

BARTLEY, JODI L., Ph.D. Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth. (2015)  
Directed by Dr. Craig S. Cashwell. 305 pp.

It is well established that the therapeutic relationship is an important factor in the success of counseling (Lambert & Barley, 2001; Norcross & Wampold, 2011; Orlinsky, Rønnestad, & Willutzki, 2004). Furthermore, researchers (Price, 2012; Wiggins, 2013) have found that *relational depth* – characterized by profound moments of connection (Mearns & Cooper, 2005) – accounted for unique variance in client outcome over and above the therapeutic relationship. Therapists' experiences during moments of relational depth have been explored (Cooper, 2005a; Macleod, 2013); however, researchers have yet to validate those specific therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. Learning more about these factors could inform relational depth research, therapist training, and supervision. The primary aim of the following study was to better describe the relational depth process using concept mapping (Kane & Trochim, 2007; Trochim, 1989a) to explore therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients.

Twenty peer-nominated therapists participated in the first round of data collection, generating a synthesized set of 90 therapist factors believed to contribute to the ability to invite and facilitate moments of relational depth. Eighteen of these initial therapists participated in the second round of data collection, sorting and rating the statements based on importance and frequency. From there, the multivariate analyses of nonmetric multidimensional scaling and agglomerative hierarchical cluster analysis were

performed in order to create pictorial concept maps of the participants' aggregated conceptualizations. Furthermore, the importance and frequency ratings were represented by statement in a table and by cluster in a bar graph. Finally, nine therapists participated in the third phase of data collection – a focus group where they were invited to interpret the results of the study. The participants named the ten clusters: *Tuning In, Offering Genuine Connection, Practicing Presence, Being Emotionally Present, Using Engagement Skills, Bringing Immediacy, Structuring Intentionally, Facilitating Intimate Connection, Attending with Focus, and Honoring the Client*. Furthermore, as part of this focus group, the participants also offered their impressions of the importance and frequency ratings, described the ways they developed the capacity to invite and facilitate moments of relational depth, explored the results in light of the three positions of the therapist's use of self (Rowan & Jacobs, 2002), and offered implications for educators, supervisors, and relational depth researchers.

Six major findings emerged from the results of this study: (a) relational depth appears to represent a synergy of Rogers' (1957, 1980, 1989) core conditions; (b) experiences of relational depth seem to be predicated on therapists' intentional creation of a therapeutic structure and their deliberate use of specific counseling skills; (c) therapists seem to have developed the capacity to relate on deep levels after experiencing this type of engagement in their relationships with others (e.g., family members, therapists, supervisors, mentors, clients); (d) experiences of the transpersonal may perhaps set people on the path toward becoming therapists and eventually cultivating the capacity to engage on deeper levels; (e) relational depth appears to be trainable, though individuals

must have some capacity and desire, and finally; (f) relational depth appears to exist within and incorporate all three positions of the therapist's use of self (Rowan & Jacobs, 2002). Finally, these six results are explored in light of the literature on relational depth and implications and suggestions are offered for educators, supervisors, and researchers.

TOUCHSTONES OF CONNECTION: A CONCEPT MAPPING STUDY OF  
THERAPIST FACTORS THAT CONTRIBUTE TO  
RELATIONAL DEPTH

by

Jodi L. Bartley

A Dissertation Submitted to  
the Faculty of The Graduate School at  
The University of North Carolina at Greensboro  
in Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Philosophy

Greensboro  
2015

Approved by

---

Committee Chair

Dedicated to

The many cherished mentors who have graced my life.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of  
The Graduate School at The University of North Carolina at Greensboro.

Committee Chair \_\_\_\_\_  
Craig S. Cashwell

Committee Members \_\_\_\_\_  
L. DiAnne Borders

\_\_\_\_\_  
Bennett H. Ramsey

\_\_\_\_\_  
Richard M. Luecht

\_\_\_\_\_  
Date of Acceptance by Committee

\_\_\_\_\_  
Date of Final Oral Examination

## ACKNOWLEDGEMENTS

“The river has taught me to listen. . . You have already learned from the river that it is good to strive downwards, to sink, to seek the depths” (Hesse, 1951, p. 105). Offered to Siddhartha in his time of heartache, these words mirror the collected wisdom of the many mentors, friends, and family members who have journeyed with me through the depths of all that life is.

First, I want to thank my dissertation committee. My Dissertation Chair, Dr. Craig Cashwell, is simply the embodiment of grace. He journeyed with me through what honestly turned out to be the most personally challenging years of my life. It was through his gentle encouragement that I found the courage to examine the “books on my shelf,” to edge into painful vulnerability, to sink into the depths and risk new beginnings, to embrace the messiness of being real, and to experience a connection that exists beyond the façade of perfection. There is something so humbly beautiful in the archetypal image of the mentor *journeying with* a student in the midst of self-doubt and despair. I will never forget his words during such a time in my life, “The world needs you, Jodi.”

If Dr. Cashwell is the embodiment of grace, then Dr. L. DiAnne Borders is the personification of depth. There is something utterly unique and indescribable in her ability to resonate with the breadth and depth of the human condition. She taught me what it means to hold the paradoxes in life: to offer poignant gentleness in the midst of a firm message, to hold memories of yesterday while attuning to every nuance in the present moment, to dance in the intellectual while also traversing a bridge to the

emotional, and to listen from both deep within and far beyond. Wherever I go and whatever I do, her lasting presence will forever echo in my counseling and supervision, and for that, I am truly honored.

In addition to Dr. Cashwell and Dr. Borders, this dissertation absolutely would not have been possible without Dr. Bennett Ramsey and Dr. Richard Luecht. Working with Dr. Ramsey was an educationally enlightening experience, for he continually engaged me in the mental gymnastics of intellectualism, and for that, I am very thankful. I also acknowledge Dr. Luecht's guidance in conducting practice-based research, and finally, I want to express my gratitude for Dr. Robert Henson, who graciously helped me write R code.

Beyond those mentors at UNCG, I would also like to thank the many mentors who have shaped me along my educational journey. Dr. Deanna Lamb, who taught me the spirit of pedagogical engagement; Dr. Gail Mears, who first exposed me to the world of counseling; Dr. Gary Goodnough, who encouraged me to make the ineffable "effable" (a difficult challenge in this dissertation); and Dr. Hridaya Hall, who taught me the true gift of counseling presence.

In addition to my mentors, I also acknowledge my cohort members: Melissa, Kate, Tamarine, Bradley, Stephen, and Alwin. I could not have done any of this without their steadfast support and good humor. Long live *The Order of the Maigical Draigon* (spoken in a Minnesotan accent, of course)! I also thank the many friends in the cohorts above and below me – especially those in Cohort Bango and in Cohort Bearclaw.

And finally, I thank my family. Thank you to Caleb, who inspired me to venture across the country and follow my dreams. To my father, who gave me the gift of intellectual curiosity and a peculiar sense of humor. To my older brothers, Chris and Jason, who offered protective guidance throughout my life. And most importantly, I offer the utmost gratitude to my mother. It was my mom who taught me the origins of relational depth, rooted in a profound sense of compassionate love. For the rest of my life, I shall live to grace others with the love that she has consistently shown me.

## TABLE OF CONTENTS

	Page
LIST OF TABLES .....	xii
LIST OF FIGURES .....	xiii
CHAPTER	
I. INTRODUCTION.....	1
Overview .....	1
Therapeutic Relationship.....	4
The Person of the Therapist.....	4
Relational Depth.....	8
Therapist Factors Contributing to Relational Depth .....	9
Overarching themes.....	9
Clients' and therapists' perceptions.....	10
Conceptual presuppositions and development .....	14
Statement of the Problem .....	16
Purpose of the Study.....	17
Need for the Study.....	18
Research Questions .....	19
Definition of Terms .....	20
Brief Overview .....	21
II. LITERATURE REVIEW.....	23
The Construct of Relational Depth.....	23
Theoretical Background of Relational Depth.....	25
Person-Centered Therapy .....	26
Person-Centered Therapy and Relational Depth .....	28
Current Research on Relational Depth .....	30
Experiences of Relational Depth .....	30
Therapists' experiences .....	32
Clients' experiences.....	34
Relational Depth Across Populations .....	37
Younger populations .....	38
Clients with learning disabilities .....	39
Clients with trauma.....	39
Diverse populations .....	41
Relational Depth Across Modalities.....	42

Groups .....	43
Supervision .....	44
Process of Relational Depth .....	46
Conceptual Therapist Factors of Relational Depth .....	47
Measures of Relational Depth .....	50
Descriptions of the measures .....	50
Validity and reliability .....	51
Plausible factors inherent in the existing measures .....	52
Therapist Development .....	55
Therapist Development Models .....	56
Master Therapists .....	59
Therapist's Use of Self .....	62
Development of Relational Depth Capacity .....	66
Existential contact .....	66
Self-acceptance .....	68
Congruence .....	69
Dimensions of Relational Depth .....	71
Empathy .....	72
Genuineness .....	74
Unconditional Positive Regard .....	76
Therapeutic Presence .....	77
Comfort Inviting and Sustaining Emotional Intensity and Intimacy .....	80
Spiritual/Transcendent Openness .....	82
Personal Depth with a Willingness to be Vulnerable .....	85
Concept Mapping .....	87
Overall Summary .....	89
 III. METHODOLOGY .....	 91
Research Questions .....	91
Participants .....	92
Inclusion Criteria .....	92
Procedures .....	94
Step One: Preparing for Concept Mapping .....	95
Defining the issue .....	96
Initiating the process .....	96
Selecting the facilitator .....	97
Determining the goals and purposes .....	97
Defining the focus .....	97
Gaining approval by the IRB .....	98
Selecting the participants .....	98
Determining the participation methods .....	99

Developing the schedule, plan, and format .....	99
Determining the resources .....	99
Writing the concept mapping plan .....	99
Step Two: Generating the Statements .....	99
Preparing for the brainstorming session .....	100
Introducing the process .....	100
Synthesizing the statements .....	102
Step Three: Structuring the Statements .....	102
Planning the structuring activity .....	102
Introducing the process .....	103
Sorting the statements .....	103
Rating the statements .....	104
Step Four: Representing the Statements .....	104
Creating the total square symmetric dissimilarity matrix .....	105
Using multidimensional scaling .....	105
Using hierarchical cluster analysis .....	106
Representing importance and frequency ratings .....	106
Step Five: Interpreting the Concept Maps .....	107
Preparing for the session .....	107
Introducing the process .....	108
Presenting the cluster listings and naming the clusters .....	108
Presenting the point and cluster map .....	108
Presenting the point and cluster ratings .....	109
Discussing the results and identifying implications .....	109
<i>A Priori</i> Limitations .....	110
Pilot Study .....	112
Purpose .....	112
Participants .....	113
Procedures .....	113
Results .....	113
Modifications for the Full Study .....	114
Summary .....	116
IV. RESULTS .....	118
Research Questions .....	118
Participants .....	119
Procedures and Results .....	123
Preparing for Concept Mapping .....	123
Generating the Statements .....	123
Research question one .....	124

Structuring the Statements.....	124
Representing the Statements.....	125
Research question two .....	127
Research question three .....	127
Interpreting the Concept Maps .....	137
Cluster one.....	137
Cluster two.....	138
Cluster three.....	138
Cluster four.....	139
Cluster five .....	140
Cluster six.....	141
Cluster seven .....	141
Cluster eight.....	141
Cluster nine.....	143
Cluster ten.....	143
Importance and frequency ratings .....	148
Development of relational depth capacity .....	149
Representation of the therapist’s use of self.....	150
Implications for therapist educators and supervisors .....	152
Implications for relational depth researchers.....	153
Summary.....	155
V. DISCUSSION.....	156
Discussion of Results .....	156
Research Question One .....	157
Person-centered therapy .....	157
Conceptual therapist factors of relational depth.....	160
Research Question Two.....	168
Research Question Three.....	170
Development of Relational Depth Capacity.....	171
Representation of the Therapist’s Use of Self.....	174
Limitations.....	177
Implications for Training and Recommendations for	
Future Research.....	180
Implications for Educators and Supervisors.....	180
Recommendations for Relational Depth Researchers .....	182
Conclusion.....	186
REFERENCES.....	187
APPENDIX A. SITE APPROVAL.....	205

APPENDIX B. IRB APPROVAL .....	206
APPENDIX C. NOMINATION SCRIPT E-MAIL .....	208
APPENDIX D. SNOWBALL SAMPLING SCRIPT .....	210
APPENDIX E. INITIAL CONTACT E-MAIL .....	212
APPENDIX F. RESEARCH CONSENT FORM .....	214
APPENDIX G. DEMOGRAPHIC INFORMATION .....	218
APPENDIX H. GENERATING THE STATEMENTS INSTRUCTIONS .....	220
APPENDIX I. SORTING AND RATING THE STATEMENTS E-MAIL .....	221
APPENDIX J. SORTING AND RATING THE STATEMENTS INSTRUCTIONS.....	223
APPENDIX K. INTERPRETING THE RESULTS E-MAIL.....	225
APPENDIX L. INTERPRETING THE CONCEPT MAPS AGENDA .....	226
APPENDIX M. CERTIFICATE OF CONFIDENTIALITY .....	228
APPENDIX N. PILOT STUDY .....	229
APPENDIX O. PARTICIPANTS' INITIAL STATEMENTS .....	282
APPENDIX P. SYNTHESIZED STATEMENTS .....	296
APPENDIX Q. R SYNTAX AND DATA OUTPUT .....	299

## LIST OF TABLES

	Page
Table 1. Demographic Information .....	122
Table 2. Initial 10-Cluster Solution and Associated Ratings .....	132
Table 3. Final 10-Cluster Solution and Associated Names .....	144

## LIST OF FIGURES

	Page
Figure 1. Point Map.....	130
Figure 2. Cluster Tree/Dendrogram .....	131
Figure 3. Initial Cluster Map .....	135
Figure 4. Average Ratings by Cluster .....	136
Figure 5. Final Cluster Map.....	147

# **CHAPTER I**

## **INTRODUCTION**

### **Overview**

Mental health issues are prevalent in our society. Approximately 34 million adults in the United States receive professional help each year for mental health concerns (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012) and, worldwide, mental and substance use disorders were believed to account for 232,000 deaths in 2010 (Whiteford et al., 2013). Further, approximately 900,000 people die by suicide worldwide each year, often resulting from the effects of mental disorders (World Health Organization [WHO], 2013). Nationally, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) has reported an 18.6% prevalence rate for mental illness for adults in the United States, with a 4.1% prevalence rate for serious mental illness. Lack of adequate resources and the stigma of mental illness only compound the burdensome effects of these disorders (WHO, 2008). Further, beyond diagnosable mental illnesses, over a third of Americans report that high stress levels impact their mental health, and 5% of adults attempt to manage stress by seeking professional mental health services (American Psychological Association [APA], 2014). From these statistics, it seems clear that mental illness and stress are prevalent and that millions of people seek professional mental health services for these concerns.

A broad range of mental health professionals, including counselors, counselor educators, social workers, marriage and family therapists, pastoral counselors, psychologists, psychiatrists, and psychiatric nurses, provide these services. Throughout this document, the generic terms *therapist* and *mental health professional* will be used to refer to all of these types of individuals.

From the prevalence of mental health, substance abuse, and stress-related problems in society, it seems readily apparent that mental health professionals must provide qualified and competent care. In 1993, as part of an effort to improve mental health treatment, the American Psychological Association's (APA) Task Force on Promotion and Dissemination of Psychological Procedures sought to identify treatment practices that could be validated by research (Chambless & Ollendick, 2001). Since then, the evidence-based movement, including both evidence-based practices and empirically supported treatments, has proliferated in the mental health services field (Wampold & Bhati, 2004). Currently, SAMHSA's (2014) national registry of evidence-based programs and practices includes over 300 interventions.

Despite efforts to improve mental health practice, the evidence-based movement has not existed without controversy (Laska, Gurman, & Wampold, 2013; Norcross, 2001; Norcross & Lambert, 2011; Wampold & Bhati, 2004). According to Laska et al. (2013), empirically supported treatment relies on the specificity of the disorder and the specificity of the type of treatment. Relying on such an approach, therapists may fail to acknowledge the effects of the *common factors* of therapy (Laska et al., 2013; Norcross, 2001, 2011;

Wampold & Bhati, 2004), a presupposition that has existed for many years (see Rosenzweig, 2002 reprint of 1936 article; Watson, 1940).

Although both evidence-based techniques and common factors impact the therapeutic process (Laska et al., 2013; Norcross & Lambert, 2011; Siev, Huppert, & Chambless, 2009), Lambert and Barley (2001) concluded that common factors account for 30% of the variance in treatment outcome, as opposed to 15% of the variance accounted for by specific interventions. Discerning what these factors are and how many of them exist seems to depend on how they are categorized and labeled. According to Grenavage and Norcross' (1990) review of the literature, the number of common factors could range from one to 20. They organized these factors into five superordinate categories: (a) therapist qualities, (b) client characteristics, (c) change processes, (d) treatment structure, and (e) therapeutic relationship. Others (Frank & Frank, 1991; Laska et al., 2013; Rosenzweig, 2002 reprint of 1936 article; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003; Wampold, 2001; Watson, 1940) have explored similar variations of these common elements of therapy. One of the factors – the relationship or alliance between the therapist and the client – has proven especially important (Horvath, Del Re, Flückiger, & Symonds, 2011; Norcross & Lambert, 2011; Norcross & Wampold, 2011). In 1999, Norcross established a task force to examine the effects of the therapeutic relationship and individualized therapeutic interventions – irrespective of diagnostic labels (see Norcross, 2001) – and concluded that the therapeutic relationship and aspects therein are critical to effective client outcomes (Norcross & Wampold, 2011).

## **Therapeutic Relationship**

Scholars clearly have demonstrated that the therapeutic relationship is an important factor in client outcome (Lambert & Barley, 2001; Norcross & Wampold, 2011; Orlinsky, Rønnestad, & Willutzki, 2004). In addition to Lambert and Barley's (2001) assertion that the *common factors* of therapy (one of which includes the client-therapist relationship) account for 30% of the outcome variance, Orlinsky et al. (2004) explored over 1,000 studies and found that the therapist-client bond consistently factored significantly into client outcome. Furthermore, Horvath et al. (2011) analyzed the specific effects of the therapeutic alliance by conducting a large-scale meta-analysis reviewing over 14,000 treatments and found the therapeutic alliance to be a predictor of treatment with a robust meta-analytic outcome variance of 7.5% and an effect size of  $r = 0.275$ . It seems apparent, then, that the relationship between therapist and client is critical. Perhaps stated best by the Task Force on Evidence-Based Therapy Relationships: without the relationship component, evidence-based practice is "seriously incomplete" (Norcross & Wampold, 2011, p. 423).

## **The Person of the Therapist**

In addition to the therapeutic relationship, researchers have examined the characteristics and qualities of therapists, similarly finding these person-of-the-therapist issues to be a significant factor in client outcome. Although effects of such studies typically range from 5 to 8.6% of client outcome, researchers have not yet determined the exact cause of these effects. In a large-scale study including 6,146 patients and 581 therapists, Wampold and Brown (2005) found effective therapists accounted for 5% of

the outcome variance; however, none of the variables they explored (age, gender, degree, and experience level) accounted for significant portions of the variance. Similarly, using a sample of 1,841 clients and 91 therapists, Okiishi, Lambert, Nielsen, and Ogles (2003) reported significant differences between client outcomes depending on therapists; however, these differences could not be attributed to therapists' theoretical orientation, their type of education, their years of training, or their gender. The authors concluded that other qualities, as yet undetermined, might have caused these differences.

Other researchers, though, have identified therapist factors that may contribute to the variance in client outcome. For example, Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) found therapists' interpersonal skills (ability to effectively communicate with and persuade others) to be a significant predictor of client outcome, and Crits-Christoph, Baranackie, Kurcias, and Beck (1991) found that therapist experience level and adherence to treatment manuals impacted therapy outcome variance. Although it does appear that client outcome at least somewhat depends on the therapist, the specific therapist factors that contribute to improved client outcomes are not yet fully established. As part of the Division of Psychotherapy and Division of Clinical Psychology Task Force to explore evidence-based therapy relationships (cf. Norcross, 2011) researchers (Norcross & Lambert 2011; Norcross & Wampold, 2011) have recommended more exploration into therapist qualities and characteristics that help foster and sustain effective therapeutic relationships.

One possibility is that therapists at the higher stages of therapist development – specifically master therapists (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003;

Skovholt, Jennings, & Mullenbach, 2004) – emphasize and are better able to establish a strong therapeutic relationship (Jennings & Skovholt, 1999). Based on research with peer-nominated master therapists (with an average of over 29 years of experience), these individuals not only highlighted the importance of the therapeutic relationship, but also possessed expert relational skills (Jennings & Skovholt, 1999). Furthermore, therapists with more experience are believed to be more empathic, insightful, integrated, and open; are better able to respond to clients' unique needs; and can use themselves as a therapeutic tool in the relationship (Stoltenberg & McNeill, 1997).

In fact, therapists' ability to use *themselves* in the therapeutic process might explain differences in client outcomes. Such a framework focuses more on the therapist's personal features and way of being than specifically on the tasks of counseling (Reupert, 2008; Rowan & Jacobs, 2002). Theoretically, the therapist's use of self is commonly discussed in Family Systems theory (see Aponte & Winter, 1987; David & Erickson, 1990; Haber, 1990; Koehne-Kaplan, 1976; Lum, 2002). However, references to the use of self also are prevalent across various theories (see Cheon & Murphy, 2007; Miller, 1990; Omylinska-Thurston & James, 2011; Pagano, 2012). Although use of self may be conceptualized differently across theories, the essence of the concept remains the idiosyncratic ways that therapists use themselves in therapy.

Rowan and Jacobs (2002) described three different positions that therapists adopt as they use themselves in the counseling process. These three positions (instrumental, authentic, and transpersonal) are considered somewhat developmental, with the transpersonal position subsuming the previous two. In other words, a beginning therapist

typically operates from the instrumental self. However, an advanced therapist can operate from all three positions depending on what a client needs at any given point in time. With the first position (instrumental), skills-based, manualized treatment approaches prevail. Therapists operating from this position rely on technical treatment approaches to help clients. In fact, they may view this as using *the* approach to *fix* clients. Moving to the second position, the authentic way of being is characterized by more authentic interactions between the therapist and the client. In this position, the therapeutic relationship is considered much more important. In the third position of the therapist's use of self, the therapist relates in a transpersonal way with clients. Rowan and Jacobs (2002) described this transpersonal way of being as a place where the egoic concept of the self dissolves. Therapists who are able to relate from this place have been described as those “. . . who are open to experiences beyond or deep within themselves. . . This subtle consciousness cannot be ‘willed’ into existence, but often comes in brief moments” (Rowan & Jacobs, 2002, pp. 71-72). As postulated by Rowan and Jacobs (2002), the therapist's use of self provides a framework for the ways in which a mental health professional uses her or himself to heighten and deepen the therapeutic relationship. One aspect of this heightening and deepening that has drawn attention in the scholarly literature is relational depth, a powerful phenomenon believed to occur within the transpersonal position of Rowan and Jacobs' (2002) three positions of the therapist's use of self.

## **Relational Depth**

Relational depth is grounded in Rogers' (1957, 1980, 1989) Person-Centered Therapy, a theoretical approach centered on the salience of three core conditions: empathy, genuineness, and unconditional positive regard. It has been proposed that the synergetic effects of Rogers' core conditions can lead to powerful moments of connection, termed relational depth (Knox, Wiggins, Murphy, & Cooper, 2013b; Mearns & Cooper, 2005). Relational depth can be defined as "a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level" (Mearns & Cooper, 2005, p. xii). Although relational depth can be used to describe the overall quality of the therapeutic relationship, it is more often used to describe discrete moments of profound connection between two people (Knox et al., 2013b; Mearns & Cooper, 2005).

Relational depth is believed to account for client outcome over and above the working alliance (Price, 2012; Wiggins, 2013). Researchers have found that relationally deep moments may promote client change (Leung, 2008, as cited in Cooper, 2013a; Price, 2012; Wiggins, Elliott, & Cooper, 2012) and result in positive therapeutic effects (Knox, 2008, 2013). For example, in one study exploring the differential client outcome effects between relational depth (as measured by a version of the Relational Depth Inventory [RDI]; Price, 2012) and the therapeutic working alliance (as measured by the Working Alliance Inventory Short Form-Revised [WAI-SR]; Hatcher & Gillaspay, 2006), Price (2012) found that after accounting for pre-therapy effects, relational depth accounted for client outcome over and above the therapeutic working alliance (14%

accounted for by relational depth versus 0.5% accounted for by the therapeutic working alliance).

More specifically, clients have reported that moments of relational depth improved their connections to themselves, improved their relationships with others, improved the process of therapy, facilitated healing (Knox, 2008), promoted insight, gave them a lasting feeling of their therapist's presence (McMillan & McLeod, 2006), and helped them move forward and face issues (Knox, 2008; McMillan & McLeod, 2006). Summarily, although the outcome effects of relational depth are still in a nascent stage of discovery, the results thus far have proven promising and suggest that additional inquiry is warranted, specifically around therapist factors that may invite and facilitate the process of a relationally deep moment.

### **Therapist Factors Contributing to Relational Depth**

Certain therapist factors appear to increase the likelihood for relational depth. To explore this in greater depth, these factors can be examined from three different perspectives: (a) overarching themes of therapist factors drawn from empirical research, (b) clients' and therapists' perceptions of these factors inferred from qualitative research of their experiences of relational depth, and (c) conceptual presuppositions of therapist factors and the hypothesized developmental trajectory of learning how to invite and facilitate moments of relational depth.

**Overarching themes.** Based on the empirical literature on clients' and therapists' experiences of relational depth, it is posited that therapists who experience moments of relational depth possess certain qualities that fall into seven major themes: (a) empathy

(Cooper, 2005a; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006; Price, 2012; Wiggins et al., 2012); (b) genuineness (Cooper, 2005a; Frzina, 2012; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006; Price, 2012; Wiggins et al., 2012); (c) unconditional positive regard (Cooper 2005a; Knox 2008, 2013; Knox & Cooper 2010, 2011; McMillan & McLeod, 2006; Price, 2012; Wiggins et al., 2012), (d) therapeutic presence (Cooper 2005a; Frzina, 2012; Knox, 2008; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006; Price, 2012; Wiggins et al., 2012); (e) comfort inviting and sustaining emotional intensity and intimacy (Cooper, 2005a; Knox 2008; Knox & Cooper, 2010, 2011; Price, 2012; Wiggins et al., 2012); (f) spiritual and/or transcendent openness (Cooper, 2005a; Macleod, 2013; Price, 2012; Wiggins et al., 2012); and (g) personal depth with a willingness to be vulnerable (Cooper, 2005a; Knox & Cooper, 2010; McMillan & McLeod, 2006; Price, 2012; Wiggins et al., 2012). Taken together, these factors underscore a Rogerian essence to the mental health professional who experiences moments of relational depth. However, the ways in which therapists develop the capacity to *use* these Rogerian qualities to invite and facilitate deepened moments of connection with clients remains unclear. To explore this further, researchers have qualitatively examined clients' and therapists' experiences of relational depth.

**Clients' and therapists' perceptions.** Currently, there are limited published studies of therapists' (Cooper, 2005a; Macleod, 2013) and clients' (Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) experiences of relational depth. Based on these studies, certain therapist factors that contribute to moments of

relational depth can either be summarized or inferred. These studies highlight the apparent Rogerian essence of the therapist who experiences moments of relational depth; however, they also attempt to capture some of the more nuanced factors of these therapists.

Cooper (2005a) and Macleod (2013) used qualitative interviews to explore therapists' experiences of relational depth. Therapists reported that in moments of relational depth, they experienced themselves as highly congruent, empathic, accepting, immersed, alive, satisfied (Cooper, 2005a), deeply moved, and connected to their clients (Macleod, 2013). Interpreting and discussing the results of his study, Cooper (2005a) emphasized the importance of therapists' presence, and linked this finding to the therapeutic presence research conducted by Geller and Greenberg (2002). Macleod (2013) – specifically exploring therapists' experiences working with people with learning disabilities – emphasized communication, creativity, flexibility, care, and nondirectiveness as important therapist factors in relational depth. Although Cooper's (2005a) and Macleod's (2013) studies are beneficial in highlighting therapists' experiences of themselves in these moments, they fail to capture some of the nuanced ways that therapists use themselves to prepare for or specifically invite moments of relational depth.

As the process of relational depth is outlined, the therapist's ability to create an atmosphere conducive for relational depth and invite the client to participate in such moments is critical. However, Knox and Cooper (2011) and McMillan and McLeod (2006) found that *clients* initiate moments of relational depth when they are ready and

willing to be vulnerable and open to such an experience. Interestingly, though, clients' initiations were predicated on an invitation by their therapist (Knox, 2008, 2013; Knox & Cooper, 2010, 2011) and on certain qualities and characteristics clients perceived in these therapists. According to clients, qualities of therapists with whom they have experienced relational depth include the ability to be genuine (Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006); warm (Knox, 2008, 2013; Knox & Cooper, 2010); gentle (Knox 2008, 2013), positive, affirming (Knox, 2013), accepting (Knox, 2008, 2013; Knox & Cooper, 2010; 2011) trustworthy (Knox, 2008, Knox & Cooper, 2011); present (Knox, 2008; Knox & Cooper, 2010); competent (McMillan & McLeod, 2006); similar or right in some way (Knox, 2013; Knox & Cooper, 2010, 2011), psychologically sound (Knox, 2013; Knox & Cooper, 2010), patient, professional (Knox, 2013; Knox & Cooper, 2010), and mutual (Knox & Cooper, 2010).

Beyond the qualities of these therapists (or who they *are*), clients have identified certain actions they *do* that enable clients to risk being vulnerable and initiate moments of relational depth. Clients have stated that their therapists created the opportunity for relational depth (Knox, 2008) by establishing a safe atmosphere (Knox & Cooper, 2010) and inviting clients into it (Knox, 2008, 2013; Knox & Cooper, 2010, 2011) – perhaps through a subtle challenge (Knox, 2013; Knox & Cooper, 2011). Furthermore, they have commented on therapists' abilities to open inward (Knox, 2008; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006), understand them (Knox, 2008, 2013; Knox & Cooper, 2010, 2011), and support (Knox, 2008) and psychologically hold them (Knox & Cooper, 2010). In a more personal way, clients perceived these therapists as committed

(Knox & Cooper, 2010) in their willingness to offer something “over and above” what was necessary (Knox, 2008, p. 185; Knox, 2013, p. 25; Knox & Cooper, 2010; McMillan & McLeod, 2006). They even stated that these therapists were perceived as ideal parental figures (McMillan & McLeod, 2006). Accentuating the intuitive nature of clients’ perceptions of these therapists, clients have stated that they *knew* from the beginning with whom they could initiate such moments – that in some way, they knew their therapist was ready and could relate on a relationally deep level (McMillan & McLeod, 2006).

Conversely, clients stated that relational depth is unlikely to occur when they perceived their therapist as shallow/superficial (Knox & Cooper, 2010; McMillan & McLeod, 2006), over-controlling, too focused on the relationship, not able to provide what the client needs (McMillan & McLeod, 2006), inexperienced, cold, uncaring, too different from the client (in style or personality), disrespectful (perhaps misusing power), unprofessional, unable to understand the client, and unable to make the client feel comfortable (Knox & Cooper, 2010).

Taken together, it is evident that clients have been able to identify some clear therapist factors that contribute to or hinder moments of relational depth. However, other factors (like sensing from the beginning that they could engage on such a level with certain therapists) seem rather intuitive, which lends question to the more intangible therapist factors that may contribute to these deep connections. These intangible factors could be captured by conceptual presuppositions of the therapist who experiences moments of relational depth.

**Conceptual presuppositions and development.** Conceptually, scholars have suggested possible therapist factors that contribute to the ability to invite and facilitate moments of relational depth. Mearns and Cooper (2005) postulated that in order to facilitate moments of relational depth, therapists need to establish a safe environment, relinquish the desire to cure clients, bracket their assumptions, forego techniques, practice “holistic listening” (p. 120), gently invite deeper exploration, be with and engage all sides of clients, allow themselves to be touched by clients, decrease distractions, remain self-aware, practice transparency, and work in the “here and now” (p. 133). Mearns (1996, 1997) stated that relational depth is predicated on a therapist’s ability to be highly congruent, slow down, become still, and remain open to the experience, which requires a certain level of courage.

Along with these in-session factors, Mearns and Cooper (2005) outlined possible developmental factors that allow therapists to cultivate the capacity for relational depth. These factors included deepening existential contact and increasing self-acceptance, both of which they believed could be cultivated through personal therapy, supervision, group work, and training. To deepen existential awareness and contact, Mearns and Cooper (2005) stated that therapists needed to be open to the depths within themselves, which includes places of personal suffering. These emotional, ontological experiences of personal suffering have been described as the “existential touchstones” (p. 138) of the therapeutic encounter. In essence, “. . .we enter our own ‘depths’ to meet our clients in theirs” (p. 137). Coupled with increasing self-acceptance, therapists may develop a

greater capacity for inviting and facilitating profound moments of connection with clients.

Closely related to these in-session and developmental factors, Mearns and Schmid (2006) outlined a number of criteria for facilitating relationally deep moments. These criteria included existentiality, freedom of choice, immediacy, relationship-centeredness, mutuality, openness to risk, spontaneity, addressing all parts of the self, co-reflectiveness, quality, contextuality, and awareness of power (wordings exact). Furthermore, Mearns and Schmid (2006) echoed Mearns and Cooper's (2005) proposed developmental factors that increase therapists' capacity to engage on relationally deep levels. Beyond existential contact and self-acceptance, they also added increasing congruence, transparency, and self-awareness. Perhaps stated best, the authors asserted, "The endeavor [facilitating moments of relational depth] is so firmly tied to who the therapists is as a person – their personal awareness and security – that it is their *self* that must be the developmental agenda" (pp. 262-263).

Taken together, Mearns' (1996, 1997), Mearns and Cooper's (2005), and Mearns and Schmid's (2006) conceptual overviews of the possible therapist factors (both in-session and developmental) that contribute to moments of relational depth coincide with Rowan and Jacobs' (2002) three positions of the therapist's use of self. In the transpersonal position of the therapist's use of self, therapists are able to use skills (from the instrumental position) and their authentic selves (from the authentic position) in order to connect with others in a profound way. This research, coupled with reviews of therapists' and clients' experiences of relational depth in qualitative research, begins to

illuminate possible therapist factors that contribute to their ability to invite and facilitate moments of relational depth.

Although Rowan and Jacobs (2002) believed that relational depth occurs within the transpersonal position of the therapist's use of self, it remains unclear how their three positions might offer a frame for the therapist factors associated with relational depth. Specifically, from Rowan and Jacobs' (2002) first position (instrumental), are there any specific techniques that mental health professionals use to invite the moment (e.g., immediacy, emotional heightening, self-disclosure, evocative responding)? From the second position (authentic way of being), do moments of relational depth simply stem from who therapists are as people and how they authentically bring themselves into sessions? If so, how do they attend to themselves in ways that capitalize on their authenticity? From Rowan and Jacobs' (2002) third position (transpersonal), do mental health professionals enter into any subtle forms of consciousness (e.g., mindfulness, centering, loving-kindness) in order to facilitate such moments? In essence, what therapist factors (both what they *do* and who they *are*) contribute to the ability to invite and facilitate moments of relational depth? These types of questions have yet to be explored empirically.

### **Statement of the Problem**

Researchers have explored the phenomenon of relational depth from multiple angles (cf. Knox, Murphy, Wiggins, & Cooper, 2013a; Mearns & Cooper, 2005). For the most part, however, researchers have focused on the moment of relational depth (Frzina, 2012) or on therapists' (Cooper, 2005a; Macleod, 2013) and clients' (Knox, 2008, 2013;

Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) recollections of these moments. Although researchers have confirmed that therapists factor into the initiation of moments of relational depth and scholars have outlined conceptually how this may occur, these therapist factors have yet to be empirically validated and explored inside a larger theoretical framework (such as Rowan and Jacobs' [2002] three positions of the therapist's use of self), which could help explain the developmental trajectory of cultivation. In essence, then, although certain therapist factors have been suggested or can be implied based on participants' experiences, the specific factors that contribute to the ability to invite and facilitate moments of relationally deep connection with clients have yet to be explored in a purposeful manner.

### **Purpose of the Study**

The purpose of the study was fourfold: (a) to identify those specific therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients; (b) to identify the importance therapists ascribe to these factors in contributing to the ability to invite and facilitate moments of relational depth; and (c) to examine the frequency with which therapists practice these factors in their work with clients. Additionally, participants were invited to offer implications for research, therapist training, and supervision. As part of this, they examined whether or not these factors coincided with the three positions of the therapist's use of self as described by Rowan and Jacobs (2002). Answering these questions extended the current relational depth literature.

## **Need for the Study**

Although it seems clear from existing research that therapists play a vital role in the initiation of moments of in-session relational depth with clients and some conceptual framework exists for this, researchers have yet to empirically validate these ideas nor have they examined relational depth within a theoretical framework of the therapist's use of self (i.e., Rowan and Jacobs' [2002] three positions). Among mental health professionals, then, it is as yet unknown what contributes to their ability to invite and facilitate moments of relationally deep connection with clients.

Examining therapists' insights on those specific factors (and underlying themes) that contribute to their ability to invite and facilitate moments of relational depth could offer numerous implications for research, therapist training, and supervision. Currently, the best knowledge that we have suggests that mental health professionals need to possess empathy, genuineness, unconditional positive regard, therapeutic presence, comfort inviting and sustaining emotional intensity and intimacy, spiritual and/or transcendent openness, and personal depth with a willingness to be vulnerable in order to facilitate relational depth (Mearns & Cooper, 2005). These broad qualities are certainly beneficial but fail to capture the specific ways in which therapists use themselves (based on Rowan and Jacobs' [2002] three positions of the therapist's use of self) to invite and facilitate deepened moments of contact. Answering this question could guide future relational depth research exploring therapist training and supervision. For example, if researchers could identify and empirically validate factors that contribute to therapists' ability to invite and facilitate moments of relational depth, this logically would influence

training and supervision. As stress and mental illness are significant concerns worldwide and relational depth has been proven to account for positive client outcome over and above the working alliance, determining specific trainable factors that invite such deepened moments of connection warrants attention.

Furthermore, the results of this exploratory study could inform future research. Researchers could confirm the directional relationships between the emergent therapist factors (and underlying themes) and relational depth. For example, if participants engage in some practice before or in the midst of relationally-deep moments or if they utilize a certain skill to invite these experiences, researchers could find measures of these practices and/or skills and use them in prediction studies of relational depth and client outcome. Furthermore, process studies could be utilized to confirm the presence of these factors in recordings of counseling sessions. After confirming the validity of these factors, therapists could be better trained how to further cultivate, learn, and/or capitalize upon them in key moments in the counseling process.

### **Research Questions**

1. What therapist factors (prior to or during therapy) do participants believe contribute to the ability to invite and facilitate moments of relational depth with clients?
2. How important do participants believe each of the factors are in contributing to their ability to invite and facilitate moments of relational depth?
3. How often do participants practice these factors in their work with clients?

## Definition of Terms

*Relational depth* has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level” (Mearns & Cooper, 2005, p. xii). Although relational depth can be attributed to the overall relationship, it is more often attributed to specific and discrete moments in therapy (Knox et al., 2013b).

The *therapeutic relationship* is defined as “the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed” (Gelso & Carter, 1985, p. 159).

The *therapist’s use of self* or *use of self* is the therapist’s way of being in a therapeutic relationship, whether from an instrumental, authentic, or transpersonal position (Rowan & Jacobs, 2002). The *instrumental* position is the therapist’s ability to engage with a client through techniques, whereas the *authentic* position involves the use of self whereby “the therapist meets with and engages with the client additionally through attending to and experiencing what is going on within the therapist, through self-reflection, and monitoring her or his own feelings and thoughts” (Rowan & Jacobs, 2002, p. 121). The *transpersonal* position is the therapist’s engagement with “. . . what is passing *between or beyond* the therapist and client, in one way not attending to anything, neither self nor the client; but still open to feelings, thoughts and experiences that appear to come from nowhere” (Rowan & Jacobs, 2002, p. 121). Taken together, these ideas coalesce on the idiosyncratic ways that therapists use themselves in the therapist-client relationship.

The characteristics of Person-Centered Therapy (Rogers, 1957, 1980, 1989) – oft included in descriptions of relational depth – include genuineness, empathy, and unconditional positive regard. *Genuineness* is the transparency, congruence, and realness of the therapist, disregarding a professional façade. Additionally, genuineness includes the therapist’s openness to “. . . the feelings and attitudes that are flowing within at the moment” (Rogers, 1980, p. 115). *Empathy* occurs when a mental health professional intuits the “. . . feelings and personal meanings that the client is experiencing and communicates this understanding to the client” (Rogers, 1980, p. 116). *Unconditional positive regard* is defined as the therapist’s “. . . positive, acceptant attitude toward whatever the client *is* at that moment. . .” (Rogers, 1980, p. 116).

*Therapists or mental health professionals* are defined in this study as individuals who have graduated from master’s-level mental health therapy training programs (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling). Therapists may be practicing across a variety of settings (e.g., community mental health centers, university counseling centers, private practice settings, faith-based settings, in-patient treatment centers, and hospitals).

### **Brief Overview**

The following research study is divided into five chapters. The first chapter was developed to provide a broad overview of mental concerns worldwide, establish the importance of the therapeutic relationship and specific therapist factors, introduce the phenomenon of relational depth, illuminate current gaps in relational depth research, set the stage for the study, and suggest ways that the study may positively impact training

and research. In Chapter Two, relational depth is analyzed, synthesized, and contextualized within and across various theoretical frameworks, with a particular focus on the presupposed therapist factors that contribute to their ability to invite and facilitate moments of relational depth. The proposed study is outlined in Chapter Three, along with specific methodological steps and considerations. In Chapter Four, the results of the study are described, and these results along with limitations, implications, and directions for future research are discussed in Chapter Five.

## **CHAPTER II**

### **LITERATURE REVIEW**

In Chapter One, the current research on relational depth was described and critiqued and, from this, a study was proposed that explores the factors that contribute to a therapist's ability to invite and facilitate moments of relational depth. In this chapter, the construct of relational depth is summarized and compared across theories, therapist and client experiences of relational depth are described, the dimensions of the construct are analyzed and synthesized, the therapist's use of self and therapist development are outlined and examined in light of relational depth, and the methodology of concept mapping is summarized as a bridge to the procedures section outlined in Chapter Three. To sustain focus throughout this review, relevant literature is synthesized as it applies to and illuminates the factors that contribute to therapists' ability to invite and facilitate moments of relational depth.

#### **The Construct of Relational Depth**

Coined by Mearns in 1996, relational depth was first defined as “. . . relating with a client at very high levels of psychological contact. . .” (Mearns, 1996, p. 306). Later, it was defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level” (Mearns & Cooper, 2005, p. xii). The term can be

used to describe both the overall quality of the therapeutic relationship and discrete moments of deep contact (Knox et al., 2013b; Mearns & Cooper, 2005). More recently, however, researchers have focused more on the latter of the two conceptualizations (Knox et al., 2013b).

Although relational depth has been defined, capturing the heightened and deepened power of such phenomenological experiences has proven challenging (Cooper, 2013a; Knox, 2013) and, in fact, as stated so eloquently by Cooper (2013a):

Relational depth is not something that we can, or would ever want to, pin down. It exists by the virtue of its mystery, its ability to surprise and take hold of us and transform our lives in ways that we cannot predict or control. (p. 75)

The term “ineffable” seems to best capture the elusive quality of relational depth. It seems as though descriptions of the experience of relational depth transcend dualities – having been described as both energizing yet peaceful (Knox, 2008), scary yet safe, and empowering yet provoking vulnerability (Wiggins, 2013). Furthermore, participants have commented on the distinct change in the environment at such moments (Knox, 2008, 2013; McMillan & McLeod, 2006), with a slowed pace (Knox, 2008, 2013) leading to an experience that has been likened to states of flow (Cooper, 2005a; Knox & Cooper, 2011; McMillan & McLeod, 2006; Mearns & Cooper, 2005; Price, 2012; Wiggins, 2013; Wiggins et al., 2012) or altered states of consciousness (Cooper 2005a; Cooper, 2013a; Lago & Christodoulidi; 2013; Mearns & Cooper, 2005; Price, 2012; Wiggins, 2013; Wiggins et al., 2012). Participants have described moments of relational depth as mystical (Cooper, 2013a; Knox, 2013), unifying (Knox, 2008), magical, loving

(Wiggins et al., 2012), deeply meaningful, and healing (Knox, 2008). It also has been quoted as a “peak experience” (Knox, 2008, p. 187) and as a “heightened spiritual moment” (Knox, 2013, p. 26). The reaching quality of these descriptions underscores the power and ineffability of such experiences.

Illuminating the indescribability and elusiveness of relational depth could lead to a nihilistic attitude toward studying the construct. However, the intended purpose in highlighting its ineffability is to honor the phenomenological power of such moments and to recognize the inherent limitations of language and research. Thus, to study the construct with integrity is to acknowledge that part of its power resides in its mysterious ability to leave people struggling for words.

### **Theoretical Background of Relational Depth**

Mearns coined the term *relational depth* in 1996, so it might appear that relational depth is a contemporary, or perhaps novel, construct. The concept is not new, however, but simply characterizes the profundity of moments of connection within the theory of Rogers’ (1957, 1980, 1989) Person-Centered Therapy (Mearns, 2012). Relational depth, as a term, can be compared to terms across various theories, such as the *I-thou relationship* (Buber, 1958) in existential theory; *moments of meeting* (Stern, 2004), *implicit relational knowing* (Lyons-Ruth, 1998), and *working at the intimate edge* (Ehrenberg, 1974, 2010) in psychoanalytic theory; *dialogical approach* (Hycner, 1985, 1990) in Gestalt theory; *peak relational experiences* (Fosha, 2000) and *relational therapeutic presence* (Geller & Greenberg, 2012) in experiential theory; and *linking* (Rowan, 1998) in transpersonal theory, to name a few. Although it is beyond the scope of

this literature review to explore all synonymous terms across theories, they are mentioned to give credence to the theoretical breadth and historical depth of the construct. The focus of this review will center on relational depth as it is grounded in the core conditions (empathy, genuineness, and unconditional positive regard) of Rogers' (1957, 1980, 1989) Person-Centered Therapy.

### **Person-Centered Therapy**

Developed by Carl Rogers in the 1940s, Person-Centered Therapy was first termed *Nondirective Therapy* to differentiate it from the more directive approaches characteristic of the time period (Rogers, 1942). Using Nondirective Therapy, Rogers (1942) encouraged therapists to talk less, direct less, and notice emotions more. In essence, then, therapists could be conceptualized as tuning forks, ever tuning themselves to the goals set forth by clients and the unique emotional processes by which they arrived at those goals. With the publication of his book *Client-Centered Therapy*, Rogerian counseling was re-titled *Client-Centered Therapy* (Cain, 2010). Later in his life, Rogers' influence extended geographically (beyond the United States) and professionally (beyond the counseling field). With this expansion, the term *Client-Centered Therapy* changed to the most current term *Person-Centered Therapy* (Cain, 2010). However, researchers sometimes use *person-centered* and *client-centered* interchangeably.

Rogers (1957) believed that the tendency of humans is toward self-actualization and that given the necessary and sufficient conditions, people will gravitate toward their greatest potential. According to Rogers' theory, pathology stems from introjected childhood values, which creates a discrepancy between one's real and ideal self (Rogers,

1989). In an accepting environment, individuals know intuitively where they need to focus, and therapists simply provide space and encouragement to facilitate that process (Rogers, 1986). This inherent trust in individuals' self-actualizing potential epitomizes the essence of Person-Centered Therapy and served as the base within which Rogers' assumptions about the therapeutic process emerged.

Certainly one of the major underpinnings of Person-Centered Therapy is the emphasis and importance placed on the quality of the therapeutic relationship (Rogers, 1957, 1980, 1989). Rogers (1957) posited that this relationship could be considered a precondition and that "without it... the remaining items would have no meaning..." (p. 96). In discussing the most critical aspects of this relationship, Rogers (1989) emphasized the therapist's attitudes toward her or his clients. As such, he asked, "Can I let myself experience positive attitudes toward this other person – attitudes of warmth, caring, liking, interest, respect?" (p. 52). This relationship is characterized by the presence of the core conditions of Person-Centered Therapy, which serve as the foundation for relational depth.

The core conditions – empathy, genuineness, and unconditional positive regard – could be considered the hallmarks of Person-Centered Therapy, for it is within these conditions that Rogers believed healing occurred. In Rogers' (1957) first conceptualization of the conditions, they were nested inside a larger framework outlining six procedural steps of change: (a) psychological contact, (b) client incongruence, (c) therapist congruence, (d) therapist unconditional positive regard, (e) therapist empathy, and (f) communication of the empathy and unconditional positive regard to the client. In

Rogers' (1980, 1989) later writings, these steps were condensed into the three conditions of empathy, genuineness, and unconditional positive regard.

In one of his earlier writings, Rogers (1957) briefly described each of these conditions. According to him, empathy is the ability to “sense the client’s private world as if it were your own, but without ever losing the ‘as if’ quality” (Rogers, 1957, p. 99). He defined genuineness as a therapist’s ability to be “freely and deeply himself” (Rogers, 1957, p. 97), and he described unconditional positive regard as “the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client’s experience” (p. 98). Taken together, these three conditions form the core of Person-Centered Therapy, and serve as the necessary ingredients for relational depth. Furthermore, because Person-Centered Therapy serves as the foundation for relational depth, it would seem likely that these conditions could emerge in exploring the therapist factors that contribute to their ability to invite and facilitate deepened moments of contact with clients.

### **Person-Centered Therapy and Relational Depth**

As it relates to Person-Centered Therapy, relational depth represents an “upward extension of the working alliance” (Wiggins et al., 2012, p. 14) – one that capitalizes on the synergy of Rogers’ core conditions (Knox et al., 2013b; Mearns & Cooper, 2005). In other words, although the core conditions could be considered distinct constructs, Mearns and Cooper (2005) postulated that the combined effect of empathy, genuineness, and unconditional positive regard interacting at high levels engender moments of relational depth.

Other researchers also have compared the concepts of relational depth and Person-Centered Therapy. Cox (2009) found that inclusivity, meeting and connectivity, unity of the core conditions, co-creativity, and the therapist's ability to enter into the client's world characterize both Person-Centered Therapy and relational depth. Similarly, O'Leary (2006) postulated that certain Rogerian qualities were characteristic of relational depth: congruence, commitment to the relationship, confidence in the actualizing tendency, imagination (in terms of empathy), and generosity in prizing others.

Although Person-Centered Therapy seems to be a natural theoretical grounding for relational depth, this has been challenged. Wilders (2013) asserted that working at relational depth is more directive than warranted for Person-Centered Therapy, and thus, therapists do not fully rely upon Rogers' actualizing tendency. Then again, research on relational depth has shown that clients initiate the process (Cooper, 2013a; Knox, 2013; Knox & Cooper, 2011; McMillan & McLeod, 2006), which seems to counter, at least in part, the assertion that relational depth emerges from a more directive approach. In the current study of the therapist factors that invite and facilitate moments of relational depth, it will be important to consider this existing tension in the literature between the directive and non-directive aspects that occasion relational depth.

In summary, the concept of relational depth often is grounded within the core conditions of Person-Centered Therapy; however, the concept exists across theories (albeit named differently), and some controversy exists surrounding the connection between relational depth and Person-Centered Therapy. To examine relational depth

more closely beyond theoretical speculation, it may be helpful to review current research published on clients' and therapists' recollected experiences of the phenomenon.

### **Current Research on Relational Depth**

Because the Person-Centered concept of relational depth is relatively new, the research is in a rather nascent state of discovery and has primarily emanated from scholars working in the United Kingdom. In the following review, the relational depth literature is summarized and the findings are examined in light of the overarching research question (exploring the therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients) in the current study. First, therapists' and clients' experiences of the phenomenon are summarized.

### **Experiences of Relational Depth**

The similarities and differences between therapists' and clients' experiences of relational depth are noteworthy. In a review of published and unpublished studies of therapists' and clients' experiences, Cooper (2013a) highlighted their combined descriptions of aliveness, authenticity, openness, stillness, intensity, and clarity. Some even described a connection that felt almost spiritual or mystical. Wiggins et al. (2012) also found therapists' and clients' experiences to be somewhat similar. After doing a factor analysis to explore the factors of relational depth for an early version of her Relational Depth Inventory, Wiggins et al. (2012) unearthed five factors characteristic of relational depth for both therapists and clients: (a) *respect, empathy, and connectedness*; (b) *invigorated/liberating*; (c) *transcendence*; (d) *scared/vulnerable*; and (e) *other person*

*empathic/respectful*. Based on these broad reviews, it is evident that there is some similarity in how the phenomenon is experienced by both populations.

Additionally, it has been suggested that clients and therapists experience relational depth slightly differently, perhaps due to their respective roles (Cooper, 2013a). For example, although the quality of empathy is characteristic of both therapists' and clients' experiences, therapists are more likely to feel empathy as it is *given*, whereas clients are more likely to experience empathy as it is *received* (Wiggins et al., 2012). Furthermore, when Wiggins et al. (2012) conducted specific factor analyses on therapists' and clients' separate experiences, the factors that emerged for each suggested that they experience the phenomenon slightly differently. For therapists, the factors that emerged were (a) *transcendence/invigorated*, (b) *respect*, and (c) *scared/vulnerable*, whereas for clients, the factors were (a) *respect*, (b) *invigorated/transcendence*, and (c) *weird/scared*. These differences, although slight, coincide with Cooper's (2013a) assertion that the differences in experiences may be attributed to respective roles. Illustrating this difference using Wiggins et al.'s (2012) therapist-client factors, therapists – with a focus on their clients – were more inclined to *transcend* themselves in order to be of service to another (*transcendence/invigorated* factor), whereas clients – with a focus on themselves – appeared more inclined to feel an embodied sense of *invigoration* (*invigorated/ transcendence* factor). From this, we gain a clearer picture of clients' and therapists' idiosyncratic experiences.

Because the proposed study is intended to explore mental health professionals' beliefs about the factors that contribute to their ability to invite and facilitate moments of

relational depth, it would seem that emergent factors might gravitate toward a theme of service to another. As therapist receptivity is believed to be another important quality in facilitating moments of relational depth (Cooper 2005a, 2005b; Mearns & Cooper, 2005; O’Leary, 2006), however, the emergent factors might prove paradoxical. Such findings would only further confirm and substantiate the elusive and mysterious quality of relational depth. To further explore the phenomenon beyond basic similarities and differences, the research on therapists’ and clients’ specific experiences are summarized.

**Therapists’ experiences.** To date, Cooper’s (2005a) phenomenological study and Macleod’s (2013) review of a similar study are the only known empirical pieces that have been published exploring therapists’ specific experiences of relational depth. In 2005a, Cooper interviewed eight therapists and asked them about their experiences of relational depth with clients. Almost all of the therapists reported experiencing, in themselves, the qualities of a Person-Centered therapist: empathy, congruence, and acceptance. Furthermore, many of the therapists reported experiencing themselves as energized, alive, and immersed in the moment, to the point where their perception seemed to shift. In fact, one participant is quoted by Cooper (2005a) as saying, “. . . in the moment of connection. . . nothing else in my life matters to me beyond that” (p. 91). Beyond their experiences of themselves, they experienced their clients as very real, and they perceived the relationship as intimate and mutual – even quoted as a place “. . . where both therapist and client can see, and be seen, right down to their very depths” (Cooper, 2005a, p. 92). Furthermore, the therapists reported that there was a knowing that passed between

themselves and the client in such moments. Often, the moment was experienced non-verbally.

Similarly, Macleod (2013) interviewed ten therapists specifically working with clients with learning disabilities. In a review of her findings, she highlighted the depths of therapists' experiences of interpersonal connection and their ability to be very “. . . in touch, almost in tune. . .” (p. 39) with their clients. Furthermore, the therapists in her study reported that they experienced their clients as open to personal vulnerability, and they experienced the relationship as mutual and trustworthy. When describing the phenomenon itself, Macleod (2013) emphasized the numinous atmosphere of such experiences, accenting her description with a participant's words, “. . . it's as if there are moments when our souls are touching. . .” (p. 42).

Taken together, therapists in both Cooper's (2005a) and Macleod's (2013) studies highlighted the power of moments of relational depth. The specific therapist factors needed to invite and facilitate such moments with clients remain rather ambiguous, though. Cooper's (2005a) findings suggest certain therapist factors – such as empathy, genuineness, unconditional positive regard, openness, and receptivity – that could emerge as factors needed to invite and facilitate moments of relational depth. Unfortunately, however, these were not specifically explored nor empirically validated. Interestingly – and highly related to this study – Macleod (2013) did ask therapists to identify a few factors that helped them facilitate moments of relational depth. The therapists noted the ability to be communicative, creative, flexible, caring, and nondirective. Although these factors inform the research in question, Macleod (2013) did not specifically purport to

ascertain these factors, and thus, her results remain somewhat limited. Furthermore, the findings are limited to her specific population – therapists working with clients with learning disabilities – and thus, may not generalize to broader therapist-client dyads. To further illuminate possible therapist factors that may contribute to the ability to invite and facilitate moments of relational depth, research on clients’ experiences is summarized.

**Clients’ experiences.** Clients’ experiences of relational depth have been studied more widely than therapists’ experiences (see Cooper, 2013a; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006). To date, Knox has conducted much of the relational depth research with clients and, even as a researcher, she highlighted the power and paradoxical nature of relational depth:

Often during the interviews, I had a sense of being handed a delicate, precious flower to hold in my hand, and was acutely aware of the gentle handling that was needed in order not to damage it in any way, or even to bend it out of shape. . . I became aware not only of its delicacy, but also of its strength and power, and I knew that it had changed me in some way. (Knox, 2013, p. 23)

It is with an awareness of this power and ineffability that research on clients’ experiences is reviewed.

To date, most researchers who have examined clients’ experiences of relational depth have conducted qualitative interviews (Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) and the findings are quite similar across the studies. Clients have deemed moments of relational depth powerful (Knox, 2013), ineffable (Knox, 2013; McMillan & McLeod, 2006), and emotional (Knox, 2008, 2013; Knox & Cooper, 2011). Furthermore, they reported that moments of relational depth led to change

and healing, whereby they gained insight (McMillan & McLeod, 2006) and felt more connected to themselves and to others (Knox, 2008, 2013). Some even stated that such experiences were so powerful that they felt spiritual and mystical (Knox, 2013), like being in a different dimension (Knox, 2008, 2013) or state of flow (Knox & Cooper, 2011; McMillan & McLeod, 2006). In this state, they felt a high level of mutuality in the relationship (Knox & Cooper, 2010) – even a sense of merging with their therapist (Knox, 2008, 2013).

Clients also reported specific feelings about themselves and their therapists in such moments. As for their experiences of themselves, clients reported feeling as though their pace slowed (Knox, 2008, 2013) and they were willing to explore the depths of themselves (Knox, 2008; Knox & Cooper, 2011). Furthermore, they reported feeling vulnerable (Knox, 2008, 2013; Knox & Cooper, 2011), open, validated, present (Knox, 2008), real, alive, and peaceful (Knox, 2008, 2013). Knox and Cooper (2011) quoted one participant as saying, “It wasn’t just the words. It wasn’t just the way she looked at me. There was something that she . . . really understood how I felt, and the depth that left me with” (p. 72). Such descriptions underscore the depth of clients’ experiences of themselves.

With regard to their experiences of their therapists, clients stated that they felt their therapists were supportive (Knox, 2008), understanding, accepting (Knox, 2008, 2013; Knox & Cooper, 2010, 2011), safe/supportive, warm (Knox, 2008, 2013; Knox & Cooper, 2010), similar (Knox, 2013; Knox & Cooper, 2010, 2011), psychologically sound (Knox, 2013; Knox & Cooper, 2010), real/congruent (Frzina, 2012; Knox, 2008,

2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006), vulnerable/open (Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006), present (Knox, 2008; Knox & Cooper, 2010), patient, professional (Knox, 2013; Knox & Cooper, 2010), competent (McMillan & McLeod, 2006), gentle (Knox, 2008, 2013), trustworthy (Knox, 2008; Knox & Cooper, 2011), committed (Knox & Cooper, 2010), positive, and affirming (Knox, 2013). In a case study, the therapist's ability to really listen to the client and allow time for processing also was considered critical (Frzina, 2012).

Perhaps most significant, clients emphasized the belief that their therapists truly cared for them and were willing to go "over and above" to help them (Knox, 2008, p. 185; Knox, 2013, p. 25; Knox & Cooper, 2010; McMillan & McLeod, 2006). As one participant is quoted as saying, "It felt like she was giving from her core" (Knox, 2008, p. 185). Some even likened these therapists to an ideal parental figure, one who remained present to them even in their minds (McMillan & McLeod, 2006). Generally, these therapists seem to embody the Rogerian conditions of empathy, genuineness, and unconditional positive regard (Knox, 2013; Knox & Cooper, 2011).

Clients also identified therapist qualities and characteristics that hindered relational depth, such as inexperience (Knox & Cooper, 2010), shallowness or superficiality, an inability to connect with (Knox & Cooper, 2010; McMillan & McLeod, 2006) or attune to the client, an inability to provide what the client needs, overemphasis on the relationship (McMillan & McLeod, 2006), and interestingly, trying too hard (Frzina, 2012). Furthermore, they stated that if their therapist was too different or not

welcoming, understanding, respectful, or professional (Knox & Cooper, 2010), relational depth was unlikely to occur.

By synthesizing clients' experiences, one could infer possible factors needed to invite and facilitate moments of relational depth. Unfortunately, however, there is both a lack of intentional and empirically validated research of these factors and a dearth of literature exploring these factors from therapists' perspectives. As previously mentioned, Macleod's (2013) qualitative analysis of therapists' experiences working with clients with learning disabilities is the only known study that tangentially explored these factors. Interestingly, except for caring, the other factors that emerged from her study (the ability to be communicative, creative, flexible, and nondirective) did not coincide with clients' perspectives of their therapists. Furthermore, even though it has been suggested that qualities such as therapist genuineness and caring are critical in inviting and facilitating moments of relational depth, it remains unclear how therapists develop the ability to cultivate these characteristics and convey them to their clients. As postulated in Chapter One, are there certain practices that mental health professionals engage in before these types of sessions? Is there something in who they are or what they do that contributes to these qualities? To explore these questions more broadly, it may be helpful to review the research on relational depth across populations.

### **Relational Depth Across Populations**

The research on relational depth across populations is limited. To date, researchers have published only a few studies exploring relational depth with younger populations (Hawkins, 2013), clients with learning disabilities (Macleod, 2013), clients

experiencing trauma (Mearns & Cooper, 2005; Murphy & Joseph, 2013), and diverse populations (Lago & Christodoulidi, 2013). For the most part, the findings in these studies align with findings in studies of generic client-therapist experiences of relational depth.

**Younger populations.** Currently, the only known publication on relational depth with younger populations (children or adolescents) is Hawkins' (2013) conceptual review of her experiences working primarily with adolescents who have been convicted of various offenses. In her descriptions, she underscored the need for therapists to be open to oneself and to the client, accepting, empathic, authentic, and deeply present. In fact, she often likened her experiences of relational depth with younger populations to her experiences of stillness in meditation – feeling as though she is “. . . ‘plugged into’ something greater” (Hawkins, 2013, p. 82). She emphasized the qualities of love and compassion as healing elements in the therapeutic encounter, and illuminated these within the context of childhood development. At the same time, though, Hawkins (2013) noted the tenuousness of deep love and compassion, especially with regard to the boundaries of the counseling relationship with younger populations. Taken together, her descriptions and emphasis on the Rogerian qualities of therapists in moments of relational depth coincide with earlier research on therapists' and clients' experiences. One of the highlights of Hawkins' (2013) chapter, though, is her conceptual connection between the practice of mindfulness to the facilitation of moments of relational depth, a finding which could be relevant in the proposed study.

**Clients with learning disabilities.** Macleod's (2013) qualitative research on relational depth with clients with learning disabilities was largely summarized above in descriptions of therapists' experiences of relational depth. Additionally, she highlighted a few characteristics of the encounter that were germane to the current study. First, she reported therapists' beliefs that clear communication was essential in working with clients with learning disabilities. Because clients with learning disabilities may not completely understand what is being communicated, therapists also emphasized the importance of their own creativity and flexibility. Furthermore, therapists in her study deemed it critical to demonstrate authentic caring and acceptance, believing that the clients may be sensitive to rejection. Taking this a step further, Macleod (2013) also summarized therapists' perspectives of the client factors needed to facilitate moments of relational depth, which included the ability to tap into emotion and feel empowered. These findings coincide with results of the more generic studies of therapists' (Cooper, 2005a) and clients' (Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) experiences. As evidenced in the emphasis on certain types of qualities (e.g., therapists' ability to be creative and flexible in communication), however, the emergent factors appear to be more nuanced based on the population in question.

**Clients with trauma.** Although relational depth has yet to be empirically studied in clients with trauma, two conceptual pieces (Mearns & Cooper, 2005; Murphy & Joseph, 2013) have explored the phenomenon using case studies. Through these case studies, certain therapist factors needed to invite and facilitate moments of relational depth with this specific population can be inferred. Murphy and Joseph (2013) reviewed

literature on posttraumatic stress and posttraumatic growth and hypothesized that experiences of relational depth help clients integrate traumatic events from their past. When outlining a case study, the authors emphasized the therapist qualities of surrender, empathy, presence, unconditional positive regard, and openness as key factors for working with these individuals. Further, they underscored the need for therapists to “bear witness” (p. 95) to the trauma; in essence, allowing clients space for integration and healing.

Mearns and Cooper (2005) offered similar recommendations in their case study. They described the work of the first author with a traumatized individual for twenty-seven sessions before the client even spoke. From there, the relationship blossomed to the point where the client felt safe enough to reveal his traumatic experiences. Mearns attributed this eventual therapeutic connection to (or it could be inferred based on) his ability to be real, accepting, sensitive, direct, open, grounded, empathic, attuned, committed, caring, patient, willing to learn about others’ experiences of trauma, and willing to explore the situation in supervision. Furthermore, he described the importance of delicately balancing “encounter and invasion” (Mearns & Cooper, 2005, p. 103) when working with clients with traumatic backgrounds. In other words, Mearns continually balanced an invitation to engage in deeper connection with what could be perceived as an invasion of the client’s boundaries. In terms of specific practices, Mearns also took a few minutes of quiet time before the sessions to center himself. Interestingly, rather than perceiving relational depth as a *product* of these practices, they described it as a *precondition* to therapy (Mearns & Cooper, 2005).

Taken together, many of the emergent therapist qualities – such as empathy, genuineness, presence, and unconditional positive regard – mirror those found in generic studies of therapists’ and clients’ experiences. Other qualities, however, such as the ability to “bear witness” to clients’ stories of trauma (Murphy & Joseph, 2013, p. 95) and to sensitively balance “encounter and invasion” (Mearns & Cooper, 2005, p. 103), seem especially conducive to working with clients who have experienced trauma.

**Diverse populations.** In addition to exploring relational depth with younger populations, clients with learning disabilities, and clients with traumatic backgrounds, scholars (Lago & Christodoulidi, 2013) have conceptually explored relational depth in diverse populations. Although empirical research in this area is lacking, Lago and Christodoulidi (2013) hypothesized certain factors needed to facilitate moments of relational depth across cultural differences. First, they outlined many barriers to achieving deep levels of connection across diverse populations. Such barriers include therapist insensitivity or lack of knowledge, communication difficulties, the power differential (especially if the therapist has the privileged advantage), and the difficulty in achieving high levels of empathy for and understanding of another when faced with unfamiliar circumstances. Lago and Christodoulidi (2013) acknowledged that relational depth could be more difficult when faced with such barriers; however, they stated that it was possible. The authors outlined certain therapist-client dyadic factors needed to achieve such moments, including acceptance, non-directiveness, readiness, openness, empathy, and relaxation.

Lago and Christodoulidi's (2013) review elucidated certain therapist factors that may be necessary in inviting and facilitating moments of relational depth with clients. Furthermore, their research underscored the need for mental health professionals to be truly open to and accepting of clients regardless of their backgrounds. It is still unclear, however, what specifically contributes to their ability to cultivate such openness and acceptance. Mearns and Cooper (2005) theorized that self-acceptance is critical – that as therapists develop the capacity to be open to and accepting of the depths of themselves, then they are able to do so with others. To date, however, such an assertion has not been empirically validated among a sample of mental health professionals.

In summary, the research on relational depth across populations underscores the basic – yet profound – qualities of a Person-Centered therapist: empathy, genuineness, and unconditional positive regard. Although these qualities generally emerged in the research across populations, they manifested in somewhat nuanced ways, depending on the population in question, suggesting that client characteristics may be important to consider. From here, it is advantageous to explore plausible factors as presented in relational depth research across various modalities, such as group work and supervision.

### **Relational Depth Across Modalities**

Thus far, researchers primarily have focused on individual counseling/therapy and few have explored relational depth across other modalities. One researcher (Wyatt, 2013) examined the tenability of relational depth in group work and three others (Lambers, 2006, 2013; Mearns & Cooper, 2005) highlighted the plausibility of relational depth in

supervision. The research is summarized here in light of hypothesized therapist factors needed to invite and facilitate moments of relational depth.

**Groups.** To conduct research on group relational depth, Wyatt (2013) asked 17 practitioners questions about their experiences of deep moments of connection in groups. Wyatt's (2013) findings largely coincide with research results on relational depth in individual counseling. Participants described qualities of authenticity, trust, openness, empathy, compassion, vulnerability, and presence as ingredients for such occurrences. Furthermore, their descriptions contained the reaching quality mentioned earlier, with phrases such as "union," "higher energy," and a "spiritual experience" (Wyatt, 2013, p. 106). One participant is quoted as saying that the experience was like "being in tune with both 'I am' and 'they are'" (p. 105). Wyatt (2013) also asked participants to suggest possible factors needed to facilitate such moments within a group. Participants highlighted the importance of establishing the right atmosphere (including selecting participants, arranging the room, and identifying the purpose), imbuing the basic facilitative conditions within the group atmosphere and, essentially, waiting for a group member to risk vulnerability and open to the group.

As it relates to this study, Wyatt (2013) is one of the first to mention the importance of setting the stage for the emergence of relational depth. Surely, qualities such as empathy, genuineness, and unconditional positive regard are critical in facilitating moments of relational depth. Perhaps, though, something more, such as creating the therapeutic ambience, is also an important factor (Wyatt, 2013). Setting the stage – either concretely in the physical sense or internally (such as Mearns' [in Mearns

& Cooper, 2005] centering himself before sessions or Hawkins' [2013] continuing to engage in a meditation practice) – could emerge as an important therapist factor needed to invite and facilitate moments of relational depth. In fact, supervision may be the context in which to learn such practices.

**Supervision.** In conceptual writings on relational depth in supervision, Lambers (2006, 2013) and Mearns and Cooper (2005) emphasized the need for a special, relationally-deep type of supervision in order to aid the therapist in developing the capacity to facilitate moments of relational depth with clients. Lambers (2006) stated, “Relational therapy is best supported by relational supervision” (p. 274) and further defined relational depth in supervision as:

A high level of contact and engagement in which both persons are contributing to a real dialogue around their shared experience in the moment – both of the supervisee’s experience of self in relation to the client and of the relationship between supervisee and supervisor. (p. 274)

In this context, high levels of empathy, genuineness, and unconditional positive regard characterize relational supervision (Lambers, 2006, 2013). Essentially, the supervisor provides a space where a therapist can explore her or himself and develop the openness to meet clients in deep and meaningful ways. Lambers (2006) coined this “supervising the *humanity* [italics added] of the therapist” (p. 266) and further stated, “The path to relational depth is often through our own fallibility, fear, struggle, or through our own sense of our existence” (Lambers, 2006, p. 273). With a nurturing and accepting supervisor, therapists can explore their struggles as they relate to their clients (Lambers, 2006, 2013). Interestingly, the focus in both Lambers’ (2006, 2013) and

Mearns and Cooper's (2005) writings centered on the supervisor qualities and supervision atmosphere needed in order to help supervisees grow into deeper and more relationally-oriented therapists. Relational depth experienced within the *supervisory* relationship is only peripherally explored. Certainly, greater research is needed in this area.

As it relates to this study, the emergent supervisor factors from Lambers' (2006, 2013) and Mearns and Cooper's (2005) conceptual reviews align with research on therapists' (Cooper, 2005a; Macleod, 2013) and clients' (Knox, 2008, 2013; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) experiences of relational depth. The core conditions of empathy, genuineness, and unconditional positive regard are emphasized (Lambers 2006, 2013) along with such qualities as openness, presence (Lambers 2006, 2013), reflectiveness (Lambers, 2006), respect, self-acceptance, and a willingness to be affected (Lambers, 2013). When posing the question of what therapist factors contribute to the ability to invite and facilitate moments of relational depth, not only might some of these types of factors emerge, but the presence of a deep, authentic supervisor may emerge as an important factor as well.

Thus far, relational depth, as a construct, has been described, therapists' and clients' experiences of relational depth have been summarized, and relational depth as it occurs across populations and modalities has been explored. From all of this, a hazy outline of possible therapist factors needed to invite and facilitate moments of relational depth with clients emerges. In order to further explore these factors, it is advantageous to

examine the moment-to-moment process of relational depth as it occurs between therapists and clients.

### **Process of Relational Depth**

Although empirically validated process research is lacking, Knox (2013) conceptualized and outlined the apparent sequence of micro-processes that occur in moments of relational depth. First, the therapist creates an atmosphere where the client is able to slow her or his pace and, with a slowed pace, the therapist subtly invites the client to go deeper (Knox, 2008, 2013; Knox & Cooper, 2010, 2011). This invitation may even take the form of a challenge (Knox, 2013; Knox & Cooper, 2011). Clients have reported feeling a change in their therapist at this point (Knox, 2008; Knox & Cooper, 2011). Then, feeling the therapist's openness and compassion, the client initiates the process (Cooper, 2013a; Knox, 2013; Knox & Cooper, 2011; McMillan & McLeod, 2006) by opening to vulnerability and "letting go" (McMillan & McLeod, 2006, p. 277). In this way, then, the client is credited for initiating the moment (Cooper, 2013a; Knox, 2013; Knox & Cooper, 2011; McMillan & McLeod, 2006). Interestingly, clients have intimated that they *knew* from the very beginning of therapy with whom they could initiate this process (McMillan & McLeod, 2006).

According to Knox (2013), once the client has initiated the process, the therapist journeys with the client, providing safety, understanding, and acceptance. Such an experience of utmost support allows the client to delve deeper into the experience. In response, the therapist provides deeper acceptance and affirmation, which enables the client to further connect with her or himself, leading to feelings of self-worth and

validation. In this process, Knox (2013) suggested that therapists primarily needed “. . . to be aware of the client’s efforts to meet them at a level of relational depth, to be open to such a meeting, and to maintain a warm, human and inviting attitude. . .” (p. 35). This statement underscores the need for an open and inviting presence, a finding consistent with clients’ experiences of therapists in moments of relational depth (Knox, 2008; Knox & Cooper, 2010, 2011). Furthermore, as the process is outlined, it is ultimately a dyadic experience, which corroborates Frzina’s (2012) research that relational depth is experienced synchronously between client and therapist.

Based on the above description, the moment-to-moment process of relational depth seems deceptively clear. As previously mentioned, however, there is a dearth of process research on such moments. Furthermore, although it is believed that clients initiate such moments based on invitations from their therapists (Knox, 2008, 2013; Knox & Cooper, 2010, 2011), the actual manifestation of these occurrences remain ambiguous. In essence, what does a therapist’s invitation *look like* in practice? Related to the proposed study, what specific therapist factors contribute to their ability to invite and facilitate these moments of relational depth? Although empirical research in this area is lacking, researchers (Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006) have conceptually explored factors that might engender such a process.

### **Conceptual Therapist Factors of Relational Depth**

As mentioned in Chapter One, researchers have conceptually explored possible therapist factors that contribute to their ability to invite and facilitate moments of relational depth. According to Mearns (1996, 1997), therapists need to have a certain

level of fearlessness in order to create an atmosphere conducive to relational depth. Along with this, they need to become very present and still, slow their pace with the client, and open to the client's experience. Mearns and Cooper (2005) further elaborated on this, stating that therapists need to create a non-threatening atmosphere, forego any desires to "fix" their clients, caution against holding any preconceived notions about them, relinquish specific techniques, listen very deeply, invite clients to deeper levels, be present to all parts of their clients, allow themselves to be affected by their clients, reduce distractions, maintain a high level of self-understanding, be transparent, and focus on the present moment.

Similar to these presuppositions, Mearns and Schmid (2006) delineated a number of criteria for deep engagement: the ability to communicate on an existential level, the freedom to deliberately choose deeper contact, the ability to be real and immediate, the focus on the relationship, the ability to invite clients into mutual contact (but not force it), the openness to being touched by the client, the openness to a certain level of spontaneity in authentic encounters, the ability to be engage in and accept all parts of the client, the ability to reflect on the relationship with the client, a willingness to venture forth to affect the client, an effort to maintain awareness of the environment, and an awareness of the power differential. More important than any of these criteria, though, Mearns and Schmid (2006) characterized deep therapists as those capable of "devoting their whole awareness to the service of the Other" (p. 260).

In addition to these presumptions, Cooper (2013b) outlined a ". . . relational way of being person-centered . . ." (p. 142) that may set the stage for relational depth. In

speaking of his own experiences, he asserted that being very real (i.e., “. . . less of a mirror and more of an actual other. . .” [p. 142]), engaging in multiple ways and on multiple levels, actively “prizing” (p. 142) the client, and genuinely demonstrating care for the client served to create a deeper dyadic connection. Furthermore, he outlined certain ways in which people intentionally disconnect from others, such as being busy, being overly compliant, appeasing, using humor or laughter, being controlling, and criticizing oneself, to name a few. All of these characteristics are nested inside Cooper’s (2013b) broader assumption that greater therapist self-awareness and reflection on relational patterns will aid in a greater capacity to connect with others.

In summary, the factors that have been conceptually proposed mirror those emergent in empirical studies of therapists’ and clients’ experiences. In practice, however, these therapist characteristics yield a more nuanced and complex image of the therapist who has the capacity to relate on a level of relational depth. For example, Mearns and Cooper (2005), Mearns and Schmid (2006), and Cooper (2013b) all either explicitly or implicitly emphasized the importance of therapist self-awareness. Although a certain level of therapist awareness emerged in empirical studies (Cooper, 2005a), the awareness seemed to center more on what was occurring in the moment of connection – rather than a historical self-awareness that may have aided in creating the necessary atmosphere conducive to the emergence of such a moment. In the proposed study, these types of nuanced therapist factors may emerge. Beyond individuals’ experiences of relational depth, the hypothesized process of the phenomenon, and conceptual therapist factors aiding in the process, it is advantageous to review measures of the construct.

Exploring emergent factors of relational depth measures helps illuminate possible factors that engender its occurrence.

### **Measures of Relational Depth**

Currently, there are two assessment instruments that purport to measure relational depth: (1) the Relational Depth Inventory-Revised 2 (RDI-R2; Wiggins, 2013) – an updated version of the Relational Depth Inventory (RDI; Price, 2012; Wiggins et al., 2012) and various versions therein (see also Wiggins et al., 2012), and (2) the Relational Depth Event Content Rating Scale (RDECRS; Price, 2012; Wiggins et al., 2012). Because the RDI-R2 (Wiggins, 2013) items could illuminate the hypothesized therapist factors needed to invite and facilitate moments of relational depth, this measure, in particular, is intentionally summarized and explored.

**Descriptions of the measures.** The RDI-R2 is a 26-item, client-only measure created by Sue Wiggins/Price (latter is married name) that includes two portions. The first portion asks clients to describe a “particularly helpful moment or event” (Wiggins, 2013, p. 59) in therapy, and the second portion requires participants to rate their description based on 26 items, using a Likert-type scale ranging from *not at all* to *completely*. Items include examples such as, “I felt a spiritual experience”, “I felt a profound connection between my therapist and me”, and “I felt the experience with my therapist was beyond words” (Wiggins, 2013, pp. 59-60).

The RDECRS is a content rating scale that Wiggins/Price created in order to initially validate (through correlations) the Relational Depth Inventory items. More specifically, using the RDECRS, researchers (Price, 2012; Wiggins et al., 2012) rated

descriptions of participants' experiences based on the presence or absence of relational depth, ranging from 0 to 3 (*0=no relational depth to 3=relational depth strongly present*). From there, the ratings were used to identify which of the earlier Relational Depth Inventory items best assessed the presence of relational depth. That is, although there are two measures of relational depth, they were actually created together with the purpose of one (RDECRS) being to validate the other (RDI-R2).

**Validity and reliability.** Throughout the process of creating the Relational Depth Inventory, Wiggins/Price assessed the reliability and validity of the various versions. Price (2012) established content validity by developing items based on 361 descriptions of relational depth and soliciting feedback on an earlier version of the measure from colleagues, administrators, and therapists. An earlier 24-item version of the measure (RDI-R; Price, 2012) evidenced predictive validity with three outcome measures (the Clinical Outcome Routine Evaluation-Outcome Measure [CORE-OM; Barkham et al., 1998]; the Strathclyde Inventory [SI; Freire & Cooper, 2007], and the Personal Questionnaire [PQ; Elliott, Shapiro, & Mack, 1999; Wagner & Elliott, 2001]). Furthermore, Price (2012) examined construct validity and found an earlier version of the measure to correlate with the Working Alliance Inventory-Short Form (WAI-SR; Hatcher & Gillaspay, 2006). The internal consistency of the measure has been examined with various versions of the measure, with Cronbach's alphas ranging from .93 to .97 (Price, 2012; Wiggins et al., 2012). No current alpha exists for the most recent version of the measure, though. From this cursory summary, the Relational Depth Inventory (and

various versions therein) appears to be a relatively reliable and valid measure of relational depth.

There are, however, a few of limitations associated with the most current version of the measure (RDI-R2; Wiggins, 2013). First, the RDI-R2 is intended only for clients; however, the initial sample ( $n = 343$ ) used to create the instrument included therapists as over 50% of the participants (Price, 2012; Wiggins et al., 2012). Therefore, the external validity of the measure is at least somewhat questionable. Second, although the measure correlated with a measure of the working alliance (WAI-SR; Horvath & Gillaspay, 2006) – suggesting convergent validity – it raises questions that the RDI Index (an earlier version of the Relational Depth Inventory; Price, 2012; Wiggins et al., 2012) and the WAI-SR correlated more highly ( $r = .72$ ) than the RDI Index and the presence of relational depth ( $r = .50$ , as measured by dichotomized scores on the RDECRS), since the latter two were developed to measure the same construct. Finally, the RDI-R2 has not been tested for other types of reliability (test-retest, alternate forms, or split half), limiting knowledge of its psychometric soundness.

**Plausible factors inherent in the existing measures.** As previously mentioned, the relational depth measures are summarized here in order to examine possible therapist factors needed to invite and facilitate moments of relational depth with clients.

Price/Wiggins conducted a factor analysis when creating her Relational Depth Inventory and unearthed five factors characterizing participants' experiences: (a) *respect, empathy, and connectedness*; (b) *invigorated/liberating*; (c) *transcendence*; (d) *scared/vulnerable*; and (e) *other person empathic/respectful* (Price, 2012; Wiggins et al., 2012). In later

versions of her Relational Depth Inventory, Price (2012) stated that the construct only included two factors: *interdependence* (ranging from “enmeshment” [p. 230] to “differentiation” [p. 230]) and *self-other focus* (ranging from “focus on self with self” [p. 229] to “focus on self with therapist” [p. 230]). Later in her analysis, she determined the construct of relational depth to be largely unidimensional (Price, 2012; Wiggins, 2013).

Regardless of the number of factors associated with the construct, their emergence underscores possible therapist qualities needed in order to invite and facilitate moments of relational depth. For example, the difference between enmeshment and differentiation on Price’s (2012) interdependence scale coincides with Mearns’ assertion that therapists need to balance “encounter and invasion” (Mearns & Cooper, 2005, p. 103) in facilitating moments of relational depth. Furthermore, the juxtaposition between the earlier factors of *invigorated/liberating* and *scared/vulnerable* (Price, 2012; Wiggins et al., 2012) underscore the inherent paradoxical nature of relational depth (Knox, 2008) suggesting, perhaps a certain level of therapist complexity and ability to transcend dualities in order to invite and facilitate moments of relational depth.

Beyond iterations of the factors associated with the Relational Depth Inventory (and various versions therein; Price, 2012; Wiggins, 2013; Wiggins et al., 2012), assumptions can be made of therapist factors based on qualitative categories of the original 64 items of the Relational Depth Inventory (outlined in Price, 2012; Wiggins, 2013). These categories were grouped under four major headings: *experience of relationship*, *experience of self*, *experience of/towards other*, and *experience of atmosphere* (Wiggins, 2013). Within the *experience of the relationship*, subcategories of

items included *connected*, *mutuality*, and *security*. The subcategories of *heightened self*, *invigorated self*, *immersed self*, and *true self* emerged within the category of *experience of self* (Wiggins, 2013). For *experience of/towards other*, the subcategories included *respect*, *trust*, *being available*, *empathy*, and *other being real*; and finally, the subcategories of *dynamic*, *peace*, *significance*, and *true self* emerged under the category of *experience of atmosphere* (Wiggins, 2013).

Although all categories and subcategories illuminate therapists' and clients' experiences of relational depth and shed light on the construct as a whole, the category of *experience of self* may be especially relevant for the proposed study. Example items within this overarching category included *spiritual*, *in an altered state*, *I was transcendent*, *intense feelings*, *courageous*, *empowered*, *paradoxical*, *immersed*, *soulful*, *a sense of being in the moment*, *vulnerable*, and *in touch with self* (Wiggins, 2013). These items have a certain numinous or otherworldly quality to them, reminiscent of Rowan and Jacobs' (2002) transpersonal mode of being as a therapist. However, *how* mental health professionals do this – what factors contribute to this ability to invite such a deep way of relating with clients – remains a mystery. Perhaps Hawkins' (2013) earlier comparison between the numinous, still quality characteristic of her meditation practice and the same feeling emergent in her work with clients is relevant here. If relational depth is as numinous, paradoxical, and ineffable as it is postulated, how do therapists invite such moments?

At this point, the therapist factors needed to invite and facilitate moments of relational depth with clients have been explored in light of (a) the nature of the construct

itself, (b) therapists' and clients' experiences of the phenomenon, (c) various populations' experiences of it, (d) its emergence across various modalities, (e) the moment-to-moment process of its dyadic occurrence, and (f) the ways in which it has been measured. To explore the plausible factors a little more closely, research on therapist development is reviewed.

### **Therapist Development**

In the following review, therapist development is explored generally based on generic therapist development models and master therapist research, and it is explored more specifically based on the therapist's use of self (Rowan & Jacobs, 2002) and conceptual theories of relational depth capacity development. Therapist development – and specifically characteristics of master therapists and the therapist's use of her or his self – is explored because it is believed that relational depth occurs more often with experienced therapists (Leung, 2008, as cited in Cooper, 2013a). Furthermore, clients have stated that relational depth is unlikely to occur when they perceived their therapist as inexperienced (Knox & Cooper, 2010), shallow or superficial (Knox & Cooper, 2010; McMillan & McLeod, 2006), or trying too hard (Frzina, 2012). Likewise, clients asserted that therapists' confidence (Knox & Cooper, 2010), competence (McMillan & McLeod, 2006), and fearlessness (Knox, 2008) increased the likelihood of relational depth. Because these qualities suggest a higher level of therapist development, it is important to explore this area in greater depth. Thus, the purpose in this review is to gain a picture of *who* the deep, relational therapist is based on her or his development. As the development

of the person of the therapist is explored, the possible factors that contribute to the ability to invite and facilitate moments of relational depth may also be illuminated.

### **Therapist Development Models**

Many researchers (e.g., Hess, 1986; Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Skovholt, Rønnestad, & Jennings, 1997; Stoltenberg, 1981; Stoltenberg & McNeill, 1997) have explored therapist development. Based on a review of these theories, four general themes characterize therapist development: (a) increasing autonomy, (b) stabilizing motivation, (c) growing awareness, and (d) increasing focus on internally-driven ways of working with clients. These themes are summarized and explored in light of research on master therapists, Rowan and Jacobs' (2002) three positions of the therapist's use of self, and relational depth.

Across theories, there is a general consensus that therapists move from dependency on their supervisor to more independent functioning as they gain experience (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997). Furthermore, this beginner-level dependency is often fueled by the therapist's anxiety and insecurity about this new role (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997). As they gain more experience, though, therapists generally become more comfortable and confident (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997). Although this broad-based move from dependence to independence is a general theme across therapist development, Stoltenberg and McNeill (1997) theorized that this occurs

idiosyncratically across eight domains of development: *intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics.*

For example, a therapist may operate rather independently when conceptualizing clients; however, she or he may be dependent on her or his supervisor for guidance on how to intervene with clients. In their model, therapists have reached the highest state of functioning once they have become more integrated in all areas of development.

In addition to the transition from dependency to autonomy, therapists also experience fluctuations in their motivation across developmental stages (Hogan, 1964; Stoltenberg, 1981; Stoltenberg & McNeill, 1997). In some ways, this theme of motivation could be likened to the concept of *disillusionment* that often occurs in intermediate-level professionals (Rønnestad & Skovholt, 2003). Beginning therapists are typically highly motivated to learn the craft and learn it well (Hogan, 1964; Stoltenberg & McNeill, 1997). This motivation wanes and fluctuates throughout the intermediate stages of development – as they perhaps feel disillusioned by the profession (Rønnestad & Skovholt, 2003) – and then becomes more stable as the therapists develop a more integrated sense of themselves and the profession (Stoltenberg, 1981; Stoltenberg & McNeill, 1997).

Another area of therapist development across theories is awareness (Hogan, 1964; Rønnestad & Skovholt, 2003; Stoltenberg, 1981; Stoltenberg & McNeill, 1997). This capacity for self-awareness also could be characterized by and predicated on the ability to be reflective (Rønnestad & Skovholt, 2003; Skovholt and Rønnestad, 1992; Skovholt et

al., 1997). Beginning therapists are typically characterized by low levels of awareness, lack of insight, (Hogan, 1964; Stoltenberg, 1981; Stoltenberg & McNeill, 1997) and focused attention on themselves (their anxiety) and how they are performing (Rønnestad & Skovholt, 2003; Stoltenberg & McNeill, 1997). Expert level practitioners are believed to be much more self-aware (Hogan, 1964; Rønnestad & Skovholt, 2003; Stoltenberg, 1981) and able to focus on themselves and their clients (Stoltenberg & McNeill, 1997).

Finally, in addition to themes of dependency-autonomy, motivation, and awareness, therapists move from more externally-driven (Rønnestad & Skovholt, 2003; Skovholt et al., 1997), rule-bound, and rigid ways of working with clients (Hogan, 1964; Stoltenberg, 1981) to more internally-driven (Rønnestad & Skovholt, 2003; Skovholt et al., 1997), integrated (Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997), creative, and intuitive approaches (Hogan, 1964). Concerned with choosing and implementing the “right” interventions with clients, beginning-level therapists often are rigid in their approaches with clients, and they tend to focus more on techniques (Hogan, 1964; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997). Advanced-level therapists – with a more integrated sense of themselves – are more flexible, and thus, they often creatively use their authentic selves to engender client change (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg & McNeill, 1997). Rather than relying on outside perspectives and techniques, they rely on their own internal sense of how to work with their clients (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997).

Based on the four themes of therapist development, therapists with more experience are more autonomous, steadily motivated, aware, and internally-driven. These themes align with research on master therapists, research on the therapist's use of self (based on Rowan & Jacobs' [2002] conceptualizations), and relational depth research.

### **Master Therapists**

Over the past two decades, Skovholt and colleagues have explored qualities and characteristics of expert practitioners, whom they called "master therapists." Related to the theme of development described above, becoming a master therapist is "... just as much about optimal human development as it is about specific skill development within the narrow realm of the therapist's role" (Skovholt, Vaughan, & Jennings, 2012, p. 226). In fact, master therapists have been compared to Maslow's (1950) description of the self-actualized person. Based on existing research (cf. Jennings & Skovholt, 1999; Jennings, Goh, Skovholt, Hansen, & Banerjee-Stevens, 2003; Rønnestad & Skovholt, 2001, 2003; Skovholt et al., 2004; Skovholt et al., 1997; Skovholt et al., 2012; Sullivan, Skovholt, & Jennings, 2005), four characteristics of master therapists seem especially salient to the proposed study: (a) their cognitively complexity, (b) their emotional receptivity, (c) their personal and professional realness, and (d) their emphasis on – and ability to establish – a strong therapeutic relationship with clients.

Cognitive complexity defined here includes the ability to learn and think in multiple complex and paradoxical ways. Cognitive complexity includes a certain tolerance for – and even comfort with – ambiguity. Master therapists are characterized by the capacity to embrace ambiguity (Jennings & Skovholt, 1999; Jennings et al., 2003;

Skovholt et al., 2004) – perhaps holding the tension between seemingly dualist frameworks as a mode for greater understanding of the human condition. In fact, master therapists have been defined using paradoxical terms, such as humble yet confident (Skovholt et al., 2004) – an outward paradox that perhaps mirrors the inward complexity of cognition and being. Additionally, master therapists have been characterized by their insatiable desire to learn (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004), demonstrating great curiosity (Skovholt et al., 2004) and the ability to create their own knowledge (Rønnestad & Skovholt, 2003) based on what they have learned and integrated. Such cognitive complexity could mirror the paradoxical nature of relational depth (Knox, 2013). To become a master therapist, however, one needs to also move beyond the cognitive realm (Skovholt et al., 1997).

In addition to cognitive complexity, master therapists are characterized by emotional receptivity (Jennings & Skovholt, 1999), perhaps an openness stemming from personal suffering. In fact, early life suffering is prevalent in master therapists (Rønnestad & Skovholt, 2001, 2003; Skovholt et al., 2004) as is the prevalence of the emotional wounding (Jennings & Skovholt, 1999) of personal challenges later in life (Rønnestad & Skovholt, 2001, 2003; Skovholt et al., 2004). These personal hardships may account for what Skovholt et al. (2004) called master therapists’ “reverence for the human condition” (p. 132). Because of this, they also may have the capacity to be with a range of client emotion (Jennings & Skovholt, 1999). Furthermore, master therapists have been characterized by emotional health (Jennings & Skovholt, 1999; Skovholt et al., 2004) and are able to regulate their own emotions (Rønnestad & Skovholt, 2003). At the same time,

they are open to being affected by their clients (Rønnestad & Skovholt, 2003) and use their emotions to help clients (Sullivan et al., 2005). These findings suggest the importance of therapist congruency as well.

Therapists' ability to be real and congruent emerged as another important factor of therapy (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005). Closely related to this, master therapists have been described as highly self-aware (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004) and reflective (Jennings & Skovholt 1999; Rønnestad & Skovholt, 2001, 2003; Skovholt et al., 1997; Skovholt et al., 2004). Perhaps stemming from this capacity for introspection, master therapists have integrated their personal and professional lives (Rønnestad & Skovholt, 2003; Skovholt et al., 2004). Furthermore, they accept themselves (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004) despite their mistakes and shortcomings (Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005). Perhaps master therapists' ability to be real is related to their ability to establish strong therapeutic relationships with their clients.

A predominant characteristic of master therapists is the importance they place on the therapeutic relationship (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004) and their ability to foster a strong relationship (Jennings & Skovholt, 1999). Jennings and Skovholt (1999) offered unique insight into this ability, stating, "Perhaps master therapists have a gift for helping clients feel special" (p. 8). Their ability to acutely perceive relational dynamics and engage others (Skovholt et al., 2004) perhaps aids in helping clients feel special and building a strong therapeutic

relationship. Furthermore, fostering such a relationship may be predicated on therapists' ability to "deeply enter the inner world of another" (Skovholt et al., 2004) and work in a variety of ways depending on what clients need (Skovholt et al., 2004).

Taken together, master therapists' cognitive complexity, their emotional receptivity, their realness, and their ability to establish a strong therapeutic relationship represent a higher echelon of the themes of therapist development described earlier. Although these characteristics form a foundation for therapist expertise, they are limited when exploring specific therapist characteristics that engender profound moments of connection in therapy (i.e., relational depth). Perhaps a deeper factor of therapist development is their unique ability to use themselves as instruments in the therapeutic process. In fact, therapists have stated that they consider themselves to be their primary instrument in therapy (Jennings & Skovholt, 1999). Rowan and Jacobs' (2002) three positions of the therapist's use of self may help to bridge this gap between therapist developmental models, master therapist literature, and relational depth.

### **Therapist's Use of Self**

As previously mentioned, Person-Centered Therapy is largely considered the foundation for relational depth (Mearns & Cooper, 2005; Knox et al., 2013b) and the research on therapist development and master therapists helps inform the developmental trajectory of the mental health professional capable of inviting and facilitating moments of relational depth. These theoretical frameworks are slightly limited, however, when attempting to explore the development of the numinous quality of the therapist with the

capacity for relational depth. Furthermore, Person-Centered Therapy offers little explanation regarding the transcendent and spontaneous nature of relational depth.

Such knowledge emerges more in the literature on therapist use of self. Often grounded theoretically in Marriage and Family Therapy (see examples from Aponte & Winter, 1987; David & Erickson, 1990; Haber, 1990; Koehne-Kaplan, 1976; Lum, 2002), the therapist's use of self also has emerged in Psychoanalytic Therapy (Miller, 1990; Pagano, 2012); Person-Centered Therapy (Omylinska-Thurston & James, 2011); and postmodern theories (Cheon & Murphy, 2007).

Rowan and Jacobs (2002) defined the therapist's use of self as the therapist's way of being in a therapeutic relationship – beyond techniques, environment, and theories. Anderson, Sanderson, and Košutić (2011) defined the construct a bit differently as “. . . a representational system comprised of attitudes, beliefs, and values that influence the stance the therapist takes in-relation-to his or her clients” (p. 366). Perhaps one of the most concise definitions of the therapist's use of self is one by Reupert (2008), who stated that it is “the personal features of the therapist. . .” (p. 371). Although these definitions vary, they seem to hone in on the idiosyncratic ways that therapists use themselves in the therapeutic relationship.

Much of the literature surrounding the therapist's use of self has focused on aspects of it, such as self-disclosure (Kramer, 2013), boundaries (Piercy & Bao, 2013), congruence (Cheung & Pau, 2013), and transference (Miller 1990; Pagano, 2012). Research is limited, however, in exploring therapist use of self at a broader level. Rowan and Jacobs (2002) were the first to examine it more broadly by creating a structure of

three ways of being, and Anderson et al. (2011) quantitatively validated parts of their model years later.

It is important to note that Rowan and Jacobs' (2002) three positions of the therapist's use of self are based on the premise that there is a *self* to transcend, which may conflict with philosophical tenets positing that the concept of the *self*, in itself, is a misnomer. Ontologically, perhaps the self is simply a collection of archetypal ways of being – essentially non-egoic. These tenets are mentioned simply to highlight Rowan and Jacobs' (2002) assumptions about the nature of a self, and to recognize other philosophical notions of being. Keeping this in mind, the three positions are described.

As discussed in Chapter One, Rowan and Jacobs (2002) conceptualized three different ways of being as a therapist: instrumental, authentic, and transpersonal. They conceptualized these as developmental levels, and stated, "Each of these possibilities makes different assumptions about the self, about the relationship and about the level of consciousness involved in doing therapy" (Rowan & Jacobs, 2002, p. 4). The instrumental self is the technical way of working with clients where therapists focus on clients' problems and utilize manualized treatments in order to fix them. Although Rogers' (1957, 1980, 1989) condition of empathy is discussed within this realm, it is typically more external.

When operating from the authentic self, therapists use themselves and work to develop a relationship with the client to engender growth and change. As suggested by the title of this level, authenticity is more apparent as is deeper empathy. Additionally, it is at the authentic level where Rowan and Jacobs (2002) more explicitly positioned the

general suppositions of Person-Centered Therapy. Extending up from this level is the transpersonal.

When describing the transpersonal level, Rowan and Jacobs (2002) described therapists who are open to dimensions or states of consciousness beyond themselves, and stated that it is at this level that relational depth occurs. Rowan and Jacobs (2002) attempted to summarize it by stating, “Perhaps the best way of summing up the third way of using the self in therapy is to say that it involves moving into an altered state of consciousness. That is the aspect of it which we call Being” (p. 87). This relates to one of Rogers’ (1980) poignant quotations, “When I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing” (p. 129). From this, it is evident that Person-Centered Therapy exists across the levels of the therapist’s use of self; however, the therapist’s use of self more explicitly outlines the developmental arc of Rogers’ conditions in greater depth.

Anderson et al. (2011) were the first to attempt to quantitatively validate Rowan and Jacobs’ (2002) three positions of the therapist’s use of self, and found support for three orientations. Instead of the authentic self, however, they found empirical support for the contextual self, which included attention toward sociopolitical factors such as class, sex, and race. They stated that perhaps the authentic self did not emerge in their final analysis simply because it exists across each of the levels. Interestingly, their conceptualization of these orientations appeared less developmental than Rowan and

Jacobs' (2002) descriptions. It seems that more research is needed to further validate Rowan and Jacobs' (2002) three positions.

The therapeutic conditions of Person-Centered Therapy (empathy, genuineness, and unconditional positive regard [Rogers, 1957, 1980, 1989]), general characteristics of therapist development (autonomous, steadily motivated, aware, and internally-driven) and master therapists (cognitive complexity, emotional receptivity, realness, and ability to establish a strong therapeutic relationship), and research on the therapist's use of self (Rowan & Jacobs, 2002) inform the concept of relational depth. To further illuminate possible therapist factors that contribute to their ability to invite and facilitate moments of relational depth, the conceptual research on the development of relational depth capacity is explored in light of these theories.

### **Development of Relational Depth Capacity**

Beyond general therapist development models, it is advantageous to review researchers' theories exploring how therapists develop the capacity to engage in relational depth with clients. Researchers (Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006) have conceptually postulated developmental factors associated with the cultivation of relational depth capacity. Based on their research, three critical factors emerged: existential contact, self-acceptance, and congruence. Furthermore, to develop these characteristics, Mearns and Cooper (2005) suggested engaging in personal therapy, supervision, group therapy, and education.

**Existential contact.** When describing existential contact, Mearns and Cooper (2005) and Mearns and Schmid (2006) referred to the poignancy of “existential

touchstones” (Mearns & Cooper, 2005, p. 138) of experience. These are places in the therapists’ lives, situated in the farthest and deepest emotions of the human condition, that serve as bridges to profound connection with clients. For example, a therapist’s past experience of crippling shame and her or his ability to *contact* that emotion (frightening as it may be) allows her or him to deeply connect with and understand a client in the midst of a similar emotion. In this way, contacting the deep existential themes of the human condition – based on personal experiences of suffering – allows therapists a greater level of empathy. As so beautifully stated by Mearns and Cooper (2005), “If it means finding our own tear for ourself and that being shared with our client while acknowledged as our own, then that can be a most powerful moment in relationship” (pp. 142-143).

In order to cultivate such a capacity, though, therapists must have faced, and perhaps integrated, difficult circumstances in their own lives. This relates to the personal suffering characteristic of master therapists (Rønnestad & Skovholt, 2001, 2003; Skovholt et al., 2004) and their “reverence for the human condition” (Skovholt et al., 2004, p. 132). Furthermore, the advanced empathy at this level is characteristic of the authentic and transpersonal position of the therapist’s use of self (Rowan & Jacobs, 2002). Specifically at the transpersonal level, there is a certain merging and sense of “I am you” (Rowan & Jacobs, 2002, p. 23). Speaking to this depth, Rogers is quoted as saying:

. . . I find that when I am the closest to my inner, intuitive self—when perhaps I am somehow in touch with the unknown in me—when perhaps I am in a slightly altered state of consciousness in the relationship, then, whatever I do seems to be

full of healing. Then simply my presence is releasing and helpful. At those moments, it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself, and has become part of something larger. Profound growth and healing and energy are present. (Baldwin, 1987, p. 50)

Taken together, across Person-Centered Therapy, therapist development, and the therapist's use of self, therapists' ability to contact the existential depths of themselves and use these as bridges of connection to their clients conceptually appears to be an important factor in developing the capacity to relate on deep levels with clients. In this process, though, perhaps the oft painful experience of contacting experiences of personal suffering is buffered by therapists' self-acceptance.

**Self-acceptance.** Self-acceptance can be defined as “. . . the degree to which we see our self as a ‘reasonable’ human being, capable of a range of actions and reactions, but fundamentally reliable to self and others” (Mearns & Cooper, 2005, p. 143). In order to develop the capacity for self-acceptance, therapists must find the courage to face and deeply accept the darkest parts of themselves (Mearns & Cooper, 2005). Developing a humble sense of self-acceptance allows them to engage in a deeper relationship with clients (Mearns & Schmid, 2006).

The development of self-acceptance also relates to tenets of Person-Centered Therapy, therapist development, master therapist development, and the therapist's use of self. As stated earlier, Person-Centered Therapy is founded on the belief that lack of acceptance early in life creates a discrepancy between one's real and ideal self (Rogers, 1989). As these two versions of the self merge – in an environment replete with empathy, genuineness, and unconditional positive regard – a person becomes more self-accepting

(Rogers, 1980, 1989). Furthermore, master therapists are characterized by self-acceptance (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004) despite their errors (Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005). Additionally, Rowan and Jacobs (2002) highlighted the importance of self-acceptance in developing the capacity to use oneself therapeutically. Thus, the ability to deeply accept these parts of the self seem conducive to developing the capacity to enter into deep moments of contact with others (i.e., relational depth). Furthermore, perhaps greater self-acceptance leads to congruence.

**Congruence.** From the very first writing on relational depth, congruence was believed to be an important characteristic in the development of therapists' relational depth capacity (Mearns, 1996). Furthermore, Mearns and Schmid (2006) stated that therapists capable of relational depth are “. . . utterly committed to congruence. . . “ (p. 262). Increasing congruence is characterized by therapists' ability to move beyond surface-level qualities of themselves to more authentic ways of being. In this way, they are better able to use themselves authentically in the therapeutic relationship (Mearns, 1996; Mearns & Schmid, 2006). Mearns (1997) explored the congruency of a Person-Centered therapist (not explicitly discussing relational depth) a little more deeply and suggested that therapists' endeavors to become aware of, explore, and transcend their fears in relationships facilitated deeper congruency. They highlighted qualities of stillness, awareness, courage, and understanding in this process.

Therapist congruency is prevalent in Person-Centered Therapy, therapist development, master therapist development, and the development of the therapist's use of

self (Rowan & Jacobs, 2002). Very simply, one of the core conditions of Person-Centered Therapy is congruence (Rogers, 1957, 1980, 1989). As stated earlier, Rogers (1957) described this genuineness as a therapist's ability to be "freely and deeply himself (sic)" (p. 97). Furthermore, related to therapist development, advanced-level therapists are more able to use their integrated, authentic selves (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg & McNeill, 1997), and as stated earlier, master therapists are characterized by their ability to be real (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005). The authentic self is also one of the three positions of Rowan and Jacobs' (2002) therapist's use of self, and in fact, the path to the transpersonal self (where Rowan and Jacobs [2002] positioned relational depth) is paved by an awareness of union of self and other (Rowan & Jacobs, 2002). Finally, genuineness – similar to congruence – was cited earlier as a major dimension of relational depth.

Interestingly, the three developmental factors of existential contact, self-acceptance, and congruence seem to mirror an *internalized* version of the proffered core conditions of Person-Centered Therapy (empathy, genuineness, and unconditional positive regard; Rogers, 1957, 1980, 1989). By contacting the existential depth and personal suffering of oneself, the capacity for great empathy emerges. Furthermore, developing the capacity for self-acceptance perhaps mirrors the ability to provide unconditional positive regard for clients. Finally, congruence in oneself seems to enable one to be genuine in relationship with another. Taken a step further, if relational depth is characterized by the synergy of the core conditions interacting at high levels (Knox et al.,

2013b; Mearns & Cooper, 2005), then perhaps the synergy of the aforementioned developmental conditions interacting at high levels fosters the paramount use of the therapist's self in inviting and facilitating moments of relational depth.

The relational depth literature has been summarized and therapist developmental models have been explored. In all of this, the intended focus has been to illuminate possible therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. Multiple plausible factors have emerged – based on therapists' and clients' experiences, measures of the construct, and theories of therapist and relational depth capacity development. Furthermore, a number of these plausible factors either overlap or are related to one another. To synthesize all of the research presented thus far, the factors have been consolidated into seven overarching dimensions of relational depth summarized below.

### **Dimensions of Relational Depth**

The proposed research study is intended to unearth the therapist factors that contribute to the ability to invite and facilitate moments of relational depth. Based on a review of relational depth literature, it is postulated that seven major themes (or dimensions) could emerge: (a) empathy, (b) genuineness, (c) unconditional positive regard, (d) therapeutic presence, (e) comfort inviting and sustaining emotional intensity and intimacy, (f) spiritual/transcendent openness, and (g) personal depth with a willingness to be vulnerable. Although Price (2012)/Wiggins (2013) determined relational depth to be a one-dimensional construct, her earlier factor analyses unearthed anywhere from two to five factors, with possible variations between therapists and

clients. Furthermore, much of the variance in the construct was not accounted for, suggesting that perhaps there are more factors (or dimensions) associated with the construct. Because the purpose of the proposed study is to examine the therapist factors that contribute to the ability to invite and facilitate moments of relational depth, the seven dimensions are examined with a particular focus on therapists' contributions to the emergence of relational depth and situated within research on therapist development and the therapist's use of self as described by Rowan and Jacobs (2002).

### **Empathy**

Empathy was defined by Rogers (1957) as the ability to "sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers, 1957, p. 99). Later, Rogers (1980) expanded his definition, stating, "To be with another in this way means that for the time being, you lay aside your own views and values in order to enter another's world without prejudice" (p. 143). Taken together, these definitions underscore the affective and cognitive components of empathy (Hart, 1999).

Empathy has emerged in multiple writings on relational depth (Cooper 2005a; 2005b; 2007; 2013a; 2013b; Cox, 2009; Hawkins, 2013; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; Lago & Christodoulidi, 2013; Lambers, 2006, 2013; McMillan & McLeod, 2006; Mearns 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Murphy & Joseph, 2013; Price, 2012; Schmid & Mearns, 2006; O'Leary, 2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013). Therapists have reported experiencing heightened empathy – even somatically embodied – in moments of relational depth (Cooper, 2005a). Similarly, clients reported experiencing their therapists as highly

empathic in these moments (Knox, 2008; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006). In fact, clients even stated that their therapists understood them so well that it was as if they were “a part of them” (Knox, 2008, p. 186). Furthermore, in the early Relational Depth Inventory, *respect, empathy, and connectedness* emerged as a major factor of relational depth, accounting for more of the construct’s variance than other factors (Wiggins et al., 2012; Price, 2012).

Exploring empathy within relational depth a little more closely, Schmid and Mearns (2006) described two different types of empathy: concordant and complementary. Concordant empathy is empathy in its classic form – accurately perceiving another’s pain (Schmid & Mearns, 2006). Complementary empathy, however, occurs when therapists confront clients, in essence, providing them with a broader picture of themselves (Schmid & Mearns, 2006). Using both types, therapists endeavor to work *with* and *counter to* their clients (Mearns & Schmid, 2006; Schmid & Mearns, 2006). A high level of empathy, with a particular ability to both be with and challenge clients is characteristic of master therapists as well (Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005).

In addition to concordant and complementary empathy, there could exist certain degrees of empathy. This idea connects with research on the therapist’s use of self (Rowan & Jacobs, 2002), whereby empathy is perceived to exist on certain levels (concurrent with the instrumental, authentic, and transpersonal positions). Instrumental empathy is a safe form of empathy, where the therapist recognizes another’s situation in a more external manner. Authentic empathy, on the other hand, is the ability to experience

the other person's situation while still remaining cognizant of one's own being. Empathy on the transpersonal level is characterized by an opening to a different level of consciousness. Descriptions of transpersonal empathy coincide with descriptions of transcendental or deep empathy (Hart, 1997, 1999). Transcendental empathy is poetically compared to “. . . the sympathetic acoustical resonance of a violin string that when played in a room with other violins, particularly excites other strings tuned to the same note” (Hart, 1997, p. 254). In writings on this, Hart (1997) highlighted a necessary openness and receptivity needed to enter into this world, one that could be fostered by a certain shift in consciousness.

These descriptions of profound empathy coincide with therapists' experiences of relational depth: “. . . therapists will often feel awe and wonder at these moments of relational depth, struck by the sheer novelty and beauty of the world that is disclosed to them” (Mearns & Cooper, 2005, p. 41). Based on these descriptions, it is plausible that empathy will emerge as an important factor contributing to the ability to invite and facilitate moments of relational depth. However, some of the more nuanced elements of empathy – such as the openness to a different level of consciousness – could emerge and further characterize these mental health professionals and provide implications for relational depth research, education, and supervision. Along with empathy, another important dimension of relational depth is genuineness.

### **Genuineness**

Genuineness, congruence, authenticity, transparency, and realness are used synonymously in this review and can be characterized by one's ability to act

spontaneously from her or his core being, as it is known. Rogers (1980) described this quality as the ability to communicate with another based on one's honest, integrated awareness in the moment. These definitions coincide with the core definition of relational depth, which includes the ability to be “. . . fully real with the Other. . .” (Mearns & Cooper, 2005, p. xii).

Genuineness appears to be a critical dimension of relational depth (Cooper, 2005a, 2005b, 2007, 2013a, 2013b; Cox, 2009; Frzina, 2012; Hawkins, 2013; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; Lambers, 2006, 2013; McMillan & McLeod, 2006; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Price, 2012; Schmid & Mearns, 2006; O'Leary, 2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013). Both therapists (Cooper, 2005a) and clients (Knox, 2008; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) have highlighted therapist genuineness in moments of relational depth. Furthermore, clients have stated it was therapists' humanness and ability to be real – not perfect – that contributed the most to moments of relational depth (Knox & Cooper, 2010). In fact, relational depth was unlikely to occur when clients perceived therapists as “too lovely” (Knox & Cooper, 2010, p. 244).

The findings on therapist genuineness align with those on therapist development and the therapist's use of self (Rowan & Jacobs, 2002). Master therapists are characterized by their ability to be real, congruent (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005), and human (Skovholt et al., 2004). In this way, master therapists are not perfect, by any means; rather, they are comfortable with and able to be themselves to foster a therapeutic

relationship. Furthermore, Rowan and Jacobs' (2002) authentic way of using oneself is characterized by an awareness and willingness to use one's thoughts and emotions in the therapeutic encounter. From these descriptions, it would seem plausible that therapists in the proposed study may either discuss genuineness generally, or perhaps, offer certain methods or practices that help them become more genuine with clients. In addition to empathy and genuineness, unconditional positive regard is an important dimension of relational depth.

### **Unconditional Positive Regard**

Unconditional positive regard can be defined as an active *prizing* of the totality of another person as she or he is in the moment (Rogers, 1980). In this way, unconditional positive regard is characterized by a deep acceptance of another person, and it is prevalent in relational depth research (Cooper, 2005a, 2005b, 2007, 2013a; Cox, 2009; Hawkins, 2013; Knox, 2008, 2013; Knox & Cooper 2010, 2011; Lambers, 2006, 2013; Lago & Christodoulidi, 2013; Macleod, 2013; McMillan & McLeod, 2006; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Murphy & Joseph, 2013; Price, 2012; Schmid & Mearns, 2006; O'Leary, 2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013). Clients have stated that in moments of relational depth, they felt as though their therapist was really "on their side" (Knox, 2013, p. 31) and willing to "go the extra mile" (McMillan & McLeod, 2006, p. 285). Furthermore, Mearns and Cooper (2005) and Mearns and Schmid (2006) stated that relational depth is predicated on therapists' ability to accept all "parts" of clients – perhaps resulting in clients' assertions that their therapists seemed like ideal parental figures (McMillan & McLeod, 2006).

Unconditional positive regard, as a construct in and of itself, is not emphasized as much as empathy and genuineness in research on therapist development and the therapist's use of self (Rowan & Jacobs, 2002). However, master level therapists are characterized by their deep acceptance of the human condition (Skovholt et al., 2004) – including the world around them, others, and themselves. In fact, perhaps their ability to accept others is predicated on the development of self-acceptance, a quality of master therapists (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004), therapists who use themselves therapeutically (Rowan & Jacobs, 2002), and therapists who relate on deep levels with clients (Mearns & Cooper, 2005; Mearns & Schmid, 2006).

In summary, the core conditions of Rogers' (1957, 1980, 1989) empathy, genuineness, and unconditional positive regard serve as a foundation for relational depth, and when interacting at high levels, create moments of profound interpersonal connection (Knox et al., 2013b; Mearns & Cooper, 2005). Interestingly, later in Rogers' life, he is quoted as saying “. . . I am inclined to think that in my writing perhaps I have stressed too much the three basic conditions (congruence, unconditional positive regard and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy – when my self is very clearly, obviously present” (Baldwin, 1987, p. 45).

### **Therapeutic Presence**

At the most basic level, therapeutic presence can be defined as being in the moment on multiple levels (Geller & Greenberg, 2002). Bugental (1987) noted the

integration of both therapist *expressiveness* and *accessibility* associated with the power of presence. He described expressiveness as a therapist's willingness to let a client know her or him, and accessibility as the willingness to be affected by the client (Bugental, 1987). These components are related to Geller and Greenberg's (2012) more recent research on therapeutic presence, where they delineated four criteria associated with the construct: (a) being grounded in oneself, (b) being absorbed in the moment, (c) feeling a sense of expansion, and (d) maintaining the aim to be truly with the client. It seems, then, that a certain therapist stillness and receptivity is associated with therapeutic presence.

Therapeutic presence is frequently associated with moments of relational depth (Cooper, 2005a, 2005b, 2007, 2013a; Cox, 2009; Frzina, 2012; Geller, 2013; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; Lago & Christodoulidi, 2013; Lambers, 2006, 2013; Macleod, 2013; McMillan & McLeod, 2006; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Murphy & Joseph, 2013; O'Leary, 2006; Price, 2012; Schmid & Mearns, 2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2012). When therapists spoke of their experiences, they reported feeling immersed in the moment, as though they were in an altered state of consciousness (Cooper, 2005a). Clients also experienced their therapists as very present in moments of relational depth (Knox, 2008; Knox & Cooper, 2010; McMillan & McLeod, 2006). Perhaps the concept of deep presence can be best captured by Mearns and Cooper's (2005) description of *holistic listening* as “. . . a listening that ‘breathes in’ the totality of the Other. . .” (p. 120).

The characteristics associated with therapeutic presence are also those characteristic of master therapists and therapists using a transpersonal way of being

(Rowan & Jacobs, 2002). Master therapists immerse themselves in clients' stories, allow themselves to be affected by them (Rønnestad & Skovholt, 2003), and are more able to be present to a wide range of clients' emotions (Jennings & Skovholt, 1999), qualities that coincide with Bugental's (1987) *expressiveness* and *accessibility*. Furthermore, the confidence of more developed therapists (Hogan, 1964; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992; Stoltenberg, 1981; Stoltenberg & McNeill, 1997) appears to be related to the grounded characteristic of therapeutic presence (Geller & Greenberg, 2002, 2012). When therapists are more confident and secure in themselves, they can perhaps attend to clients with more openness and personal grounding.

These presuppositions align with the openness representative of Rowan and Jacobs' (2002) transpersonal way of being. In their descriptions of this position, they highlighted the ability to enter into a different level of consciousness, where numinous experiences occur. This numinous realm also has been associated with therapeutic presence (Geller & Greenberg, 2002). Furthermore, such contemplative practices as mindfulness are believed to help therapists become more deeply present (Geller & Greenberg, 2002, 2012), more able to use themselves in a transpersonal way (Rowan & Jacobs, 2002), and have been associated with moments of relational depth (Hawkins, 2013).

Interestingly, Geller and Greenberg's (2002) Model of Therapist Presence in the Therapeutic Relationship includes three stages: *preparing the ground for presence*, *process of presence*, and *experiencing presence*. In this, they highlighted practices that therapists engage in before sessions (e.g., setting aside personal thoughts, cultivating an

open attitude) and in their daily lives (e.g., self-care, meditation) in order to develop the capacity for deep presence. Such a finding is poignant for this study, as the therapist factors that contribute to the ability to invite and facilitate moments of relational depth have yet to be empirically validated. It may be that mental health professionals engage in certain practices *beforehand*, similar to the way in which therapists in Geller and Greenberg's (2002) study prepared to be present to their clients. Uncovering specific therapist factors could inform training and supervision. Next, it appears important that therapists develop some level of comfort inviting and sustaining emotional intensity and intimacy.

### **Comfort Inviting and Sustaining Emotional Intensity and Intimacy**

Generally, intimacy can be defined as “. . . an optimal state of felt relatedness. . .,” and one predicated on an environment of safety (Levenson, 1981, p. 3). Furthermore, Ehrenberg's (1974, 2010) concept of *working at intimate edge* is closely related, defined as “. . . that point of maximum and acknowledged contact at any given moment in a relationship without fusion, without violation of the separateness and integrity of each participant” (p. 424-425, 127, respectively). This capacity for deep contact also emerged in Mearns' (1996) early definition of relational depth.

Relational depth is characterized by intimacy, an “emotional charge” (Cooper, 2005a, p. 91) of deep connection (Cooper, 2005a, 2007, 2013a, 2013b; Cox, 2009; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; Lago & Christodoulidi, 2013; Lambers, 2006; Macleod, 2013; McMillan & McLeod, 2006; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; O'Leary, 2006; Price, 2012; Schmid & Mearns, 2006;

Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013). This is a broad and elusive theme, and thus, is described in different ways across conceptual and empirical studies. Conceptualized here, it seems as though something ignites such moments, often attributed to a therapist's invitation (Knox, 2008, 2013; Knox & Cooper, 2010, 2011) that leads to a client's willingness to risk vulnerability and surrender into the process (Cooper, 2013a; Knox, 2013; Knox & Cooper, 2011; McMillan & McLeod, 2006). Prior to these moments, participants have noted the intense emotional atmosphere (Cooper, 2005a; Knox, 2008; Knox & Cooper, 2011; Macleod, 2013) – almost like electricity (Cooper, 2013a) or “a tingling all over” (Cooper, 2005b, p. 139). In fact, two of the items most associated with the presence of relational depth are love and intimacy (Price, 2012). In these ways, it seems as though an intimate and intense emotional charge is the spark that initiates, deepens, and sustains moments of relational depth. It would follow, then, that therapists would most likely need some level of comfort inviting and sustaining such intense emotional intimacy.

Such a level of intense contact could be frightening to clients, though, and could account for the *scared/vulnerable* factor found in an earlier version of the Relational Depth Inventory (Price, 2012; Wiggins et al., 2012). With the intense feelings of vulnerability and the riskiness of opening up, clients have reported feeling scared (Knox, 2008; Knox & Cooper, 2011). Such emotional intensity may be detrimental to the therapeutic relationship if clients are not seeking a relationally-deep experience (McMillan & McLeod, 2006). Thus, Knox (2008, 2013) concluded that therapists needed

to be open to such an experience (and thus possess some comfort with a heightened level of emotional intensity) without forcing it.

More developed therapists and therapists using themselves in a transpersonal way (Rowan & Jacobs, 2002) also seem to be comfortable inviting and sustaining emotional intensity and intimacy. Master therapists have been described as intense (Skovholt et al., 2004), willing to be with the intensity of others (Jennings & Skovholt, 1999), capable of high levels of engagement (Skovholt et al., 2004; Sullivan et al., 2005), and able to “. . . dance with the client. . .” (Skovholt et al., 2004, p. 38). This metaphor aligns with Rowan and Jacobs’ (2002) description of the transpersonal way of using the self – as a place where a person is paradoxically joined with another and separate, perhaps two dancers merged in the same dance. Furthermore, these descriptions mirror Mearns’ earlier descriptions of “encounter and invasion” (Mearns & Cooper, 2005, p. 103). In these ways, therapists possess some level of comfort with these intense emotional interactions; however, they are acutely perceptive of clients’ readiness and willingness at any given point in time. The openness needed for such an interaction is characteristic of the next dimension of spiritual/transcendent openness.

### **Spiritual/Transcendent Openness**

The sixth dimension of relational depth is spiritual/transcendent openness. Due to the numinosity of this dimension, it is difficult to identify a term that captures it. Rowan (2013) underscored the spiritual nature of relational depth, stating that it is an experience that occurs on the subtle level of consciousness – also where Jungian archetypes, imagery, compassion, and intuition exist. Therefore, relational depth seems to possess

some mysterious, numinous essence that is, by its very nature, elusive, and perhaps transcends even traditional understanding.

Broadly, spirituality has been defined as the “universal human capacity to experience self-transcendence and awareness of sacred immanence, with resulting increases in greater self-other compassion and love” (Young & Cashwell, 2011, p. 7). In many ways, this definition mirrors that of transcendence: “Transcendence refers to the very highest and most inclusive or holistic levels of human consciousness, behaving and relating, as ends rather than as means to oneself, to significant others, to human beings in general, to other species, to nature, and to the cosmos” (Maslow, 1969, p. 66). Both of these definitions underscore an expanded level of consciousness for aspects both beyond and within oneself. Exploring human development from a consciousness perspective, Wilber (2000) posited that evolution occurs as humans transcend and include the elements of a society in any given point in time. The transcendent element of development also seems evident in Walsh and Vaughan’s (1993) quotation: “A common characteristic of higher development is that our identity or ego changes, eventually losing its sense of solidarity and separateness and becoming transpersonal” (p. 114).

Both concepts of transcendence and spirituality are strongly associated with current understandings of relational depth. First, *transcendence* emerged as one of the five factors of relational depth in an earlier factor analysis of the Relational Depth Inventory (Price, 2012; Wiggins et al., 2012). Additionally, the spiritual and transcendent experience of relational depth has been touched upon in many descriptions of the phenomenon. Relational depth has been described as *spiritual* (Cooper, 2013a; Hawkins,

2013; Knox, 2013; Macleod, 2013; Mearns 1997; Price, 2012; Rowan, 2013; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013) and *mystical* (Cooper, 2013a; Knox, 2013; Mearns, 1997). Such an experience leaves people feeling paradoxically *alive* and peaceful (Knox, 2008, 2013) – almost as if in a *peak experience* (Knox, 2008, 2013), on a *different dimension* (Cooper, 2013a; Knox, 2008, 2013; Macleod, 2013), in a *flow state* (Cooper, 2005a; Knox & Cooper, 2011; McMillan & McLeod, 2006; Mearns & Cooper, 2005; Price, 2012; Wiggins, 2013; Wiggins et al., 2012), or in an *altered state of consciousness* (Cooper 2005a; Cooper, 2013a; Lago & Christodoulidi; 2013; Mearns & Cooper, 2005; Price, 2012; Wiggins, 2013; Wiggins et al., 2012). Stated succinctly by Rowan (2013) “. . .working at relational depth is a spiritual activity. . .” (p. 208), believed to occur on Wilber’s (1993) subtle level of transpersonal development. Taken together, this research evidences some numinous component of relational depth.

The concept of spiritual/transcendent openness can be found in some research on master therapists and is highly prevalent in research on the therapist’s use of self (Rowan & Jacobs, 2002). It appears that much of the research on master therapists culminates in Rowan and Jacobs’ authentic way of being, with emphasis on therapists’ congruence (Jennings & Skovholt, 1999; Rønnestad & Skovholt, 2003; Skovholt et al., 2004; Sullivan et al., 2005). However, Skovholt et al. (2004) stated that a spiritual or religious foundation served to inform master therapists’ understanding of life, which could indicate some evidence of master therapists’ work in the transpersonal realm. Rowan and Jacobs’ (2002) transpersonal position is defined by spiritual/transcendent openness, with descriptions of therapists who are able to enter into subtle states of consciousness and

form profound connections. Taken together, the dimension of spiritual/transcendent openness is somewhat limited in therapist development research (and more specifically, research on master therapists); however, it is fully representative of Rowan and Jacobs' (2002) transpersonal way of being. The final dimension centers on therapists' personal depth.

### **Personal Depth with a Willingness to be Vulnerable**

Although one may be able to conjure images of a “deep” versus “superficial” person, research on this construct is lacking. Sanford (1956) explored the construct of depth in nine different ways, and concluded that depth is related to the unconscious. The construct of depth here is described from a relational depth perspective, however, and, as such, is linked with – and in some ways characterized by – therapists' vulnerability.

In empirical studies and conceptual reviews, therapists' willingness to be vulnerable was associated with relational depth (Cooper, 2005a, 2007; Knox, 2013; Knox & Cooper, 2010; Lambers, 2006, 2013; Mearns & Cooper, 2005; Price, 2012; Wiggins, 2013; Wiggins et al., 2012) as was an ability to relate at a level of personal depth (Cooper, 2005b, 2013; Knox, 2013; Knox & Cooper, 2010; McMillan & McLeod, 2006; Mearns, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Schmid & Mearns, 2006). Although clients are credited for capitalizing upon their own vulnerability and *initiating* moments of relational depth (Knox & Cooper, 2011; McMillan & McLeod, 2006), their willingness is predicated on a perception of their therapist as deep and vulnerable (Knox & Cooper, 2010), and therapists have reported feeling similarly vulnerable (Cooper, 2005a). Therapists' personal depth and vulnerability are related to

the points of connection deemed “existential touchstones” (Mearns & Cooper, 2005, p. 138) discussed earlier. In other words, to develop relational depth capacity, therapists need to contact the existential core of themselves, which facilitates personal depth and a willingness to be vulnerable with clients.

This dimension relates to research on therapist development (specifically research on master therapists) and the therapist’s use of self (Rowan & Jacobs, 2002). As stated earlier, therapist development is characterized by greater integration of their personal and professional lives (Rønnestad & Skovholt, 2003; Skovholt et al., 2004), and master therapists are characterized by a level of personal suffering (Rønnestad & Skovholt, 2001, 2003; Skovholt et al., 2004). These qualities could be related to the concept of the *wounded healer* (Grosbeck, 1975), an archetypal image suggesting that a healer’s power lay in her or his woundedness (Zerubavel & Wright, 2012). Thus, it is believed that a healer’s intimate connection with and acceptance of her or his own brokenness facilitates healing potential in clients (Grosbeck, 1975; Miller & Baldwin, 1987). Rønnestad and Skovholt (2001, 2003) challenged this idea, stating that unhealed wounds may not positively impact master therapists’ work. As postulated here, however, therapists’ willingness to tap into their own vulnerable places of suffering may provide them with the necessary depth to empathize with clients. The concept of the wounded healer is believed to exist within Rowan and Jacobs’ (2002) authentic position of the therapist’s use of self. In this way, therapists’ contact with the core of their inner being – along with conscious and perhaps unconscious woundedness – gives them greater depth in relating to their clients.

Taken together, the seven dimensions of relational depth represent a synthesized version of the many possible therapist factors discussed earlier. Furthermore, based on theoretical understanding, each of the dimensions can be nested inside therapist developmental models (specifically research on master therapists) and compared to Rowan and Jacobs' (2002) three positions of the therapist's use of self. As stated earlier, Rowan and Jacobs (2002) posited that moments of relational depth occur within the transpersonal way of being. The synthesized dimensions described above would suggest that relational depth represents a culmination of many therapist factors – perhaps drawing from all three (instrumental, authentic, and transpersonal) modes of using the self. However, empirical research is lacking on both the emergent therapist factors and the ways that these factors could represent aspects of Rowan and Jacobs' (2002) developmental framework. This could offer numerous implications for research, therapist training, and supervision. To explore these questions, the research approach of *concept mapping* (as outlined by Trochim [1989a] and Kane and Trochim [2007]) was used. A review of the method is described here, and the methodological details of the proposed study are outlined in Chapter Three.

### **Concept Mapping**

To explore therapists' conceptualizations of the factors that contribute to the ability to invite and facilitate moments of relational depth, the integrated mixed methods approach of concept mapping – as outlined by Trochim (1989a) and Kane and Trochim (2007) – was used. Established in the early to mid 1980s, “Concept mapping is a generic term that describes any process for representing ideas in pictures or maps” (Kane &

Trochim, 2007, p. 1). By using the interactional nature of both participants' qualitative conceptualizations and quantitative multivariate statistical analyses to create novel representations, concept mapping can be considered an *integrated* mixed methods approach (Caracelli & Greene, 1993). In fact, because of its ability to creatively represent groups' conceptualizations using statistically rigorous methods, concept mapping has been considered both a "soft science" and a "hard art" (Trochim, 1989b, p. 87). Although concept mapping was developed for project planning and evaluation using stakeholders' opinions (Kane & Trochim, 2007; Trochim, 1989a), it has also become a valid approach for researching phenomena in the counseling field (see, for example, Bedi, 2006; Goodyear, Tracey, Claiborn, Lichtenberg, & Wampold, 2005; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003).

To establish the scientific rigor of concept mapping, researchers (Bedi, 2006; Rosas & Kane, 2012; Trochim, 1989b) have explored the reliability and validity of the approach. Early in concept mapping, Trochim (1989a) defined reliability as researchers' ability to replicate the same map at a different period in time and validity as researchers' ability to accurately represent the group's conceptualizations (Trochim, 1989a). Since then, though, these notions of reliability and validity have expanded. For example, Rosas and Kane (2012) sought to examine the reliability and validity of concept mapping by conducting an analysis of 69 studies using the approach. They determined that within-study participants' maps evidenced strong internal validity and the sorting and rating tasks evidenced strong reliability. Furthermore, because emergent concept maps are directly created from participants' aggregated responses and interpretations, the final

maps possess inherent testimonial validity (Bedi, 2006). Moreover, reliability is typically ensured through the process of calculating stress values, which determine how well the aggregated model fits individual participants' responses – almost like a measure of internal consistency (Bedi, 2006). Taken together, concept mapping appears to be a valid and reliable research method.

More specifically related to this study, concept mapping was chosen because of its ability to use participants' voices to create a picture of a certain construct's components – in this case, the therapist factors that contribute to their ability to invite and facilitate moments of relational depth with clients. Furthermore, it is believed that through the use quantitative and qualitative approaches, a more integrated, empirically-sound, and nuanced perspective of these factors will emerge.

### **Overall Summary**

The purpose of Chapter Two was to review the literature on relational depth, with a particular emphasis on illuminating possible therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. In summary, relational depth is grounded in Person-Centered Therapy (Rogers, 1957, 1980, 1989), and capitalizes on the synergistic effects of the core conditions (Knox et al., 2013b; Mearns & Cooper, 2005). Clients' and therapists' experiences of relational depth across populations and modalities have underscored the power and ineffability of such moments. Exploring the dimensions, process, conceptual qualities, and measures of relational depth further illuminate the construct. Additionally, research on therapist development, master

therapists, and the therapist's use of self elucidate plausible therapist factors that may contribute to a capacity for relational depth.

Prior to this study, the specific therapist factors that contribute to the ability to invite and facilitate moments of relational depth had yet to be empirically validated. Thus, although these factors could certainly be postulated based on conceptual research and tangential empirical research, they had yet to be studied in a consolidated manner. Furthermore, it remained unclear whether or not such factors coincided with the three positions of Rowan and Jacobs' (2002) therapist's use of self. To address this gap in the literature, the mixed methods approach of concept mapping (Kane & Trochim, 2007; Trochim, 1989a) was used. The specific methodology of this approach is described in the next chapter.

## **CHAPTER III**

### **METHODOLOGY**

In Chapter One, the researcher considered the existing relational depth literature, illuminated the limitations in the current research, and proposed a study examining the therapist factors that contribute to the ability to invite and facilitate moments of relational depth. From there, relational depth was analyzed, synthesized, and contextualized within and across various theoretical frameworks in Chapter Two. In this chapter, the proposed methodology for the study is outlined, including participant selection, instrumentation, and procedural implementation.

#### **Research Questions**

The overall purpose of the study was to explore therapists' conceptualizations of the factors that contribute to the ability to invite and facilitate moments of relational depth with clients. Based on these results, emergent factors were then compared to Rowan and Jacobs' (2002) three positions (instrumental, authentic, and transpersonal) of the therapist's use of self. It was believed that by identifying the therapist factors that contribute to relational depth, numerous implications for relational depth research, therapist training, and supervision would emerge. The following research questions guided this study:

1. What therapist factors (prior to or during therapy) do participants believe contribute to the ability to invite and facilitate moments of relational depth with clients?
2. How important do participants believe each of the factors are in contributing to their ability to invite and facilitate moments of relational depth?
3. How often do participants practice these factors in their work with clients?

## **Participants**

### **Inclusion Criteria**

For participants to be included in the study, they had to (a) be at least 18 years of age, (b) work within approximately a 30-mile radius of the research site, and (c) possess at least a master's degree in a mental health discipline (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling). Furthermore, to be included in all three phases of data collection, participants had to respond affirmatively to a screening question asking them if they had experienced a moment of relational depth with a client.

Requiring that participants work within approximately a 30-mile radius of the research site improved the likelihood that they would participate in the face-to-face interpretation phase of data collection. Instituting the criterion that participants possess at least a master's degree in a mental health discipline ensured that they were trained in helping skills and theories, and ensured that their training was at least somewhat homogenous in scope and emphasis. Finally, instituting the criterion that prospective participants respond affirmatively to the relational depth screening question presumably

ensured that selected individuals had experienced at least one moment of relational depth with a client.

Potential participants were identified through a peer nomination process. After receiving site approval (see Appendix A: Site Approval), the researcher e-mailed all faculty members from one counselor education program in the southeastern United States, gave them the definition and a description of relational depth, and asked them to identify up to seven therapists working within approximately a 30-mile radius who met the inclusion criteria and who they believed may have experienced relational depth with their clients (see Appendix C: Nomination Script). Nominators were encouraged to contact these seven individuals, inform them of the study, and provide them with the researcher's e-mail address for follow-up contact (see Appendix D: Snowball Sampling Script). Nominators' names were not collected to preserve their privacy. To select additional participants as part of the first phase of data collection, the researcher asked potential participants to send information about the study to other therapists in the geographic area who they would nominate to participate (see Appendix D: Snowball Sampling Script). This snowball sampling continued until a minimum of 10 and a maximum of 40 participants agreed to participate in the study. The names and e-mail addresses of participants who chose to participate in the study were handwritten and matched with code number identifiers. This list was kept in a locked box owned by the researcher. The participants' data was kept secure on the researcher's password-protected computer, and only identified through code numbers.

There were no pre-established limitations regarding participants' age, gender, race, ethnicity, sexual orientation, spiritual and/or religious background, or theoretical orientation. Additionally, therapists could work across a variety of settings (e.g., community mental health centers, university counseling centers, private practice settings, faith-based settings, in-patient treatment centers, hospitals). These inclusion criteria were intentionally broad to allow for diverse experiences across a variety of mental health professional settings.

### **Procedures**

To explore participants' conceptualizations of the factors that contribute to their ability to invite and facilitate moments of relational depth, the integrated mixed methods approach of concept mapping (Kane & Trochim, 2007; Trochim, 1989a) was used. Trochim (1989a) and Kane and Trochim's (2007) concept mapping process includes six steps (with various tasks included therein): (a) preparing for concept mapping, (b) generating the statements, (c) structuring the statements, (d) representing the statements, (e) interpreting the concept maps, and (f) utilizing the concept maps.

For the purposes of this study, the researcher slightly modified Trochim (1989a) and Kane and Trochim's (2007) concept mapping approach. To streamline the process, all prospective participants were asked to complete a demographic form (typically part of step three) (see Appendix G: Demographic Information) and generate statements (see Appendix H: Generating the Statements Instructions), and only the demographic information and statements from those individuals who met the inclusion criteria and responded affirmatively to the relational depth screening question were formally included

in the study. Furthermore, only the individuals who met these aforementioned criteria were contacted to participate in the final two phases of data collection (sorting and rating the statements and interpreting the concept maps). Along with this, two rating scales were used, one asking therapists to rate the importance of each factor and one asking them to identify how frequently they use each factor in their work with clients. Finally, because this study was not designed for subsequent policy planning, outcome evaluation, and/or measure development (as outlined by Kane & Trochim, 2007), the sixth step (utilization) in concept mapping was not formally included. Rather, in the fifth step (interpreting the concept maps), participants were encouraged to share their thoughts about how they developed the capacity to invite and facilitate moments of relational depth; discuss whether or not the results represent Rowan and Jacobs' (2002) three positions of the therapist's use of self; and offer implications for research, therapist education, and supervision.

### **Step One: Preparing for Concept Mapping**

Before beginning the study, it was important to prepare for the concept mapping process (Kane & Trochim, 2007). According to Kane and Trochim (2007), this step includes (a) defining the issue; (b) initiating the process; (c) selecting the facilitator; (d) determining the goals and purposes; (e) defining the focus; (f) selecting the participants; (g) determining the participation methods; (h) developing the schedule, communication plan, and format; (i) determining resources; (j) gaining approval by the Institutional Review Board (IRB); and (k) writing the concept mapping plan. In the following

description, each of Kane and Trochim's (2007) tasks are outlined; however, gaining IRB approval is included earlier after defining the focus.

**Defining the issue.** As described in the statement of the problem and need for the study in Chapter One, there was a lack of empirical research on those therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. Researchers had qualitatively explored therapists' (Cooper, 2005a; Macleod, 2013) and clients' (Knox, 2008; Knox & Cooper, 2010, 2011; McMillan & McLeod, 2006) experiences of relational depth, which provided a glimpse into what may constitute these factors (e.g., empathy, genuineness, unconditional positive regard). However, these had not yet been purposefully studied nor had emergent qualities been explored within a framework, such as Rowan and Jacobs' (2002) three positions of the therapist's use of self. Conceptually, Mearns and Cooper (2005) and Mearns and Schmid (2006) have offered a possible developmental trajectory and possible therapist factors that contribute to the ability to invite and facilitate moments of relational depth; however, this had yet to be empirically validated. Not only was this study specifically designed to illuminate these factors, but also, through the use of concept mapping methodology, these factors were illustrated in a statistically sound pictorial representation of participants' aggregated conceptualizations.

**Initiating the process.** As part of the initiation process, it was important to determine the scope of the study (Kane & Trochim, 2007). The scope of this study was bounded by the research questions previously outlined. Chiefly, participants'

conceptualizations of those therapist factors that contribute to their ability to invite and facilitate moments of relational depth were explored.

**Selecting the facilitator.** The primary author (and researcher) of this document served as both the initiator and facilitator of the study with guidance from the dissertation committee.

**Determining the goals and purposes.** The primary goal of this study was to construct a concept map of participants' conceptualizations of the specific therapist factors that contribute to their ability to invite and facilitate moments of relational depth. Based on the emergent clusters, participants were invited to reflect upon the ways in which they cultivated this capacity; discuss the results in light of Rowan and Jacobs' (2002) three positions of the therapist's use of self; and offer implications for research, therapist education, and supervision.

**Defining the focus.** Before beginning the study, researchers need to identify the foci for both the steps of generating the statements and rating the statements (Kane & Trochim, 2007). Although detailed later in step two, the primary focus in generating the statements was to identify therapist factors that participants believed contribute to their ability to invite and facilitate moments of relational depth with clients. There was a twofold focus in rating the statements: (a) to determine how important participants believe they are in contributing to this ability and (b) to determine the frequency with which participants use these factors when working with clients. Both of these rating scales were written on 5-point Likert-type scales.

**Gaining approval by the IRB.** Prior to starting the pilot study and full study, the researcher secured approval by the university's IRB (see Appendix B: IRB Approval). Modifications to the pilot study were submitted later for further approval by the IRB.

**Selecting the participants.** Kane and Trochim (2007) recommended that 10 to 40 participants be selected based on their experience with and/or understanding of the topic. The researcher used peer nomination and snowball sampling to select a sample of mental health professionals who had experienced at least one moment of relational depth with a client. To target prospective participants working approximately within a 30-mile radius of the location in which the data collection procedures would occur (for feasibility purposes), the researcher sought nominations (see Appendix C: Nomination Script E-mail) from all counselor educators at one university in the southeastern United States. More specifically, the researcher e-mailed these faculty members, provided them with a definition and description of relational depth and the inclusion criteria for the study, and asked these individuals to contact up to seven therapists working approximately within a 30-mile radius who met the inclusion criteria and who they believed had the capacity to invite and facilitate moments of relational depth with clients. The researcher provided the nominators with information about the study and the researcher's contact information to give to prospective participants (see Appendix D: Snowball Sampling Script). The nominated individuals who contacted the researcher and chose to participate were included in step two of the process (generating the statements). If, however, it was determined from responses to demographic information that a participant did not meet the inclusion criteria, the data from this individual was not included in the data set.

**Determining the participation methods.** Kane and Trochim (2007) asserted that it is important to identify the ways in which selected individuals will participate in each phase of data collection. In this study, there were three phases of data collection: (a) generating the statements, (b) sorting and rating the statements, and (c) interpreting the concept maps. The first round of data collection was completed remotely using electronic methods, the second round was completed using mail services, and the third round of data collection was conducted face-to-face.

**Developing the schedule, plan, and format.** The researcher facilitated the three rounds of data collection within a period of approximately six months. Communication with participants was done through face-to-face contact, e-mail, and mail.

**Determining the resources.** The researcher was responsible for funding all resource needs, including, but not limited to, computer software, paper, envelopes, postage, facilities management, and snacks for the face-to-face meeting.

**Writing the concept mapping plan.** Kane and Trochim (2007) highlighted the importance of documenting a plan for any concept mapping study. This document served as that plan.

### **Step Two: Generating the Statements**

After establishing the plan for the concept mapping study, the researcher initiated the first round of data collection: generating the statements (Kane & Trochim, 2007). There are four tasks involved in this stage of the process: (a) preparing for the brainstorming session, (b) introducing the process, (c) managing the session, and (d)

synthesizing the statements. Because the process was conducted remotely, the task of managing the session was not included in this study.

**Preparing for the brainstorming session.** The prospective participants who chose to contact the researcher to be included in the study were sent an initial e-mail (see Appendix E: Initial Contact E-mail), which included the research consent form, a link to the Qualtrics (2014) site for data collection, and a sheet of information about the study (see Appendix D: Snowball Sampling Script). They were encouraged to send this information to other mental health professionals who they believed were eligible to participate.

**Introducing the process.** Prospective participants received the invitation e-mail (see Appendix E: Initial Contact E-mail) and were directed to the associated Qualtrics (2014) site where they were asked to (a) read the research consent form (see Appendix F: Research Consent Form) and agree to the terms included therein (a copy of the research consent form was also included in the initial e-mail for their records); (b) complete a demographic form (see Appendix G: Demographic Information), including questions about their age, gender, race/ethnicity, sexual orientation, spiritual and/or religious background, theoretical orientation, practice setting, employment location, mental health degree status, licensure status, years of experience, and relational depth experience; (c) provide their contact information (name, e-mail address, mailing address, and phone number) for follow-up contact; (d) generate the statements; and finally, (e) send information about the study to other mental health professionals who they would nominate as potential participants.

To generate the statements, participants were directed to a Qualtrics (2014) open-response page and encouraged to generate as many ideas as possible related to the focus statement and prompt (see Appendix H: Generating the Statements Instructions). The focus statement and prompt read: “For my study, I am exploring the phenomenon of relational depth. Relational depth has been defined as ‘a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level’ (Mearns & Cooper, 2005, p. xii). Please take a moment to reflect on your counseling career thus far and the clients you have counseled. Identify one or more times when you feel as though you and a client have experienced a moment of deep connection. How did you do that? What do you believe contributed to your ability to invite and facilitate this moment of deepened connection with your client? You may consider who you are and/or what you do before and/or during these therapy sessions. When you have identified a factor, please type it in one of the boxes in the form of a word or short phrase. Brainstorm as many factors as you can, but please limit each box to ONE factor or concept only. To guide you in this process, please use the following focus prompt: ‘Either before or during counseling, one way I invite and facilitate moments of relational depth with clients is \_\_\_\_\_.’

Once the prospective participants’ responses were received, the researcher separated their contact information from their data and used code number identifiers with their actual data. The data from those prospective participants who did not meet the inclusion criteria or did not answer affirmatively to the relational depth screening question was not used. The remaining participants’ statements were then synthesized.

**Synthesizing the statements.** Because the purpose of the brainstorming activity was to generate as many statements as possible related to the focus prompt, the final number of statements was quite lengthy. Trochim (1989a) and Kane and Trochim (2007) recommended that researchers analyze, edit, and synthesize the statements to a maximum number of 100. This target number allows for a breadth of ideas without becoming unmanageable for participants in the future sorting and rating tasks. In order to synthesize the statements and cross check results, the researcher solicited assistance from a member of the dissertation committee. Together, these two individuals read all of the statements, removed all of the redundancies, and edited them for clarity in grammar, structure, and wording. Any disagreements between the two researchers were discussed until a consensus was reached.

### **Step Three: Structuring the Statements**

The third step in Trochim (1989a) and Kane and Trochim's (2007) concept mapping process (structuring the statements) constitutes the second phase of data collection and includes four researcher tasks: (a) planning the structuring activity, (b) introducing the process, (c) sorting the statements, and (d) rating the statements.

**Planning the structuring activity.** As previously mentioned, the second phase of data collection was conducted remotely. After synthesizing and editing all of the statements (as part of step two), the researcher prepared the sorting and rating materials, placed them in manila envelopes, and mailed an envelope to each of the participants. Each manila envelope included an overall sheet of instructions, a set of statement cards,

15 letter-size envelopes for the sorting task, the rating sheets, and a folded manila envelope (stamped and addressed to be returned to the researcher).

**Introducing the process.** To initiate the process, the researcher sent e-mails to each of the participants (see Appendix I: Sorting and Rating the Statements E-mail), informing them that they were selected to participate in the second phase of data collection and would be receiving a manila envelope in the mail. The e-mail also included a copy of the instructions (see Appendix J: Sorting and Rating the Statements Instructions) for participants to peruse before receiving their copy in the mail. Participants were informed of the deadline, thanked for their time, and encouraged to contact the researcher if they had any questions or concerns. Those prospective participants who did not meet the inclusion criteria were also e-mailed at this time, thanked for their participation, and notified that they were not selected for subsequent phases of data collection.

**Sorting the statements.** Each manila envelope included a set of statement cards and 15 letter-sized envelopes for sorting the statements. Participants were invited to sort the statements “in a way that makes sense to you” (Kane & Trochim, 2007, p. 12; Trochim, 1989a, p. 5). However, they were informed that (a) each card may only be placed in one pile, (b) the cards may not all be placed in the same pile, and (c) each card cannot be its own pile (Kane & Trochim, 2007; Trochim, 1989a). Once the cards were sorted in piles, the participants were encouraged to place each pile in an envelope, seal the envelope, and write a conceptual name for that pile on the front of the envelope.

**Rating the statements.** After the participants sorted all of the statements into piles, they were then instructed to rate all of the statements based on (a) how important they believe each statement (or therapist factor) was in contributing to their ability to invite and facilitate a moment of relational depth with a client and (b) how frequently they practiced these factors in their work with clients. Statements were rated on 5-point Likert-type scales. Additionally, to seek greater variation in participants' scores, they were encouraged to use the full range of the Likert-type scales as recommended by Kane and Trochim (2007). Once they completed the rating tasks, they were encouraged to place these sheets along with all of the smaller sorting envelopes inside the folded manila envelope (stamped and self-addressed) to mail back to the researcher. The sorting envelopes and rating sheets included participants' code numbers in order to identify and use their data in a confidential manner after it was received.

Once the researcher received these materials, the data was once again separated from participants' contact information, preserving their confidentiality. The only information that was kept with participants' contact information was a check mark noting whether or not they participated in the second round of data collection, as those who participated were invited to interpret the maps in the third round of data collection.

#### **Step Four: Representing the Statements**

In order to represent the statements pictorially through concept maps, the data from the sorting and rating tasks had to be transformed using multivariate analyses. According to Kane and Trochim (2007), this step includes three major tasks: (a) creating the group binary symmetric similarity matrix, (b) using multidimensional scaling to

create a two-dimensional point map, and (c) using hierarchical cluster analysis to group the points (statements) into conceptual clusters. Trochim (1989a) explicitly included the task of creating the point rating and cluster rating concept maps as part of this step, and thus, it was added as a fourth task in this study as well. All statistical analyses were completed with de-identified data using R editor (R Development Core Team, 2011) and SPSS (IBM Inc., 2013).

**Creating the total square symmetric dissimilarity matrix.** To create the concept maps, each participant's sorting data was entered into a sort table and transformed into a total square symmetric dissimilarity matrix. Though Kane and Trochim (2007) recommended using a *similarity* matrix, the syntax for the R editor (R Development Core Team, 2011) software program was written to analyze a *dissimilarity* matrix. The resulting point map is the same as it would have been using a similarity matrix.

**Using multidimensional scaling.** Using data from the total square symmetric dissimilarity matrix, the researcher then performed nonmetric multidimensional scaling in order to construct a two-dimensional point map (Kane & Trochim, 2007). Although multidimensional scaling may result in diverse numbers of dimensions, Kane and Trochim (2007) recommended the use of two dimensions. To ensure that the point map adequately represents the participants' data, the stress value (goodness-of-fit indicator) was examined, which should be between 0.205 and 0.365 (Trochim, 1993, as cited in Kane & Trochim, 2007). The stress value was acceptable, and thus, the resulting two-dimensional point map was used to conceptually illustrate the relationships between the

statements (points). In other words, points that were located closer together on the point map indicated statements that were sorted together more frequently by the participants.

**Using hierarchical cluster analysis.** Once the point map was created, the researcher performed agglomerative hierarchical cluster analysis, using Ward's method (recommended by Trochim [1989a] and Kane and Trochim [2007]), to group the points into conceptual clusters. After performing the hierarchical cluster analysis, a cluster tree/dendrogram was generated that positioned specific statements next to each other and provided a visual framework for selecting the number of clusters. Deciding on the number of clusters is subjective (Kane & Trochim, 2007; Trochim, 1989a) and depends on the purpose of the study and the ways that the statements group together in the cluster tree/dendrogram. To decide on the number of clusters, the researcher followed Kane and Trochim's (2007) guidance and started with a twenty-cluster solution and continually reduced the number of clusters, searching for patterns in the data until a logical cluster solution emerged. In this process, a larger cluster solution was preferred over one that was too small (Trochim, 1989a). As an integrity check, the researcher consulted with a member of the dissertation committee before the final number of clusters was chosen.

**Representing importance and frequency ratings.** The purpose of the rating sheets was to illustrate (a) how important participants believed the statements were in contributing to their ability to invite and facilitate moments of relational depth and (b) how frequently participants reported using these factors in their work with clients. To represent these areas, the researcher created a table of importance and frequency ratings (and the difference scores) by factor and created a bar graph of importance and frequency

ratings by cluster (using SPSS [IBM Inc., 2013]). Higher factor and cluster values in the table and bar graph indicated that participants deemed these more important or used them more frequently. From there, the data was interpreted.

### **Step Five: Interpreting the Concept Maps**

Interpreting the concept maps constituted the final phase of data collection. The researcher modified and synthesized Kane and Trochim's (2007) ten steps in order to allow sufficient time for group discussion. Thus, for the purposes of this study, the tasks included (a) preparing for the session, (b) introducing the process, (c) presenting the cluster listings and naming the clusters, (d) presenting the point and cluster maps, (e) presenting the factor and cluster ratings by table and bar graph, respectively, and (f) discussing the overall results and identifying implications.

**Preparing for the session.** To prepare for the session, the researcher e-mailed the participants who returned their sorting and rating materials and invited them to participate face-to-face in the third round of data collection (see Appendix K: Interpreting the Results E-mail). More specifically, the e-mail included an expression of gratitude for the participants' willingness to participate thus far; a general statement about the purpose of the final meeting; the date, time, and location of the interpretation event; a request to RSVP; and a statement that free snacks would be served to those who participate. Before the event, the researcher reserved the room, obtained the food, procured writing utensils, prepared the agenda, copied the necessary handouts (i.e., the cluster listings, the point and cluster concept map, and the rating table and bar graph), and sought note-taking assistance from a member of the dissertation committee.

**Introducing the process.** The researcher first thanked the participants for their presence, introduced the person taking notes, and then described the two major tasks for the meeting: (a) naming the clusters and (b) engaging in a discussion about the findings. (See Appendix L: Interpreting the Concept Maps Agenda.)

**Presenting the cluster listings and naming the clusters.** To begin the interpretation, the researcher reminded the participants of the previous data collection processes (generating the statements and sorting and rating them). From there, each participant was provided with a copy of all of the statements grouped together by emergent clusters. The researcher briefly described how the clusters were formed and then invited the participants to take five to ten minutes and work individually to name each of the clusters (based on the statements included in each group). After they individually named these clusters, the researcher encouraged the group to discuss the cluster names and work together to designate one name for each cluster. This process was done iteratively, one cluster at a time. When the group failed to reach a consensus on any specific cluster, the researcher proposed that they select a mixture of names for that cluster (Kane & Trochim, 2007; Trochim, 1989a).

**Presenting the point and cluster map.** Once all of the clusters were named, the researcher presented participants with the point and cluster maps and explained that points and clusters located closer together were grouped together more often by participants. At that point, the participants were asked if they believed any changes should be made to the clusters (e.g., removing specific statements, merging clusters).

**Presenting the point and cluster ratings.** From there, the researcher presented the factor ratings by table and the cluster ratings by bar graph. Participants were informed that higher ratings indicated that the factor or cluster was either deemed more important or used more frequently. Participants were given time to examine the table and bar graph and offer any general insights or impressions. This discussion led into the final task of identifying implications.

**Discussing the results and identifying implications.** Finally, the participants were encouraged to share their reflections and offer implications for research, therapist education, and supervision in light of the concept mapping results. This discussion was guided by four overarching questions: (a) How do participants believe they initially developed the ability to invite and facilitate moments of relational depth with clients and do they believe this can be trained?; (b) Do the participants believe their conceptualizations of these factors represent Rowan and Jacobs' (2002) three positions (instrumental, authentic, and transpersonal) of the therapist's use of self? If so, how?; (c) Based on the emergent clusters, what implications do the participants offer for therapist educators and supervisors in teaching students to develop the capacity to invite and facilitate moments of relational depth?; and (d) Based on the emergent clusters, what implications do the participants offer for future relational depth research? As the participants discussed these reflections and implications, the researcher facilitated the discussion while the note-taker continued to document participants' statements. (See Appendix M: Certificate of Confidentiality for note-taker confidentiality agreement.) Participants' names were not included in these notes, and the notes were kept on the

researcher's password-protected computer. When writing the results of the study, the participants' reflections were used to substantiate and contextualize the findings.

In summary, the methodology included five steps as outlined by Trochim (1989a) and Kane and Trochim (2007): (a) preparing for concept mapping, (b) generating the statements, (c) structuring the statements, (d) representing the statements, and (e) interpreting the concept maps. The results of the study were used to answer the overarching research questions and guide future research regarding therapist factors that contribute to the ability to invite and facilitate moments of relational depth. In the following sections, the *a priori* limitations of the full study and results of the pilot study are examined and discussed.

### ***A Priori* Limitations**

There were a number of *a priori* limitations in the proposed study, including reliance on nominations, limited screening approach, limited geographical representation, lack of client data, and assumptions about the construct of relational depth. First, the researcher asked for nominations from counselor educators within only one university. This was done, to some extent, for convenience and there were no established criteria for the nominators beyond teaching in this one program. Furthermore, as the nomination approach relied on others' opinions, it did not ensure that nominated mental health practitioners were, in fact, working in a manner that consistently facilitated relational depth.

To address this limitation, the researcher instituted a simple screening question that asked prospective participants to read the definition and a description of relational

depth and confirm that they had experienced such a moment with a client. Although this approach was intended to ensure that participants had experienced relational depth, it was limited as well. The primary limitation in this approach was the use of only one self-report question, which weakened the robustness and accuracy of the screening method. Social desirability could have played a role in participants' response to this item. As an alternative approach, the researcher considered using the Relational Depth Inventory – Revised 2 (Wiggins, 2013) as a screening measure. The most current iteration of the measure is intended only for clients, however, and it lacks psychometric information to determine a cut score. Further, the Relational Depth Event Content Rating Scale (Price, 2012; Wiggins et al., 2012) was considered as another screening measure; however, it requires more involvement from prospective participants, and the scoring procedures for the measure are subjective. Although both relational depth measures are beneficial in relational depth research, their conduciveness and applicability to this study proved impractical.

In addition to the nominator and screening limitations, the restriction that therapists work within approximately a 30-mile radius of the research site was another limitation. Although the testimonial validity of the concept mapping results (Bedi, 2006) was preserved, the external validity was compromised based on the limited geographical representation and the fact that a substantive percentage of the sample could have been alumni from the program from which initial nominations were sought. For the feasibility of face-to-face concept map interpretation in the third phase of data collection, however, the researcher chose to limit the radius of participant selection.

The lack of client data throughout the process was another limitation. Although the purpose of the study was to explore *therapists'* conceptualizations of the factors that contribute to their ability to invite and facilitate moments of relational depth, the process of relational depth is interactional by nature (Knox, 2013). Thus, it may be that these factors are largely predicated on the uniqueness of their clients and their idiosyncratic relationships.

Finally, limitations existed with regard to the construct of relational depth as a whole. Relational depth has been described as ineffable (Cooper, 2013a; Knox, 2013; McMillan & McLeod, 2006). Accordingly, it was a difficult construct to define and research with integrity. Thus, it is important to consider issues of construct validity and interpret emergent results with an awareness of the inherent elusiveness of the construct. Taken together, these *a priori* limitations were important to consider when preparing for, conducting, and examining the results of the study. In the following section, the preliminary pilot study is outlined and various limitations and modifications for the full study are described.

## **Pilot Study**

### **Purpose**

The purpose of the pilot study was to test the concept mapping process. The researcher instituted the concept mapping methodology as outlined; however, rather than using the peer nomination and snowball sampling approach, the researcher invited two doctoral students to participate. The goal of the pilot study was to use these two

participants to test the concept mapping methodology and then use their feedback to improve the full study.

### **Participants**

To select the pilot-study participants, the researcher identified two doctoral students who previously exhibited interest in the topic and asked them if they would participate. Because the purpose of the pilot study was to test the concept mapping methodology, the participants were not required to meet all inclusion criteria for the full study in order to participate.

### **Procedures**

The researcher utilized the first five steps of the concept mapping methodology as outlined by Trochim (1989a) and Kane and Trochim (2007): (a) preparing for concept mapping, (b) generating the statements, (c) structuring the statements, (d) representing the statements, and (e) interpreting the concept maps. The participants received the preliminary information and screening e-mail and then participated in the three phases of data collection: generating the statements, sorting and rating the statements, and interpreting the concept maps. (For detailed pilot study procedures and results, see Appendix N: Pilot Study.) Chiefly, the participants were encouraged to provide feedback and suggestions for the full study.

### **Results**

The participants initially generated 48 statements, which were edited and synthesized to a total of 39 statements. Using nonmetric multidimensional scaling and hierarchical cluster analysis, the researcher initially selected seven preliminary clusters

and created associated concept maps. During the focus group, the participants reduced the clusters to a total of six and named them *Self of the Counselor*, *Deep Awareness*, *Taking Client Perspective*, *Tuned In To Client*, *Deep Respect and Acceptance*, and *Cultivating Safe Space*. Additionally, participants discussed their process of developing the capacity to invite and facilitate moments of relational depth; and they offered implications for therapist education, supervision, and relational depth research. Much of their discussion centered on the role of supervisors in developing the capacity to invite and facilitate moments of relational depth. For an expanded review of the results and implications, see Appendix N: Pilot Study.

### **Modifications for the Full Study**

Based on the participants' responses, faculty feedback during and after the dissertation proposal, and the researcher's experience in the process, the following list of modifications were implemented in the full study.

1. The researcher endeavored to keep the list of statements as small and as manageable as possible. Kane and Trochim (2007) recommended no more than 100; however, one participant suggested no more than 50. Using these recommendations, the researcher aimed to develop a statement list between 50 and 100 statements.
2. The researcher included a section in the Snowball Sampling Script that acknowledged the possibility that potential participants may receive duplicate invitation e-mails (if they were nominated by more than one person). These potential participants were encouraged to complete the study only once.

3. Instead of using concept maps, the researcher created a table of frequency and importance ratings (and the difference scores) to represent the statement ratings for the focus groups.
4. Instead of using concept maps, the researcher created a bar graph to represent the frequency and importance ratings for each of the clusters.
5. When describing the process of naming the clusters, the researcher informed participants that they may use a word or a phrase (a few words) to title each cluster.
6. In the pilot study, the researcher created a total square similarity matrix based on the data from both participants. In the full study, the researcher created a sorting table and converted this into a square dissimilarity matrix using R editor (R Development Core Team, 2011). Furthermore, the stress value reported from the SPSS (IBM Inc., 2013) output appeared rather low, lending some concern about the data entry and software computations. Thus, for the full study, R editor (R Development Core Team, 2011) was used exclusively to create the initial concept maps. SPSS (IBM Inc., 2013) was used to create the simple cluster rating bar graph.
7. Not explicitly stated in the proposal, the nominators were *e-mailed* (see Appendix C) and encouraged to nominate potential participants using the Snowball Sampling Script (see Appendix D).

8. During the dissertation proposal, faculty members suggested that the question “How did you do that?” be added to the instructions for generating the statements in order to simplify the request.
9. During the dissertation proposal, it was suggested that the earlier inclusion criteria be relaxed so that *any* mental health professional with a master’s degree in their discipline could be included in the study. Thus, the prior inclusion criteria that prospective participants have a master’s degree in counseling, possess a professional counseling license, and have at least five years of post-master’s-level experience were eliminated. This modification allowed for a larger and more diverse participant pool.
10. During the dissertation proposal, it was suggested that the intangible rewards of participation be added to the IRB consent form.
11. After the dissertation proposal, it was suggested that the fourth research question be deleted from the actual study. Participants’ insights and implications were sought during the focus group; however, these responses were not formally analyzed. They were only be used to contextualize and substantiate the findings.
12. After the dissertation proposal, it was suggested that the title of the study be changed to something more concrete and inclusive, thus “Deep Calls to Deep” was changed to “Touchstones of Connection.”

### **Summary**

The purpose of Chapter One was to describe the need for and purpose of the study. In Chapter Two, relational depth and associated literature was analyzed and

synthesized with a specific focus on the therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. In this chapter, the concept mapping methodology was outlined and results of a preliminary pilot study were described. In the following two chapters, the results and implications of the full study are presented.

## **CHAPTER IV**

### **RESULTS**

In Chapter One, the researcher examined current relational depth research, identified limitations, and proposed a study examining the therapist factors that contribute to the ability to invite and facilitate moments of relational depth. The construct of relational depth was explored across multiple theoretical frameworks in Chapter Two. In Chapter Three, the researcher outlined the methodology for a concept mapping study intended to explore the therapist factors that contribute to relational depth. The results of this study are presented in this chapter.

#### **Research Questions**

The following research questions guided the concept mapping process:

1. What therapist factors (prior to or during therapy) do participants believe contribute to the ability to invite and facilitate moments of relational depth with clients?
2. How important do participants believe each of the factors are in contributing to their ability to invite and facilitate moments of relational depth?
3. How often do participants practice these factors in their work with clients?

The researcher addressed research question one in the first phase of data collection (generating the statements) and questions two and three in the second phase of data collection (sorting and rating the statements). In the third phase of data collection

(interpreting the concept maps), participants contextualized the results from questions one, two, and three.

### **Participants**

To select the participants, the researcher e-mailed eight counselor education faculty members at a university, provided them with a definition and description of relational depth, informed them of the inclusion criteria, and asked them to nominate up to seven therapists in the local area whom they believed met the inclusion criteria and may have experienced a moment of relational depth with a client. Faculty members were encouraged to contact these individuals and send them information about the study (see Appendix D: Snowball Sampling Script). Because the researcher was not privy to the faculty members' nominations (as required by the IRB), the total number of individuals nominated is unavailable.

Twenty-two potential participants e-mailed the researcher and expressed interest in participating in the study. One participant did not complete the first round of data collection and one lived outside the 30-mile radius, leaving the total number of participants for phase one at 20. All 20 participants met the inclusion criteria (were at least 18 years of age, worked within approximately a 30-mile radius of the research site, possessed at least a master's degree in a mental health discipline, and reportedly experienced a moment of relational depth). Demographically, the average age of the participants was 43.05, ranging from 24 to 64. The participants averaged 14.275 years of counseling experience, with a range from 0.5 to 35. In terms of their practice settings, 11 (55%) participants worked in private practice, one (5%) worked in both private practice

and in an agency setting, three (15%) worked in schools (i.e., a private boarding school, a high school, and a university), one (5%) worked in a cancer center, one (5%) worked in a hospital, one (5%) identified as a doctoral student (perhaps working in the university), one (5%) did not identify, and one (5%) stated that she or he was not currently employed.

In terms of other demographic information, 16 (80%) of the participants identified as female, with four (20%) identifying as male. Furthermore, 17 (85%) of the participants identified as heterosexual, one (5%) identified as gay, one (5%) identified as queer, and one (5%) identified as bisexual. Exploring race and ethnicity, 19 (95%) of the participants identified as White/Caucasian, and one (5%) identified as Hispanic.

The participants' theoretical orientations widely varied. Three (15%) participants identified as exclusively Person-Centered, one (5%) identified as Psychodynamic, one (5%) identified as Experiential, one (5%) identified as Adlerian, one (5%) identified as Solution-Focused, two (10%) identified as Emotion-Focused, one (5%) identified as Social Constructivist, three (15%) identified as Cognitive-Behavioral, one (5%) identified as Interpersonal, and the remaining six (30%) participants identified combinations of multiple theoretical orientations (i.e., Person-Centered and Developmental, Attachment, and Mind-Body-Spirit based approaches; Person-Centered and Existential [three participants]; Humanistic, Emotion-Focused, Family Systems, and Person-Centered; and Eclectic).

Similar to the diversity of theoretical orientations, the participants' spiritual/religious affiliations varied widely as well. Nine (45%) of the participants identified as Christian, two (10%) identified as Catholic, one (5%) identified as Quaker,

and one (5%) identified as Christian and open to other religions. Two (10%) participants identified as Spiritual (one stating that she or he was raised Christian), two (10%) identified as Agnostic (one, again, stating that she or he had a Christian background), one (5%) identified a Connection to Nature, one (5%) stated her or his spiritual/religious affiliation was “Complex,” and one (5%) participant did not respond.

In summary, based upon these results, the participants varied in age and years of experience, and most of the participants were White/Caucasian, female, and heterosexual. Participants’ practice settings, theoretical orientations, and spiritual/religious orientations varied, with most participants working in private practice, relying on a combination of theoretical orientations, and identifying primarily as Christian. However, it is important to note that the sample changed (due to attrition) during each phase of data collection. To more clearly identify the sample by phase of data collection, see Table 1.

Table 1

## Demographic Information

Phase	1 Generating the Statements	2 Structuring the Statements	3 Interpreting the Concept Maps
<b>Number of Participants</b>	20	18	9
<b>Mean Age</b>	43.05 Range = 24 to 64	44.67 Range = 27 to 64	48.11 Range = 27 to 64
<b>Gender</b>	16 = Female 4 = Male	14 = Female 4 = Male	6 = Female 3 = Male
<b>Race/Ethnicity</b>	19=Caucasian 1=Hispanic	17=Caucasian 1=Hispanic	9=Caucasian
<b>Sexual Orientation</b>	17=Heterosexual 1=Gay 1=Queer 1=Bisexual	15=Heterosexual 1=Gay 1=Queer 1=Bisexual	7=Heterosexual 1=Gay 1=Bisexual
<b>Spiritual/Religious Background</b>	9=Christian 2=Catholic 1=Quaker 1=Christian and open to other religions 2=Spiritual 2=Agnostic 1=Nature 1= "Complex" 1=Did not identify	9=Christian 1=Catholic 1=Quaker 1=Christian and open to other religions 2=Spiritual 2=Agnostic 1=Nature 1= "Complex"	5=Christian 1=Quaker 1=Christian and open to other religions 1=Spiritual 1=Agnostic
<b>Theoretical Orientation</b>	6=Theoretical Combination 3=Person-Centered 3=Cognitive Behavioral 2=Emotion-Focused 1=Psychodynamic 1=Experiential 1=Adlerian 1=Solution-Focused 1=Social Constructivist 1=Interpersonal	6=Theoretical Combination 3=Person-Centered 3=Cognitive Behavioral 2=Emotion-Focused 1=Psychodynamic 1=Experiential 1=Solution-Focused 1=Social Constructivist	4=Theoretical Combination 2=Cognitive Behavioral 1=Person-Centered 1=Emotion-Focused 1=Experiential
<b>Practice Setting</b>	11=Private Practice 3=Schools 1=Private Practice & Agency 1=Cancer Center 1=Hospital 1=Doctoral Student 1=Did not identify 1=Not Employed	10=Private Practice 3=Schools 1=Private Practice & Agency 1=Cancer Center 1=Hospital 1=Doctoral Student 1=Did not identify	5=Private Practice 1=Schools 1=Private Practice & Agency 1=Hospital 1=Did not identify
<b>Mean Years of Experience</b>	14.75 Range = 0.5 to 35	15.33 Range = 2 to 35	18.89 Range = 3 to 35

## **Procedures and Results**

To conduct the study, the researcher utilized the first five steps of the concept mapping methodology as outlined by Trochim (1989a) and Kane and Trochim (2007): (a) preparing for concept mapping, (b) generating the statements, (c) structuring the statements, (d) representing the statements, and (e) interpreting the concept maps. These were completed in three rounds of data collection: generating the statements, sorting and rating the statements, and interpreting the concept maps.

### **Preparing for Concept Mapping**

To prepare for concept mapping, the researcher defined the issue; initiated the process; selected the facilitator; determined the goals and purposes; defined the focus; selected the participants; determined the participation methods; developed the schedule, communication plan, and format; determined resources; gained approval by the IRB; and wrote the concept mapping plan. After soliciting nominations, 22 therapists followed-up with the researcher, and 20 of these individuals participated in the first phase of data collection: generating the statements.

### **Generating the Statements**

After receiving e-mail inquiries from potential participants, the researcher followed up with an initial e-mail, which included a copy of the research consent form and a link to the Qualtrics (2014) survey. Within Qualtrics (2014), the participants (a) read the research consent form and agreed to the terms included therein; (b) completed a demographic form, including questions about their age, gender, race/ethnicity, sexual orientation, spiritual and/or religious background, theoretical orientation, practice setting,

employment location, mental health counseling degree status, counseling licensure status, years of counseling experience, and relational depth experience; (c) provided their contact information (name, e-mail address, mailing address, and phone number) for follow-up contact; (d) generated the statements; and, finally, (e) were encouraged to send information about the study to other therapists whom they would nominate as potential participants.

**Research question one.** Together, the participants generated 452 statements (see Appendix O: Participants' Initial Statements). The researcher and a member of the dissertation committee edited and synthesized these statements to a total of 90 statements (see Appendix P: Synthesized Statements). These 90 statements were then transferred onto small cards and onto frequency and importance rating sheets, to be sorted and rated, respectively. The statement cards and rating sheets were then combined with an overall sheet of instructions, smaller envelopes for sorting, and a self-addressed manila envelope (to be used to return materials to the researcher), and mailed to the participants for sorting and rating.

### **Structuring the Statements**

After receiving the manila envelope of materials, the participants sorted the 90 statement cards based on their conceptualizations of how the statements might group together. Although the participants were given latitude in creating these groups, they were informed that (a) each card could only be placed in one pile, (b) the cards could not all be placed in the same pile, and (c) each card could not be its own pile (Kane & Trochim, 2007; Trochim, 1989a). After sorting the cards into groups, participants placed

each group in an envelope, sealed the envelope, and wrote a conceptual name for that group on the front of the envelope. Eighteen of the original 20 participants returned their sorting data (90% response rate). On average, the participants sorted the 90 statement cards into nine groups, ranging from as few as four groups to as many as 15. All participants returned the full set of statement cards, leaving no missing data.

After sorting the statements, the participants rated the statements based on (a) how important they believed each statement (or therapist factor) was in contributing to the ability to invite and facilitate a moment of relational depth with a client and (b) how frequently they practiced these factors in their work with clients. Statements were rated on 5-point Likert-type scales. Eighteen of the original 20 participants returned their importance and frequency rating sheets (90% response rate). A detailed analysis of the associated ratings is examined in the following section.

### **Representing the Statements**

To represent the statements in the form of visual data (point map, cluster map, table, and bar graph), the researcher used nonmetric multidimensional scaling and agglomerative hierarchical cluster analysis, the latter specifically analyzed using Ward's method. The participants' sorting data were first entered into a sort table, with similar numbers denoting similar groupings. From there, the researcher used R editor (R Development Core Team, 2011) to aggregate and transform the sort table into a total square dissimilarity matrix. This total square dissimilarity matrix was used to perform nonmetric multidimensional scaling and generate a point map (see Figure 1: Point Map). The point map visually represented the frequency with which participants grouped certain

statements together. For example, statement numbers that were closer together in the point map indicated that they were more often grouped together by participants. The associated stress value for the procedure was 0.2506, which falls within the recommended range – between 0.205 and 0.365 – identified by Trochim (1993, as cited in Kane & Trochim, 2007). As a goodness-of-fit indicator, this stress value indicated that, for the most part, the resultant multidimensional scaling point map accurately represented participants' aggregated sorting tendencies.

To create the cluster map, the researcher first performed agglomerative hierarchical cluster analysis (using Ward's method) in order to generate a cluster tree/dendrogram (see Figure 2: Cluster Tree/Dendrogram) of possible cluster solutions. A number of cluster-solution possibilities were examined. Based on the natural groupings of statements in the cluster tree/dendrogram and the average number of clusters (nine) created by participants in the initial phase, the researcher chose a 10-cluster solution (see Table 2: Initial 10-Cluster Solution and Associated Ratings and Figure 3: Cluster Map). To validate this decision, the researcher sought feedback from a member of the dissertation committee, who agreed with the initial 10-cluster solution.

More descriptively, the number of statements per cluster ranged from as few as five (cluster two) to as many as eighteen (cluster eight). One statement was inadvertently duplicated (numbers 6 and 25: providing support), but then used as a validity check for the agglomerative hierarchical cluster analysis function. The numbers (6 and 25) were separated by only one statement in the cluster tree/dendrogram and grouped together in the same cluster in the cluster map, validating the statistical accuracy of the multivariate

analyses. A detailed interpretation of the point map and cluster map is provided in the *Interpreting the Concept Maps* section of this chapter.

**Research question two.** After creating the initial clusters, the importance and frequency ratings of the statement and clusters were examined. Any individual missing values were not included to complete the total mean average score. Across all 18 participants, the overall mean importance rating for all 90 statements was 4.08, with a mean average range from 2.65 to 4.94. The lowest average importance rating statement was statement number 13 (praying), with the highest average importance rating statement being statement number 22 (attending fully). Examining the importance ratings based on cluster, the lowest-rating group was cluster seven, with a mean average rating across statements of 3.43. Lower-rated statements in this cluster included examples such as statement number 5 (structuring within and across sessions) and statement number 86 (setting process/relational goals). On the other hand, the highest-rated group was cluster ten, with a mean average rating across statements of 4.5. Higher-rated statements in this cluster included examples such as statement number 71 (accepting the client as she/he is) and statement number 26 (respecting the client).

**Research question three.** In comparison, the overall mean frequency rating for the 18 participants across all 90 statements was 4.03, ranging from a mean average of 2.76 to 4.83. The lowest average frequency rating was, again, statement number 13 (praying), and the highest average frequency rating was shared by two statements: numbers 45 (validating the client's experience) and 75 (communicating empathy). Examining the frequency ratings based on cluster, the lowest-rating group was, again,

cluster seven, with a mean average rating across statements of 3.54. Lower-rated statements in this cluster included examples such as statement number 73 (setting the clinical environment [e.g., quiet yoga music in background, indirect lighting]) and statement number 55 (initiating conversations around existential issues [e.g., death, isolation, freedom]). The highest-rated group was, again, cluster ten, with a mean average rating across statements of 4.49. Higher-rated statements in this cluster included examples such as statement number 26 (respecting the client) and statement number 72 (honoring the humanity of the client).

Beyond the overall average ratings based on importance and frequency, it was noteworthy to compare the difference scores between the ratings across statements and clusters. The difference score was calculated by subtracting the frequency rating score from the importance rating score. Thus, a positive value indicated that the importance rating score was higher than the frequency one, and a negative value indicated that the frequency rating score was higher than the importance one. Values closer to zero indicated smaller differences between the scores. The overall mean difference score across all 90 statements was 0.05, ranging from -0.73 to 0.61. Using the range scores as examples, participants reported that they used statement number 5 (structuring within and across sessions) much more than they found it important in inviting relational depth (an average discrepancy of 0.73 of a point on a 5-point Likert-type scale). Similarly, participants reported that they deemed statement number 64 (practicing self-care) important in inviting relational depth; however, they did not use it very often (an average discrepancy of 0.61 of a point on a 5-point Likert-type scale).

To examine the difference scores based on cluster, the researcher averaged all of the difference scores within respective clusters. Resulting values closer to zero indicated a smaller difference between importance and frequency ratings based on cluster. Two clusters (six and ten) shared the smallest mean difference scores (-0.02 and 0.02, respectively). Cluster four had the greatest mean difference score (0.29). It is important to note that negative values were used to average difference scores, so it is possible that greater positive values and negative values within a specific cluster brought the average closer to zero. (For detailed rating scores, see Table 2: Initial 10-Cluster Solution and Associated Ratings, and for a visual of the importance and frequency ratings, see Figure 4: Average Ratings by Cluster.) A detailed interpretation of the importance and frequency ratings is provided in the *Interpreting the Concept Maps* section of this chapter.

# Point Map

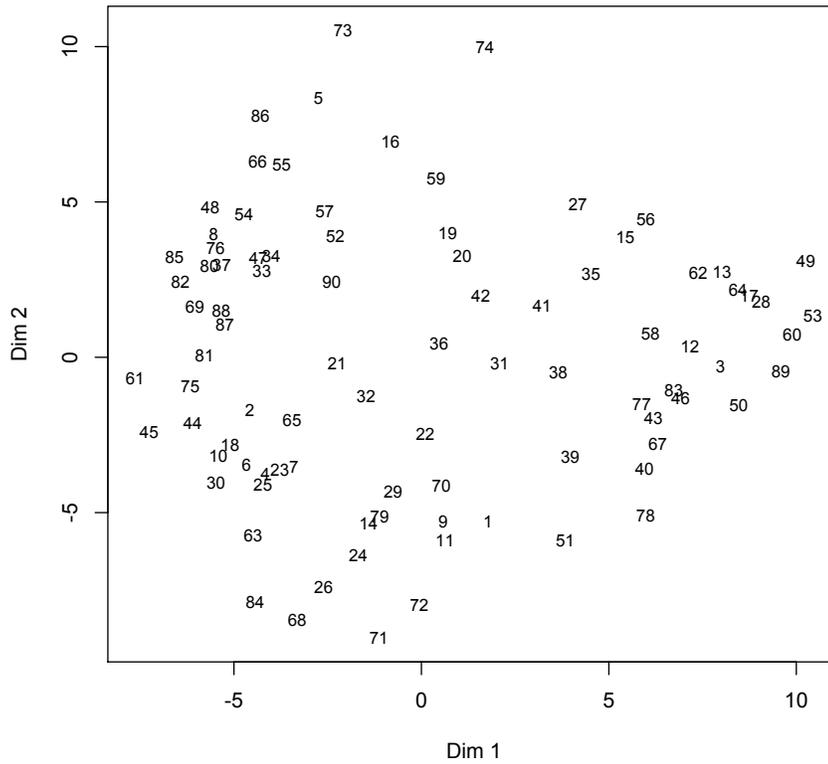


Figure 1. Point Map. Participants' aggregated sorting data based on the group dissimilarity matrix. Statements that were grouped together more often by participants appear closer together on the map.

## Cluster Tree/ Dendrogram

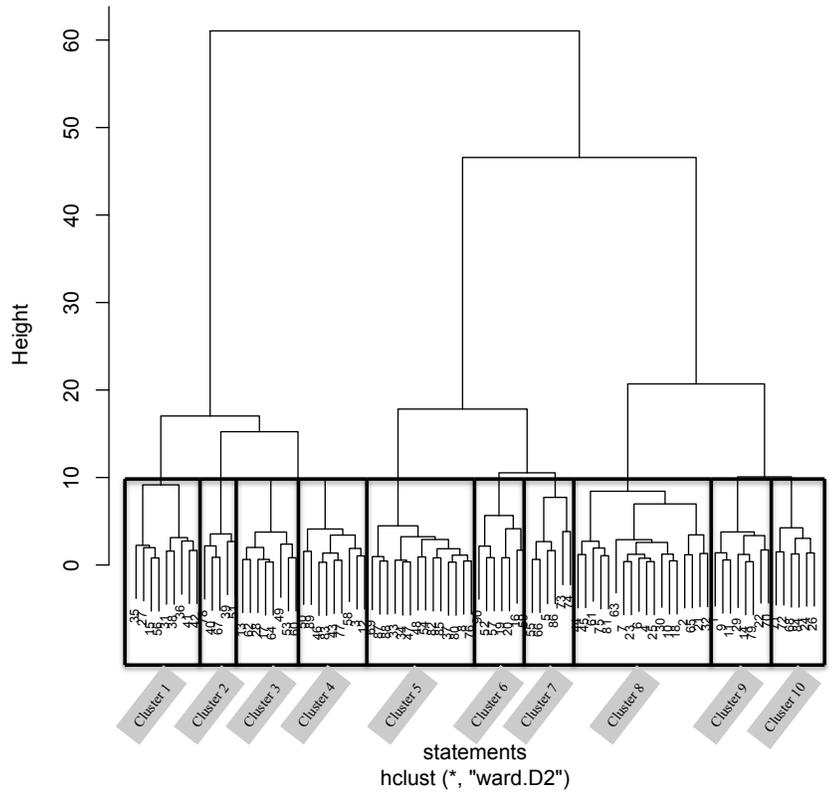


Figure 2. Cluster Tree/Dendrogram. Cluster tree/dendrogram of the 10-cluster solution.

Table 2

## Initial 10-Cluster Solution and Associated Ratings

\*Numbers were rounded to the nearest hundredth of a decimal, and thus, may not appear to sum across rows and columns perfectly.

Cluster	Statements	Ave Imp	Ave Freq	Diff
1	35. following intuition	4.61	4.44	0.17
	27. pausing when I feel reactive	3.94	3.76	0.18
	15. having confidence in ability to treat the client's issues	3.67	3.78	-0.11
	56. being still – inside and outside	4.06	3.61	0.45
	31. listening – not just with ears but with whole self	4.72	4.39	0.33
	38. sensing energy and energetic shifts	4.39	4.00	0.39
	36. remaining curious	4.06	4.28	-0.22
	41. being transparent	4.22	4.17	0.05
	42. being totally honest with the client	3.86	3.78	0.08
	<b>Cluster Average</b>	<b>4.17</b>	<b>4.02</b>	<b>0.15</b>
2	78. entering as profoundly as I can into an experientially felt sense of the client's world	4.61	4.33	0.28
	40. connecting with and listening from the depths of my soul	4.24	3.94	0.30
	67. being genuinely myself with clients	4.56	4.36	0.20
	39. offering/sharing with the client my energy when the client lacks the energy to go deeply	2.76	2.89	-0.13
	51. staying open to the client's experience	4.61	4.44	0.17
	<b>Cluster Average</b>	<b>4.16</b>	<b>3.99</b>	<b>0.16</b>
3	13. praying	2.65	2.76	-0.11
	62. remembering other experiences of relational depth and what that felt like to me	3.22	2.78	0.44
	28. attending to my breathing	3.65	3.67	-0.02
	17. possessing self-awareness	4.83	4.56	0.27
	64. practicing self-care	4.28	3.67	0.61
	49. grounding/centering myself before sessions	4.44	3.89	0.55
	53. practicing mindfulness	4.28	3.89	0.39
	60. embracing my own suffering	3.56	3.56	0
<b>Cluster Average</b>	<b>3.86</b>	<b>3.60</b>	<b>0.27</b>	
4	50. opening my heart center	4.11	3.56	0.55
	89. attending to the internal emotional processes happening in me	4.44	4.22	0.22
	46. being vulnerable	3.83	3.50	0.33
	83. being open with my own emotional experience (e.g., crying with the client)	3.61	3.33	0.28
	43. being humble – seeing the client as similar to me in the most profound human ways	4.33	4.06	0.27
	77. being unafraid of the intensity of emotions	4.89	4.61	0.28
	58. being fully present	4.83	4.41	0.42
	3. conceiving of myself as a conduit for transformation	3.50	3.11	0.39
	12. letting go of all expectations	3.22	3.39	-0.17
	<b>Cluster Average</b>	<b>4.09</b>	<b>3.80</b>	<b>0.29</b>

5	69. using the client's words	4.00	4.17	-0.17
	87. using facial nonverbals with the client (e.g., mirroring expressions, conveying empathy through facial expressions)	4.17	4.39	-0.22
	88. using body nonverbals with the client (e.g., tilting head, opening posture, leaning in, mirroring body language)	4.11	4.39	-0.28
	33. sustaining intentional eye contact	3.83	4.06	-0.23
	34. using gentle confrontation	4.00	4.06	-0.06
	47. using immediacy	4.33	4.33	0
	48. exploring interpsychic relational dynamics	3.50	3.24	0.26
	54. using metaphors/imagery	3.89	4.00	-0.11
	82. reflecting and summarizing content	3.44	3.89	-0.45
	85. using tentative language	3.78	4.00	-0.22
	37. exploring with the client what's happening in client's body	3.72	3.44	0.28
	80. intentionally reflecting meaning	4.33	4.39	-0.06
	8. attacking shame	2.78	3.06	-0.28
	76. probing gently to create more depth	4.06	4.22	-0.16
	<b>Cluster Average</b>	<b>3.85</b>	<b>3.97</b>	<b>-0.12</b>
6	90. intentionally using self-disclosure	3.83	3.61	0.22
	52. being comfortable with and using silence intentionally	4.06	4.11	-0.05
	57. speaking softly	3.67	3.61	0.06
	19. being willing to "name the thing"	4.06	4.00	0.06
	20. taking risks	3.89	3.83	0.06
	16. resisting temptation to focus solely on goals	3.17	3.56	-0.39
	59. making my presence in the room very quiet	3.56	3.67	-0.11
		<b>Cluster Average</b>	<b>3.75</b>	<b>3.77</b>
7	55. initiating conversations around existential issues (e.g., death, isolation, freedom)	3.28	3.33	-0.05
	66. slowing down the pace of the session	4.17	3.89	0.28
	5. structuring within and across sessions	2.94	3.67	-0.73
	86. setting process/relational goals	3.11	3.39	-0.28
	73. setting the clinical environment (e.g., quiet yoga music in background, indirect lighting)	3.33	3.28	0.05
	74. preparing for the session (e.g., reviewing notes, reflecting on previous experience)	3.72	3.67	0.05
	<b>Cluster Average</b>	<b>3.43</b>	<b>3.54</b>	<b>-0.11</b>

8	44. expressing understanding	4.50	4.67	-0.17
	45. validating the client's experience	4.72	4.83	-0.11
	61. establishing a safe space	4.72	4.72	0
	75. communicating empathy	4.78	4.83	-0.05
	81. "touching" and reflecting emotions	4.44	4.50	-0.06
	63. assuring the client that I will not leave her/him, that I will walk with her/him	3.83	3.56	0.27
	7. providing nurturance	3.89	4.06	-0.17
	23. conveying warmth	4.39	4.56	-0.17
	6. providing support	4.22	4.61	-0.39
	4. giving hope	4.11	4.33	-0.22
	25. providing support	4.22	4.44	-0.22
	30. establishing trust	4.89	4.72	0.17
	10. collaborating with the client	4.17	4.33	-0.16
	18. acknowledging the client's strengths	4.11	4.39	-0.28
	2. establishing a strong relationship/rapport	4.83	4.72	0.11
	65. communicating real compassion for the client	4.72	4.44	0.28
	21. staying close with the client's emotional experience	4.61	4.22	0.39
	32. "speaking" through my eyes to the client's eyes	3.58	3.33	0.25
	<b>Cluster Average</b>	<b>4.37</b>	<b>4.40</b>	<b>-0.03</b>
	9	1. caring deeply for the client	4.28	4.28
9. noticing the little things about the client		3.53	3.61	-0.08
11. focusing completely on the client		3.89	4.18	-0.29
29. attending to my client's breathing		4.00	3.56	0.44
14. honoring cultural differences		4.39	4.39	0
79. attuning to the client		4.67	4.56	0.11
22. attending fully		4.94	4.56	0.38
70. being nonjudgmental		4.89	4.67	0.22
<b>Cluster Average</b>		<b>4.32</b>	<b>4.23</b>	<b>0.10</b>
10	71. accepting the client as she/he is	4.89	4.64	0.25
	72. honoring the humanity of the client	4.61	4.72	-0.11
	68. respecting the client's boundaries	4.39	4.33	0.06
	84. empowering the client	4.06	4.06	0
	24. viewing the client holistically	4.28	4.39	-0.11
	26. respecting the client	4.78	4.78	0
<b>Cluster Average</b>	<b>4.50</b>	<b>4.49</b>	<b>0.02</b>	

# Initial Cluster Map

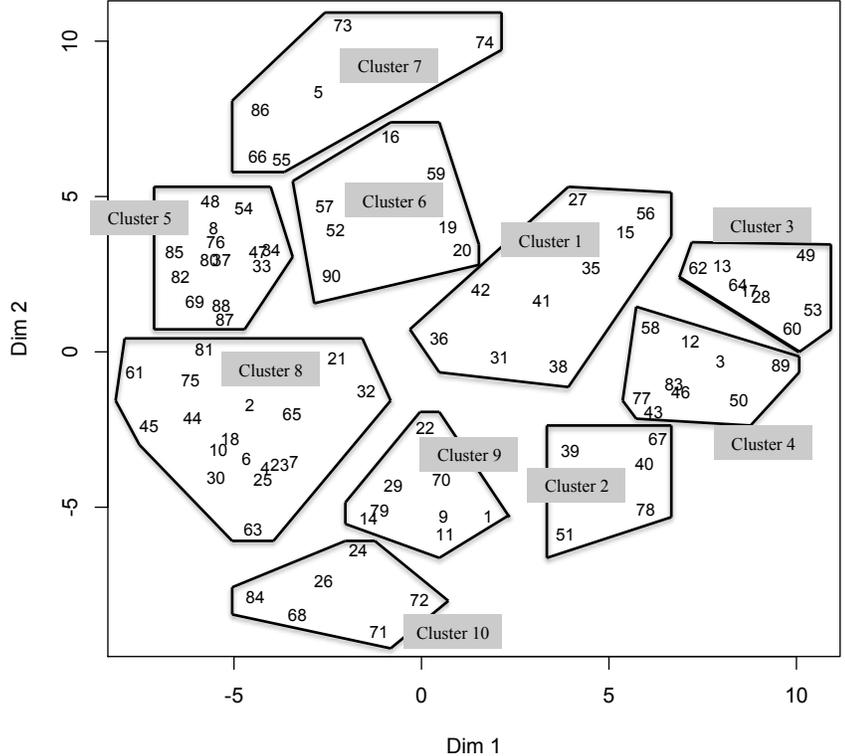


Figure 3. Initial Cluster Map. Initial cluster map of the 90 statements grouped into 10 preliminary clusters.

## Average Ratings by Cluster

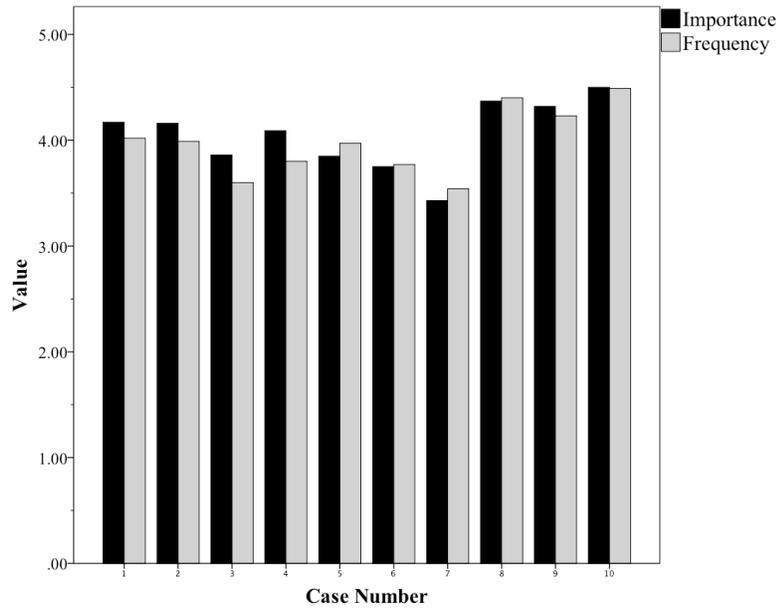


Figure 4. Average Ratings by Cluster. Participants' mean average ratings by cluster based on importance and frequency.

## **Interpreting the Concept Maps**

After creating the concept maps, the table of clusters and importance and frequency ratings, and the bar graph, the researcher invited the 18 participants who completed the sorting and rating tasks to a one-and-a-half hour focus group. Nine participants agreed to take part in this focus group and interpret the concept maps. At the outset of the focus group, the researcher summarized the previous two phases of data collection and then briefly outlined the agenda for the meeting: (a) to name the clusters, and (b) to discuss the findings and offer subsequent implications for therapist training, supervision, and research. The researcher also encouraged the participants to keep the information private until the completion of the study.

From there, participants were given a collection of handouts, including the Point Map (see Figure 1), the Initial 10-Cluster Solution and Associated Ratings (see Table 2), the Cluster Map (see Figure 3), and the Average Ratings by Cluster (see Figure 4). The researcher first asked the participants to work individually to review each of the clusters and generate a thematic name (using a word or a phrase) for each cluster. Participants worked individually for approximately 10 minutes. Once they had completed this individual review, the researcher encouraged the participants to discuss their titles and agree upon a name for each cluster. The process of naming each cluster is described below and the specific statements included in each cluster can be found in Table 3 (Final 10-Cluster Solution and Associated Names).

**Cluster one.** The participants named cluster one *Tuning In*. In the deliberation process, they considered titles such as *Presence*, *Tuning Into Self*, *Attunement*, *Self-*

*Awareness, Felt Sense, Attunement from Self, and Presence-Driven Attunement.* Their discussion centered on *who* and/or *what* they were tuning into, as some participants believed that the cluster centered more on tuning into self, whereas others believed that some of the statements indicated an ability to tune into others and into the atmosphere in the room. One participant mentioned that it almost felt as though there were clusters within a cluster. Participants also discussed the difficulty in naming the cluster, and one participant said that it seemed as though the title needed to be profound. For example, when discussing the possibility of the title *Self-Awareness*, one person stated that there seemed to be something beyond self-awareness that could not quite be named. Along with this, one participant said that at a certain point, more words made it seem like less. After this discussion, though, they reached an agreement on the title *Tuning In*.

**Cluster two.** After discussing a number of possibilities, the participants named cluster two *Offering Genuine Connection*. Other possible cluster names that were considered included *Connection, Authentic Connection, Profound Connection, Deep Connection, Real Good Connection, Inviting Connection, Genuine Connection, Felt Connection, and Opening Self to Client*. When first considering the title *Connection*, several people agreed; however, they said that it needed something more to adequately convey the statements. They included the word *Offering* after noting the importance of what the therapist gives, and they added *Genuine* to highlight the authentic and real relationship.

**Cluster three.** The participants named cluster three *Practicing Presence*. Other names that were considered included *Monitoring Self, Self-Management, Being Prepared*

or *Preparing, Internal Framework, Attending to Self or Attuning, Grounding, Self-Awareness, Holistic Self-Management, Preparation, Preparing Self, Way of Being, Cultivating Self-Awareness, Awareness of Self, Conditioning, Tempering, Raising Myself Up, Nurturing, Self-Nurturance, Nurturing Whole Self, Nurturing Self, Self-Nourishment, and Nurturing Self Growth*. As evidenced in the number of possible names, the participants considered a number of options. During the discussion, one participant noted that there seemed to be a spiritual facet to this cluster and others agreed, noting the statements about praying, being mindful, and embracing suffering. One participant used the spiritual phrase *Raising Myself Up*, but others wondered if this might have a connotation of putting oneself above the client. For the most part, participants also agreed that there seemed to be an active lifestyle component to the items. They likened this to the metaphor of an athlete training for a sporting event. From this, they considered training words such as *practice, envisioning, and conditioning*. They also noted the aspirational and inspirational nature of the cluster, highlighting a therapist's endeavor to grow her or himself and engage in her or his own practice so that she or he could be well and be there for others. From there, they discussed the importance of nurturing the self. When they agreed upon the cluster name *Practicing Presence*, they said that this could also capture the importance of nurturing oneself.

**Cluster four.** The agreed-upon name for cluster four was *Being Emotionally Present*. Other cluster names that were considered included *Surrender, Giving of Self to the Process, Open, Receiving, Intentional Openness, Opening to Interpersonal Process, Letting Go, Vulnerability, and Surrendering to the Process*. The word *surrendering* was

considered; however, some participants thought that it might be too passive. When discussing other possible names for this cluster, participants noted some similarity to the items in cluster three; however, one participant noted that cluster three was about practicing/preparing and cluster four seemed to be more about doing/implementing. Another participant noted that there seemed to be a lot of emotion associated with this cluster, and a different individual emphasized statement 77 of being unafraid of the emotion. Based on the emotionality of the cluster and its similarity to cluster three, they titled it *Being Emotionally Present*.

**Cluster five.** After discussing many options, participants agreed to name cluster five *Using Engagement Skills*. Other options that were discussed included *Intentional Interventions, Counselor Skills, Core Skills, Helping Skills, Linking Verbal and Non-Verbal, Intentional Actions, Passenger Seat* (with the client driving the session), *Navigating, Carl Rogers, Meeting the Client, Verbal and Non-Verbal Empathy, Engaging the Client, Skills of Engagement, and Engagement Skills*. For the most part, the participants agreed that this cluster was more skill-oriented. However, one person noted that perhaps simply naming them *skills* would miss something. Another participant stated that the statements all seemed to be facets of empathy. While deliberating upon a name for this cluster, the participants compared it to cluster six, and one said that the skills in cluster six seemed to be even more intentional than cluster five. Another noted that cluster six seemed to have an element of vulnerability to it. Eventually, they agreed upon the title *Using Engagement Skills*, and continued this discussion in exploring names for cluster six.

**Cluster six.** The participants named cluster six *Bringing Immediacy* after considering other names such as *Immediacy*, *Present-Moment Experience*, and *Vulnerability*. Participants noted the higher-stakes intentionality of the skills in this cluster (as compared to cluster five) and stated that they were more explicit skills based on the intentional use of self. They also noted that the skills seemed more pointed toward moment-to-moment engagement. When considering *Immediacy*, one participant stated that it needed a verb like *creating or cultivating*, and after some discussion, they agreed on *Bringing Immediacy*.

**Cluster seven.** After discussing a few options, the participants agreed to name cluster seven *Structuring Intentionally*. In the process, they considered other names such as *Session Navigation*, *Structuring*, *Management*, *Directing*, *Process*, *Navigating to the Deep*, *Building the Well* (as a metaphor), *Intentional Structuring*, *Creating Opportunity for Depth*, and *Scaffolding*. For the most part, participants stated that the structuring component of this cluster seemed critical and paved the way for greater depth between the therapist and the client. One participant stated that this cluster could be metaphorically compared to the process of building the structure of a well so that, eventually, a person could draw from the depths of the well. Capturing the intentional nature of this process, the cluster was named *Structuring Intentionally*.

**Cluster eight.** The participants considered multiple possible names for cluster eight, and they finally agreed upon the title *Facilitating Intimate Connection*. Other cluster names that were considered included *Safe Space*, *Relational Connection*, *Client Connection*, *Relational Communication*, *I'm Here*, *Felt Sense of Empathy*, *Nurturing the*

*Client, Embodiment and Communication of Core Conditions, Lifting Up the Client, Spiritual Enlightenment, Joining with the Client, Holding Space, Sharing Space, Advancing the Connection, Cultivating Connection, Promoting or Developing Connection, Cultivating Relational Depth, Creating Safe Space, Entering the Client's World, Entering the Therapeutic Zone, Sweet Spot, Therapeutic Sweet Spot, Creating a Safe Connection, Creating Safety through Connection, Creating Empowerment through Connection, Creating Secure Connection, Safety to Make Contact, and Intimacy.* The two facets of the cluster that seemed to stand out to participants were a relational connection and a safe space. First, participants stated that something about the depth of the relationship needed to be there. When the word *connection* was considered, one participant asked if there was a synonym for the next level of connection. Others wondered about *bond, joining, relational, and interpersonal*. At this point, one participant stated that we almost do not have the language for it, and others corroborated this by emphasizing the depth of the connection. Another participant stated that the space is different from the connection itself and, similarly, one participant noted the desire to title this cluster with a profound name. Furthermore, they commented on the person-centered, Rogerian nature of the cluster, whereby the client feels fully understood – as though the therapist has entered her or his world. These ideas led to more consideration of what happens for the client when these factors are present. One participant stated that the client would feel safely understood at the depths of her or his reality. Another participant noted the quality of hope in this cluster and likened it to the spiritual notion of *lifting up the*

*client*. Others noted the importance of what the therapist was doing with these factors in order to facilitate the client being able to do what she or he needed to do.

The other aspect of the cluster that participants emphasized was the importance of creating safe space. However, one individual said that *creating safety* seemed to fall short of capturing the depth of the items. One participant wondered how *safety* and *joining* could be combined. Others wondered if a different word could be used for *safety* – such as *security*, *attachment*, *empowerment*, or *contact*. From this, they moved back to the importance of the relationship, and finally settled on the term *intimate*, which led to *Facilitating Intimate Connection*. Interestingly, around this point, one of the participants noted the sequencing nature of the clusters, stating that the implementation of the earlier characteristics (such as *Tuning In* and *Practicing Presence* could eventually lead to *Facilitating Intimate Connection*).

**Cluster nine.** The participants named cluster nine *Attending with Focus* after having considered multiple options such as *Caring*, *Attunement with Client*, *Focus and Attention*, *Here and Now*, *Immediate Attending*, and *Focused Attending*. For the most part, they arrived at this title fairly quickly; however, many of them stated that they felt as though statement 70 (being nonjudgmental) did not fit in this cluster. They eventually moved this item to cluster ten.

**Cluster ten.** Similar to cluster nine, participants named cluster ten fairly quickly too, agreeing upon the title *Honoring the Client*. In the process, they considered other names such as *Radical Acceptance*, *Putting the Client First*, and *Radical Honoring*. They noted that this cluster seemed to be about the client as a human being and prioritizing her

or him. They discussed the possibility of *acceptance*, but later agreed that the term *honoring* seemed to indicate a deeper level of acceptance, and thus, titled the cluster *Honoring the Client*.

After naming the clusters, the researcher asked the participants if they wanted to merge any clusters or remove any items. They discussed a few options and agreed that statements 14 (honoring cultural differences) and 70 (being nonjudgmental) should be removed from cluster nine (*Attending with Focus*) and moved to cluster ten (*Honoring the Client*). They also decided to change the language in statement number 15 from “having confidence in ability to treat the client’s issues” to “being confident.” The final listing of named clusters is shown in Table 3 and the graphical representation of these clusters is shown in Figure 5.

Table 3

Final 10-Cluster Solution and Associated Names

Cluster Name	Statements
<p style="text-align: center;">1 Tuning In</p>	<p>35. following intuition            27. pausing when I feel reactive            15. <del>having confidence in ability to treat the client’s issues</del> being confident            56. being still – inside and outside            31. listening – not just with ears but with whole self            38. sensing energy and energetic shifts            36. remaining curious            41. being transparent            42. being totally honest with the client</p>
<p style="text-align: center;">2 Offering Genuine Connection</p>	<p>78. entering as profoundly as I can into an experientially felt sense of the client’s world            40. connecting with and listening from the depths of my soul            67. being genuinely myself with clients            39. offering/sharing with the client my energy when the client lacks the energy to go deeply            51. staying open to the client’s experience</p>

<p>3</p> <p>Practicing Presence</p>	<p>13. praying</p> <p>62. remembering other experiences of relational depth and what that felt like to me</p> <p>28. attending to my breathing</p> <p>17. possessing self-awareness</p> <p>64. practicing self-care</p> <p>49. grounding/centering myself before sessions</p> <p>53. practicing mindfulness</p> <p>60. embracing my own suffering</p>
<p>4</p> <p>Being Emotionally Present</p>	<p>50. opening my heart center</p> <p>89. attending to the internal emotional processes happening in me</p> <p>46. being vulnerable</p> <p>83. being open with my own emotional experience (e.g., crying with the client)</p> <p>43. being humble – seeing the client as similar to me in the most profound human ways</p> <p>77. being unafraid of the intensity of emotions</p> <p>58. being fully present</p> <p>3. conceiving of myself as a conduit for transformation</p> <p>12. letting go of all expectations</p>
<p>5</p> <p>Using Engagement Skills</p>	<p>69. using the client’s words</p> <p>87. using facial nonverbals with the client (e.g., mirroring expressions, conveying empathy through facial expressions)</p> <p>88. using body nonverbals with the client (e.g., tilting head, opening posture, leaning in, mirroring body language)</p> <p>33. sustaining intentional eye contact</p> <p>34. using gentle confrontation</p> <p>47. using immediacy</p> <p>48. exploring interpsychic relational dynamics</p> <p>54. using metaphors/imagery</p> <p>82. reflecting and summarizing content</p> <p>85. using tentative language</p> <p>37. exploring with the client what’s happening in client’s body</p> <p>80. intentionally reflecting meaning</p> <p>8. attacking shame</p> <p>76. probing gently to create more depth</p>
<p>6</p> <p>Bringing Immediacy</p>	<p>90. intentionally using self-disclosure</p> <p>52. being comfortable with and using silence intentionally</p> <p>57. speaking softly</p> <p>19. being willing to “name the thing”</p> <p>20. taking risks</p> <p>16. resisting temptation to focus solely on goals</p> <p>59. making my presence in the room very quiet</p>
<p>7</p> <p>Structuring Intentionally</p>	<p>55. initiating conversations around existential issues (e.g., death, isolation, freedom)</p> <p>66. slowing down the pace of the session</p> <p>5. structuring within and across sessions</p> <p>86. setting process/relational goals</p> <p>73. setting the clinical environment (e.g., quiet yoga music in background, indirect lighting)</p> <p>74. preparing for the session (e.g., reviewing notes, reflecting on previous experience)</p>

<p style="text-align: center;">8</p> <p style="text-align: center;">Facilitating Intimate Connection</p>	<p>44. expressing understanding  45. validating the client’s experience  61. establishing a safe space  75. communicating empathy  81. “touching” and reflecting emotions  63. assuring the client that I will not leave her/him, that I will walk with her/him  7. providing nurturance  23. conveying warmth  6. providing support  4. giving hope  25. providing support  30. establishing trust  10. collaborating with the client  18. acknowledging the client’s strengths  2. establishing a strong relationship/rapport  65. communicating real compassion for the client  21. staying close with the client’s emotional experience  32. “speaking” through my eyes to the client’s eyes</p>
<p style="text-align: center;">9</p> <p style="text-align: center;">Attending with Focus</p>	<p>1. caring deeply for the client  9. noticing the little things about the client  11. focusing completely on the client  29. attending to my client’s breathing  <del>14. honoring cultural differences</del>  79. attuning to the client  22. attending fully  <del>70. being nonjudgmental</del></p>
<p style="text-align: center;">10</p> <p style="text-align: center;">Honoring the Client</p>	<p>71. accepting the client as she/he is  72. honoring the humanity of the client  68. respecting the client’s boundaries  84. empowering the client  24. viewing the client holistically  26. respecting the client  14. honoring cultural differences (<i>moved from Cluster 9</i>)  70. being nonjudgmental (<i>moved from Cluster 9</i>)</p>

# Final Cluster Map

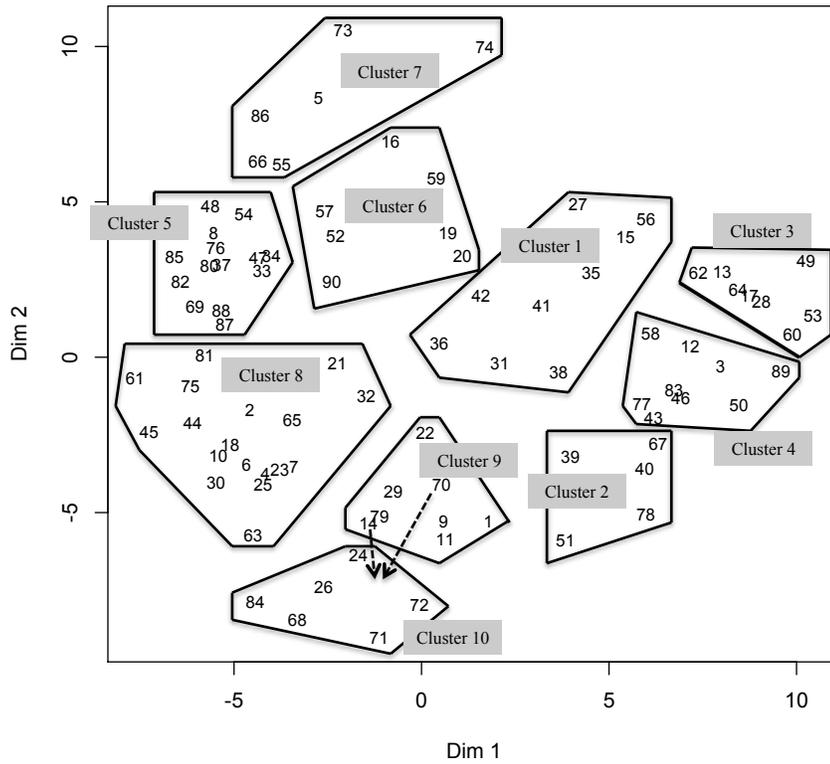


Figure 5. Final Cluster Map. Statements 14 and 70 are shown to move to cluster ten.

**Importance and frequency ratings.** After the group had reached consensus on cluster names and associated statements, the researcher introduced the next step in the focus group: discussing the findings and offering subsequent implications for therapist training, supervision, and research. To begin this process, the researcher asked participants to examine the importance and frequency ratings for each item (see Table 2: Initial 10-Cluster Solution and Associated Ratings) and the importance and frequency ratings by cluster (see Figure 4: Average Ratings by Cluster), and offer general impressions. One participant noted that clusters five (*Using Engagement Skills*), seven (*Structuring Intentionally*), and eight (*Facilitating Intimate Connection*) were the only ones where the frequency ratings were greater than the importance ratings. (Note that cluster six [*Bringing Immediacy*] also has frequency ratings that are slightly higher.) Another participant noted that it was surprising that the importance and frequency ratings were basically the same. Furthermore, it was noted that cluster ten (*Honoring the Client*) was the highest overall and had the least discrepancy between the importance and frequency ratings. Referring to this, one participant stated, “That’s got to mean something, right?” Participants also drew attention to the lowest rated cluster (cluster seven, *Structuring Intentionally*), and one participant reported that it seemed the least ephemeral of all the clusters. Examining the statement ratings, one participant stated that perhaps some of the lower-rated items (such as statement numbers 13 [praying] and 8 [attacking shame]) could be more individualistic based on the therapist, whereas the other statements seemed more universal.

**Development of relational depth capacity.** After discussing the importance and frequency ratings by statement and cluster, the researcher asked the participants a series of questions intended to reveal future implications. First, participants were asked how they believed they developed the capacity to invite and facilitate moments of relational depth and, along with this, they were asked whether or not they believed it could be trained.

Answering the first part of this question, one participant started the discussion by stating that he developed the capacity by being in the client chair and experiencing the impact of that presence. Others agreed with this, and another participant reported that he experienced profound depth in the client chair. A different individual added to this, stating that she had learned this based on her experiences as both a client and a student. Extending from this, one participant reported that his training opened him up to the importance of it, and his clients taught him how to do it. Others reported influences such as the meaning in spiritual experiences; the experience of unconditional love, acceptance, and safety from family; the opportunity to witness it being modeled by a parent; the opportunity to see it or have it validated in supervision; the experience of observing it (and the power of it) in various situations; and the experience of good mentorship and supervision in helping them develop the ability to engage on deeper levels. Interestingly, one person stated that she wondered how she learned to *access* it, rather than how she learned *it*. Others referenced being in the client seat again and learning how to access themselves and learning that it was okay to be human. One person stated that the ability to invite and facilitate relational depth was learned as a client; however, there appeared to

be evidence of it along the way. Extending this, another person stated that we are “born counselors.” Furthermore, they discussed the process of learning to use oneself as a tool and focus on what is actually there rather than the stuff around it. In summary, it appeared that a number of relational experiences (e.g., with family members, therapists, supervisors, mentors, clients, themselves, spiritual experiences) taught them how to invite and facilitate moments of relational depth.

From there, the participants offered their opinions as to whether or not they believed the capacity for inviting and facilitating relational depth could be trained. One participant said that it could be trained, but not everyone could do it. Others built upon this, stating that people could be trained in the necessary skills to potentially get there, but that not everybody could develop the capacity. In other words, they said there was a gap that could not be trained. To clarify this, one person said that those who have the capacity can be trained to do it. Another participant added that a person has to *want* to learn it as well, which can get lost when people jump from one model to another. Explaining this, a participant hypothesized that the “jumping” was about *doing* something rather than learning how to *be* something. Taken together, the participants seemed to agree that the ability to invite and facilitate moments of relational depth could be trained; however, a person first needed to have some sort of initial capacity and desire to learn it.

**Representation of the therapist’s use of self.** In the next portion of the focus group, the researcher introduced Rowan and Jacobs’ (2002) three positions of the therapist’s use of self (instrumental, authentic, and transpersonal), and asked participants to consider how these areas might reflect some of the clusters. One participant started the

discussion by stating that the instrumental way of being seemed to be the least represented by the clusters; the authentic and transpersonal seemed to better reflect the clusters. Another person responded to this by stating that this made sense, since relational depth was the construct of interest – not necessarily about specific how-to's, problems, goals, or outcomes. Rather, the focus seemed to be more on the process of relational depth. Another participant stated that maybe it was so difficult to name the clusters because the experience of relational depth goes beyond words. Another person agreed with this, stating that the experience was like tuning in to something more in the space in-between the therapist and the client, like an I-Thou experience.

Reflecting upon Rowan and Jacobs' (2002) three positions a little differently, one participant stated that the instrumental, authentic, and transpersonal seemed to unfold like Erikson's epigenetic model of development. Another person agreed with this idea, and stated that it was possible to be transpersonal and have a lousy skill set, but with relational depth, a solid skill set in all three could occur at the same time. Although the researcher presented Rowan and Jacobs' (2002) positions as developmental, starting with the instrumental, and then moving to the authentic and the transpersonal, one participant stated that perhaps experiences of the transpersonal are what inspire individuals to want to become therapists. Then, when they enter their training programs, they need to take a step back and learn skills from the instrumental way of being before moving toward the authentic and transpersonal. Reflecting upon this insight, a different participant stated that perhaps this could explain why some students feel like terrible helpers when they first start counseling – because they have to undo some behaviors first. Then from there,

the instrumental skills that students learn begin to have more depth, and the students begin to move from one position to the next. Another participant corroborated this reflection, stating that students begin to have “aha” moments in Advanced Practicum. Finally, one participant noted that she did not prefer the term “transpersonal”; however, she could not think of another word to describe this way of being.

In summary, the participants underscored the profundity of relational depth as an experience beyond words that incorporates at least the authentic and transpersonal – and perhaps the instrumental as well – positions of Rowan and Jacobs’ (2002) three ways of being. From there, they explored these three positions in light of therapist development, and proposed that perhaps development *began* with experiences of the transpersonal before entering the profession.

**Implications for therapist educators and supervisors.** With a better understanding of how therapists developed the capacity to invite and facilitate moments of relational depth and how the clusters reflect Rowan and Jacobs’ (2002) three positions, the researcher asked participants to offer implications for educators, supervisors, and researchers. For educators and supervisors, participants mentioned that they could normalize the process of learning to engage in a relationally-deep way. This suggestion was offered in light of the earlier statement that sometimes students become discouraged in the process of learning and practicing the instrumental skills. Beyond this, several participants commented on the realization that their own experiences as clients helped them develop the capacity for relational depth. Thus, they said that perhaps supervisors and educators could encourage students to seek counseling for themselves. Furthermore,

participants stated that many of the initial clusters were focused on the therapist and her or his intentionality in setting up for the experience of relational depth. Thus, perhaps educators and supervisors could encourage students to focus on themselves and their ability to intentionally set up a space for their clients. In other words, therapists with this capacity focused on and prepared *themselves* first – then they fully attended to their clients. Finally, participants highlighted the importance of establishing a safe supervisory relationship and validating the supervisee’s strengths. In fact, one participant stated that it would be important for the qualities of relational depth to be present in supervisory relationships.

In summary, the participants underscored the importance of (a) encouraging students to seek counseling for themselves, (b) encouraging students to learn more about themselves and the developmental process of intentionally inviting relational depth, and (c) establishing a strong supervisory relationship with students.

**Implications for relational depth researchers.** In addition to implications offered for educators and supervisors, the participants offered implications for researchers. First, they noted the apparent sequential nature of relational depth – from practicing presence and tuning into the self, to intentionally setting up the space, to really focusing on the client. They recommended further research into this seemingly sequential process. Along with this, they later stated that, if it is a sequential process, then perhaps Rowan and Jacobs’ (2002) three positions do not reflect the process, since the process begins with the whole person of the therapist and those life experiences that inspired her or him to become a therapist.

Beyond wonderings about the sequential nature of inviting relational depth, participants wondered more about the ways that therapists learned the associated components of the construct. Participants questioned where therapists learned the confidence to engage in relational depth and where they learned how to follow their intuition, both of which could present subsequent training implications. Another person wondered how therapists learn to attend to a client's breathing. Based on these types of questions, participants recommended more research on how to teach certain skills (e.g., how to develop confidence, follow intuition, and attend to client's breathing). Furthermore, one participant wondered what *barriers* might be holding a person back from practicing the various skills and ways of being, and recommended more research exploring the ways those barriers could be addressed in therapist training and supervision.

Finally, some participants wondered about the broad nature of the construct itself. For example, one person recommended that future researchers use analyses such as discrimination analysis and classification analysis to further validate the differences and similarities amongst the clusters. Another participant sought to extend research beyond therapy, and recommended that future researchers explore where else people experience relational depth (perhaps in other professional or personal relationships).

In summary, when offering research implications, participants seemed to wonder most about (a) the apparent sequential nature of the therapist's process in inviting moments of relational depth, (b) the ways in which participants learn various components

of relational depth (e.g., intuition, confidence) and how those could be taught, and (c) the ways that relational depth presents in other settings and relationships.

### **Summary**

The purpose of Chapter Four was to present the results of the concept mapping study and answer the three research questions. Twenty participants generated statements, answering the first research question of what therapist factors (prior to or during therapy) contribute to the ability to invite and facilitate moments of relational depth with clients. Using sorting and rating data from 18 participants, these statements were grouped into 10 clusters and importance and frequency ratings were calculated. Finally, nine therapists participated in the focus group and offered reflections and implications for educators, supervisors, and researchers. In the following chapter, the researcher explores the results in light of relational depth literature; reports the limitations of the study; and offers implications and suggestions for educators, supervisors, and researchers.

## **CHAPTER V**

### **DISCUSSION**

In Chapter One, the researcher reviewed the relational depth literature and proposed a study exploring the therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. In Chapter Two, the relational depth literature was reviewed in light of those possible therapist factors that might contribute to the ability to invite and facilitate these occurrences. From there, the researcher outlined the methodology of the concept mapping study in Chapter Three and presented the results in Chapter Four. In this chapter, the researcher discusses the results in light of relational depth literature, outlines the limitations of the study, and offers implications and suggestions for educators, supervisors, and researchers.

#### **Discussion of Results**

The results are discussed first with respect to each of the three research questions and then more broadly based on the first two focus group questions (regarding the development of relational depth capacity and its representation with the three positions of the therapist's use of self [Rowan & Jacobs, 2002]). To avoid redundancy, the results of the final two focus group questions (regarding implications and recommendations for educators, supervisors, and researchers) are discussed in the implications section of this chapter.

## **Research Question One**

To answer the first research question, therapists were asked to generate statements describing what therapist factors (prior to or during therapy) they believe contribute to the ability to invite and facilitate moments of relational depth with clients. The 90 synthesized statements (see Appendix P: Synthesized Statements) and their associated clusters (see Table 3: Final 10-Cluster Solution and Associated Names) reflect and extend the literature on relational depth. In the following section, the clusters and associated items are examined in light of the Person-Centered theoretical foundation (Rogers, 1957, 1980, 1989) of relational depth and the conceptual therapist factors of relational depth (as described by Cooper, 2013b; Mearns, 1996, 1997; Mearns & Cooper, 2005; and Mearns & Schmid, 2006).

**Person-centered therapy.** According to Rogers' (1957, 1980, 1989) Person-Centered Therapy, when clients feel as though their therapists are empathic, genuine, and unconditionally accepting, they naturally gravitate toward greater self-growth. These three core conditions (empathy, genuineness, and unconditional positive regard) are widely reflected in the statements generated by participants and the subsequent names of the clusters.

Starting with empathy, items such as statement number 78 (entering as profoundly as I can into an experientially felt sense of the client's world), statement number 44 (expressing understanding), statement number 75 (communicating empathy), and statement number 65 (communicating real compassion for the client) reflect the importance of an empathic connection in relational depth. Most of these example

statements stem from cluster two (*Offering Genuine Connection*) and cluster eight (*Facilitating Intimate Connection*). These descriptions mirror Rogers' (1957) early definition of empathy as the ability to "sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (p. 99).

Along with empathy, genuineness is another core condition of Person-Centered Therapy (Rogers, 1957, 1980, 1989), defined as the therapist's ability to be "freely and deeply himself (sic)" (Rogers, 1957, p. 97). Genuineness was widely represented in the participants' generated statements and in the subsequent cluster names. For example, statement number 41 (being transparent), statement number 42 (being totally honest with the client), statement number 67 (being genuinely myself with clients), statement number 83 (being open with my own emotional experience [e.g., crying with the client]), and statement number 90 (intentionally using self-disclosure) all reflect a certain level of genuineness. These statements were drawn from a number of clusters, including cluster one (*Tuning In*), cluster two (*Offering Genuine Connection*), cluster four (*Being Emotionally Present*), and cluster six (*Bringing Immediacy*).

Finally, Rogers (1957, 1980, 1989) underscored the importance of unconditional positive regard, defined as "the extent that the therapist finds himself (sic) experiencing a warm acceptance of each aspect of the client's experience" (Rogers, 1957, p. 98). Similar to empathy and genuineness, unconditional positive regard was represented in a number of statements, such as statement number 1 (caring deeply for the client), statement number 71 (accepting the client as she/he is), statement number 72 (honoring the humanity of the client), statement number 14 (honoring cultural differences), and

statement number 70 (being nonjudgmental). Most of these statements stemmed from cluster ten (*Honoring the Client*) with one item in cluster nine (*Attending with Focus*).

Based upon the aforementioned results, it is evident that many of the statements and associated clusters represent Rogers' (1957, 1980, 1989) Person-Centered Therapy. Interestingly, though, the *way* that these statements emerged within the clusters seems to reflect the very nature of relational depth as a *synergy* of the core conditions (Knox et al., 2013b; Mearns & Cooper, 2005). Rogers conceptualized the core conditions as distinct constructs, and Mearns and Cooper (2005) took this a step further and postulated that relational depth was comprised of the *combined effect* these three conditions interacting at high levels. Similarly, Wiggins et al. (2012) characterized relational depth as an “upward extension of the working alliance” (p. 14). The fact that the representative statements of empathy, genuineness, and unconditional positive regard – for the most part – were present *across* clusters perhaps indicates the synergistic effect of the construct. If relational depth were simply comprised of the three core conditions then, presumably, the groupings would have reflected the presence of three distinct clusters – to be named *Empathy, Genuineness, and Unconditional Positive Regard*. Furthermore, some of the statements and clusters that emerged are not necessarily representative of Person-Centered Therapy, perhaps indicating that relational depth is, indeed, something *more*, lending plausibility to Rowan and Jacobs' (2002) three positions of the therapist's use of self (described later). Although the purpose of this study was not to *define* relational depth or to explore the specific components of the construct, the aforementioned finding empirically validates some theoretical presuppositions of the phenomenon.

**Conceptual therapist factors of relational depth.** Beyond the three core conditions of Rogers' (1957, 1980, 1989) Person-Centered Therapy, researchers (Cooper, 2013b; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006) have conceptualized possible therapist factors that contribute to relational depth. For the most part, these were corroborated in this study.

Relational depth researchers have postulated that the following therapist factors contribute to the ability to invite and facilitate moments of relational depth with clients: demonstrating care (Cooper, 2013b); maintaining self-awareness (Cooper, 2013b; Mearns & Cooper, 2005); accepting and prizing the client (Cooper 2013b; Mearns & Schmid, 2006); being fearless and opening oneself to the client (Mearns, 1996, 1997); creating a safe atmosphere, relinquishing the desire to fix clients, relinquishing preconceived notions of clients, relinquishing specific techniques, and listening deeply (Mearns & Cooper, 2005); devoting one's whole self to another, opening to the spontaneity of the encounter, communicating on an existential level, focusing and reflecting on the relationship, being willing to affect the client, maintaining awareness of the power differential, and maintaining awareness of the environment (Mearns & Schmid, 2006); allowing oneself to be affected by clients and inviting clients to deeper engagement (Mearns & Cooper, 2005; Mearns & Schmid, 2006); being present (Mearns, 1996, 1997; Mearns & Cooper, 2005); and being real/transparent/immediate (Cooper, 2013b, Mearns & Cooper, 2005; Mearns & Schmid, 2006). In the following paragraphs, these conceptual characteristics are compared to the statements participants generated and the clusters they named in this study. For clarity, this discussion will be organized by cluster, though some

conceptual characteristics appeared to be represented by more than one statement/cluster.)

Two of the conceptual characteristics seem to be represented by statements in cluster one (*Tuning In*): listening deeply (Mearns & Cooper, 2005) and being real/transparent/immediate (Cooper, 2013b, Mearns & Cooper, 2005; Mearns & Schmid, 2006). Listening deeply relates to statement number 31 (listening – not just with ears but with whole self) and being real/transparent/immediate seems to link to statement numbers 41 (being transparent) and 42 (being totally honest with the client).

The two conceptual characteristics of listening deeply (Mearns & Cooper, 2005) and being real/transparent/immediate (Cooper, 2013b; Mearns & Cooper, 2005; Mearns & Schmid, 2006) also seem to be represented by various statements in cluster two (*Offering Genuine Connection*). Listening deeply can be likened to statement number 40 (connecting with and listening from the depths of my soul) and being real/transparent/immediate is similar to statement number 67 (being genuinely myself with clients). Furthermore, the conceptual characteristics of opening oneself to the client (Mearns, 1996, 1997) and opening to the spontaneity of the encounter (Mearns & Schmid, 2006) appear to be linked to statement number 51 (staying open to the client's experience).

Similar to cluster one, two conceptual characteristics seem representative of items in cluster three (*Practicing Presence*). First, maintaining self-awareness (Cooper, 2013b; Mearns & Cooper, 2005) appears to be similar to statement number 17 (possessing self-awareness). The conceptual characteristic of being present (Mearns 1996, 1997; Mearns

& Cooper, 2005) seems to be generally associated with two statements: statement number 49 (grounding/centering myself before sessions) and statement number 53 (practicing mindfulness). Though these are not perfect one-to-one associations, the research on therapeutic presence (see Geller & Greenberg, 2002) includes such practices as centering oneself and being mindful.

Cluster four (*Being Emotionally Present*) seems to incorporate seven of the conceptual characteristics – one of which is, again, being present (Mearns, 1996, 1997; Mearns & Cooper, 2005). Within this cluster, being present (Mearns 1996, 1997; Mearns & Cooper, 2005) can be directly linked to statement number 58 (being fully present). Along with the dual representation of being present, two conceptual characteristics described earlier (opening oneself to the client [Mearns, 1996, 1997] and opening to the spontaneity of the encounter [Mearns & Schmid, 2006]) seem to be represented by statement number 50 (opening my heart center) and statement number 83 (being open with my own emotional experiences [e.g., crying with the client]). Other conceptual characteristics are also representative of cluster four (*Being Emotionally Present*). Allowing oneself to be affected by clients (Mearns & Cooper, 2005; Mearns & Schmid, 2006) appears similar to statement numbers 46 (being vulnerable) and 83 (being open with my own emotional experience [e.g., crying with the client]). The quality of being fearless (Mearns, 1996, 1997) can be likened to statement number 77 (being unafraid of the intensity of emotion), and relinquishing the desire to fix clients (Mearns & Schmid, 2006) and relinquishing preconceived notions of clients (Mearns & Cooper, 2005) appear similar to statement number 12 (letting go of all expectations).

Cluster five (*Using Engagement Skills*) appears to include two of the conceptual characteristics. Inviting clients to deeper engagement (Mearns & Cooper, 2005; Mearns & Schmid, 2006) and being willing to affect the client (Mearns & Schmid, 2006) appear to be at least somewhat representative of statement numbers 76 (probing gently to create more depth) and statement number 48 (exploring interpsychic relational dynamics).

A number of conceptual characteristics appear to be represented by statements in cluster six (*Bringing Immediacy*). First, being real/transparent/immediate (Cooper, 2013b; Mearns & Cooper, 2005; Mearns & Schmid, 2006) is similar to statement 90 (intentionally using self-disclosure). In some ways, being fearless (Mearns, 1996, 1997) and being willing to affect the client (Mearns & Schmid, 2006) seem to reflect statement numbers 19 (being willing to “name the thing”) and 20 (taking risks). Finally, relinquishing specific techniques and the desire to fix clients (Mearns & Cooper, 2005) can be compared to statement number 16 (resisting temptation to focus solely on goals).

Moving onto cluster seven (*Structuring Intentionally*), two conceptual characteristics seem to be reflected by associated statements. Communicating on an existential level (Mearns & Schmid, 2006) can be compared to statement number 55 (initiating conversations around existential issues [e.g., death, isolation, freedom]), and maintaining awareness of the environment (Mearns & Schmid, 2006) appears similar to statement number 73 (setting the clinical environment [e.g., quiet yoga music in background, indirect lighting]).

The conceptual characteristics of creating a safe atmosphere (Mearns & Cooper, 2005) and focusing and reflecting on the relationship (Mearns & Schmid, 2006) appear

representative of statements in cluster eight (*Facilitating Intimate Connection*).

Furthermore, creating a safe atmosphere is similar to statement numbers 61 (establishing a safe space) and 30 (establishing trust). And, finally, focusing and reflecting on the relationship is similar to statement number 2 (establishing a strong relationship/rapport).

Cluster nine (*Attending with Focus*) seems to incorporate two conceptual characteristics: demonstrating care (Cooper, 2013b) and devoting one's whole self to another (Mearns & Schmid, 2006). Demonstrating care is analogous to statement number 1 (caring deeply for the client), and devoting one's whole self to another can be compared to statement numbers 11 (focusing completely on the client) and 22 (attending fully).

Finally, three conceptual characteristics seemed to fall within cluster ten (*Honoring the Client*). Accepting and prizing the client (Cooper 2013b; Mearns & Schmid, 2006) is similar to statement numbers 70 (being nonjudgmental), 71 (accepting the client as she/he is), and 72 (honoring the humanity of the client). Similarly, relinquishing preconceived notions of clients (Mearns & Cooper, 2005) could be loosely linked to statement numbers 70 (being nonjudgmental) and 71 (accepting the client as she/he is). Finally, perhaps the conceptual characteristic of maintaining awareness of the power differential (Mearns & Schmid, 2006) could be loosely linked to statement numbers 68 (respecting the client's boundaries), 84 (empowering the client), and 26 (respecting the client).

Based on the aforementioned analysis, it appears that the statements and clusters, for the most part, encompass the existing conceptual characteristics of relational depth. Furthermore, although the statements may not have a one-to-one correlation with the

conceptual characteristics, they seem relatively similar. For example, statement numbers 60 (embracing my own suffering) and 43 (being humble – seeing the client as similar to me in the most profound human ways) largely mirror various descriptions of relational depth. As Mearns and Cooper (2005) stated “. . . we enter into our own ‘depths’ to meet our clients in theirs” (p. 137).

On a broader level, however, there appear to be some differences between the conceptual literature and the empirical results driven by participants in this study. First, many of the statements in this study centered on the specific counseling skills needed to invite and facilitate moments of relational depth. Examples of these skills stem from cluster five (*Using Engagement Skills*) and cluster six (*Bringing Immediacy*) and include statement numbers 69 (using the client’s words), 87 (using facial nonverbals with the client [e.g., mirroring expressions, conveying empathy through facial expressions]), 88 (using body nonverbals with the client [e.g., tilting head, opening posture leaning in, mirroring body language]), 54 (using metaphors/imagery), 82 (reflecting and summarizing content), 85 (using tentative language), 37 (exploring with the client what’s happening in the client’s body), 80 (intentionally reflecting meaning), 90 (intentionally using self-disclosure), and 57 (speaking softly). Mention of these specific types of skills is largely missing from relational depth literature.

Secondly, beyond the specific skill components contributing to relational depth, participants also noted the structuring nature necessary to engender moments of deeper engagement. This is illustrated in statements from cluster seven (*Structuring Intentionally*): statement numbers 5 (structuring within and across sessions), 86 (setting

process/relational goals), and 74 (preparing for the session [e.g., reviewing notes, reflecting on previous experience]). For the most part, this type of intentional structuring is lacking in the conceptual research.

Although these types of skills and structuring are less “ephemeral” (as one participant in the focus group stated) than some of the more numinous qualities of the construct, it seems that they provide the framework and strategies needed to engender moments of relational depth. Such a discovery offers implications for educators and supervisors, and informs the ways in which Rowan and Jacobs’ (2002) three positions of the therapist’s use of self perhaps reflect the nature of relational depth (discussed further later in this chapter). Perhaps one of the reasons that counseling skills and structure emerged in this study is that many of the participants were educators and supervisors, in addition to being therapists. Although the researcher did not ask participants to identify whether or not they were educators, it was known that at least 10 participants were doctoral-level counselor educators and supervisors, and at least four participants were doctoral students training to be counselor educators and supervisors. Their specific training in the *pedagogical* aspects of therapist development may have informed their understanding of those specific therapist factors that invite and facilitate moments of relational depth. Thus, the assertion that counseling skills and structure are important in relational depth may be a product of the idiosyncratic sample in this study and warrants further study.

In addition to examining the 10 emergent clusters, research question one could be further explored by interpreting the associated dimensions on the multidimensional

scaling point map. Dimension 1 on the x-axis could be interpreted as moving from *focus on client* (closest to the x-axis origin) to *focus on self* (farthest from x-axis origin). For example, the items farthest on the left include statement numbers 61 (establishing a safe space), 45 (validating the client's experience), and 85 (using tentative language). Furthermore, the clusters farthest on the left include clusters eight (*Facilitating Intimate Connection*) and five (*Using Engagement Skills*). These statements and clusters represent more of a focus on the *client*. On the other hand, items farthest on the right include statement numbers 49 (grounding/centering myself before sessions), 53 (practicing mindfulness), and 60 (embracing my own suffering). Similarly, the clusters located farthest on the right include clusters three (*Practicing Presence*) and four (*Being Emotionally Present*). Rather than focusing on the client, these statements and clusters seem to focus more on the *therapist*.

Dimension 2 could be interpreted as moving from *therapist being* (closest to the y-axis origin) to *therapist doing* (farthest from the y-axis origin). For example, the items closest to the y-axis origin include statement numbers 71 (accepting the client as she/he is), 68 (respecting the client's boundaries), and 72 (honoring the humanity of the client). Furthermore, the cluster closest to the y-axis origin is cluster ten (*Honoring the Humanity of the Client*). These statements and this cluster (only one cluster used as an example since the whole cluster is clearly below the others) seem to represent a focus on the therapist's *way of being*. Contrarily, the uppermost items include statement numbers 73 (setting the clinical environment [e.g., quiet yoga music in background, indirect lighting]), 74 (preparing for the session [e.g., reviewing notes, reflecting on previous

experience]), and 5 (structuring within and across sessions). The uppermost clusters include clusters seven (*Structuring Intentionally*), six (*Bringing Immediacy*), and five (*Using Engagement Skills*). These statements and clusters appear to represent what the therapist *does*.

Although the purpose of question number one was for therapists to generate statements and name emergent clusters in order to determine what factors contribute to relational depth, the researcher's brief interpretation of the resultant dimensions could offer directions for future research and, if these dimensions are subsequently borne out, counselor preparation.

### **Research Question Two**

The importance ratings of the statements and clusters largely mirror relational depth literature. As outlined in Chapter Four, the lowest average importance rating statement was statement number 13 (praying), and the highest average importance rating statement was statement number 22 (attending fully). As one participant in the focus group noted, perhaps statement number 13 (praying) is based more on people's specific religious affiliations – not as universal – and thus was rated as less important by some participants. However, although *praying*, per se, is lacking in relational depth literature, the spiritual nature of it could be encompassed in the spiritual nature of relational depth (Cooper, 2013a; Hawkins, 2013; Knox, 2013; Macleod, 2013; Mearns 1997; Price, 2012; Rowan, 2013; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013).

Moving to the highest-rated item, statement number 22 (attending fully) is widely encompassed in the therapeutic presence dimension associated with relational depth

(Cooper, 2005a, 2005b, 2007, 2013a; Cox, 2009; Frzina, 2012; Geller, 2013; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; Lago & Christodoulidi, 2013; Lambers, 2006, 2013; Macleod, 2013; McMillan & McLeod, 2006; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Murphy & Joseph, 2013; O’Leary, 2006; Price, 2012; Schmid & Mearns, 2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2012). The ability to fully attend to the client appears to set the stage for the possibility of relational depth, and, noted here, is regarded as highly important by participants.

The importance ratings by cluster also largely reflect relational depth research. The lowest-rating group was cluster seven (*Structuring Intentionally*), with a mean average rating across statements of 3.43, and the highest-rated group was cluster ten (*Honoring the Client*), with a mean average rating across statements of 4.5. As stated previously, research exploring the ways that therapists structure sessions and how this might engender moments of relational depth is currently lacking. Although it is possible that researchers, like the participants in this study, consider structuring as less important, the finding in this study that structuring activities are part of relational depth is a new contribution to the literature.

The concept of honoring the client is widely represented in the literature – mostly when discussing relational depth and unconditional positive regard (Cooper, 2005a, 2005b, 2007, 2013a; Cox, 2009; Hawkins, 2013; Knox, 2008, 2013; Knox & Cooper 2010, 2011; Lambers, 2006, 2013; Lago & Christodoulidi, 2013; Macleod, 2013; McMillan & McLeod, 2006; Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Murphy & Joseph, 2013; Price, 2012; Schmid & Mearns, 2006; O’Leary,

2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013). Taken together, the importance ratings by statement and by cluster largely reflect the literature – whether in the evident associations (such as between attending fully and the therapeutic presence associated with relational depth) or in the *lack* of information available (such as the dearth of information about structuring for relational depth).

### **Research Question Three**

To answer research question three, participants were asked how often they practice these factors in their work with clients. Similar to the importance ratings, the frequency ratings also largely reflect relational depth literature. The lowest average frequency rating was, again, statement number 13 (praying). This could be a reflection of the composition of the participant group, as not all participants identified as Christian. As stated earlier, beyond the apparent spiritual nature of relational depth (described above), praying, per se, is not noted in the relational depth literature. The highest average frequency rating was shared by two statements: numbers 45 (validating the client's experience) and 75 (communicating empathy). These two statements underscore the practice of empathy as an endeavor to truly understand (and thus validate) another's experience and communicate that deep understanding. Empathy is noted as a key component of relational depth (Cooper 2005a; 2005b; 2007; 2013a; 2013b; Cox, 2009; Hawkins, 2013; Knox, 2008, 2013; Knox & Cooper, 2010, 2011; Lago & Christodoulidi, 2013; Lambers, 2006, 2013; McMillan & McLeod, 2006; Mearns 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006; Murphy & Joseph, 2013; Price, 2012; Schmid & Mearns, 2006; O'Leary, 2006; Wiggins, 2013; Wiggins et al., 2012; Wyatt, 2013), and

thus it is not surprising that participants stated that they practice it frequently in their work with clients.

Examining the frequency ratings based on cluster, the lowest-rating cluster was, again, cluster seven (*Structuring Intentionally*), with a mean average rating across statements of 3.54, and the highest-rated group was, again, cluster ten (*Honoring the Client*), with a mean average rating across statements of 4.49. Both of these clusters are compared to relational depth research under research question two. It is interesting to note, however, that statements and clusters rated most and least important often coincided with the frequency ratings. Since the importance ratings are intended to explore how important each factor is in inviting and facilitating moments of relational depth, then it seems that the participants in this study are continually working to engender these moments – since the importance and frequency ratings often coincided, in spite of the fact that participants did not rank frequency and importance paired with each item, but instead rated each of the items on importance and then separately on frequency. This discovery leads to a broader discussion about how the participants developed the capacity to invite and facilitate moments of relational depth.

### **Development of Relational Depth Capacity**

In the focus group, participants were asked how they developed the capacity to invite and facilitate moments of relational depth and whether or not they believed it could be trained. As outlined in Chapter Four, participants answered the first part of this question by reflecting upon a number of powerful relational experiences (e.g., with family members, therapists, supervisors, mentors, clients, themselves, or even their

spiritual experiences), which taught them how to invite and facilitate moments of relational depth. To answer the second part of this question, participants stated that the ability to invite and facilitate moments of relational depth could be trained; however, a person first needed to have some sort of capacity and desire to learn it.

These findings somewhat reflect the relational depth literature. Researchers (Mearns, 1996, 1997; Mearns & Cooper, 2005; Mearns & Schmid, 2006) have conceptually postulated developmental factors associated with the cultivation of relational depth capacity, and, based on their research, three developmental factors emerged: existential contact, self-acceptance, and congruence. More specifically, they asserted that the therapist's ability to face and integrate the depth of her or his suffering (existential contact), truly accept all parts of her or himself (self-acceptance), and act in a real and authentic manner (congruence) served as milestones on the journey toward developing relational depth capacity.

Comparing the participants' responses to the literature, it seems that participants focused a bit less on the qualities within themselves; instead, they seemed to focus more on the ways in which they learned these qualities *in the context* of their close relationships with others. For example, they mentioned that supervisors and mentors could *model* relational ways of deeper engagement – in essence, providing participants with an *experience* of relational depth whereby they could, perhaps, move to greater existential contact, self-acceptance, and congruence. In fact, the participants' responses closely mirror the sparse conceptual literature on relational depth and supervision. Lambers (2006, 2013) encouraged supervisors to supervise the *humanity* of therapists,

essentially providing them an experience with which they could open to themselves, and thus, open more to their clients. Participants also emphasized the importance of personal counseling as a method of developing relational depth capacity. When discussing this, they seemed to describe both the power of the therapist's ability to *model* this level of engagement and the opportunity to explore themselves on a deeper level. Mearns and Cooper (2005) echoed this assertion, stating that personal therapy and group therapy could aid in developing the capacity for relational depth. In summary, the participants seemed to focus more on their relationships with important others (such as family members, therapists, supervisors, mentors, clients, etc.) as perhaps a *vehicle* toward developing relational depth capacity, whereas relational depth researchers seem to focus a bit more on certain qualities (i.e., existential contact, self-acceptance, congruence) to be learned in the process.

Finally, examining the second portion of the question, participants largely agreed that relational depth could be trained; however, they stated that students needed to have some initial capacity and desire to learn it. Interestingly, it is still a little unclear what this *capacity* is. The researcher asked about relational depth capacity, assuming that this was the construct of interest, but perhaps there is a different type of capacity that leads to relational depth. When discussing the ways that the statements and clusters reflect Rowan and Jacobs' (2002) three positions of the therapist's use of self, one participant noted that perhaps individuals enter into the counseling profession after having experienced glimpses of the transpersonal in their lives – whether through their relationships with significant others (e.g., therapists, family members, mentors) or through significant

spiritual experiences in their lives. Based on this, perhaps transpersonal (defined here as deep, transformative, and ineffable) experiences serve as the initial capacity that eventually leads to the learned capacity to invite and facilitate moments of relational depth. Overall, though, it became more and more evident in attempting to explore this developmental process that the concept of *capacity* is unclear. Perhaps even more concerning, it may be indefinable. More research is certainly needed in this area. This discussion leads to the ways in which the three positions of the therapist's use of self (Rowan & Jacobs, 2002) represent the research on relational depth.

### **Representation of the Therapist's Use of Self**

In discussing the ways that the statements and clusters in this study represent Rowan and Jacobs' (2002) three positions of the therapist's use of self, the participants first stated that it seemed as though the authentic and transpersonal positions were represented more than the instrumental. Later in the discussion, however, participants stated that perhaps relational depth is comprised of all three positions unfolding in an epigenetic manner. In other words, perhaps therapists learn instrumental skills, then incorporate their authentic being, and finally relate on the realm of the transpersonal. This hypothesis parallels Rowan and Jacobs' (2002) beliefs regarding the developmental nature of learning to use oneself in therapy. Participants also noted, however, that perhaps the development of therapists who have the capacity for relational depth begins *before* they enter mental health training programs. Perhaps participants possess the capacity to experience the transpersonal, and then they enter training programs where educators and supervisors teach them the skills (instrumental) and facilitate the self-awareness process

(authentic) whereby they can re-contact the transpersonal level when engaging with their clients.

One of the primary differences between the therapist's use of self (Rowan & Jacobs, 2002) literature and the results in this study is the positioning of the construct of relational depth. Rowan and Jacobs (2002) postulated that moments of relational depth occur exclusively in the transpersonal position. Early in the discussion, participants in this study noted that it seemed as though relational depth could occur across both authentic and transpersonal levels. This assertion certainly reflects researchers' descriptions of relational depth, focusing on the Person-Centered (Rogers, 1957, 1980, 1989) core conditions and the numinous essence (Rowan, 2013) of the construct.

Later in the discussion, however, participants stated that relational depth incorporates aspects from the instrumental position as well. As one participant stated, a therapist could be transpersonal, but possess lousy counseling skills. Furthermore, the clusters of relational depth reflect *all three* positions of the therapist's use of self. Statements from the clusters of *Practicing Presence*, *Being Emotionally Present*, *Facilitating Intimate Connection*, *Attending with Focus*, and *Honoring the Client* largely reflect the authentic way of being. *Tuning In* and *Offering Genuine Connection* appear to include some more transpersonal-oriented statements (e.g., statement numbers 35 [following intuition], 38 [sensing energy and energetic shifts], 40 [connecting with and listening from the depths of my soul]). Informing our understanding of relational depth and the therapist's use of self, though, it appears that relational depth also may incorporate elements from the instrumental self, as can be seen in the clusters of *Using*

*Engagement Skills, Bringing Immediacy, and Structuring Intentionally.* The intention in adopting an instrumental way of being might not be to “fix” clients (as implied by Rowan and Jacobs, 2002) but rather to use skills to enhance the therapeutic relationship, immediacy, and structure. That is, from a relational depth perspective, skills are not used mechanistically on clients, but rather artistically *with* clients. When engaging at a level of relational depth, it seems important that therapists develop the ability to create a therapeutic framework by intentionally structuring sessions and deliberately choosing various skills to invite deeper levels of therapeutic engagement.

At this point, the results of the study have been compared to the theoretical foundation of relational depth, the conceptual therapist factors believed to engender deeper levels of engagement, the emphasized aspects of the construct (in light of the importance and frequency ratings), the therapist’s developmental trajectory, and the three positions of the therapist’s use of self (Rowan & Jacobs, 2002). Based on this exploration, six major findings seem most illuminating: (a) relational depth appears to represent a synergy of Rogers’ (1957, 1980, 1989) core conditions; (b) experiences of relational depth seem to be predicated on therapists’ intentional creation of a therapeutic structure and their deliberate use of specific counseling skills; (c) therapists seem to have developed the capacity to relate on deep levels after experiencing this type of engagement in their relationships with others (e.g., family members, therapists, supervisors, mentors, clients); (d) experiences of the transpersonal may perhaps set people on the path toward becoming therapists and eventually cultivating the capacity to engage on deeper levels; (e) relational depth seems to be trainable, though individuals must have some capacity

and desire; and, (f) relational depth appears to exist within and incorporate all three positions of the therapist's use of self. These discoveries will be further explored in the training implications and research recommendations section. It is important, however, to first note the limitations of the study.

### **Limitations**

There are a number of limitations that are important to acknowledge, including the definitional issues regarding the construct of relational depth, the reliance on nominations, the use of a limited sample, the participant attrition rate and possible participant fatigue, and the threats to validity within each phase of data collection.

First of all, researchers have noted the difficulty in defining and measuring the subjective and intrapsychic phenomenon of relational depth. In fact, many have stated that relational depth is ineffable (Cooper, 2013a; Knox, 2013; McMillan & McLeod, 2006). The participants in the study corroborated this assertion, with one person stating that perhaps it was difficult to name the clusters because the construct, as a whole, exists beyond language. This definitional issue presents a limitation in that the *experience* of inviting and facilitating moments of relational depth may exist in a realm difficult to capture with language as well. Thus, the statements and clusters may not fully capture the depth and transformative power of the construct. The lack of client data throughout the process was another limitation. Furthermore, the process of relational depth is inherently dyadic and *interactional* in nature (Knox, 2013), and clients' contributions to moments of relational depth were not taken into account.

Along with this, the nomination approach presents a limitation to the findings. The researcher sought nominations from eight counselor educators at one university. First, this is a rather small sample size, albeit considered sufficient for concept mapping (Kane & Trochim, 2007). Second, these individuals were all counselor educators (limiting representativeness of other mental health disciplines) and they were all located at one university (limiting representativeness of various universities and locations). Third, the researcher assumed that these individuals would understand the construct of relational depth and have the ability to recognize its capacity in others.

Beyond the nominations, other sampling limitations exist. The individuals who were nominated were asked to contact the researcher if they wanted to participate in the study. It is unknown how participants may have differed systematically from those nominated participants who chose not to do so. Participants answered a number of preliminary questions – one of which was a screening question asking them if they had experienced a moment of relational depth with a client. Although the researcher attempted to define and fully describe the construct in this screening question, the participants may have wanted to respond in a socially-desirable way. There was no external verification that all of the participants in the study actually experienced such a moment. Furthermore, the attrition in the sample sizes across data phases (20, 18, and nine, respectively) and the limited diversity (especially with regard to ethnicity) of the sample pose threats to external validity. Finally, the requirement that participants work within a 30-mile radius of the research location presents concerns regarding the generalizability of the results.

Beyond the initial construct and sampling limitations, various issues arose throughout each phase of data collection. In the first phase of data collection (generating the statements), participants could have become fatigued with the expansiveness of the task. Furthermore, when editing and synthesizing the statements, the researcher could not obtain clarification from the participants to ensure that the statements accurately represented their thoughts. Additionally, it is possible that some of the breadth of the construct could have been lost in the distillation process.

Even more than in the first phase of data collection, the participants could have suffered from participant fatigue in the second phase of data collection (sorting and rating the statements). Furthermore, in aggregating participants' responses, some of the individual conceptualizations of the clusters and ratings were surely lost. Along with this issue, although the researcher sought external validation in choosing the number of clusters and associated items, the final decision was ultimately a subjective endeavor.

Limitations exist in the third phase of data collection as well. First of all, only nine therapists participated in the third phase, and they were tasked with naming the clusters and discussing the overall results. Because the number of participants in this phase represents less than half of the original sample (20 participants), the results could be biased based on their idiosyncratic opinions.

Taken together, it is important that when reporting these results researchers carefully consider the inherent limitations of the study. To improve the robustness of the study, future researchers are encouraged to replicate the methodology using a larger and

more diverse sample. Other suggestions for future researchers and implications for educators and supervisors are offered in the following section.

### **Implications for Training and Recommendations for Future Research**

In the process of conducting this study, a number of implications arose for educators, supervisors, and relational depth researchers. These are organized below as follows: (a) implications for educators and supervisors and (b) recommendations for relational depth researchers. Both of these sections are based on nine participants' recommendations and the six major results of the study.

### **Implications for Educators and Supervisors**

Based on participants' suggestions and the six major results of the study, seven implications are offered for educators and supervisors: (a) encouraging students to seek personal counseling; (b) establishing strong supervisory and mentoring relationships with students; (c) encouraging students to learn more about themselves, their relationships, and the developmental process of intentionally inviting relational depth; (d) teaching students how to intentionally structure sessions and deliberately use counseling skills to invite depth; (e) emphasizing the power of the synergistic effects of the core conditions; (f) teaching students about the three positions of the therapist's use of self (Rowan & Jacobs, 2002); and (g) helping students connect with and reflect upon deep and profound (perhaps transpersonal) experiences.

First, because many of the participants reported that they learned the capacity to relate on deeper levels with clients after *being* clients themselves, it follows that encouraging students to seek their own counseling would be an advantageous

recommendation. Participants also noted the impact that strong relational encounters (e.g., with family members, supervisors, mentors, therapists, clients) had on their journeys toward developing the capacity to invite and facilitate moments of relational depth with clients. Thus, it would be advantageous for educators and supervisors to develop strong relationships with students, encourage them to reflect upon significant relational encounters they have experienced in the past, and help them consider ways that these encounters might relate to the development of relational depth. Additionally, experiential pedagogical approaches (e.g., eye contact maintenance activity, back-to-back breath exercise) might be used in supervision and in the classroom to put students in closer psychological contact with other students, which might facilitate some of these developmental encounters.

The fourth, fifth, and sixth implications center on the skills and ways of being that educators and supervisors can help students learn. First, participants considered the abilities to intentionally structure sessions and deliberately use counseling skills important components of relational depth. Thus, educators and supervisors could emphasize the importance of learning how to structure sessions and use counseling skills. In an effort to teach students the more ephemeral aspects of the therapeutic encounter, some educators may neglect the foundational elements of counseling. Similar to the way in which an accomplished musician needs to first learn the musical scales before composing a masterpiece, perhaps the developing therapist needs to first learn the counseling skills and structuring before engaging in relational depth. At the same time, educators and supervisors are encouraged to balance these teachings with an emphasis on

the power of Rogers' (1957, 1980, 1989) basic core conditions. Helping students understand the importance of both these aspects of *doing* effective therapy and *being* an effective therapist may require that educators and supervisors teach them the three positions of the therapist's use of self (Rowan & Jacobs, 2002). Students could situate themselves inside these positions and develop greater self-awareness of their professional and personal development.

The final implication extends from the therapist's use of self (Rowan & Jacobs, 2002). Participants stated that they learned the capacity to engage on deeper levels with clients after experiencing transformative experiences in their own lives. Furthermore, when discussing the developmental trajectory of the therapist's use of self (from instrumental to authentic to transpersonal), the participants hypothesized that perhaps early experiences of the transpersonal may have led them into helping professions. To capitalize upon this insight, it would be beneficial for educators and supervisors to help students connect with and reflect upon deep and profound (perhaps transpersonal) experiences in their lives. These experiences could serve as bridges to help them understand the *feeling* of a deeper level of personal engagement. Taken together, the seven implications appear to be promising future endeavors to further mental health training, supervision, and practice. Described below, the suggestions for relational depth researchers appear promising as well.

### **Recommendations for Relational Depth Researchers**

After considering the participants' recommendations and the six major findings of the study, nine recommendations are offered for relational depth researchers: (a) exploring

the apparent sequential nature of relational depth; (b) validating the counseling microskills associated with relational depth; (c) determining whether or not relational depth can be trained and what relational depth *capacity* actually means; (d) investigating the ways that therapists learn elements of relational depth (e.g., intuition, confidence); (e) further exploring the transpersonal nature of relational depth; (f) further researching the ways in which relational depth reflects the three positions of the therapist's use of self (Rowan & Jacobs, 2002); (g) researching the experience of relational depth across other settings and relationships; (h) establishing a quantitative assessment of relational depth grounded in the findings of this study, and; (i) further exploring the dimensions of the multidimensional scaling point map.

The first two suggestions are centered on the process of relational depth experiences. First, participants wondered about the apparent sequential nature of inviting moments of relational depth – beginning with a focus on the self to an eventual focus on the client. The sequential nature they hypothesized somewhat mirrors the series of micro-processes inherent in a moment of relational depth (Knox, 2013; see Chapter Two). In actuality, however, their conceptualizations of it more closely represent the research on therapeutic presence. Geller and Greenberg (2002) outlined a model of therapeutic presence that includes three phases: preparing the ground for presence (e.g., clearing a space, bracketing, engaging in personal growth, practicing presence in life, meditating), experiencing the process of presence (e.g., opening to the client, listening with the “third ear” [p. 76]), inwardly attending, responding intuitively, acting congruently), and experience presence as a whole (e.g., being absorbed in the experience, feeling a sense of

spaciousness and expansion, being grounded, experiencing awe and love). These descriptions parallel the emergent clusters in this study – from intentionally structuring, practicing emotional presence, and being emotionally present to tuning in, offering genuine connection, using engagement skills, bringing immediacy, and attending with focus to honoring the client and facilitating intimate connection. At this point, therapeutic presence has been considered a *subset* of relational depth; however, perhaps relational depth is a *subset* of therapeutic presence. Moreover, perhaps these concepts represent the same ineffable construct. Exploring the apparent sequential nature of relational depth as compared to something like therapeutic presence and verifying the counseling microskills associated with each step in the sequence would advance the relational depth research. Such an endeavor could be achieved by engaging in process-oriented research – perhaps viewing multiple videos of relational depth and discerning common elements in the process and therapists’ associated skills.

The third and fourth suggestions explore whether or not relational depth capacity can be trained and, moreover, how therapists learn elements of relational depth (e.g., intuition, confidence). Future researchers could first conduct qualitative analyses, asking participants to more specifically describe their experiences of deeper engagement and ways in which these can be translated to counseling pedagogy. Additionally, researchers could explore participants’ definitions of what relational depth *capacity* actually means in order to inform therapist development and pedagogy. From there, researchers could create and teach associated curricula, and design experimental studies intended to explore the effects of these teachings.

Moving onward, the fifth and sixth suggestions are centered on the exploration of the transpersonal nature of relational depth and, furthermore, the ways in which the construct reflects the three positions of the therapist's use of self (Rowan & Jacobs, 2002). To investigate these questions, researchers could use qualitative analyses to explore participants' specific experiences of the transpersonal nature of relational depth. Alternately, researchers could give therapists various measures of transpersonal constructs (such as measures of spiritual openness, transcendence, etc.) and correlate these with scores on the Relational Depth Inventory - Revised 2 (RDI-R2; Wiggins, 2013). Finally, to explore and validate the ways that relational depth exists within the three positions of the therapist's use of self, researchers could design studies that quantitatively examine both relational depth and the positions of therapist's use of self.

Additionally, future researchers could explore the ways that relational depth is experienced in other settings and relationships. Many of the participants stated that they learned the capacity to engage on deeper levels from their relationships with others (e.g., family members, supervisors, mentors). Future researchers could conduct qualitative studies aimed at exploring the idiosyncrasies of these experiences across a variety of relationships. Results could then be compared to relational depth in therapeutic relationships, to further understand the nature of the construct.

Finally, per the eighth and ninth suggestions, the results of this study could be used to inform the development of a quantitative research instrument to measure relational depth from the therapist's perspective. Such an instrument, constructed through factor analytic procedures on existing items and exploration of the two multidimensional

scaling point map dimensions, would serve to launch additional research on the construct of relational depth. The results of this concept mapping study not only proved illuminating; they also raise many more questions and offer numerous directions for educators, supervisors, and researchers. At this point, the possibilities for future exploration are vast and promising.

### **Conclusion**

William James once stated, “We are like islands in the sea, separate on the surface but connected in the deep” (Goodreads Inc., 2015, para. 1). The purpose of this study was to investigate those touchstones that facilitate movement beyond isolation and into deeper therapeutic connections. More specifically, the researcher sought to explore the therapist factors that contribute to the ability to invite and facilitate moments of relational depth. Ten clusters emerged, which somewhat reflect the tenets of Person-Centered Therapy (Rogers, 1957, 1980, 1989), the three positions of the therapist’s use of self (Rowan & Jacobs, 2002), and the research on relational depth. The six major results of the study lead to a number of implications for educators, supervisors, and researchers. Capitalizing upon the results of the study, those engaged in mental health professions may truly begin to discern the ways in which humans connect on deeper and more profound levels, and discover methods of systematically enhancing the therapeutic process.

## REFERENCES

- American Psychological Association (APA). (2014). Stress in America™: Are teens adopting adults' stress habits?. Retrieved April 19, 2014, from <http://www.apa.org/news/press/releases/stress/2013/stress-report.pdf>
- Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*, 755-768.  
doi:10.1002/jclp.20583
- Anderson, S. A., Sanderson, J., & Košutić, I. (2011). Therapist Use-of-Self Orientation Questionnaire: A reliability and validity study. *Contemporary Family Therapy: An International Journal, 33*, 364-383. doi:10.1007/s10591-011-9146-6
- Aponte, H. J., & Winter, J. E. (1987). The person and practice of the therapist: Treatment and training. *Journal of Psychotherapy & the Family, 3*(1), 85-111.  
doi:10.1300/J287v03n01\_10
- Baldwin, M. (1987). Interview with Carl Rogers on the use of the self in therapy. *Journal of Psychotherapy & The Family, 3*(1), 45-52.
- Barkham, M., Evans, C., Margison, F., McGrath, G., Mellor-Clark, J., Milne, D. & Connell, J. (1998). The rationale for developing and implementing core outcome batteries for routine use in service settings and psychotherapy outcome research. *Journal of Mental Health, 7*, 35-47.

- Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology, 53*(1), 26-35. doi:10.1037/0022-0167.53.1.26
- Buber, M. (1958). *I and thou*. New York, NY: Scribner.
- Bugental, J. F. T. (1987). *The art of the psychotherapist*. New York, NY: WW. Norton & Company.
- Cain, D. J. (2010). *Person-centered psychotherapies*. Washington, DC: American Psychological Association.
- Caracelli, V. J., & Greene, J. C. (1993). Data analysis strategies for mixed-method evaluation designs. *Educational Evaluation & Policy Analysis, 15*, 195-207.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*(1), 685-716.
- Cheon, H., & Murphy, M. J. (2007). The self-of-the-therapist awakened: Postmodern approaches to the use of self in marriage and family therapy. *Journal of Feminist Family Therapy: An International Forum, 19*, 1-16. doi:10.1300/J086v19n01\_01
- Cheung, P. K. H., & Pau, G. Y. K. (2013). Congruence and the therapist's use of self. In M. Baldwin (Ed.), *The use of self in therapy* (3rd ed.) (pp. 166-185). New York, NY: Routledge.
- Cooper, M. (2005a). Therapists' experiences of relational depth: A qualitative interview study. *Counselling & Psychotherapy Research, 5*, 87-95. doi:10.1080/17441690500211130

- Cooper, M. (2005b). Working at relational depth. *Therapy Today*, 16(8), 16-20.
- Cooper, M. (2007). Humanizing psychotherapy. *Journal of Contemporary Psychotherapy*, 37, 11-16. doi:10.1007/s10879-006-9029-6
- Cooper, M. (2013a). Experiencing relational depth in therapy: What we know so far. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 62-76). New York, NY: Palgrave MacMillan.
- Cooper, M. (2013b). Experiencing relational depth: Self-development exercises and reflections. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 137-152). New York, NY: Palgrave MacMillan.
- Cox, S. (2009). Relational depth: Its relevance to a contemporary understanding of person-centered therapy. *Person-Centered and Experiential Psychotherapies*, 8, 208-223.
- Crits-Christoph, P., Baranackie, K., Kurcias, J. S., & Beck, A. T. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research*, 1(2), 81-91. doi:10.1080/10503309112331335511
- David, A. B., & Erickson, C. A. (1990). Ethnicity and the therapist's use of self. *Family Therapy*, 17, 211-216.
- Ehrenberg, D. B. (1974). The intimate edge in therapeutic relatedness. *Contemporary Psychoanalysis*, 10, 423-437.
- Ehrenberg, D. B. (2010). Working at the 'intimate edge.' *Contemporary Psychoanalysis*, 46, 120-141.

- Elliott, R., Shapiro, D. A., & Mack, C. (1999). Simplified personal questionnaire procedure manual. Toledo, Ohio: University of Toledo, Department of Psychology.
- Fosha, D. (2000). *The transforming power of affect: A model of accelerated change*. New York, NY: Basic Books.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.
- Freire, E. & Cooper, M. (2007). The Strathclyde Inventory: validation of a person-centred outcome measure. Paper presented at BACP Research Conference, Birmingham, UK.
- Frzina, J. (2012). A case study exploring experience of relational depth between therapist and client in a single session recorded during a skills practice. *Counselling Psychology Review, 27*, 52-62.
- Geller, S. M. (2013). Therapeutic presence as a foundation for relational depth. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 175-184). New York, NY: Palgrave MacMillan.
- Geller, S. M., & Greenberg, L. S. (2002). Therapeutic presence: Therapists' experience of presence in the psychotherapy encounter. *Person-Centered and Experiential Psychotherapies, 1*, 71-86.
- Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic presence: A mindful approach to effective therapy*. Washington, DC: American Psychological Association.

- Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 13*, 155-243. doi:10.1177/0011000085132001
- Goodreads Inc. (2015). "William James Quotes." Retrieved January 19, 2015, from <http://www.goodreads.com/quotes/837455-we-are-like-islands-in-the-sea-separate-on-the>
- Goodyear, R. K., Tracey, T. G., Claiborn, C. D., Lichtenberg, J. W., & Wampold, B. E. (2005). Ideographic concept mapping in counseling psychology research: Conceptual overview, methodology, and an illustration. *Journal of Counseling Psychology, 52*, 236-242. doi:10.1037/0022-0167.52.2.236
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors?. *Professional Psychology: Research and Practice, 21*(5), 372-378. doi:10.1037/0735-7028.21.5.372
- Groesbeck, C. (1975). The archetypal image of the wounded healer. *Journal of Analytical Psychology, 20*, 122-145.
- Haber, R. (1990). From handicap to handy capable: Training systemic therapists in use of self. *Family Process, 29*, 375-384. doi:10.1111/j.1545-5300.1990.00375.x
- Hart, T. (1997). Transcendental empathy in the therapeutic encounter. *The Humanistic Psychologist, 25*, 245-270. doi:10.1080/08873267.1997.9986885
- Hart, T. (1999). The refinement of empathy. *Journal of Humanistic Psychology, 39*(4), 111-125. doi:10.1177/0022167899394007

- Hatcher, R., & Gillaspay, J. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*, 12-25.  
doi:10.1080/10503300500352500
- Hawkins, S. (2013). Working at relational depth with children and young people. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 79-89). New York, NY: Palgrave MacMillan.
- Hess, A. K. (1986). Growth in supervision: Stages of supervisee and supervisor development. *The Clinical Supervisor, 4*(1-2), 51-67.  
doi:10.1300/J001v04n01\_04
- Hesse, H. (1951). *Siddhartha*. New York, NY: New Directions Publishing.
- Hogan, R. A. (1964). Issues and approaches in supervision. *Psychotherapy: Theory, Research & Practice, 1*(3), 139-141. doi:10.1037/h0088589
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.) (pp. 25-69). New York, NY: Oxford University Press.
- Hycner, R. H. (1985). Dialogical Gestalt therapy: An initial proposal. *Gestalt Journal, 8*, 23-49.
- Hycner, R. A. (1990). The I-thou relationship and Gestalt therapy. *Gestalt Journal, 13*, 41-54.
- IBM Corp. (2013). IBM SPSS statistics for windows, Version 22.0. Armonk, NY: IBM Corp.

- Jennings, L., Goh, M., Skovholt, T. M., Hanson, M., & Banerjee-Stevens, D. (2003). Multiple factors in the development of the expert counselor and therapist. *Journal of Career Development, 30*, 59-72. doi:10.1023/A:1025177608990
- Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology, 46*(1), 3-11.
- Kane M., & Trochim, W. M. K. (2007). *Concept mapping for planning and evaluation*. Thousand Oaks, CA: Sage.
- Knox, R. (2008). Clients' experiences of relational depth in person-centred counselling. *Counselling & Psychotherapy Research, 8*, 182-188.  
doi:10.1080/14733140802035005
- Knox, R. (2013). Relational depth from the client's perspective. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 21-35). New York, NY: Palgrave MacMillan.
- Knox, R., & Cooper, M. (2010). Relationship qualities that are associated with moments of relational depth: The client's perspective. *Person-Centered and Experiential Psychotherapies, 9*, 236-256.
- Knox, R., & Cooper, M. (2011). A state of readiness: An exploration of the client's role in meeting at relational depth. *Journal of Humanistic Psychology, 51*, 61-81.  
doi:10.1177/0022167810361687
- Knox, R., Murphy, D., Wiggins, S., & Cooper, M. (Eds.) (2013a). *Relational depth: New perspectives and developments*. New York, NY: Palgrave MacMillan.

- Knox, R., Wiggins, S., Murphy, D., & Cooper, M. (2013b). Introduction: The in-depth therapeutic encounter. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 1-10). New York, NY: Palgrave MacMillan.
- Koehne-Kaplan, N. S. (1976). The use of self as a family therapist. *Perspectives in Psychiatric Care, 14*, 29-33. doi:10.1111/j.1744-6163.1976.tb00872.x
- Kramer, C. H. (2013). Revealing our selves. In M. Baldwin (Ed.), *The use of self in therapy* (3rd ed.) (pp. 36-63). New York, NY: Routledge.
- Lago, C., & Christodoulidi, F. (2013). Client-therapist diversity: Aspiring towards relational depth. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 101-113). New York, NY: Palgrave MacMillan.
- Lambers, E. (2006). Supervising the humanity of the therapist. *Person-Centered and Experiential Psychotherapies, 5*, 266-276.
- Lambers, E. (2013). Supervision and relational depth: A companion on the journey. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 125-136). New York, NY: Palgrave MacMillan.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*, 357-361. doi:10.1037/0033-3204.38.4.357

- Laska, K. M., Gurman, A. S., & Wampold, B. E. (2013). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy*, doi:10.1037/a0034332
- Levenson, E. A. (1981). The rhetoric of intimacy. *Group*, 5(4), 3-11.  
doi:10.1007/BF01456609
- Lum, W. (2002). The use of self of the therapist. *Contemporary Family Therapy: An International Journal*, 24, 181-197. doi:10.1023/A:1014385908625
- Lyons-Ruth, K. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal*, 19, 282-289.  
doi:10.1002/(SICI)1097-0355(199823)19:3<282::AID-IMHJ3>3.0.CO;2-O
- Macleod, E. (2013). Therapists' experiences of relational depth with clients with learning disabilities. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 36-48). New York, NY: Palgrave MacMillan.
- Maslow, A. H. (1950). Self-actualizing people: A study of psychological health. *Personality, Symposium I*, 11-34.
- Maslow, A. H. (1969). Various meanings of transcendence. *Journal of Transpersonal Psychology*, 1, 56-66.
- McMillan, M., & McLeod, J. (2006). Letting go: The client's experience of relational depth. *Person-Centered and Experiential Psychotherapies*, 5, 277-292.
- Mearns, D. (1996). Working at relational depth with clients in Person-Centered Therapy. *Counselling*, 7, 306-311.

- Mearns, D. (1997). *Person-centred counselling training*. London: SAGE Publications Ltd. doi: <http://dx.doi.org/10.4135/9781446217290>
- Mearns, D. (2012). Forward. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.) (2013), *Relational depth: New perspectives and developments* (pp. vii-ix). New York, NY: Palgrave MacMillan.
- Mearns, D., & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*. London: Sage.
- Mearns, D., & Schmid, P. F. (2006). Being-with and being-counter: Relational depth: The challenge of fully meeting the client. *Person-Centered and Experiential Psychotherapies*, 5, 255-265.
- Miller, R. C. (1990). Projective identification and the therapist's use of self. *Journal of Contemporary Psychotherapy*, 20, 63-73. doi:10.1007/BF00946020
- Miller, G. D., & Baldwin, D. C. (1987). Implications of the wounded-healer paradigm for the use of the self in therapy. *Journal of Psychotherapy & The Family*, 3, 139-151. doi:10.1300/J287v03n01\_13
- Murphy, D., & Joseph, S. (2013). Facilitating posttraumatic growth through relational depth. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 90-100). New York, NY: Palgrave MacMillan.
- Norcross, J. C. (2001). Purposes, processes and products of the task force on empirically supported therapy relationships. *Psychotherapy: Theory, Research, Practice, Training*, 38, 345-356. doi:10.1037/0033-3204.38.4.345

- Norcross, J. C. (Ed.). (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press.
- Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.) (pp. 3-21). New York, NY: Oxford University Press.
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. In J. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.) (pp. 423-430). New York, NY: Oxford University Press.
- O'Leary, C. J. (2006). Carl Rogers: Lessons for working at relational depth. *Person-Centered and Experiential Psychotherapies*, 5, 229-239.
- Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy*, 10, 361-373. doi:10.1002/cpp.383
- Omylinska-Thurston, J., & James, P. E. (2011). The therapist's use of self: A closer look at the processes within congruence. *Counselling Psychology Review*, 26, 20-33.
- Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York, NY: John Wiley and Sons.

- Pagano, C. J. (2012). Exploring the therapist's use of self: Enactments, improvisation and affect in psychodynamic psychotherapy. *American Journal of Psychotherapy*, 66, 205-226.
- Piercy F. P., & Bao, A. K. (2013). Uses of self in therapeutic boundaries: Lessons from training and treatment. In M. Baldwin (Ed.), *The use of self in therapy* (3rd ed.) (pp. 97-108). New York, NY: Routledge.
- Price, S. (2012). *Development and testing of a measure of relational depth in counselling and psychotherapy*. (Doctoral thesis). Retrieved from author.
- Qualtrics. (2014). Retrieved June 1, 2014, from <http://www.qualtrics.com/>
- R Development Core Team. (2011). *R: A language and environment for statistical computing*. Vienna, Austria: R Foundation for Statistical Computing.
- Reupert, A. (2008). A trans-disciplinary study of the therapist's self. *European Journal of Psychotherapy and Counselling*, 10, 369-383. doi:10.1080/13642530802577125
- Rogers, C. R. (1942). *Counseling and psychotherapy: Newer concepts in practice*. Boston, MA: Houghton Mifflin.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103. doi:10.1037/h0045357
- Rogers, C. R. (1980). *A way of being*. New York, NY: Houghton Mifflin.
- Rogers, C. R. (1986). A client-centered/person-centered approach to therapy. In H. Kirschenbaum, & V. L. Henderson (Eds.) (1989), *The Carl Rogers reader* (pp. 135-152). Boston, MA: Houghton Mifflin.

- Rogers, C. R. (1989). *On becoming a person: A therapist's view of psychotherapy*. New York, NY: Houghton Mifflin.
- Rønnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development: Retrospective accounts of senior psychotherapists. *Professional Psychology: Research And Practice, 32*(2), 181-187. doi:10.1037/0735-7028.32.2.181
- Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*(1), 5-44.
- Rosas, S. R., & Kane, M. (2012). Quality and rigor of the concept mapping methodology: A pooled study analysis. *Evaluation and Program Planning, 35*, 236-245. doi:10.1016/j.evalprogplan.2011.10.003
- Rosenzweig, S. (2002). Some implicit common factors in diverse methods of psychotherapy. *Journal of Psychotherapy Integration, 12*(1), 5-9. doi:10.1037/1053-0479.12.1.5
- Rowan, J. (1998). Linking: Its place in therapy. *International Journal of Psychotherapy, 3*, 245-254.
- Rowan, J. (2013). The transpersonal and relational depth. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 208-216). New York, NY: Palgrave MacMillan.
- Rowan, J., & Jacobs, M. (2002). *The therapist's use of self*. Philadelphia, PA: Open University Press.

- Sanford, N. (1956). Surface and depth in the individual personality. *Psychological Review*, 63, 349-359. doi:10.1037/h0044110
- Siev, J., Huppert, J. D., & Chambless, D. L. (2009). The Dodo Bird, treatment technique, and disseminating empirically supported treatments. *The Behavior Therapist*, 32(4), 69, 71-76.
- Schmid, P. F., & Mearns, D. (2006). Being-with and being-counter: Person-centered psychotherapy as an in-depth co-creative process of personalization. *Person-Centered and Experiential Psychotherapies*, 5, 174-190.
- Skovholt, T. M., Jennings, L., & Mullenbach, M. (2004). Portrait of the master therapist: Developmental model of the highly functioning self. In T. M. Skovholt, & L. Jennings (Eds.), *Master therapists* (pp. 125-146). Boston, MA: Allyn & Bacon.
- Skovholt, T. M., & Rønnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling and Development*, 70, 505-515.
- Skovholt, T. M., Rønnestad, M., & Jennings, L. (1997). Searching for expertise in counseling, psychotherapy, and professional psychology. *Educational Psychology Review*, 9, 361-369. doi:10.1023/A:1024798723295
- Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York: W.W. Norton.
- Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology*, 28(1), 59-65. doi:10.1037/0022-0167.28.1.59

- Stoltenberg, C. D., & McNeill, B. W. (1997). Clinical supervision from a developmental perspective: Research and practice. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 184-202). New York: Wiley.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). Results from the 2012 national survey on drug use and health: Mental health findings. Retrieved April 19, 2014, from [http://www.samhsa.gov/data/NSDUH/2k12MH\\_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm](http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm)
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's national registry of evidence-based programs and practices. Retrieved May 3, 2014, from <http://www.nrepp.samhsa.gov/>
- Sullivan, M. F., Skovholt, T. M., & Jennings, L. (2005). Master therapists' construction of the therapy relationship. *Journal of Mental Health Counseling, 27*(1), 48-70.
- Tracey, T. G., Lichtenberg, J. W., Goodyear, R. K., Claiborn, C. D., & Wampold, B. E. (2003). Concept mapping of therapeutic common factors. *Psychotherapy Research, 13*, 401-413. doi:10.1093/ptr/kpg041
- Trochim, W. M. (1989a). An introduction to concept mapping for planning and evaluation. *Evaluation and Program Planning, 12*(1), 1-16. doi:10.1016/0149-7189(89)90016-5
- Trochim, W. M. (1989b). Concept mapping: Soft science or hard art?. *Evaluation and Program Planning, 12*(1), 87-110. doi:10.1016/0149-7189(89)90027-X

- Wagner, J., & Elliott, R. (2001). *The Simplified Personal Questionnaire*. Manuscript submitted for publication, Department of Psychology, University of Toledo.
- Walsh, R., & Vaughan, F. (Eds.). (1993). *Paths beyond ego: The transpersonal vision*. New York, NY: Penguin.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahway, NJ: Erlbaum.
- Wampold, B. E., & Bhati, K. S. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research and Practice*, *35*, 563-570. doi:10.1037/0735-7028.35.6.563
- Wampold, B. E., & Brown, G. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, *73*, 914-923. doi:10.1037/0022-006X.73.5.914
- Watson, G. (1940). Areas of agreement in psychotherapy: Section meeting, 1940. *American Journal of Orthopsychiatry*, *10*, 698-709. doi:10.1111/j.1939-0025.1940.tb05736.x
- Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., & ... Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. *The Lancet*, *382*(9904), 1575-1586. doi:10.1016/S0140-6736(13)61611-6
- Wiggins, S. (2013). Assessing relational depth: Developing the Relational Depth Inventory. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational*

- depth: New perspectives and developments* (pp. 49-61). New York, NY: Palgrave MacMillan.
- Wiggins, S., Elliott, R., & Cooper, M. (2012). The prevalence and characteristics of relational depth events in psychotherapy. *Psychotherapy Research*, 22, 139-158.
- Wilber, K. (1993). The spectrum of transpersonal development. In R. Walsh, & E. Vaughan, F. (Eds.), *Paths beyond ego: The transpersonal vision* (pp. 116-117). New York, NY: Penguin.
- Wilber, K. (2000). *A brief history of everything*. Boston, MA: Shambhala.
- Wilders, S. (2013). The Person-Centred approach: Similarities and differences with relational depth. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 196-207). New York, NY: Palgrave MacMillan.
- World Health Organization (WHO). (2013). 10 mental health facts. Retrieved April 19, 2014, from [http://www.who.int/features/factfiles/mental\\_health/mental\\_health\\_facts/en/](http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/)
- World Health Organization (WHO). (2008). Mental health gap action programme: Scaling up care for mental, neurological, and substance use disorders. Retrieved April 19, 2014, from [http://whqlibdoc.who.int/publications/2008/9789241596206\\_eng.pdf?ua=1](http://whqlibdoc.who.int/publications/2008/9789241596206_eng.pdf?ua=1)
- Wyatt, G. (2013). Group relational depth. In R. Knox, D. Murphy, S. Wiggins, & M. Cooper (Eds.), *Relational depth: New perspectives and developments* (pp. 101-113). New York, NY: Palgrave MacMillan.

- Young, J. S., & Cashwell, C. S. (2011). Integrating spirituality and religion into counseling: An introduction. In C. S. Cashwell & J. S. Young (Eds.), *Integrating spirituality and religion into counseling: A guide to competent practice* (2nd ed.) (pp. 1-24). Alexandria, VA: American Counseling Association.
- Zerubavel, N., & Wright, M. (2012). The dilemma of the wounded healer. *Psychotherapy, 49*, 482-491. doi:10.1037/a0027824

**APPENDIX A**  
**SITE APPROVAL**

Jodi Bartley has approval to collect her dissertation data within the Department of Counseling and Development. She intends to utilize a peer nomination approach to identify subjects by asking CED faculty to suggest study participants. This approach is acceptable and supported by the department.

Dr. Scott Young, Department Chair

---

--

***J. Scott Young, PhD, Professor and Chair***

Department of Counseling and Educational Development

The University of North Carolina at Greensboro

222 Curry Building / PO Box 26170 / Greensboro, NC 27402-6170

Office: 336-334-3464 / Fax:336-334-3433 / Email: [jsyoung3@uncg.edu](mailto:jsyoung3@uncg.edu)

Office Managers Phone: 336-334-3423

Visit us on Facebook at: <http://www.facebook.com/pages/UNCG-Department-of-Counseling-and-Educational-Development/306293056090011>

## APPENDIX B

### IRB APPROVAL



THE UNIVERSITY of NORTH CAROLINA  
**GREENSBORO**

**OFFICE OF RESEARCH INTEGRITY**  
2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
336.256.0253  
Web site: [www.uncg.edu/orc](http://www.uncg.edu/orc)  
Federalwide Assurance (FWA) #216

**To:** Jodi Bartley  
Counsel and Ed Development  
228 Curry Building, PO Box 26170, Greensboro, NC 27402

**From:** UNCG IRB

Authorized signature on behalf of IRB

**Approval Date:** 8/20/2014  
**Expiration Date of Approval:** 8/19/2015

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)  
**Submission Type:** Initial  
**Expedited Category:** 7.Surveys/interviews/focus groups  
**Study #:** 14-0227

**Study Title:** Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

#### **Study Description:**

The purpose of the study is to use concept mapping to explore counselors' conceptualizations of the counselor factors that contribute to their ability to invite and facilitate moments of relational depth with clients. After an initial small scale pilot study (conducted with two doctoral students at UNCG to test research process), three phases of data collection will be instituted: generating the statements, sorting and rating the statements, and interpreting the concept maps. Resultant implications will be used to inform relational depth research and counselor training and supervision.

#### **Regulatory and other findings:**

- This research meets criteria for waiver of a signed consent form according to 45 CFR 46.117(c)(2).

#### **Investigator's Responsibilities**

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the

modification application available at <http://integrity.uncg.edu/institutional-review-board/>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website.

Please be aware that valid human subjects training and signed statements of confidentiality for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found [http://policy.uncg.edu/research\\_data/](http://policy.uncg.edu/research_data/).

CC:  
Craig Cashwell, Counsel and Ed Development

## APPENDIX C

### NOMINATION SCRIPT E-MAIL

Dear *Name*:

Hello, I am writing to ask you to nominate prospective participants for my dissertation study. You are being asked to serve as a nominator because you are currently a counselor educator at The University of North Carolina at Greensboro. Please note that should you choose to participate, I will not identify you in any way nor will I have the capability to identify who you chose to nominate.

The study I am conducting is titled “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth,” and it is directed by Dr. Craig S. Cashwell. The purpose of the study is to explore the therapist factors that contribute to therapists’ ability to invite and facilitate moments of relational depth with clients.

As mentioned, I am seeking your assistance to identify prospective therapist participants. In order to be eligible to participate, participants must:

- (a) be at least 18 years of age,
- (b) work approximately within a 30-mile radius of the principal investigator’s location (Greensboro, NC),
- (c) possess a master’s degree in a mental health profession (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling), and
- (d) have experienced a moment of relational depth with a client.

**It is the final criterion – identifying therapists who may have experienced moments of relational depth with clients – where I most need your assistance.**

To help you identify prospective participants, let me define and attempt to describe relational depth for you. Relational depth has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level” (Mearns & Cooper, 2005, p. xii). It typically occurs in discrete moments of profound connection with another person (Knox, Wiggins, Murphy, & Cooper, 2013; Mearns & Cooper, 2005). These relationally-deep moments are characterized by a synergy of Rogers’ (1980) core conditions of empathy, genuineness, and unconditional positive regard (Knox et al., 2013; Mearns & Cooper, 2005).

Here is an example description of relational depth: A client finds the courage to share her buried guilt and shame over her secret, sexually promiscuous behavior as a teenager. In

response, the counselor empathizes with the client and responds with deep acceptance and compassion – fully embracing the client in her struggle. In a shared moment of eye contact, the client knows that her counselor truly feels the depth of her pain and fully accepts her as a person. With no words being spoken, they share in a deep moment of genuine connection.

Based on the eligibility criteria, the definition, and the description of relational depth, I ask that you nominate up to seven potential participants by contacting them, informing them of the study, and providing them with my contact information. To make this as simple as possible for you, I have attached to this e-mail a script that you can cut and paste into an e-mail to each potential participant. You will only need to add their name at the beginning and your name at the end to invite each participant.

Thank you very much for your time and consideration. I really appreciate it!

Sincerely,  
Jodi L. Bartley

Enc: Snowball sampling script

## APPENDIX D

### SNOWBALL SAMPLING SCRIPT

Dear *Name*:

I am contacting you because I would like to nominate you to participate in a study titled “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.” (If you have already received a similar e-mail from another person, this means that more than one nominator has nominated you).

The purpose of the study is to use concept mapping to explore therapists' conceptualizations of the therapist factors that contribute to the ability to invite and facilitate moments of relational depth with clients. The primary researcher of the study is Jodi L. Bartley, and she is currently a doctoral student at The University of North Carolina at Greensboro.

I identified you as someone who may have experienced moments of relational depth with your clients and, as such, someone who can contribute to research in this area. To eligible to participate, you must (a) be at least 18 years of age, (b) work approximately within a 30-mile radius of the principal investigator's location (Greensboro, NC), (c) possess a master's degree in a mental health profession (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling), and (f) have experienced a moment of relational depth with a client.

Relational depth has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level” (Mearns & Cooper, 2005, p. xii). It typically occurs in discrete moments of profound connection with another person (Knox, Wiggins, Murphy, & Cooper, 2013; Mearns & Cooper, 2005). These relationally-deep moments are characterized by a synergy of Rogers' (1980) core conditions of empathy, genuineness, and unconditional positive regard (Knox et al., 2013; Mearns & Cooper, 2005).

Here is an example description of relational depth: A client finds the courage to share her buried guilt and shame over her secret, sexually promiscuous behavior as a teenager. In response, the counselor empathizes with the client and responds with deep acceptance and compassion – fully embracing the client in her struggle. In a shared moment of eye contact, the client knows that her counselor truly feels the depth of her pain and fully accepts her as a person. With no words being spoken, they share in a deep moment of genuine connection.

The study includes three phases of data collection: generating the statements, sorting and rating the statements, and interpreting the results. Your expected time commitment for this is approximately three hours total, spread over several months. If you would like more information about the study or would be willing to participate, please e-mail the primary researcher, Jodi L. Bartley, at [jlbart12@uncg.edu](mailto:jlbart12@uncg.edu)

Thank you very much for your time and consideration!

*Your Name*

## APPENDIX E

### INITIAL CONTACT E-MAIL

Dear *Name*:

Thank you for contacting me to participate in my study titled “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.” It is exciting to work with individuals who have been nominated by their peers as therapists who may have experienced moments of relational depth with clients.

To provide you with background information, my name is Jodi L. Bartley, and I am a doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro. As part of my dissertation, directed by Dr. Craig S. Cashwell, I am conducting a study exploring the therapist factors that contribute to a therapist’s ability to invite and facilitate moments of relational depth with clients. To recruit participants, I asked counselor educators and therapists to identify and contact individuals who they believe have experienced moments of relational depth with clients.

To be eligible to participate in the study, you must (a) be at least 18 years of age, (b) work approximately within a 30-mile radius of the research site (Greensboro, NC), and (c) possess a master’s degree in a mental health profession (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling). Finally, to be included in all three phases of data collection, you must have experienced a moment of relational depth with a client.

If you meet the eligibility criteria, you will be asked to participate in three phases of data collection. In the first phase of data collection, you will be asked to consent to participate in the study, complete a demographic form, provide your contact information (for future follow-up contact), generate statements, and send information about the study to other therapists who you would nominate to participate in the study as well (you may copy the “Snowball Sampling Script” attached to this e-mail). You are not required to nominate additional participants.

In the second phase of data collection, I will mail you sorting and rating materials, and you will be asked to sort and rate the statements that you previously generated and return to me via mail. In the final phase of data collection, you will be invited to participate in a face-to-face 1.5-hour focus group on the UNCG campus to interpret the resultant concept maps. All together, the three phases of data collection should take approximately three hours of your time.

Before you consent to participate in the study, it is important that you are apprised of all of the risks and benefits of the study, as well as procedures for maintaining

confidentiality. I have attached the research consent form for you to read and keep as part of your records. This consent form is also embedded in the online Qualtrics site, and you will be required to consent online before participating in the study.

If you are willing to participate in the study, please click on the following link to participate in the first phase of data collection:

[https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV\\_eSgwbdCT8Itg3Zz](https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_eSgwbdCT8Itg3Zz)

If you have any questions or concerns, please feel free to contact me, Jodi L. Bartley, at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my Dissertation Chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Thank you so much for your consideration!

Sincerely,  
Jodi L. Bartley

Enc: Research consent form; Snowball sampling script

## APPENDIX F

### RESEARCH CONSENT FORM

#### RESEARCH CONSENT FORM

#### UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

#### CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth

Principal Investigator: Jodi L. Bartley  
Faculty Advisor: Dr. Craig S. Cashwell

#### **What are some general things you should know about research studies?**

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or The University of North Carolina at Greensboro.

Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

As part of the initial e-mail to you, you will be given a copy of this consent form. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

#### **What is the study about?**

This is a research project. Your participation is voluntary. The purpose of the study is to use concept mapping to explore therapists' conceptualizations of the therapist factors that contribute to their ability to invite and facilitate moments of relational depth with clients.

#### **Why are you asking me?**

You are being asked to participate in the study because it is believed that you may have experienced moments of relational depth with clients. In order to participate in the study, you must (a) be at least 18 years of age, (b) work approximately within a 30-mile radius of the research site (Greensboro, NC), and (c) possess a master's degree in a mental health profession (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling). Finally, to be included in all three phases of data collection, you must have experienced a moment of relational depth with a client.

UNCG IRB  
Approved Consent Form  
Valid from:  
10/16/14 to 8/19/15

**What will you ask me to do if I agree to be in the study?**

If you agree to be involved in the study, you may be asked to participate in up to three phases of data collection, which will take a total of approximately three hours of your time. (If you do not meet the screening criteria, you will not be eligible to participate in the second and third phases of data collection.) In the first phase of data collection, you will be asked to complete a demographic form, provide your contact information for follow-up data collection, generate statements about the factors that contribute to your ability to invite and facilitate moments of relational depth, and if you choose, send information about the study to other therapists who may be eligible. You are not required to nominate other individuals. This phase should take approximately 30 minutes.

In the second phase of data collection, you will receive a manila envelope in the mail that includes statement cards and two rating sheets. You will be asked to sort the statements in a way that makes sense to you and rate the statements based on their importance in contributing to relationally-deep moments and how often you practice these factors in your work with clients. This phase should take approximately one hour.

In the third phase of data collection, you will be invited to participate in a focus group where you will interpret the resultant concept maps. During the focus group, a member of the research team will document your responses. The statements that you provide will be used anonymously to contextualize the findings. The focus group should take approximately one and a half hours.

Relational depth is considered a profound moment of connection, and reflecting upon such intense moments may cause some feelings of vulnerability. If you feel any emotional distress, you are encouraged to seek counseling with a qualified professional. The following database of counselors may be helpful:  
<http://www.nbcc.org/CounselorFind>

If you have any questions about the study, you are encouraged to contact the principal investigator, Jodi L. Bartley, at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu)

**Is there any audio/video recording?**

There will be no audio/video recording involved in this study. However, you should know that in the third round of data collection (the focus group), a member of the research team will take notes of the session. Although these notes will not include identifying information, specific statements that you voice may be used to contextualize the findings.

**What are the risks to me?**

The Institutional Review Board at The University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. As mentioned above, relational depth is characterized by a profound moment of connection with another person. Reflecting upon such moments may be emotionally triggering. Although this is a minimal risk, you are encouraged to seek counseling from a qualified

UNCG IRB  
Approved Consent Form  
Valid from:

10/16/14 to 8/19/15

professional if you feel any emotional distress. You may use the following database to locate a professional: <http://www.nbcc.org/CounselorFind>

If you have questions, want more information or have suggestions, please contact Jodi L. Bartley (principal investigator) at [jlbartl2@uncg](mailto:jlbartl2@uncg) or Dr. Craig Cashwell (faculty advisor) at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

**Are there any benefits to society as a result of me taking part in this research?**

Society may benefit from this research study. The therapeutic relationship has proven critical to client outcome, and society may be directly benefited from exploring the therapist factors that contribute to the depth of relational connection. Furthermore, learning more about the factors that contribute to therapists' ability to invite and facilitate moments of relational depth with clients could provide implications for research, therapist training, and supervision. Based on the findings, researchers and educators could further explore the ways in which mental health professionals use themselves in order to establish deep connections with clients.

**Are there any benefits to *me* for taking part in this research study?**

There are no direct benefits to participants in this study. However, you may experience the intangible benefit of having the opportunity to converse with your peers about the therapist factors of relational depth.

**Will I get paid for being in the study? Will it cost me anything?**

There are no costs to you or payments made for participating in this study.

**How will you keep my information confidential?**

All information obtained in this study is strictly confidential unless disclosure is required by law. Electronic information will be kept on the principal investigator's password-protected computer and physical copies of materials will be kept secure in a locked box. When sharing results with other team members, all information will be de-identified.

The first phase of data collection will be done through an Internet site called Qualtrics. It is important that you know that absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. Additionally, I will ask for your contact information in the first phase of data collection. Your name and contact information will be kept in a separate file from the data that you provide, which will be identified only by a number.

In the second phase of data collection, I will mail you an envelope with the sorting and rating materials. The data that you provide from this process will be entered into the

UNCG IRB  
Approved Consent Form  
Valid from:  
10/16/14 to 8/19/15

computer in a de-identified state, and resultant concept maps will be aggregated representations of yours and other participants' conceptualizations.

In the third phase of data collection, you will be asked to participate in a face-to-face focus group. During this time, a member of the research team will document your and other participants' interpretations of the concept maps. When reporting these results, no names or identifying information will be used. Please note that confidentiality cannot be secured in a group setting; however, all participants will be encouraged not to share the information outside of the group.

After the study is complete, your name and contact information will be deleted. The de-identified data will be kept for a minimum of one year.

**What if I want to leave the study?**

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

**What about new information/changes in the study?**

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

**Voluntary Consent by Participant:**

By completing this activity, you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By completing this activity, you are agreeing that you are 18 years of age or older and are agreeing to participate, or have the individual specified above as a participant participate, in this study described to you by Jodi L. Bartley.

UNCG IRB  
Approved Consent Form  
Valid from:

10/16/14 to 8/19/15

## APPENDIX G

### DEMOGRAPHIC INFORMATION

Please provide the following demographic information.

1. Age:
2. Gender:
3. Race/ethnicity:
4. Sexual orientation:
5. Spiritual/religious background (e.g., Atheist, Buddhist, Christian):
6. What is your primary theoretical orientation (e.g., Person-Centered, Cognitive-Behavioral)?:
7. In what type of practice setting do you currently work (e.g., private practice, hospital)?:
8. What is the city location of your place of employment (e.g., Greensboro, Winston-Salem)?:
9. Did you earn a master's degree in a mental health profession (e.g., mental health counseling, social work, marriage and family therapy, clinical psychology, pastoral counseling)?: Yes/No
10. Are you currently licensed as a mental health professional in the state of North Carolina or in another state?: Yes/No
11. How many years of post master's-level counseling experience do you have?:
12. This study purports to study the phenomenon of relational depth. Relational depth has been defined as "a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level" (Mearns & Cooper, 2005, p. xii). It typically occurs in discrete moments of profound connection with another person (Knox, Wiggins, Murphy, & Cooper, 2013; Mearns & Cooper, 2005). These relationally-deep moments are characterized by a synergy of Rogers' (1980) core conditions of empathy, genuineness, and unconditional positive regard (Knox et al., 2013; Mearns & Cooper, 2005).

Example description: A client finds the courage to share her buried guilt and shame over her secret, sexually promiscuous behavior as a teenager. In response, the counselor empathizes with the client, responding with deep acceptance and compassion – fully embracing the client in her struggle. In a shared moment of eye contact, the client knows that her counselor truly feels the depth of her pain and fully accepts her as a person. With no words being spoken, they share in a deep moment of genuine connection.

Have you experienced a moment of relational depth with a client?: Yes/No

- \*\* I would like to request that you nominate other individuals to participate in this study. You may do so by sending them information about the study (see the IRB-approved “Snowball Sampling Script”) and directing them to contact Jodi L. Bartley if they are interested. Please note that you are not required to nominate others.

## APPENDIX H

### GENERATING THE STATEMENTS INSTRUCTIONS

For my study, I am exploring the phenomenon of relational depth. Relational depth has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level” (Mearns & Cooper, 2005, p. xii).

Please take a moment to reflect on your counseling career thus far and the clients that you have counseled. Identify one or more times when you feel as though you and a client have experienced a moment of deep connection. How did you do that? What do you believe contributed to your ability to invite and facilitate this moment of deepened connection with your client? You may consider who you are and/or what you do before and/or during these therapy sessions.

When you have identified a factor, please type it in one of the boxes in the form of a word or short phrase. Brainstorm as many factors as you can, but please limit each box to ***ONE*** factor or concept only. To guide you in this process, please use the following focus prompt:

**Either before or during counseling, one way I invite and facilitate moments of relational depth with clients is \_\_\_\_\_.**

## APPENDIX I

### SORTING AND RATING THE STATEMENTS E-MAIL

#### ELIGIBLE PARTICIPANTS

Dear *Name*:

Thank you very much for your participation in the first phase of data collection as part of the study “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.”

As part of the second phase of data collection, I will be sending you a manila envelope in the mail, which will include instructions and all of the materials needed to sort and rate the statements. I have also attached a copy of the sorting and rating instructions to this e-mail for you to review before beginning the task.

The sorting and rating process should take approximately one hour of your time. I ask that you please complete the task and return the materials (in the enclosed, stamped and self-addressed envelope) to me no later than **MONDAY, DECEMBER 8, 2014**.

If you have any questions or concerns, please feel free to contact me at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my dissertation chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Again, thank you very much for your time and willingness to participate in this study. I very much appreciate it!

Sincerely,  
Jodi L. Bartley

Enc: Sorting and rating instructions

#### NON-ELIGIBLE PARTICIPANTS

Dear \_\_\_\_\_ :

Thank you very much for your participation in the first phase of data collection as part of the study “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.”

At this point, you were not selected to participate in the final two phases of data collection. However, I very much appreciate your willingness to participate in generating the statements.

If you have any questions or concerns, please feel free to contact me at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my dissertation chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Again, thank you very much for your time and willingness to participate in the first phase of data collection.

Sincerely,  
Jodi L. Bartley

## APPENDIX J

### **SORTING AND RATING THE STATEMENTS INSTRUCTIONS**

Thank you very much for agreeing to participate in the study “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.”

There are two primary tasks involved in this portion of the study: (1) sorting the statements, and (2) rating the statements. Detailed instructions are provided below.

#### **(1) SORTING THE STATEMENTS:**

##### Materials included:

- 90 white pieces of paper with statements written on them
- 15 letter-sized envelopes (for grouping the statements)

Instructions: Inside of the manila envelope, you will find 90 small white pieces of paper with statements written on them and 15 letter-sized envelopes for sorting the statements. Please sort the statements (printed on the white cards) into groups in a way that makes sense to you. There are a few guidelines for this process: (a) each card may only be placed in one pile, (b) the cards may not all be placed in the same pile, and (c) each card cannot be its own pile.

Once you have grouped the statements, place each group of statements in a letter-sized envelope, seal it, and write a label (conceptual name) for that group on the outside front of the envelope. You do not need to use all of the envelopes.

*Example: You decide that the statements “dog,” “cat,” “hamster,” and “goldfish” all belong in the same group. You believe that they all represent the category “Pets.” You place these four statements in one envelope, seal it, and write the name “Pets” on the front of the envelope.*

#### **(2) RATING THE STATEMENTS:**

##### Materials included:

- The “Rating the Statements based on Importance” sheet of paper with Likert-type scales included.
- The “Rating the Statements based on Frequency” sheet of paper with Likert-type scales included.

Instructions: Please rate the statements based on (a) how important you believe they are in contributing to your ability to invite and facilitate a moment of relational depth with a client and (b) how often you believe you practice these factors in your work with clients. You are encouraged to use the full range of the Likert-type scale.

*For example, on the importance rating form, if you do not believe that the statement “center myself beforehand” is important to your overall ability to invite and facilitate a moment of relational depth with a client, you would rate it a 1.*

*For example, on the frequency rating form, if you do not believe that you “center yourself beforehand” when working with clients, you would rate this factor a 1.*

**COMPLETION OF TASKS:** Once you have completed both the sorting and rating tasks, place all of the sealed letter-sized envelopes and the rating sheet into the enclosed manila envelope (stamped and addressed to be returned to me), and mail it back to me for data analysis.

These envelopes are due by: Monday, December 8, 2014

**THANK YOU AGAIN!!!**

## APPENDIX K

### INTERPRETING THE RESULTS E-MAIL

Dear *Name*:

Thank you very much for participating in the first two phases of data collection as part of the study “Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.”

For the third and final phase of data collection, you are invited to participate in a focus group where you (and other participants) will have the opportunity to interpret the concept maps. You do not need to bring anything for the session, and snacks will be provided for you. This meeting will take approximately 90 minutes.

The focus group will take place on DATE from TIME to TIME at The University of North Carolina at Greensboro in the Nicholas A. Vacc Counseling and Consulting Clinic, Ferguson Building, room NUMBER. If you are not familiar with the Vacc Clinic, it is located on the second floor of the Ferguson Building. The physical address is 524 Highland Avenue, Greensboro, NC 27412. Parking is available in the Oakland Parking Deck. Please bring your parking pass with you and you will be given an exit pass for free parking.

Click here for directions to campus (<http://parking.uncg.edu/access/access.html>).

Please RSVP to this invitation by DEADLINE, so that I can plan accordingly.

If you have any questions or concerns, you are encouraged to contact me at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my Dissertation Chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Thank you again for your time and participation. I really appreciate it!

Sincerely,  
Jodi L. Bartley

## APPENDIX L

### INTERPRETING THE CONCEPT MAPS AGENDA

1. **Beforehand:** Make sure that the room is reserved, the snacks are available, writing utensils are available, the note-taker is ready and taking notes on my computer, the agenda is printed for me, and copies of the necessary handouts are ready: (a) the cluster listings, (b) the point and cluster concept maps, and (c) the table and bar graph of factor and cluster importance and frequency ratings.
2. **Introduction to the task:** “Thank you very much for your participation in ‘Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth.’ It is great to have you here! Also, I want to introduce the note-taker for this session, NAME.

I have analyzed the data from your responses in the sorting and rating tasks, and you will see – and be able to provide feedback on – the results of that analysis today. The two goals for today are to (a) to name the clusters and (b) discuss the findings. With your help, implications can be provided for subsequent research, therapist training, and supervision.” Please keep the information shared in this group private.

3. **Present the listings of clusters and statements under each cluster:** “Prior to today, you participated in two rounds of data collection – first generating the statements and then sorting and rating them. Based on your groupings, I created clusters of specific statements. As you will see here, certain statements have been grouped into categories or clusters based on how often they were grouped together in the same piles by all of you. What we will do is go through each cluster and name them based on the statements in that category. Please take five to ten minutes to individually look through the statements under each of the clusters and write a name for each cluster. You may use a word or a phrase to name these clusters. When everyone is done, we will work as a group to reach consensus on a name for each cluster.”
4. **Present the point and cluster map:** “The point and cluster map here is a graphical display of how the statements were grouped together. This is a concept map of the same clusters that you just named. As you can see, if two statements were commonly placed in the same group by all of you, then these two statements appear closer together on this point and cluster map. In the same way, clusters that are more similar should be closer together on the map. Do you have any responses to anything here? Do you think that any clusters should be merged? Do you think that any specific statement under any cluster should be removed?”
5. **Present the table and bar graph:** “The table here shows how important you believed each of the statements were in contributing to your ability to invite and

facilitate a moment of relational depth with a client and how frequently you use these factors in your work with clients. There is also a difference score to aid in comparing the importance and frequency ratings. Similarly, the bar graph shows how important you believed each of the clusters were in contributing to your ability to invite and facilitate moments of relational depth with a client and how frequently you use these clusters in your work with clients. Feel free to examine these findings. Do you have any insights or impressions that you would like to share?”

6. **Implications:** “Now that you have reviewed the results, I would like to ask you a few questions:
  - (a) How do you believe you initially developed the ability to invite and facilitate moments of relational depth with clients? Do you believe this can be trained?
  - (b) Two researchers, Rowan and Jacobs, stated that there are three ways that therapists use themselves when working with clients: instrumental, authentic, and transpersonal (these three terms will be written on a chalkboard in the meeting room). In the first position (instrumental), skills-based, manualized treatment approaches prevail. Therapists operating from this position rely on technical treatment approaches in order to fix clients. Moving to the second way of being, the authentic position is characterized by more authentic interactions between the therapist and the client. In this position, the therapeutic relationship is considered much more important. In the third position of the therapist’s use of self, the therapist relates in a transpersonal way with clients. Rowan and Jacobs (2002) described their transpersonal way of being as a place where the egoic concept of the self dissolves. Therapists who are able to relate from this place have been described as those “. . . who are open to experiences beyond or deep within themselves. . . This subtle consciousness cannot be ‘willed’ into existence, but often comes in brief moments” (Rowan & Jacobs, 2002, pp. 71-72). Do you believe the concept maps represent Rowan and Jacobs’ (2002) three positions (instrumental, authentic, and transpersonal) of the therapist’s use of self? If so, how?
  - (c) Based on the emergent clusters, what implications could you offer for therapist educators and supervisors in teaching students to develop the capacity to invite and facilitate moments of relational depth?
  - (d) Based on the emergent clusters, what implications could you offer for future relational depth research?”
7. **Conclusion:** “This concludes the focus group session. Thank you very much for your participation today and in the previous phases of data collection. I really appreciate it! If you have any follow-up questions or concerns, please feel free to contact me.”

**APPENDIX M**

**CERTIFICATE OF CONFIDENTIALITY**

**APPENDIX M**

**CERTIFICATE OF CONFIDENTIALITY**

I, Melissa Fickling, will be responsible for taking notes as part of Jodi L. Bartley's third phase of data collection (the focus group) in her dissertation: "Touchstones of Connection: A Concept Mapping Study of Therapist Factors that Contribute to Relational Depth."

As part of my responsibilities, I agree to keep all participants' information strictly confidential.

Signed: Melissa Fickling Date: 12-3-14  
Melissa Fickling

**APPENDIX N**

**PILOT STUDY**

**TABLE OF CONTENTS**

	Page
PILOT STUDY .....	231
LIST OF TABLES	
Pilot Study Table 1. Participants’ Initial 48 Responses .....	235
Pilot Study Table 2. Synthesized Statements .....	236
Pilot Study Table 3. Initial Clusters of Statements.....	242
Pilot Study Table 4. Final Clusters of Statements .....	251
LIST OF FIGURES	
Pilot Study Figure 1. Point Map .....	240
Pilot Study Figure 2. Cluster Tree/Dendrogram.....	241
Pilot Study Figure 3. Cluster Map .....	243
Pilot Study Figure 4. Point Rating Map by Importance .....	244
Pilot Study Figure 5. Point Rating Map by Frequency .....	245
Pilot Study Figure 6. Cluster Rating Map by Importance .....	246
Pilot Study Figure 7. Cluster Rating Map by Frequency .....	247
PILOT STUDY APPENDICES	
PILOT STUDY APPENDIX A. SITE APPROVAL .....	258
PILOT STUDY APPENDIX B. IRB APPROVAL .....	259
PILOT STUDY APPENDIX C. NOMINATION SCRIPT .....	261

PILOT STUDY APPENDIX D. SNOWBALL SAMPLING SCRIPT.....	263
PILOT STUDY APPENDIX E. INITIAL CONTACT E-MAIL.....	265
PILOT STUDY APPENDIX F. RESEARCH CONSENT FORM.....	267
PILOT STUDY APPENDIX G. DEMOGRAPHIC INFORMATION .....	271
PILOT STUDY APPENDIX H. GENERATING THE STATEMENTS INSTRUCTIONS.....	273
PILOT STUDY APPENDIX I. SORTING AND RATING THE STATEMENTS E-MAIL .....	274
PILOT STUDY APPENDIX J. SORTING AND RATING THE STATEMENTS INSTRUCTIONS .....	276
PILOT STUDY APPENDIX K. INTERPRETING THE RESULTS E-MAIL .....	278
PILOT STUDY APPENDIX L. INTERPRETING THE CONCEPT MAPS AGENDA .....	279
PILOT STUDY APPENDIX M. CERTIFICATE OF CONFIDENTIALITY .....	281

## **PILOT STUDY**

### **Purpose**

The purpose of the pilot study was to test the concept mapping process. The researcher instituted the concept mapping methodology as outlined; however, rather than using the peer nomination approach, the researcher invited two doctoral students to participate. The goal of the pilot study was to use these two participants to test the concept mapping methodology and then use their feedback to improve the full study.

### **Research Questions**

The following research questions were tested in the pilot study:

1. What counselor factors (prior to or during counseling) do mental health counselors believe contribute to the ability to invite and facilitate moments of relational depth with clients?
2. How important do mental health counselors believe each of the factors are in contributing to their ability to invite and facilitate moments of relational depth?
3. How often do mental health counselors practice these factors in their work with clients?
4. Based on the results of the first three questions, what implications do mental health counselors offer for research, counselor education, and supervision? More specifically:
  - (a) How do participants believe they initially developed the ability to invite and facilitate moments of relational depth with clients? Do they believe it can be trained?

- (b) Do the participants believe their conceptualizations of these factors represent Rowan and Jacobs' (2002) three positions (instrumental, authentic, and transpersonal) of the therapist's use of self? If so, how?
- (c) Based on the emergent clusters, what implications do the participants offer for counselor educators and supervisors in teaching mental health counseling students to develop the capacity to invite and facilitate moments of relational depth?
- (d) Based on the emergent clusters, what implications do the participants offer for future relational depth research?

The researcher addressed research question one in generating the statements, questions two and three in sorting and rating the statements, and question four (with associated sub-questions) in interpreting the concept maps.

### **Participants**

To select the pilot-study participants, the researcher identified two doctoral students who previously exhibited interest in the topic and asked them if they would participate. Thus, these individuals were not specifically nominated by their professional peers. Because the purpose of the pilot study was to test the concept mapping methodology, the participants were not required to meet all inclusion criteria for the full study in order to participate.

Both identified doctoral students consented to participate in the study.

Demographically, they both identified as female, Caucasian, and heterosexual. One stated she was atheist and the other did not provide information about her spiritual/religious

background. They ranged in age from 30 to 41, and their counseling experience ranged from five to 11 years. Both earned a master's degree in counseling, held independent professional counseling licenses in either North Carolina or another state, and reported to currently work within 30 miles of the primary research site (Greensboro, NC). One participant worked in a private practice and ascribed to Existentialism, whereas the other worked in a college setting and identified as a Person-Centered counselor.

### **Procedures and Results**

The researcher utilized the first five steps of the concept mapping methodology as outlined by Trochim (1989a) and Kane and Trochim (2007): (a) preparing for concept mapping, (b) generating the statements, (c) structuring the statements, (d) representing the statements, and (e) interpreting the concept maps. These were completed in three rounds of data collection: generating the statements (answering research question one), sorting and rating the statements (answering research questions two and three), and interpreting the concept maps (answering research question four).

#### **Preparing for Concept Mapping**

In writing Chapter Three, the researcher largely prepared the concept mapping procedures for the pilot study. More specifically, the researcher defined the issue; initiated the process; selected the facilitator; determined the goals and purposes; defined the focus; selected the participants; determined the participation methods; developed the schedule, communication plan, and format; determined resources; gained approval by the IRB; and wrote the concept mapping plan. For a detailed review of this process, please refer to Chapter Three. The one major alteration from the outlined procedures was that

two doctoral students were specifically identified and asked to participate in the study – rather than soliciting nominations from counselor education faculty members. Because the primary purpose of the pilot study was to test the concept mapping methodology – rather than identify the nominated participants – this change was deemed acceptable.

### **Generating the Statements**

After the preparation phase, the researcher transitioned into the first phase of data collection: generating the statements. To begin the process, the researcher sent the two participants an initial e-mail, which included a copy of the research consent form and a link to the Qualtrics (2014) survey. Within Qualtrics (2014), the participants (a) read the research consent form and agreed to the terms included therein; (b) completed a demographic form, including questions about their age, gender, race/ethnicity, sexual orientation, spiritual and/or religious background, theoretical orientation, practice setting, employment location, mental health counseling degree status, counseling licensure status, years of counseling experience, and relational depth experience; (c) provided their contact information (name, e-mail address, mailing address, and phone number) for follow-up contact; (d) generated the statements; and finally, (e) were encouraged to send information about the study to other mental health counselors who they would nominate as potential participants.

**Research question 1.** Together, the participants generated 48 statements (see Pilot Study Table 1: Participants' Initial 48 Responses). The researcher edited and synthesized these statements to a total of 39 statements (see Pilot Study Table 2: Synthesized Statements). Along with transferring all 39 statements onto small statement

cards to be sorted by the participants, the researcher also transferred all the statements onto the frequency and importance rating sheets. The statement cards and rating sheets were then combined with an overall sheet of instructions, smaller envelopes for sorting, and a self-addressed manila envelope (to be used to return materials to the researcher) and mailed to the participants for sorting and rating.

### Pilot Study Table 1

#### Participants Initial 48 Responses

##### Participant One

1. openness
2. genuineness
3. safety
4. empathy
5. acceptance
6. patience
7. congruent
8. deep belief in the client
9. listening with all of my being – heart, mind, soul, ears, body, eyes
10. emanate and radiate warmth
11. sincerity
12. sense of closeness
13. willingness to wait
14. comfortable
15. silence
16. supportive
17. caring
18. compassionate
19. balanced support and challenge
20. understanding
21. appreciation for the client's view and perspective of the world
22. willingness to try and see through the client's eyes
23. willingness to just be with the client
24. fully present in the moment
25. appreciation for who the client is
26. being open and willing to learn from the client
27. no preconceptions
28. seeing the world through the client's eyes

29. trusting myself
30. trusting the client
31. willingness to be real
32. willingness to take risks

#### Participant Two

1. being grounded in my physical body
2. being present
3. awareness
4. tuned into client
5. tuned into myself
6. feeling loving kindness toward client
7. feeling patient
8. openness
9. peacefulness
10. being relaxed
11. being very attentive
12. being very real or authentic with the client
13. genuine empathy
14. deep respect for the client's process
15. a sense of understanding or knowing what the client is going through
16. feeling like I am "enough"

#### Pilot Study Table 2

##### Synthesized Statements.

1. openness
2. genuineness/congruence/realness/authenticity
3. safety
4. empathy
5. acceptance
6. patience/willingness to wait
7. deep belief in the client
8. listening with all of my being – heart, mind, soul, ears, body, eyes
9. emanate and radiate warmth
10. sincerity
11. sense of closeness
12. comfortable
13. silence
14. supportiveness
15. caring
16. compassion

17. balancing support and challenge
18. appreciation for the client's view and perspective of the world
19. willingness to try and see through the client's eyes
20. willingness to just be with the client
21. being fully present in the moment
22. appreciation for who the client is
23. being open and willing to learn from the client
24. no preconceptions
25. seeing the world through the client's eyes
26. trusting myself
27. trusting the client
28. willingness to take risks
29. being grounded in my physical body
30. awareness
31. being tuned into the client
32. being tuned into myself
33. feeling loving kindness toward the client
34. peacefulness
35. being relaxed
36. being very attentive
37. deep respect for the client's process
38. a sense of understanding or knowing what the client is going through
39. feeling like I am "enough"

### **Structuring the Statements**

Upon receiving the manila envelope of materials, the participants were encouraged to sort the 39 statement cards in a "way that makes sense" to them (Kane & Trochim, 2007, p. 12; Trochim, 1989a, p. 5). However, they were also informed that (a) each card could only be placed in one pile, (b) the cards could not all be placed in the same pile, and (c) each card could not be its own pile (Kane & Trochim, 2007; Trochim, 1989a). After sorting the cards into piles, the participants were directed to place each pile in an envelope, seal the envelope, and write a conceptual name for that pile on the front of the envelope.

After sorting the statements, the participants were encouraged to rate the statements based on (a) how important they believed each statement (or counselor factor) was in contributing to their ability to invite and facilitate a moment of relational depth with a client and (b) how frequently they practiced these factors in their work with clients. Statements were rated on 5-point Likert-type scales. Once they completed the rating tasks, they placed these sheets along with all of the smaller sorting envelopes inside the folded manila envelope and mailed them back to the researcher.

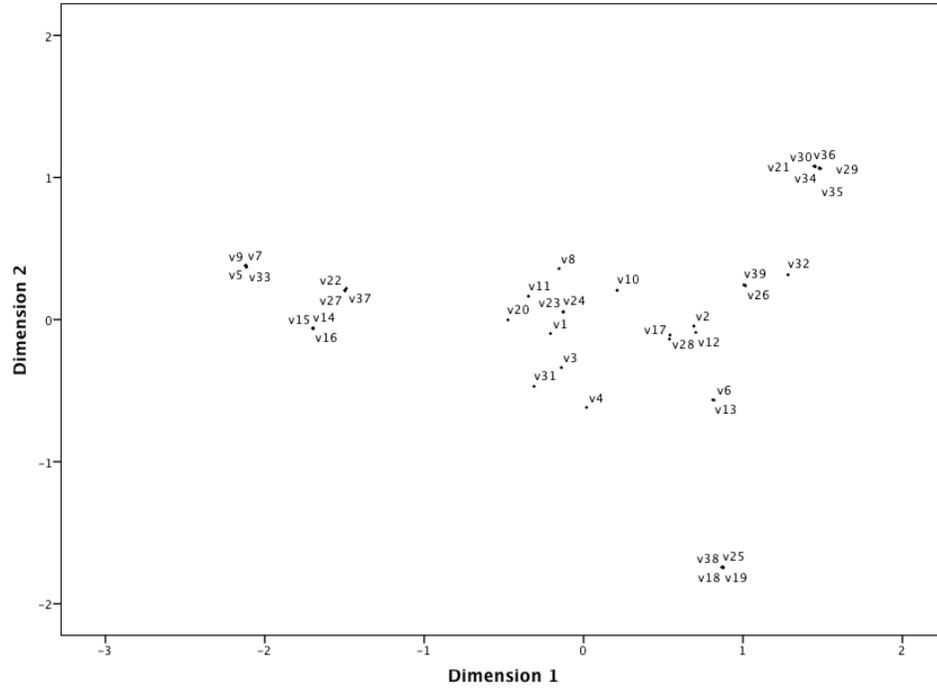
### **Representing the Statements**

Upon receiving the participants' sorting and rating data, the researcher used multivariate statistics to represent the statements in the form of concept maps. The participants' data was first entered into a total square similarity matrix, with the grouping frequencies aggregated across each person's total sort data. From there, the researcher used SPSS (IBM Corp., 2013) to conduct nonmetric multidimensional scaling. Through the use of nonmetric multidimensional scaling, the statements were placed on a map that represented the frequency with which statements were grouped together. For example, statements that were commonly grouped together appeared closer together on the point map than statements that were not grouped together. The associated stress value for the procedure was 0.16341. Although this is outside of what is generally considered an acceptable range (Kane & Trochim, 2007) acceptable range, it is likely that this is an artifact of having only two participants. The resultant point map is pictured in Pilot Study Figure 1: Point Map.

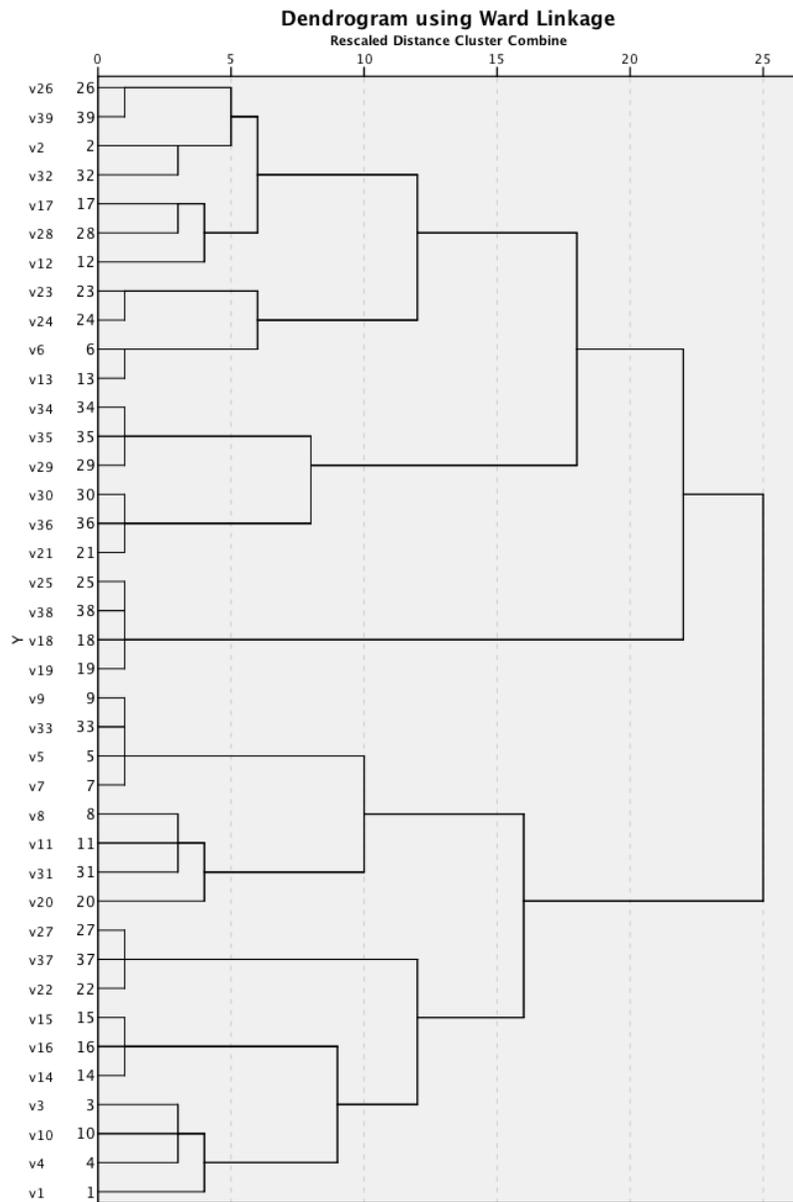
After creating the initial point map, the researcher used agglomerative hierarchical cluster analysis (using Ward's method) to create a cluster tree/dendrogram of cluster possibilities (see Pilot Study Figure 2: Cluster Tree/Dendrogram). Based on the natural groupings of statements, the researcher chose a preliminary solution of seven clusters (see Pilot Study Table 3: Initial Clusters of Statements). The clusters were also visually represented on the multidimensional scaling point map (see Pilot Study Figure 3: Cluster Map).

**Research questions 2 and 3.** Once the point map and cluster map were created, the researcher analyzed the participants' importance and frequency data. The mean frequency and importance ratings of each statement and each cluster were documented along with the Initial Clusters of Statements (see Pilot Study Table 3: Initial Clusters of Statements). To represent these ratings pictorially, the researcher used shapes to denote importance and frequency ratings on the point map (see Pilot Study Figure 4: Point Rating Map by Importance and Pilot Study Figure 5: Point Rating Map by Frequency). Likewise, various colors were used to pictorially represent the importance and frequency ratings by cluster (see Pilot Study Figure 6: Cluster Rating Map by Importance and Pilot Study Figure 7: Cluster Rating Map by Frequency).

# Point Map



Pilot Study Figure 1. Point Map. The figure represents a graphical display of participants' aggregated sorting data based on the group similarity matrix. Statements that were grouped together more often by participants appear closer together on the map.

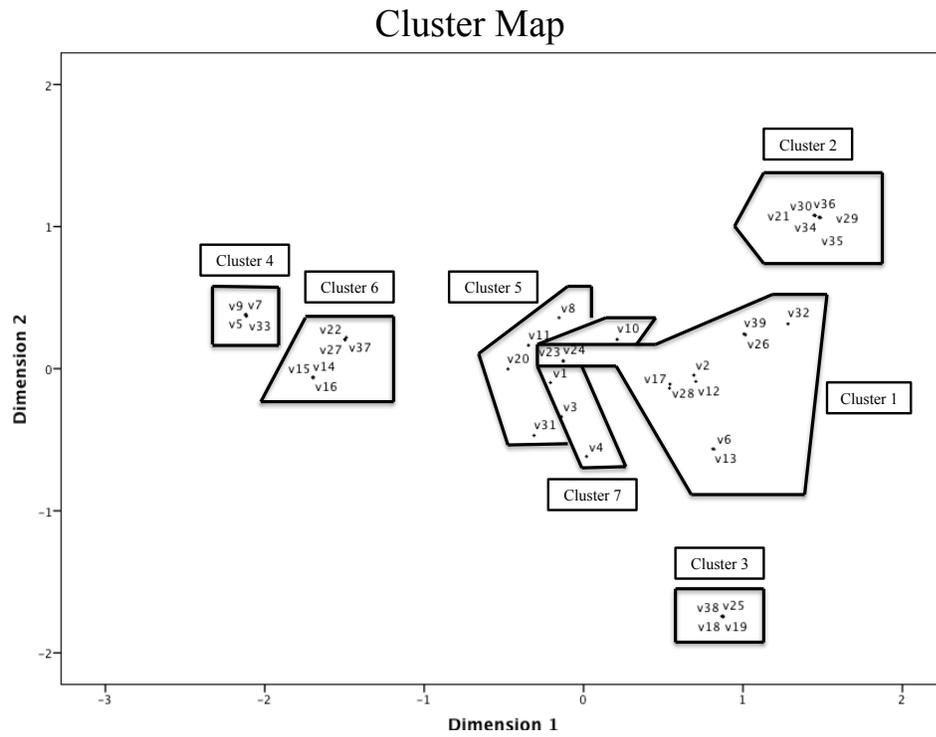


Pilot Study Figure 2. Cluster Tree/Dendrogram. The above cluster tree/dendrogram represents possible cluster solutions for participants' sorting data. Based on the groupings of the statements, seven preliminary clusters were chosen.

Pilot Study Table 3

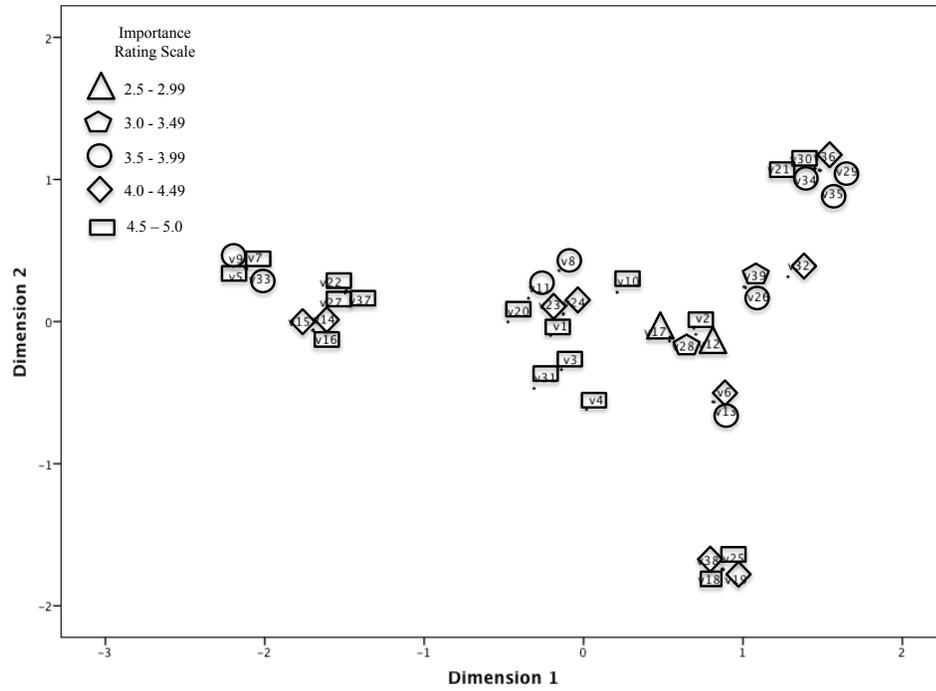
Initial Clusters of Statements

<p><b>Cluster 1</b></p> <p>Mean Imp = 3.545 Mean Freq = 3.454</p>	<p>26. trusting myself (Imp = 3.5, Freq = 3.5) 39. feeling like I am “enough” (Imp = 3, Freq = 2.5) 2. genuineness/congruence/realness/authenticity (Imp = 5 , Freq = 4) 32. being tuned into myself (Imp = 4, Freq = 4) 17. balancing support and challenge (Imp = 2.5, Freq = 3.5) 28. willingness to take risks (Imp = 3, Freq = 3) 12. comfortable (Imp = 2.5, Freq = 2.5) 23. being open and willing to learn from the client (Imp = 4, Freq = 4) 24. no preconceptions (Imp = 4, Freq = 3.5) 6. patience/willingness to wait (Imp = 4, Freq = 4.5) 13. silence (Imp = 3.5, Freq = 3)</p>
<p><b>Cluster 2</b></p> <p>Mean Imp = 4 Mean Freq = 3.58</p>	<p>34. peacefulness (Imp = 3.5, Freq = 3.5) 35. being relaxed (Imp = 3.5, Freq = 4) 29. being grounded in my physical body (Imp = 3.5, Freq = 3) 30. awareness (Imp = 4.5, Freq = 3.5) 36. being very attentive (Imp = 4, Freq = 4) 21. being fully present in the moment (Imp = 5, Freq = 3.5)</p>
<p><b>Cluster 3</b></p> <p>Mean Imp = 4.25 Mean Freq = 4</p>	<p>25. seeing the world through the client’s eyes (Imp = 4.5, Freq = 3.5) 38. a sense of understanding or knowing what the client is going through (Imp = 4, Freq = 4.5) 18. appreciation for the client’s view and perspective of the world (Imp = 4.5, Freq = 4) 19. willingness to try and see through the client’s eyes (Imp = 4, Freq = 4)</p>
<p><b>Cluster 4</b></p> <p>Mean Imp = 4.125 Mean Freq = 3.75</p>	<p>9. emanate and radiate warmth (Imp = 3.5, Freq = 3) 33. feeling loving kindness toward the client (Imp = 3.5, Freq = 3.5) 5. acceptance (Imp = 5, Freq = 4.5) 7. deep belief in the client (Imp = 4.5, Freq = 4)</p>
<p><b>Cluster 5</b></p> <p>Mean Imp = 4 Mean Freq = 3.25</p>	<p>8. listening with all of my being – heart, mind, soul, ears, body, eyes (Imp = 3.5, Freq = 3) 11. sense of closeness (Imp = 3.5 , Freq = 3) 31. being tuned into the client (Imp = 4.5, Freq = 3.5) 20. willingness to just be with the client (Imp = 4.5, Freq = 3.5)</p>
<p><b>Cluster 6</b></p> <p>Mean Imp = 4.5 Mean Freq = 4.08</p>	<p>27. trusting the client (Imp = 4.5, Freq = 3.5) 37. deep respect for the client’s process (Imp = 5, Freq = 4.5) 22. appreciation for who the client is (Imp = 4.5, Freq = 4) 15. caring (Imp = 4, Freq = 4) 16. compassion (Imp = 5, Freq = 4.5) 14. supportiveness (Imp = 4, Freq = 4)</p>
<p><b>Cluster 7</b></p> <p>Mean Imp = 4.625 Mean Freq = 4.25</p>	<p>3. safety (Imp = 4.5, Freq = 4.5) 10. sincerity (Imp = 4.5, Freq = 4) 4. empathy (Imp = 5, Freq = 4.5) 1. openness (Imp = 4.5, Freq = 4)</p>



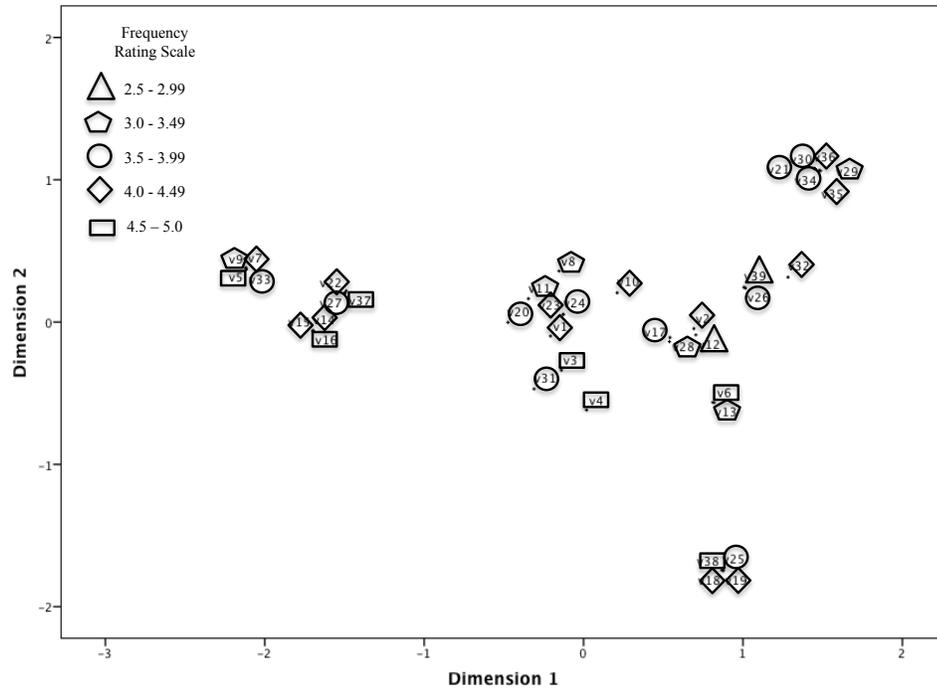
Pilot Study Figure 3. Cluster Map. The cluster map graphically represents the 39 statements grouped into seven preliminary clusters.

### Point Rating Map by Importance



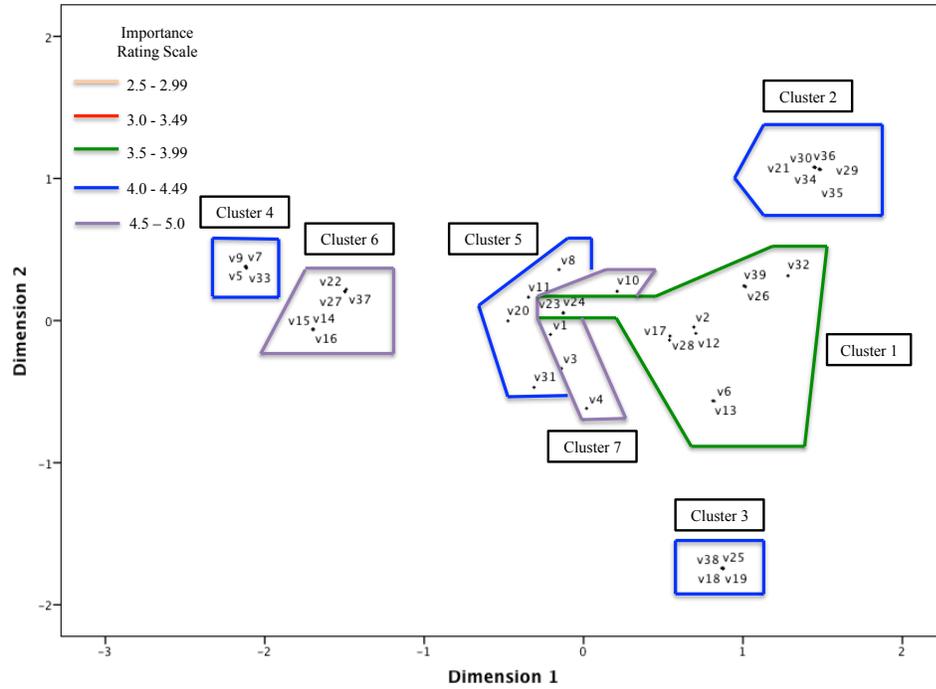
Pilot Study Figure 4. Point Rating Map by Importance. The point rating map by importance illustrates participants' mean average ratings based on how important they believe each of the factors are in contributing to moments of relational depth with clients.

### Point Rating Map by Frequency



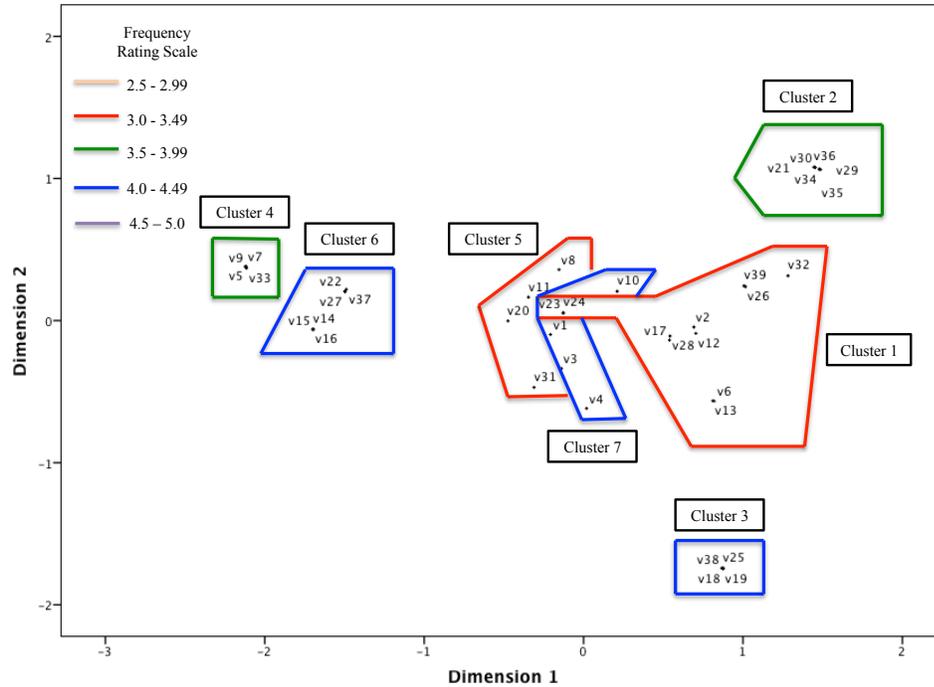
Pilot Study Figure 5. Point Rating Map by Frequency. The point rating map by frequency illustrates participants’ mean average ratings based on how frequently they believe they use the factors in inviting and facilitating moments of relational depth with clients.

## Cluster Rating Map by Importance



Pilot Study Figure 6. Cluster Rating Map by Importance. The cluster rating map by importance illustrates participants' mean average ratings based on how important they believe each of the clusters are in contributing to moments of relational depth with clients.

## Cluster Rating Map by Frequency



Pilot Study Figure 7. Cluster Rating Map by Frequency. The cluster rating map by frequency illustrates participants' mean average ratings based on how frequently they believe they use the clusters in inviting and facilitating moments of relational depth with clients.

### Interpreting the Concept Maps

After creating the point and cluster rating maps, the researcher invited the two participants to a one-and-a-half hour focus group to interpret the maps. Both participants agreed to be a part of this final phase of data collection. To begin the process, the researcher thanked the participants for their willingness to participate and then briefly outlined the agenda for the meeting: (a) to name the clusters, and (b) to engage in a

discussion about the findings and offer subsequent implications for counselor education, supervision, and research.

From there, participants were given a collection of handouts which included the Initial Clusters of Statements (see Pilot Study Table 3), the Point Map (see Pilot Study Figure 1), the Cluster Map (see Pilot Study Figure 3), the Point Rating Map by Importance (see Pilot Study Figure 4), the Point Rating Map by Frequency (see Pilot Study Figure 5), the Cluster Rating Map by Importance (see Pilot Study Figure 6), and the Cluster Rating Map by Frequency (see Pilot Study Figure 7). To contextualize the packet of results, the researcher briefly reviewed the previous participant tasks – generating the statements and sorting and rating the statements. The participants were then asked to work individually to review each of the clusters and generate a thematic name for each cluster. Participants worked silently and wrote notes for approximately 10 minutes.

Once they had completed this individual review, the researcher briefly described the Point Map and Cluster Map (see Pilot Study Figures 1 and 2, respectively). The participants were then guided iteratively through each cluster and encouraged to agree upon a name for each one. One participant asked how many words could be included in each name, to which the researcher clarified that it could be a phrase (a few words). In discussing the first group of statements, the participants initially discussed the self-assuredness of the counselor. They decided to retain all of the statements and title this cluster *The Self of the Counselor*. The statements in this cluster included *trusting myself, feeling like I am “enough,” genuineness/congruence/realness/authenticity, being tuned*

*into myself, balancing support and challenge, willingness to take risks, comfortable, being open and willing to learn from the client, no preconceptions, patience/willingness to wait, and silence.*

Participants readily named Cluster 2 *Deep Awareness*. They kept all of the statements in this cluster as well, which included *peacefulness, being relaxed, being grounded in my physical body, awareness, being very attentive, and being fully present in the moment*. After this, participants had a difficult time naming Cluster 3. They discussed possible titles centering on the perspective of the client or co-journeying with the client; however, they could not agree upon a name that they believed fit the depth of the statements. Together, they agreed to name the other clusters and return to this one at the end.

Moving onward, the participants named Cluster 4 *Loving-Kindness*. They engaged in a discussion about the Buddhist tenets of this term as a possible limitation, but they ultimately agreed that it captured the essence of the associated statements. These statements included *emanate and radiate warmth, feeling loving kindness toward the client, acceptance, and deep belief in the client*. Transitioning to Cluster 5, participants titled this *Tuned In To Client* and retained the following factors: *listening with all of my being – heart, mind, soul, ears, body, eyes; sense of closeness; being tuned into the client; and willingness to just be with the client*. Similarly, the participants retained all of the statements in Cluster 6 and named it *Deep Respect and Acceptance*. Associated statements included *trusting the client, deep respect for the client’s process, appreciation for who the client is, caring, compassion, and supportiveness*.

From there, participants moved onto Cluster 7, and they engaged in a longer discussion about the concept of safety. They decided to title this cluster *Cultivating Safe Space*, and retained the four statements: *safety, sincerity, empathy, and openness*. They then transitioned back to Cluster 3 and agreed on the title *Client Perspective*. The statements in this cluster included *seeing the world through the client's eyes, a sense of understanding or knowing what the client is going through, appreciation for the client's view and perspective of the world, and willingness to try and see through the client's eyes*.

Once all of the clusters were named, the researcher asked participants if they believed any clusters could be merged or changed. They initially considered combining Cluster 2 and Cluster 5; however, they later decided to retain both clusters. Examining Cluster 4 (*Loving-Kindness*) more closely, they decided to move statement 5 (*acceptance*) and statement 7 (*deep belief in the client*) to Cluster 6 (*Deep Respect and Acceptance*), and move statement 9 (*emanate and radiate warmth*) and statement 33 (*feeling loving kindness toward the client*) to Cluster 7 (*Cultivating Safe Space*). Thus, they dissolved Cluster 4 (*Loving-Kindness*), resulting in a six-cluster solution.

Examining their final cluster names a little more closely, the participants acknowledged the lack of parallel language across the clusters. Although they did not alter the names of all of the clusters, they did change Cluster 3 from *Client Perspective* to *Taking Client Perspective*. Taken together, the final six clusters were named *Self of the Counselor, Deep Awareness, Taking Client Perspective, Tuned In To Client, Deep*

*Respect and Acceptance, and Cultivating Safe Space.* (See Pilot Study Table 4: Final Cluster of Statements for a consolidated list of all of these changes).

Pilot Study Table 4

Final Clusters of Statements

<p><b>Cluster 1</b>  Self of the Counselor</p>	<p>26. trusting myself 39. feeling like I am “enough” 2. genuineness/congruence/realness/authenticity 32. being tuned into myself 17. balancing support and challenge 28. willingness to take risks 12. comfortable 23. being open and willing to learn from the client 24. no preconceptions 6. patience/willingness to wait 13. silence</p>
<p><b>Cluster 2</b>  Deep Awareness</p>	<p>34. peacefulness 35. being relaxed 29. being grounded in my physical body 30. awareness 36. being very attentive 21. being fully present in the moment</p>
<p><b>Cluster 3</b>  Taking Client Perspective</p>	<p>25. seeing the world through the client’s eyes 38. a sense of understanding or knowing what the client is going through 18. appreciation for the client’s view and perspective of the world 19. willingness to try and see through the client’s eyes</p>
<p><b>Cluster 4</b> (Removed)</p>	
<p><b>Cluster 5</b>  Tuned In To Client</p>	<p>8. listening with all of my being – heart, mind, soul, ears, body, eyes 11. sense of closeness 31. being tuned into the client 20. willingness to just be with the client</p>
<p><b>Cluster 6</b>  Deep Respect and Acceptance</p>	<p>27. trusting the client 37. deep respect for the client’s process 22. appreciation for who the client is 15. caring 16. compassion 14. supportiveness 5. acceptance 7. deep belief in the client</p>
<p><b>Cluster 7</b>  Cultivating a Safe Space</p>	<p>3. safety 10. sincerity 4. empathy 1. openness</p>

---

9. emanate and radiate warmth
33. feeling loving kindness toward the client

---

Once the participants had named all of the clusters, the researcher invited them to review the importance and frequency ratings of each statement (see Pilot Study Figures 4 and 5, respectively), and the importance and frequency ratings of each cluster (see Pilot Study Figures 6 and 7, respectively). The participants reported that it was difficult to compare the importance and frequency ratings across maps and suggested that in the future, the researcher create a table of these ratings, including a column of the difference scores between importance and frequency ratings. Additionally, they generally reported that when selecting importance ratings, they considered past experiences; however, when selecting frequency ratings, they considered their current experiences. Their insight may simply be an artifact of their current statuses as doctoral students – as opposed to the practitioner population that will be solicited for the full study.

**Research question 4.** After naming the clusters and reflecting upon the importance and frequency ratings, the researcher engaged the participants in an overall discussion about the cultivation of relational depth capacity and subsequent implications for counselor education, supervision, and research.

**Research question 4.a.** First, the researcher asked participants how they believed they initially developed the ability to invite and facilitate moments of relational depth with clients. One participant stated that it came from a moment of breakdown where she developed greater mindfulness and acceptance. Another stated that at that time in her life, she became more grounded in her body and practiced greater self-care, which allowed her

to get into a deeper place with a client – a place where she felt deeply touched by this specific client.

As part of this question, the researcher also asked participants if they believed the ability to invite and facilitate moments of relational depth could be trained. One participant discussed her negative experiences in supervision and stated that these experiences prompted her to come into herself more and work in a deeper way with clients. Another stated that relational depth was not discussed in supervision and she wondered how these types of discussions may have influenced her development as a counselor – rather than the encouragement to rely solely on the technical skills of counseling. However, participants stated that relational depth could possibly be broken down into various components that could be trainable – such as the ability to be more attuned and mindful. Participants also postulated that the capacity to engage on relationally deep levels could be an issue of development and/or maturity. Self-help and spiritual growth were cited as precursors to this development. Participants seemed to agree that the capacity to invite moments of relational depth could not be trained, per se, but that supervisors could facilitate (or impede) counselor development of this capacity.

**Research question 4.b.** From there, the researcher described Rowan and Jacobs' (2002) three positions of the therapist's use of self and asked participants if they believed the concept maps represented this model and, if so, how. Participants acknowledged that their early developmental trajectory was largely geared toward instrumental ways of being. Furthermore, they saw the ways in which the instrumental and authentic positions reflected in the clusters; however, they stated that there were times when the counseling

work qualitatively differed from the authentic position. When the researcher described Rowan and Jacobs' (2002) third position (transpersonal) as a particular kind of merging with the client, both participants agreed and noted this concurrence with various representative statements. Finally, they stated that the emergence of relational depth was predicated on a deeper level of merging or joining.

**Research question 4.c.** To foster greater research applicability, the researcher asked the participants to offer implications for counselor educators and supervisors in teaching mental health counseling students to invite and facilitate moments of relational depth. Participants reported that supervisors could help students learn to cultivate mindfulness and self-awareness. Furthermore, they stated that supervisors could be mindful of students' development and maintain an atmosphere of support. They also recommended that supervisors frequently check in with students, asking them what is going on for *them* in each moment, as a way of fostering greater student self-awareness. Finally, although the participants were unsure whether or not relational depth expressly translated to the supervisory relationship, they asserted that supervisors could model certain components of it with students. Interestingly, participants focused almost exclusively on the influence of supervisors in developing this capacity – an area of research largely unexplored at this point.

**Research question 4.d.** For the final research question, the researcher asked participants to offer implications for future relational depth research. The participants agreed that future research could focus on (a) the ways in which supervisors focus on students' self-awareness, and (b) the ways in which experienced counselors learn to be

aware of themselves in the process. The participants suggested that future researchers could ask experienced counselors how they believe they developed the capacity to invite and facilitate moments of relational depth with clients. They also suggested that researchers could explore whether or not supervisors are even aware of the concept. Taken together, the implications seemed to center on supervisors' roles in helping students develop this deep capacity for connection.

### **Participant Feedback**

To end the focus group, the researcher asked participants to provide feedback on the process and suggest ways that the methodology could be improved for the full study. One of the participants expressed concern about the number of statements that could be generated from a larger sample size and suggested that the researcher edit and synthesize the statements into a list of no more than 50 statements. Also, there was some confusion about whether or not to seal the sorting envelopes. (This directive was included in the instructions, and thus, no changes are needed.) Additionally, participants suggested that the researcher create a table of frequency and importance ratings for the statements rather than creating rating concept maps to make this easier to review. Additionally, they encouraged the researcher to include a difference score between these two ratings in the table. In terms of the frequency and importance ratings for each cluster, they encouraged the researcher to represent these ratings using a simple bar graph. Finally, one participant stated that she wanted to know more about the statistical procedures; however, the other recommended that the researcher use less statistical jargon. Overall, they stated that the process was fairly straightforward.

### **Modifications for the Full Study**

Based on the participants' responses and the researcher's experience in the process, the following list of modifications will be implemented in the full study.

1. The researcher will endeavor to keep the list of statements as small and as manageable as possible. Kane and Trochim (2007) recommended no more than 100; however, one participant suggested no more than 50. Using these recommendations, the researcher will aim to develop a statement list between 50 and 100 statements.
2. The researcher will include a section in the Snowball Sampling Script that acknowledges the possibility that potential participants may receive duplicate e-mails invitations (if they were nominated by more than one person). These potential participants will be encouraged to complete the study only once.
3. Instead of using concept maps, the researcher will create a table of frequency and importance ratings (and the difference scores) to represent the statement ratings for the focus groups.
4. Instead of using concept maps, the researcher will create a bar graph to represent the frequency and importance ratings for each of the clusters.
5. When describing the process of naming the clusters, the researcher will inform participants that they may use a word or a phrase (a few words) to title the clusters.
6. In the pilot study, the researcher created a total square similarity matrix based on the data from both participants. In the full study, the researcher will create a

sorting table and convert this into a square dissimilarity matrix using R editor (R Development Core Team, 2011). Furthermore, the stress value reported from the SPSS (IBM Inc., 2013) output appeared rather low, lending some concern about the data entry and software computations. Thus, for the full study, R editor (R Development Core Team, 2011) will be used exclusively.

## PILOT STUDY APPENDIX A

### SITE APPROVAL

Jodi Bartley has approval to collect her dissertation data within the Department of Counseling and Development. She intends to utilize a peer nomination approach to identify subjects by asking CED faculty to suggest study participants. This approach is acceptable and supported by the department.

Dr. Scott Young, Department Chair

---

--

***J. Scott Young, PhD, Professor and Chair***

Department of Counseling and Educational Development

The University of North Carolina at Greensboro

222 Curry Building / PO Box 26170 / Greensboro, NC 27402-6170

Office: 336-334-3464 / Fax:336-334-3433 / Email: [jsyoung3@uncg.edu](mailto:jsyoung3@uncg.edu)

Office Managers Phone: 336-334-3423

Visit us on Facebook at: <http://www.facebook.com/pages/UNCG-Department-of-Counseling-and-Educational-Development/306293056090011>

# PILOT STUDY APPENDIX B

## IRB APPROVAL



THE UNIVERSITY of NORTH CAROLINA  
**GREENSBORO**

**OFFICE OF RESEARCH INTEGRITY**  
2718 Beverly Cooper Moore and Irene Mitchell Moore  
Humanities and Research Administration Bldg.  
PO Box 26170  
Greensboro, NC 27402-6170  
336.256.0253  
Web site: [www.uncg.edu/orc](http://www.uncg.edu/orc)  
Federalwide Assurance (FWA) #216

**To:** Jodi Bartley  
Counsel and Ed Development  
228 Curry Building, PO Box 26170, Greensboro, NC 27402

**From:** UNCG IRB

Authorized signature on behalf of IRB

**Approval Date:** 8/20/2014  
**Expiration Date of Approval:** 8/19/2015

**RE:** Notice of IRB Approval by Expedited Review (under 45 CFR 46.110)  
**Submission Type:** Initial  
**Expedited Category:** 7.Surveys/interviews/focus groups  
**Study #:** 14-0227

**Study Title:** Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth

This submission has been approved by the IRB for the period indicated. It has been determined that the risk involved in this research is no more than minimal.

### Study Description:

The purpose of the study is to use concept mapping to explore counselors' conceptualizations of the counselor factors that contribute to their ability to invite and facilitate moments of relational depth with clients. After an initial small scale pilot study (conducted with two doctoral students at UNCG to test research process), three phases of data collection will be instituted: generating the statements, sorting and rating the statements, and interpreting the concept maps. Resultant implications will be used to inform relational depth research and counselor training and supervision.

### Regulatory and other findings:

- This research meets criteria for waiver of a signed consent form according to 45 CFR 46.117(c)(2).

### Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented (use the

page 1 of 2

modification application available at <http://integrity.uncg.edu/institutional-review-board/>). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the "Unanticipated Problem-Adverse Event Form" at the same website.

Please be aware that valid human subjects training and signed statements of confidentiality for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found [http://policy.uncg.edu/research\\_data/](http://policy.uncg.edu/research_data/).

CC:  
Craig Cashwell, Counsel and Ed Development

## PILOT STUDY APPENDIX C

### NOMINATION SCRIPT

“Hello, I am wondering if you would be willing to nominate prospective participants for my dissertation study. You are being asked to serve as a nominator because you are currently a counselor educator at The University of North Carolina at Greensboro. Please note that should you choose to participate, I will not identify you in any way nor will I have the capability to identify who you chose to nominate.

The study I am conducting is titled ‘Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth,’ and it is directed by Dr. Craig S. Cashwell. The purpose of the study is to explore the counselor factors that contribute to counselors’ ability to invite and facilitate moments of relational depth with clients.

As mentioned, I am seeking your assistance to identify prospective counselor participants. In order to be eligible to participate, participants must:

- (a) be at least 18 years of age,
- (b) work approximately within a 30-mile radius of the principal investigator’s location (Greensboro, NC),
- (c) possess a master’s degree in counseling,
- (d) possess a license to practice mental health counseling in their state of residence,
- (e) possess at least five years of post-master’s-level experience counseling clients and most importantly,
- (f) have experienced a moment of relational depth with a client.

**It is the final criterion – identifying counselors who may have experienced moments of relational depth with clients – where I most need your assistance.**

To help you identify prospective participants, let me define and attempt to describe relational depth for you. Relational depth has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level” (Mearns & Cooper, 2005, p. xii). It typically occurs in discrete moments of profound connection with another person (Knox, Wiggins, Murphy, & Cooper, 2013; Mearns & Cooper, 2005). These relationally-deep moments are characterized by a synergy of Rogers’ (1980) core conditions of empathy, genuineness, and unconditional positive regard (Knox et al., 2013; Mearns & Cooper, 2005).

Here is an example description of relational depth: A client finds the courage to share her buried guilt and shame over her secret, sexually promiscuous behavior as a teenager. In response, the counselor empathizes with the client and responds with deep acceptance and compassion – fully embracing the client in her struggle. In a shared moment of eye

contact, the client knows that her counselor truly feels the depth of her pain and fully accepts her as a person. With no words being spoken, they share in a deep moment of genuine connection.

Based on the eligibility criteria, the definition, and the description of relational depth, I ask that you nominate up to seven potential participants by contacting them, informing them of the study, and providing them with my contact information should they choose to participate. I have included a sheet of information about that study that you may use when you contact them.

Thank you very much for your time and consideration. I really appreciate it!”

**PILOT STUDY APPENDIX D**  
**SNOWBALL SAMPLING SCRIPT**

Hello *Name*,

I am contacting you because I would like to nominate you to participate in a study titled “Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth.” The purpose of the study is to use concept mapping to explore counselors' conceptualizations of the counselor factors that contribute to the ability to invite and facilitate moments of relational depth with clients. The primary researcher of the study is Jodi L. Bartley, and she is currently a doctoral student at The University of North Carolina at Greensboro.

I identified you as a prospective participant because I believe you may have experienced moments of relational depth with your clients, and thus, may be able to contribute to research in this area. To eligible to participate, you must (a) be at least 18 years of age, (b) work approximately within a 30-mile radius of the principal investigator’s location (Greensboro, NC), (c) possess a master’s degree in counseling, (d) possess a license to practice mental health counseling in their state of residence, (e) possess at least five years of post-master’s-level experience counseling clients and most importantly, and (f) have experienced a moment of relational depth with a client.

Relational depth has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level” (Mearns & Cooper, 2005, p. xii). It typically occurs in discrete moments of profound connection with another person (Knox, Wiggins, Murphy, & Cooper, 2013; Mearns & Cooper, 2005). These relationally-deep moments are characterized by a synergy of Rogers’ (1980) core conditions of empathy, genuineness, and unconditional positive regard (Knox et al., 2013; Mearns & Cooper, 2005).

Here is an example description of relational depth: A client finds the courage to share her buried guilt and shame over her secret, sexually promiscuous behavior as a teenager. In response, the counselor empathizes with the client and responds with deep acceptance and compassion – fully embracing the client in her struggle. In a shared moment of eye contact, the client knows that her counselor truly feels the depth of her pain and fully accepts her as a person. With no words being spoken, they share in a deep moment of genuine connection.

Again, I believe that you would be an excellent participant for this study. The study includes three phases of data collection: generating the statements, sorting and rating the

statements, and interpreting the results. Your expected time commitment for this is approximately three hours. If you would like more information about the study or would be willing to participate, please e-mail the primary researcher, Jodi L. Bartley, at [jlbart12@uncg.edu](mailto:jlbart12@uncg.edu)

Thank you very much for your time and consideration!

*Your Name*

## PILOT STUDY APPENDIX E

### INITIAL CONTACT E-MAIL

Dear *Name*:

Thank you for contacting me to participate in my study titled “Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth.” It is exciting to work with individuals who have been nominated by their peers as counselors who may have experienced moments of relational depth with clients.

To provide you with background information, my name is Jodi L. Bartley, and I am a doctoral student in the Counseling and Counselor Education program at The University of North Carolina at Greensboro. As part of my dissertation, directed by Dr. Craig S. Cashwell, I am conducting a study exploring the counselor factors that contribute to a counselor’s ability to invite and facilitate moments of relational depth with clients. To recruit participants, I asked counselor educators and mental health counselors to identify and contact individuals who they believed have experienced moments of relational depth with clients.

To be eligible to participate in the study, you must (a) be at least 18 years of age, (b) work approximately within a 30-mile radius of the research site (Greensboro, NC), (c) possess a master’s degree in counseling, (d) possess a license to practice mental health counseling in your state of residence, and (e) possess at least five years of post master’s-level experience counseling clients. Finally, to be included in all three phases of data collection, you must have experienced a moment of relational depth with a client.

If you meet the eligibility criteria, you will be asked to participate in three phases of data collection. In the first phase of data collection, you will be asked to consent to participate in the study, complete a demographic form, provide your contact information (for future follow-up contact), generate statements, and send information about the study to other mental health counselors who you would nominate to participate in the study as well (you may copy the “Snowball Sampling Script” attached to this e-mail). In the second phase of data collection, I will mail you sorting and rating materials, and you will be asked to sort and rate the statements that you previously generated and return to me via mail. In the final phase of data collection, you will be invited to participate in a face-to-face 1.5-hour focus group on the UNCG campus to interpret the resultant concept maps and provide implications for research, counselor education, and supervision. All together, the three phases of data collection should take approximately three hours of your time.

Before you consent to participate in the study, it is important that you are apprised of all of the risks and benefits of the study, as well as procedures for maintaining confidentiality. I have attached the research consent form for you to read and keep as part

of your records. This consent form is also embedded in the online Qualtrics site, and you will be required to consent online before participating in the study.

If you are willing to participate in the study, please click on the following link to participate in the first phase of data collection: PROVIDE LINK HERE

If you have any questions or concerns, please feel free to contact me, Jodi L. Bartley, at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my Dissertation Chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Thank you so much for your consideration!

Sincerely,  
Jodi L. Bartley

Enc: Research consent form; Snowball sampling script

**PILOT STUDY APPENDIX F**  
**RESEARCH CONSENT FORM**

**RESEARCH CONSENT FORM**

**UNIVERSITY OF NORTH CAROLINA AT GREENSBORO**

**CONSENT TO ACT AS A HUMAN PARTICIPANT**

Project Title: Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth

Principal Investigator: Jodi L. Bartley  
Faculty Advisor: Dr. Craig S. Cashwell

**What are some general things you should know about research studies?**

You are being asked to take part in a research study. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. There also may be risks to being in research studies. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with the researcher or The University of North Carolina at Greensboro.

Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study.

As part of the initial e-mail to you, you will be given a copy of this consent form. If you have any questions about this study at any time, you should ask the researchers named in this consent form. Their contact information is below.

**What is the study about?**

This is a research project. Your participation is voluntary. The purpose of the study is to use concept mapping to explore counselors' conceptualizations of the counselor factors that contribute to their ability to invite and facilitate moments of relational depth with clients.

**Why are you asking me?**

You are being asked to participate in the study because it is believed that you may have experienced moments of relational depth with clients. In order to participate in the study, you must (a) be at least 18 years of age, (b) work approximately within a 30-mile radius of the research site (Greensboro, NC), (c) possess a master's degree in counseling, (d) possess a license to practice mental health counseling in your state of residence, and (e) possess at least five years of post master's-level experience counseling clients. Finally, to be included in all three phases of data collection, you must have experienced a moment of relational depth with a client.

UNCG IRB  
Approved Consent Form  
Valid from:  
8/20/14 to 8/19/15

**What will you ask me to do if I agree to be in the study?**

If you agree to be involved in the study, you may be asked to participate in up to three phases of data collection, which will take a total of approximately three hours of your time. (If you do not meet the screening criteria, you will not be eligible to participate in the second and third phases of data collection.) In the first phase of data collection, you will be asked to complete a demographic form, provide your contact information for follow-up data collection, generate statements about the factors that contribute to your ability to invite and facilitate moments of relational depth, and if you choose, send information about the study to other mental health counselors who may be eligible. This phase should take approximately 30 minutes.

In the second phase of data collection, you will receive a manila envelope in the mail that includes statement cards and two rating sheets. You will be asked to sort the statements in a way that makes sense to you and rate the statements based on their importance in contributing to relationally-deep moments and how often you practice these factors in your work with clients. This phase should take approximately one hour.

In the third phase of data collection, you will be invited to participate in a focus group where you will interpret the resultant concept maps and provide implications for subsequent research, counselor education, and supervision. During the focus group, a member of the research team will document your responses. The statements that you provide will be used anonymously to contextualize the findings. The focus group should take approximately one and a half hours.

Relational depth is considered a profound moment of connection, and reflecting upon such intense moments may cause some feelings of vulnerability. If you feel any emotional distress, you are encouraged to seek counseling with a qualified professional. The following database of counselors may be helpful:  
<http://www.nbcc.org/CounselorFind>

If you have any questions about the study, you are encouraged to contact the principal investigator, Jodi L. Bartley, at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu)

**Is there any audio/video recording?**

There will be no audio/video recording involved in this study. However, you should know that in the third round of data collection (the focus group), a member of the research team will take notes of the session. Although these notes will not include identifying information, specific statements that you voice may be used to contextualize the findings.

**What are the risks to me?**

The Institutional Review Board at The University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. As mentioned above, relational depth is characterized by a profound moment of connection with another person. Reflecting upon such moments may be emotionally triggering. Although this is a minimal risk, you are encouraged to seek counseling from a qualified

UNCG IRB  
Approved Consent Form  
Valid from:  
8/20/14 to 8/19/15

professional if you feel any emotional distress. You may use the following database to locate a professional: <http://www.nbcc.org/CounselorFind>

If you have questions, want more information or have suggestions, please contact Jodi L. Bartley (principal investigator) at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or Dr. Craig Cashwell (faculty advisor) at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

**Are there any benefits to society as a result of me taking part in this research?**

Society may benefit from this research study. The therapeutic relationship has proven critical to client outcome, and society may be directly benefited from exploring the counselor factors that contribute to the depth of relational connection. Furthermore, learning more about the counselor factors that contribute to counselors' ability to invite and facilitate moments of relational depth with clients could provide implications for research, counselor education, and supervision. Based on the findings, researchers and counselor educators could further explore the ways in which counselors use themselves in order to establish deep connections with clients.

**Are there any benefits to *me* for taking part in this research study?**

There are no direct benefits to participants in this study.

**Will I get paid for being in the study? Will it cost me anything?**

There are no costs to you or payments made for participating in this study.

**How will you keep my information confidential?**

All information obtained in this study is strictly confidential unless disclosure is required by law. Electronic information will be kept on the principal investigator's password-protected computer and physical copies of materials will be kept secure in a locked box. When sharing results with other team members, all information will be de-identified.

The first phase of data collection will be done through an Internet site called Qualtrics. It is important that you know that absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. Additionally, I will ask for your contact information in the first phase of data collection. Your name and contact information will be kept in a separate file from the data that you provide, which will be identified only by a number.

In the second phase of data collection, I will mail you an envelope with the sorting and rating materials. The data that you provide from this process will be entered into the computer in a de-identified state, and resultant concept maps will be aggregated representations of yours and other participants' conceptualizations.

UNCG IRB  
Approved Consent Form  
Valid from:

8/20/14 to 8/19/15

In the third phase of data collection, you will be asked to participate in a face-to-face focus group. During this time, a member of the research team will document your and other participants' interpretations of the concept maps. When reporting these results, no names or identifying information will be used.

After the study is complete, your name and contact information will be deleted from the computer. The de-identified data will be kept for a minimum of one year.

**What if I want to leave the study?**

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

**What about new information/changes in the study?**

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

**Voluntary Consent by Participant:**

By completing this activity, you are agreeing that you read, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By completing this activity, you are agreeing that you are 18 years of age or older and are agreeing to participate, or have the individual specified above as a participant participate, in this study described to you by Jodi L. Bartley.

UNCG IRB  
Approved Consent Form  
Valid from:  
8/20/14 to 8/19/15

**PILOT STUDY APPENDIX G**  
**DEMOGRAPHIC INFORMATION**

Please provide the following demographic information.

13. Age:
14. Gender:
15. Race/ethnicity:
16. Sexual orientation:
17. Spiritual/religious background (e.g., Atheist, Buddhist, Christian):
18. What is your primary counseling theoretical orientation (e.g., Person-Centered, Cognitive-Behavioral)?:
19. In what type of practice setting do you currently work (e.g., private practice, hospital)?:
20. What is the city location of your place of employment (e.g., Greensboro, Winston-Salem)?:
21. Did you earn a master's degree in counseling?: Yes/No
22. Are you currently licensed as a mental health counselor in the state of North Carolina or in another state?: Yes/No
23. How many years of post master's-level counseling experience do you have?:
24. This study purports to study the phenomenon of relational depth. Relational depth has been defined as “a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level” (Mearns & Cooper, 2005, p. xii). It typically occurs in discrete moments of profound connection with another person (Knox, Wiggins, Murphy, & Cooper, 2013; Mearns & Cooper, 2005). These relationally-deep moments are characterized by a synergy of Rogers' (1980) core conditions of empathy, genuineness, and unconditional positive regard (Knox et al., 2013; Mearns & Cooper, 2005).

Example description: A client finds the courage to share her buried guilt and shame over her secret, sexually promiscuous behavior as a teenager. In response, the counselor empathizes with the client, responding with deep acceptance and compassion – fully embracing the client in her struggle. In a shared moment of eye contact, the client knows that her counselor truly feels the depth of her pain and fully accepts her as a person. With no words being spoken, they share in a deep moment of genuine connection.

Have you experienced a moment of relational depth with a client?: Yes/No

\*\*Please nominate other individuals to participate in this study by sending them information about the study and directing them to contact Jodi L. Bartley if they are interested. You are encouraged to use the “Snowball Sampling Script” provided in the initial e-mail.

## PILOT STUDY APPENDIX H

### GENERATING THE STATEMENTS INSTRUCTIONS

For my study, I am exploring the phenomenon of relational depth. Relational depth has been defined as ‘a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other’s experiences at a high level’ (Mearns & Cooper, 2005, p. xii).

Please take a moment to reflect on your counseling career thus far and the clients that you have counseled. Identify one or more times when you feel as though you and a client have experienced a moment of deep connection. What counselor factors do you believe contributed to your ability to invite and facilitate this moment of deepened connection with your client? You may consider who you are and/or what you do before and/or during these counseling sessions.

When you have identified a factor, please type it in one of the boxes. Brainstorm as many factors as you can, but please limit each box to ***ONE*** factor or concept only. To guide you in this process, please use the following focus prompt:

**“One counselor factor that contributes to my ability to invite and facilitate a moment of relational depth with a client is \_\_\_\_\_.”**

**PILOT STUDY APPENDIX I**  
**SORTING AND RATING THE STATEMENTS E-MAIL**

ELIGIBLE PARTICIPANTS

Dear \_\_\_\_\_ :

Thank you very much for your participation in the first phase of data collection as part of the study “Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth.”

As part of the second phase of data collection, I will be sending you a manila envelope in the mail, which will include instructions and all of the materials needed to sort and rate the statements. I have also attached a copy of the sorting and rating instructions to this e-mail for you to review before beginning the task.

The sorting and rating process should take approximately one hour of your time. I ask that you please complete the task and return the materials (in the enclosed, stamped and self-addressed envelope) to me no later than **PROVIDE DATE HERE**.

If you have any questions or concerns, please feel free to contact me at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my dissertation chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Again, thank you very much for your time and willingness to participate in this study. I very much appreciate it!

Sincerely,  
Jodi

Enc: Sorting and rating instructions

NON-ELIGIBLE PARTICIPANTS

Dear \_\_\_\_\_ :

Thank you very much for your participation in the first phase of data collection as part of the study “Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth.”

At this point, you were not selected to participate in the final two phases of data collection because you did not meet the eligibility criteria. However, I very much appreciate your willingness to participate in generating the statements.

If you have any questions or concerns, please feel free to contact me at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my dissertation chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Again, thank you very much for your time and willingness to participate in the first phase of data collection.

Sincerely,  
Jodi

## PILOT STUDY APPENDIX J

### SORTING AND RATING THE STATEMENTS INSTRUCTIONS

Thank you very much for agreeing to participate in the study “Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth.”

There are two primary tasks involved in this portion of the study: (1) sorting the statements, and (2) rating the statements. Detailed instructions are provided below.

#### (3) SORTING THE STATEMENTS:

Materials included:

- NUMBER of white pieces of paper with statements written on them
- 15 letter-sized envelopes (for grouping the statements)

Instructions: Inside of the manila envelope, you will find NUMBER of small white pieces of paper with statements written on them and 15 letter-sized envelopes for sorting the statements. Please sort the statements (printed on the white cards) into groups in a way that makes sense to you. There are a few guidelines for this process: (a) each card may only be placed in one pile, (b) the cards may not all be placed in the same pile, and (c) each card cannot be its own pile.

Once you have grouped the statements, place each group of statements in a letter-sized envelope, seal it, and write a label (conceptual name) for that group on the outside front of the envelope. You do not need to use all of the envelopes.

*Example: You decide that the statements “dog,” “cat,” “hamster,” and “goldfish” all belong in the same group. You believe that they all represent the category “Pets.” You place these four statements in one envelope, seal it, and write the name “Pets” on the front of the envelope.*

#### (4) RATING THE STATEMENTS:

Materials included:

- The “Rating the Statements based on Importance” sheet of paper with Likert-type scales included.
- The “Rating the Statements based on Frequency” sheet of paper with Likert-type scales included.

Instructions: Please rate the statements based on (a) how important you believe they are in contributing to your ability to invite and facilitate a moment of relational depth

with a client and (b) how often you believe you practice these factors in your work with clients. You are encouraged to use the full range of the Likert-type scale.

*For example, on the importance rating form, if you do not believe that the statement “center myself beforehand” is important to your overall ability to invite and facilitate a moment of relational depth with a client, you would rate it a 1.*

*For example, on the frequency rating form, if you do not believe that you “center yourself beforehand” when working with clients, you would rate this factor a 1.*

**COMPLETION OF TASKS:** Once you have completed both of the sorting and rating tasks, place all of the sealed letter-sized envelopes and the rating sheet into the enclosed manila envelope (stamped and addressed to be returned to me), and mail it back to me for data analysis.

These envelopes are due by: DATE

**THANK YOU AGAIN!!!**

## PILOT STUDY APPENDIX K

### INTERPRETING THE RESULTS E-MAIL

Dear \_\_\_\_\_ :

Thank you very much for participating in the first two phases of data collection as part of the study “Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth.”

For the third, and final, phase of data collection, you are invited to participate in a focus group where you (and other participants) will have the opportunity to interpret the concept maps. Additionally, you will be invited to offer implications for subsequent research, counselor education, and supervision. You do not need to bring anything for the session, and snacks will be provided for you. This meeting will take approximately an hour and a half.

The focus group will take place on DATE from TIME to TIME at The University of North Carolina at Greensboro in the Nicholas A. Vacc Counseling and Consulting Clinic, Ferguson Building, room NUMBER. If you are not familiar with the Vacc Clinic, it is located on the second floor of the Ferguson Building. The physical address is 524 Highland Avenue, Greensboro, NC 27412. Parking is available in the Oakland Parking Deck. Please bring your parking pass with you and you will be given an exit pass for free parking.

Click here for directions to campus (<http://parking.uncg.edu/access/access.html>).

Please RSVP to this invitation by DEADLINE, so that I can plan accordingly.

If you have any questions or concerns, you are encouraged to contact me at [jlbartl2@uncg.edu](mailto:jlbartl2@uncg.edu) or my Dissertation Chair, Dr. Craig S. Cashwell, at [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu)

Thank you again for your time and participation. I really appreciate it!

Sincerely,  
Jodi L. Bartley

## PILOT STUDY APPENDIX L

### INTERPRETING THE CONCEPT MAPS AGENDA

1. **Beforehand:** Make sure that the room is reserved, the snacks are available, writing utensils are available, the note-taker is ready and taking notes on my computer, the agenda is printed for me, and copies of the necessary handouts are ready: (a) the cluster listings, (b) the point and cluster concept maps, and (c) the point rating and cluster rating concept maps.
2. **Introduction to the task:** “Thank you very much for your participation in ‘Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Moments of Relational Depth with Clients.’ It is great to have you here! Also, I want to introduce the note-taker for this session, NAME.

I have analyzed the data from your responses in the sorting and rating tasks, and you will see – and be able to provide feedback on – the results of that analysis today. The two goals for today are to (a) to name the clusters and (b) discuss the findings. With your help, implications can be provided for subsequent research, counselor education, and supervision.”

3. **Present the listings of clusters and statements under each cluster:** “Prior to today, you participated in two rounds of data collection – first generating the statements and then sorting and rating them. Based on your groupings, I created clusters of specific statements. As you will see here, certain statements have been grouped into categories or clusters based on how often they were grouped together in the same piles by all of you. What we will do is go through each cluster and name them based on the statements in that category. Please take five to ten minutes to individually look through the statements under each of the clusters and write a name for each cluster. When everyone is done, we will work as a group to reach consensus on a name for each cluster.”
4. **Present the point and cluster map:** “The point and cluster map here is a graphical display of how the statements were grouped together. This is a concept map of the same clusters that you just named. As you can see, if two statements were commonly placed in the same group by all of you, then these two statements appear closer together on this point and cluster map. In the same way, clusters that are more similar should be closer together on the map. Do you have any responses to anything here? Do you think that any clusters should be merged? Do you think that any specific statement under any cluster should be removed?”
5. **Present the point and cluster rating maps:** “The point and cluster rating map here is a graphical display of how important you believed each of the statements were in

contributing to your ability to invite and facilitate a moment of relational depth with a client and how frequently you use these factors in your work with clients. Feel free to examine these findings. Do you have any insights or impressions that you would like to share?”

6. **Implications:** “Now that you have reviewed the results, I would like to ask you a few questions:
  - (e) How do you believe you initially developed the ability to invite and facilitate moments of relational depth with clients? Do you believe this can be trained?
  - (f) Two researchers, Rowan and Jacobs, stated that there are three ways that therapists use themselves when working with clients: instrumental, authentic, and transpersonal (these three terms will be written on a chalkboard in the meeting room). In the first position (instrumental), skills-based, manualized treatment approaches prevail. Therapists operating from this position rely on technical treatment approaches in order to fix clients. Moving to the second way of being, the authentic position is characterized by more authentic interactions between the therapist and the client. In this position, the therapeutic relationship is considered much more important. In the third position of the therapist’s use of self, the therapist relates in a transpersonal way with clients. Rowan and Jacobs (2002) described their transpersonal way of being as a place where the egoic concept of the self dissolves. Therapists who are able to relate from this place have been described as those “. . . who are open to experiences beyond or deep within themselves. . . This subtle consciousness cannot be ‘willed’ into existence, but often comes in brief moments” (Rowan & Jacobs, 2002, pp. 71-72). Do you believe the concept maps represent Rowan and Jacobs’ (2002) three positions (instrumental, authentic, and transpersonal) of the therapist’s use of self? If so, how?
  - (g) Based on the emergent clusters, what implications could you offer for counselor educators and supervisors in teaching mental health counseling students to develop the capacity to invite and facilitate moments of relational depth?
  - (h) Based on the emergent clusters, what implications could you offer for future relational depth research?”
7. **Conclusion:** “This concludes the focus group session. Thank you very much for your participation today and in the previous phases of data collection. I really appreciate it! If you have any follow-up questions or concerns, please feel free to contact me.”

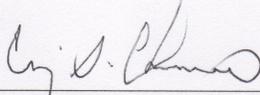
**PILOT STUDY APPENDIX M**  
**CERTIFICATE OF CONFIDENTIALITY**

**APPENDIX M**

**CERTIFICATE OF CONFIDENTIALITY**

I, Craig Cashwell, will be responsible for taking notes as part of Jodi L. Bartley's third phase of data collection (the focus group) in her dissertation: "Deep Calls to Deep: A Concept Mapping Study of Counselor Factors that Contribute to Relational Depth."

As part of my responsibilities, I agree to keep all participants' information strictly confidential.

Signed:  Date: 8-8-14  
Dr. Craig S. Cashwell

## APPENDIX O

### PARTICIPANTS' INITIAL STATEMENTS

#### Participant One

1. Before and during counseling, one way I invite and facilitate moments of relational depth with clients is to ground myself in the present moment.
2. Before and during counseling, one way I invite and facilitate moments of relational depth with clients is to use present moment techniques such as breath and mindfulness.
3. During counseling, one way I invite and facilitate moments of relational depth with clients is to embody and communicate unconditional positive regard/acceptance of who they are.
4. During counseling, one way I invite and facilitate moments of relational depth with clients is to use my voice as a tool to connect (intentionality of tone, volume, and pacing).
5. During counseling, one way I invite and facilitate moments of relational depth with clients is to use silence to give space to emotion.
6. During counseling, one way I invite and facilitate moments of relational depth with clients is to use all or part of the DCT interview (help the client to have an embodied process of their experiences and mirror that for them).
7. During counseling, one way I invite and facilitate moments of relational depth with clients is to entrain my breath with theirs.
8. During counseling, one way I invite and facilitate moments of relational depth with clients is to slow the process down whenever possible.
9. During counseling, one way I invite and facilitate moments of relational depth with clients is to do my best to be congruent.
10. During counseling, one way I invite and facilitate moments of relational depth with clients is to be aware of and respond to incongruence (both within my clients and within myself).
11. During counseling, one way I invite and facilitate moments of relational depth with clients is to match client language.
12. During counseling, one way I invite and facilitate moments of relational depth with clients is to use reflections with meaning to communicate understanding.
13. During counseling, one way I invite and facilitate moments of relational depth with clients is to validate the clients struggle.
14. During counseling, one way I invite and facilitate moments of relational depth with clients is to highlight the client's strengths.
15. During counseling, one way I invite and facilitate moments of relational depth with clients is to highlight the client's progress.
16. During counseling, one way I invite and facilitate moments of relational depth with clients is to use immediacy.

17. Before or after counseling, one way I invite and facilitate moments of relational depth with clients is to practice loving-kindness meditation for clients I find challenging.
18. During counseling, one way I invite and facilitate moments of relational depth with clients is to take several slow full breaths.
19. During counseling, one way I invite and facilitate moments of relational depth with clients is to validate the clients inherent goodness by helping them to separate who they are from their past behavior or experiences.
20. During counseling, one way I invite and facilitate moments of relational depth is to summarize with meaning and ask if I'm getting it right.
21. During counseling, one way I invite and facilitate moments of relational depth with clients is to communicate non-judgment of not only the client but of other people in general including the people that they care about.
22. During counseling, one way I invite and facilitate moments of relational depth is to mirror or mismatch client body language.
23. During counseling, one way I invite and facilitate moments of relational depth with clients is to be willing to "name the thing."
24. Between counseling sessions, one way I invite and facilitate moments of relational depth with clients is to engage in contemplative practices that cultivate self and other compassion.
25. During counseling, one way I invite and facilitate moments of relational depth with clients is to communicate empathy.
26. During counseling, one way I invite and facilitate moments of relational depth with clients is through intentional use of eye contact.
27. Between counseling sessions, one way I invite and facilitate moments of relational depth with clients is to practice non-judging.
28. During counseling, one way I invite and facilitate moments of relational depth with clients is to validate and explore the clients worldview and beliefs.
29. During counseling, one way I invite and facilitate moments of relational depth with clients is to use self-disclosure to facilitate a sense of universality ("you are not alone") around some aspects of the clients struggle.
30. During counseling, one way I invite and facilitate moments of relational depth with clients is to validate, validate, validate.

### Participant Two

1. Sustained intentional eye contact
2. Intentional vulnerability and transparency (on my part) about my own thoughts, feelings, fears... modeling I suppose
3. Shame attacking
4. Expressing powerful honest regard for the client
5. At times, crying with a client
6. Setting the clinical environment (quiet yoga music in background, indirect lighting, etc.)

7. "Soft/low/slow" voice
8. Esteeming the client
9. Helping the client understand the (often times very understandable) reasons for the choices they've made
10. Assuring client that I will not leave them, that I will walk with them
11. Thanking client genuinely for moments of vulnerability
12. Swear therapy :)
13. For clients who pray, I might pray for or with them in session
14. Grounding and meditation exercises in which we both participate

### Participant Three

1. Meditating
2. Praying
3. Breathing prior to session
4. Embrace own suffering
5. Practice compassion
6. Practice self-compassion
7. Practice non-judgment
8. Attend fully
9. Experience empathy
10. Communicate empathy
11. Slow session pace
12. "Touch" client emotions
13. Use silence
14. Be in the moment
15. Get my own counseling
16. Recognize own limitations
17. Be transparent
18. Be immediate
19. Challenge with compassion
20. Release my need for client to change
21. Empower client
22. Honor client's narrative
23. Congruence
24. Positive regard
25. Slow deep breaths in session
26. Active listening
27. Pause when feel reactive
28. Self-attunement (i.e., what is going on with me)
29. Attuning to client
30. Releasing need to "perform"
31. Practicing self-care
32. Setting process/relational goals

33. Honoring cultural differences
34. Prizing client's voice
35. Collaborating with client
36. Honoring client right not to change
37. Remaining curious
38. Owning in-session mistakes
39. Structuring sessions
40. Following client's agenda
41. Trusting client's goals
42. Centering prior to session
43. Reviewing notes before session
44. Setting intentions

#### Participant Four

1. Vulnerability
2. A sense of equality
3. Curiosity
4. Self-disclosure
5. Silence paired with highly connected nonverbal communication
6. Presence
7. Honoring differences
8. Transparency
9. Rapport
10. Trust
11. Risk-taking
12. Intuition
13. Positive regard for client
14. History of strong collaboration with client
15. Authenticity
16. Mindfulness
17. Self-awareness
18. Ability to confront or challenge client in a therapeutic manner.
19. Honesty
20. Empathy
21. Genuine care for the client
22. An approach that considers the client's story sacred
23. Showing up as "me" in session-using my personality as a therapeutic tool

#### Participant Five

1. Becoming fully present
2. Deep breathing
3. Pushing ego out of the way

4. Opening my heart center
5. Focusing on client
6. Quieting my mind
7. Prayer
8. Being real/genuine
9. Creating space of safety
10. Creating space of trust
11. Creating space of non-judgment
12. Truly listening - not just with ears but with whole self
13. Allowing myself to safely but fully feel (boundaries in place)
14. Valuing gift of client's sharing
15. Silence
16. Leaning in
17. Eye contact

#### Participant Six

1. I mindfully breathe.
2. I quiet my mind.
3. I scan my body for felt sense feedback related to the client.
4. I identify my own felt sense experience.
5. I identify my perception of the client's emotions related to death, dying, isolation, freedom of choice, and anxiety.
6. I validate the client's emotions, thoughts, and experiences until I can feel a strong rapport.
7. I reflect content.
8. I reflect feelings.
9. I am completely transparent.
10. I am completely genuine.
11. I am completely authentic.
12. I use immediacy.
13. If I sense my own hesitation related to being authentic then I scan my body and breathe through any tension until it is released.
14. I initiate conversations around death, dying, and living with vitality.
15. I assess the client's reactions to hearing the words, "death", "dying", "fear", and "being alone".
16. Depending on the client's reactions to the existential givens, I match them where they are and provide support.
17. When I sense that the client feels supported, I probe toward "the pain" or primary emotions.
18. I stay with the client and breathe through my own emotional and felt sense reactions related to our depth.
19. I never pace the session faster than the client.
20. I either match the client's pace or go slower, depending on the client's anxiety.

21. I use immediacy related to the content of the conversation.
22. I use immediacy related the emotions in the room.
23. I share my own experiences in the room.
24. I express positive regard toward the client.
25. I use silence intentionally when I assess that the client needs time to stay with the emotion.
26. I stay connected to the client during silences with soft eye contact.
27. I mirror clients who look at me with strong eye contact.
28. I empower the client to connect with their wisdom using direct language.
29. I find metaphors helpful when clients are stuck or avoidant.
30. I am open to the client and their experiences.
31. I am nonjudgemental.
32. I prioritize our relationship versus moving the session in a particular direction.

### Participant Seven

1. Mindful - checking my stuff before sitting with client
2. Grounding - couple of deep breaths before sitting with client
3. Preparation - intentional thought about the client and client struggles before sitting down with client
4. Presence - as a result of first factors, I am as intentionally present to the moment and client as I possibly can be
5. Listening - actively attuning to client's verbal and nonverbal communication
6. Phenomenology - stepping into client's worldview, to my best ability, to understand their story, struggles, wounds, and pain
7. Non-judgmental
8. Congruence/Genuineness
9. Empathy
10. Silence
11. Present moment focus on the experience happening in the here-and-now
12. Slow pace
13. Soft tone
14. Open body language
15. Reflections of feeling
16. Reflections of meaning
17. Immediacy
18. Process comments
19. Mindful - of own visceral/intuitive feelings in session
20. Humble - client is expert on their story
21. Authenticity - I am human, too

### Participant Eight

1. Staying present in session
2. Being genuinely myself with clients
3. Providing validation
4. Staying close with client's emotional experience
5. Demonstrating empathy for their experience
6. Asking where they are feeling their emotions in their body
7. Using metaphors
8. Slowing my breathing when I feel uncomfortable during session
9. Use self-involving disclosure when I am struggling to connect to a client and their experience
10. Asking clients to help me understand their experience better
11. Reflecting emotion repeatedly
12. Leaning in towards clients
13. Slowing down the pace of the session
14. Using the client's words
15. Using imagery
16. Speaking softly
17. Keeping my reflections and questions simple
18. Trying not to get caught in just the content of what the client is saying
19. Focusing on the process of what the client is experiencing in the room
20. Focusing on the process of what I am experiencing in the room
21. Using process comments
22. Using nonverbals as the client is talking
23. Interrupting as needed to help the client stay with their present experience
24. Reflecting on what happened in sessions afterwards
25. Considering how to enhance the therapeutic relationship with the client
26. Using gentle confrontation
27. Holding clients accountable for their actions
28. Using tentative language to conjecture about the client's experience
29. Externalizing the problem
30. Taking at least a few minutes between sessions to reorient myself
31. Engaging in self-care practices for myself
32. Managing my caseload (e.g., trying not to see more than 6 clients in a day)

### Participant Nine

1. By being totally focused on what the client is "saying" to me - in words and nonverbally and just the client's presence in the room
2. By making a response to the client's unspoken message
3. By making my presence in the room very quiet
4. By trying to identify what the client wants and needs from me
5. By opening up my experience of the client to the client

6. By being open to sharing a similar experience of my own with the client
7. By being there with the client, quietly
8. By being with and in the depth in the room
9. By connecting to my soul and "speaking" to the client from there
10. By feeling the power of God's grace for both of us in the room
11. By avoiding any rescuing or problem-solving thoughts/urges
12. By being totally honest with the client
13. By "speaking" through my eyes to the client's eyes
14. By listening from the depths of my soul
15. By honoring the humanity of the client
16. By staying open to the client's experience in the room
17. By not assuming to know what will happen next/where this is going
18. By naming "it" - whatever that may be
19. By offering myself as the "place" where the client is safe to experience deeply and express that in whatever way is needed
20. By letting go of all expectations
21. By offering/sharing with the client my energy when the client lacks the energy to go deeply
22. By being still - inside and outside
23. By centering myself before the session
24. By centering my thoughts around the client
25. By reflecting on my previous experiences with the client
26. By reflecting on what may be getting in our way in counseling
27. By remembering other experiences of relational depth and what that felt like to me
28. By noticing the little things about the client

#### Participant Ten

1. Establish a safe environment
2. Establish trust
3. Provide support
4. Provide non judgement
5. Show understanding
6. Provide nurturance
7. Provide feedback when appropriate
8. Allow them to see that I am right there with them
9. Allow them to see that I care
10. Sometimes, appropriate self disclosure

#### Participant Eleven

1. Listening
2. Empathic attunement

3. Reflection
4. Softening my voice
5. Slowing my pace of speaking
6. Validating client experience
7. Physically leaning in towards client
8. Mirroring client facial expression (during reflection)
9. Mirroring client body language (during reflection)
10. Repeating cue for client response
11. Empathic attunement
12. Checking to see if I understand
13. Being tentative with reflections
14. Tentative conjectures (just on leading edge)
15. Staying right with client experience in room
16. Using immediacy with observations
17. Using immediacy regarding my experience in room
18. Exploring with client what's happening in client's body
19. Linking cue to emotional response (including physical response)
20. Linking emotional response to meaning-making
21. Linking meaning-making to action
22. Making sense of client experience (in context)
23. Tracking client experience
24. Checking in with client about present-moment experience

#### Participant Twelve

1. Listen attentively
2. Being fully present
3. Providing space for client to share
4. Encouraging client to explore at a deeper level
5. Being nonjudgemental
6. Intentional use of self-disclosure
7. Maintaining nonverbal connections (e.g., eye contact, minimal encouragers)
8. Intentionally reflecting meaning
9. Showing genuine interest in client's stories
10. Modeling authenticity
11. Seeking to understand client's subjective experiences
12. Communicating empathy
13. Encouraging exploration of issues/events around which client seems to have particular energy
14. Accepting the client as he/she is
15. Empowering the client
16. Being supportive of the client's efforts in counseling
17. Maintaining the big picture of who the client is and what he/she is trying to accomplish in counseling

## 18. Viewing the client holistically

### Participant Thirteen

1. Being open and vulnerable in session
2. Being genuine and real
3. Demonstrating empathy
4. Strong eye contact
5. Warmth
6. Nonjudgment
7. Unconditional positive regard
8. Respecting the client
9. Honoring the client as a person
10. Honoring client vulnerability
11. Comfort with silence
12. Strong rapport
13. Work to build trust between client and counselor
14. Open with my emotional experience
15. Heartful
16. Not guarded
17. Compassionate
18. Accepting
19. Honoring of client story
20. Awareness of resiliency
21. Awareness of client strengths and beauty
22. Sensing energy and energetic shifts
23. Being fully present
24. Caring about the client
25. Belief in client ability
26. Humility as a counselor
27. Admiration for client's work
28. Honored to share space with client
29. No facade
30. Transparency
31. Mindfulness of self

### Participant Fourteen

1. Pray for client prior to session
2. Cry with client
3. Review notes of previous session to remind self of what has been discussed
4. Show interest in client by referring to things discussed in previous sessions
5. Focus completely on client during session.
6. Being completely present

7. Facial expressions conveying empathy and understanding (happens naturally, not intentional)
8. Listen for what is there and not being said
9. Ask gentle questions around what is there and not being said
10. Express understanding
11. Reflect or name emotions
12. Convey complete acceptance
13. Convey complete safety
14. Follow intuition
15. Allow natural conversation rather than scripting
16. Occasional appropriate self-disclosure
17. Normalize emotion or experience
18. Listen

#### Participant Fifteen

1. Consistency over time (trust)
2. Self-disclosure of common experiences
3. Interpreting emotions (outside of clients immediate awareness)
4. Facilitating new connections or meaning
5. Intensity of emotions - high energy in the session
6. Creating safety through warmth and empathy
7. Discussing client trauma over time
8. Gentle probing questions to create more depth
9. Supportive and not pushing (timing)
10. Acknowledging clients strength
11. Addressing transference and counter transference, esp when its empathic
12. Immediacy of reflection
13. Interpretation of client reactions
14. Acting on intuitive/internal responses
15. Expressing encouragement or protectiveness toward client
16. Very high (atypical) level of awareness
17. Confrontation

#### Participant Sixteen

1. Being very open to the client
2. Immediacy
3. Attending to the internal emotional processes happening in me
4. Attending to the subtle level of emotions within the client's communications
5. Using in depth reflective listening
6. Working to communicate real compassion for the client
7. Working first on the therapeutic relationship before working on any other clinical goals

8. Viewing the relationship as THE vehicle for change
9. Working to be highly attuned to the client's experience
10. Holding no judgment about the client
11. Believing in the client's ability to transform his or her life
12. Talking about the therapeutic relationship as it develops
13. Respecting the client's boundaries
14. Honoring the personhood of the client
15. Bringing spiritual energy into the process through meditation or prayer
16. Attending to the creation of relational safety
17. Communicating directly about relational dynamics that occur in counseling
18. Exploring intersubjective relational dynamics
19. Conceiving of myself as a conduit for transformation
20. Striving to keep my heart very open

#### Participant Seventeen

1. Eye contact
2. Warmth
3. Open posture, body language
4. Empathy
5. Acknowledge and reflect emotions expressed
6. Understanding
7. Non-judgmental approach
8. Unconditional acceptance
9. Give hope
10. Show respect
11. Fully present with client in the moment
12. Provide safety in the environment
13. Unafraid of painful emotions
14. Reflective listening
15. Authentic
16. Genuinely care about client
17. Honest
18. Direct
19. Clear
20. Convey ability to be helpful with client goals
21. Confidence in ability to treat client's issues
22. Comfortable to receive client feedback and questions
23. Appropriate self-disclosure

#### Participant Eighteen

1. Spend the first 2 sessions on establishing rapport throughout the time spent together

2. Creating a safe environment; from the pictures on the wall, pillows and furniture, etc.
3. I don't take notes during the sessions
4. Authentic
5. Open-minded
6. Non-judgmental feedback
7. Tone-of-voice: calm, even-toned
8. Thoughtful facial expression
9. Normalizing behaviors/feelings/thoughts
10. Honesty
11. Self-care
12. Self-disclosure (minimum)

#### Participant Nineteen

1. Use silence
2. Attend to my breathing
3. Maintain eye contact
4. Practice mindfulness
5. Attend to my client's breathing
6. Use immediacy
7. Resist temptations/urges to give a "comfort smile"
8. Resist temptations/urges to fill silences
9. Check in with myself before session
10. Practice fuller breaths before session
11. Stretch muscles before session
12. Modulate voice
13. Lower voice
14. Slow down pace of speech
15. Slow down rate of head nod/minimal encouragers
16. Tilt head
17. Lean forward
18. Reflect client's feelings in the present moment
19. At times, self-disclose
20. Resist temptation to focus solely on goals (vs. present moment)

#### Participant Twenty

1. Slow down internally and be aware of our shared presence
2. Enter as profoundly as I can into an experientially felt sense of the client's world
3. Attune and reflect empathically on the leading edge of the client's words - what I hear his/her saying, and the emotional edge of what I sense they are intending to say
4. Lots of simple reflection - using clients words, in a soft, slow tone

5. Strive at all times for accurate empathic reflections - and for indications from client as to whether I am on base or off base
6. Allow for silence to attune to what client has said and to allow client to tune into my best reflection of what I heard him/her say
7. Transparency - share when client has said something which particularly touches me (e.g. feeling sadness regarding what he/she shared)
8. Transparency - sharing very briefly a similar emotional process whether or not the content is similar
9. After sharing a personal experience which I feel is relevant to client, returning to how this may or may not expand on their experience (maintaining the focus on the client)
10. Shared eye gaze
11. Validation - that a client's experience makes sense (in the attachment frame) and that he / she is clearly doing the best s/he knows to meet his/her needs
12. Tracking the client's emotional process\*, also to deeply engage with how valid and poignant his/her experience is. (\*i.e. from external cue, to internal limbic, neocortical meanings, bodily expressions, and behavioral responses)
13. Tuning into my own bodily felt sense as I attune to client's verbal expressions
14. Tuning into my own bodily felt sense as I attune to client's non-verbal expressions
15. Humility - seeing client as similar to me in the most profound human ways.
16. Caring deeply for the person
17. Tuning in as best I can to the client's needs
18. Accessing a felt sense of acceptance, and appreciation for this client's humanity

## APPENDIX P

### SYNTHESIZED STATEMENTS

1. caring deeply for the client
2. establishing a strong relationship/rapport
3. conceiving of myself as a conduit for transformation
4. giving hope
5. structuring within and across sessions
6. providing support
7. providing nurturance
8. attacking shame
9. noticing the little things about the client
10. collaborating with the client
11. focusing completely on the client
12. letting go of all expectations
13. praying
14. honoring cultural differences
15. having confidence in ability to treat the client's issues
16. resisting temptation to focus solely on goals
17. possessing self-awareness
18. acknowledging the client's strengths
19. being willing to "name the thing"
20. taking risks
21. staying close with the client's emotional experience
22. attending fully
23. conveying warmth
24. viewing the client holistically
25. providing support
26. respecting the client
27. pausing when I feel reactive
28. attending to my breathing
29. attending to my client's breathing
30. establishing trust
31. listening – not just with ears but with whole self
32. "speaking" through my eyes to the client's eyes
33. sustaining intentional eye contact
34. using gentle confrontation
35. following intuition
36. remaining curious
37. exploring with the client what's happening in client's body
38. sensing energy and energetic shifts

39. offering/sharing with the client my energy when the client lacks the energy to go deeply
40. connecting with and listening from the depths of my soul
41. being transparent
42. being totally honest with the client
43. being humble – seeing the client as similar to me in the most profound human ways
44. expressing understanding
45. validating the client’s experience
46. being vulnerable
47. using immediacy
48. exploring interpsychic relational dynamics
49. grounding/centering myself before sessions
50. opening my heart center
51. staying open to the client’s experience
52. being comfortable with and using silence intentionally
53. practicing mindfulness
54. using metaphors/imagery
55. initiating conversations around existential issues (e.g., death, isolation, freedom)
56. being still – inside and outside
57. speaking softly
58. being fully present
59. making my presence in the room very quiet
60. embracing my own suffering
61. establishing a safe space
62. remembering other experiences of relational depth and what that felt like to me
63. assuring the client that I will not leave her/him, that I will walk with her/him
64. practicing self-care
65. communicating real compassion for the client
66. slowing down the pace of the session
67. being genuinely myself with clients
68. respecting the client’s boundaries
69. using the client’s words
70. being nonjudgmental
71. accepting the client as she/he is
72. honoring the humanity of the client
73. setting the clinical environment (e.g., quiet yoga music in background, indirect lighting)
74. preparing for the session (e.g., reviewing notes, reflecting on previous experience)
75. communicating empathy
76. probing gently to create more depth
77. being unafraid of the intensity of emotions
78. entering as profoundly as I can into an experientially felt sense of the client’s world

79. attuning to the client
80. intentionally reflecting meaning
81. “touching” and reflecting emotions
82. reflecting and summarizing content
83. being open with my own emotional experience (e.g., crying with the client)
84. empowering the client
85. using tentative language
86. setting process/relational goals
87. using facial nonverbals with the client (e.g., mirroring expressions, conveying empathy through facial expressions)
88. using body nonverbals with the client (e.g., tilting head, opening posture, leaning in, mirroring body language)
89. attending to the internal emotional processes happening in me
90. intentionally using self-disclosure

## APPENDIX Q

### R SYNTAX AND DATA OUTPUT

```
> setwd("/Users/jodibartley/Documents/Dissertation/Dissertation Document/Data/Full Study")
```

```
>
```

```
> gsm.data <- read.csv(file="FS Sort Table for R.csv",header=FALSE)
```

```
> gsm.data
```

```
  V1 V2 V3 V4 V5 V6 V7 V8 V9 V10 V11 V12 V13 V14 V15 V16 V17 V18
```

```
1 7 7 8 5 3 2 9 2 1 3 8 4 8 13 5 3 1 7
2 6 10 6 5 3 3 8 1 2 3 2 3 8 8 7 2 3 6
3 4 3 4 1 4 5 6 7 1 1 4 8 4 7 3 4 5 2
4 6 2 8 5 3 13 8 1 4 3 4 10 8 13 7 3 2 1
5 8 9 11 4 1 7 7 1 2 11 10 10 6 1 2 2 3 3
6 6 2 8 4 3 13 8 1 4 3 2 10 2 13 7 3 2 1
7 6 2 8 5 3 13 8 1 4 3 4 10 8 13 7 3 2 6
8 5 2 10 3 7 9 4 7 4 12 1 10 6 11 7 2 2 1
9 6 6 8 4 3 12 3 3 1 6 9 1 9 2 5 1 5 6
10 5 6 8 4 3 12 8 2 2 10 2 1 7 5 5 1 2 5
11 6 6 8 5 3 5 3 2 1 6 8 10 7 3 5 1 1 5
12 4 8 7 1 10 12 6 4 1 1 11 10 4 12 3 3 4 2
13 4 5 4 1 7 8 6 7 1 9 1 5 5 10 3 4 4 7
14 6 10 8 3 3 12 5 2 1 10 3 1 2 5 1 2 5 6
15 4 7 2 2 4 7 6 7 1 1 7 8 4 12 7 2 4 7
16 4 9 6 4 1 7 2 5 2 9 9 10 6 7 2 2 5 1
17 4 3 2 1 8 11 6 6 1 1 7 9 4 12 4 4 4 7
18 6 10 6 4 3 13 2 2 4 2 2 1 7 13 7 1 2 4
19 4 1 7 3 13 1 10 4 1 2 4 4 6 4 7 2 2 4
20 4 1 10 4 13 1 1 4 1 7 4 4 4 4 7 2 2 1
21 3 6 3 5 10 6 4 4 2 5 3 4 8 3 7 1 1 5
22 3 10 7 5 3 5 3 2 1 6 2 3 3 3 4 3 2 6
23 7 2 6 4 3 3 1 1 4 3 6 2 8 8 4 3 2 6
24 6 6 6 5 3 12 9 2 3 10 2 1 4 5 7 1 5 2
25 6 2 8 5 3 13 8 1 4 3 4 10 2 13 7 3 2 1
26 6 2 6 5 3 12 9 1 4 10 2 1 2 5 1 1 5 6
27 4 7 7 4 5 11 10 6 1 2 9 9 6 12 6 4 5 4
28 1 8 1 1 11 8 3 6 1 1 11 9 1 12 4 4 4 7
29 3 10 1 5 11 6 3 2 3 8 3 3 1 3 5 1 5 4
30 6 2 6 3 3 3 8 1 2 3 2 2 8 8 7 3 3 1
31 5 2 4 1 2 5 3 4 1 8 5 3 9 10 3 3 2 6
32 3 2 4 5 12 6 1 3 3 9 10 1 1 6 7 3 1 5
33 3 10 9 4 12 6 10 3 2 3 5 3 1 10 7 2 2 5
```

34 5 10 9 4 3 1 10 3 2 2 5 3 6 11 7 2 2 4  
35 2 3 4 1 9 5 3 4 1 9 7 4 6 7 4 4 2 5  
36 4 3 2 5 3 4 1 3 1 5 7 3 6 12 7 3 2 6  
37 3 1 1 3 7 6 4 3 3 13 1 3 1 9 5 1 2 4  
38 2 5 4 5 14 5 3 7 3 8 9 9 3 3 3 4 2 5  
39 2 7 4 5 14 5 10 7 3 12 9 7 6 13 3 4 1 6  
40 2 7 4 1 2 5 3 4 1 9 8 4 9 10 3 3 1 6  
41 4 7 10 4 15 1 1 3 1 7 7 4 4 4 3 3 2 6  
42 4 1 10 4 15 1 1 4 3 7 6 4 4 4 5 3 2 6  
43 4 7 2 1 3 11 9 3 1 10 7 8 4 1 3 3 4 7  
44 6 2 8 4 10 4 5 1 4 3 6 3 8 9 7 3 2 5  
45 5 10 6 4 10 4 5 2 4 5 4 3 2 5 7 1 5 5  
46 4 3 8 1 9 11 1 3 1 7 7 4 4 4 3 3 4 6  
47 5 10 10 3 3 1 10 4 2 5 6 3 3 4 7 2 2 5  
48 2 5 6 3 7 6 2 4 3 5 1 10 6 11 7 2 5 5  
49 1 8 2 2 9 10 6 6 1 1 11 5 5 1 3 4 4 3  
50 1 3 4 1 9 11 3 3 1 1 11 4 8 2 3 4 1 7  
51 4 7 6 3 10 12 5 4 1 8 9 4 2 2 5 1 5 6  
52 5 4 5 5 5 6 10 3 1 2 6 3 6 6 7 2 2 5  
53 1 8 2 2 6 8 6 6 1 1 11 5 3 3 3 4 4 7  
54 5 7 9 3 7 6 4 4 2 13 6 3 6 10 7 2 2 5  
55 5 5 10 3 7 7 4 4 2 2 1 10 6 11 7 2 2 4  
56 1 4 5 1 5 11 10 3 1 2 11 9 4 6 3 4 2 7  
57 3 4 5 4 5 6 10 3 2 4 4 3 1 6 6 3 2 6  
58 1 3 7 1 6 11 3 3 1 8 7 4 3 3 3 4 2 6  
59 3 4 5 5 5 11 10 3 2 2 11 6 4 6 4 2 2 6  
60 4 3 2 1 8 8 6 6 1 1 8 9 4 12 3 4 4 7  
61 6 4 8 2 3 3 8 1 2 4 10 3 2 1 7 2 3 1  
62 4 3 11 1 9 11 4 4 1 1 8 9 4 12 7 4 4 2  
63 6 2 8 4 3 3 8 3 3 3 3 7 3 4 5 3 3 4  
64 4 8 2 2 3 8 6 7 1 1 7 5 4 7 2 4 4 3  
65 3 2 6 3 3 2 9 3 3 3 5 2 8 10 7 3 2 6  
66 5 4 5 4 5 6 10 3 2 4 10 3 6 6 6 2 2 4  
67 4 7 6 1 15 11 1 3 1 7 8 4 4 7 4 3 3 6  
68 6 2 8 5 3 12 9 2 4 10 2 1 7 5 1 1 5 1  
69 5 10 9 4 3 6 5 3 2 13 5 1 7 9 7 2 2 4  
70 7 7 4 5 3 2 9 1 1 8 8 2 2 9 7 2 3 6  
71 7 2 6 5 10 2 9 1 4 10 8 1 2 5 5 1 1 6  
72 7 2 6 5 3 12 9 2 1 10 2 1 2 5 5 1 5 7  
73 8 4 11 2 3 10 7 5 2 4 10 6 5 1 2 2 3 3  
74 8 8 11 2 1 10 7 5 2 11 9 10 5 1 2 2 4 3  
75 7 2 6 3 3 2 5 1 3 3 5 2 8 9 7 2 2 5  
76 5 10 10 3 3 6 4 3 2 5 5 3 6 11 7 2 2 4  
77 4 3 3 1 9 8 4 4 1 4 8 4 8 4 7 3 5 7



```

> gsm[3,3]
[1] 18
>
>
> write.table(npeople - gsm,file="jodi_gsm_matrix.csv", row.names=FALSE,
col.names=FALSE,
+           quote=FALSE,sep=",")
> # MDS
> library(MASS)
>
> #sim <- 17-gsm
> sim <- as.matrix(read.csv("jodi_gsm_matrix.csv", header=FALSE))
> str(sim)
int [1:90, 1:90] 0 14 17 11 18 13 11 18 14 14 ...
- attr(*, "dimnames")=List of 2
..$ : NULL
..$ : chr [1:90] "V1" "V2" "V3" "V4" ...
> sim[sim==0] <- .01
> s1 <- isoMDS(sim, k=2)
initial value 31.552529
iter 5 value 27.010671
iter 10 value 25.397379
final value 25.064108
converged
> s1$stress
[1] 25.06411
> s1$points
      [,1]      [,2]
[1,] 1.7757235 -5.29732994
[2,] -4.5803531 -1.71209951
[3,] 7.9748133 -0.29906134
[4,] -4.1651852 -3.73569671
[5,] -2.7499922  8.35328486
[6,] -4.6706539 -3.44881623
[7,] -3.3992452 -3.52777613
[8,] -5.5436611  3.97994615
[9,]  0.5828514 -5.29947369
[10,] -5.4185242 -3.17144988
[11,]  0.6285625 -5.87369368
[12,]  7.1625324  0.34950634
[13,]  8.0171078  2.74760319
[14,] -1.4131197 -5.35457726
[15,]  5.4360765  3.85352994
[16,] -0.8288324  6.93607674

```

[17,] 8.7422478 1.97671036  
[18,] -5.1048112 -2.81215340  
[19,] 0.6995543 3.99729879  
[20,] 1.0900048 3.26232033  
[21,] -2.2494844 -0.19558724  
[22,] 0.1007488 -2.44984966  
[23,] -3.7776661 -3.62111411  
[24,] -1.6847656 -6.37283394  
[25,] -4.2282483 -4.11400399  
[26,] -2.6101866 -7.39131267  
[27,] 4.1731985 4.91750977  
[28,] 9.0638417 1.77495509  
[29,] -0.7540011 -4.32335559  
[30,] -5.4822288 -4.04532105  
[31,] 2.0846335 -0.18970420  
[32,] -1.4757532 -1.25738202  
[33,] -4.2547169 2.76738098  
[34,] -4.0023392 3.26814206  
[35,] 4.5233264 2.69806026  
[36,] 0.4710497 0.43037948  
[37,] -5.3270496 2.95880306  
[38,] 3.6525761 -0.47470630  
[39,] 3.9680128 -3.19776544  
[40,] 5.9485385 -3.59696262  
[41,] 3.2152559 1.64809456  
[42,] 1.5831841 1.98548793  
[43,] 6.1905792 -1.95262536  
[44,] -6.1020860 -2.11466238  
[45,] -7.2630246 -2.39542200  
[46,] 6.9162316 -1.30472619  
[47,] -4.3503228 3.21080183  
[48,] -5.6283246 4.84427893  
[49,] 10.2541714 3.10449593  
[50,] 8.4631231 -1.54142382  
[51,] 3.8351629 -5.87925631  
[52,] -2.2942081 3.90614723  
[53,] 10.4417623 1.34836938  
[54,] -4.7339205 4.61163733  
[55,] -3.7307803 6.19583873  
[56,] 5.9857762 4.44611796  
[57,] -2.5790871 4.69488096  
[58,] 6.1105410 0.77336419  
[59,] 0.3912783 5.74912447  
[60,] 9.8917389 0.73177568

```

[61,] -7.6402117 -0.66531303
[62,]  7.3818901  2.70954881
[63,] -4.4909944 -5.73001485
[64,]  8.4455969  2.16224201
[65,] -3.4500374 -2.01208933
[66,] -4.3650554  6.29971892
[67,]  6.3067148 -2.78861813
[68,] -3.3109491 -8.46510872
[69,] -6.0415078  1.62750907
[70,]  0.5322587 -4.11722271
[71,] -1.1365570 -9.02331077
[72,] -0.0552016 -7.98027593
[73,] -2.0916947 10.51795044
[74,]  1.6926525  9.97267081
[75,] -6.1647145 -0.92822575
[76,] -5.4869254  3.52488747
[77,]  5.8759035 -1.50273499
[78,]  5.9803975 -5.07767873
[79,] -1.1153464 -5.11974038
[80,] -5.6539981  2.95297280
[81,] -5.7854807  0.06526109
[82,] -6.4281766  2.41914872
[83,]  6.7344350 -1.04946678
[84,] -4.4346845 -7.88028272
[85,] -6.5863765  3.22485050
[86,] -4.2961456  7.77539570
[87,] -5.2414357  1.04723998
[88,] -5.3402530  1.48965756
[89,]  9.5859779 -0.45051348
[90,] -2.3917138  2.42976258
> plot(s1$points[,1],s1$points[,2], type="n", xlab="Dim 1", ylab="Dim 2")
> text(s1$points[,1],s1$points[,2], paste(1:nstatements), cex=.80)
>
> #plot(s1$points[,1],s1$points[,3], type="n", xlab="Dim 1", ylab="Dim 3")
> #text(s1$points[,1],s1$points[,3], paste(1:nstatements), cex=.80)
>
> #plot(s1$points[,2],s1$points[,3], type="n", xlab="Dim 2", ylab="Dim 3")
> #text(s1$points[,2],s1$points[,3], paste(1:nstatements), cex=.80)
> plot(hclust(dist(s1$points),method = "ward.D2"), xlab="statements", cex=.6,)
> #plot(hclust(dist(s1$points),method = "complete"), xlab="statements", cex=.7,)
> #plot(hclust(dist(s1$points),method = "complete"), xlab="statements",
cex=.7,ylim=c(0,400))
>
> # to get cluster output another way

```

```
> # h is the height used to make group selection. Play with that to get the right number of
clusters
> mygroups <- cutree(hclust(dist(s1$points)), h=5)
> mygroups
[1] 1 2 3 2 4 2 2 5 1 2 1 3 6 1 7 8 6 2 9 9 10 1 2 11 2 11 7 6 1 2 12 10 5
5 7 10 5 12 13 13 12 12 3 14 14 3 5 15 6 3
[51] 13 9 6 15 15 7 9 3 8 6 14 6 11 6 2 15 13 11 5 1 11 11 4 8 14 5 3 13 1 5 14
5 3 11 5 4 5 5 3 9
>
```