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The Cognitive, Emotional, and Relational Characteristics of Master Therapists

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Cognitive, emotional, and relational characteristics among 10 peer-nominated master therapists were identified through qualitative research methods. Results suggest that master therapists (a) are voracious learners; (b) draw heavily on accumulated experiences; (c) value cognitive complexity and ambiguity; (d) are emotionally receptive; (e) are mentally healthy and mature and attend to their own emotional well-being; (f) are aware of how their emotional health impacts their work; (g) possess strong relationship skills; (h) believe in the working alliance; and (i) are experts at using their exceptional relational skills in therapy. These findings suggest that researchers studying therapist expertise may want to explore emotional and relational characteristics in addition to an almost exclusive focus on the therapist's cognitive attributes.

In the last few decades, the focus of many researchers has been on identifying the complex factors that go into effective psychotherapy. Factors explored include client variables, therapist variables, client–therapist personality matching, the therapeutic alliance, and "common factors" across various therapeutic modalities (Miller, 1993). In particular, the therapeutic alliance is considered to play a central role in producing effective psychotherapy outcomes (Beutler, Machado, & Neufeldt, 1994; Horvath & Symonds, 1991; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). Sexton and Whiston (1994) stated in the first line of their abstract that "the quality of the counseling relationship has consistently been found to have the most significant impact on successful client outcome" (p. 6).

Assuming that the personal characteristics of the therapist influence the quality of the therapeutic alliance, it may be useful to understand more fully the qualities effective therapists bring to their work. Even more helpful would be to identify the characteristics of master therapists, those considered the "best of the best" among mental health practitioners.

In reviewing the literature on therapist effectiveness, the majority of studies used neophyte therapists or even therapist trainees as subjects. The few investigations that did study experienced therapists revealed scant information on the personal characteristics of effective therapists. Wicas and Mahan (1966) found effective therapists to be more self-controlled and sympathetic toward others compared with less effective therapists. Jackson and Thompson (1971) reported that effective therapists held more positive attitudes toward themselves, clients, most people, and therapy than did ineffective therapists. Studying two therapists intensively, Ricks (1974) found major differences in the success of the two therapists treating disturbed adolescent boys and attributed these differences to therapist personality differences and the handling of countertransference reactions by the two therapists. In a classic study, Orlinksy and Howard (1975) used the data from 890 patient sessions and 470 therapist sessions to focus on subjective reports of therapists and clients about their experiences in therapy. Wiggins and Weslander's (1979) research revealed that highly effective therapists reported greater job satisfaction than did less effective therapists. Luborsky et al. (1985) found a significant relationship between patient outcomes and therapeutic alliance, and stated that "the major agent of effective psychotherapy is the personality of the therapist, particularly the ability to form a warm and supportive relationship" (p. 609). Although Luborsky et al. (1985) asserted that the personality of the therapist is critical in forming therapeutic alliances that make therapeutic successes possible, therapist effectiveness research has yielded only minimal information on what these therapeutic personality characteristics may be.

Even the few studies seeking to define characteristics of master therapists have revealed little. Harrington (1988) found that Diplomates of the American Board of Professional Psychology (defined as master therapists) scored similar to each other on 30 of 37 subscales of the Adjective Check List. With Diplomates sharing 30 descriptors, the results of this study served to cloud, not clarify, the definition of master therapists. Goldberg (1992) interviewed 12 psychiatrists recommended by colleagues as exceptional therapists. Goldberg found that, as a group, these therapists seemed to be sensitive, caring, and dedicated to their clients' welfare and their own personal and professional growth. They seemed pleased by their career choice and reported being helped by a competent mentor and rejuvenated professionally by mentoring others. Finally, Albert (1997) interviewed 12 psychiatrists nominated by their colleagues as expert clinicians and found that the therapists' flexibility,

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sensitivity, ability to create a place of sanctuary for the client, and ability to create a therapeutic alliance were all important in providing effective psychotherapy.

Apart from therapist efficacy, another potential factor in being a master therapist relates to the knowledge and skill base of the therapist and the cognitive processes that help organize and access that knowledge base. Although the literature on therapist expertise is limited, interest has increased in this line of research. Hillerbrand (1989) defined the expert therapist as a person who

> is able to conceptualize clients, integrate factual information into performance, and recognize interpersonal processes. Expertise consists of the cognitive skills of comprehension and problem solving. That is, the ability to identify and understand incoming information and then cognitively process this information for the purpose of reaching a conclusion or solution. (p. 292)

Similar to expertise research in other domains, research on differences between expert and novice therapists suggests that expert therapists have more complex schemata and tend to notice more subtle features of problems than novice therapists (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989). This promising line of research is not without problems, however. For instance, many of the studies purporting to study therapist expertise use years of experience as the main criterion for judging expertise (Martin et al., 1989; Cummings, Hallberg, Martin, Slemon, & Hiebert, 1990; Kivlighan & Quigley, 1991). However, years of experience has not been found to clearly differentiate levels of expertise (Skovholt, Ronnestad, & Jennings, 1997).

In an attempt to define the term *master therapist* better, the present study focuses on the question, "What are the personal characteristics of master therapists?" More specifically, what are the characteristics of therapists considered outstanding by their professional colleagues? Despite the lack of a clear definition, the term master therapist is used frequently in the mental health lexicon to describe therapists considered to be "the best of the best" among fellow practitioners. Whereas much of psychotherapy research has focused on neophyte therapists (Goldberg, 1992), we believe that a considerable amount can be learned about potentially efficacious therapist characteristics by studying highly experienced, well-regarded therapists across various professional mental health disciplines.

Qualitative methodology was used in this study of master therapists. Many methodologists consider qualitative designs to be the most effective means for exploratory phases of investigation (Hoshmand, 1989; Patton, 1990). Because of the exploratory nature of the current study and the desire to gain a better understanding of a complex human construct (i.e., master therapists), qualitative interviews were chosen as the data-gathering method.

Method

Respondents

Of the 10 master therapists (7 women and 3 men) interviewed, there were 6 PhD psychologists, 3 master's-level social workers, and 1 psychiatrist. All held licenses in their respective fields; some held more than one license. The master therapists ranged in age from 50 to 72 years (M = 59 years, SD = 7.89 years). Their level of experience practicing psychotherapy ranged from 21 to 41 years (M = 29.50 years, SD = 6.62 years). The theoretical orientations of the master therapists were divided into four major camps: psychodynamic therapists (n = 4), family systems therapists (n = 2), integrative therapists (n = 2), and existential-humanistic therapists (n = 2). All of the master therapists were European American. All worked full time in private practice. Overall, their therapy practices included short- and long-term work, with both managed-care and "out-of-pocket" clients who paid fees within the fee structure of the community.

Procedure

In this qualitative study, a purposeful sampling strategy was used to identify master therapists. With purposeful sampling, exemplars of the concept being studied are identified (Patton, 1990). In the present study, well-regarded therapists in a major midwestern metropolitan area were asked to nominate colleagues whom they considered to be master therapists. This type of purposeful sampling is called "snowball sampling." With snowball sampling, "well-situated" people are asked to identify information-rich key informants. Individuals who are repeatedly named by a variety of informants constitute the core subject pool (Patton, 1990).

Reliance on the judgment of peers or colleagues is inherent in the snowball sampling method. Peer nomination techniques have been found to accurately assess personal and interpersonal characteristics for therapists and a wide variety of other subject groups (Cole & White, 1993; Hillerbrand & Claiborn, 1990; Luborsky et al., 1985; Serbin, Lyons, Marchessault, Schartzman, & Ledingham, 1987). For example, on the basis of their research, Luborsky et al. (1985) stated that "therapists are able to identify other potentially effective therapists and to discriminate them from those who are less effective" (p. 609). In the present study, the snowball sampling–peer nomination method continued until therapists ultimately chosen for the sample were distinguished from a larger pool of individuals who received only one or two nominations.

To begin the nomination procedure, three well-regarded practicing psychologists (two male, one female) with a mean of 31 years of therapy experience were chosen as key informants. These three initial key informants were chosen because of their: (a) involvement in the training of therapists; (b) long-standing involvement with the local mental health community; and (c) reputation for being well-regarded therapists. Two of the key informants worked at a major university counseling center and one worked in private practice.

Each key informant was asked to nominate three master therapists within the large metropolitan area of the sample group. Nomination of master therapists was based on the following criteria: (a) This person is considered to be a "master therapist"; (b) this person is most frequently thought of when referring a close family member or a dear friend to a therapist because the person is considered to be the "best of the best"; and (c) one would have full confidence in seeing this therapist for one's own personal therapy. Therefore, this therapist might be considered a "therapist's therapist."

Len Jennings telephoned each person nominated as a master therapist by one of the key informants. In the next step of sample selection, the nominated master therapist was asked to nominate three master therapists using the same criteria. Master therapists were not allowed to nominate themselves.

Patton (1990) recommended that the investigator conclude this sample-gathering method when a point of redundancy and saturation occurs, that is, when certain individuals are repeatedly

nominated and few new names emerge. Eight repetitions of the nomination procedure were needed to reach a point of redundancy and saturation. When the nomination process was concluded, a total of 103 different therapists had been nominated as master therapists. Of the 103 therapists nominated, 66 therapists received one nomination, 12 received two nominations, 15 received three nominations, 3 received four nominations, 2 received six nominations, 2 received seven nominations, and the remaining 3 therapists received 10, 12, and 17 nominations, respectively.

A minimum of four nominations was chosen as the cutoff point for the sample group. This break point was chosen so that neither too many nor too few master therapists were interviewed. In choosing between breadth (brief interviews with many subjects) and depth (in-depth interviews with few subjects), we chose what we considered a sufficient number of participants to obtain an adequate balance between breadth and depth. The mean number of nominations for the $N = 10$ sample group was eight (range = 4–17). Overall, the 10 master therapists from the pool of 103 accounted for 36% of the total nominations (77 of 212).

An interview–follow-up design (a first interview set and a follow-up interview set) was selected in an attempt to achieve "validity through dialogue" (Skovholt & Ronnestad, 1995, p. 147). Guba (1978) stated that this methodological approach enhances validity: "Who is in a better position to judge whether the categories appropriately reflect their issues and concerns than the people themselves?" (pp. 56–57).

The principal investigating method was a semistructured interview questionnaire consisting of 16 open-ended questions (see Table 1). Initially, a list of questions was generated partly by Len Jennings drawn from topics illuminated by a literature review on therapist effectiveness (Goldberg, 1992; Harrington, 1988; Jackson & Thompson, 1971; Luborsky et al., 1985; Miller, 1993; Wicas & Mahan, 1966; Wicas & Weslander, 1979) and partly from a list of questions produced by a survey of cohorts from Len Jennings's counseling program. The questionnaire was designed to elicit information concerning the characteristics of master therapists. The counseling students were instructed to think of questions they would like to have answered by a master therapist. After an initial rating process for clarity and salience by three doctoral interns in counseling psychology, the questionnaire was revised. Next, Len Jennings conducted two pilot interviews with experienced therapists using the questionnaire. Then the interview questionnaire was modified once more by the researchers.

The first set of interviews were audiotaped and conducted at the respondent's practice site. Before each interview, Len Jennings explained the purpose of the study, and each respondent signed an informed consent form. Each interview proceeded through the 16 open-ended questions and averaged approximately 90 min in duration.

A necessary step before data analysis was to transcribe verbatim the audiotaped interviews. Because of an equipment malfunction, one of the audiotapes from the first round of interviews was deemed inaudible. The respondent agreed to be interviewed again, and another interview covering the same questions was conducted with that respondent. After the transcripts were completed, Len Jennings listened to each interview while reading the typed transcriptions to ensure the accuracy of the transcriptions.

Analysis of the data was based on inductive analysis (Patton, 1990), which starts with specific observations and builds toward general patterns. The data analysis consisted of organizing the smallest units of data (concepts) into meaningful and progressively broader themes, categories, and domains. The inductive analysis procedure used in this study was a collaborative process in which the researchers, a research assistant, and the master therapists themselves contributed to the analysis of the data. In the beginning stages of the analysis, the researchers and the research assistant identified the concepts and themes. The latter stages of analysis involved the master therapists and the researchers identifying themes and categories.

To begin the data analysis, Len Jennings and the research assistant analyzed each paragraph and wrote one or two words that best represented the concept for that paragraph. Next, each concept was written on one side of a note card with the corresponding supporting data, which was a quote from the respondent on the opposite side. A total of 1,043 concepts were generated from a paragraph by paragraph analysis of the 10 written transcripts. At this stage of analysis, Patton (1990) emphasized identification of important examples, themes, patterns, and natural variation in the data. The 1,043 concepts were then sorted by Len Jennings and the research assistant into many different groupings until themes and categories emerged. From this process, 40 preliminary themes were identified by the researchers and organized under four major categories.

Approximately 2 months after the first interviews were analyzed, a 60-min follow-up interview was conducted with each respondent. The follow-up interview focused on validating and refining prelimi-

Table 1
Interview Questions for Master Therapists

1. How are you different from when you started your career?
2. What distinguishes a good therapist from a great therapist?
3. What do you think are the characteristics of a master therapist?
4. To become a master therapist, does one need years of experience? Explain.
5. Given two equally experienced therapists, why does one become an expert whereas the other remains mediocre?
6. What is particularly "therapeutic" about you?
7. Is there one distinguishing aspect of your expertise?
8. How does your emotional health impact the therapy you do?
9. How does the person you are impact the therapy you do?
10. How do you know when you are doing a good job with a client?
11. Are you helpful with some clients and not others? Explain.
12. Can you estimate what percentage of your clients you have helped?
13. What is psychotherapy?
14. How does psychotherapy heal?
15. How much of psychotherapy is an art versus a science?
16. If there were a recipe for making a master therapist, what ingredients would you include?

nary results derived from an analysis of the first interview data. The follow-up interviews were also audiotaped. During this interview, respondents were asked to evaluate the accuracy of the preliminary data by indicating which themes and categories seemed to fit with their individual experience. Respondents were invited to comment regarding how the results did or did not reflect their experience. Finally, respondents were asked to add any information not yet addressed that they considered relevant in defining the term "master therapist." Quotes that best represented each theme were later transcribed.

On the basis of feedback obtained from respondents during the follow-up interviews, themes and categories were again modified. We included in the results only themes in which the majority of respondents (i.e., 8 of 10) agreed accurately represented their individual experiences, perceptions, and beliefs. Domains as the major organizer were then selected based on themes and categories. Twenty-six themes within eight categories were organized under the following three broad domains: cognitive, emotional, and relational. These domains represent major attribute areas of a master therapist. In the final data analysis by the researchers, the themes were incorporated within the text to describe the categories and another category emerged. The results presented here have nine categories under three domains.

Results

The findings are organized under three domains representing key attribute areas of master therapists: cognitive, emotional, and relational. Within each domain, there are three categories. Next, selected quotes from the respondents are offered as "raw data" to best illustrate both category and domain.

Cognitive Domain

Category 1: Master therapists are voracious learners. Continuous professional development seems to be a hallmark of the master therapist. When speaking about learning and knowing, many respondents used terms such as "hunger" or "thirst." Their voracious appetite for knowledge appears to be an intense source of development. One respondent said:

> I can't stay content in what I know. And I get embarrassed at how much I seek out other learning experiences. My family is forever kidding me about it. Because I do take classes, I still do . . . Oh, my joke is that when I die, they ought to put on my epitaph, "Now her question is answered," like the curiosity of what the death experience would be. So curiosity has been a big thing all my life.

Another respondent shared how a love for learning is a source of renewal:

> [I] go to workshops, give workshops, teach in consultation groups. All those kinds of things that take energy, take interest, take wanting to know more . . . I love getting together with people, reading and talking about what we're reading. Some people don't like that at all, and I just love it . . . It provides constant energy for one thing, and I think what happens in our field is that we can get tired and exhausted. But I think that's one of the things that keeps me feeling high energy, and [it creates] a lot of interest and love for what we do, and it's exciting.

Category 2: Accumulated experiences have become a major resource for master therapists. Over time, the respondents, with an average of 29.5 years of professional experience, have rich life and work experiences upon which they draw in their work. These experiences seem to have increased respondents' depth and competence as human beings and mental health practitioners. The benefits of experience were cited frequently during the interviews. For example, one respondent shared how a returning client noticed the development of character and expertise the respondent had gained over the years:

> I was really lucky just 2 years ago, a fellow whom I had seen 17 years ago called me and said that he wanted to come back into therapy . . . probably about 3 months into it, he said "Boy, you're really different." And I said, "You know what, I'd like to hear it." And it was wonderful. He said, "You've just got so much more of yourself, and there's so much more of you in the room, and I'm getting so much more out of this. You know, my sense of you back then was that you were going by the book." And I was, because that's all I knew how to go by.

Although respondents gained greatly from accumulated experience, most agreed that experience alone did not guarantee optimal professional development. Several respondents shared that it was a commitment and openness to learning from one's experiences that counted. One respondent stated:

> I don't think years of experience by itself does it . . . I might have the same year of experience 20 times. So [one] needs to put that together with good consultation and a good collegial system so that you actually are learning from what you're doing, [learning] more about yourself and about how you are impacting people.

Category 3: Master therapists value cognitive complexity and the ambiguity of the human condition. Respondents do not merely tolerate ambiguity and complexity, they seek it out. One respondent said it would be fun to be a meteorologist and deal with complex systems such as the weather. Another reads about chaos theory as a leisurely pursuit. When therapists are on the "cutting edge" of understanding human life, they are likely to encounter complexity and the unknown. The respondents seemed to welcome the complexity. For example, one respondent said:

> None of us ever arrive when we're in this business of working with people. . . There's always an AIDS, the thing around the corner. There's always that level of complexity. . . And the minute you start thinking things are simple, you better quit [psychotherapy]. That [reminds me of] my favorite quote, by the way: "If the brain was simple enough for us to understand it, we'd be too simple to understand it."

Similarly, respondents use complex and multiple criteria in judging therapy outcomes. Respondents recognize the difficulty of assessing a process as complex as psychotherapy. Like other therapists, respondents look for positive changes in clients' behaviors, cognitions, and feelings as evidence of efficacious therapeutic outcome. However, respondents shared a number of sophisticated and somewhat idiosyncratic methods for judging effective outcome. For example,

one respondent said:

> On some levels, I don't think psychotherapy has an end point. I think that successful therapies have continued internally for clients. And I think I wouldn't have known it in the earlier years, but after having practiced so many years, I've had the opportunity to have people who knew me 15 years ago come back because of life circumstances or whatever, and quite clearly they have had an ongoing process with me even though we didn't meet for 15 years. So [psychotherapy] is in some ways a process that activates something internally for people, and I think therapy that truly ends on the last meeting day maybe wasn't psychotherapy.

Emotional Domain

Category 4: Master therapists appear to have emotional receptivity defined as being self-aware, reflective, nondefensive, and open to feedback. Respondents spoke of engaging in personal therapy, peer consultation, and supervision to obtain various sources of feedback to heighten their awareness of themselves and others. Respondents seem to be constantly striving to learn more about their work and themselves. For example, one respondent spoke of a need for continuous self-reflection and feedback:

> [I need to be] fully aware of myself and my own motivational system, what's moving me inside . . . So I get a chance to look at myself on the outside over and over and over again, through personal therapy, through lots of supervision, through ongoing consultation. That helps incredibly.

Their openness to feedback includes feedback from clients. One respondent shared a critical incident in which valuable feedback from a client was offered and received:

> My clients have taught me a lot. Early in my career, I saw a couple for a year, and what she complained about was his drinking. What he was basically saying was "I wouldn't be drinking if you didn't bug me so much." And I knew absolutely nothing about alcoholism at that point. They kind of faded out [of therapy], and I don't blame them when I look back on it because we didn't do much. A year later, she called me to make an appointment, came in, sat down, and said "I just want to tell you face-to-face how destructive you were to us." And that was one of the most powerful things that could have happened. I mean, I am forever grateful. It was incredibly hard to hear, but I had a sense that I had really done a lousy job and there was something about her being strong enough to come back. I was embarrassed. . . . It made a powerful impression. . . . I knew it was true and that I had a lot to learn. And I think that the other part was that I was incredibly impressed with the fact that she had the guts to do it. And I thought, you know, if she had the guts to do it, then I've got the guts to learn from it. . . . It colored my absolute commitment to learn about what I didn't know.

Category 5: Master therapists seem to be mentally healthy and mature individuals who attend to their own emotional well-being. As one indicator of emotional health, respondents strive to act congruently in their personal and professional lives. Many respondents described themselves as congruent, authentic, and honest. For example, one respondent said:

> My integrity or my believability rests on what I do in my work *and what I do in my personal life*. . . I don't go to work and come home and live a different life. . . I fully require in my personal life and in my professional life a kind of absolute, and in this sense it's rigid but absolute honesty. . . . It's not that you're making a dedication to the client, it's that you're making a dedication to a congruent life. . . . It's a life in which the inside and the outside match. It's when what people think you are, it's who you are.

As another indicator of emotional health, respondents seem to have a healthy perspective on their sense of importance. Respondents displayed a genuine sense of humility and were not self-centered or grandiose in presentation. They appeared to be comfortable with themselves and held a realistic perspective on their importance in the world. In short, respondents seemed to have struck a healthy balance between confidence and humility.

In addition, respondents attend to their well-being through personal therapy and other self-care practices. Respondents take preventive action to protect what they consider their most important therapeutic tool: themselves. They understand that maintaining their emotional well-being is an ongoing process and have found numerous ways to do so, such as with personal therapy, exercise, and the practice of spirituality. One respondent, wanting to be sure of "practicing what one preaches" concerning self-care, said:

> I exercise every day. I try to do what I encourage other folks to do. I have a strong support system. I have a lot of long-term good friends whom I meet with regularly, that I do things with. I have quiet time every day, where I have a chance just to be with myself. I eat well. I would feel really fraudulent to not do [these things]. . . . To not do it would not be good self-care, I think.

Category 6: Master therapists are aware of how their emotional health affects the quality of their work. Respondents are keenly aware of how their emotional health affects their work. One respondent offered a convincing argument for the saliency of the therapist's emotional health when observing the following:

> See, one of my firm beliefs is that the only way, the only hope we have of becoming good therapists is if we're willing to look at our own stuff. Because we can learn all the skills in the world and if we're in this long enough, we learn plenty of skills, but if we haven't gotten our own stuff cleared out of the way, we're going to be acting that out on our clients over and over and over again. . . . [There needs to be a] commitment to getting [our] own psychological shit out of the way, with whatever that's going to take. And the understanding that we have to be willing to do that all of our lives, because practically every hour that we see somebody, there's something hitting on our old stuff.

Relational Domain

Category 7: Master therapists possess strong relationship skills. In their families of origin, many respondents developed skills of listening, observing, and caring for the welfare of others. This may have given the respondents a 10- to 15-year head start on developing relational skills. For example, one respondent said:

> My father would always come to me for solace when he was upset with my mother. My mother would come to me when she was upset with him, and I was always trying to help both

> of them. So maybe that created a need to be needed . . . to be there for people [was] well ingrained very early.

In addition, the respondents' own emotional wounds seemed to have increased their sensitivity and compassion to others. Respondents shared personal accounts of suffering and how their experiences increased their sensitivity to others. For example, one respondent said:

> I have been through a hard 5 years, during which time I sold my house, moved into another place, and had my last surviving sibling die of a brain tumor and my mother and an aunt die. So I was picking myself up and kind of holding onto myself for a while. And the interesting thing is, when I was in the most pain, I was a very good therapist. And it was like the bank robbers who sandpaper their skin so that they can really be sensitive to the movements of the machine they are trying to break open. . . . I think I was more sensitive to what my clients were doing.

During the interview process, respondents exuded warmth, respect, caring, and a genuine interest in people. Respondents seem to have highly developed social skills, which enabled them to relate well with others. Perhaps master therapists have a gift for helping clients feel special. One respondent described relationship skills this way:

> Well, I think I have a pretty natural capacity for empathy, which is the starting place for most relationships. The ability to put myself in the other person's shoes and to imagine that even if I haven't lived a life anything like theirs, I have the capacity to imagine what that would be. I am terribly responsible and reliable. I think I create an environment where people can visit pain and count on me to be there, both in terms of time and space, and be predictable . . . I think [empathy and predictability] create a safe environment. People bring in problems that are frightening and abhorrent to themselves and to most people in their lives. I try to create a situation where these problems are approachable, something that can kind of counteract the person's embarrassment or shame or whatever and be able to go on to address the problems. I think the empathy has the effect of helping someone be empathic to themselves.

Category 8: Master therapists believe that the foundation for therapeutic change is a strong working alliance. Although the respondents represented a variety of disciplines and theoretical orientations, all agreed on the necessity of establishing a strong working alliance. One respondent spoke of the relationship's importance:

> Therapy is a real partnership, as I view it. . . I think we generate an alliance that allows us to do what, without it, we could not otherwise do. . . That's where the healing is, in the use of the relationship.

Some spoke of the relationship as therapy itself. For example, one respondent explained:

> The core of psychotherapy to me is the development of that relationship and the connection, and so it's the development of a relationship . . . the purpose of which is to heal or help the other person. . . Psychotherapy is the relationship, as opposed to a technique that I do or whatever else. It's really about forming and working in the in-between.

Moreover, respondents firmly believe in their clients' ability to change, which may instill hope and strengthen the working alliance. Respondents have a deep respect for their clients' right to self-determination and believe that client change is possible. In fact, one respondent explained how change is inevitable:

> The very fact that they're sitting in this office means that they've got a push to make things better, and that's what you have to support all of the time. . . It's a part of the function of the human cell, if you want to get down to that [level]. . . Growth is part of life. So there will always be growth, just like change is a constant; there will always be change. The issue isn't whether there will be change, the issue is whether you can steer it a little bit, you know, help it go in one direction as opposed to another . . . help them choose what direction they want to go, and then help them make it go in that way.

Category 9: Master therapists appear to be experts at using their exceptional relationship skills in therapy. Not only do respondents provide safety and support, but they can also challenge clients when necessary. After establishing a relationship through warmth and safety, respondents seem to be able to address very difficult and painful client issues. Respondents seem to have a strength of character and a personal power that enables them to face tough issues and challenge clients when needed. For example, one respondent said:

> I think that part of the reason that I probably get good feedback has to do with both being supportive and challenging. . . I guess that I'm both gentle and strong, and I can be really soft and compassionate. But if need be, I can also be strong. I'm someone that [a client] can push against and I won't fold over.

Another common characteristic was that respondents expressed no fear of their clients' strong emotions. Respondents expressed their willingness to be with clients during very intense moments. One respondent explained that the therapist can be present with the client's pain only to the degree that the therapist has dealt with his or her own pain:

> If therapists are afraid of their own pain, they cannot stay with their clients in their pain, they'll cut them off. And what the client learns from that, because they pick up on your discomfort, is that there's something wrong with them for having that kind of pain. It's so important not to be afraid of someone's pain.

In addition, respondents seem to have become skilled at the art of timing, pacing, and "dosage" when working with clients. With years of experimenting and learning from mistakes and successes, respondents have a fine-tuned sense of judgment related to the timing and intensity of their interventions. One respondent gave an example of dosage:

> You trust that you won't overrespond or underrespond. You see, if [a client] had gotten mad at me, then I would have pulled back and done something else. Part of it is a gestalt concept of dosage. That you have to put out the right level of experiment. Because if it isn't enough, it is not going to get the adrenaline going and if it is too much, they get overwhelmed.

Discussion

Only a few researchers, such as Harrington (1988), Goldberg (1992), Skovholt and Ronnestad (1995), and Albert (1997), have sought to tap the wealth of knowledge and wisdom that seasoned, well-regarded practitioners pos-

sess. Similarly, we sought to identify and illuminate the characteristics of master therapists, those considered the "best of the best" among their professional colleagues.

On the basis of the current findings, it appears that becoming a master therapist is more than just an accumulation of time and experience. The master therapists in this sample seem to continuously capitalize on and proactively develop a number of characteristics in an effort to improve professionally. These master therapists appear to be voracious learners who are open to experience and nondefensive when receiving feedback from clients, colleagues, and others. The master therapists seem to use both experience and intelligence to increase their confidence and comfort when dealing with complexity and ambiguity. In addition, they appear to be quite reflective and self-aware and use these attributes to continue to learn and grow personally and professionally. These master therapists seem to possess emotional maturity and strength of character that come from years of active learning and living. Finally, the master therapists appear to be able to relate superbly with others, which one can assume often leads to a strong working alliance and positive therapeutic outcomes.

There is convergence between the results reported here and those of other research. For example, many of the themes embedded in the nine categories of the present research are similar to the stages and themes presented by Skovholt and Ronnestad (1995). Regarding the qualities which develop competence and expertise, there is strong agreement between the results reported here and other reports in the literature (Colton & Sparks-Langer, 1993; Neufeldt, Karno, & Nelson, 1996; Ronnestad & Skovholt, 1991, 1997; Schon, 1983, 1987; Skovholt & Ronnestad, 1995; Tremmel, 1993; Ward & House, 1998; Worthen & McNeill, 1996). A central tenet in this literature involves an embracing of complexity and reflecting on this complexity in order to grow professionally. The underlying concern here is how to use experience to increase competence and the move toward expertise. The alternative is "misuse of experience," where the practitioner is not impacted by it but just routinely repeats the same process over and over again.

Ward and House (1998) discussed the embracing of complexity in the education and supervision process when they described how professional growth for the practitioner in training comes through "experiencing increased levels of emotional and cognitive dissonance" (p. 23). They add that

> counselors are encouraged to reflect in the moment of action when situations do not present themselves as given, and clinical direction must be constructed from events that are puzzling, troubling, and uncertain (Schon, 1983). It is this recognition of discomfort in response to professional experiences that highlights the reflective learning process and . . . encourages supervisees to willingly explore dissonant counseling experiences. (p. 25)

This emphasis on facing complexity and working through it through reflection is central to the Uncertainty–Certainty Principle of Professional Development (Ronnestad & Skovholt, 1997). Here the supervisor's orientation is to always present a searching stance through the uncertainty while also presenting the certainty of specific techniques and ideas to the novice.

Regarding implications of the present study, we offer the following scenarios, posed as questions, for consideration. Could it be that some therapists have the cognitive ability to understand the dynamics of difficult cases but lack the relationship skills needed to establish a therapeutic alliance with their clients? Could it be that some therapists relate extremely well with their clients, but their own emotional needs interfere with their clients' work? Could it be that some emotionally healthy therapists do not have the cognitive wherewithal to understand the complexity of their clients' problems? On the basis of the present research findings, we propose the CER model of the master therapist: It is hypothesized here that those who go on to become master therapists have developed cognitive (C), emotional (E), and relational (R) domains to a very high level and have all three domains at their service when working with clients. The CER model of the master therapist consists of a blend of this three-legged expertise stool, which includes cognitive attributes (cognitive complexity and voracious appetite for learning), emotional attributes (emotional receptivity and maturity), and relational attributes (interpersonally gifted).

Three suggestions for future research are offered. First, although the therapist expertise research has offered a substantive contribution to the understanding of the cognitive processes of a therapist (Cummings et al., 1990; Hillerbrand & Claiborn, 1990; Kivlighan & Quigley, 1991; Martin et al., 1989), the present findings suggest that therapist expertise researchers expand the definition of expertise to include the emotional and relational domain of the therapist. Again, we suggest that expertise in psychotherapy is much more than a cognitive dimension. The cognitive domain is only one leg of the three-legged expertise stool. We believe that all three legs (i.e., cognitive, emotional, and relational) are needed for a solid base to perform as an expert in psychotherapy (Skovholt, Ronnestad, & Jennings, 1997).

Second, although the present research highlights a number of potentially desirable therapist characteristics, future researchers will want to explore whether master therapists actually achieve better results than other therapists on measures such as establishing a therapeutic alliance, reducing clients' symptoms, and satisfying clients.

Finally, it appears that many of the master therapist characteristics highlighted in this study are related to concepts such as Rogers's (1961) "fully functioning person," Maslow's (1970) "self-actualized" person, Skovholt and Ronnestad's (1995) senior therapist in the integrity stage of therapist development, and Erikson's (1963) ego integrity stage of human development. In the future, researchers may want to explore commonalities between master therapists and highly functioning individuals found in a variety of professional fields, that is, those who have acquired a high level of maturity and wisdom through their experiences. Our study may have tapped personal characteristics resulting from optimal human development, regardless of career field.

The results of this study should be interpreted in light of several limitations. As with any qualitative design, the

findings are not generalizable beyond the context of this group because the sampling method focused on an information-rich versus representative participant pool (Patton, 1990). In addition, the sampling method may have excluded some outstanding therapists who are lesser known among their colleagues. Next, although attempts were made to minimize experimenter bias by using a collaborative data analysis between the researchers and the respondents, there was still subjectivity throughout the research process. Another limitation was the lack of diversity in the research sample. Although the sample was fairly representative of the northern state in which the study was conducted, future researchers would do well to incorporate the richness of a diverse participant pool.

If future research replicates our findings, then these characteristics of master therapists may serve as guideposts for therapists and therapist training programs seeking to promote optimal therapist development. For therapists, the results suggest attending to several areas of personal and professional development. Therapists are encouraged to seek out opportunities for continuous learning, feedback, and reflection. Therapists would do well to keep an open mind when dealing with complexity and ambiguity in their work. Therapists are encouraged to attend to their own emotional well-being, seek their own therapy when necessary, and continue to hone their relational skills. Training programs may want to consider elevating the saliency of the personal characteristics of prospective students to a level on par with the emphasis given to the candidate's cognitive abilities (e.g., Graduate Record Exam scores and grade point average). Moreover, training programs can strive to provide a learning environment to develop these desirable characteristics further in their trainees. Overall, the results of this study highlight the importance of developing the emotional domain, the relational domain, as well as the cognitive domain of the therapist.

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