" (Jennings, 1996; Skovholt & Jennings, 1999; 2004). The second category, which differentiates this study from previous master therapist research, is a matched control group, identified through a search of professional licensing databases and a targeted survey.

Master Therapists: Snowball Sampling Process, Criteria for Inclusion

The following is a description of the process Jennings used to select subjects:

> To begin the nomination procedure, three well-regarded practicing psychologists (two male, one female) with a mean of thirty-one years of therapy experience were chosen as key informants. These three initial key informants were chosen because of their: (a) involvement in the training of therapists, (b) longstanding involvement with the local mental health community, and (c) reputation for

> being well-regarded therapists. Two of the key informants worked at a major university counseling center and one worked in private practice.
>
> Each key informant was asked [by telephone] to nominate three master therapists within the large metropolitan area of the sample group. Nomination of master therapists was based on the following criteria: (a) This person is considered to be a "master therapist," (b) this person is most frequently thought of when referring a close family member or a dear friend to a therapist because the person is considered to be the "best of the best," and (c) one would have full confidence in seeing this therapist for one's own personal therapy. Therefore, this therapist might be considered a "therapist's therapist" (Skovholt & Jennings, 1999, p. 4).

In turn, the nine new contacts each nominated three others. The process continued until few new names emerged and Jennings had a sample group of 103. Jennings' (1996) final sample consisted of the 10 psychotherapists who had each received four or more nominations.

The nomination process for this study also began by choosing three key informants who meet the criteria in (a), (b), and (c), then proceeded as outlined above.

In qualitative research, the snowball is a form of purposeful sampling sometimes used to recruit unusual cases (Patton, 1990) or hard-to-reach subpopulations by tapping into subjects' social networks (Sadler, et al., 2010). The success of the technique is predicated on the judgment of peers regarding the construct under study (Skovholt & Jennings, 2004).

Although there is some research (Luborsky *et al*., 1985) which suggests that psychotherapists can discriminate between more effective and less effective colleagues, it is also possible that nominations could be based on characteristics which have little or nothing to do with client outcomes (e.g. familiarity).

Controls: Identification and Criteria for Inclusion

For each master therapist, there was a control, a psychotherapist who was matched across the following variables identified by Jennings: gender, age, primary professional license, years of experience, and theoretical orientation. The term "theoretical orientation" can be imprecise, so the variable was divided into the following traditional classifications of therapeutic modalities: psychodynamic, behavioral/cognitive behavioral, humanistic, systemic, and the medical model.

The process of finding a match began by asking each master therapist to identify his/her primary professional license, then conducting a survey of clinicians of the appropriate gender chosen randomly from the corresponding professional licensing database. Using data from returned surveys, a matched control was chosen for each master therapist, taking into account the variables of age, primary professional license held, years of experience, and theoretical orientation.

To illustrate: an initial search of professional licensing databases indicated that as of July 18, 2013, there were 214 psychologists, 949 clinical social workers, and 480 professional counselors listing addresses in Cumberland County. If a master therapist who agreed to participate in the study self-identified as a psychologist, recruitment letters and surveys were

mailed to a percentage of psychologists on that list. The individuals selected were chosen based on a random number generated by computer, then sorted by gender (*i.e.*, if the subject to be matched was male, the survey went to males; if female, to females).

Ultimately nine of the 10 experimental subjects had a close match for the following variables: gender, age, primary professional license held, and years of experience. The variable of theoretical orientation was ultimately discarded due to high numbers of survey respondents who provided nonspecific or multiple answers to this query, e.g. "eclectic" or "cognitive behavioral, dialectical behavioral therapy, and humanistic." (To view the documents used, see Appendix C-1: Recruitment Letter; Appendix C-2: Survey; and Appendix C-3: Informed Consent Form, Survey.)

Figure 2: Process for Identifying Matched Controls

The other master therapist was a female licensed psychiatrist. As of July 18, 2013 there were 122 psychiatrists in Cumberland County, only 42 of whom were female. Rather than send

out surveys, a matched control was located by conducting an internet search, extrapolating age and years of experience from data found, and contacting the subject directly.

Location

For two reasons, the search for subjects was limited to Cumberland County, Maine (Appendix E-1, Map of Cumberland County). First, Jennings (2012) conducted his study "in a major midwestern metropolitan area" identified as Minneapolis (Jennings, personal communication), which is located in Hennepin County, Minnesota (Appendix E-2, Map of Hennepin County). In spite of significant differences in terms of ethnicity and population density, Cumberland County in 2010 was roughly comparable to the City of Minneapolis in 2000 in terms of population size (281,674 versus 382,578, or minus 26.4 percent) and age distribution (see Appendices E-1, E-2, and E-3). Second, the available professional databases are searchable at the county level.

Basis for Conclusions

The conclusions drawn from this analysis were derived from a comparison of the results of the Cumberland County interviews with the data and conclusions reported in the Jennings study. This dissertation is intended to address problems stemming from three observations the primary researcher noted about the research to date. The first is that the terms "therapist variables" and "therapist characteristics" have no consistent operational definitions, and that lack of definition makes comparing studies difficult or impossible. For example, Hiatt and Hargrave (1995) stated:

> In order to further understand these results, we conducted interviews with the high-rated and low-rated therapists. Those rated highly were found to be interpersonally effective, warm, sensitive and empathic, while the low-rated therapists tended to be viewed as cold, distant, and insensitive (p. 21).

The description of a therapist as "cold" or "distant" is nonspecific and may have different meanings for different researchers.

The second observation is that easily observed and measured personal and professional characteristics of psychotherapists (including age, gender, race, professional training, and years of experience) have not been found to be reliable predictors of client outcome (Beutler *et al*, 1994; Beutler et *al.,* 2004; Lambert & Ogles, 2004; Parloff *et al*., 1978). That suggests that those variables are either not important, or are only important in combination with other variables which have not yet been clearly identified.

The third observation is that efforts to find differences between psychotherapists using standardized personality tests have not delivered meaningful results. For example, Harrington's (1988) subjects—all highly trained psychologists who had achieved certification—overlapped on 30 of the 37 Adjective Checklist (ACL) subscales. That may be because psychotherapists tend to be similar to one another, but not to the general population on which those standardized personality tests are based. CER is based on the characteristics of therapists only, so may be able to detect subtle within-group differences.

The goal of this study is to replicate the research conducted by Jennings, which provided the data underlying the CER model of therapist excellence. As outlined in Jennings' research

protocol, data was gathered through semi-structured interviews with ten master therapists. In addition, in an effort to provide insight about the generalizability of CER, this dissertation included a matched control group. The master therapists were recruited through a snowball sampling technique, and the matched controls through targeted sampling of professional databases (with the exception of one female psychiatrist, who was recruited based on information available on the Internet). The resulting transcripts were systematically analyzed using CER.

The specific research question is: are there significant differences between master therapists and their matched controls in any of the domains or categories outlined in CER? If significant differences between the two groups exist, CER might serve as a model in future research efforts focused on how therapists leverage personal and professional characteristics into concrete results. This analysis is of importance to the field of public policy because better models which reflect current research findings will increase the effectiveness and efficiency of service provision in mental health.

Collection and Analysis

Jennings (1996) used a qualitative research design featuring semi-structured interviews and inductive analysis as later conceptualized by Michael Patton (1990) in his widely cited book *Qualitative Research and Evaluation Methods*. "Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis" (1990).

Patton differentiates between indigenous typologies (those identified by the participants) and analyst-constructed typologies, and suggests that one way to make sure that the latter are accurate and useful is to discuss them with the subjects and ask for feedback. In his view, the goal of qualitative research is to facilitate understanding of the object of study. To that end, Patton advises that researchers provide enough information so that readers can decide for themselves if the patterns, themes, and categories used make sense of the data.

Interview Protocol

After selecting a group of ten master therapists using the snowball sampling technique, Jennings interviewed each of them using sixteen open-ended questions. Those questions emerged from a literature review of therapist effectiveness, and from suggestions generated by a survey of his cohorts from the counseling psychology program at the University of Minnesota. The interview guide was revised after each question was rated for clarity and salience by three doctoral interns, and again after two pilot interviews with experienced therapists (1996).

Figure 3: Interview Guide (Jennings,)

1. How are you different from when you started your career?
2. What distinguishes a good therapist from a great therapist?
3. What do you think are the characteristics of a master therapist?
4. To become a master therapist, does one need years of experience? Explain.

5. Given two equally experienced therapists, why does one become an expert whereas the other remains mediocre?

6. What is particularly "therapeutic" about you?

7. Is there one distinguishing aspect of your expertise?

8. How does your emotional health impact the therapy you do?

9. How does the person you are impact the therapy you do?

10. How do you know when you are doing a good job with a client?

11. Are you helpful with some clients and not others? Explain.

12. Can you estimate what percentage of your clients you have helped?

13. What is psychotherapy?

14. How does psychotherapy heal?

15. How much of psychotherapy is an art versus a science?

16. If there were a recipe for making a master therapist, what ingredients would you include?

Procedure

As in the Jennings (1996) study, each subject in this research was interviewed for approximately one hour, at a place and time convenient for him or her. The interview was taped, the tape transcribed, and the subject received a copy, which he or she was asked to review for accuracy.

Data Analysis: Jennings

To begin the data analysis process, Jennings and a research assistant reviewed the transcripts paragraph-by-paragraph, writing a word or two for each which seemed to best capture the concept being articulated by the subject. The researchers then sorted the data into

themes and categories. That process resulted in 1043 concepts which were later organized into 40 themes in four categories.

After all ten transcripts were analyzed, Jennings conducted a one-hour follow-up interview with each subject to receive feedback about the themes and categories. If eight of the 10 subjects agreed that a theme reflected "their individual experiences, perceptions, and beliefs," it was included in the final analysis, during which another category emerged. Skovholt and Jennings (1999) simplified his original findings (see Appendix C-1) to three domains (cognitive, emotional, and relational) and nine categories.

Figure 4: The Cognitive, Emotional, and Relational Model

Domain	**Category**
Cognitive	1. Master Therapists are Voracious Learners 2. Accumulated Experiences Have Become a Major Resource for Master Therapists 3. Master Therapists Value Cognitive Complexity and the Ambiguity of the Human Condition
Emotional	1. Master Therapists Appear to Have Emotional Receptivity Defined as Being Self-Aware, Reflective, Non-defensive, and Open to Feedback 2. Master Therapists Seem to Be Mentally Healthy and Mature Individuals Who Attend to Their Own Emotional Well Being 3. Master Therapists Are Aware of How Their Emotional Health Affects the Quality of Their Work

Relational	1. Master Therapists Possess Strong Relational Skills 2. Master Therapists Hold a Number of Beliefs about Human Nature That Help to Build Strong Working Alliances 3. Master Therapists Appear to Be Experts at Utilizing Their Exceptional Relationship Skills in Therapy
Skovholt, T.M. & Jennings, L. (1999). The cognitive, emotional, and relational characteristics of master therapists. Journal of Counseling Psychology, 46 (1): 3-11	

The data analysis protocol Jennings used was standard qualitative content analysis (his domains and categories were derived inductively from raw data). The approach used in the current study was directed content analysis, using the domains/categories developed by Jennings and Skovholt as the basis for coding (Hsieh & Shannon, 2005). The purpose of Jennings'follow-up interviews was to clarify the domains/categories of his typology with his subjects. In the current research, the typology was predetermined, negating the need for a second conversation with subjects.

Data Analysis: Dissertation

As mentioned previously, the CER model consists of three domains (cognitive, emotional, and relational) each with three categories (Jennings & Skovholt 1999; Skovholt & Jennings, 2004). For each category, the authors provide one or more quotations to illustrate the concept they are attempting to convey (Jennings & Skovholt, 1999, p. 6). For example, within the cognitive domain, the first category is entitled "Master Therapists are Voracious Learners." Jennings chose the following quotation to clarify what was meant by the term:

> I can't stay content in what I know. And I get embarrassed at how much I seek out other learning experiences…because I do take classes, I still do (1999, p. 6).

Using those words, as well as the authors' comments, the primary researcher for the current study developed an operational definition for each domain/category. For example, in the case of the cognitive domain, category one, the operational definition became:

- Cognitive Domain, Category 1, Operational Definition 1 (C1-1). "The therapist stated that ongoing learning is important."
- Cognitive Domain, Category 1, Operational Definition 2 (C1-2). "The therapist mentioned staying current with new theories/techniques, or obtaining continuing education."

Those operational definitions provided the basis for the code book used to analyze the interview data. The number of operational definitions per category varies because Jennings and Skovholt described some concepts in greater depth than others.

Figure 5: Operational Definitions Per Category

Domain	**Category 1**	**Category 2**	**Category 3**	**Operational Definitions**	**"Other"**
Cognitive	2	4	2	8	3
Emotional	3	5	4	12	3
Relational	4	4	4	12	3
Totals	**9**	**13**	**10**	**32**	9

In order to measure inter-rater reliability, two research assistants (both social workers) separately reviewed each transcript and determined if any statement (or cluster of statements articulating a single concept) matched a domain/category/operational definition. The responses were analyzed using Cohen's Kappa (K). The statistics used to explore possible differences between the two groups (master therapists and matched controls) included the t-test and Pearson Correlation (*r*) for continuous variables, Fisher's Exact Test and Cramer's V (*V)* for categorical variables.

In addition to the 32 operational definitions, the two raters were encouraged to contribute to the analysis by noting aspects of the operational definition not identified by the primary researcher. These were listed as "other" within each category (Appendix F-1 for Code Book, Appendix F-2 for Directions).

CHAPTER 3: RESULTS

Respondents

Master Therapists (Compared to Jennings' Sample)

Our snowball sampling was conducted from 6/9/2013 to 10/1/2013; a total of 62 different therapists were nominated. Of the 62, 29 (45.3 percent) participated in this study, either by providing nominations, being part of the master therapist group, or both.

Figure 6: Results of Snowball

Snowball (Conducted 6/9/2013 to 10/1/2013)		
Responded	29	45.3%
No Response	21	32.8%
Refused	4	7.8%
Could Not Locate	3	6.3%
Ineligible (Did Not Meet Criteria)	5	7.8%
Totals	62	100%

Jennings contacted 109 therapists and chose a minimum of four nominations as the cutoff point for his master therapists (J-MT) (Skovholt & Jennings, 1999, p.6). By contrast, the snowball sampling process for this study was complete after only 62 therapists were contacted, because no new names emerged. Also, among the 15 therapists with the most nominations, 10

either did not respond to requests to participate, or declined to do so. That left a sample of therapists with relatively few nominations (D-MT). Jennings had a range of four to 17 nominations for J-MT (M = 7.70, SD = 4.19) in comparison to two to four nominations for D-MT (M = 2.80, SD = .92). The difference was statistically significant (t-test, t =3.61, p = .002, two tailed).

Figure 7: Number of Nominations

Top 10 Nominations		Number of Nominations Received
1	MT-1	4
2	MT-2	3
3	MT-3	4
4	MT-4	3
5	MT-5	2
6	MT-6	2
7	MT-7	2
8	MT-8	4
9	MT-9	2
10	MT-10	2

The final sample of master therapists for this dissertation (D-MT) consisted of four psychologists, four licensed clinical social workers (LCSW), one licensed clinical professional counselor (LCPC), and one psychiatrist (MD). J-MT consisted of six psychologists, three LCSWs, and one MD. That is not a statistically significant difference (Fisher's Exact Test, p = .809).

There were also no significant differences found between J_MT and D_MT for the variables of age (J-MT: range 50 to 72, M = 59, SD = 7.89; D-MT: range 45 to 66, M = 57.4, SD =

6.92) (t-test, t = .4821, p = .6355) or years of experience (J-MT: range 21 to 41 years, M = 29.50, SD = 6.62; J-MT: range 15 to 41, M = 29, SD = 8.92) (t-test, t = .1423, p = .8884).

Figure 8: Master Therapists

Master Therapists	Psychologist	LCSW	LCPC	MD	**Total**
Dissertation	4	4	1	1	10
Jennings	6	3	0	1	10

Jennings reported that "some" of the subjects in J-MT held more than one license; in D-MT, none did. In both J-MT and D-MT, 100 percent were of European-American descent (Skovholt & Jennings, 1999, p.4). All 10 of Jennings' subjects worked in private practice (Skovholt & Jennings, 1999, p.4). In the dissertation group of master therapists, nine worked in private practice and one in a nonprofit setting.

Controls: Survey Response Rates

The number of surveys sent was intended to be approximately proportional to the percentage of licenses held and gender of the master therapist group, e.g. 10 percent of male psychologists, 30 percent of female psychologists, et.cetera. However, due to the small number of psychologists in Cumberland County (214), the survey would have gone to only nine male psychologists, greatly decreasing the chances of a match, thus necessitating repeated mailings to small numbers of potential subjects. By contrast, surveys were sent to 100 percent of eligible psychologists (194), 30 percent of eligible LCSWs (234), and 36 percent of eligible

LCPCs (172). If an address clearly suggested that a clinician would be ineligible to participate (*e.g*. "Children's Mental Health") s/he was not included in the sample. The response rate was low, 15.3 percent (92 of the 600 surveys mailed).

Figure 9: Surveys Sent to Eligible Respondents

Cumberland County **Active License, 7/18/2013**	Male	Female	Total	Surveys
Psychologists	91	123	214	100%
LCSW	184	765	949	30%
LCPC	127	353	480	36%
Psychiatrist	80	44	122	N/A

Figure 10: Response Rates

Surveys (Controls)	Sent	Undeliverable	Net Total	Responded	Percentage
Psychologist	194	6	188	24	**12.8%**
LCSW	234	10	224	39	**17.4%**
LCPC	172	8	164	29	**17.7%**
Total	**600**	**24**	**576**	**92**	**16.0%**

Data Analysis

Comparison of Master Therapists and Matched Controls: Descriptive Variables

There were no differences between the master therapist and control groups for the variables of gender or race (the study controlled for gender, and all the subjects were of

European- American descent). Of the 20 subjects (10 master therapists, 10 controls) the majority worked primarily in private practice (*n* = 16) (two master therapists and one control worked in non-profit settings, one control had recently retired). There were no significant differences between the two groups in age (D-MT: range 45 to 66, M = 57.4, SD = 6.92; Control: range 45 to 66, M = 61.10, SD= 6.26) (t-test, *t* = 1.2539, *p* = .2259) or years of experience (D-MT: range 15-41, M = 29, SD = 8.92; Control: range 15-41, M = 29.70, SD = 7.85) (t-test, *t* = .1863, *p* = .8543). As expected, there was a strong positive correlation between age and number of years of experience (Pearson correlation, *r* = .870, *p* > .001).

On their surveys or during their interviews, two master therapists and five controls who held masters-degree level licenses reported having obtained a doctorate at some point during their careers. That affected the matching process. To achieve as close a match as possible, one female control licensed as an LCSW who held a doctorate in social work was ultimately matched with a female master therapist who is a psychologist. Also, due to the small number of male LCSWs who responded to the survey, a male master therapist who was an LCSW was matched with a male LCPC.

Inter-Rater Reliability

Cohen's Kappa was designed to estimate agreement between two raters of nominal or interval data. If K = 0.0, this indicates that the agreement is no better than would be expected by chance; 0.0 to 20 is considered "slight agreement," .21 to .40 "fair," .41 to .60 "moderate," .61 to 80 "substantial," and .81 to 1.00 "almost perfect" (Viera & Garrett, 2005, p. 362).

Here is an example to provide perspective as to the interpretation of these scores within the field of psychology: in adult field trials conducted at Menninger Clinic (Houston Veteran's Administration) for the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (2013), the test-retest reliability for some common disorders was found to be quite low. In spite of the fact that most laypeople have a general idea of what the symptoms of these mental health diagnoses are, K was only .40 for "Alcohol Use Disorder," .25 for "Major Depressive Disorder," and .20 for "Generalized Anxiety Disorder" (Regier, Narrow, Clarke, et al, 2013).

The Kappa statistic has several significant shortcomings. The most obvious is that two raters can agree for different reasons, or both can be wrong, or one may be better than the other at identifying the construct under study. Also, scores are dependent on the number of items rated, so comparisons between studies should be made with care. Lastly, if the phenomenon to be identified occurs rarely, the K will be low, even if the two raters have high levels of agreement.

In this study, for each item, the two raters could choose, "Yes," "No," or "Not Sure." Prior to computing inter-rater reliability, the categories of "No" and "Not Sure" were combined under the assumption that a "Not Sure" score indicated that the concept was not clearly articulated in the transcript. Results: inter-rater reliability for operational definitions (excluding "Other") was moderate (n = 640, K = .460, SE = .033, p = <.000).

Quantitative Analysis: Operational Definitions

In both Figure 11 and Full Results Chart (Appendix F), column "Yes" indicates the number of times that both raters could identify the operational definition in the 20 transcripts. Column "No" indicates the number of times that both raters did not believe that the operational definition was present in the 20 transcripts (or failed to identify it). Column "Disagree" indicates the number of times that the two raters had differing opinions.

There were no statistically significant differences found between the Master Therapists and Matched Controls on 31 of the 32 items (Full Results Chart, Appendix F). Item C3-1 was statistically significant only due to inter-rater disagreement (Cramer's $V = .588$, $p = .031$). Therefore, the null hypothesis that there would be no differences between groups could not be rejected. As a result, both groups—master therapists and controls—were combined for the remaining analyses.

Quantitative Analysis: Comparison with the CER Model

The raters agree that all 32 operational definitions were mentioned by at least one subject (range = 1-19). This is consistent with Jennings' findings (1996).

Identification and Discussion of Items Demonstrating High Inter-Rater Agreement

In order to cull only those items with a high level of inter-rater agreement, the following criteria were established (Figure 11: Results Based on Inter-Rater Agreement). In order for an item to be included, the two raters had to agree at least 75 percent of the time (any item with

more than five in the column "Disagree" was discarded). In addition, at minimum, the two raters needed to agree at least 50 percent of the time that a transcript did (or did not) contain the specific operational definition; any item with a score of less than ten in either column "Yes" or "No" was also discarded. Of the original 32 items, 12 remained.

Figure 11: Results, Based on 75%/50% Inter-Rater Agreement

Domain and Category	Operational Definition	Yes	No	Raters Disagree	Percent
Cognitive Domain					
Category 1. Master Therapists are Voracious Learners					
C1-1	The therapist states that ongoing learning is important.	**13**	4	3	65% Yes
Category 2. **Accumulated Experiences Have Become A Major Resource for Master Therapists**					
C2-3	Notes that experience alone isn't enough to become a good therapist.	**17**	0	3	85% Yes
Category 3. **Master Therapists Value Cognitive Complexity and the Ambiguity of the Human Condition**					

Emotional Domain					
Category 1. Master Therapists Appear to Have Emotional Receptivity (Defined as Being Self-Aware, Reflective, Non-defensive, and Open to Feedback)					
E1-2	Admits to a limitation (e.g. can't work with certain types of clients).	**19**	0	1	95% Yes
E1-3	Seeks feedback (e.g. peer consultation, supervision, personal therapy).	**10**	5	5	50% Yes
Category 2. Master Therapists Appear to Have Emotional Receptivity (Defined as Being Self-Aware, Reflective, Non-defensive, and Open to Feedback)					
E2-2	Tries to be the same person both at work and in personal life.	3	**12**	5	60% No
Category 3. Master Therapists Are Aware of How Their Emotional Health Affects the Quality of Their Work					
E3-2	Mentions counter-transference, or some variant of, "I ask myself if the problem is the client's or mine."	3	**15**	2	75% No
Relational Domain					
Category 1. Master Therapists Possess Strong Relational Skills					
R1-1	Discusses how role in family prepared him/her for the work.	2	**18**	0	90% No

Category 2. Master Therapists Hold a Number of Beliefs about Human Nature That Help to Build Strong Working Alliances					
R2-1	Mentions the importance of client/therapist relationship/alliance.	**17**	1	2	85% Yes
R2-3	Believe that clients can change/heal	**13**	2	5	65% Yes
R2-4	Any statement which suggests respect for clients, awareness of their competence.	**15**	2	3	75% Yes
Category 3. Master Therapists Appear to be Experts at Utilizing Their Exceptional Relationship Skills in Therapy					
R3-1	Willing to challenge clients.	3	**13**	4	65% No
R3-4	No fear of strong emotions, or hearing difficult material.	6	**10**	4	50% No

Study participants tended to agree that one of the most important factors that etermines whether therapy will be successful in an individual case is the quality of the client/therapist relationship (R2-1, Yes = 17, 85 percent). On the part of the therapist, good working alliances have as a foundation genuine respect for clients (R2-4, Yes = 15, 75 percent) and the belief that clients can change/heal (R2=3, Yes = 13, 65 percent). One therapist notes:

> I'm not any better than they are. ..I'm just here to serve them…they help me figure out what they need from me, not to fix them. They're not broken. I think that's a big point to understand to be a great therapist (C-8).

One of the interview questions asked participants to disclose perceived professional limitations (E1-2, Yes = 19, 95 percent). The most common answer was difficulty working with

clients who fit the profile of the malignant narcissist (Cluster B personality traits—Borderline, Narcissistic, Antisocial—combined with interpersonal sadism). The majority agreed that some conditions (*e.g*. severe, ongoing substance abuse; mental retardation; chronic psychosis) require specialized skills to treat successfully, and referral prior to intake or within the first few sessions was common. One therapist comments:

> I think I know what my capacities are now. I know where my strengths lie, I know where my weaknesses lie, and I don't try to do things I'm not good at anymore (C-5).

The ability to recognize and respond to these limitations was considered a skill which took time to develop. For example:

> I remember when I first started, I thought that if I loved enough, if I said the right things, if I did the right things, if I worked hard enough, that I was going to change a person's life. That *I* was capable of doing that….I think over time my ego's gotten out of the way, I can better meet a person where they are at, and not jump to some kind of expectation of where I think they should be and what I think they should do. I still might have those feelings come up but I'm much more realistic (MT-7).

The two raters agreed that over 50 percent of the transcripts did not mention the following five items: E2-2, No = 12, 60 percent; E3-2, No = 15, 75 percent; R1-1, No = 18, 90 percent; R3-1, No = 13, 65 percent; R3-4, No = 10, 50 percent. It should be noted that the

interview protocol combined with the short amount of time spent with each subject (approximately an hour on average) precluded a comprehensive assessment of participants' views. As a result, subjects may have failed to mention an item, but that does not necessarily mean that they do not think it is important.

The interview protocol asks several questions intended to elicit participants' views about whether they believe there are specific professional and personal characteristics which are necessary in order to become an exceptional therapist (C2-3, Yes = 17, 85 percent), and if so, what are they (Figure 12: Important Personal Characteristics of Exceptional Therapists).

The prevailing view was that while certain personal and professional characteristics give some therapists a head start, life experience is also important. For example:

> It is hard for someone in their twenties. You can have a very smart, warm, wonderful person, but developmentally they are still where they are developmentally. It's only through the integration of life experience and the qualities that person may have as a human being that it ripens…the fruit is there, but it ripens over time (MT-7).

When the data were re-examined using a lower level of inter-rater agreement, from 75 percent to 60 percent (any item with more than 8 in the column "Disagree" was discarded) there were few significant changes in the results. Although the second analysis added eight items to the 12 already identified, the two raters agreed that five of them had not been

mentioned (C2-2, No = 12, 60 percent; E3-3, No – 12, 60 percent; R1-3, No = 11, 55 percent; R3-3, No= 13, 65 percent; R3-4, No = 10, 50 percent). The remaining three items were strongly related to findings described in this section.

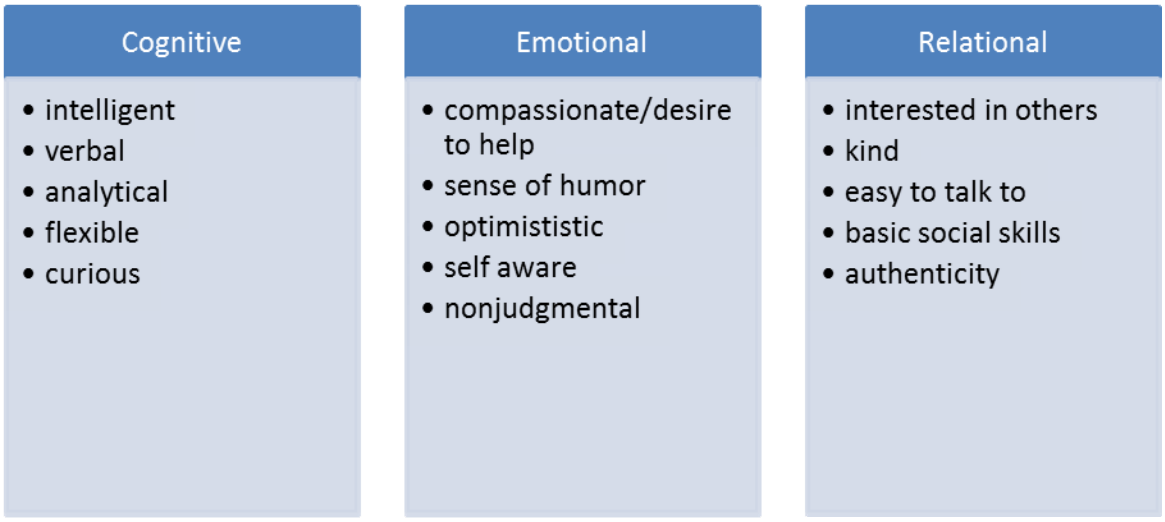
Figure 12: Change in Results, Based on 60%/50% Inter-Rater Agreement

Domain/Category	Item	Results
E1-2	Some variant of, "You need to know yourself."	Yes = 14, 70%
R1-2	Mentions importance of compassion or empathy.	Yes = 12, 60%
R1-4	States s/he has genuine care for clients.	Yes = 11, 55%

Qualitative Analysis: Operational Definitions

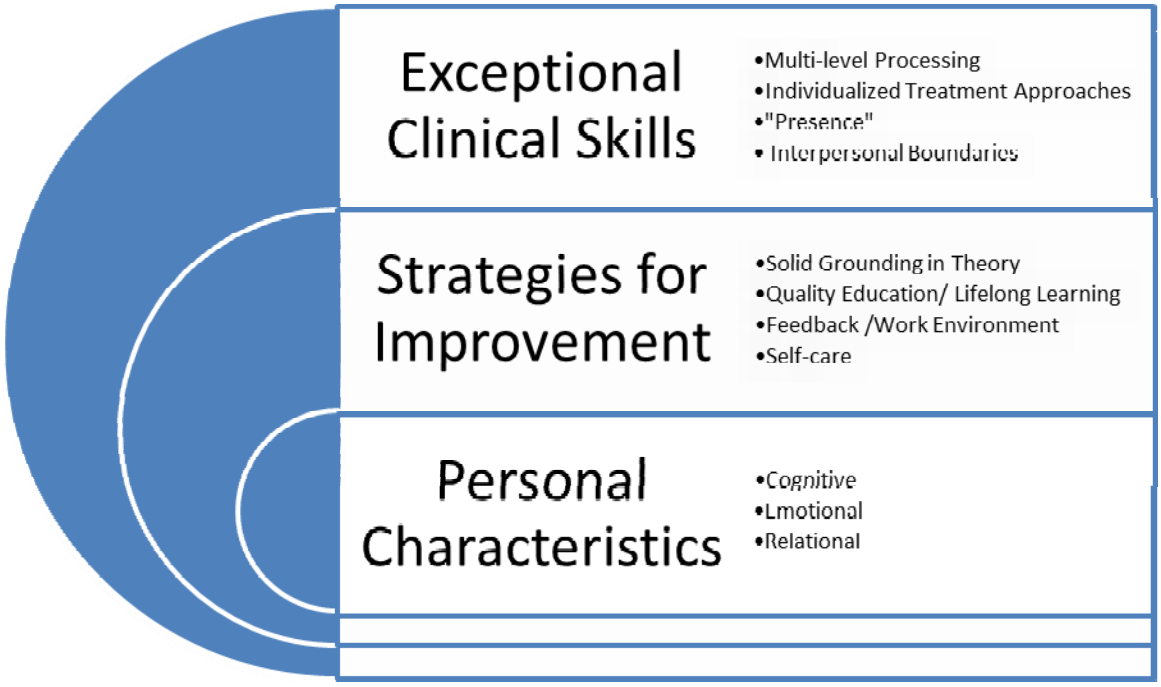
Figure 12 is a compilation of the most frequently and clearly articulated personal characteristics identified by participants. As a distillation of the content of 20 interviews with 20 different therapists, it is not representative of the views of any one of them, and individual subjects may disagree in part or whole with the following results and conclusions.

Figure 13: Important Personal Characteristics of Exceptional Therapists



As subjects outlined the personal characteristics listed, they described the components of clinical excellence, such as the ability to form a working relationship with clients. They then discussed the specific strategies they themselves had found helpful in their efforts to improve. In other words, there are personal and professional characteristics (the seeds) therapists must have in order to successfully employ strategies (sun and water) that support the development of higher level clinical skills (the "fruit" mentioned by MT-7).

Figure 14: Representation of Therapist Development



In the Cognitive Domain, subjects opined that the prerequisite personal characteristics for achieving clinical exceptionality include intelligence, verbal ability, an analytical mindset, cognitive flexibility, and curiosity about ideas, people and their stories. Without those, novice therapists are unlikely to actively engage in strategies that would ultimately train them to engage in multi-level processing, described in the following way:

> [The] capacity to listen intently but be thinking on more than one level at the same time, so that they are actively engaged in the interaction with their

> patient, but they also have other processes going on that allow them to take that information and work with it (MT-10).

Many subjects emphasized the importance of ongoing learning (C1-1, Yes = 13, 65 percent); a related theme was the importance of understanding and internalizing the structure of one or more psychological theories early on. With that foundation, over time, participants learned to choose techniques which seem to best fit the client and his/her situation while still remaining grounded. At the same time, there was some gentle criticism of therapists who engage in overly theoretical and/or technique driven practice. One example:

> I think that there are a lot of good therapists out there, and a lot of people who do good work. But…I think that there is a difference between people who are very technically competent and someone who is more artistic in what they do… there are certain things about the therapeutic process that I don't think you can teach someone… some [are able to] get better at it and grow…and there are some folks that just don't have that innate ability. I think that separates the artists from the technicians. And there are a lot of people who do very good work with folks who are very technique-driven. I don't necessarily think of them as the greater therapists. I think that there is a limit or there is a wall that they hit that they probably will not very easily get beyond (C-8).

In the Emotional Domain, characteristics frequently identified by subjects as crucial included compassion combined with the desire to help others, a good sense of humor, an optimistic outlook, self-awareness, and a nonjudgmental attitude. One strategy for improvement emphasized by those subjects who addressed the question was seeking feedback (E1-3, Yes = 10, 50 percent). That took the form of peer consultation, personal therapy, clinical supervision, and asking clients questions about their perception of how therapy is going. Without the characteristics listed, a therapist will lack the capacity to benefit from negative feedback, will avoid it, and may become prone to blaming clients for not improving. As described by one participant:

> I think [exceptional therapists must have] the capacity to bear enormous pain without flinching and then deciding to go into it even deeper. And I think also the capacity to bear incredible feelings of closeness and intimacy and to bear that. I don't think you can do that for someone else unless you can do it for yourself (MT-8).

A large number of therapists in this study reported that as their self-awareness increased, they tended to engage in more self-care activities, were less likely to work in unsupportive environments, and in general treated themselves and clients in a more nurturing way. As one therapist explained:

> I'm going to use DBT language because I think it fits. I would include radical genuineness, acceptance of your own and the patient's limitations, and non-

> judgment, which is vastly different than neutral, vastly… non-judgment doesn't mean you're neutral or don't feel…non-judgment sounds like a judgment in and of itself (C-4).

In the Relational Domain, identified characteristics included a genuine interest in other people, kindness, being a good listener, basic social skills, and authenticity. The ability to connect with others is essential, but without self-awareness, the therapist may be unable to detach from the client or the situation. Most participants emphasized the importance of identifying emotional reactions to clients, and managing them in a professional manner.

> [To be] really aware of what your issues are at any given moment is critical, because otherwise either you're not fully present for your clients or you don't listen well or you don't listen with that much curiosity or you're preoccupied because you're thinking about your own issues. I try to be pretty aware of my countertransference at any given time. I think it's important to be aware of if there are certain types of either individuals or types of problems that are stirring you up too much…I think sometimes people make the mistake of believing that to be good you have to always say yes to any person that comes along (MT-1).

As mentioned previously, one of the major problems previous studies looking at therapist effects on client outcomes have had is the inherent "mushiness" of words and phrases

such as “intelligence” and “compassion.” Although the analysis outlined in Figure 12 and Figure 13 does not solve that problem, it does describe some clinical skills and provides some suggestions for developing these skills, based on interviews asking the opinions of 20 experienced clinicians regarding the components of therapeutic excellence.

CHAPTER 4: DISCUSSIONS AND CONCLUSIONS

Research Questions

The research questions were:

(1) Would the results of this replication study be similar to Jennings' findings?

(2) Are there significant differences between master therapists and their matched controls in any of the domains or categories outlined in the CER model?

The answer to the first question is "yes." The CER model consists of three domains, each with three categories, and clearly describes the personal and professional characteristics of psychotherapists identified as "exceptional" through a peer nomination process (Skovholt & Jennings, 2004). The results of this dissertation are that the importance of each domain/category was mentioned by at least one, and typically more, research subjects.

The answer to the second question is "no." The answer to the second question is no: there were no significant differences found between groups on any of the 32 items. There are four possible explanations for this. (1) CER is a not a sensitive enough tool to differentiate between groups of clinicians. (2) The characteristics CER describes are not unique to master therapists. (3) The characteristics that professional peers believe are markers of superlative performance may not be valid. (4) The snowball sampling technique identifies exceptional therapists within a limited social network which may—or may not—be reflective of the profession as a whole.

On 23 of the 32 items, the raters agreed 50 percent or more of the time; inter-rater reliability was in the moderate range (K = .460). Nevertheless, the two research assistants disagreed 25 percent or more of the time on 20 of the 32 items. On four of those items, they disagreed 50 percent or more of the time (C2-1, C2-4, C3-2, and E2-4). The cutoff for inclusion in the analysis was less than 25 percent, which left only 12 items. Of those, two were responses to direct questions in the interview protocol. Overall, the research assistants failed to consistently identify the majority of operational definitions (n = 23, 72 percent). That suggests that the operational definitions were insufficiently clear, the research assistants were insufficiently trained, or both.

The two interview questions which asked for a either a “yes” or “no” response followed by an open-ended explanation by the subject had high inter-rater agreement (C2-3, Yes = 17, 85 percent; E1-2, Yes = 19, 95 percent). That suggests that in order to gather information related to a specific operational definition, the interview protocol should ask about it directly.

A subsequent qualitative analysis did not address the problems in the study of therapist effects identified by the primary researcher, *e.g*. non-specificity of identified characteristics which precluded generalization of study findings, and difficulty measuring within group differences in homogeneous populations. Nevertheless, the results provide some general guidelines for therapists who want to improve clinical outcomes, and suggest some concrete goals to which therapists might aspire.

Convergence with Research in the Field

The results of this study provide some support for two popular branches of research. First, the importance of therapists obtaining feedback in order to improve performance—a prevailing theme among subjects in this study—is consistent with findings coming out of the common factors school.

In 2004, authors Hubble, Duncan, and Sparks proposed a radical framework which empowered a client to define his or her theory of change. The focus of treatment becomes the therapeutic alliance, monitored each session by structured feedback from the client via a checklist. The psychotherapist, in collaboration with the client, uses that feedback to create an individualized service delivery plan which may (or may not) include standard therapeutic techniques. There is significant supporting evidence that feedback improves client outcomes (Eugster & Wampold, 1996; Whipple *et al*, 2003) and that in the absence of feedback, therapists may overestimate their competence (Hiatt & Hargrave, 1995).

Second, the results of this study converge with the research related to professional mastery. With the rise of professional coaching and the "positive psychology" movement, researchers have begun to take a strong interest in performance improvement. That area of research has tended to base hypotheses about workplace excellence on results from studies focused on the personality characteristics, personal histories, and interpersonal behavior of highly successful (often famous) individuals.

In *Outliers: The Story of Success*, Malcolm Gladwell presents a series of essays, each outlining a different component of what he argues are the underlying bases for mastery in any endeavor (2008). He hypothesized that success is predicated on talent and timing, but also experience; Gladwell proposed that it takes about ten years of concentrated effort to become exceptional (p. 35). As one example, he described a study of musicians, all of whom started playing around the age of five, which found a direct correlation between hours practiced and skill level:

> [Ericsson's] research suggests that once a musician has enough ability to get into a top music school, the thing that distinguishes one performer from another is how hard he or she works. That's it. And what's more, the people at the very top don't just work harder or even much harder than everyone else. They work much, *much* harder (p. 39).

Of course, without feedback, improvement is impossible. The majority of psychotherapists interviewed for this dissertation emphasized the importance of obtaining feedback; of that group, most admitted that receiving negative feedback from respected colleagues or clients can be painful. For example: I pay for supervision, and probably will until I retire (MT-8).

The primary tool that a clinician uses is the self, and several participants noted that willingness to accept the pain of what is often personal criticism is a key to professional growth. As MT-4 put it:

> I think to become an expert—I think that's true of most things—requires an enormous amount of self-discipline, because you have to be self-disciplined to keep up on the literature to go to conferences, to ask questions, to get supervision. And along with that, I think you also have to be willing to be vulnerable. Because if you're really utilizing supervision it means that you're making yourself vulnerable to critique and to all sorts of things, so I think that's another very important quality (MT-4).

Limitations of This Study

This study has several limitations. One is that the research protocol precluded obtaining a random sample of therapists in Cumberland County; by design, the sample size was small (*n*=20), and homogeneous. In addition, because the informants used their subjective judgment to identify master therapists, there are no quantifiable determinants of effectiveness. Therefore, the sample is not representative of the population of psychotherapists in Cumberland County, and the results of this study should not be generalized.

The attempt to follow Jennings' research protocol was not entirely successful. In large part that is because the response rate among potential participants for this study was very low. The snowball became redundant relatively early in the process (leaving only 62 potential subjects), the majority of therapists nominated (55 percent) did not participate, and of the final sample of 29 therapists, 10 in the top 15 either did not respond to inquiries or refused to participate. As a result, five of the 10 master therapists only received two nominations each. In addition, only 15.3 percent of surveys were returned, making it difficult to precisely match master therapists to controls.

There are substantial differences between the two demographic regions for the subject pools for this study versus Jennings' (Hennepin County, Minnesota versus Cumberland County, Maine), and these could have influenced the outcome of this study in unpredictable ways (See Appendices D-1, D-2, E-1, E-2, and E-3).

The research questions at times seemed to constrain, rather than facilitate, conversations with subjects. It was frequently necessary to cut off interesting and productive lines of thought in order to get all sixteen questions answered. A simpler, more open-ended series of questions and more time would have given the subjects more opportunity to elaborate on the points they felt most important.

Possibilities for Future Research

The snowball sampling technique uses a proxy—professional reputation—for actual clinical outcome measures. An obvious (and potentially interesting) future research project would be a similar study using objective outcome data.

An ongoing problem with research regarding therapist effects is the difficulty identifying personal characteristics clearly, *e.g*. "curiosity" "intelligence" and "self-awareness" are elusive constructs. The approach taken in this study failed, but this may have been in part due to differences between raters in their understanding of psychological terminology. Any later efforts could consider further simplifying operational definitions, using professional clinicians as raters, and spending considerable time training prior to coding interviews. Although some interesting findings emerged from these analyses of the data, problems arising from rater

disagreement limited the reliability of such a study. Future quantitative research efforts in the area of therapist effects would have to address this problem in order to the studies to be useful.

Finally, this study brings up interesting questions about what "exceptional clinical skill" looks like, successful strategies for achieving it, and the personal and professional characteristics necessary to fuel progress. A qualitative study could produce a process flow diagram describing what highly rated clinicians believe are the connections between these factors, and this analysis could provide the basis of some interesting future studies about therapist development.

Implications for Public Policy

The potential contribution of this study to the field of public policy is the suggestion that it might be possible to develop a replicable model of therapist excellence. Such a tool could lead to more effective and efficient mental health care. If research efforts could be directed towards using the CER model to explore the personal and professional characteristics of therapists who demonstrate exceptional client outcomes, items which are not supported by empirical evidence could be modified or eliminated, and new items added, ultimately resulting in a reliable instrument.

Final Conclusions

One of the problems with the concept of "master therapist" is that it implies a static state, or, if looked at from a developmental point of view, an end state. Although the

therapists in this study readily admitted that some therapists are better than others, and that much of that difference can be attributed to personal and professional characteristics, the prevailing sentiment was that over time, they themselves had improved their skills and grown as professionals. To do so, they *consciously* employed specific strategies, obtaining feedback from such sources as peer consultation and personal therapy, for example. In retrospect, most could identify which strategies most helped them improve (*e.g*. obtaining a solid grounding in one or more psychological theories). More importantly, they described what that improvement looks like (*e.g*. the ability to engage in multi-level processing). Therefore, any changes in policy based on the body of research regarding therapist effects should take into account that identifying the personal and professional characteristics associated with above-average client outcomes is just the beginning.

If a valid and reliable tool that could identify young therapists with the potential to produce exceptional outcomes existed, the primary challenge at the macro level would be developing policies to support their professional growth. In Jennings' study, all 10 master therapists worked in private practice (Skovholt & Jennings, 1999, p. 4). In this study, eight of the 10 subjects in the master therapist group worked in private practice (one was retired; another worked for a nonprofit agency). The reasons why private practice might be preferable were not addressed directly in either study, but the loss to institutions of well regarded, highly trained, and highly motivated clinicians should be worrisome to policymakers interested in maximizing the efficiency and effectiveness of the workforce of mental health professionals. The results of this study suggest that without institutional support for professional development, including

continuing education and structured feedback, beginning clinicians with the potential to be exceptional will either remain mediocre or seek opportunities in the private sector.

Appendix A-1: Informed Consent Form, Master Therapists

University of Southern Maine, Muskie School of Public Service

Consent for Participation in Research-Master Therapist

The Personal and Professional Characteristics of Master Therapists and Matched Controls

Principal Investigator

The principal investigator for this study is Barbara Granville, LCSW who is a doctoral candidate at Muskie School of Public Service and practicing psychotherapist.

Whom may I contact with questions?

For questions or more information concerning this project, the principal investigator may be reached at Barbara.Granville@maine.edu, (207) 212-3634 or (207) 933-6916.

If you choose to participate in this research study and believe you may have suffered a research related injury, contact the Chair of the PhD Program, Barbara Fraumeni, PhD (207) 228-8245 (email bfraumeni@usm.maine.edu) or Dissertation Committee Member Kate Forhan, PhD at (207) 288-8352 (email kforhan@usm.maine.edu), for further instructions.

None of these researchers have any financial interest in this study at present. You will receive no reimbursement for participation.

If you have any questions about your rights as a research subject or concerns about the study itself, please contact the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

Introduction

We are requesting your participation in a research study exploring the personal and professional characteristics of psychotherapists.

Please read this form. You may also request that the form is read to you. You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. Your participation is voluntary. You will be given a copy of this consent form.

Why is this study being done?

- We are attempting to replicate the results of researchers who described specific personal and professional characteristics of psychotherapists who were identified as exceptional through a peer nomination process.
- Using a variety of qualitative and quantitative techniques, we will compare your responses to a series of interview questions to those of other psychotherapists in Cumberland County who were also nominated, as well as others similar to you but not nominated, and look for differences.

Who will be in this study?

- You were selected for possible participation because several colleagues nominated you when asked to identify individuals considered to be exceptional psychotherapists.
- In total, there will be twenty psychotherapists included in this study (ten nominated by colleagues, and ten located through a survey of psychotherapists in Cumberland County).

What will I be asked to do?

If you agree to be in this study, the primary researcher will schedule an interview with you at your convenience, in a location of your choice. The interview will take about an hour and consist of approximately sixteen open ended questions. You can choose to not answer any question and can stop the interview any time you want. This interview will be taped, and the tape transcribed. You will be provided with a copy of the transcript and a synopsis for your review. Then, about ten days later, you will be contacted by telephone or email to confirm that the synopsis is accurate. If it is not, you will be given the opportunity to correct it.

What are the possible risks of taking part in this study?

- Although in any sort of report we may publish, we will attempt to exclude information that could be identified with any individual participant, given the small number of psychotherapists in Cumberland County it is possible that others might recognize you from the demographic data you provide or your comments.
- There is also a risk that participation in this study might have an impact-negative or positive-on your assessment of your professional skills.

What are the possible benefits of taking part in this study?

- The only anticipated benefit to you is the knowledge that you have contributed to our understanding of the personal and professional characteristics of psychotherapists.

How will my privacy be protected?

Any identifying information will be maintained by the principal investigator in a secure location for at least three years after the project is completed before being destroyed.

A copy of your signed consent form will be maintained by the principal investigator for at least three years after the project is completed before it is destroyed. The consent forms

will be stored in a secure location that only members of the research team will have access to and will not be affiliated with any data obtained during the project.

Please note that regulatory agencies and the Institutional Review Board may review the research records.

What are my rights as a research participant?

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the Muskie School of Public Service. You may skip or refuse to answer any question for any reason. You are free to withdraw from this research study at any time, for any reason. If you choose to withdraw from the research there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive. If you chose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.

Participant's Statement:

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

_____ _____

Participant's signature or legally authorized representative Date

_____

Printed name

Researcher's Statement:

The participant named above had sufficient time to consider this information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

_____ _____

Researcher's signature Date

_____

Printed name

Appendix A-2: Informed Consent Form, Controls

University of Southern Maine, Muskie School of Public Service

Consent for Participation in Research-Control

The Personal and Professional Characteristics of Master Therapists and Matched Controls

Principal Investigator

The principal investigator for this study is Barbara Granville, LCSW who is a doctoral candidate at Muskie School of Public Service and practicing psychotherapist.

Whom may I contact with questions?

For questions or more information concerning this project, the principal investigator may be reached at Barbara.Granville@maine.edu, (207) 212-3634 or (207) 933-6916.

If you choose to participate in this research study and believe you may have suffered a research related injury, contact the Chair of the PhD Program, Barbara Fraumeni, PhD (207) 228-8245 (email bfraumeni@usm.maine.edu) or Dissertation Committee Member Kate Forhan, PhD at (207) 288-8352 (email kforhan@usm.maine.edu), for further instructions.

None of these researchers have any financial interest in this study at present. You will not receive any reimbursement for participation.

If you have any questions about your rights as a research subject or concerns about the study itself, please contact the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

Introduction

We are requesting your participation in a research study exploring the personal and professional characteristics of psychotherapists.

Please read this form. You may also request that the form is read to you. You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. Your participation is voluntary. You will be given a copy of this consent form.

Why is this study being done?

- We are attempting to replicate the results of researchers who described specific personal and professional characteristics of psychotherapists who were identified as exceptional through a peer nomination process.
- Using a variety of qualitative and quantitative techniques, we will compare your responses to a series of interview questions to those of other psychotherapists in Cumberland County who were nominated, and look for differences.

Who will be in this study?

- You were selected for possible participation because the survey you completed and returned indicated that your demographic profile is similar to that of a psychotherapist who was nominated as exceptional by his/her colleagues.
- In total, there will be twenty psychotherapists included in this study (ten nominated by colleagues, and ten located through a survey of psychotherapists in Cumberland County).

What will I be asked to do?

If you agree to be in this study, the primary researcher will schedule an interview with you at your convenience, in a location of your choice. The interview will take about an hour and consist of approximately sixteen open ended questions. You can choose to not answer any question and can stop the interview any time you want. This interview will be taped, and the tape transcribed. You will be provided with a copy of the transcript and a synopsis for your review. Then, about ten days later, you will be contacted by telephone or email to confirm that the synopsis is accurate. If it is not, you will be given the opportunity to correct it.

What are the possible risks of taking part in this study?

- There is a risk that your involvement in this study could become known to other psychotherapists, as you were nominated by several colleagues for inclusion.
- Although in any sort of report we may publish, we will attempt to exclude information that could be identified with any individual participant, given the small number of psychotherapists in Cumberland County it is possible that others might recognize you from the demographic data you provide or your comments.
- There is also a risk that participation in this study might have an impact-negative or positive-on your assessment of your professional skills.

What are the possible benefits of taking part in this study?

- The only anticipated benefit to you is the knowledge that you have contributed to our understanding of the personal and professional characteristics of psychotherapists.

How will my privacy be protected?

Any identifying information will be maintained by the principal investigator in a secure location for at least three years after the project is completed before being destroyed.

A copy of your signed consent form will be maintained by the principal investigator for at least three years after the project is completed before it is destroyed. The consent forms will be stored in a secure location that only members of the research team will have access to and will not be affiliated with any data obtained during the project.

Please note that regulatory agencies and the Institutional Review Board may review the research records.

What are my rights as a research participant?

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the Muskie School of Public Service. You may skip or refuse to answer any question for any reason. You are free to withdraw from this research study at any time, for any reason. If you choose to withdraw from the research there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive. If you chose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.

Participant's Statement:

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

_____ _____

Participant's signature or legally authorized representative Date

_____

Printed name

Researcher's Statement:

The participant named above had sufficient time to consider this information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

_____ _____

Researcher's signature Date

_____

Printed name

Appendix A-3: Informed Consent Form, Survey

University of Southern Maine, Muskie School of Public Service

Consent for Participation in Research-Survey

The Personal and Professional Characteristics of Master Therapists and Matched Controls

Principal Investigator

The principal investigator for this study is Barbara Granville, LCSW who is a doctoral candidate at Muskie School of Public Service and practicing psychotherapist.

Whom may I contact with questions?

For questions or more information concerning this project, the principal investigator may be reached at Barbara.Granville@maine.edu, (207) 212-3634 or (207) 933-6916.

If you choose to participate in this research study and believe you may have suffered a research related injury, contact the Chair of the PhD Program, Barbara Fraumeni, PhD (207) 228-8245 (email bfraumeni@usm.maine.edu) or Dissertation Committee Member Kate Forhan, PhD at (207) 288-8352 (email kforhan@usm.maine.edu), for further instructions.

None of these researchers have any financial interest in this study at present. You will not receive any reimbursement for participation.

If you have any questions about your rights as a research subject or concerns about the study itself, please contact the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

Introduction

We are requesting your participation in a research study exploring the personal and professional characteristics of psychotherapists.

Please read this form. You may also request that the form is read to you. You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. Your participation is voluntary. You will be given a copy of this consent form.

Why is this study being done?

- We are attempting to replicate the results of researchers who described specific personal and professional characteristics of psychotherapists identified as exceptional through a peer nomination process.
- We will interview two groups of psychotherapists and, using a variety of qualitative and quantitative techniques, look for differences.
- The first group will consist of psychotherapists considered exceptional by colleagues, and the second-similar to the first in terms of demographic profile, but not nominated for inclusion in the first group-will be located through this survey.

Who will be in this study?

- Your name was chosen at random from the professional licensing database.
- If you are selected for participation, it will be because the survey you completed and returned indicated that your demographic profile is similar to that of a psychotherapist who was nominated as exceptional by his/her colleagues.
- In total, there will be twenty psychotherapists included in this study (ten identified by colleagues, and ten located through this survey of psychotherapists in Cumberland County).

What will I be asked to do?

If you meet criteria and agree to be in this study, the primary researcher will schedule an interview with you at your convenience, in a location of your choice. The interview will take about an hour and consist of approximately sixteen open ended questions. You can choose to not answer any question and can stop the interview any time you want. This interview will be taped, and the tape transcribed. You will be provided with a copy of the transcript and a synopsis for your review. Then, about ten days later, you will be contacted by telephone or email to confirm that the synopsis is accurate. If it is not, you will be given the opportunity to correct it.

What are the possible risks of taking part in this study?

- There is a risk that your involvement in this study could become known to other psychotherapists, as you were nominated by several colleagues for inclusion.
- Although in any sort of report we may publish, we will attempt to exclude information that could be identified with any individual participant, given the small number of psychotherapists in Cumberland County it is possible that others might recognize you from the demographic data you provide or your comments.
- There is also a risk that participation in this study might have an impact-negative or positive-on your assessment of your professional skills.

What are the possible benefits of taking part in this study?

- The only anticipated benefit to you is the knowledge that you have contributed to our understanding of the personal and professional characteristics of psychotherapists.

How will my privacy be protected?

Any identifying information will be maintained by the principal investigator in a secure location for at least three years after the project is completed before being destroyed.

A copy of your signed consent form will be maintained by the principal investigator for at least three years after the project is completed before it is destroyed. The consent forms will be stored in a secure location that only members of the research team will have access to and will not be affiliated with any data obtained during the project.

Please note that regulatory agencies and the Institutional Review Board may review the research records.

What are my rights as a research participant?

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the Muskie School of Public Service. You may skip or refuse to answer any question for any reason. You are free to withdraw from this research study at any time, for any reason. If you choose to withdraw from the research there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive. If you chose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.

Participant's Statement:

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

_____ _____

Participant's signature or legally authorized representative Date

_____

Printed name

Researcher's Statement:

The participant named above had sufficient time to consider this information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

_____ _____

Researcher's signature Date

_____

Printed name

Appendix B-1: Recruitment Letter for Controls

Barbara Granville, LCSW
499 Main Street
Monmouth, ME 04259
(207) 933-6916
Barbara.Granville@maine.edu

Dear _____:

I am a doctoral student at the Muskie School of Public Policy, and am looking for ten outpatient psychotherapists who work with adults and are willing to participate in my dissertation research project.

Your name was chosen at random from the professional licensing database, and I hope that you might be willing to help.

The ten psychotherapists I am looking for need to meet specific criteria including professional license(s) held, gender, age, years of experience, and possibly theoretical orientation.

I would very much appreciate it if you would review and sign the enclosed Informed Consent Form, fill out the enclosed (very brief) survey and return both in the stamped envelope provided. There is a second Informed Consent Form provided which you can keep for future reference.

If you meet criteria for inclusion in the study, I will be in touch to provide you with more information and schedule a time to meet.

Please don't hesitate to contact me with any questions, and thank you for your consideration of my request.

Sincerely Yours:

Barbara Granville, LCSW

Appendix B-1: Survey

Survey

Do you currently provide outpatient mental health services to adults? **Yes** **No**

What professional license(s) do you currently hold?

Your gender:

The year of your birth:

Approximately how many years of clinical experience do you have?

Do you consider any of the following to be your primary theoretical orientation?
If so, please circle.

Psychodynamic Behavioral/Cognitive Behavioral Humanistic

Systemic Medical Model

If selected to be in this study, would you be willing to participate? Yes No

Description of Study Procedures

If you meet criteria and agree to be in this study, the primary researcher will schedule an interview with you at your convenience, in a location of your choice. This interview will take about an hour and consist of approximately sixteen open ended questions. You can choose to not answer any question and can stop the interview any time you want. The interview will be taped, and the tape transcribed. You will be provided with a copy of the transcript and a synopsis for your review. Then, about ten days later, you will be contacted by telephone or email to confirm that the synopsis is accurate. If it is not, you will be given the opportunity to correct it.

Your contact information:

Thank you for completing our survey…!

Appendix C-1: Typology from Jennings' (1996) Original Work

Jennings, L. (1996). *Personal characteristics of master therapists.* Unpublished dissertation, University of Minnesota, Minneapolis, MN

Cognitive Domain

Category A: Master Therapists are Voracious Learners

Theme 1. Respondents are intensely curious, and driven to learn more about the human condition, human behavior, and therapy practices.

Theme 2. Respondents gained valuable knowledge from positive mentoring experiences.

Theme 3. Accumulated experiences have become a major resource for Respondents.

Theme 4. Respondents' commitment and openness to learning allowed them to glean the maximum benefit from their experiences.

Category B: Master Therapists are Reflective and Self-Aware

Theme 1. Respondents are highly reflective, introspective, and self aware.

Theme 2. Respondents utilize their awareness and reflective stance to skillfully manage transference and countertransference.

Category C: Master Therapists are Comfortable with Ambiguity and Complexity.

Theme 1. Respondents value cognitive complexity and the ambiguity of the human condition.

Theme 2. Respondents are cognizant of the multitude of cultural/individual differences among clients.

Theme 3. Respondents use complex and multiple criteria in judging therapy outcomes.

Category D: Master Therapists Appear to be Open and Non-Defensive

Theme 1. Respondents willingly engage in intense feedback processes such as therapy, supervision, and peer consultation to enhance their professional development.

Theme 2. Respondents have a non-defensive posture which enables them to learn from client feedback.

Theme 3. Respondents openly acknowledge their limitations as therapists.

Emotional Domain

Category E: Master Therapists are Emotionally Mature Individuals Who Attend to Their Own Well Being.

Theme 1. As an indicator of emotional health, Respondents appear to act congruently in their personal and professional lives.

Theme 2. Respondents seem to have a healthy perspective on their sense of importance.

Theme 3. In their work, Respondents appear to have a deep sense of meaning and spiritual connection. This serves to enhance their emotional well-being.

Theme 4. Respondents attend to their well-being through personal therapy and other self-care practices.

Category F: Master Therapists are Aware of How Their Emotional Health Affects the Quality of Their Work.

Theme 1. Respondents know their own emotional well-being directly impacts their therapy work.

Theme 2. Through increased experience and emotional maturity, Respondents' level of pervasive professional anxiety has markedly decreased, permitting confidence to be present while working.

Relational Domain

Category G. Master Therapists Possess Strong Relationship Skills

Theme 1. Many Respondents learned a number of their relationship skills by taking on the role of therapist in their family of origin.

Theme 2. Respondents own emotional wounds have increased their compassion for others' pain.

Theme 3. Respondents possess a number of personal qualities (e.g. warmth, empathy, respect) that are conducive to establishing a strong working alliance.

Category H. Master Therapists Appear to be Experts at Applying Their Relationship Skills in Therapy.

Theme 1. Respondents believe that the foundation for therapeutic change is a strong working alliance.

Theme 2. Respondents believe in the clients' ability to change which may instill hope and strengthen the working alliance.

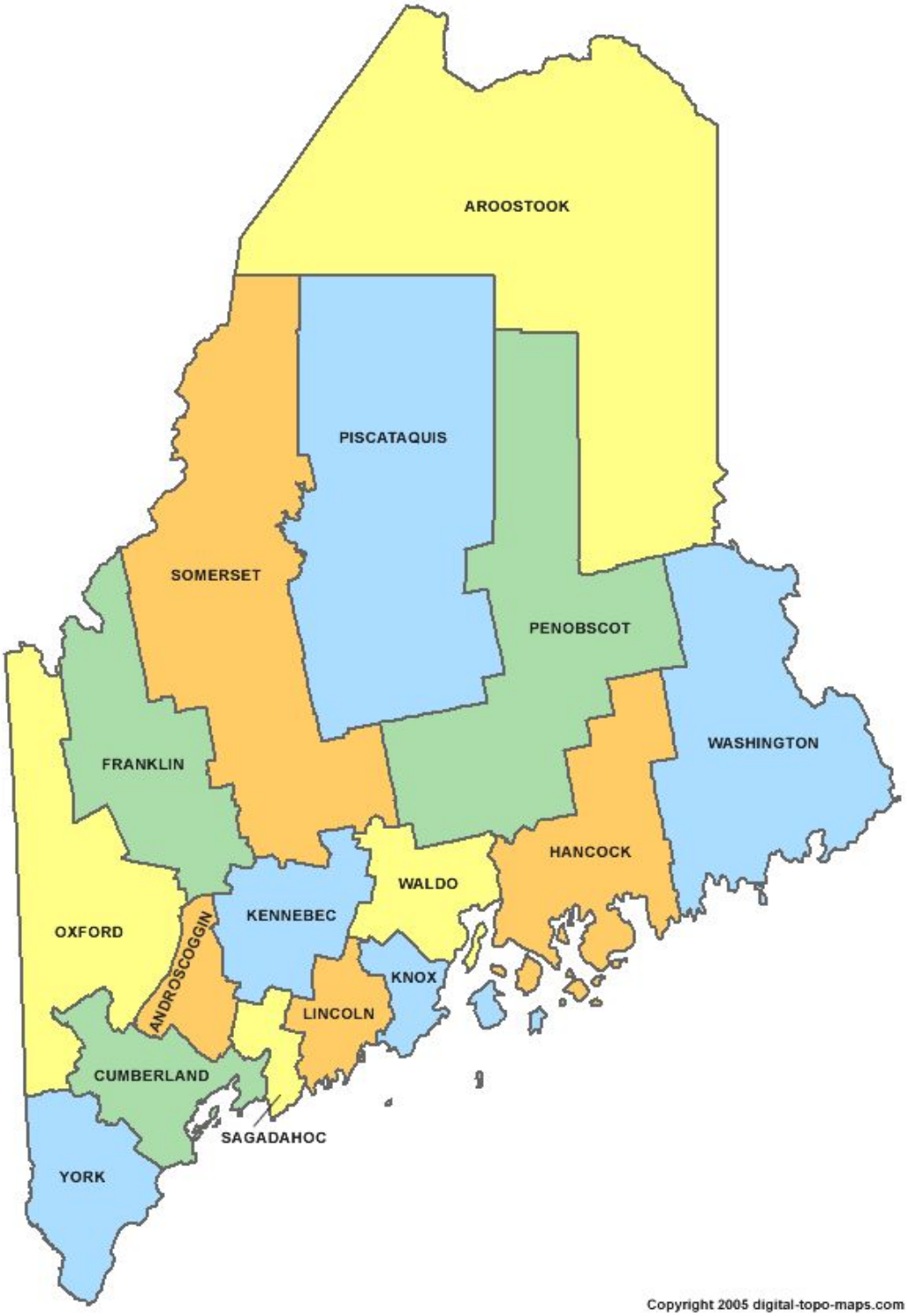
Theme 3. Not only are Respondents safe and supportive, they can also be strong with clients.

Theme 4. Respondents expressed no fear of their clients' strong emotions.

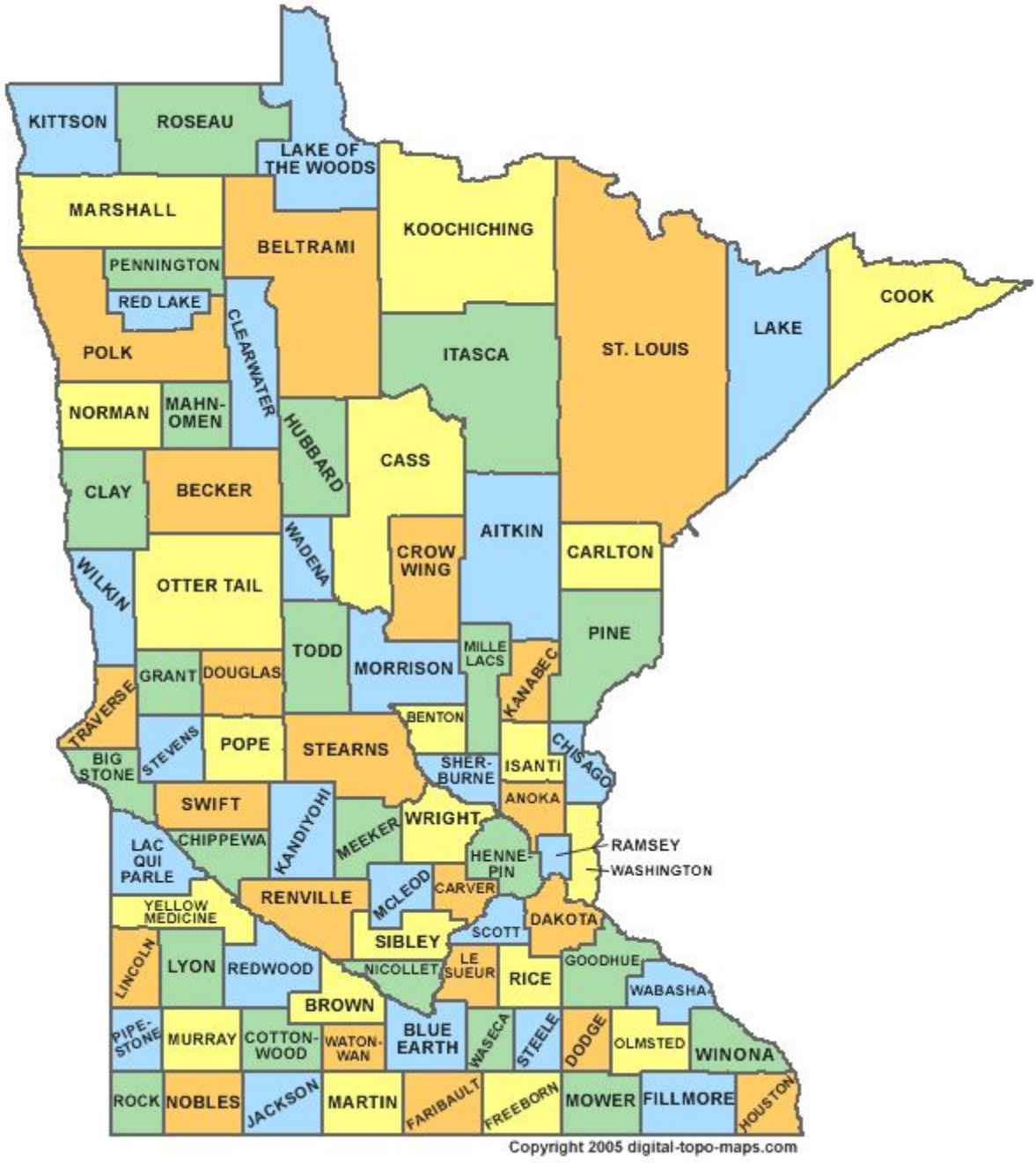
Theme 5. Respondents are highly skilled at the art of timing, pacing, and "dosage" while maintaining a strong working alliance.

Theme 6. Respondents learned the rules of science, but became masterful by artistically applying the rules within a therapeutic relationship.

Appendix D-1: Map of Cumberland County, Maine



Appendix D-2: Map of Hannepin County, Minnisota



Appendix E-1: Population Comparison of ME, 2010 and MN, 2000

Table 2.1	
Comparison: Population	State Population
Maine, 2010	1,328,361
Minnesota, 2000	4,919,479

Appendix E-2: Comparison of Cumberland County, ME 2010 and Hannepin County, MN 2000

Population, Ethnicity, Age Distribution

Table 2.2

Comparison: Population and Ethnicity	Population	White	Black	Asian	Hispanic or Latino Origin	American Indian and Alaska Native
Cumberland County, ME 2011	281,674	92.8%	2.4%	2.0%	1.8%	.03%
Hennepin County, MN 2000	1,116,200	74.4%	11.8%	6.2%	6.7%	0.9%
Portland, ME 2010	66,194	85%	7.1%	3.5%	3.0%	0.5%
Minneapolis, MN 2000	382,578	63.8%	18.6%	5.6%	10.5%	5.6%

Table 2.3

Age Distribution	**Cumberland County, 2006-2010**	**Portland, 2006-2010**	**Hennepin County, 2000**	**Minneapolis, 2000**
Under 5	5.2%	5.4%	6.6%	6.58%
Under 18	20.9%	17.1%	22%	24%
65 and Older	14.3%	12.6%	9.12%	11%

Population Density, Education, Income

Table 2.4		
Comparison: Population Density	Square Miles	Approximate Number of Persons Per Square Mile
Cumberland County, ME 2011	835.24	337
Hennepin County, MN 2000	553.59	2,016
Portland, ME 2010	21.31	3,107
Minneapolis, MN 2000	53.97	7,089

Table 2.5

Appendix E-2: Comparison of Cumberland County, ME 2010 and Hannepin County, MN 2000 **Comparison:** **Education and Income**	**Cumberland County, 2006-2010**	**Portland, 2006-2010**	**Hennepin County, 2000**	**Minneapolis, 2000**
Education				
High School Graduate (age 25+)	93.3%	91.3%	21.2%	20.74%
Bachelor's Degree or Higher (age 25+)	39.5%	43.2%	39.1%	24.33%
Income				
Per Capita	$31,041	$27,794	$28,789 $37,308* $35,902**	$22,685 $29,397* $29,551**
Household	$55,658	$44,422	$51,711 $67,013* $61,328**	$37,974 $49,211* $46,075**

* Adjusted for inflation, using http://www.westegg.com/inflation/

** In 2010.

Appendix F: Results Chart

Cognitive Domain				
Category 1. Master Therapists are Voracious Learners				
Operational Definition C1-1. The therapist states that ongoing learning is important.				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	7	6	**13**	= 65%*
No	1	3	4	
Rater Disagreement	2	1	3	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .266, *p* = .494
Operational Definition C1-2. *Mentions staying current with new theories/techniques, or obtaining continuing education.*				
Yes	6	3	**9**	= 45%
No	1	4	5	
Rater Disagreement	3	3	6	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .374, *p* =.247

Category 2. **Accumulated Experiences Have Become A Major Resource for Master Therapists**				
Operational Definition C2-1. Reports less need for therapeutic models ("going by the book").				
Yes	5	4	9	
No	1	0	1	
Rater Disagreement	4	6	**10**	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .275, *p* = .470

Cognitive Domain				
Operational Definition C2-2. Mentioned better ability to handle angry/critical clients.				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	2	0	2	
No	5	7	**12**	= 60%
Rater Disagreement	3	3	6	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .342, *p* = .311
Operational Definition C2-3. Notes that experience alone isn't enough to become a good therapist.				
Yes	9	8	**17**	= 85%*
No	0	0	0	
Rater Disagreement	1	2	3	‹ 5

Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .140, *p* = .531
Operational Definition C2-4. Notes increased confidence, decreased anxiety.				
Yes	5	4	9	
No	0	0	0	
Rater Disagreement	5	6	**11**	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .101, *p* = .653
Category 3. **Master Therapists Value Cognitive Complexity and the Ambiguity of the Human Condition**				
Operational Definition C3-1. Mentions variant of the word "curious."				
Yes	7	2	**9**	‹ 50%
No	0	4	4	
Rater Disagreement	3	4	7	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .588, *p* = .031**
Operational Definition C3-2. *Finds some therapeutic approaches and models too simplistic, don't take enough into account.*				
Yes	5	2	7	
No	1	3	4	
Rater Disagreement	4	5	**9**	› 5

Total				
Difference Between Groups (Not Significant)				*V* = .346, *p* = .302

Emotional Domain				
Category 1. Master Therapists Appear to Have Emotional Receptivity				
Operational Definition E1-1. Some variant of, "You need to know yourself."				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	8	6	**14**	= 70%
No	0	0	0	
Rater Disagreement	2	4	6	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .218, *p* = .329
Operational Definition E1-2. Admits to a limitation.				
Yes	10	9	**19**	= 95%*
No	0	0	0	
Rater Disagreement	0	1	1	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .299, *p* = .305

Operational Definition E1-3. Seeks feedback, e.g. peer consultation, own therapy, etc.				
Yes	7	3	**10**	= 50%*
No	1	4	5	
Rater Disagreement	2	3	5	= 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .424, *p* = .165
Category 2. Master Therapists Seem to be Mentally Healthy and Mature Individuals Who Attend to Their Own Emotional Well-Being				
Operational Definition E2-1. Mentions importance of being authentic/real with clients.				
Yes	7	2	**9**	‹ 50%
No	0	2	2	
Rater Disagreement	3	6	**9**	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .537, *p* = .056
Operational Definition E2-2. Tries to be the same person both at work and in personal life.				
Yes	2	1	3	
No	5	7	**12**	= 60%*
Rater Disagreement	3	2	5	= 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .208, *p* = .648

Emotional Domain				
Operational Definition E2-3. Mentions humility (or criticizes arrogance).				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	5	3	**8**	= 40%
No	3	4	7	
Rater Disagreement	2	3	5	= 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .205, *p* =.656
Operational Definition E2-4. Mentions honestly/integrity.				
Yes	2	2	4	
No	4	2	6	
Rater Disagreement	4	6	**10**	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .231, *p* = .587
Operational Definition E2-6. Mentions self-care activities such as exercise, meditation, etc.				
Yes	4	4	8	
No	5	4	**9**	= 45%
Rater Disagreement	1	2	3	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .149, *p* = .801
Emotional Domain				

Category 3. Master Therapists Are Aware of How Their Emotional Health Affects the Quality of Their Work

Operational Definition E3-1. Some variant of, "You need to be aware of what you are thinking and feeling so your own stuff doesn't get in the way.

Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	5	2	7	
No	1	4	5	
Rater Disagreement	4	4	**8**	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .393, *p* = .214

Operational Definition E3-2. Mentions counter-transference, or some variant of, "I ask myself if the problem is the client's or mine."

Yes	2	1	3	
No	7	8	**15**	= 75%*
Rater Disagreement	1	1	2	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .141, *p* =.819

Operational Definition E3-3. Mentions therapy being for the benefit of the client, not the therapist.				
Yes	1	0	1	
No	5	7	**12**	= 60%
Rater Disagreement	4	3	7	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .272, *p* = .478
Operational Definition E3-4. *Mentions an instance in which their own "stuff" (or life event) had an impact on their work.*				
Yes	4	2	6	
No	3	4	**7**	= 35%
Rater Disagreement	3	4	**7**	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .218, *p* = .621

Relational Domain				
Category 1. Master Therapists Possess Strong Relational Skills				
Operational Definition R1-1. Discusses how role in family prepared him/her for the work.				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	1	1	2	
No	9	9	**18**	= 90%*
Rater Disagreement	0	0	0	‹ 5
Total	10	10	20	
Difference Between Groups				*No variance.*
Operational Definition R1-2. Mentions the importance of compassion or empathy.				
Yes	8	4	**12**	= 60%
No	0	2	2	
Rater Disagreement	2	4	6	› 5
Total	10	10	10	
				V = .447, *p* = .135

Operational Definition R1-3. Discusses how personal events/tragedies have made them better therapists.				
Yes	1	1	2	
No	4	7	**11**	= 55%
Rater Disagreement	5	2	7	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .324, *p* = .349
Operational Definition R1-4. States that s/he has genuine care for clients.				
Yes	7	4	**11**	= 55%
No	1	1	0	
Rater Disagreement	2	5	8	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .324, *p* = .349

Relational Domain				
Category 2. Master Therapists Hold a Number of Beliefs about Human Nature That Help to Build Strong Working Alliances				
Operational Definition R2-1. Mentions the importance of the client/therapist relationship/alliance.				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	9	8	**17**	= 85%*
No	0	1	1	
Rater Disagreement	1	1	2	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .230, *p* = .589
Operational Definition R2-2. The responsibility in therapy is shared by both the therapist and client.				
Yes	4	2	6	
No	3	5	**8**	= 40%
Rater Disagreement	3	3	6	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .242, *p* = .558

Operational Definition R2-3. Believe that clients can change/heal.				
Yes	7	6	**13**	= 65%*
No	1	1	2	
Rater Disagreement	2	3	5	= 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .118, *p* = .871
Operational Definition R2-4. *Any statement which suggests respect for clients, awareness of their competence.*				
Yes	7	8	**15**	= 75%*
No	1	1	2	
Rater Disagreement	2	1	3	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .141, *p* = .819

Relational Domain				
Category 3. Master Therapists Appear to Be Experts at Utilizing Their Exceptional Relationship Skills in Therapy				
Operational Definition R3-1. Willing to challenge clients.				
Subject	Master Therapists (10)	Matched Controls (10)	Total	Significance
Yes	2	1	3	
No	5	8	**13**	= 65%*
Rater Disagreement	3	1	4	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .318, *p* = .363
Operational Definition R3-2. Creates safety.				
Yes	7	2	9	= 45%
No	2	4	6	
Rater Disagreement	1	4	5	= 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .512, *p* = .073

Operational Definition R3-3. Mentions dosage, timing, pacing.				
Yes	0	1	1	
No	6	7	**13**	= 65%
Rater Disagreement	4	2	6	› 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .295, *p* = .418
Operational Definition R3-4. No fear of strong emotions, or hearing difficult material.				
Yes	4	2	6	
No	3	7	**10**	= 50%*
Rater Disagreement	3	1	4	‹ 5
Total	10	10	20	
Difference Between Groups (Not Significant)				*V* = .404, *p* = .195

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