UNDERSTANDING A THERAPIST'S WAY OF BEING:

A MODIFIED DELPHI STUDY

by

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ABSTRACT

Understanding a Therapist's Way of Being: A Modified Delphi Study

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Scholars have identified and researched different types of common factors in the therapeutic process, and *therapist way of being* may be one such common factor. Some scholars have emphasized the importance of way of being in the therapeutic process, but empirical research on concept is nonexistent. The purpose of this study was to form a definition of therapist way of being, to gain an understanding of how way of being influences therapeutic change, and to describe and define ways of being that are beneficial and detrimental to therapeutic change.

Data were collected through a modified Delphi study, which employed both qualitative and quantitative methodologies to pool together ideas from panelists. All panelists were licensed clinicians and reported being at least somewhat familiar with the concept of way of being.

The results of the study include a proposed definition of way of being, descriptions of ways of being that promote and deter therapeutic change, questions that might be asked of a therapist to better understand his or her way of being, and potential

responses to these questions that might indicate a change-promoting or change-deterring way of being. Suggestions for future research on therapist way of being were also given by panelists and are discussed.

(138 pages)

PUBLIC ABSTRACT

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Research has indicated that there are certain ingredients that make therapy successful. One of these ingredients may be the actual therapist providing the therapy. The concept of a person's *way of* being appears in some literature, but the concept of *therapist way of being* has not been well developed and explored. The purpose of this study was to form a definition of therapist way of being, to gain an understanding of how way of being influences a client's change in therapy, and to describe and ways of being that are beneficial and detrimental to a client's journey of change.

Data were collected from panelists, who were all licensed clinicians and all reported being at least somewhat familiar with the concept of way of being. The results of the study include a proposed definition of way of being, descriptions of ways of being that promote and deter client change, questions that might be asked of a therapist to better understand his or her way of being, potential responses to these questions that might indicate a change-promoting or change-deterring way of being, and lastly, suggestions for future research on therapist way of being.

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CHAPTER I

INTRODUCTION

While much of marriage and family therapy (MFT) research has focused on developing and understanding specific models (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Fals-Stewart, & Lam, 2008; Fristad, Goldberg-Arnold, & Gavazzi, 2003; Greenberg, Warwar, & Malcolm, 2010; Hartnett, Carr, & Sexton, 2016), in recent years, some scholars have turned to researching the common factors among most models, and common themes in the therapeutic experience, which influence change (Blow, Sprenkle, & Davis, 2007; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Davis, Lebow, & Sprenkle, 2012; Fife, Whiting, Bradford, & Davis, 2014; Karam, Blow, Sprenkle, & Davis, 2015; Lebow, 2016; Sprenkle, Davis, & Lebow, 2009). Therapist *way of being* was recently proposed as a possible common factor, and scholars have called for more research on the topic (Fife, 2015; Fife et al., 2014). A few scholars have included the therapist's way of being into their view on how change occurs and into their models of therapy, thus supporting the idea that a therapist's way of being be considered a common factor. Although some scholars discuss way of being, there are subtle differences in their conceptualizations and definitions, and the way of being construct has not been empirically tested and explored. The purpose of this study was to bring together multiple scholars' ideas to form a definition of therapist way of being, gain an understanding of how way of being influences therapeutic change, and to describe and define ways of being that promote and do not promote client change.

Researchers both within the MFT field (as well as in the field of psychotherapy in

general) have now long valued the study of evidenced-based treatments or empirically-supported treatments (ESTs) (Lebow, Rohrbaugh, & Stroud, 2016; Piercy, Chenail & Sprenkle, 2012; Sprenkle, Pinsof, & Wynne, 1995). EST research aims to discover which treatments work best for particular presenting problems and populations (Coatsworth et al., 2001; Fals-Stewart, & Lam, 2008; Fristad et al., 2003; Greenberg et al., 2010; Hartnett et al., 2016). Such research involves a natural focus on the question, "which model is best?" However, more recently scholars have begun to focus on exploring the principles that make models effective (Blow et al., 2007; Davis et al., 2012; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Fife et al., 2014; Karam et al., 2015; Sprenkle et al., 2009). Furthermore, researchers are emphasizing such principles even with EST research (Fischer, Baucom, & Cohen, 2016; Henggeler & Sheidow, 2012; Lebow, Chambers, Christensen, & Johnson, 2012; Roddy, Nowlan, Doss, & Christensen, 2016; Rowe, 2012; Slesnick & Prestopnik, 2009).

Thus, it seems that common factors are widely valued in the MFT field. Common factors include both model-dependent factors and model-independent factors (Davis & Piercy, 2007a; Davis & Piercy, 2007b). Model-dependent common factors include model-informed ways of conceptualization and intervention that all models share, such as conceptualizing a couple's current problems through understanding the influences of their families of origin (Davis & Piercy, 2007a). Model-independent factors are factors inherent in therapy itself, such as therapist or client variables (Davis & Piercy, 2007b; Lebow, 2014). While research about which models are most effective (usually for a particular presenting problem) is very helpful and important (Lebow et al., 2012), many models serve similar purposes, such as guiding the therapist to intervene on cognitive,

emotional, and behavioral levels (Davis & Piercy, 2007a). It may also be that factors outside of models also influence therapeutic outcomes (Davis & Piercy, 2007b). Research points to the possibility that little difference exists between the effectiveness of therapeutic models (Lambert, 2004; Shadish & Baldwin, 2003; Wampold, 2001), and thus common factors are an area of interest in determining what makes therapy effective.

Scholars have focused research on model-independent factors, including client factors, the therapeutic alliance, and therapist factors. Client factors refer to any element or quality of the client's life, situation, or personality that may influence change independent of the therapeutic process, such as personal characteristics—like being very motivated—or having very supportive family members (Karam et al., 2015). The therapeutic alliance refers to the client-therapist relationship, which may include the client feeling accepted and respected by the therapist (Blow & Sprenkle, 2001; see Blow et al., 2007 for a brief review of therapeutic alliance). The type of common factor most pertinent to this current study lies under the umbrella of therapist factors. Research on therapist factors involves an attempt to understand how the therapist influences change, as opposed to the impact of his or her model of choice (Blow & Karam, 2017; Blow et al., 2007). Therapist factors include any factors that may influence client outcomes that are unique to the therapist. Some therapist factors, such as gender, age, training, and experience, have not yet been proven to significantly influence therapeutic change (Beutler et al., 2004; Blow et al., 2007). Others, such as empathy, have been shown to have significant influence over client outcomes (Elliot, Bohart, Watson, & Greenberg, 2011). While some researchers may include the therapeutic alliance as a therapist factor, I treat it separately in this study. While the therapeutic alliance is certainly a therapist-

influenced factor, it may also be a client-influenced factor. Furthermore, it may be helpful to see therapist factors as influencing the alliance, as well as other client outcomes.

In much psychotherapy research, therapist factors are actually a variable to be controlled for because questions often focus on the effectiveness of treatments, not the therapist. In such cases, researchers strive to statistically eliminate any influence the therapist may have over treatment outcomes, to focus on whether a particular treatment or therapeutic model is effective. Thus, research on therapist factors indicates a different paradigm than much other research, as it believes the therapist to be an important variable, perhaps even more so than his or her model, in influencing change (Beutler et al., 2004). In general, research on therapist effects is lacking in MFT and psychotherapy (Blow et al., 2007). However, some research has been conducted to determine whether therapists do differ (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Firth, Barkham, Kellet, & Saxon, 2015; Green, Barkham, Kellet, & Saxon, 2014; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Bolt, 2006). Namely, some therapists more than others tend to average fewer number of sessions with clients (efficiency), and their clients experience more improvement between pre- and post-tests (effectiveness) (Lambert, 2010). So, while we may have an understanding that therapist factors are important, much more research is needed to understand *why* some therapists are more effective and efficient (Anderson, McClintock, Himawan, Song, & Patterson, 2016; Anderson et al., 2009; Blow et al., 2007).

In the current study, I focused on understanding therapist way of being, which has many connections with therapist factors, and may be an area of research that can further explain why some therapists are more effective and efficient than others. However, later I

will also discuss how way of being may be separate and different from therapist factors all together. The therapist's way of being has been described as a therapist's "in-the-moment stance or attitude toward clients" (Fife et al., 2014, p. 21). The concept stems from the work of Martin Buber. Born in Austria in 1878, Buber was a philosopher well known for his philosophy of dialogue, his German translation of the Bible, and his interests in Hasidic Judaism (Fife, 2015). His work has been referenced by some, but not many, psychotherapists (Boszormenyi-Nagy & Krasner, 1986; Fife, 2015; Fife & Hachquet, 2018; Fife et al., 2014; Fishbane, 1998). In one of Buber's most well-known works, *I and Thou*, he explained that we are either I-It or I-Thou in our way of being (1970). An I-It way of being might be summarized as when we see others as objects. A therapist in an I-It way of being may view a client as an obstacle to success, or see the client as a means to validate his or her competency (Fife et al., 2014). In an I-It way of being, the client essentially becomes a thing. When we reduce clients to diagnoses (Fife, 2015; Littlejohn & Foss, 2011), we objectify them, and our way of being is I-It.

On the other hand, an I-Thou way of being is when the therapist is fully present with and listening to "the whole being of another" (Fife, 2015, p. 215). In an I-Thou way of being, one is alive to the wholeness of others, not just parts of them. Buber (1990a) explained that in an I-Thou way of being, "the therapist awaits the unexpected and does not put what comes into categories" (p. 168). Furthermore, Harlene Anderson (2012) described way of being as "including our thinking, talking, acting, orienting, connecting, and responding with the other: it is a way of positioning oneself with. *With* is the significant word, suggesting a withness process of orienting and re-orienting oneself to the other" (p. 13). In an I-Thou way of being, we do not remain isolated in our own

agendas, techniques, and plans, but we turn outward to embrace entirely the person before us. Because we do not try to place the person before us into categories, we notice all of his or her uniqueness (Buber 1990a). Buber called this *confirmation* (Friedman, 2002).

Buber's philosophy centers on relationships, and so it is especially pertinent for clinicians who employ systemic theories (Fife & Hachquet, 2018). Buber's ideas also provide a valuable framework for MFT research and practice that has been relatively unused (Fife, 2015; Fishbane, 1998). The concept of way of being is discussed in different models of therapy, including a few MFT models. My review will include scholars who have either explicitly written about way of being, or whose work seems to have strong connections to way of being. Still other therapists have also written about ideas that are similar to way of being that will not be covered in this paper (see Fife et al., 2014 for more connections of way of being to other scholars' works).

Maurice Friedman formulated *dialogical* psychotherapy using many of Buber's ideas, which focused on how genuine dialogue happens in an I-Thou way of being, when we are open to others' uniqueness (Friedman, 1960). Contextual therapists also pull from the work of Martin Buber, in that they seek to help families repair relational imbalances, which have often occurred when family members have objectified each other (Friedman, 2002). Mona Fishbane has used Buber's ideas in working with couples as she guides the couple to consider more their relationship, as opposed to just "the other or their own agenda" (Fishbane, 1998, p. 45). Collaborative language theory also includes the therapist's way of being, which influences different features of collaborative language therapy, including taking a not-knowing stance, creating an environment in which both

therapist and client's expertise is valued, and therapist transparency in sharing his or her thoughts with clients (Anderson, 2012). Way of being also has many connections to therapeutic presence, which "is a state of being open and receiving the client's experience in a gentle, non-judgmental and compassionate way, rather than observing and looking at or even into the client" (Geller & Greenberg, 2002, p. 85).

In sum, research shows that therapist factors are a type of common factor that influence client outcomes in therapy, namely that some therapists are more efficient and effective than others (Lambert, 2010). Furthermore, a variety of scholars have included the therapist's way of being into their view on how change occurs and into their models of therapy, thus supporting the idea that a therapist's way of being might be considered a common therapist factor. Although these scholars have each discussed way of being, there are subtle differences in their conceptualizations and definitions. Some theorists have focused on the importance of genuine acceptance in meeting with another (Friedman, 1960), while other scholars have focused more on how one must be when meeting with another, such as being "composed, calmed, and readied" (Anderson, 2012, p. 13). And yet other scholars have described something similar to way of being, but have referred to it using different terms, such as *therapist presence* (Geller & Greenberg, 2002). Furthermore, the way of being construct has not been empirically tested and explored. In a recent article, scholars have specifically identified the therapist's way of being as a possible common factor and called for more research on the topic (Fife et al., 2014, see also Fife, 2015). The current study is an attempt to collect and synthesize many scholars' ideas into a definition of a way of being, as well as into an understanding of what kind of way of being is beneficial to therapeutic change and what is detrimental.

Another aim of this study is to understand how way of being influences clients. Joining many scholars' ideas may provide a richer understanding of way of being than only using one scholar's ideas. The formation of a clearer definition of way of being, a theoretically richer conceptualization of how the therapist's way of being influences therapy change processes, and deeper understandings about what may constitute beneficial versus detrimental ways of being are all necessary to future research on way of being. Future research will be needed to test whether the ideas formulated in this study actually result in better or worse therapeutic outcomes. Such future research will ideally advance the literature on understanding why some therapists are more effective and efficient than others, and thus deepen our understanding of therapist common factors.

To accomplish the purposes of this study outlined above, a modified Delphi approach was employed to gather expert opinions from therapists about how to describe way of being, and how a therapist's way of being influences therapeutic change in positive and negative ways. The Delphi method "allows for grouping and analyzing the speculations of many experts on a topic to move closer to knowledge on that topic" (Dawson & Brucker, 2001, p. 126). It is important to note, that Delphi studies are intended to move the field forward research-wise, as opposed to deciding on a single truth (Stone Fish & Busby, 2005). This modified Delphi study took primarily a qualitative approach, as scholars' written opinions on way of being were coded by a team to separate out each individual idea presented, and then those ideas were represented to the participants for feedback on how much they agreed with each idea. A more quantitative approach was then taken to determine which ideas had the most agreement and consensus on. Finally, rather than a tradition third round, a qualitative thematic

analysis was done on the items with the most agreement and consensus. This methodology served the purpose of finding a clearer definition of way of being in therapeutic practice, and more concise ideas around ways of being that help and hurt the therapeutic relationship and client outcomes, thus providing a stepping stone to further the research on way of being and common factors of therapeutic change.

CHAPTER II

LITERATURE REVIEW

In recent years, scholars within MFT, as well as outside of the MFT field (Tschacher, Junghan, & Pfammatter, 2014; Wampold, 2001), have stressed the importance of certain factors which are common across multiple models and in the general therapeutic process (Blow et al., 2007; Davis et al., 2012; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Fife et al., 2014; Karam et al., 2015; Lebow, 2016; Sprenkle et al., 2009). Common factors may include, among others, client factors, therapist factors, and the therapeutic alliance. Way of being is a recently proposed common factor (Fife et al., 2014), which may be considered a therapist factor. While a few scholars have included the idea of way of being into their work and models, no empirical research has been conducted on way of being (Anderson, 2012; Fife & Hachquet, 2018; Fife et al., 2014; Fishbane, 1998; Friedman 1960, 2002, 2008). This study brought together multiple scholars' ideas to form a definition of way of being, as well as gain an understanding of how way of being might help or hinder therapeutic change. To gather these opinions, a modified Delphi study was conducted. This chapter will overview the importance of common factors, research on therapist factors, and various scholars' understandings of way of being. I also discuss how way of being helps illuminate the potential implications of focusing exclusively on models and techniques. And finally, I discuss whether way of being fits among therapist factors or is a different type of common factor on its own.

An Evolution of MFT Research: The Integration of Common Factors Research

While the field of family therapy began with many shared theoretical ideas, it

seems that competition and the search for novelty fed an allegiance to and focus on specific and separate treatment models for several years (Lebow, 2014). Some scholars have compared this division between models to a type of civil war or arms race within the field of marriage and family therapy, which was especially prevalent during the 1970s (Fife, 2016; Karam et al., 2015; Weeks & Fife, 2014). In the beginnings of MFT, "a series of rebellious pioneers . . . rejected the dominant individual-based behavior and psychoanalytic models of the time in favor of something new" (Karam et al., 2015, p. 137). This emphasizing of differences between MFT and other approaches may have influenced the drive to differentiate between models within the MFT field (Sprenkle et al., 2009). Yet, other fields of mental health have also seemed to focus on specific model treatments. In fact, Sprenkle et al. (2009) have said that "at least 400 different models of psychotherapy have been documented" (p. 4). Historically, most of individual psychotherapy has emphasized differences in models and treatments (Sprenkle et al., 2009), and as such, perhaps we as MFTs are only mimicking what existed before us.

Such competition between models may have also originated in the beginnings of MFT simply by "charismatic model developers" (Karam et al., 2015, p. 137; Sprenkle & Piercy, 2005).

> These psychotherapeutic 'rock stars' toured the country, looking for new fans from the worlds of social work, psychiatry, and other related mental health disciplines that would be recruited to become the first generation of MFT students. At this time, empirical evidence was not necessary in the sales pitch, as model popularity primarily relied on word of mouth, emotional appeal, and the powerful live demonstrations of family therapy techniques (Karam et al., 2015, p. 137).

Yet, some have said that in the beginning of family therapy, "there were no distinctions between researchers and therapists" (Sprenkle & Moon, 1996, p. 3; see also

Haley, 1978; Wynne, 1983). While this "rock star" appeal has been one element of the culture of MFT, there were nevertheless empirical efforts made from the beginning of MFT to support developing interventions and practice (Sprenkle & Moon, 1996; Sprenkle & Piercy, 2005; Wynne, 1983). The field eventually turned much attention to researching "gold standard" models—empirically supported treatments (ESTs) (Lebow et al., 2016; Piercy et al., 2012; Sprenkle et al., 1995). EST research focuses on determining which treatments work best for particular presenting problems and for particular populations, often through randomized controlled trials (RCTs) (Coatsworth et al., 2001; Fals-Stewart, & Lam, 2008; Fristad et al., 2003; Greenberg et al., 2010; Hartnett et al., 2016). So, while still is a search for the "best model(s)," researchers typically search for the best model for a particular problem and population, and not necessarily just in general. While an improvement in specificity, "the label 'empirically validated' might be interpreted as suggesting that only these list of treatments were effective; and this way of thinking about treatments substantially ignored the shared common base of effective practice" (Lebow, 2016). And so, some proponents of common factors viewed ESTs as quite controversial, and many who valued ESTs mistakenly believed that research on common factors did not value EST research (Sprenkle et al., 2009). Herein, either ESTs or common factors were quite controversial to some (Lebow, 2016).

Such a dispute existed for some time in the psychology field as well (Norcross & Lambert, 2011). For after many years of randomized clinical trials focusing on the effectiveness of treatments on client outcomes, others began to conduct research to prove the importance of the therapist-client relationship on treatment outcomes (Norcross & Lambert, 2011). This research raised a debate between those who believed in the

importance of treatments, and those who believed in the relationship (Norcross & Lambert, 2011). In many ways, Sprenkle and colleagues within MFT followed in the footsteps of Norcross and his colleagues in psychology to empirically prove the importance of factors other than the model or particular treatment. However, many have taken a moderate view of common factors and supported EST research, yet called for the integration of common factors research within EST trials (Sprenkle et al., 2009). Similarly, in a recent proposal for a new model of criteria for ESTs by scholars of clinical psychology, the authors devote a section to the importance of research to determine which components and interventions within treatments actually effect change (Tolin, McKay, Forman, Klonsky, & Thombs, 2015).

Currently within MFT research, this integration is becoming a reality. Many researchers have given focus to common factors and mechanism of change within EST research (Lebow, 2016). In 2012, scholars explained that, "an exciting preliminary development over this decade has been the beginning of the generation of evidence-based principles for the practice of couple therapy that transcends approach" (Lebow et al., 2012, p. 157). Herein we see a convergence of two previously divided paradigms. Research is moving toward not only seeking best treatments, but MFT scholars are also exploring the principles that are making these models effective (Fischer et al., 2016; Henggeler & Sheidow, 2012; Lebow et al., 2012; Roddy et al., 2016; Rowe, 2012; Slesnick, & Prestopnik, 2009). In fact, "it is rare today that any such treatment does not explicitly pay considerable attention to nurturing vital common factors in treatment" (Lebow, 2016, p. 386). Thus we see that common factors have generally become important to many researchers, and it might be said that common factors research and

EST research are becoming one in the same.

The current study, while focusing on a possible common factor, does not discount the great importance of using a model to guide us in treating clients (more discussion on this below), and especially the necessity of researching model effectiveness (Sprenkle et al., 2009). However, I, with others striving to integrate more common factors' research into our MFT research base, challenge the relative efficacy among efficacious models (Sprenkle et al., 2009), and emphasize the commonalities among them, which may hold the keys for why therapy works at all.

Common Factors

Proponents of the common factors paradigm believe that little of therapeutic outcomes are related to factors which are unique to a particular model of therapy. Research suggests that there is little difference between the effectiveness of therapeutic models (Lambert, 2004; Shadish & Baldwin, 2003; Wampold, 2001), and so many have begun to research and theorize about common factors, which may be more salient influences on therapeutic outcomes (Blow et al., 2007; Davis et al., 2012; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Fife et al., 2014; Karam et al., 2015; Lambert, 2004; Sprenkle et al., 2009; Wampold, 2001). Davis and Piercy (2007a & 2007b) have separated common factors into two main types: model-dependent common factors and model-independent common factors. Model-dependent common factors are any factors that influence therapy which derive from employing a model, but yet which are common to many models (Davis & Piercy, 2007a). An example of this is that many models promote that conceptualization of a case include considering how a couple's family of origin is influencing current patterns (Davis & Piercy, 2007a). Model-independent factors

include those factors which are simply inherent in the therapy process, such as therapist factors, client factors, the therapeutic alliance, therapeutic process, and expectancy and motivational factors (Davis & Piercy, 2007b; Lebow, 2014). Researchers of common factors have tended to focus on model-independent factors.

Most of the research on common factors has been within individual-based psychotherapies, while research on common factors in MFT remains small and in its beginnings (Davis et al., 2012; D'Aniello & Fife, 2017; Sprenkle et al., 2009). It is likely, however, that many of the key ingredients that make good therapy for an individual may be the same for couples and families (Davis et al., 2012; Sprenkle et al., 2009). Because of this and the fact that comparatively less research in MFT on common factors exists, much of the literature reviewed in this paper will not be focused on MFT. However, research within MFT on common factors is continuing. And as discussed above, it is building upon and broadening the research in psychology, as Sprenkle and colleagues explore any ingredients that are key to therapy regardless of model.

Many meta-analyses have shown that while psychotherapy with individuals is effective to produce change, there exists little difference in client outcomes when comparing models of therapy (see Lambert, 2013). In a large review of 20 meta-analyses of marriage and family therapy interventions, Shadish and Baldwin (2003) similarly found that while MFT treatments are effective, the results of comparing specific treatments were usually nonsignificant or very small. Wampold (2001) found that 70% of outcome variance in psychotherapy could be attributed to common factors, while specific factors (such as model) accounted for only 8% of outcome variance.

Currently, some frequently discussed types of common factors include client

factors, the therapeutic alliance, and therapist factors (Lebow, 2014). Client factors might include anything unique to a client that may influence therapeutic outcomes, such as a variety of personal characteristics, like being very goal-oriented and driven, family resources, and chance events, such as having an enlightening experience (Karam et al., 2015). The therapeutic alliance refers to the client-therapist relationship, which may include the client's trust in the therapist and feeling secure in therapy. The most pertinent type of common factor to our current study lies under the umbrella of therapist factors, which I will review below. As discussed in Chapter I, some include the therapeutic alliance under therapist factors, however, rather than seeing the alliance as a therapist factor, it may be more of a therapist-influenced factor. It is important to understand that therapist factors influence the quality of the alliance, but that does not mean that the alliance is a therapist factor. As such, I will not include a review on the therapeutic alliance within my discussion of therapist factors (see Blow et al., 2007 for a brief review of therapeutic alliance).

A frequent misunderstanding is that common factors replace models. Many proponents of common factors do not discount models, but rather believe that models are the vehicle through which we can deliver common factors (Sprenkle et al., 2009). Sprenkle et al. (2009) explained that common factors do not suggest that a therapist simply fly by the seat of his or her pants, but that he or she recognizes what elements actually drive change in therapy. Understanding that models and common factors are not opposing paradigms, may encourage more to emphasize common factors.

Another critique of a common factors is that they are broad, unspecific and provide little guidance to actual practice (Sexton & Ridley, 2004). This is not helped by

the fact that there is comparatively less research on common factors than there is on specific models in EST research. This study is one attempt to empirically examine common factors and to more specifically define one possible common factor—the therapist's way of being. I next introduce some of the literature on therapist factors, as it seems that the therapist's way of being may fit into this category of common factors. The review is not meant to be exhaustive, but more so to prime our discussion of way of being as a possible therapist factor. Although, I will later discuss how the therapist's way of being may be its own category of common factor.

Therapist Factors

Therapist factors include any factors that may influence client outcomes that are unique to the therapist. Beutler et al. (2004) divided the research on therapist factors into four types: observable traits, observable states, inferred traits, and inferred states. I will briefly explain some of the traits and states here to give a general understanding of types of therapist factors; however, Beutler et al. (2004) discussed many others (see Blow et al., 2007 for a more detailed review of Beutler and others' categories). Many of the conclusions which Beutler et al. (2004) made about the influence of the particular factors discussed below were determined by meta-analysis whenever a sufficient number of studies could be obtained by the researchers. They looked for studies in the 20 years previous to 2000. Therefore, some of these conclusions are based on older researcher; nevertheless, their review is quite extensive and helpful to gaining an understanding of the types of therapist factors, and which are more or less likely to affect change. In cases in which the researchers could not find a sufficient number of studies, variables were examined without doing a meta-analysis and conclusions were drawn. I will discuss some

of their findings and conclusions here [see Beutler et al. (2004) for the original articles that were reviewed and used in their meta-analyses], as well as a couple of Blow and others' (2007) conclusions.

Observable traits and states are those qualities which can be found out without the therapist's input, such as by checking records (Beutler et al., 2004). Observable traits, which include fixed therapist traits such as therapist sex and age do not seem to have much influence over therapy (Beutler et al., 2004). Therapist ethnicity is another observable trait. Based on their meta-analysis of research specifically on racial/ethnic matching of therapist and client, Beutler et al. (2004) expressed doubts as to its influence, saying that more research is needed to determine possible moderating factors. Beutler et al. also discussed observable states. A state (as opposed to a trait) is more flexible and includes variables that a therapist uses to "further one's role as a psychotherapist" (Beutler et al., 2004, p. 228). Observable states include, among others, therapist training, experience, and types of interventions used (Beutler et al., 2004). Beutler et al. (2004) concluded that specific therapist training (such as in a particular type of therapy) seems unlikely to influence the success of therapy. Blow et al. (2007) stated that while many moderating factors need to be teased out to understand the effects of therapist experience (referring to time spent in the profession), "effect sizes relating experience to outcome remain relatively small" (p. 304). As far as interventions go, mixed research results indicate that therapist directiveness can benefit therapeutic outcomes at times, and hurt it at other times; but the effect may be moderated by the level of client resistance, with less resistance benefitting from more therapist-directiveness (Beutler et al., 2004). Beutler et al. (2004) also reviewed studies which looked at the effectiveness of arousing emotions.

While some evidence does suggest that interventions which focus on emotions correlate to better treatment outcomes than those which do not focus on emotions, Beutler and others' analysis produced lower effect sizes than other previous meta-analyses (Beutler et al., 2004). However, Beutler and others' (2004) review has suggested that when treatments specifically focus on arousing emotion, rather than simply addressing them, these treatment do have better outcomes. In sum, there is evidence that some therapist observable traits and states are influential on therapeutic outcomes, but for some their influence remains unclear and warrant further research.

Inferred traits and states are those that can only be reported by the therapist. Inferred traits include, among others, emotional well-being, values, and cultural attitudes (Beutler et al., 2004). Studies indicate that therapist emotional well-being does positively correlate with various beneficial treatment outcomes (Beutler et al., 2004). Blow et al. (2007) found no studies examining how values influence outcomes in MFT. But, there seems to be much indication that attitudes towards culture do influence client outcomes (see Blow et al., 2007 for specific references used to draw this conclusion). Some psychotherapy research outside of MFT has been conducted on the influence of therapist values (Beutler et al., 2004). Results of these studies are generally inconsistent, and have methodological issues, however some research suggests that client value changes are associated with therapeutic improvement (Beutler et al., 2004).

Inferred states are also those that can only be reported by the therapist but are more variable or otherwise not related to a therapist's extratherapy life (which would be a trait) (Beutler et al., 2004). Beutler et al. (2004) included the therapeutic alliance and theoretical orientation in inferred traits. Their general conclusion about theoretical

orientation is that while research indicates that various models of therapy benefit clients (compared to no treatment), differences between models are small (Beutler et al., 2004). They suggested that "the effectiveness of treatment may be more closely related to the particular beliefs and values that are passed from the therapist to the patient during treatment than of a more specific effect of the techniques used" (Beutler et al., 2004, p. 289).

Beutler et al. (2004) included the therapeutic alliance as an inferred state therapist factor, while I have chosen to take the stance that the therapeutic alliance is not necessarily a therapist factor, but that certain therapist factors influence the alliance. Granted, Beutler et al. (2004) did bring up the difficulty of "clearly assigning ownership" (p. 229) of certain factors, and decided to err more on the side of being very inclusive with the types of therapist factors they included in their study. The alliance is certainly highly influenced by the therapist, and so it makes sense that they included it in a discussion on therapist factors. However, it seems more that therapist factors influence the alliance, and that many of these therapist factors fall best under Beutler and others' (2004) inferred traits category (while the alliance is considered a state), which includes the therapist's personality and specific therapist qualities. For example, in Blow and Sprenkle's modified Delphi study (2001), experts agreed that certain factors attributable to the therapist influence the therapeutic alliance, such as empathy, respect, self-awareness, care, warmth, presence and authenticity. Furthermore, empathy has been shown account for 9% of variability in client outcomes (Elliot et al., 2011). Another study found that positive regard, as promoted by Carl Rogers has moderate effects on therapy outcomes (Farber & Doolin, 2011). All of these might be considered therapist

qualities that influence the therapeutic alliance.

Research on therapist factors indicates a different paradigm than much other research, as some researchers attempt to control for the individual effects of a therapist, such as in RCTs (Beutler et al., 2004). Such research suggests a belief that the type of treatment is more important than the therapist giving the treatment. Lebow (2006) suggested that the model-focused paradigm of MFT is grounded in a medical metaphor, in which treatments are viewed almost as prescriptions to treat certain symptoms. In such a paradigm, the person delivering a prescription is irrelevant, as only the prescription brings change and healing (Blow et al., 2007). On the other hand, others "emphasize that treatment models do not exist in therapy outside of the therapist delivering them, and therefore the qualities of the therapist delivering the treatment are more important than the treatment itself" (Davis et al., 2012). Furthermore, some evidence exists that even when extensive efforts are made to eliminate therapist factors, a therapist can still have significant influence on client outcomes (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). This suggests that therapist factors are powerful, even unavoidable.

George Simon has suggested that there is a middle ground between a common factors approach, and a model-focused approach. He stressed the importance of the therapist in affecting therapeutic change, but believed there is a way to incorporate both sides of the debate, namely that therapists are most effective when they use a model, but one that matches the therapist's own worldview (Simon, 2006, 2012a, 2012b). Those therapists who use a model that matches their own worldview may more fully present their own "personhood" to the client, and thus evoke a more authentic "encounter between persons" (Simon, 2003, p. 11). This ability to be fully authentic in the therapy

room may have important connections to therapist way of being. Those who promote common factors, as well as Simon, agree that more research needs to be conducted on understanding the influence of the therapist on therapy (Simon 2012a, 2012b).

While it may seem quite intuitive that therapists differ in their effectiveness and efficiency (Blow et al., 2007), much research has been conducted to determine whether therapists do differ (Anderson et al., 2009; Firth et al., 2015; Green et al., 2014; Okiishi et al., 2003; Wampold & Bolt, 2006). Results show that some therapists more than others, tend to average fewer number of sessions with clients, indicating that some therapists might be more efficient than others (Lambert, 2010). And, with some therapists' clients experience more improvement between pre- and posttests, indicating that some therapist might be more effective than others (Lambert, 2010). But little of this research seeks to discover the source of the differences, or why there are differences (Anderson et al., 2009; Blow et al., 2007; Lambert, 2010).

Furthermore, it seems that very little research has been conducted on marriage and family therapist differences (Blow et al., 2007). While MFT research on common factors seems to be moving forward, it is weak in the area of therapist factors. One study which focused on MFTs, and was anchored in the idea that the therapist has an important influence over therapeutic outcome found that the clients of therapists who received feedback on their clients progress and then used that to address any lack of progress had significantly more improvement than those who worked with a therapist that did not receive feedback (Anker, Duncan, & Sparks, 2009). But this is just one study, and much more research is needed in understanding why some marriage and family therapists more effectively bring about change than others (Anderson et al., 2016; Anderson et al., 2009;

Blow et al., 2007). In this study, I focus on the therapist's way of being, which may be considered a therapist factor, and may be an area of research that fosters more understanding on why some therapists are more effective and efficient than others. Furthermore, most of the participants in this study will be in the field of MFT, and so this will more specifically help further the research on common factors in MFT and why MFTs differ in effectiveness and efficiency.

Therapist Way of Being

The concept of way of being stems from the work of Martin Buber. Buber explained that at any moment of being with another person, we are either *I-Thou* or *I-It* in our being (1970). Way of being stems from and reveals our true attitude toward another person. In a therapeutic context, Fife et al. (2014) explained way of being as a concept that reflects a therapist's "in-the-moment stance or attitude toward clients" (p. 21). An *I-It* way of being essentially describes one relating to another as if he or she is an object or a means to an end (Fife et al., 2014). Whether intentional or not, it involves objectification, and may be detrimental to therapeutic change. In an *I-Thou* way of being, we see another person for all that they are, in their strength and weakness, and accept the other before us as another human being—one with needs as real and urgent as our own (Warner, 2001). In much of the literature on way of being, I-You is used instead of I-Thou.

Buber's philosophy has been applied only narrowly by MFT research and practice, but because it centers on relationships, it may provide a valuable framework for MFT academics and clinicians (Fife, 2015; Fishbane, 1998). As a philosophy of relationships, it is especially pertinent for any clinicians who practice by systemic

philosophies (Fife & Hachquet, 2018). Buber explained that "a soul is never sick alone, but always through a betweenness, a situation between it and another existing being" (1965, p. 47). In other words, he seems to believe that all of life is inextricably tied to our relationship interactions. We cannot understand an individual outside of his or her relation to other beings. Therapy theories of systemic underpinnings seem to hold this belief as well.

I-It Way of Being

An I-It way of being may be detrimental to therapeutic change. A therapist in an I-It way of being may view a client as an obstacle to his or her satisfaction or success (such as a client that is not progressing well), or the therapist may seek to gain the approval or affection of clients (thus seeing the client as a means to validate him or herself) (Fife et al., 2014). In both instances, the client essentially becomes a thing to the therapist, either to promote his or her own interests or hinder them. It may be that some early family therapists worked through an I-It way of being, in that a "therapist's techniques were frequently hidden from the family . . . mystification was justified and even glorified. . . the family [was viewed] with suspicion, as a pathogenic breeding ground (e.g. the "schizophrenogenic mother") or a broken or deficit-ridden structure" (Fishbane, 1998, p. 43). This type of objectification of clients also happens when we reduce them to diagnoses or symptoms, or any other kind of collection of attributes and characteristics (Fife, 2015; Littlejohn & Foss, 2011). Buber described that "even as a melody is not composed of tones, nor a verse of words . . . one must pull and tear to turn a unity into a multiplicity" (1970, p. 59). As soon as we tear apart our clients into a "multiplicity" of diagnoses and case notes, he is no longer You, a complete being before

us (Buber, 1970). The client becomes a thing because we can compare and place him among other things (Buber, 1970). We can sum up a human being as a tall depressed man, but he is only so simple as he is placed against a man who is not depressed and short. As Buber (1970) explained,

> For wherever there is something there is also another something; every It borders on other Its; It is only by virtue of bordering on others. But where You is said there is no something. You has no borders. Whoever says You does not have something; he has nothing. But he stands in. (p. 55)

I-Thou Way of Being

I suggest that an I-Thou way of being should be beneficial to therapeutic change. In an I-Thou way of being, others' needs are as real as our own (Warner, 2001). When we are I-Thou, we allow others' "inward reality—their needs and aspirations and fears—[to] write themselves upon our hearts and guide our responses to them" (Warner, 2001, p. 299). An important aspect of an I-Thou way of being requires that we be fully present and listening to "the whole being of another" (Fife, 2015, p. 215). Buber (1970) explained,

> When I confront a human being as my You . . . then he is no thing among things nor does he consist of things. He is no longer He or She, limited by other Hes and Shes, a dot in the world grid of space and time, nor a condition to be experienced and described, a loose bundle of named qualities. Neighborless and seamless, he is You and fills the firmament. Not as if there were nothing but he; but everything else lives in his light. (p. 59)

When our being is I-Thou, we embrace fully the person before us. An I-Thou way of being includes "imagin[ing] the real," a phrase from Buber which Friedman (1960) described as "to imagine quite concretely what another man is wishing, feeling, perceiving, and thinking" (p. 30). In contrast, Buber explained that most therapists impose categories "on the patient without being aware of it" (1990a, p. 168). Instead, "the

patient must be left to himself . . . and then the therapist awaits the unexpected and does not put what comes into categories . . . the real master responds to uniqueness" (Buber, 1990a, p. 168). Buber called this responding to uniqueness *confirmation* (see Friedman, 2002).

Lest an I-Thou way of being sounds simply like empathy, Freidman distinguished empathy as different, in which we forget or abandon ourselves to understand the other. Instead, confirmation is a "bold swinging over into the life of the person one confronts" (Friedman, 2008, p. 299) while our rope simultaneously remains firmly anchored in our own experience. For in completely loosing ourselves to understand another, we lose their uniqueness. Another person can only be confirmed in their uniqueness, if I, another unique being, is also present. Friedman (1960) further explained that there must be distance between us and the other, for if not, we cannot see uniqueness. We will struggle to help another if we do not keep this distance because if not,

> We shall see him in our own image or in terms of our ready-made categories. . . . But if we allow him to be different and still accept and confirm him, then we shall have helped him realize himself as he could not without us (Friedman, 1960. p. 30).

Similar to Friedman's notion, Geller and Greenberg (2002) described that "therapeutic presence involves a careful balancing of contact with the therapist's own experience and contact with the client's experience, while maintaining the capacity to be responsive from that place of internal and external connection" (p. 83). They borrowed a phrase from another scholar (Robbins, 1998) and called this phenomenon a *dual level of consciousness.*

One's way of being in a relationship seems to have a reciprocal quality, in that one's way of being often invites others into a similar way of being (Warner, 2001). For

example, a wife that relates to her husband in an I-It way of being, may invite him to respond in an I-It way of being. The same may happen with one spouse relating in an I-Thou way of being. As systemic therapists, MFTs must seek ways to stop destructive cycles between family members, some of which may include responding to each other's I-It way of being (Fife & Hachquet, 2018). A therapist who regards clients in an I-Thou manner may invite clients to move from an I-It to an I-Thou way of being within their own relationships. Similarly, Fishbane (1998) stressed witnessing in therapy as a relationally healing process, and suggested that "empathic witnessing by the therapist often stimulates the partners' empathic witnessing of the other and of self" (p. 52). If way of being is, in part, an invitation, then the therapist's I-Thou way of being may invite clients to also become I-Thou, and thus be a key influence in breaking destructive interpersonal cycles characterized by I-It relationships. But if we relate to our clients in an I-It way of being, then we may encourage patterns reflective of I-It relationships.

Literature on Way of Being in Models and Therapy

The concept of way of being does appear in some models, both in psychology and MFT. One of those models is *dialogical therapy*, formulated by Maurice Friedman. Dialogical therapy "is centered on the *meeting* between the therapist and his or her client or among family members as the central healing mode" (Friedman, 2008). This model of therapy focuses on Buber's distinction between monologue and dialogue. Dialogue happens in an I-Thou way of being, when we accept others in their uniqueness (Friedman, 1960). Monologue happens in an I-It way of being, in which the other "exist[s] as a content of [our] experience" (Friedman, 1960, p. 27). Dialogical therapy strongly emphasizes Buber's ideas that man's existence is genuine meeting with man, as

opposed to individuation (Friedman, 1960). While many therapists may focus on the importance of human meeting, it is often emphasized as a means to further developing the individual (Friedman, 1960). The development of the individual can occur through meeting, but only through genuine meeting, which does not occur when it is entered into as a means to an end (individuation) (Friedman, 1960).

Contextual therapy also includes Buber's ideas. Friedman (2002) saw contextual therapists as embracing healing through meeting as central to their work because they seek to help families repair the imbalances that have come from treating each other as objects to be used. This I-It way of being comes from an individual "making one's partner fit the internal relationship format" (Boszormenyi-Nagy & Krasner, 1986, p. 26) that he or she formed in childhood. Furthermore, "the more one squeezes the partner into an internally desirable image, the more one is likely to be unfair and exploitative" (Boszormenyi-Nagy & Krasner, 1986, p. 27). Helping partners to see their own parents as Thou instead of It, may be helpful to shift from I-It to I-Thou with one's romantic partner (Fishbane, 1998).

Other than shifting to an I-Thou way of being with one's own parents, an I-Thou way of being is manifest in genuine dialogue (Fife, 2015), which relates to contextual therapy's focus on creating trustworthy relationships (Boszormenyi-Nagy & Krasner, 1986). Genuine dialogue includes becoming aware of the wholeness of another person (i.e. one's partner) (Buber, 1965). According to Buber (1965), "[If] I thus give to the other who confronts me his legitimate standing as a man with whom I am ready to enter into dialogue, then I may trust him" (pp. 79-80). I-It relationships may relate to the injustices that contextual therapists focus on healing, and I-Thou relationships to the

relationships of trust they seek to promote.

Although defined in a way that is slightly different than Buber's definition, way of being also appears in collaborative language theory. Harlene Anderson (2012) described way of being as "how you are, not what you do. It is about being poised: composed, calmed, and readied to spontaneously respond in the current situation and whatever it calls for" (p. 13). Under this theory, Anderson (2012) described way of being as having seven features: *mutual inquiry* includes the therapist being hospitable, creating an environment of "two-way curiosity" (p. 16), and listening; *relational expertise* involves including both client and therapist expertise; *not-knowing* is humbly accepting and expressing that the therapist "can never fully understand another person" (p. 18); *being public* involves the therapist openly sharing his or her thoughts about clients and therapy with clients; *living with uncertainty* is about being willing to be surprised and not guiding therapy with predetermined plans; *mutually transforming* means that therapy will influence both the client and the therapist; and lastly, *orienting toward everyday life* includes therapy resembling an everyday social interaction, and viewing challenges that clients experience as part of everyday life (Anderson, 2012). The feature on living with uncertainty fits especially well with Buber's (1965) belief that for genuine dialogue "there is essentially necessary the moment of surprise" (p.178), and that "no one, of course, can know in advance what it is that he [or she] has to say; genuine dialogue cannot be arranged beforehand" (p. 87) (see also Fishbane, 1998). This readiness to be surprised, as well as taking a not-knowing position, may also have connections with narrative therapy, although Buber is not explicitly referenced in narrative literature (Fishbane, 1998).

Way of being also has many connections to the concept of therapeutic presence, as defined by Geller and Greenberg (2002). Presence "is understood as the ultimate state of moment-by-moment receptivity and deep relational contact. It involves a being with the client rather than a doing to the client" (Geller & Greenberg, 2002, p. 85). This definition echoes Buber's ideas of being open to others, and refraining from seeing others as objects. In Geller and Greenberg's (2002) qualitative study on therapeutic presence, the authors developed a model of therapeutic presence that included *preparing the ground for presence, process of presence, and experiencing presence.* Each aspect of the model seems to echo many of the ideas already discussed about way of being. Preparing included the therapist putting aside self-concerns, theories and plans of how the session would go, and gaining an attitude of openness and non-judgment (Geller & Greenberg, 2002). Therapists also prepared in their personal lives by practicing presence with others and attending to their personal needs and concerns, so as to be more present with clients (Geller & Greenberg, 2002). Process of presence included receptivity to anything that arises (Geller & Greenberg, 2002), which is reminiscent of Buber's (1965) ideas on a readiness to be surprised. Process of presence also included inwardly attending to what is going on inside oneself as the therapist to determine how the client may be experiencing the session and to be more authentic and congruent, which was discussed above as dual level of consciousness (Geller & Greenberg, 2002; Robbins, 1998). The experience of presence included feeling immersed and absorbed in the moment, energy and flow, and a sense of enhanced perception, thinking, and emotional experiencing (Geller & Greenberg, 2002). Therapists also reported feeling grounded, love for their clients, and a lack of self-conscious awareness (Geller & Greenberg, 2002). It seems that many of the

qualities of presence may relate to an I-Thou way of being.

Finally, an I-Thou way of being may also have some connections to humility. In a Delphi study on the influence of humility as a catalyst for change in relational therapy, panelists agreed that humility has an interpersonal effect, specifically that "with less of a focus on the self, we can orient ourselves to the needs of others" and that "feeling humble towards another, in turn, can lead to softening of behavior toward him/her (Rowden, Harris, & Wickel, 2014, p. 387). Orienting the self to the needs of others and softening our behavior towards another seems to echo Warner's description of a way of being in which other's "needs and aspirations and fears . . . write themselves upon our hearts and guide our responses to them" (Warner, 2001, p. 299). Furthermore, the panelists in Rowden et al.'s (2014) study determined that "one partner's humility often invites humility from the other partner" (p. 387), which seems quite similar to the idea that one's way of being may invite another to change their way of being (Fife & Hachquet, 2018; Fishbane, 1998; Warner, 2001). However, much of what the panelists in this Delphi study concluded about the role of humility in therapy was intrapersonal in nature, with less focus on the interpersonal role (Rowden et al., 2014). It may be that humility is an important aspect of being I-Thou in our way of being; however the two concepts are not likely synonymous.

Thus, while a few scholars discuss way of being or similar concepts, there is variation in their conceptualizations and definitions. Friedman (1960) focused on the importance of genuine acceptance in meeting with another, while Anderson (2012) explained that way of being is "how you are" (p. 13). And still there are other concepts, such as therapist presence and humility (Geller & Greenberg, 2002; Rowden et al., 2014),

that may have connections to way of being even though they are given different titles. Forming a clear definition of way of being, understanding how way of being influences change, as well as describing ways of being that promote and do not promote client change, will bring more clarity to discussion and research on way of being.

Our Way of Being among Techniques and Models

Thus far, I have overviewed the literature on way of being, in part to introduce a possible common factor. As discussed earlier, there exists a debate about whether models or factors common across models are a greater influence on change. I do believe in the importance of common factors, and that at times, focusing too much on a particular model as the main instigator of change can be detrimental. This opinion can be better explained now that I have provided an understanding of way of being. Our way of being, may be the common factor through which we can render our models effective or not (Fife et al., 2014).

Warner and Olson (1981) suggested that perhaps those we serve as family professionals continue to struggle, in part, because of the way that *we* see and treat them. If we see our clients in an objectified way as the problem, we will seek techniques to solve the problem. In this sense, our techniques and models can become tools for the manipulation of people (Warner & Olson, 1981). Yet, our techniques can help to guide us in our treatment. Buber (1990b) described the psychotherapist as a

> [w]atcher and healer of sick souls, [who] again and again confronts the naked abyss of man, man's abysmal lability. . . . [And so] it is understandable enough that he strives to objectivize the abyss that approaches him and convert the raging "nothing-else-than-process" into a thing that can, in some degree be handled. (p. 94)

Our models and techniques guide us to approach the complexity and diversity of

human experience. Yet, we walk a careful line of our techniques becoming, as Warner and Olson (1981) suggested, tools of manipulation. Buber (1990b) explained that while a therapist seeks to "objectify" the "abyss" of man, at some point, he will realize the importance of meeting his client as a human. Buber (1990b) said that the therapist realizes he or she must

> [d]raw the particular case out of the correct methodological objectification and himself step forth out of the role of professional superiority, achieved and guaranteed by long training and practice, into the elementary situation between one who calls and one who is called. . . to the abyss, that is to the self of the doctor, that selfhood that is hidden under the structures erected through training and practice, that is itself encompassed by chaos, itself familiar with demons, but is graced with the humble power of wrestling and overcoming, and is ready to wrestle and overcome thus ever anew. (pp. 94-95)

So the question remains whether one can meet another as Thou, and still operate through "structures erected through training and practice." Buber (1990b) claimed that after such an experience of meeting another as Thou, the therapist "will return from the crisis to his habitual method, but as a changed person in a changed situation" (p. 95). The therapist now knows "the necessity of genuine personal meetings in the abyss of human existence between the one in need of help and the helper" (Buber, 1990b, p. 95). He or she will then find a "modified methodic" in which the "unexpected" aspects of human meeting find its place among the expectedness that theories and models provide (Buber, 1990b, p. 95).

Based on the phrase "modified methodic," it seems that Buber believed in a place and time for using therapy models and techniques, but that the therapist must realize the primacy of his or her clients' humanity and the possibility of abandoning his or her models and techniques as well. Similarly, I do not suggest that the use of techniques necessarily involve the manipulation of clients, but rather that it may more easily lead to

manipulation if we are not aware of more encompassing ideas beyond useful techniques, such as our way of being, that influence change. Yet certainly, one may relate to clients in an I-Thou way of being, and do so while implementing a model using techniques. But our way of being, a possible common factor, may be the foundation upon which our techniques and models become helpful to clients (Fife et al., 2014).

How Way of Being Fits into Therapist Factors

Earlier, I provided a simple review of therapist factors, including a discussion of Beutler and others' (2004) categories, because it may be that among types of common factors, way of being is a therapist factor, and thus fits into one of these categories. After having reviewed way of being, it seems important to now explore whether way of being is a therapist factor.

First, way of being seems to be more of a state, rather than a trait, in the sense that way of being is not static (Fife et al., 2014), and a therapist's way of being with clients may change from client to client, or even moment to moment. A therapist may find it quite natural to relate to one client in an I-Thou way of being, but struggle to escape an I-It way of being with another client. As such, one way to examine a therapist's way of being could be on a client-to-client basis. Although some therapists may generally relate in an I-Thou way more often, their way of being may fluctuate depending on the client(s) present or other personal or contextual factors in the therapists' lives. This is not to suggest that a client controls a therapist's way of being, but that a therapist may simply have more difficulty relating to a particular client as Thou. It may, however, be that another therapist finds it quite easy to relate to the same client as Thou.

Another outstanding question is whether the therapist or the client would best be

able to report on a therapist's way of being, which would determine whether or not way of being is an inferred or observable state. An inferred state or trait depends upon the therapist's report, rather than an outside observer (Beutler et al., 2004), but it is possible that a therapist may be unaware of his or her own way of being. Fife explained that Buber, like other existential philosophers, believed that way of being was "prereflective" (Fife, 2015, p. 210). A therapist's way of being exists even before the therapist is aware of it. It may be that a client experiences a therapist's way of being before the therapist is aware of it her or himself. If this is the case, it would seem that way of being is an observable state. But, a client completely unfamiliar with the concept of way of being, may not have the ability to observe and report on way of being. In this case, it seems hardly an observable state. Furthermore, it does seem possible that some therapists may frequently and actively reflect on their way of being, and therefore be aware of their own way of being in the very first moments of meeting with a client. In this scenario, it could be an inferred state.

Regardless of whether it is an inferred or observable state, it seems that way of being might be a difficult state to describe or measure. Jeffery Zeig (2015) wrote about the importance of states for therapists and clients, but he does not attempt to clearly define even the word *states,* "because they are difficult to define, being a temporally variable amalgamation of emotions, moods, relationship patterns, physiological arousal, psychological habits, and contextual determinants, to name a few" (Zeig, 2015, p. 16). Zeig (2015) explained that breaking a state down into components, may make it easier to discuss and describe a particular state. Some of the components that make up a state may include behavior, affect, thought, attitude, perception, sensation, additional senses such as

kinesthesis, imagery, fantasies, memories, relationship patterns, relationship to the environment, energy level, gestures, expressions, posture, vocabulary, linguistic characteristics such as prosody and tone, attention, and concentration (Zeig, 2015, see p. 55). Perhaps, the best format to talk about way of being is to break it down into components such as these. But if it is, then is way of being qualitatively a similar concept to other "states" as proposed by Beutler and colleagues, which include seemingly more concrete ideas, such as therapist training and theoretical orientation? It would seem not. Furthermore, Beutler et al. (2004) described a state as a "therapist variable," which is "employed, developed, or defined specifically in order to further one's role as a psychotherapist" (Beutler et al., 2004, p. 228). But, way of being is a concept that extends beyond one's role as a psychotherapist. We have a way of being always, therapist or not. In this sense, it seems to fit more the definition of a trait, because those are "manifested in the therapist's extratherapy life" (Beutler et al., 2004, p. 228). But, way of being is also not a trait for the reason given above—way of being is not necessarily "an enduring quality" (Beutler et al., 2004, p. 228), but rather changes. Perhaps way of being is a "state," but more so the type of state described by Zeig than by Beutler et al. (2004).

The complications of whether way of being is an inferred or observable state raise the question of whether way of being is a therapist factor at all. Fife et al. (2014) made the proposal that "the person of the therapist, including the therapist's facilitative conditions and the therapist's interpersonal attributes and style" (p. 23), which sounds much like therapist factors, is part of the therapeutic alliance, which is *grounded in* the therapist's way of being. Therefore, way of being may be the foundation upon which therapist factors rest, and be distinct from any type of therapist factor. In the current

study, I hope to explore this hypothesis, including who would be best to report on therapist way of being.

Purpose of This Study

Many MFT researchers are focusing on the salience of factors common across models (Blow et al., 2007; Davis et al., 2012; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Fife et al., 2014; Karam et al., 2015; Lambert, 2004; Sprenkle et al., 2009; Wampold, 2001). Scholars have identified and researched different types of common factors, including therapist factors. Way of being seems to fit best under the category of therapist factors, but as discussed above, may be its own type of common factor. Regardless, some scholars have emphasized the importance of way of being in the therapeutic process, but empirical research on way of being is non-existent. This study's purpose was to bring together multiple scholars' ideas to form a definition of way of being, as well as gain an understanding of how way of being might help or hinder therapeutic change. Before being able to test whether way of being influences change, we must know how to define it, and have clear ideas on what kind of way of being may benefit and even perhaps hurt clients.

I believe that a more rich and complete definition of way of being and understanding of way of being might be reached by joining many scholars' ideas, as opposed to only focusing on one opinion. To gather these opinions together, a modified Delphi methodology was employed. Both qualitative and quantitative methods were employed, as is the case with many Delphi studies (Hasson, Keeney, & McKenna, 2000). For this study, the first round of qualitative methodology allowed for gathering a variety of opinions on way of being from our particular sample of participants. Subsequent

quantitative methods helped bring the numerous and various opinions to a more manageable amount. And lastly, another qualitative round helped to provide more meaning to the several ideas. I will detail the methodology further in the next chapter.

CHAPTER III

METHODOLOGY

Research Design

The current study's purpose was to form a definition of therapist way of being, gain more understanding into how way of being influences therapeutic change, and to describe and define ways of being that promote and do not promote client change. At present, there is not a broadly accepted operationalization of way of being, nor is there a method of measuring or assessing it empirically. Given the theoretical arguments suggesting that a therapists' way of being is central to the process of therapy, the MFT field may benefit from a measure on way of being to empirically test whether or not it influences change across models. However, no empirical research exists on therapist way of being and how it influences therapeutic change. The dearth of empirical research on therapist's way of being may be due to the challenge of operationalizing way of being. Furthermore, scholars understand the concept in various ways, as discussed above. Given the lack of empirical research and a clear operational definition or way of measuring or assessing way of being, it seemed that an important step toward understanding the influence of a therapist's way of being was to develop a clear definition of way of being, as well as ideas on how way of being might benefit and harm therapeutic change. These ideas could then be utilized by therapists and researchers in the future.

To gather rich data that would help in better understanding the various aspects of a therapist's way of being, it seemed that a methodology that allowed for multiple voices and experiences to be heard would best provide that. Yet at the same time, I wanted to bring the variety of opinions to a manageable consensus, in order that the results of the

study could more easily lead to future research on way of being. To achieve these aims, a modified Delphi method was chosen. The Delphi method includes pooling many experts' opinions on a topic (Stone Fish & Busby, 2005). Researchers often use the Delphi method approach when a new idea is germinating in the literature (Stone Fish & Busby, 2005). It includes multiple stages, in which participants (sometimes referred to as panelists in a Delphi study) receive and comment on feedback from other participants (Stone Fish & Busby, 2005), which allows for many experts to engage together in the exploration of uncharted territories. Delphi studies often involve the collection of both qualitative and quantitative data, with the first round often being qualitative, and subsequent rounds involving descriptive and inferential statistics (Hasson et al., 2000). Further benefits of using the Delphi method include anonymity of responses and lack of pressure to conform to group opinions (Dalkey, 1969; Stone Fish & Busby, 2005).

In the past, Delphi studies have been used for a variety of purposes (for examples see Linstone & Turnoff, 2002). While one common purpose has been for prediction or forecasting, other Delphi studies have aimed at bringing a variety of opinions to a more manageable consensus (Stone Fish & Busby, 2005). Dawson and Brucker (2001) argued that Delphi studies can help to address criticisms that the MFT research field lacks "clear and concise definitions, concepts, and treatment protocols" (p. 125). The Delphi method is intended produce greater clarity and understanding of a particular topic, as it "allows for grouping and analyzing the speculations of many experts on a topic to move closer to knowledge on that topic" (Dawson & Brucker, 2001, p. 126). However, one important intent behind Delphi studies is to move the field forward with regard to research, and not necessarily to discover one truth (Stone Fish & Busby, 2005). This study aimed to help

turn expert opinions into clearer ideas to move the field toward more empirical research on way of being.

The concept of therapist way of being has appeared sparsely in the literature for a number of years, but has received little attention; therefore, the Delphi methodology served to promote clearer ideas around a topic that has been generally ignored. Way of being was recently proposed as an important common factor in Fife and colleagues' 2014 article. After being published, the *Journal of Marital and Family Therapy* editorial council deemed the article as one of two best articles of the 2014 year. As a recently well-received concept in the field of MFT, I predicted a number of scholars to have interest in commenting on the topic.

A Modified Delphi Study

Some scholars claim that the classic Delphi method consisted of four rounds (Hasson et al., 2000). Stone Fish and Busby (2005) claimed that the Delphi method traditionally includes three stages. Discrepancies on the number of ideal rounds may simply reflect a change in preference throughout the years, but an essential question is how many rounds it takes to reach consensus (Hasson et al., 2000). Furthermore, participant fatigue should be taken into account. With these in mind, Delphi studies can also simply be two rounds (Hasson et al., 2000). In a typical three-round Delphi study, the first stage would allow panelists to provide their views in written form on the topic in as much detail as they would like, the second stage would include the researcher(s) gathering together the responses to determine the group's opinions on the topic, and the third stage would address disagreements in the responses (Stone Fish & Busby, 2005).

As explained previously, Delphi studies often involve both qualitative and

quantitative data—the first round being qualitative, and ensuing rounds involving descriptive and inferential statistics (Hasson et al. 2000). The current study began with a qualitative round and was followed by a round involving descriptive statistics. But while many Delphi studies are then followed by another quantitative round, after the second round of this study, further qualitative analysis was performed. Due to time constraints and panelist dropout on the second survey (indicating panelist fatigue), I conducted two traditional rounds rather than three. However, after the second round, a qualitative thematic analysis was done to provide further meaning and manageability to the results. Hence, the current study being a *modified* Delphi study.

This final qualitative analysis was done to help compensate for the valuable data lost due to not conducting a third round. In addition to addressing panelist disagreements, a third round would have likely provided data which would have helped bring the many ideas gathered in this survey to a more manageable and meaningful consensus. While the final qualitative analysis did not necessarily address panelist disagreements, its purpose was to further the ideas gathered in the second round to meaningful conclusions. Albeit, one obvious and significant difference is that the qualitative analysis was performed primarily by me, the principal researcher, rather than the last round coming from the panelists who provided data in the first two rounds. The lack of a traditional third round, as will be explained further later on, may be considered a serious limitation to the current study.

Panelist Recruitment

Not any scholar will do for a Delphi study—Delphi studies call for experts on a particular topic. Panelists are chosen for their expertise on a particular topic, which is

critical for a Delphi study to produce quality results (Stone Fish & Busby, 2005). For the purpose of this study, I focused on inviting those that were familiar with the concept of way of being. Furthermore, it seemed that those with experience as a therapist would be best qualified to comment on therapist way of being because they likely have had experiences in which they saw how their own or another therapist's way of being influenced therapeutic change. Specifically, I chose potential participants based upon the following criteria: (a) the participant indicated that he/she was at least somewhat familiar with the concept of way of being, and (b) the participant indicated he/she was a licensed clinician.

As discussed previously, clients may also have opinions, and perhaps an even better perception of their therapists' way of being. As such, who the "expert" is in this situation is debatable, for the client's perspective may certainly be one empirical aspect of a therapist's way of being. However, for the purposes of this study, I determined to begin with the professional's side of the concept. Therapists who have practiced for at least a few years may more easily understand that their way of being influences therapeutic change because they have had much more experience in the therapy room than clients. Furthermore, therapists may have experienced how their way of being changes from client to client or even within a therapy session, and such differences may allow them to clearly articulate how their own way of being has been both beneficial and detrimental for therapeutic change. For these reasons, I decided that therapists would be appropriate for this study. However, future studies may benefit from understanding the client's perspective on his/her therapist's way of being. To further explore this idea, I also asked panelists in this study a question about whether self-report, client report, or both

would most accurately capture a therapist's way of being.

There are not established guidelines for the number of panelists for a Delphi study; scholars have suggested somewhere between 10 and 50 (DeLoe, 1995; Miller, 1993; Rowden et al., 2014; Tersine & Riggs, 1976). I invited approximately 39 people to participate (this does not include anyone that was invited via an invitee forwarding the invitation) via email, and the study was also posted on Facebook. Twenty-one panelists participated in answering questions in the first questionnaire (Q1).

From data gathered on the initial 21 panelists, ages of panelists ranged from 28 to 82 years old. 10 reported as male, and 11 as female. Sixteen reported as Caucasian/white, 2 as Hispanic/Mexican, 1 as German American, and 1 as Asian American. Eleven reported having a PhD/Doctorate and 10 reported having a master's degree. For work setting, 7 were in academic settings, 6 in private practice, 6 in inpatient care, 3 in outpatient care, and 1 was unemployed and 1 was retired. Furthermore, 17 panelists reported being *very familiar* with the concept of way of being, and 4 panelists reported being *somewhat familiar*.

Procedures

To begin, an email was sent to potential panelists inviting them to provide their opinions on therapist's way of being. The invitation further explained that if they choose to participate, they would be sent three questionnaires, each of which would take approximately 20-60 minutes of their time over the course of a few months (in the end, only two questionnaires were sent out; this will be explained in the subsequent section). If the potential panelist wanted to participate, the link to the first survey was provided in the invitation email. At the end of the invitation, recipients were also asked for referral

for any other licensed therapist they knew that may qualify for the study. They were told to send the referral to my email address. In a later iteration of the invitation email, I added that they were welcome to simply forward the invitation email on. The first survey was also made available on one of my thesis committee member's Facebook page.

First Questionnaire (QI)

The first questionnaire began by determining whether or not the person qualified for the study by asking if he or she was currently a licensed clinician, what his or her current license was, and whether he or she was familiar with the concept of way of being (See Appendix A for exact questions for QI). Electronic signatures consenting to participate were downloaded separately in order to determine who had participated, so that they could be sent the subsequent questionnaires. Unfortunately, this signature was left blank for several panelists, however they still selected the option indicating consent to participate in the study.

As stated previously, the first round was qualitative in nature. The beginning of the survey included a definition of way of being as "the in-the-moment attitude a therapist has towards a client (Fife et al., 2014)[1]." Panelists were asked to comment on this definition. The remaining questions were open-ended prompts. The survey was available for several weeks until a sufficient number of responses were received.

Coding process of QI. The next step was coding the qualitative data received. Corbin and Strauss (2008) described coding as "taking raw data and raising it to a conceptual level" (p. 66). Our goal in this stage of coding was to take all of the responses and break them down into individual concepts—similar to taking a brick building and

[1] Fife et al. (2014) defined way of being using this phrase, but at another point in their article, also included the word "stance" in the definition. I did not notice the difference until after sending out the survey. As such, panelists only commented on way of being as an attitude, but not as a stance.

breaking it down into individual bricks (Corbin, Strauss, & Strauss, 2014). Even more specifically, this could be considered the *open coding* stage of analysis. Open coding involves, "breaking data apart and delineating concepts to stand for blocks of raw data." (Corbin & Strauss, 2008, p. 195). At this stage, we broke apart the responses to determine our individual blocks of data for QII. This included analyzing each response to determine the number of ideas presented and deciding when to break ideas apart and when to keep them together. I analyzed the responses of QI two other volunteer coders; one was a female undergraduate student who graduated in family, consumer, and human development, with a minor in psychology, during the process of coding, and the other was a woman with her bachelor's degree in communication disorders.

A letter was used to label each respondent [Respondent A (RA), Respondent B (RB), etc.], and all of the responses were put into a spreadsheet. Each of us had our own version of this document. All coders read the responses and put every unique and nonoverlapping response into a separate cell (Blow & Sprenkle, 2001). Special attention was made to separate items into single ideas. This was so that in the second round, panelists were not required to comment on double-barreled ideas—meaning that one item contains more than one idea, leaving the possibility that a panelist may agree with one of the ideas but not the other (Rowden, 2009). After each coder went through the responses, the three coders collaborated together to find agreement on how the responses should be divided up. Triangulation of coders was employed to help increase the validity of the coding results. "Triangulation is a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study" (Creswell & Miller, 2000, p. 126). Specifically, this was done by

all three coders reviewing all data together and ensuring that at least two of the coders agreed on how to divide each response.

The next step involved a form of axial coding. Axial coding has been defined simply as, "crosscutting or relating concepts to each other" (Corbin & Strauss, 2008, p. 195). After coming to consensus on how to divide up the responses in to individual concepts, the coders looked for any repeated ideas. It involved looking for related concepts in the data (i.e. axial coding), however, this coding process was much stricter than looking for themes, as coders looked for items that were so similar, one of the items could be thrown out because the other item captured it's meaning. This process was done primarily so that participants in the second survey did not have to comment on the same idea more than once. Each coder had their own sheet of the responses (this time coded into individual concepts). Each coder indicated on the spread sheet which ideas they believed to be repeat ideas. Again, triangulation of coders was employed as any ideas in which two or more coders agreed were repeat ideas, were considered repeat ideas. With the repeat ideas, I chose one that seemed to best articulate the idea, and the others were not included in the second questionnaire (QII). The final list consisted of every unique and nonoverlapping idea presented by the 21 panelists, and this list was turned into a 382-item questionnaire for QII.

In this process, all coders strived to preserve the original responses as much as possible (Hasson et al., 2000). Some minor editing was done mainly to correct spelling/grammatical errors, but also was necessary when splitting one answer into several ideas so that each idea made sense standing on its own in QII. In very few cases, we had to significantly reword a response or leave it out because the way it was written

would be difficult or incomprehensible for others to comment on.

Second Questionnaire (QII)

The purpose of the second questionnaire was to allow all the panelists to provide feedback about the other panelists' responses so that a consensus might be made about what the group agrees upon (Stone Fish & Busby, 2005). Because there were many ideas (382 items), the easiest way to get feedback on all of the ideas was through a quantitative process, which involved rating each item on a Likert scale to indicate level of agreement. A qualitative process that involved the panelists responding to each of the ideas in a more open format would likely have been far too time consuming.

QII Measures. The survey consisted of 10 different measures, created by the original 10 questions for QI and all of the panelists responses to those questions. First, one of the 10 questions was stated, and then all of the coded ideas in response to that question were listed underneath as individual items to rate. The questions were listed in the same order as they were in QI. For example, the fourth question/prompt listed in QII was, *please describe a therapist's way of being that promotes client change*. Then, listed below this question were all of the responses (coded into individual ideas). To continue the example, the first five items listed under this question were: *Humble*; *Safety. Security-trustworthy*; *Competent*; *On the path of personal growth as well*; *A guide not an expert.* A Likert scale was provided next to each item for the panelists to indicate their level of agreement with each item as a response to the question. Originally, I intended to have all questions be on a 7-point scale (Blow & Sprenkle, 2001; Stone Fish & Busby, 2005), however I made an error in making the survey and some questions were on a 5-point scale and others were on a 7-point scale. The limitations of this oversight will be

discussed in the limitations section. After each question and its items, there was a space provided for optional additional comments.

Other questions in the survey were listed at the beginning, before the 10 questions. These included asking participants if they had participated in the first questionnaire, and then asked for his or her email address (participants were not allowed to continue and take QII unless they indicated that they had participated in the first questionnaire). It was explained that their email address would be downloaded separately from their responses to protect their confidentiality. The email address was to facilitate tracking down those who participated in the case of doing a third round.

Recruitment for QII. The panelists received an invitation email with a link to the second questionnaire. Those who had put their name on the informed consent in the first survey were sent an email thanking them for their participation in the first survey and asking for their participation in the second survey. Another email was sent out to all those who were invited to participate in the first survey (unless they had specifically contacted me and told me that they were unable to participate), asked for anyone who completed the first survey to complete the second survey, and provided a link to QII.

Analysis of QII. Nine panelists responded to the second questionnaire, meaning that more than 50% of panelists dropped out from the first round. This influenced my decision to not send out a third survey. With the information from the second questionnaire, I calculated the median and interquartile ranges for each item. “Medians provide information on the central tendency of responses, indicating where most items fall on the disagreement-agreement scale” (Stone Fish & Busby, 2005, p. 244). So, on a 7-point scale, where 7 indicates “strongly agree,” then a median of 6.5 would indicate

more panelist agreement. The interquartile range is the range of scores in the middle 50% of responses, and indicates how much consensus each item had (Stone Fish & Busby, 2005). The smaller the interquartile range, the more consensus the item reached (Stone Fish & Busby, 2005). A list of each item with its median and interquartile range was created.

In order to include in this report those items which had the most consensus and agreement, I included only those items with a median of 6 or above and an interquartile range (IQR) of 1.5 or below for those items on the 7-point scale (Stone Fish & Busby, 2005). On the 7-point scale, a 6 represented "agree" and a 7 represented "strongly agree." Those with a median of 6 or above indicated that most panelists at least "agreed" with the item. On a 7 point scale, the highest possible IQR would be 6, and would indicate low consensus, and the lowest possible IQR would be 0. For the 7-point scales, I included all those items with an IQR of 1.5 or below, as this should have represented a high level of consensus among panelists.

For those on the 5-point scale, I included those items with a median of 4 or above, and an interquartile range of 1 or below. On the 5-point scale, a 4 represented "somewhat agree" and a 5 represented "strongly agree." Those with a median of 4 or above indicated that most panelists at least "somewhat agreed" with the item. Because there is less of a range in the 5-point scale than the 7-point scale, I lowered the requirement for the IQR to 1. Appendix B includes a report of all these items, organized into tables by the original open-ended questions which prompted them.

Final Qualitative Analysis

The analysis of the data from QII narrowed down the number of concepts from

the initial coding process performed on the data from QI. However, the number of total items was still 222, making drawing meaningful conclusions difficult. Additional rounds were needed to come to more consensus about which ideas were the most important to the panelists, but due to panelist dropout rate, another method of bringing more meaning to the data was needed. As such, I performed a theoretical thematic analysis on the data from QII (Braun & Clarke, 2006). Thematic analysis has been described as foundational to qualitative analysis, and defined as "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006). The theoretical purpose of employing a thematic analysis in the current study was primarily to report the meanings given by panelists that I found in the data (Braun & Clarke, 2006). The panelists each had certain understandings about way of being and tried to convey those in their written descriptions. The thematic analysis was an attempt to synthesize the meanings given by panelists, and report those in a manner which would be easily digestible by readers. The analysis was driven by the research questions for the study, and thus was more of a theoretical thematical analysis, rather than an inductive thematic analysis.

To perform the analysis, I primarily employed axial coding. While a form of axial coding was done previously to weed out any repeated ideas, this time it was a "looser" form of axial coding, in that I was relating concepts to each other looking for themes, rather than identical ideas (Corbin & Strauss, 2008). A theme has been defined as "captur[ing] something important about the data in relation to the research question, and represent[ing] some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). I coded the 222 ideas into themes within each of the 10 questions, but also took note of any themes that were repeated across questions. I decided to code

within each question, rather than across the whole data set, because each question was essentially a different research question. If I had coded across the whole dataset, then some themes may have appeared rather obscure and unimportant, while, within the question they were asked, they were proportionally significant. Coding within questions did result in themes with fewer items than may have been found if I had coded across all 222 ideas; however, as Braun and Clarke (2006) explained, "the 'keyness' of a theme is not necessarily dependent on quantifiable measures—but rather on whether it captures something important in relation to the overall research question" (p. 82). The themes I coded represented patterns, and therefore did include multiple items in each one. But ultimately in coding I strove to identify themes which were significant in answering one of the research questions.

I did not code some ideas into any one theme because I saw no pattern or repeating of the idea in other statements. All these items were placed in a separate "no theme" category. Because I did the thematic coding by myself, there was a risk of my personal bias influencing the validity of the themes truly reflecting what the panelists agreed upon. To help check this, I sent the results to the two coders who helped in the previous coding, and both of them reviewed my coding and indicated that they agreed with themes I had created.

As noted, some ideas were unique, and I did not code them into any one theme. In some qualitative research, it may be considered that these items were therefore not as important, because they were mentioned only once (or a limited number of times). For this study, however, I do not treat these items as such for two important reasons. First, repeated ideas were already coded for and removed in earlier coding. This means, that

one idea may have been originally mentioned several times but was only presented once in QII. During the final coding, if no other item shared a theme with this item, it was placed in aside in the "no theme" category, despite it possibly having been an idea that was mentioned repeatedly in the QI data. The second reason these items are still important is that these items still made the final profile from the quantitative analysis and had high agreement and consensus among participants. So with these two reasons in mind, the results section below will be an attempt to balance presenting themes found in the final qualitative analysis because they help to manage and give meaning to the many concepts, but also presenting those items with the highest consensus and agreement, regardless of whether or not they were included in a theme.

Additional Coding for Question One

In many ways, all future research on therapist way of being rests on one question—what is way of being? Unless a clear definition of way of being is established, it is difficult to explore how way of being influences client change, as well as describe helpful and unhelpful ways of being. And so, in many ways this question of defining way of being was the most important of the current study. As such, I did a further level of coding for this question only in order to come to a clearer definition of way of being.

After formulating a few themes for this question during axial coding of the final qualitative analysis, I further analyzed the data and themes in a *selective coding* stage. In selective coding "previously identified discrete concepts and categories are further defined, developed, and refined and then brought together to tell a larger story" (Price, 2010). In this case, the "larger story" was a definition. The coding involved taking a closer look at the themes, noticing any patterns or themes that I previously did not

recognize, and then bringing together the concepts and themes to form a definition of way of being. The selective coding was an attempt to focus in on a generic definition of way of being (rather than specific ideas about what constitutes a therapeutically beneficial or detrimental way of being) and bring together ideas that were patterned. The results of this analysis are included in the next chapter.

CHAPTER IV

RESULTS

Of those items on the 7-point scale, 54% (*n*=76) had a median of 6 or above and an interquartile range (IQR) of 1.5 or below. Of those on the 5-point scale, 61% (*n*=146) had a median of 4 or above and an IQR of 1 or below. As this is still a high number of items, I will highlight only a few for each question that had the highest levels of agreement and consensus. Each question includes a table (see Appendix B for all tables) of all items that made the final report; these items are organized by the highest medians at the top, and then by the lowest IQRs within each of those medians. Some items presented in the tables are condensed from how they were originally presented to panelists to make the tables more manageable to read and navigate. When discussing the quantitative results, I treat each of the concepts as items, and italicize them.

I will also present the themes found from the final thematic analysis within each question, as well as note some items which may relate to themes in other questions. I will focus on presenting those themes with the most items, those relevant to answering the research questions for this study, and some on themes that seemed to appear across questions. When discussing qualitative results, I treat items as quotes from panelists.

Lastly, for clarification purposes, sometimes after providing a quote from a panelist I used the language of "another panelist said/explained" and then provide another (or a few more) quotes. But in reality, I did not actually know if it was in fact another, different panelist. Several of the quotes in one theme could have originally come from the same panelist, but I use this language simply for ease of discussion.

Question 1: Forming a Definition of Way of Being

Quantitative Results

The first question asked panelists to comment on a proposed definition of therapist way of being: "the in-the-moment attitude a therapist has towards a client" (Fife et al., 2014). Panelists were also invited to provide their own definition of way of being. This question was on a 5-point scale. The majority of items included in the final report for this question had a median of 4, although two items had a median of 5, and one item had a median of 4.5 (see Table 1).

Panelists agreed that (median: 5; IQR: 1) *if someone is critical in their perceptions and attitudes, it will come across, even without critical words. The nonverbal messages, tone, and expressions will always come across. This is why way of being is fundamental.* Another item (median: 5; IQR: 1) with high agreement describes that *when someone is in a self-centered or bitter way of being, it will permeate their sense of self and interactions with others, and when they are in a generous and honest way of being it will as well.*

One item received high agreement (median of 4.5) and consensus (IQR of 1), which contained a proposed definition (this is only an excerpt from the item): *the current definition emphasizes attitude toward client only . . . I would change it to "the fundamental manner in which a therapist regards self and client*." In fact, only the two items described above had a higher median than this one, and neither of these seemed to clearly propose a new definition. It is also important to note that no item made the final profile that suggested that the definition proposed was sufficient as is, and from this we

might infer that overall the participants did not feel that "the in-the-moment attitude a therapist has towards a client" (Fife et al., 2014) was an acceptable definition. One item in the final report explained that *the word attitude is good, but insufficient.*

Qualitative Results

As mentioned in the previous chapter, I did additional coding for this question only. Forming a clear definition of way of being was, in many ways, the most important question of this project. Knowing how way of being influences change or knowing about helpful and harmful ways of being won't be helpful if we don't know how to define way of being. And so, I did additional coding to help develop a potential a definition of way of being.

In this selective coding stage for question one, I noticed that the ideas presented by panelists consisted of general descriptions about what way of being is, but also descriptions that inherently described a way of being that is helpful or in some way beneficial. It was difficult to determine how to fit the ideas that focused on a more helpful way of being into a more generic definition. These ideas included some of the following ideas from panelists: "being fully present with one's self and with one's client, with the intention of compassionately helping another"; "being attuned to one's self and to the client"; "that [the in-the-moment attitude a therapist has towards a client] plus who the therapist [is] and if they are congruent in and out of therapy"; and, "one way I've come to understand way of being is the in-the-moment ability to be alive to the humanity of the other person." Perhaps, there are ways to incorporate these ideas more fully into a generic definition. As for this study, I separated them out, and focused on the ideas presented by panelists, which made the final report, and that were more generic in their description of

way of being. However, a few of these ideas focusing on a beneficial way of being did influence the generic definition, as will be described below.

In the selective coding process, I summarized the panelists' ideas that focused on more generic definitions of way of being—those that could be applied to both a therapeutically helpful or unhelpful way of being. First, I will present the two core themes I used to form the definition, and then the actual definition.

The first theme that I included in the definition was *Way of Being Comes Across in Interactions; it Permeates the Self* (one theme). This theme included concepts presented by panelists which stressed that way of being is communicated through our interactions with others, with or without words. Items mentioned above in the quantitative results contributed to this theme. For example, one panelist described that "if someone is critical in their perceptions and attitudes, it will come across, even without critical words. The nonverbal messages, tone, and expressions will always come across. This is why way of being is fundamental." Another panelist explained that "when someone is in a self-centered or bitter way of being, it will permeate their sense of self and interactions with others." And yet another panelist said that "a way of being captures the whole mode that the person is in. This will permeate their perceptions, words, behaviors, and general stance towards others. This is why it is hard to capture." Although these panelists do sometimes refer to helpful or unhelpful ways of being, their descriptions clearly present principles applicable to way of being as a general idea.

A second theme was *Self and Other*. This theme included any mentioning that understanding way of being involves considering the self and others. It included the item above that proposed new definition of "the fundamental manner in which a therapist

regards self and client." Other similar ideas presented by panelists were “being attuned to one’s self and to the client,” and “being fully present with one’s self and with one’s client, with the intention of compassionately helping another.” While these last two quotes focused particularly on a way of being that promotes change, the element of “self and other” did influence the generic definition.

Combining the ideas of these two themes in the selective coding process, I formed the following definition: *Way of being is the fundamental regard for self and client, which permeates our sense of self, perceptions, attitudes, words, tone, expressions, nonverbal messages, behaviors, interactions with and general stance towards others.* This definition, in no way, captures all of the ideas presented by panelists, let alone all of the ideas that made the final report after the quantitative analysis. The definition is, however, an attempt to combine key ideas presented by panelists that seemed to be patterned (hence forming themes), as well as were generic (rather than descriptive of a helpful or harmful way of being).

Furthermore, this definition reflects those items which had the highest levels of agreement from the quantitative results. Three items were highlighted above in the quantitative results with the highest medians (4.5 or 5), and these ideas make up the bulk of the definition. This was not necessarily an intentional part of analysis; rather, I noticed that after formulating the definition, it primarily reflected those top three ideas. This could be coincidental. But, it is also possible that because these ideas had the highest levels of agreement, any other similar ideas had more likelihood of making the final report, making them a more prevalent theme. Furthermore, it is possible that because I was aware of their high status in the quantitative results, this subconsciously influenced

my formation of the definition.

Question 2: The Extent to Which Way of Being Influences Client Change

Quantitative Results

For this question, panelists were asked: "To what extent do you believe that a therapist's way of being influences client change"? Panelists were also asked how way of being does (or does not) affect client change. This question was on a 7-point scale. Of the items included in the final report, two items had a median of 7, suggesting high consensus for these items, and the remainder had medians of 6 (see Table 2).

With the highest level of agreement (median: 7; IQR: 1), most scholars agreed that *a therapist's way of being can have a significant effect on client change*. Scholars also overwhelmingly agreed (median: 7; IQR: 1) that as we pay attention to *the impact of our way of being with our clients . . . this quietly slides underneath [and] permeates every aspect of our work with them. Efforts to improve the alliance, assess, initiate and refine treatment planning, etc. — all are influenced by the underlying regard we have for self and client in the therapeutic endeavor.* Another item (median 6; IQR 0) highlighted that way of being can influence clients in a damaging way: *if a therapist is reactive (unintentional) [to the] client instead of responsive and intentioned that way of being is often at minimum not helpful and often damaging and harmful.*

Qualitative Results

Two of the most significant themes in this question were *Therapist WOB Can Influence the Client and Treatment* and *The Therapist Can Influence Client and Treatment (No Mention of WOB)* (WOB is an abbreviation for way of being). Both of

these themes were very similar in discussing the influence of the therapist on a client and treatment, but the former theme included statements that specifically referred to therapist way of being, while the latter theme simply discussed the influence of the therapist.

Therapist WOB Can Influence the Client and Treatment included a couple of the items mentioned above in the quantitative results. One panelist explained that "a therapist's way of being can have a significant effect on client change." Another said that "therapy will be experienced in different ways depending on the way of being of the therapist." And yet another explained that "a therapist's way of being can influence a client's hope and motivation for change. That hope and motivation can have a positive influence on client change."

The Therapist Can Influence Client and Treatment (No Mention of WOB) included ideas from panelists such as "I believe the energy and hope a therapist has in the client has a profound influence" and, "our fundamental view of clients, with inherent assumptions about the nature of their hopes, dreams, resources, strengths, weaknesses, etc. - as well as our own in relationship to them - reflect an inevitable filter through which the entire treatment experience unfolds." Another panelist simply explained that "the therapist either presents to clients a change-friendly environment, or one that does not invite change."

A third theme also included several ideas from participants: *WOB Influences the Alliance/Therapeutic Relationship*. Many panelists mentioned that way of being influences the therapist-client relationship. For example, one panelist explained that "way of being influences the quality of therapeutic relationships, and thus has impact on what possibilities I see in my clients, and thus on how and whether I can instill hope." Another

said, “way of being could be considered an important part of the alliance, which definitely affects change.” And another said that “way of being is one of the underlying latent factors in the ‘therapeutic relationship or alliance’ - one of key contributors to positive therapeutic outcomes.”

Lastly, while not a theme within this question, one of the items mentioned in the quantitative results above did echo the previous theme of *Self and Other*, as it mentions in the last sentence that “efforts to improve the alliance, assess, initiate and refine treatment planning, etc. - all are influenced by the underlying regard we have for self and client in the therapeutic endeavor.” This echoes the proposed definition of way of being from question 1 (the fundamental manner in which a therapist regards self and client), and it seems that the participant was explaining that the regard for self and other influences many aspects of therapeutic treatment.

Question 3: How Panelists’ Way of Being Influences Client Change

Quantitative Results

This question was similar to the previous, in that panelists commented on *how* way of being influences change, however, for this question they specifically were asked to comment on how they saw their own way of being influencing client change. This question was on a 7-point scale. All items that made the final report had a median of 6, but a few also had lower IQRs (see Table 3).

With the highest consensus (median: 6: IQR: .5), panelists agreed with this statement discussing three ways in which a therapist’s way of being influences clients: *it influences our therapeutic relationship, their trust in me, and self-confidence related to how they feel I view them.* Another item (median: 6; IQR: 1) explains that clients *feel like*

[the therapist is] sincere, caring, [and] motivated by their best interest. Another item (median: 6; IQR: 1) focuses on how unconditional regard for clients helps them to *talk openly and feel supported*. Then another item (median: 6; IQR: 1), a little more generally, explained that the therapist's way of being affects how he/she sees clients and treats clients.

Qualitative Results

Within this question, one prevalent theme was *Safe and Supported*. Ideas here focused on how the therapist's way of being helps clients to feel safe in sharing feelings and supported by the therapist. One panelist simply said "[My way of being] allows clients to feel safe, heard, and understood." Another explained, "I am a non-threatening voice that promotes safe conversations for the client to discuss his or her life, and future possibilities." And another panelist said, "I like and have unconditional regard for my clients; I believe they are able to talk openly and feel supported."

A couple of other items, while not prevalent themes within this question, echoed significant themes from previous questions. One panelist explained (also mentioned above in the quantitative section) that their way of being "influences our therapeutic relationship, their trust in me, and self-confidence related to how they feel I view them." This seems to relate to the theme of *WOB Influences the Alliance/Therapeutic Relationship*. Another quote (also mentioned in the quantitative section) repeats the theme of *Therapist WOB Can Influence the Client and Treatment* as the participant explained that way of being "affects how I see them and, even more importantly, how I treat them."

Question 4: Descriptions of a Way of Being that Promote Client Change

Quantitative Results

For this prompt, panelists were asked to describe a therapist's way of being that promotes change. This prompt was on a 5-point scale, and 17 items had a median of 5, indicating very high agreement for several ideas (see Table 4). Of these 17 items, one had an IQR of 0, five had IQRs of .5, and the remainder had IQRs of 1.

The single word that had the highest level of both agreement and consensus (median: 5; IQR: 0) was *responsive*. Other descriptions with high agreement and consensus (medians: 5; IQRs: .5) included *the ability to relate authentically to clients*, having an *open mind* and *open heart*, and *being interested and invested in the client*. Another item (median: 5; IQR: .5) explained that *a non-judgmental, caring, curious, and empathetic stance is important as it conveys a genuine belief in the possibility for change and healing within the client.*

Qualitative Results

First, panelists felt that being *Humble* was important to having a way of being that promotes change. The theme of *Humble* included three quotes about being humble that appear to once have been part of one idea that was broken up into three parts in previous coding. They each begin and end with the same phrase, and each respective statement has a number after the beginning phrase (1, 2, and 3). To avoid repetition, the quote put together reads as such: "I believe a therapist that stays humble in continually trying to (1) see and understand their client(s)'s concerns & goals, (2) adjust their own efforts in support of client progress, and (3) track or measure the impact of those efforts [to support client progress] over time is demonstrating a way of being that is likely [to] promote client change." Here three elements were explained which demonstrate humility and a

change-promoting way of being. The quote actually continues to further explain that these ideas are "informed by the work of the Arbinger Institute and their current way of discussing way of being as 'outward mindset' vs. 'inward mindset'." As the ideas all focus on adjusting treatment according to the client's needs (as opposed to the therapist's needs), it would seem that an "outward mindset" has connections to humility. Another statement included in this theme was simply "humble."

The second theme, *Use of Therapist Self and Vulnerability* included ideas explaining that there is an element of using the self and our own woundedness in therapy that contributes to a way of being that promotes change. One panelist explained this process:

> Therapists need training in the therapeutically purposeful use of their personal selves just as they do for the implementation of their technical skills. Therapists, like the rest of humanity, are challenged throughout life with person specific issues - emotional, physical and spiritual - some of which become core struggles with themes that embed themselves in their personal development and professional functioning.

Similarly, another panelist described that "it is through therapists' own emotional and spiritual woundedness that they have the potential to empathize with, have insight into and gain access to the depths of their clients' woundedness."

Question 5: Descriptions of a Way of Being That Do Not Promote Client Change

Quantitative Results

Here panelists were asked to describe a therapist's way of being that does not promote client change. Similar to the previous prompt, this one was on a 5-point scale, and panelists had high levels of agreement on several items—19 items had a median of 5 (see Table 5). However, more of these items had very high levels of consensus—six

items had IQRs of 0.

There were several descriptions of a way of being that scholars agreed do not promote client change. These (medians: 5; IQRs: 0) included *self-aggrandizement*, *unethical*, *self-justifying*, *blind to self and others*, *checked out*, and *cold*. Other (medians: 5; IQRs: .5) descriptions were *being distracted* and *judgmental*. Furthermore, another item (median: 5; IQR: .5) stated that *people shut down or become defensive when they feel judged or criticized. Therapists might do this when they become overly diagnostic, or reactive or judgmental in their questions*. Another item (median: 5; IQR: .5) described that sometimes therapists do not allow clients' *humanity to matter* to them, that clients become *irrelevant* and we are *minimally invested* in their experiences.

Qualitative Results

One significant theme describing a therapist's way of being that does not promote change was *Not Interested, Attuned, and/or Engaged*. This theme included statements from panelists that described therapists being distant or disengaged from the client. Descriptions included, "checked out," "being distracted," "indifferent," and "bored." Another panelist explained (referred to above in the quantitative section) that "[Interacting with a client in such a way that they become] irrelevant--not allowing their humanity to matter to me. I think sometimes we can be too good at closing ourselves off to the experiences of those we work with to the point that we are minimally invested." And yet another explanation of a way of being was "one that is disengaged and going through the motions or has seen this diagnosis before."

Another theme with several statements was *Focus on Self as Therapist*. To clarify, this theme was different than *Use of Therapist Self and Vulnerability*. While use of the

self is important, several items in this theme pointed out the detriment of focusing too much on oneself as the therapist. One panelist simply described, "when my focus is more on myself than my clients, I likely do more harm than good." Another panelist explained that, "interacting with a client in such a way that they become an object: an obstacle in my pursuit to having positive, easy, or personally fulfilling outcomes; a vehicle for my own accomplishment, self-fulfillment, etc." does not promote change. And another explained that "some therapists get into battles with clients over homework, or power, or other things that seem to be more about meeting the therapist's needs than the clients. Even 'getting better' can become a need for the therapist who needs the client to change so they can feel competent." Thus, it seems that too much focus on oneself and one's own needs and wants may potentially lead to a damaging way of being.

Lastly, while not a theme in this question, another statement connected to the theme of *Self and Other*, which was "blind to self and others." Here again, we see the potential importance of both the self and another when it comes to understanding a way of being—change promoting or not. Another statement echoed the previously mentioned theme *Way of Being Comes Across in Interactions; it Permeates the Self*. The panelist explained, "I think that the attitudes of the therapist must be communicated somehow. I subscribe to the family systemic notion that we continuously communicate, and that communications have impact on people."

Question 6: Statements and Questions to Better Understand Way of Being

Quantitative Results

Panelists were asked to provide questions that one might ask a therapist to better understand his or her way of being with a particular client. This prompt was on a 5-point

scale. One item had a median of 5, while the remainder of the items had a median of 4 (see Table 6).

The item with the highest agreement (median 5; IQR: .5) was *describe what it feels like to work with this client*. Two other proposed questions (median: 4, and IQR: 0) were *what are the client's strengths and weaknesses?* And, *what do you see yourself currently doing that is making your client's success more likely?* Other questions (median: 4; IQR of .5) included: *What are their [the client you are seeing] strengths? What is your biggest difficulty with your clients?* And, *do you ever see your clients as a problem -- if so, under what circumstances?*

Qualitative Results

Two of the most prevalent themes for this question were: *Describe the Client* and *How the Therapist Describes and Understands Self as a Therapist. Describe the Client* included questions and prompts that focused on asking the therapist for descriptions of the client he or she was seeing. Some ideas were: "What are the client's strengths and weaknesses?" and "Tell me about your client." Also, "how do you perceive your client?" And, "what is a day like for them [the client you are seeing]?"

How the Therapist Describes and Understands Self as a Therapist included questions and prompts to try and understand how the therapist sees him or herself as a therapist, focusing on his or her struggles with clients. This theme included suggestions from panelists such as: "What is your biggest difficulty with your clients?" "What are the key patterns and underlying issues you see throughout your clientele?" And, "how do you interact with [the clients that challenge you most]?" Also, "[What do you see yourself currently doing that is making your client's success] more difficult?" And, "what do you

see yourself currently doing that is making your client's success more likely?"

Question 7: Responses Suggesting a Way of Being That Promotes Change

Quantitative Results

Panelists were then asked to describe the kind of responses (to the questions the panelists listed in prompt 6) one would expect from a therapist that would indicate that he or she has a way of being that promotes client change. This prompt was on a 7-point scale. Two items had a median of 7, indicating high levels of agreement for these items (see Table 7).

One of these items (median: 7; IQR: 1) described that a therapist whose response indicates that he or she seeks clients' *input and perspective* might suggest a change-promoting way of being. Another item was that the therapist would need to demonstrate a *good understanding not just of the pathological or irrational aspects of [the client's] life (diagnostic or problem-focused) but a good . . . understanding of their perspective, their struggles, their hopes, and perhaps even the goodness that might be difficult for them to see in themselves. In short, their humanity*. Another item idea (median 6; IQR 0) was that the therapist's *attitude/tone would be more compassionate, respectful.*

Qualitative Results

There was one significant theme for this question: *Recognize Humanity*. Panelists seemed to feel that responses that reflected a recognition of a client's humanity were more indicative of a way of being that promotes change. One panelist described (also included above in the quantitative results) that a therapist's response should reflect a "good understanding not just of the pathological or irrational aspects of [the client's] life

(diagnostic or problem-focused) but a good . . . understanding of their perspective, their struggles, their hopes, and perhaps even the goodness that might be difficult for them to see in themselves. In short, their humanity." Another panelist explained that, "when describing their work with the client, regardless of the difficulty of the work, the resistance of the client, the therapist would be able to identify elements of client's humanity in such a way that the therapist views the client as relatable and similar to him or herself." Another description from a panelist was simply, "a human being who can connect with other human beings."

Question 8: Responses Suggesting a Way of Being That Does Not Promote Change

Quantitative Results

Panelists were also asked to describe the kind of responses (to the questions the panelists listed in prompt 6) one would expect from a therapist that would indicate that he or she does not have a way of being that promotes client change. This prompt was on a 5-point scale. Several items in the final report had a median of 5, suggesting high agreement among panelists for these items (see Table 8). And of these items, four had an IQR of 0, also suggesting high consensus for these items.

Two of the items were very similar (medians: 5; IQRs: 0); one was *blaming* and another was *blaming responses that tend toward absolutes in describing/understanding clients and their progress*. Blaming was mentioned yet again in another item (median: 5; IQR: 0): *descriptions of the client that tend towards blaming, venting, or creating space between themself and the client through elevating themselves and their actions and degrading the clients' thoughts and actions*. A fourth item (median: 5; IQR: 0) was *dehumanizing*.

Qualitative Results

The most dominant theme for describing a therapist's way of being that does not promote change was *Not Owning Mistakes and Blaming*. Panelists described (some of these were mentioned above in the quantitative section) that "blaming responses that tend toward absolutes in describing/understanding clients and their progress" and "descriptions of the client that tend towards blaming, venting, or creating space between themself and the client through elevating themselves and their actions and degrading the clients' thoughts and actions" may indicate a way of being that does not promote change. Another similar description of potential responses was, "responses that tend toward defensiveness, avoidance, blame-shifting when it comes to addressing a therapist's own impact on client progress - especially when considering possible contribution to/impact in lagging client progress or outcomes." And yet another was, "if the focus is on how the client makes things difficult for the therapist, then I would say the therapist has a less productive way of being towards the client."

Another theme describing the types of responses one might expect from a therapist whose way of being does not promote change was *Does Not Recognize Complex Humanity*. This seems to be the opposite of the previous theme discussed, which described responses indicating a way of being that promotes change— *Recognize Humanity*. Some descriptions from panelists in this theme included: "dehumanizing," "labeling," "a generalizing of clients based on behaviors and resistance to change" and "responses that show lack of recognition of complexity."

While not a theme in this question, the simple word "distant" was used, which seems to fall under the previously discussed theme of *Not Interested, Attuned, and/or*

Engaged. This theme described a way of being that does not promote change. Another statement, "makes it about themselves and not client," also fell into a previous theme that described a way of being that does not promote change—*Focus on Self as Therapist*. Thus, we see connections, as would be expected between descriptions of a way of being that does not promote change and the types of responses someone might give with such a way of being.

Question 9: Measuring or Observing Way of Being in Clinical or Research Setting

Quantitative Results

This question asked panelists how one might go about measuring or observing way of being in a clinical or research setting. This question was on a 5-point scale. Three items had a median of 5 (IQRs: 1), indicating high levels of agreement, one item had a median of 4.5 (IQR: 1), and the remainder of items had medians of 4 (see Table 9).

There were a few ideas about measuring or observing way of being in a research or clinical setting that participants seemed to agree with and have consensus on. First, (median: 5; IQR: 1) *watching therapists in session*. Also, one item (median: 4.5; IQR: 1) suggested that *the way to observe is to participate as a co-facilitator in a therapy session.* Another idea (median: 5; IQR: 1) was *observations or measures that take place over time and that attempt to assess . . . clinician demonstrated efforts to adjust their approach based on assessed impact on client/goals objectives*. And yet another suggested client report, specifically on the question (median: 5; IQR: 1): *does the client report feeling heard and respected?*

Qualitative Results

I coded the majority of the statements from this question into the theme, *Observing and What to Look For*. This theme focused on observing therapists in session, and what to look for when doing the observations. Quite simply, one panelist suggested (as mentioned above), "watching therapists in sessions" is the way to measure or observe way of being in a research or clinical setting. Some other panelists went into more detail about the things one might look for while observing, such as, "I would expect to observe verbal and non-verbal behaviors that indicate responsiveness to client needs." Another suggested paying attention to "body language." And another said, "I would expect to observe a strong, mutually respectful therapeutic relationship."

Several quotes, which seem to originally be part of one statement suggested "observation or measures . . . take place over time." It was further explained that these "observations or measures" should "attempt to assess (1) clinician attunement to client goals/objectives . . . (3) clinician demonstrated efforts to adjust their approach based on assessed impact on client/goals objectives [and] (4) client outcomes (i.e. maybe via comparative control groups)." These ideas focused more on phenomena that need to be observed over several sessions, rather than just one session or interaction.

Note that the second idea in this previous quote, did not make the final report (only 1,3, and 4 did). This demonstrates the importance of breaking up the original data into individual ideas — panelists agreed with parts of the statement, but not all.

Question 10: Self-Report or Client-Report

Quantitative Results

The next question asked whether self-report or client report (or both, or neither) would more accurately capture a therapist's way of being. Panelists were also asked to

explain their responses. This question was on a 7-point scale. One item had a median of 7 (IQR: 1), and several other items had a median of 6. Five items with a median of 6, had IQRs of 0 (see Table 10).

Panelists seemed to agree that (median: 7; IQR: 1) *therapist self-report alone is not appropriate, and that client-report in some way is essential.* More specifically on client report, panelists also seemed to agree (median: 6; IQR 0) that asking a *client's experience of their therapist and of how they feel when therapists are present would be helpful*. Another item explained (median: 6; IQR 0) that *maybe some honesty from clients that self-report might not portray. . . funny how ironic that is . . . you would hope that a therapist who [has a good/helpful] way of being is self aware and would self-report honestly. But I also believe we might be hard on ourselves as well, which could skew some self-report.* Two other items with a median of 6 and IQR of 0 focused on including self-report: *self-report should be included*; and *self-report should be included. Self-report would likely capture complexity and intention that other reports couldn't.*

Qualitative Results

The two most predominant themes for this question were, *Client Report* and *Both*. While self-report was also mentioned a few times, others also included ideas about the potential issues with using self-report.

The most dominant theme was *Client Report*, which included statements about the importance of client report in measuring way of being. As mentioned above in the qualitative section, panelists agreed that "therapist self-report alone is not appropriate, and that client-report in some way is essential." Another (also included in quantitative section above), said that asking a "client's experience of their therapist and of how they

feel when therapists are present would be helpful." Another explained that "client report can offer valuable feedback for how a therapist is presenting themselves and coming across to the client." Many panelists seemed to feel that it was important to understand a client's experience of their therapist if we are to understand the therapist's way of being. However, one panelist astutely pointed out that "client report . . . will be more accurate after time depending on the population ([for example], oppositional teenagers or mandated clients may need a few weeks or months to overcome their own defenses)."

The second most predominant theme was *Both*. One panelist did acknowledge the importance of both, but still leaned toward client report: "both would be helpful, but the client is the person who is experiencing the therapeutic treatment, who experiences the therapist's way of being. This information should be more heavily weighted, although the therapist should ask him/herself about his/her experience." Another panelist simply explained that, "both [client-report and self-report] would create the opportunity for comparison." Another therapist gave a more elaborate explanation as to why both client and self-report may be helpful:

> Therapist self-report would provide perhaps the most clear evidence for a therapists' way of being. But way of being is always relational. I would imagine that a therapist generally tends to be better at having the right way of being when he/she feels comfortable and connected to a client and may be generally worse at it when experiencing resistance. Perhaps an aggregate of many interactions with many clients, receiving both the client and the therapist's self-reports would provide an overall sense of the therapist's ability to use way of being productively.

Here the panelist provides insight into the value of using both client report as well as self-report, but also brings up observing one therapist with different clients, and (as was mentioned in the previous section) the value of observing therapists with clients over several sessions/interactions.

Having reviewed the quantitative and qualitative results for each of the questions, I will now discuss the clinical and research implications of some of these findings.

CHAPTER V

DISCUSSION

The goals behind this study were to form a definition of therapist way of being, gain more understanding of how way of being influences therapeutic change, and also to describe ways of being that promote and do not promote client change. This study was also intended to enable the field to move forward in researching therapist way of being. Here I will discuss some of the possible applications of the findings presented in the results above.

A Definition of Way of Being

As explained previously, perhaps the most important goal of this study was to form a definition of therapist way of being. Knowing what way of being actually is, is a necessary first step before we can attempt to understand how way of being influences change, or describe helpful and harmful ways of being. As such, I did an additional coding phase for this question only. This additional coding process (selective coding) helped to form a possible definition of way of being that reflects some of the most agreed upon ideas of panelists. The proposed definition is, "the fundamental regard for self and client, which permeates our sense of self, perceptions, attitudes, words, tone, expressions, nonverbal messages, behaviors, interactions with and general stance towards others."

Attitude Versus Regard

It may be important to note that rather than an attitude toward (used in the original definition proposed to panelists), the word regard is used. The median was high (4.5) for

the item including a proposed way of being definition of, “the fundamental manner in which a therapist regards self and client," suggesting that panelists agreed with the term, “regard.” Furthermore, another statement to make the final report was, “the word attitude is good, but insufficient,” suggesting that panelists agreed that attitude was not quite the right word to define way of being.

Attitude can be defined as “a mental position with regard to a fact or state” or “a feeling or emotion toward a fact or state” (Attitude, 2018). Regard, on the other hand, can be defined as, “attention, consideration” or “the worth or estimation in which something or someone is held” (Regard, 2018). An attitude, in summary, is a mental position or a feeling toward a fact or state. This definition, interestingly, does not include people, and so it may be that the word “attitude” is used less often in reference to a person. Although, one could have a feeling toward a particular fact about or state of another person. But perhaps “attitude” does not quite capture that way of being may involve our feelings towards an entire person. Furthermore, “the worth in which someone is held” (regard) seems to go beyond a simple mental state or emotion. Way of being, may be more than me feeling happy toward you, or being in a pleasant state of mind as I interact with you, but rather it includes how I value you. Perhaps, a change promoting way of being involves a positive regard for another person (you have worth to me), and a change-deterring way of being involves a negative regard for another person (you do not have worth to me).

Regard for Self

None of this discussion even touches on the regard we have for ourselves. This proposed definition of way of being includes a regard not only for the client, but also for

the self. It may be that the regard we have for ourselves is deeply connected with the regard we have for a client. If I regard myself as worthless when I say something rude to my spouse, I may be more likely to regard my client as worthless when she does it in front of me in session. This may influence the way that I respond to her in the session.

On the other hand, if I regard myself overly high in some way—worth more than my client—then any situation in which that feels challenged in therapy may be met with a devaluing of my client so that I might preserve my illusions of superiority. Many panelists, in the theme *Not Owning Mistakes and Blaming*, emphasized that a therapist who seems to believe that problems in therapy are all the client's fault have a way of being that will not promote change. One panelist summarized in response to question two, that "efforts to improve the alliance, assess, initiate and refine treatment planning, etc. - all are influenced by the underlying regard we have for self and client in the therapeutic endeavor." If I believe myself to be a perfect therapist with impeccable judgment (regard for myself is too high), then I may be less likely to consider my client's lack of progress as a reflection of my own doing, and be less likely to make efforts to improve aspects therapy. Thus the regard I have for client and self influences my efforts to improve the therapy process.

The opposite of a high regard for self may be humility. *Humble* was a theme in the data of panelists describing a way of being that promotes change. I also suggested in the literature review that humility may have connections to way of being (see Rowden et al., 2014 for Delphi study on humility). Rowden et al. (2014) found that humility's role in therapy was more intrapersonal in nature, rather than interpersonal. Way of being seems to be a very interpersonal concept, but perhaps the connection to humility may be

explained by the idea that humility reflects an appropriate regard for self that leads to a change-promoting way of being. Perhaps, humility is the element of way of being that relates specifically to regard for self. Or, it might also be inseparable from our feelings toward another person, and thus actually be a very interpersonal concept. At the very least, being humble may describe the type of regard we need for ourselves as therapists.

Breaking Down Way of Being into Components

Lastly, the rest of the definition focuses on what might be considered components that constitute way of being—our sense of self, perceptions, attitudes, words, tone, expressions, nonverbal messages, behaviors, interactions with and general stance towards others. This is very similar to Zeig's (2015) idea that a state is difficult to describe, but might be better captured by breaking into components, including, perception, attitude, vocabulary, linguistic characteristics, behavior, and relationship patterns (see p. 55). It may be that way of being simply cannot be capture by one word (such as regard), but rather is a state that is made up of many moving pieces.

Clinical Implications of This Definition

The focus on client *and* self may be similar to the previously discussed concept of *dual level of consciousness* (Geller & Greenberg, 2002; Robbins, 1998). This phenomenon involves carefully balancing and being responsive to one's internal experience as therapist along with the experience of a client (Geller & Greenberg, 2002). Undeniably, therapists are taught to be responsive to the client, perhaps especially through the use of empathy (Aponte & Nelson, 2018). However, it is different to teach therapists to also be responsive to themselves, and utilize that in therapy (Aponte &

Nelson, 2018). Indeed, one theme related to these ideas was *Use of Therapist's Self and Vulnerability*. Many panelists seemed to feel that in order to have a way of being that promotes change, it involved some form of utilizing one's own woundedness (Nouwen, 1979). This might suggest that self-of-the-therapist training is important to developing the kind of way of being that will help our clients to change.

Furthermore, if a change-promoting way of being involves more than our feelings or state of mind toward clients, but rather our regard for them, then this may have important implications for therapists. Just feeling cheerful or pleasant toward a client, or calm and non-reactive may not be enough to help them him or her change. Rather, what may matter more is what that client is worth to us. Whether a therapist truly values a client or not may influence whether his or her way of being invites the client to change or not. Furthermore, how I value a client may be deeply connected to how I value myself as a therapist. In the case where a therapist has particularly low or high regard for self, it may be helpful to seek out supervision. Self-of-the-therapist work (including personal therapy) may facilitate in finding a healthy regard for self, which may lead to a healthier regard for others.

The Person-Of-The-Therapist training model (POTT) was designed to help integrate self-of-the-therapist training into graduate school programs (Aponte et al., 2009), and may be one valuable curriculum which can help therapists in the development of their way of being. It helps therapists in learning to know their own personal struggles and how to manage emotions, memories, and behaviors that arise in the therapy room because of such struggles (Aponte et al., 2009). It attempts to develop in therapists the ability "to recognize the common elements of the human experience in their clients' life-

struggles to the point of being able to track clients' personal journeys through a conscious connection with their own personal journeys" (Aponte et al., 2009, p. 382). At the same time, being anchored in our own journey of struggle will help us to maintain appropriate distance "necessary to see, and consequently challenge [our] clients in their reality" (Aponte et al., 2009, p. 382).

This leads us right back to the distinction made by Friedman between empathy and an I-Thou way of being. In an I-Thou way of being, we keep our rope grounded in our own experience. This is particularly important, as he explains, to confirm another person's uniqueness (Friedman, 1960), but we see here that it is also perhaps important to being empathetic as well as maintaining clear vision of what the client needs. Aponte et al. (2009) pointed out that perhaps the degree to which we have fought our own battles will influence our "ability to relate to clients' efforts to contend with their life battles" (p. 384). Herein may lie the answer to why regard for self inevitably influences the regard for or attitude toward another, and why a definition of way of being must consider both.

Way of Being Connections to Therapist Factors and the Therapeutic Alliance

Way of Being as a Therapist Factor

In the literature review, I discuss reasons in which way of being may be a therapist factor, but also reasons it may not be one. This question was not specifically asked to participants, and therefore, a firm conclusion on this debate cannot be drawn from this study. However, panelists did agree on certain ideas that may bring us closer to answers.

I previously discussed the difficulty of deciding whether way of being is an observable (can be determined without the therapist's input, such as by checking records)

or an inferred (reportable only by the therapist) therapist factor (Beutler et al., 2004). Many panelists agreed that either client report or both client and therapist report were necessary to capture way of being. Thus, way of being is not a factor that can easily be put into either an "observable" or "inferred" category (Beutler et al., 2004), suggesting that the concept is simply different from other therapist factors.

I also discussed the difficulty of fitting way of being into the state (flexible and used by therapist to further his/her role as therapist) or trait (fixed and related to therapist's extratherapy life) category as defined by Beutler et al. (2004). The reader should refer to that previous discussion for more details on how way of being does and does not fit into these categories, but one point to make here is based on the finding that panelists agreed that a therapist be observed over several sessions and with different clients to capture his or her way of being. Other scholars have suggested that way of being is something that is not fixed (Fife et al., 2014), and so perhaps our way of being may fluctuate from client to client. Thus, to some extent, it seems that way of being is influenced in some way by the client. It may not be that way of being is a traditional therapist factor, which are traits and states unique to the therapist. This is reminiscent of my argument as to why the therapeutic alliance is not a therapist factor—while it is a therapist-influenced factor, it may also be a client-influenced factor. As stated previously, this does not mean that way of being is controlled by clients. In fact, an ideal way of being may be one that is not swayed by the client present. However, it does seem to be that the client will likely influence the way of being of the therapist to some extent. In sum, it seems reasonable to say at the very least way of being is not a traditional therapist factor, if not a concept different from therapist factors.

How to Connect Way of Being, Therapist Factors, and The Alliance

Just as way of being may not be a therapist factor, in the literature review, I propose that the therapeutic alliance is not a therapist factor either. So one question is what the relationship is between way of being and the alliance. Several times the panelists referred to the therapeutic relationship/alliance and its connection to way of being, and it seems that panelists also used language that suggests they are connected, but not one in the same (see results in previous chapter under the qualitative section for question 2).

And so that leaves us with potentially three different concepts—therapist factors, the therapeutic alliance, and therapist way of being. It may be that the connection between these three ideas are as Fife et al. (2014) proposed: "[T]he effective use of skills and techniques rests upon the quality of the therapist–client alliance, which in turn is grounded in the therapist's way of being" (p. 21). In terms of therapist factors, skills and techniques could be considered therapist factors. Furthermore, Fife et al. (2014) explained that "the person of the therapist, including the therapist's facilitative conditions and the therapist's interpersonal attributes and style" are part of the alliance, all of which might also be considered therapist factors. And so it may be that therapist factors both contribute to and are dependent upon the quality of the therapeutic relationship, which is "grounded in the therapist's way of being" (p. 21). What exactly "grounded" means might be described by the panelists in this study—that way of being is "one of the underlying latent factors in the 'therapeutic relationship or alliance' - one of [the] key contributors to positive therapeutic outcomes."

Way of Being and the Alliance

The panelist just quoted points out the importance of the alliance or relationship in affecting change. Scholars have indeed agreed that "it is in the therapeutic relationship that therapists either make or break therapy" (Blow et al., 2007, see this also for a brief review on the therapeutic alliance). Furthermore, the therapeutic alliance is the most well-researched and well-founded common factor in relation to its effects on client outcomes (Sprenkle et al., 2009). Research has indicated that the quality of the therapeutic alliance does correlate with therapy outcomes (DeSorcy, Olver, & Wormith, 2016; Fernández, Krause, & Pérez, 2016; Horvath & Symonds, 1991; Wampold, 2001). Researchers have found that the alliance accounts for a high percentage of the variance of therapeutic outcomes—up to 29% (Horvath, Del Re, Flückiger, & Symonds, 2011; Johnson and Talitman, 1997). What this panelist said, that the relationship or alliance is "one of the key contributors to positive therapeutic outcomes" bears out in the research.

The other point that this panelist made, that way of being is an "underlying latent factor" in the alliance has been theorized by scholars, as explained in the previous section. Fife et al. (2014) proposed that the alliance is "grounded in the therapist's way of being" (p. 21). Knowing that the therapeutic alliance is empirically a very important contributing factor to client change, the possibility that way of being may be a part of that alliance suggests a need for more research on way of being. Specifically, research on how way of being possibly contributes to the influence the alliance has on outcomes could help us to better understand why the alliance is such an influential common factor. More broadly, as the alliance is such a well-researched area of common factors inquiry, then considering this way of being-alliance connection in further research may become a

significant contribution to common factors' literature.

Clinical Implications of Way of Being and the Therapeutic Alliance

My discussion on whether way of being is or is not a therapist factor is more for conceptual purposes and may not have specific clinical implications. However, if it is true that way of being is an influencing factor to the therapist-client alliance, then practicing therapists would do well to pay heed to the concept. It may be a path to more specificity. Perhaps, in a struggling case, it is not necessarily the alliance that needs addressing, but the therapist's way of being which underlies that alliance.

Furthermore, because the therapeutic alliance is a commonly discussed element of successful therapy, it may be that therapists more readily recognize that the alliance with one or many of their clients is struggling. Already trained to consider the quality of the alliance, this may be one of the most direct ways for therapists to recognize a possible need to reflect on their own way being. A struggling alliance may be indicative of a need to change their own way of being. Therapists who wish to improve their alliance with one or more clients, and believe the struggle to be connected to their own way of being, may consider reading literature about way of being to gain insight into how he or she may need to change their own way of being, and/or seeking out self-of-the-therapist training for the reasons suggested previously.

Questions and Answers to Understand a Therapist's Way of Being

I asked participants (question 6; see table 6) to provide questions that one might ask a therapist, in order to better understand his or her way of being with a particular client. Furthermore, participants were asked to provide the kinds of response(s) they

would expect from someone with a way of being that promotes client change (question 7; see table 7), and someone with a way of being that does not promote change (question 8; see table 8).

Considering the piece of my proposed definition that way of being reflects a regard for both client and self, then perhaps asking questions to the therapist that attempt to assess how he or she regards self, as well as how he or she regards the client, would provide a sense of his or her way of being. Two of the most prevalent themes proposed by panelists as possible questions to ask therapists were *Describe the Client* and *How the Therapist Describes and Understands Self as a Therapist.* The first type of question asking therapists to describe the client may facilitate in illuminating how the therapist regards the client, depending on his or her answers. For example, one theme in the type of responses that indicate a change-promoting way of being was *Recognize Humanity.* Panelists agreed that a therapist with a "good understanding not just of the pathological or irrational aspects of [the client's] life (diagnostic or problem-focused) but a good . . . understanding of their perspective, [struggles, hopes], and perhaps even the goodness that might be difficult for them to see in themselves. In short, their humanity" indicated a way of being that could help bring about change. Asking a therapist to describe their client may provide insight into a therapist's regard for the client.

The other theme of the question, *How the Therapist Describes and Understands Self as a Therapist,* in many ways seems to reflect the therapist's regard for self. One type of response mentioned by panelists that indicates a change-deterring way of being was one in which the therapist blames or does not take responsibility for his or her mistakes and role in therapy. Such responses may suggest that the therapist regards him or herself

as better than the client, or perhaps actually regards him or herself as an incompetent therapist, but blames the client to ease his or her insecurities. Either way, the type of question provides an avenue into better understanding the therapist's regard for self. In sum, it may be that questions which ask about the therapist's regard for a client and his or herself would help capture that therapist's way of being.

Clinical Implications for Questions and Answers on Way of Being

These questions and answers might be used by supervisors trying to help a therapist who is seeking supervision to improve their way of being (or perhaps a therapeutic alliance). A supervisor might ask a supervisee questions about him or herself, the therapy process, and his or her client. For example, the supervisor might ask the therapist to think of a particular client (most likely a client that the therapist would like to improve therapy with in some way). Some questions/requests that might be used include, "Tell me about your client." And, "what are the client's strengths and weaknesses?" Also, "what do you see yourself currently doing that is making your client's success more likely?" And, "[what do you see yourself currently doing that is making your client's success] more difficult?" More generic questions (not specific to one client) might also be asked, such as, "What is your biggest difficulty with your clients?" "What are the key patterns and underlying issues you see throughout your clientele?"

The data collected in this study on the types of responses to be expected from either a therapist who has a way of being that promotes change or a way of being that does not promote change might be used understand the supervisee's way of being. For example, in response to, "Tell me about your client," the panelists of this study suggest that a response that recognizes humanity would indicate a way of being that promotes

change. One panelist explained a response that recognizes the humanity of the client: "when describing their work with the client, regardless of the difficulty of the work, the resistance of the client, the therapist would be able to identify elements of client's humanity in such a way that the therapist views the client as relatable and similar to him or herself." On the other hand, responses that do not suggest a recognition of complex humanity, such as responses that are "labeling," or focus on "a generalizing of clients based on behaviors and resistance to change" might indicate a way of being that does not promote change.

After such questions, a supervisor suspecting that the therapist's way of being may be impeding therapy progress, might suggest new ways of viewing the client and self as a therapist. Self-of-the-therapist training may also be suggested.

Future Research on Therapist Way of Being

Research Implications for Questions and Answers on Way of Being

I hoped that this study would enable future research on therapist way of being. It may be that developing a measure of way of being is one way to further this research. The questions and responses presented by panelists in questions 6 through 8 may be used to develop such a measure. As many of the questions were open-ended style questions, it may be that an interview format would be appropriate. In the same format described above (between supervisor and supervisee), the interviewer might ask the therapist being interviewed to think of a particular client. Depending on the nature of the research, perhaps the therapist could be asked to think of a client that has made a lot of healthy change or a client that the therapist is struggling with. The interviewer could then ask

questions pertaining to that client (e.g. “Tell me about your client.”), or more generic questions could be asked about the therapist’s clientele (e.g. “What is your biggest difficulty with your clients?”).

The types of responses suggested by panelists in this study might be used to develop a codebook, by which to code the responses of the therapist who was interviewed to better understand his or her way of being. Responses that show a recognition of humanity would indicate a change-promoting way of being. Responses that do not show this recognition of humanity, or in which the therapist does not own their own mistakes and blames the client for lack of therapy progress may indicate a way of being that does not promote change. Furthermore, measures of efficiency and efficacy for these therapists with their clients may provide insights into connections between their way of being and ability to help clients change.

Research Suggestions by Panelists

Panelists suggested methods to further future research on way of being (see questions 9 and 10, as well as their respective tables). Many items in the final report focused on observations. Panelists agreed that “watching therapists in sessions” is one way to better understand a therapist’s way of being. Some items also suggested the types of things one might look for when observing, such as “body language” (more discussion on what to look for in observation is in the Future Directions section). It is not a new idea that observational research, also called process research, can be a valuable tool for researching interactions or the relationship between therapist and client (Oka & Whiting, 2013; Schade et al., 2015). Generally, observational research can be beneficial as it does not rely on someone’s past recollection (such as in using self-report) of, for example, a

therapy session, but rather captures data immediately (Oka & Whiting, 2013). Methods of observational research including videotaping can even be used by clinicians to better understand themselves and how to improve alliances and help clients to progress (see Oka & Whiting, 2013 for a review on process/observational research and its research and clinical implications).

A couple of panelists suggested that observations or measures take place over time. Perhaps observing several sessions over time would more accurately capture a therapist's way of being, rather than a single session. This style of research is called *sequential* research. Indeed, process and sequential research are often used together (Oka & Whiting, 2013), for "interaction with others reveals itself unfolded in time" (Bakeman & Gottman, 1997, p. 1). Furthermore, a clinician who adjusts their approach based upon a client's goals and needs may reveal a therapist, as described previously, that is humble and takes responsibility for his or her contribution to a client's progress or lack thereof.

Yet, one panelist made the point that perhaps observation is not the best way to understand a therapist's way of being: "way of being seems very difficult to empirically measure because so many actions can be done with skill and finesse but without a responsive way of being. It is more than what can be observed from without. . . . In that way, self-report may be the best way to capture it." It is unclear whether this panelist was referring to client self-report or therapist self-report, or both, but both could be valuable means to understand way of being. Yet, the item with the most agreement in question 10 was *I strongly believe that therapist self-report alone is not appropriate, and that client-report in some way is essential*. And so, it seems that most panelists agree that using self-report as the only method of studying a therapist's way of being is not an appropriate

option, and that client report must be included in any kind of study. Several other items highlighted the benefit of client report. Even in some of these items, it is acknowledged that self-report may be valuable, but that client report is most important.

Limitations of the Current Study

The current study has several limitations. First, traditional Delphi studies have three or four rounds (Hasson et al., 2000; Stone Fish & Busby, 2005), but the current study had only two. While a thematic analysis was done to provide further meaning to the results, this analysis was done by me, rather than the data coming from the participants. The third round of a Delphi study typically address disagreements in the responses (Stone Fish & Busby, 2005), which should come from the participants who originally provided those responses. While the thematic analysis may have provided interesting conclusions, it cannot replace the value of a third round which would have provided participants an opportunity to address discrepancies in the data. For example, some participants suggested that self-report would be a valuable way to study way of being, while other participants raised many issues with using self-report. Yet, both of these ideas had enough agreement and consensus to make the final report. A third round may have provided further insights into whether self-report should be used at all when measuring way of being, or how to best approach using self-report.

Another limitation, which did influence my decision to not do a third round, was participant dropout between the first and second questionnaire. However, this was also influenced by another limitation, which was a short window of time that the second questionnaire was left open for responses. QI was left open for several weeks until enough participants responded, while QII was open for less than two weeks before I

collected data and ran the analyses. In the end, only 9 of the 21 who participated in the first questionnaire participated in the second questionnaire. Having a smaller sample on the second round has two important implications. First, it could be that the sample in the second round was descriptively different than the sample which participated in the first. For example, the sample in QI had almost equal numbers of men and women (10 and 11, respectively), but it could be that primarily men responded to QII. Descriptive participant data was not collected in the second round, and therefore it is unknown how this sample could have been different. The second implication of the participant dropout is simply that a larger sample has more statistical power than a smaller one. A sample of 21 is more likely than a sample of 9 to correctly reject null hypotheses.

Another limitation is that of the oversight on the Likert scales in QII—some were on a 5-point scale, while others were on a 7-point scale. This makes it more difficult to generalize between the two types of questions. The median cut off for the 5-point scale questions was 4, which indicated "somewhat agree," but the median cut off for the 7-point scale was 6, which indicated "agree." Agreeing with a statement is qualitatively different than "somewhat" agreeing, and therefore the items which made the final report from the 7-point Likert scales likely have more agreement overall compared to the 5-point Likert scales items. Furthermore, because the scales switched randomly throughout the survey, participants may have not noticed the change, and marked an answer that they did not intend to mark.

Another limitation was that some participants expressed that some of the items in QII were unclear or too long, thus rendering them difficult to rate on a Likert scale. The coders, myself included, noticed that some panelists responses in QI were unclear how

they answered the original question or prompt. Some of these cases were reworded so that they were clearer, but in an effort to preserve the original language, we often kept them the same. The items in QII which panelists felt were unclear or too long could have been difficult for panelists to respond to. More clarity in the items may have resulted in different responses and levels of agreement and consensus. Furthermore, this issue may have been exacerbated by separating out ideas into individual items, for taking some ideas out of context could have rendered them more confusing to understand in relation to the question. This was done to avoid requiring panelists to comment on items with multiple ideas, thus risking that they might agree with one part of an item, but not another (Rowden, 2009). Some items were nevertheless left longer, and a few comments were left in QII about the long items being difficult to rate. Either way, some responses that were left long, or some of those that were broken up, may have been difficult to rate. This difficulty may have led some participants to skip the question, leading to less data, or to simply pick a response even though they did not have a clear opinion on it.

Another limitation is that the coders who participated in this study, myself included, were all female. Perhaps a male would have provided different perspectives on how to code the data.

Finally, it may be that several therapists and scholars do not believe that way of being influences client change and/or is an important common factor. A Delphi study seeks out experts in a particular topic, and thus predisposes that the participants will believe in the value of the topic. While it is beneficial to have experts share their opinions on way of being—as they are guaranteed to have a firm understanding of the concept, it may be that a more random sample of therapists would provide significantly different

opinions about the concept of way of being.

Future Directions

More immediate future directions for the study of way of being include doing subsequent traditional rounds for this Delphi study. More broadly, a next step in research may involve using the suggestions from panelist with the highest agreement and consensus to develop measures that asses the therapist's way of being. As explained, developing these measures may involve taking some of the questions and responses presented here by panelists in questions 6 through 8 (see tables 6 through 8), and turning them into an interview and codebook to assess way of being. Furthermore, it may be that self-report measures for both therapist and client can be developed using the data collected from this study. Perhaps, these self-report measures may draw from the components listed in my proposed definition: sense of self, perceptions, attitudes, words, tone, expressions, nonverbal messages, behaviors, interactions with and general stance towards others. Some of these components may be easier to grasp, and a good way to break down measuring way of being. For example, a measure may ask a client to report on the tone of voice of the therapist: "How would describe the tone of voice of your therapist in this last session?" Possible answers that the client might choose from could be: accepting and patient; neutral or unclear; disapproving and impatient. This is just one possible avenue for developing therapist and/or client self-report measures.

Suggestions were also made to observe therapists in session, as well as participate as a co-facilitator in session. A different type of measure may be required for these types of research, in which a third party assesses a therapist's way of being via observation. Some suggestions were made as to what types of behavior/phenomena to look for when

observing therapists, such as, “body language,” “verbal and non-verbal behaviors that indicate responsiveness to client needs” and, “a strong, mutually respectful therapeutic relationship” (see table 9 for other panelist suggestions on what might be looked for in observational research). However, these descriptions were vague and limited. What to pay attention to during observational research on therapist way of being was not a focus on the current study. As such, more research is needed to understand what change-promoting and change-deterring ways of being look like to an outside observer.

Furthermore, as one panelist commented in QII, “therapist WOB [way of being] is very influential. A lot of these comments leave out acknowledgement of client WOB. I think therapist WOB is the best chance we have to help them with theirs, but they still have their own WOB.” Another comment from a panelist in QII was that “sometimes a poor way of being can still have a positive effect on someone—depending on how they respond and their own WOB.” Indeed, future research may benefit from better understanding how a client’s way of being influences the therapy process.

Once we have an established way of measuring way of being, other interesting and valuable research might be conducted. For example, in light of the discussion provided here on the possible connections between way of being and the therapeutic alliance, then perhaps research might be conducted on the influence of way of being on the alliance (rather than just on client outcomes). Also, research on the influence of POTT training on way of being may illuminate whether POTT training might provide means to changing one’s way of being.

In all, my hope is that the insights provided by the panelists in this study bring deeper understanding and greater attention to the concept of therapist way of being, and

enable further research in many of the ways discussed.

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APPENDICES

Appendix A

Questions for First Questionnaire

Demographic Questions

1. Are you currently a licensed clinician?
2. What is your current license? (i.e. LMFT, MSW, PsyD)
3. How familiar are you with the concept of way of being? (Very familiar, Somewhat familiar or Not at all familiar)
4. What is your gender?
5. What is your age?
6. What is your education level?
7. What is your ethnicity?
8. What is your work setting?

Way of Being Questions

1. One possible definition of therapist way of being is “the in-the-moment attitude a therapist has towards a client" (Fife, Whiting, Bradford, & Davis, 2014). Is there anything you would change or alter about this definition of a therapist’s way of being? If so, please explain what you would change. Feel free to provide your own definition of therapist way of being.
2. To what extent do you believe that a therapist’s way of being influences client change? Please also explain your answer. How does a therapist’s way of being influence client change? And/or, how does it not influence client change?
3. How do you perceive that your own way of being influences clients?
4. Please describe a therapist’s way of being that promotes client change.
5. Please describe a therapist’s way of being that does not promote client change.

6. Please describe any question(s) you would you ask another therapist to better understand his or her way of being with a particular client.
7. In regards to the question(s) you listed in the previous prompt, please describe the kind of responses you would expect from the therapist that would indicate to you that he or she has a way of being that promotes client change.
8. Similarly, please describe the kind of responses you would expect from the therapist that would indicate to you that he or she has a way of being that does not promote client change.
9. Beyond the questions and responses you provided above, how might one go about measuring or observing way of being in a clinical or research setting?
10. For future research on therapist way of being, would self-report or client report (or both, or neither) more accurately capture a therapist's way of being? Please explain your answer

Appendix B

Quantitative Results from QII

Table 1

Statements Regarding the Proposed Definition of Way of Being as "The In-the-Moment Attitude a Therapist Has Towards a Client" (Fife et al., 2014) (Question 1)

Item	Median	IQR
If someone is critical in their perceptions and attitudes, it will come across, even without critical words. The nonverbal messages, tone, and expressions will always come across. This is why way of being is fundamental.	5	1
When someone is in a self-centered or bitter way of being, it will permeate their sense of self and interactions with others, and when they are in a generous and honest way of being it will as well.	5	1
Way of being is reflective of Martin Buber's "I-Thou" (vs. "I-It") dialectic. . . . the emphasis is really on the "hyphen" connecting the two. . . and what it suggests about the regard (vs. attitude) a therapist has for those on both sides of the hyphen. . . . I cannot have a view of or regard for my client without simultaneously maintaining a view of/regard for self that also impacts the relationship . . . I would change it to "the fundamental manner in which a therapist regards self and client."	4.5	1
Being fully in the moment and bringing all of one's self, emotionally, cognitively, relationally, physically, with and for a client.	4	0
That [the in-the-moment attitude a therapist has towards a client] plus who the therapist [is] and if they are congruent in and out of therapy.	4	0
Also an in the moment attitude about what intervention you are using. Not flying by the seat of your pants, but being . . . flexible and listening to your heart to know what the client needs at the time when meeting with client.	4	0.5
The word attitude is good, but insufficient.	4	1
A way of being captures the whole mode that the person is in. This will permeate their perceptions, words, behaviors, and general stance towards others. This is why it is hard to capture.	4	1
Being fully present with one's self and with one's client, with the intention of compassionately helping another.	4	1
Being attuned to one's self and to the client.	4	1
One way I've come to understand way of being is the in-the-moment ability to be alive to the humanity of the other person.	4	1
[It's] how open the therapist is to allowing the client to be made fully manifest to the therapist.	4	1
I would add "a therapist's ability to be authentic with a client."	4	1
"[The therapeutic role as one] who walks with the client and meets the client where he or she is at that time, recognizing the client is the expert about him or herself."	4	1

Table 2

Statements about the Extent That Participants Believe That a Therapist's Way of Being Influences Client Change and How It Does (Question 2)

Item	Median	IQR
A therapist's way of being can have a significant effect on client change.	7	1
As we increase our attentiveness to and accountability for the impact of our way of being with our clients, I believe this quietly slides underneath [and] permeates every aspect of our work with them.	7	1
If a therapist is reactive (unintentional) [to the] client instead of responsive and intentioned that way of being is often at minimum not helpful and often damaging and harmful.	6	0
The therapeutic relationship is where the dance between the therapist's and client's respective regard for themselves and each other (WOB) unfolds. We as therapists are primarily responsible for "our side of the way of being street" so to speak in that dance.	6	0
Therapy is a uniquely human endeavor, and we respond to how another person feels about us.	6	0.5
A motivated client can be diffused by an indifferent or detached therapist. A discouraged client can be motivated by a respectful and hopeful and confident therapist.	6	0.5
It [way of being] allows clients to be open to new ways of thinking because it determines when they can trust their helper.	6	0.5
Way of being builds connection and lays the foundation for walking the process of growth together.	6	0.5
I think authenticity of the therapist toward the client in a caring way promotes change by allowing a client to experience another person being authentic with them in a truly caring way	6	0.5
I believe a therapist's way of being can influence a client's hope and motivation for change. That hope and motivation can have a positive influence on client change.	6	0.5
Way of being influences the quality of therapeutic relationships, and thus has impact on what possibilities I see in my clients, and thus on how and whether I can instill hope.	6	0.5
My ways of seeing them also has impact on how I coach interactions between family members (e.g., can I both model and facilitate corrective/healthy interactions). If I see them as people with vast possibilities, I will be more likely to note their capabilities.	6	0.5
Yes. I think that it could be considered an important part of the alliance, which definitely affects change.	6	1
I've long believed therapist WOB to be one of the underlying latent factors in the "therapeutic relationship or alliance" - one of key contributors to positive therapeutic outcomes.	6	1
[How way of being influences client change is that] hopefully, the client is more able to be vulnerable, feel safe and accepted, able to share what he or she wishes to share, and feels supported, respected, and heard.	6	1
The work of therapy is conducted through the medium of the therapeutic relationship, at the core of which is a personal connection between therapist and client/patient.	6	1
Clients who describe helpful therapy usually talk about therapist character . . . or virtues . . . more than they talk about therapist skill. It would be unusual for clients to worry about the technical mastery of a therapist.	6	1

Item	Median	IQR
I believe the energy and hope a therapist has in the client has a profound influence.	6	1
If the therapist has this [an in the moment attitude about what intervention you are using. . . being . . . flexible and listening to your heart] . . . the client does not feel judged, is more likely to open up and be vulnerable in sharing.	6	1
If the client doesn't like and/or trust their therapist then there will be more resistance in session and out of session.	6	1
The most change-friendly environment is when the therapist's way of being is such that they regard clients as people, rather than objects.	6	1
Clients sense how therapist feel about them.	6	1
A way of being that sees clients as objects will inhibit the development of a therapeutic relationship. . . . A way of being in which clients are seen as people is more likely to lead to a relationship that is truly therapeutic.	6	1
Therapy will be experienced in different ways depending on the way of being of the therapist.	6	1
Therapists in touch with client issues are more effective.	6	1.5
[It is important] to prepare therapists to make active and purposeful use of their personal selves in their conduct of all aspects of their clinical practice - the relationship, the assessment and the intervention.	6	1.5
Being fully present in the moment with a client, with compassion and with sensitivity to the nuances of the moment (as a definition?) can help clients feel safe, heard and understood. Creating the conditions for . . . change.	6	1.5
Evidence suggests that factors like therapist-client relationship and hope are very influential in promoting change. I would guess that therapists who are especially gifted in establishing strong relationships and instilling hope generally tend to have the right kind of way of being,	6	1.5
Our fundamental view of clients, with inherent assumptions about the nature of their hopes, dreams, resources, strengths, weaknesses, etc. - as well as our own in relationship to them - reflect an inevitable filter through which the entire treatment experience unfolds.	6	1.5
The therapist either presents to clients a change-friendly environment, or one that does not invite change.	6	1.5

Table 3

Statements about How Participants Perceive That Their Own Way of Being Influences Clients (Question 3)

Item	Median	IQR
It influences our therapeutic relationship, their trust in me, and self-confidence related to how they feel I view them.	6	0.5
They feel like I am sincere, caring, [and] motivated by their best interest	6	1
I like and have unconditional regard for my clients; I believe they are able to talk openly and feel supported.	6	1
It affects how I see them and, even more importantly, how I treat them.	6	1
I perceive that my clients. . . know that I believe they can handle being challenged to change.	6	1
There are times when my way of being has not had a positive/helpful influence on my clients. I have been distracted or focused on myself - my own comfort or needs. I have seen clients as objects - either being irritated with them or wanting them to like me. When my focus is on myself or my agenda, clients likely feel this, and it doesn't help therapy progress.	6	1
Attention [should be made] to students developing an authentic empathic capacity, and . . . using it consciously and strategically in therapy. [This] is foundational. . . . "It has been shown that therapists' empathy accounts for more of the variance in outcome than specific interventions (Bohart et al., 2002)" [Jeanne C. Watson et al. 2015, 108]."	6	1.5
Allows clients to feel safe, heard, and understood.	6	1.5
I am a non-threatening voice that promotes safe conversations for the client to discuss his or her life, and future possibilities.	6	1.5
I have a full team of direct staff whose work I direct in treatment team. They take their cues from my own way of being in how to think about and understand the client. If I am flippant or frustrated that can be duplicated by those who are looking for my guidance to help each client.	6	1.5
Authentic interest and empathy open[s] doors in clients who [are] used to being treated poorly in the system. . . . [Clients] start to consider believing in themselves again because [a therapist holds] that attitude towards them and [isn't] casual or detached about it.	6	1.5
I perceive that my clients feel accepted, cared about.	6	1.5
When I regard clients as people . . . (rather than seeing them through my own needs/desires) . . . I understand them better, and I am able to offer interventions, comments, insights, and invitations for change that are in harmony with . . . what they need from me. They don't always like these . . . but I think they can sense that I . . . am doing my best to help them.	6	1.5

Table 4

Statements Describing a Therapist's Way of Being That Promote Client Change (Question 4)

Item	Median	IQR
Responsive	5	0
The ability to relate authentically to clients.	5	0.5
Open mind	5	0.5
Open heart	5	0.5
A non-judgmental, caring, curious, and empathetic stance is important as it conveys a genuine belief in the possibility for change and healing within the client.	5	0.5
Being interested and invested in the client and in each session.	5	0.5
Humble	5	1
Safety. Security- trustworthy.	5	1
Respect	5	1
Attunement	5	1
Then compassion- empathy, care, etc.	5	1
Understanding	5	1
Being fully present with one's self and other.	5	1
Clients who describe helpful therapy usually talk about therapist character . . . or virtues . . . more than they talk about therapist skill. It would be unusual for clients to worry about the technical mastery of a therapist.	5	1
Therapists need training in the . . . purposeful use of their personal selves just as they do for [using]. . . technical skills. Therapists, like the rest of humanity, are challenged . . . [with specific issues, some of which] embed themselves in their personal development and professional functioning.	5	1
As I acknowledge another's personhood (humanity) and potential, I treat them differently and help enable their capacity for change.	5	1
I believe a therapist that stays humble in continually trying to . . . (2) adjust their own efforts in support of client progress . . . is demonstrating a way of being that is likely promotes client change.* (* - Informed by the work of the Arbinger Institute and their current way of discussing way of being as "outward mindset" vs. "inward mindset.")	5	1
Competent	4	0
A therapist who can be him/herself and transparent will also draw these characteristics from his/her client.	4	0
"This common human vulnerability and brokenness [of both client and therapist] presents opportunity and possibility for emotional and psychological growth and healing for both therapist and client."	4	0
I would think a therapist's way of being that the client perceives as collaborative not authoritative would promote change.	4	0
Challenging the client.	4	0
When my way of being has a positive influence on clients, I am alive to them.	4	0
Integrity first and foremost. A life that has few gaps between values and actions.	4	0.5
The ability to manage anxiety and emotions in therapy.	4	0.5

Item	Median	IQR
Therapy is a uniquely human endeavor, and we respond to how another person feels about us.	4	0.5
I think that my clients respect my questions and challenges because they know that I [try] to approach their lives in a respectful and thoughtful way.	4	0.5
If I am honest but kind, then people feel safe. If they feel safe they can be more open in facing their own hard issues.	4	0.5
It is through therapists' own emotional and spiritual woundedness that they have the potential to empathize with, have insight into and gain access to the depths of their clients' woundedness.	4	0.5
Therapists' commitments to working on their own personal issues even as they deal with their clients' struggles provide a grounding that allows them to resonate deeply with their clients while simultaneously facilitating a healthy distance from which to observe and understand their clients.	4	0.5
Feeling accepted as a person, heard, and respected as the expert about oneself facilitates change because there are fewer barriers to change from the onset, and throughout the therapeutic process.	4	0.5
Maintaining a healthy awe and appreciation of the humanity of the client also leads to a mental and emotional differentiation allowing them to be self-motivated and autonomous.	4	0.5
The ability to form relationships with clients.	4	0.5
I believe a therapist that stays humble in continually trying to . . . (3) track or measure the impact of those efforts [to support client progress] over time is demonstrating a way of being that is likely [to] promote client change.	4	0.5
On the path of personal growth as well.	4	1
A guide not an expert.	4	1
Intentional	4	1
Curiosity	4	1
It [therapy] is a process of inquiry, of sharing and hearing, and that will be experienced in different ways depending on the way of being of the therapist.	4	1
"The technical aspects of the therapeutic process are mediated through the personal relationship between therapist and client."	4	1
I believe a therapist that stays humble in continually trying to (1) see and understand their client(s)'s concerns & goals . . . is demonstrating a way of being that is likely promotes client change.	4	1
Kind, while also not being a people pleaser and a pushover.	4	1
When therapists regard clients as people - truly focusing on them and their needs. Recognizing that clients have their own needs, desires, hopes, dreams, strengths, weaknesses, challenges. These are real to me.	4	1

Table 5

Statements Describing a Therapist's Way of Being That Does Not Promote Client Change (Question 5)

Item	Median	IQR
Self-aggrandizement	5	0
Unethical	5	0
Self justifying	5	0
Blind to self and others	5	0
Checked out	5	0
Cold	5	0
Being distracted	5	0.5
Judgmental	5	0.5
People shut down or become defensive when they feel judged or criticized. Therapists might do this when they become overly diagnostic, or reactive or judgmental in their questions.	5	0.5
[Interacting with a client in such a way that they become] irrelevant--not allowing their humanity to matter to me. I think sometimes we can be too good at closing ourselves off to the experiences of those we work with to the point that we are minimally invested.	5	0.5
Reactive [and] unintentional	5	1
Criticism	5	1
When my focus is more on myself than my clients, I likely do more harm than good.	5	1
Some therapists get into battles with clients over homework, or power, or other things that seem to be more about meeting the therapist's needs than the clients. Even "getting better" can become a need for the therapist who needs the client to change so they can feel competent.	5	1
Lack of self-awareness blocks sensitivity to client's personal experience.	5	1
A client who perceived she or he is not heard nor respected will be more likely to terminate.	5	1
A client who perceived she or he is not heard nor respected will be . . . less likely to feel open to different ways of thinking and being.	5	1
A client who perceived she or he is not heard nor respected will be more likely to . . . not feel safe in sharing thoughts and feelings with the therapist.	5	1
Interacting with a client in such a way that they become an object: an obstacle in my pursuit to having positive, easy, or personally fulfilling outcomes; a vehicle for my own accomplishment, self-fulfillment, etc	5	1
One that is disengaged and going through the motions or has seen this diagnosis before.	4.5	1
When we become . . . narrow-minded . . . in our work with clients, I believe our way of being is more "inwardly" focused and discourages client change.	4.5	1
Indifferent	4.5	1
Bored	4.5	1
Incongruent	4.5	1
When my view of clients gets filtered through my own needs and agenda . . . my way of being has a negative effect on them.	4.5	1
Inconsistent.	4	0

Item	Median	IQR
One that wants to feel safe in their knowledge and assessment and difference from their client.	4	0
[Being] outcome focused	4	0.5
Not comfortable with self	4	0.5
If I were a client I would be resistant to a therapist who appeared to be trying too hard to relate rather than just listen or empathize.	4	0.5
I think that the attitudes of the therapist must be communicated somehow. I subscribe to the family systemic notion that we continuously communicate, and that communications have impact on people.	4	0.5
Insecure	4	1
Makes false promises or settles low.	4	1
Ultimately, clients' agency is a crucial part of change. My way of being does not bypass that.	4	1
When we become rigid . . . in our work with clients, I believe our way of being is more "inwardly" focused and discourages client change.	4	1
When we become . . . automatic vs. intentional in our work with clients, I believe our way of being is more "inwardly" focused and discourages client change.	4	1
When clients are objects to me, I am not truly alive to them.	4	1
When I'm not truly alive to clients, my way of being has a negative effect on them.	4	1

Table 6

Statements and Questions One Would Ask Another Therapist to Better Understand His or Her Way of Being with a Particular Client (Question 6)

Item	Median	IQR
Describe what it feels like to work with this client.	5	0.5
What are the client's strengths and weaknesses?	4	0
What do you see yourself currently doing that is making your client's success more likely?	4	0
Tell me about your client.	4	0.5
What are their [the client you are seeing] strengths?	4	0.5
What is your internal experience when you are fully present and attuned and in resonance with your client?	4	0.5
What is your biggest difficulty with your clients?	4	0.5
Do you ever see your clients as a problem -- if so, under what circumstances?	4	0.5
How do you perceive your client?	4	1
What is a day like for them [the client you are seeing]?	4	1
How do you interact with [the clients that challenge you most]?	4	1
What are the key patterns and underlying issues you see throughout your clientele?	4	1
How do you know a client is progressing?	4	1
[How would you say your client currently views] your work together?	4	1
[What do you see yourself currently doing that is making your client's success] more difficult?	4	1
"Tell me about your client." I might also ask how the therapist's model is working or not. The therapist will thus convey information about how s/he regards the client, hope (or hopelessness) for the client, the nature of the therapist-client exchange (i.e., quid-pro-quo vs. altruism).	4	1
When clients are not open to your interventions, what kind of feelings do you have toward them?	4	1

Table 7

Statements Describing the Kind of Responses One Would Expect from a Therapist That Would Indicate That He or She Has a Way of Being That Promotes Client Change (Question 7)

Item	Median	IQR
Good understanding not just of the pathological or irrational aspects of [the client's] life (diagnostic or problem-focused) but a good . . . understanding of their perspective, their struggles, their hopes, and perhaps even the goodness that might be difficult for them to see in themselves. In short, their humanity.	7	1
They would seek client's input and perspectives.	7	1
Their attitude/tone would be more compassionate, respectful.	6	0
Those [responses] that are more . . . humanizing	6	1
I would want a therapist to be able to readily identify the client's strengths and to acknowledge the humanity of the other person.	6	1
When describing their work with the client, regardless of the difficulty of the work, the resistance of the client, the therapist would be able to identify elements of client's humanity in such a way that the therapist views the client as relatable and similar to him or herself.	6	1
A human being who can connect with other human beings.	6	1
Intentional	6	1
They use [a] language of hope and belief in change despite client difficulties.	6	1
Descriptions of limitations/weaknesses would not be exaggerated, nor would the therapist take a blaming/accusatory stance toward them.	6	1
They would accept responsibility for mistakes and attempt to repair breaches in the therapeutic relationship.	6	1

Table 8

Statements Describing the Kind of Responses One Would Expect from a Therapist That Would Indicate That He or She Has a Way of Being That Does Not Promote Client Change (Question 8)

Item	Median	IQR
Blaming	5	0
Blaming responses that tend toward absolutes in describing/understanding clients and their progress.	5	0
Descriptions of the client that tend towards blaming, venting, or creating space between themself and the client through elevating themselves and their actions and degrading the clients' thoughts and actions.	5	0
Dehumanizing	5	0
Evidence of burnout and resentment towards work.	5	1
Judgmental	5	1
I'm responsible for their [others'] choices.	5	1
A generalizing of clients based on behaviors and resistance to change.	5	1
Pejorative	5	1
If the focus is on how the client makes things difficult for the therapist, then I would say the therapist has a less productive way of being towards the client.	5	1
Responses that tend toward defensiveness, avoidance, blame-shifting when it comes to addressing a therapist's own impact on client progress - especially when considering possible contribution to/impact in lagging client progress or outcomes.	5	1
In responses that show . . . lack of hope	5	1
In responses that show . . . loss of possibility	5	1
Reactive	4.5	1
Labeling	4	1
Distant	4	1
Makes it about themselves and not client	4	1
The therapist believes he/she has the right to do things in a certain way and that he/she is not the one with the "problem."	4	1
Overly giving of self to work without time for self and others.	4	1
In responses that show lack of recognition of complexity	4	1
In responses that show . . . lack of empathy	4	1

Table 9

Statements on How One Might Go About Measuring or Observing Way of Being in a Clinical or Research Setting (Question 9)

Item	Median	IQR
Watching therapists in sessions	5	1
Observations or measures that take place over time and that attempt to assess . . . (3) clinician demonstrated efforts to adjust their approach based on assessed impact on client/goals objectives	5	1
Client Report: Does the client report feeling heard and respected?	5	1
The way to observe it is to participate as a co-facilitator in a therapy session.	4.5	1
Body language	4	0
Observation & Client Report: Is the therapist hierarchal?	4	1
Observations or measures that take place over time and that attempt to assess (1) clinician attunement to client goals/objectives	4	1
Observations or measures that take place over time and that attempt to assess . . . (4) client outcomes (i.e. maybe via comparative control groups).	4	1
I would expect to observe verbal and non-verbal behaviors that indicate responsiveness to client needs.	4	1
I would expect to observe a strong, mutually respectful therapeutic relationship.	4	1
Way of being seems very difficult to empirically measure because so many actions can be done with skill and finesse but without a responsive way of being. It is more than what can be observed from without. . . . In that way, self-report may be the best way to capture it.	4	1
It could be measured by a self evaluation before and after sessions, assessing attitude, interest, curiosity, compassion level, and hope on the client.	4	1
Difficult question.	4	1

Table 10

Statements About Whether Self-Report or Client Report (or Both, or Neither) More Accurately Capture a Therapist's Way of Being (Question 10)

Item	Median	IQR
I strongly believe that therapist self-report alone is not appropriate, and that client-report in some way is essential.	7	1
Client's experience of their therapist and of how they feel when therapists are present would be helpful.	6	0
Maybe some honesty from clients that self-report might not be portrayed. . . . You would hope that a therapist who [has a good/helpful] way of being is self aware and would self-report honestly. But I also believe we might be hard on ourselves as well, which could skew some self-report.	6	0
Self-report should be included.	6	0
Self-report should be included. Self-report would likely capture complexity and intention that other reports couldn't.	6	0
A helpful way of being requires some degree of vulnerability and there seem to be therapists who avoid that through their use of language, the therapist or expert power dynamic and their own needs to be seen as someone who is effective or expert.	6	0
Both	6	1
It almost doesn't matter how th[e] therapist sees it[,] . . . but [it] would be good to have what the therapist thought vs the client interpretation	6	1
Both would create the opportunity for comparison.	6	1
Therapist self-report would provide perhaps the most clear evidence for a therapists' way of being. But way of being is always relational. . . .Perhaps an aggregate of many interactions with many clients, receiving both the client and the therapist's self-reports would provide an overall sense of the therapist's ability to use way of being productively.	6	1
Both would be helpful, but the client is the person who is experiencing the therapeutic treatment, who experiences the therapist's way of being. This information should be more heavily weighted, although the therapist should ask him/ herself about his/her experience.	6	1
Client report.	6	1
Client report . . . will be more accurate after time depending on the population ([for example], oppositional teenagers or mandated clients may need a few weeks or months to overcome their own defenses)	6	1
Client report can offer valuable feedback for how a therapist is presenting themselves and coming across to the client.	6	1
Client report in response to operationalizing the moral values that inform the therapist's practice and way of being.	6	1
Therapists might also be able to reflect on and accurately report their way of being.	6	1
Self report is difficult because therapists who have a poor way of being are likely to be self-justified and self-protecting and so not as aware or able to self report.	6	1
Self report is difficult because . . . given there are industry standards therapists are likely to rate themselves higher even knowingly not wanting to admit their poor way of being.	6	1

Questions not directly about therapy for the therapist might be helpful for revealing way of being more accurately?	6	1
It would need to be in a setting that the person could be reflective and thoughtful.	6	1
I think either is appropriate.	6	1
Client report would focus on what the client felt from the therapist -- the assumption is the they can feel/sense the way in which the therapist feels about or regards them.	6	1