A Qualitative Investigation of Psychotherapy Clients’ Perceptions of Positive Regard

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Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy under the Executive Committee of the Graduate School of Arts and Sciences

COLUMBIA UNIVERSITY

2018
ABSTRACT

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This qualitative study aimed to investigate psychotherapy clients’ phenomenological experience of positive regard. Though positive regard is broadly accepted as a useful and effective clinical tool across orientations, it has been under-researched and overlooked in favor of more clearly conceptualized variables, such as empathy and working alliance. Designed as a follow-up to a quantitative study that yielded a tentative factor structure and inventory for measuring positive regard (Psychotherapist Expressions of Positive Regard, PEPR), the study also aimed to elucidate the extent to which those findings could be replicated in a qualitative format.

Following Consensual Qualitative Research (CQR) methodology, 15 psychotherapy clients, primarily white women, participated in semi-structured interviews eliciting the factors that contribute to their experience of positive regard in therapy, the absence of positive regard in therapy, and the impact of positive regard on the course of psychotherapy.

Nine domains and several key findings emerged from the analysis. While clients named a wide range of therapist behaviors and actions that served as markers of positive regard in the relationship, three constituent attitudes appeared repeatedly throughout the CQR categories, suggesting an underlying tripartite structure of positive regard – warm authenticity, flexible responsiveness, and empathic understanding. Clients viewed positive regard as a crucial ingredient of therapy, suggesting that it facilitates self-disclosure, risk-taking, personal growth, and rupture resolution. In relationships where
positive regard was lacking, clients became disengaged from treatment, and terminating without explanation was not uncommon. Clinical implications and recommendations for optimizing the experience of positive regard are offered. The substantial overlap and interdependence of positive regard with the other Rogerian facilitative conditions of congruence and empathy is discussed. Convergence and divergence between the PEPR factor structure and the results of the current study are also highlighted, with future directions proposed.

*Keywords:* positive regard, unconditionality, nonpossessive warmth, congruence, authenticity, responsiveness, empathy, self-disclosure, boundary violations, termination, PEPR
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Acknowledgments

Thank you to my Suzuki nucleus for providing me with such a strong foundation. Throughout his life, my brilliant father was unmatched in his sense of generosity, calm, and gentle humor, and he is deeply missed. My resilient mother remains an inspiring reminder that organization and persistence can get you far, as long as you don’t forget to have fun, too. Evan and Andy are the best brothers anyone could imagine, and I am the luckiest sister in the world. I am grateful to my extended family on both sides, near and far, for surrounding us with love and support. A special thank you, too, to George and Amy Goldstein, who introduced me to a new world and put me on the path towards this crazy career in the first place.

I must express my gratitude to Barry Farber for his warm and generous mentorship throughout my graduate training. I have been so fortunate to learn from and work for someone who maintains his passion for the work while also retaining impressive levels of sanity and humanity. In both a clinical and a personal sense, Barry, you are my model for unconditional positive regard, authenticity, and empathy. I have also benefited tremendously from supportive and stimulating exchanges with my colleagues in the Psychotherapy, Technology, and Disclosure Lab, especially Matt Blanchard, Sidney Coren, and Leigh Colvin. An added thank you to Sid for his thoughtful contributions as auditor of this study. Thank you also to Caryn Block for the introduction to qualitative methods, Laura Smith for lighting the way with CQR, and especially to both of you for being willing to serve on my committee at each stage of the process.

This project could not have been completed without the selfless contributions of several cohorts’ worth of research assistants. Zeynep Sahin, Megan Sommer, Jonathan
Singer, Joseph Leinwand, Elle Bernfeld were with me at the start and played a key role in the quantitative study that served as the foundation for this dissertation. The dissertation project took shape thanks to the dedication and insightful contributions of my CQR research team, Zenobia Morrill, Jin Lee, Jenna Cohen, Rachel Floyd, and Emily Pfannenstiel. Jenna, Rachel, and Emily stuck with me through maternity leave until the bitter end of the data analysis nearly two years later, and my gratitude to them knows no bounds.

Finally, a huge thank-you goes out to all of the volunteers who participated in this research. I truly enjoyed learning from you and hope that you can feel proud of the contribution you have made to this work. In speaking with all of you, I was moved by your candor and found myself wishing we could continue the discussion. For me, it has always been about trying to be the best clinician I can be. For that reason, as I complete this journey, I am grateful to my therapy clients past and present, who kept or still keep coming back each week, giving me and our work together the chance to grow. When I do this research, you are never far from my mind.
Dedication

I dedicate my dissertation to my husband, Tom Craven, and not just because I promised I would if he would help me figure out the confounded page numbering in this document. Ever since we met, Tom, you have been my devoted advocate, and your belief in me has sustained me through multiple career transitions and crises of confidence. When I look back at what we have achieved and weathered in twelve years, I am flooded with love and appreciation. Though we have grown and changed in innumerable ways, you are still the funniest, smartest, most loving, most challenging person I know, and I wouldn’t want it any other way. Thank you for teaching me the true meaning of unconditional positive regard.

Because I don’t think Tom will mind sharing top billing, I also dedicate this dissertation to Rocket, our phenomenal daughter. Becoming your mother less than two years ago was the most profound and transformative experience of my life. You astonish me every day with your curiosity and determination, and your sweetness and good humor delight me to no end. I cherish you, both as the person you already are, and as the person you will become, whoever she may be.
A QUALITATIVE INVESTIGATION OF POSITIVE REGARD

Chapter 1: Introduction and Literature Review

The primary aim of this study is to add to the current understanding of the construct of positive regard in psychotherapy. A central component of Carl Rogers’ client-centered theory, unconditional positive regard, or nonpossessive warmth, describes the affective quality of the ideal therapeutic relationship. Put simply, it refers to the therapist’s warm and affirming feelings towards the client (positive regard), regardless of how the client may behave or present in any given moment (unconditionality).

As one of the three facilitative conditions in the therapeutic relationship proposed as necessary and sufficient for meaningful client change (alongside empathy and congruence; Rogers, 1957/1992), positive regard has long occupied a privileged place in the clinical and theoretical literature on psychotherapy process. Yet the simple definition offered above is somewhat deceptive. The construct remains imprecisely operationalized and has lagged behind its sister construct, empathy, in the empirical literature on therapy outcome. The most recent meta-analyses examining the relationships between the facilitative conditions and therapy outcomes, to be published in the third edition of Norcross and Lambert’s *Psychotherapy relationships that work* (in press), hints at the massive imbalance in the number of studies on each construct. The empathy meta-analysis (Elliott, Bohart, Watson, & Murphy, in press) includes 82 studies and 6,138 clients, excluding a number of studies with measures that combine aspects of empathy and positive regard, as a means of minimizing conceptual confusion. By contrast, the positive regard meta-analysis (Farber, Suzuki, & Lynch, in press) covered 64 studies and 3,528 participants, and the authors chose to adopt more expansive criteria to increase the number of included studies. As a consequence, more than a third of the included studies
investigated positive regard as part of a broader composite of Rogerian facilitative conditions (including empathy), a common approach in the research that obscures the unique contribution of positive regard to clinical outcomes.

The existing theoretical and clinical literature conceptualizes positive regard in operationally vague terms. This lack of clarity may, in part, explain the sparseness of the literature on positive regard and its relationship to psychotherapy outcomes. Thus, this study, using a qualitative method of inquiry, aims to clarify the nature of positive regard as it is experienced by psychotherapy clients. The qualitative methodology that has been selected, Consensual Qualitative Research (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; Hill, Thompson, & Williams, 1997), was developed primarily “to investigate the unfolding of participants’ inner experiences in psychotherapy” (Hill et al., 1997) and is characterized by an open-ended quality that allows for the emergence of common and possibly unanticipated themes; participants in the current study were asked simply to report on instances when they did and did not experience positive regard in therapy.

While CQR emphasizes the importance of researchers noting and setting aside existing biases to the best of their ability, it also acknowledges that bias is an inevitable component of all research, from the questions researchers choose to ask to the way in which complex narrative data are analyzed and interpreted. This study has been conceptualized as a follow-up to a quantitative study (Suzuki & Farber, 2016) that aimed to operationalize positive regard in terms of specific therapist actions and statements, and thus carries some of the preconceived notions embedded within this first study: namely, the idea that certain therapist interventions and therapeutic contexts are more likely to
lead to the client’s perception of positive regard than others, and that therapy clients are reasonably capable of reporting on the potential of certain therapist interventions to convey or diminish an impression of positive regard.

The present study represents the second strand of an explanatory sequential mixed-methods design (Creswell & Plano-Clark, 2011), following up quantitative findings with a qualitative investigation to provide a deeper understanding of the initial results. A qualitative approach will allow for more contextualized interpretations of some of the salient findings from that quantitative study. In that study (described in Literature Review below), Suzuki and Farber (2016) supported the conceptualization of positive regard as a multi-dimensional construct, the experience of which may depend on individual difference characteristics of the client. In other words, therapists can demonstrate warm acceptance of their clients in a variety of ways, and clients’ preferences and abilities to take in this acceptance may vary according to their interpersonal styles as well as other factors. Given this conceptualization, the study goals are in line with Stiles’ (2015) designation of “enriching” rather than theory-building research. According to Stiles’ classification, “enriching” psychotherapy research “informs therapeutic practice by giving therapists a deeper sense of people and processes” (pp. 163) and “considers multiple perspectives and alternative ways of understanding a phenomenon without necessarily seeking to resolve them into a unitary account” (pp. 162). It is typically, though not exclusively, conducted using qualitative research methods. The CQR method, with its in-depth investigation of a small number of individual cases and its dual emphasis on identifying common themes as well as variant
experiences (Hill et al., 1997), offers an appropriate mode of inquiry for the next phase of this investigation.

In recent decades, the field of clinical psychology has tended towards an increasing symbiosis of scientific inquiry and clinical practice. At the same time, the field of qualitative research has expanded in popularity, with a growing number of researchers embracing a diversity of qualitative methodologies (Ponterotto, 2010). Although the alliance between research and practice can at times be an uneasy one (Lilienfeld, 2013; Shedler, 2006), it can also be constructive, particularly when conducted in a bidirectional fashion that acknowledges the importance of allowing clinical wisdom to form part of the evidence base that supports the growing understanding of treatment effectiveness (Teachman, Drabick, Hershenson, Vivian, Wolfe, & Goldfried, 2012). An open-ended, in-depth exploration of positive regard will allow better alignment between research and practice by unearthing various elements of this critical component of the therapeutic relationship, while opening the door to more precise empirical inquiry in the future.

Literature Review

**Origins in client-centered theory.** Positive regard was initially proposed as an essential ingredient of the psychotherapy relationship, and as one of the three necessary and sufficient relationship conditions that would enable therapy clients to undergo constructive personality change, in Carl Rogers’ (1959) client-centered theory. Creditling Standal with originating the term (Rogers, 1961), Rogers argued that all humans possessed a self-actualizing tendency, and that the goal of the therapeutic endeavor was to enable clients to access that tendency by increasing openness to the full range of their internal experience. This process facilitated a liberation from conditions of worth that
threatened clients’ ability to experience and accept their true and authentic selves. Thus, the goal of therapy was to help clients become more congruent, such that their perception of themselves and their internal experience more nearly matched an objective description of the same. The Humanistic therapist worked towards this goal by modeling his or her own congruence and authenticity in session, by being empathic towards clients’ self-experience on a moment-by-moment basis, and by demonstrating unconditional positive regard to show clients that all aspects of their internal experience were equally valid and acceptable. Rogers’ (1959) theory contained a developmental component as well, postulating a need for positive regard that begins in infancy and that, if not met, would need to be experienced in other contexts such as the therapeutic relationship before it could be internalized as positive self-regard. Rogers highlighted the potency of unconditional positive regard in the therapeutic relationship as bringing about change: “Gradually the client can feel more acceptance of all of his own experiences, and this makes him again more of a whole or congruent person, able to function effectively” (p. 208).

Without using the accompanying terms from Rogers’ client-centered framework (e.g., self-actualizing tendency, conditions of worth), the clinical importance of positive regard has been widely accepted and integrated in one way or another into nearly all psychotherapies, to the point that its origins in the Humanistic tradition are hardly recognized (Farber, 2007). Ranging from Kohut’s (1978) Self Psychology to Linehan’s (2014) Dialectical Behavioral Therapy, the acknowledgment that it is impossible for good clinical work to proceed without clients having some foundational sense of being liked and cared for – and, likewise, that therapists must sincerely be able to access those
feelings for their clients if they have any hope of helping them – has seemingly been embraced by the majority of practitioners as self-evident. Yet empirical support for this position remains somewhat weaker than one might expect. The current literature on positive regard is vague and sparse, and it is also lacking in a clear description of PR as it is experienced by clients.

**Vagueness in the conceptualization of PR.** One of the reasons for the relative paucity of research on positive regard is the challenge associated with clearly defining the construct. In the research and theoretical literature, it has alternately been referred to as unconditional positive regard, nonpossessive warmth, affirmation, prizing, and acceptance. Rogers’ various attempts to operationalize the construct allow for ample slippage. In his 1957 paper, he describes unconditional positive regard as follows.

To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard. This…means that there are no conditions of acceptance, no feeling of “I like you only if you are thus and so.” It means a “prizing” of the person, as Dewey has used that term. It is at the opposite pole from a selective evaluating attitude—“You are bad in these ways, good in those.” It involves as much feeling of acceptance for the client's expression of negative, “bad,” painful, fearful, defensive, abnormal feelings as for his expression of “good,” positive, mature, confident, social feelings, as much acceptance of ways in which he is inconsistent as of ways in which he is consistent. It means a caring for the client, but not in a possessive way or in such a way as simply to satisfy the therapist's own needs. It means a caring for the client as a separate person, with permission to have his own feelings, his own experiences. (p. 829)

Rogers’ initial conceptualization of unconditional positive regard thus implicitly identifies two components, *unconditionality* and *regard*. While conceptually distinct, these components are by necessity linked, in that the therapist has a warm, positive, and caring response to the client *regardless of* what experiences or attitudes he may bring to bear in therapy. Rogers appears to emphasize more heavily the unconditionality
component than the regard component, as indicated by representative statements in a hypothetical Q-sort task he proposed to characterize the therapeutic relationship:

“I feel no revulsion at anything the client says”; “I feel neither approval nor disapproval of the client and his statements—simply acceptance”; “I feel warmly toward the client—toward his weaknesses and problems as well as his potentialities”; “I am not inclined to pass judgment on what the client tells me”; “I like the client.” (p. 829)

Of these five items, only one (“I feel warmly towards the client – toward his weaknesses and problems as well as his potentialities”) integrates unconditionality with regard, while three items focus exclusively on unconditionality, and only one item (“I like the client”) is keyed to regard alone. He adds, as a footnote, that “completely unconditional positive regard would never exist except in theory,” but that therapists may experience the unconditional specifier towards their clients in certain moments, while at other times experiencing “only a conditional positive regard – and perhaps at times a negative regard, though this is not likely in effective therapy” (p. 829).

In a more fully developed treatise on client-centered theory, Rogers (1959) elaborates on each of the components of his theory, here separating clearly the definition of positive regard and unconditional positive regard. He describes positive regard as follows:

If the perception by me of some self-experience in another makes a positive difference in my experiential field, then I am experiencing positive regard for that individual. In general, positive regard is defined as including such attitudes as warmth, liking, respect, sympathy, acceptance. To perceive oneself as receiving positive regard is to experience oneself as making a positive difference in the experiential field of another. (p. 208)

While Rogers proffers some more commonly used terms that are encompassed by the broader construct of positive regard, his technical definition of positive regard is unwieldy, particularly from the perspective of the lay person or the average
psychotherapy client. One can imagine the difficulty of representing this construct to research participants in a manner that produces valid and reliable results. Rogers’ definition of unconditional positive regard offers a similar challenge:

If the self-experiences of another are perceived by me in such a way that no self-experience can be discriminated as more or less worthy of positive regard than any other, then I am experiencing unconditional positive regard for this individual. To perceive oneself as receiving unconditional regard is to perceive that of one’s self-experiences none can be discriminated by the other individual as more or less worthy of positive regard. Putting this in simpler terms, to feel unconditional positive regard towards another is to ‘prize’ him…This means to value the person, irrespective of the differential values which one might place on his specific behaviors. (p. 208)

Here, Rogers attempts to simplify by offering a single synonym that can act as a stand-in for unconditional positive regard. The notion of prizing, and Rogers’ subsequent example of a parent’s feeling toward his child, offers a vivid sense of what is meant by the construct. However, “prizing” itself is an uncommonly used term and may not, on its own, evoke a clear understanding in a lay context. Of note, Eckert, Abeles, and Graham (1988) offered a four-part definition of positive regard (warmth, respect, acceptance, and interest) and reported that warmth and respect generally appeared to be more relevant factors in the process of symptom change, particularly among clients with the most severe symptoms.

Presumably for the sake of precision and maximizing alignment with Rogers’ theory, the research literature has tended to separate unconditionality from positive regard as well. Though Lietaer (1984) proposed a three-dimensional construct consisting of positive regard, non-directivity, and unconditionality, the construct has typically been studied as having two components, positive regard and unconditionality. The best validated and most commonly used measure of Rogers’ facilitative conditions, the
Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962, 1986), contains two subscales to assess this construct – Level of Regard, “the overall level or tendency of one person’s affective response to another,” and Unconditionality of Regard, the extent to which “regard…is stable, in the sense that it is not experienced as varying with or otherwise dependently linked to particular attributes of the person being regarded” (Barrett-Lennard, 1986). Subsequent research found, however, that the Unconditionality of Regard subscale was less reliable and valid than the other three subscales (Barrett-Lennard, 1962; Cramer, 1986); furthermore, its association with expected therapy relationship and outcome variables has been weaker, or not in line with the other three subscales (e.g., Cramer, 1986; Handley, 1982; Lanning & Lemmons, 1974; Mann & Murphy, 1975; Mills & Zytowski, 1967) As a result, the Unconditionality of Regard subscale has sometimes been excluded in studies using the other three BLRI scales (Level of Regard, Empathic Understanding, and Congruence). Meanwhile, the “Unconditional” specifier has often been dropped from the label of “positive regard,” and clinical and research conceptualizations in recent decades have tended to focus more on the “positive regard” strand of Rogers’ operationalization than the “unconditionality” strand.

**Sparness of the literature**

The 2011 meta-analysis of quantitative studies on positive regard (Farber and Doolin) identified only 18 studies eligible for inclusion according to the following criteria: a) positive regard, or a synonym, such as unconditional regard, warmth, nonpossessive warmth, affirmation, or acceptance was identified as a variable of interest; b) it was used as a predictor of outcome; c) the study was quantitative and provided
statistics that could be used to calculate effect size; d) patients were adults or adolescents; and e) treatment was individual psychotherapy. While the meta-analysis found an overall effect size of $r = .27$ for positive regard on psychotherapy outcomes, suggesting that positive regard generally tended to be associated with favorable outcomes in treatment, the eligible studies dated from 1971 to 2006, with the majority published in the 1990s. As the authors noted: “positive regard has been studied primarily within the realm of client-centered therapy, an orientation that no longer attracts the attention of many prominent researchers” (p. 62). Though the term may appear less frequently in the psychotherapy research literature, the authors highlighted the trans-theoretical nature of positive regard, which has been “folded into newer concepts in the field, particularly measures of the therapeutic alliance” (p. 62). Also noted was the significant overlap between the construct of positive regard and other constructs constitutive of the working alliance, particularly empathy and understanding.

A revised meta-analysis by Farber and colleagues is currently in press. Acknowledging the dearth of positive regard-focused studies in the literature, the study adopted more expansive inclusion criteria, dropping the restrictions on child, family and group therapy, and allowing for the inclusion of studies that investigated positive regard as part of a “composite” factor, such as the Rogerian facilitative conditions. With an overall $k$ of 64, this meta-analysis was more comprehensive but yielded a smaller overall effect size for positive regard ($g = .28$). The authors suggested that this downgrade in computed effect size (from moderate to small) could be attributable to both the expanded inclusion criteria and to the methodological differences in meta-analytic approach. A multilevel random effects model that took into account the nesting of effects within
samples yielded a larger aggregate effect size ($g = .36$). No significant moderators of the relationship between positive regard and outcome were identified when all significant covariates were entered into a meta-regression model, suggesting that positive regard’s impact largely transcends diagnostic categories, treatment orientation and setting, client demographics, rating instrument and rater perspective, and more. Furthermore, the measurement of positive regard as a composite measure as opposed to a unitary construct did not have a differential effect, an unsurprising finding given the significant intercorrelations among the three facilitative conditions.

The existing research – tending to merge the three facilitative conditions into a broader construct representing the therapist’s general “facilitativeness” – has strengthened positive regard’s standing as an essential common factor in the psychotherapy relationship. However, this merging of constructs also leaves open the question about the differential impact of positive regard in comparison to the other facilitative conditions. Furthermore, it remains unclear which experiences and behaviors specifically promote clients’ experience of positive regard in therapy. In other words, when we refer to positive regard’s likely contribution to therapy outcomes, what behaviors and manifestations are we specifically referencing?

**Quantitative findings informing the proposed study**

**Psychotherapist Expressions of Positive Regard (PEPR).** A recent study (Suzuki & Farber, 2016) attempted to achieve a behavioral operationalization of positive regard. Therapy clients were asked to respond to an extensive inventory of possible therapist statements (e.g., “That was brave of you,” “I look forward to us talking about this some more,” and “You are handling this situation well”) and actions (e.g., “My
therapist laughs at a funny comment I make,” “My therapist summarizes what I have said accurately,” and “My therapist invites me to address her/him by her/his first name”), rating first how affirming it might feel for each to take place in their therapy, and next rating how likely each given statement or action would be, coming from their therapists. The data from responses to this inventory (PEPR) were subjected to a factor analysis, whose results suggested that positive regard (or “affirmation,” the term used in this study for its ability to be easily comprehensible to the general population), can be understood as consisting of a few distinct dimensions. The first factor, “Supportive and Caring Statements,” consisted of all 15 statements included in the inventory, with the most representative items being “I’m glad you shared that with me,” “This is a space for your own healing and growth,” and “That must have been very difficult.” The second factor, “Unique Responsiveness,” consisted of 11 therapist actions that suggest attentiveness and sensitivity to the patient’s history and needs, with the three highest-loading items being “My therapist summarizes what I have said accurately,” “My therapist remembers the name/details of someone or something I have discussed in the past,” and “My therapist offers me a new way of understanding a part of myself that I usually view as a weakness.” Finally, the third factor that emerged, “Intimacy/Disclosure,” included six therapist actions that represent extensions of the typical boundaries that exist in the therapeutic relationship, with the most characteristic items being “My therapist puts his/her hand on my shoulder,” “My therapist hugs me,” and “My therapist has tears in his/her eyes as I relate a sad story.”

The results of a multiple linear regression of the BLRI Level of Regard subscale on these three composite factor scores indicated a predictable positive relationship
between positive regard and Supportive and Caring Statements and Unique Responsiveness, when demographic and therapy variables were controlled for. In other words, higher reported likelihood of both supportive and caring statements and unique responsiveness behaviors predicted higher reported levels of positive regard. However, although the bivariate correlation between ratings of positive regard and Intimacy/Disclosure scores was also significantly positive, the results of the regression analysis revealed that scores on Intimacy/Disclosure negatively predicted ratings of positive regard. Thus, when other factors, including other modes of expression of positive regard were controlled for, the positive relationship between intimate and disclosing behaviors on the part of the therapist and client-rated positive regard became a negative relationship. Because two of the six items comprising this factor relate to physical contact with the therapist, it is likely that the items were suggestive to respondents of boundary violation issues in the therapy relationship.

Understandably, much of the literature on touch in psychotherapy relates to the elevated risk for sexual misconduct (e.g., Holroyd & Brodsky, 1980; Stake & Oliver, 1991). For theoretical and legal reasons, the emerging consensus among both therapists and clients seems to be that it is safer never to allow physical contact in therapy. However, other more moderate perspectives highlight the difference between boundary crossings, a neutral term referring to therapist actions that may be either constructive or destructive for the therapy, and boundary violations, harmful transgressions by the therapist. Whether interventions fall into one category or the other depends on a multitude of factors, including context, therapist intent, and patient phenomenology (Gutheil & Gabbard, 2014; Pope & Keith-Spiegel, 2008). Further along the spectrum
still, some clinician-researchers have argued for the affirmatively healing power of touch in the psychotherapy relationship (Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Smith, Clance, & Imes, 2001). Thus, the role of physical contact in psychotherapy remains highly disputed, but there is some reason to believe that under certain circumstances with certain patients, it may contribute positively to the perception of positive regard.¹

Two additional items comprising the third factor proposed by Suzuki and Farber (“My therapist has tears in his/her eyes as I relate a sad story,” and “My therapist reveals something personal about his/her life”) relate more closely to notions of therapist self-disclosure. A rich literature exists on this topic (e.g., Farber, 2006; Knox, Hess, Petersen, & Hill, 1997), containing mixed findings on the impact of therapist self-disclosure upon therapy (Henretty & Levitt, 2010). For example, Henretty and Levitt’s comprehensive review indicated no clear relationship between the presence of therapist self-disclosure and how the client viewed the level of expertise, trustworthiness, regard, and empathy of the therapist. Furthermore, mixed results were found depending on how self-disclosure was operationalized, with self-involving (thoughts and emotions about the client) disclosures generally yielding more favorable impressions than self-disclosing (extra-therapy information and experiences) disclosures. There were, however, consistent relationships found between therapist self-disclosure and outcomes such as the client’s liking the therapist more, client’s higher ratings of therapist’s interpersonal warmth, and client’s increased inclination to self-disclose. A qualitative approach to investigating the

¹It should be noted that two additional items comprising Suzuki and Farber’s Intimacy/Disclosure factor – “My therapist contacts me to see how I’m doing after a particularly emotional session,” and “My therapist notices something different about my appearance” – seem to belong in the category of non-physical boundary crossings.
nature of positive regard in psychotherapy may well help therapists understand how their boundary-extending and self-disclosing interventions may impact clients’ experience of positive regard.

**Need for “experience-near” studies of PR.** Henretty and Levitt’s (2010) conclusions about the state of the literature on therapist self-disclosure offer some useful perspectives to consider with regard to Suzuki and Farber’s (2016) proposed Intimacy/Disclosure factor, as well as the construct of positive regard more generally. The authors pointed out several problems with the existing research on self-disclosure in psychotherapy – among them, the concern that “multiple definitions of therapist self-disclosure render meaningful analysis of findings across studies difficult, if not impossible” (p. 69); the fact that therapy self-disclosure has typically been measured in terms of frequency, when in all likelihood it is a high-impact event that occurs at quite low frequency (Knox & Hill, 2003); the reality that much of the research is based on analogue methodology, rather than being “experience-near” (p. 70), and that many studies “failed to consider situational and contextual variables that may moderate and/or mediate” the impact of therapist self-disclosure (p. 70). All four of these concerns about the self-disclosure literature apply to positive regard. Unlike self-disclosure, however, the relatively sparse literature on positive regard offers the opportunity to establish a more secure foundation for future research by implementing methodologies that are open-ended – allowing for a synthesis of multiple possible definitions of positive regard – as well as experience-near and contextually sensitive. Another guiding principle – drawn from the literature on empathy but nonetheless relevant here – is the impression that “the relationship of the facilitative conditions to outcome is not strictly linear and somewhat
more complex than initially thought” (Watson, Greenberg & Lietaer, 2010, p.134). It is likely that the relationship between positive regard and outcome, as well as among Suzuki and Farber’s (2016) three proposed dimensions of positive regard and positive regard as operationalized by the BLRI, is not strictly linear, and that a full account of clients’ experiences of these variables will likely be quite complex and nuanced.

As noted above, many theorists and researchers believe that qualitative methods offer the most flexibility and depth for investigating the complex experiences and varied meanings of these psychotherapy process variables. Yet while a body of qualitative outcome studies has demonstrated the broad effectiveness of person-centered and experiential therapies (Timulak & Creaner, 2010), no targeted qualitative investigation of positive regard, a central component of these therapies, has yet been conducted from either the therapist or client perspective.

This study, then, represents the first qualitative investigation of positive regard in the psychotherapy relationship. Because of Rogers’ focus on how the facilitative conditions are received by clients, this study will focus exclusively on therapy clients’ perceptions of positive regard. Capturing the experience of positive regard in the voices of clients themselves seems particularly consonant with the values and traditions of humanistic, client-centered therapy.

**The Present Study**

Consistent with the purpose of “enriching research” (Stiles, 2015, p. 163) this study is focused on expanding and deepening an understanding of how positive regard is received and perceived by psychotherapy clients. This approach is aligned with Hill and colleagues’ (1997) dictum that “qualitative researchers do not begin with preconceived
hypotheses but seek to ‘discover’ them in the course of data collection and analysis” (p. 518). Thus, this study aims less to develop and test specific hypotheses and more to gain rich, “thick” (Morrow, 2005) data on client experiences related to positive regard. As such, the goal is to elicit data along the following lines:

**Question 1**: How prevalent, and how important, is the experience of PR in psychotherapy?

**Question 2**: How do therapists effectively communicate positive regard to their clients, and which therapist behaviors convey a lack of positive regard?

**Question 3**: What impact does therapists’ PR, or therapists’ failure to provide PR, have on clients’ experiences in therapy, on the course of therapy, and on therapy outcomes?

**Question 4**: How, and to what extent, do clients’ experiences with PR seem to shift or evolve over the course of the therapeutic relationship?

**Question 5**: To what extent do client or therapist demographic variables, or dyadic demographic variables, impact upon or relate to clients’ experience of positive regard?

**Question 6**: Do clients feel there can be such a thing as “too much PR?”

**Question 7**: What, if anything, do clients wish might be different about their experience of PR in therapy?

**Question 8**: Do clients experience PR more through their therapists’ explicit verbal statements, or more through non-verbal modes of communication?

**Question 9**: Do clients’ descriptions of PR appear to have any overlap with the Rogerian constructs of empathy and/or congruence?

**Question 10**: Do clients identify instances of therapist boundary extension, intimacy, and/or disclosure as having any impact on their perception of PR, whether positively or negatively?
Chapter 2: Method

Participants

Interview subjects were 15 psychotherapy clients living in the U.S. and Canada, drawn from an existing waitlist of participants from the original sample in the initial quantitative arm of this study (see Procedure). The original sample, recruited during the spring of 2014 via Craigslist postings for adults with current or previous therapy experience, was overwhelmingly female (81%), white (79%), and heterosexual (76%), and the final sample for this study reflected similar proportions on these variables, with 87% identifying as female, 87% self-reporting as white, and 67% endorsing heterosexual orientation. The mean age reported by the sample was 47.8 years (SD = 15), with a range from 27 to 72 years of age.

The data on all demographic variables collected on the interview subjects are reflected in Table 1. Briefly, the majority of the sample lived in an urban area (the plurality was from the northeastern US, though several other regions were represented), was unmarried, and had attained either a Bachelors or a Masters degree. Their reported household income varied widely, with six (40%) reporting annual income of less than $35,000 and two (13.3%) reporting income greater than $150,000. Regarding their lifetime experiences with therapy, six (40%) of participants had had between one and three current and former therapists, another six (40%) had had between four and ten therapists, and three (20%) reported having seen 11 or more therapists. The duration of treatment with their current therapist, who was the main focus of the interview, ranged considerably as well, from between six months to a year (26.7%) to more than five years (33.3%). The vast majority of clients saw their current therapists in a private practice.
A QUALITATIVE INVESTIGATION OF POSITIVE REGARD

Table 1
Participant Demographics (N = 15)

<table>
<thead>
<tr>
<th></th>
<th>n/mean</th>
<th>%/SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>47.8</td>
<td>15.02</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>86.6%</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td><strong>Race/ Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>13</td>
<td>86.7%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straight</td>
<td>9</td>
<td>60%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Residential Setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban/City</td>
<td>10</td>
<td>66.7%</td>
</tr>
<tr>
<td>Suburban</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>Rural/Country</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Partnered and Unmarried</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Married</td>
<td>5</td>
<td>33.3%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Annual Household Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $15,000</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td>$75,000 - $99,999</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>$100,000 - $149,999</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>$150,000 and over</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td><strong>Length of Therapy with Current Therapist</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>2 to 3 years</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>5</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Frequency of Sessions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less often than once a week</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Once a week</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Twice a week</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Number of Previous Therapists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>4-6</td>
<td>5</td>
<td>33.3%</td>
</tr>
<tr>
<td>7-10</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>11 or more</td>
<td>3</td>
<td>20%</td>
</tr>
</tbody>
</table>
setting (86.7%) and reported an even split between psychodynamic therapy and cognitive behavioral therapy (both 40%). By their report, their current therapists were also overwhelmingly female and white (both 93.3%), and the majority were estimated to be in their 50s or older (66.7%). All data on therapist and therapy variables are outlined in Table 2.

**Table 2**

*Therapist Demographics (N = 15)*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>93.3%</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Race/ Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>14</td>
<td>93.3%</td>
</tr>
<tr>
<td>Asian American</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Age Range</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>35-44</td>
<td>4</td>
<td>26.7%</td>
</tr>
<tr>
<td>45-54</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>55-64</td>
<td>7</td>
<td>46.7%</td>
</tr>
<tr>
<td>65 and over</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Therapy Setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>13</td>
<td>86.7%</td>
</tr>
<tr>
<td>Community Clinic/Hospital</td>
<td>2</td>
<td>13.3%</td>
</tr>
<tr>
<td><strong>Type of Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic/Psychoanalysis</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Humanistic/Existential</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>Other (includes talk therapy and Eclectic)</td>
<td>2</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

*Note.* Therapist and therapy characteristics as reported/estimated by clients.

Hill and colleagues (1997, 2005) suggest that CQR participants be randomly selected from a homogenous population of participants who are very knowledgeable about the phenomenon under investigation. Because the construct under study is a common factor within the psychotherapy relationship, all psychotherapy clients with
sufficient experience (at least six months of treatment with one provider) were deemed knowledgeable about the phenomenon. The clients and therapists included in the present sample were both predominantly white and female, not unlike some estimates available for these two populations in the United States (APA Center for Workforce Studies, 2015; Harris Interactive, 2004). However, the relative heterogeneity present in this sample when it came to age, education, income, treatment duration, and therapy orientation helped ensure that many possible viewpoints and experiences with positive regard in psychotherapy would be represented.

**Procedure**

**Recruitment.** When completing the online questionnaires in the spring of 2014, respondents in the original sample were invited to provide their e-mail addresses if they were interested in being contacted for a follow-up phase of the study. These addresses were not linked to their data. All respondents who indicated interest at that time (about 150 of the original participants) received a follow-up e-mail during the winter of 2015, with an invitation “to participate in a phone interview to tell us more about your experience in psychotherapy, with a particular focus on ways in which your therapist has provided or could better provide affirmation and support in the course of your relationship.” 19 people responded to confirm continued interest in participating in the qualitative study. Of these prospective participants, 18 elected to move forward after completing the consent process and a confidential online questionnaire eliciting the sociodemographic information discussed above (see Appendix B), and two (both living in Europe) were excluded due to the technological complications associated with audiotaping overseas phone calls. Interviews were therefore conducted with sixteen
participants, one of whom the research team decided by consensus to exclude after the fact, because during the interview it became clear that she was describing therapeutic aspects of her relationship with her primary care provider and was not in psychotherapeutic treatment. This decision yielded the final sample of fifteen.

All phone interviews were conducted by the author, an advanced doctoral student in clinical psychology with training in clinical interview and alliance building in the psychotherapy setting. The phone interviews were audio-recorded and both transcribed and checked by members of the author’s research team (see Research Team), all graduate students in Clinical Psychology.

**Interview.** The primary data-gathering instrument used in this study was a semi-structured interview, which was administered over the phone to ensure the inclusion of participants not within commuting distance (see Appendix A). Hill and colleagues (2005), in reviewing the corpus of CQR studies, suggested that telephone interviews were comparable, if not “somewhat preferable,” to face-to-face interviews when conducted by “skilled interviewers” (p. 9), particularly if the subject matter was sensitive, because they afforded the interviewee a greater feeling of privacy and confidentiality. The semi-structured interview protocol, designed with the principles of CQR in mind, consisted of open-ended questions that invited participants to provide thorough accounts of their own experience, as well as potential follow-up prompts for the interviewer to help clarify and elaborate upon participants’ experience. The standardized interview reflected a post-positivist orientation towards data collection in its assumption that the interviewer could “discover” meaningful truths about respondents’ experience; however, it incorporated a constructivist sensibility as well through its flexibility, its focus on the interviewee’s
subjective experience (Ponterotto, 2010), and its acknowledgment that the biases of the research team likely would influence every step of the data-gathering process (Hill et al., 2005). Approval of the interview protocol, the sociodemographic questionnaire, and the consent form (see Appendix C) was obtained from the Teachers College IRB.

The interview, about 45 minutes in length, begins with a description of positive regard as “a feeling you get from your therapist that s/he likes you, accepts you, respects you, and/or has genuine interest in you” and goes on to refer to it as a “warm, caring feeling.” This definition is a composite of the multiplicity of ways in which positive regard has been described in the research and theoretical literature and is particularly influenced by Eckert and colleagues’ (1988) four-part definition of positive regard (warmth, respect, acceptance, and interest). Keeping Eckert and colleagues’ findings in mind, the interview deliberately offers multiple ways of understanding the construct under study, and the interviewer was vigilant to apparent attempts by participants to distinguish among these different descriptors.

The remainder of the interview aims to glean as complete an understanding as possible about clients’ experiences, thoughts, and feelings related to positive regard in psychotherapy, including asking for examples of situations in which they experienced positive regard, asking for times when they experienced a lack of it, and seeking to understand how the experience of positive regard might be affected by factors such as the duration of the treatment and socio-demographic characteristics of the patient, the therapist, and the dyad. The interview also asks clients how their experience of positive regard might be optimized in their therapy and asks them to weigh in on the question of whether “too much” positive regard could be an issue in therapy.
A QUALITATIVE INVESTIGATION OF POSITIVE REGARD

Research team. Two research teams involved in this study performed different tasks: the first team was involved in designing the study methodology by investigating a variety of qualitative methods and ultimately designing, piloting, and finalizing the semi-structured interview protocol in a manner consistent with CQR, whereas the second team (henceforth referred to as “the research team”) was involved in the data analysis following CQR protocol as described below. Three team members were involved in both phases: the principal investigator, an advanced female doctoral student in clinical psychology with several years of clinical experience, who identified as biracial (Asian and white); a female masters-level student in counseling psychology who identified as biracial (white and South Asian); and a male masters-level student in clinical psychology who identified as Asian-American. These latter two team members participated in the first phase of data analysis, developing and coding domains, only; their involvement with the project ended by necessity when they began their own doctoral training programs in other states. The remaining three members of the second team – three white females, two of whom were masters-level students in clinical psychology and one of whom was a masters-level student (and later a graduate) in counseling psychology – participated in all phases of the data analysis process.

Because all members of the team were new to CQR, each member actively engaged in a training process to gain familiarity with the ethos, practices, and objectives of CQR. Team members read and discussed the guidelines provided by Hill and colleagues (1997) on CQR, as well as their updated guidelines (2005); they referred back to these guidelines, also reviewing exemplar studies, at the start of each new phase of data analysis. Additionally, oversight and feedback were provided at several stages by a
A QUALITATIVE INVESTIGATION OF POSITIVE REGARD

faculty member with specific expertise in CQR, and by an external auditor. Hill and colleagues (2005) summarized the role of the auditor as follows: “To check whether the raw material is in the correct domain, that all important material has been faithfully represented in the core ideas, that the wording of the core ideas succinctly captures the essence of the raw data, and that the cross-analysis elegantly and faithfully represents the data” (p. 15). The external auditor, a white, male, advanced doctoral student in clinical psychology with extensive clinical experience and in-depth experience with CQR methodology and psychotherapy process research, reviewed the findings during all three phases of the analysis. Feedback was discussed with the research team, and modifications and additional follow-ups were discussed to consensus with the auditor.

At the outset, the research team engaged in an inquiry process regarding their pre-existing expectations about the construct under study. This approach is recommended to raise awareness of how the team’s biases might color their interpretations of the data (Hill et al., 1997). As a whole, the team expected that respondents would report having experienced positive regard to some degree at least, and that it would manifest as general feelings of empathy, acceptance, trust and respect. A broad description of positive regard was used as a prompt during the interview, to avoid reinforcing the team’s bias towards seeing the other facilitative conditions (empathy and genuineness) as integrally related to positive regard. Most members of the team thought that respondents would say that their therapist provided moderate to high levels of positive regard frequently during therapy. The research team was also prepared for the possibility that participants would hesitate to describe instances where they felt a lack of positive regard for fear of being critical or disloyal to their therapists. With this in mind, the interview aimed to present
positive regard as neutrally as possible, conveying at the outset that this might be a very meaningful feature of some therapy relationships, and it might play a minimal role in others. Nonetheless, team members clearly held a bias that positive regard was a crucial feature in therapy that they felt was likely to be highly valued by most therapy clients, though they were also open to the possibility that some respondents would prefer a more neutral therapeutic relationship.

Because the interview was designed to elicit specific behavioral manifestations of positive regard, the team expected that participants would be able to cite specific examples (both verbal and nonverbal) of such expressions from their therapists, though the expectation was that positive regard would be most typically described as embodied in a general feeling rather than any single act. Finally, the principal investigator reported feeling particularly motivated, given the Intimacy/Disclosure findings by Suzuki and Farber (2016), to understand more about the relationship between boundary extensions and positive regard. Using feedback from a faculty mentor with CQR expertise, an open-ended question was designed to raise confidence in the validity of any findings in this area. The question asked clients if their therapists had ever done anything “unusual or surprising” that conveyed a sense of positive regard, so as not to prime participants to answer about boundaries or touch unless such content was indeed highly relevant to their experience of positive regard.

All team members, regardless of their varying levels of clinical experience, had a high level of interest in psychotherapy process generally and the principles of client-centered therapy specifically. Because the success of CQR depends on an environment in which team members feel equally comfortable expressing differences of opinion and in
which true consensus can be reached (Hill et al., 1997), the author actively engaged the team in consideration of how her role, as principal investigator and the only doctoral student on the team, might impact the consensus process. The team endeavored to create an environment in which different views were respected and fostered an appreciation for the time-consuming nature of the consensus-building process, when disagreements arose.

**Data analysis.** Following the CQR template laid out by Hill and colleagues (1997, 2005), data analysis took place in three phases – domain coding, abstraction of core ideas, and identification of trends across cases via cross analysis. The hallmark of CQR is consensus, arrived at with all members of the research team reviewing the data and offering multiple perspectives, which are discussed until consensus on the most apt reading of the text is reached. This process is used across all three phases of data analysis. The *domain coding* phase involved the identification of topics or domains within an individual case (e.g., interview) that facilitated the grouping or clustering of data. This was an iterative process, with each member of the research team first working individually to code the content of a given interview into domains of their own devising, and then meeting to discuss the domain names, scopes, and specific codes to consensus. While some of the domains were derived directly from the questions in the interview (e.g., the content offered in response to Question 1 in the semi-structured interview fell under Domain 1), others over time were merged or divided as dictated by the content that emerged. Over the course of coding the first four interviews, the list of domains was further honed and clarified until a nearly-final set of domains had been devised (though a few modifications were made retroactively as the analysis continued and more parsimonious solutions were identified). Once the auditor had provided feedback on the
scope and content of the domains, the domains were finalized and all content related to each domain within a given transcript was grouped together, in preparation for the second phase of analysis.

The core ideas phase entailed distilling interviewees’ statements into brief paraphrases that remained close to their original meaning. During this stage, team members endeavored to capture the respondents’ words and sentiments as accurately as possible without inserting their own inference or interpretations. Again, team members worked individually to generate their own summaries of what each participant had said regarding each domain; this individual work was then discussed to consensus. The auditor reviewed this work and provided feedback on the level of accuracy and thoroughness of the core ideas.

Finally, the cross analysis allowed for a higher level of abstraction by identifying categories and themes that connected core ideas across cases. This process was more interpretive, with team members seeking to combine ideas across cases in a manner that was thematically faithful while also maximizing parsimony. The team identified themes or categories that emerged within each domain and discussed the most appropriate phrasing for the names of these themes that would capture the content faithfully. The use of frequency labels – *General* (all or all but one of the participants), *Typical* (at least half of the participants up to the cut off for General), *Variant* (more than three participants up to the cutoff for General), and *Rare* (two to three cases in a sample of 15 or more) – allowed for quantifying the prevalence of each of these themes across the sample (Hill et al., 2005). Feedback from the external auditor was crucial for making sure the categories...
were comprehensible and for enhancing the parsimony of the cross analysis (e.g., combining themes to increase their representativeness across the sample).
Chapter 3: Results

The data analysis yielded nine domains, with a range of three to 11 themes, or categories (henceforth used interchangeably), characterizing each of the domains. The findings with frequency labels are summarized in Table 3. The findings in each domain are outlined below, with the names of the themes highlighted in italics. For this sample of 15 participants, the frequency labels are defined as follows: General refers to a category endorsed by 14 or 15 participants, Typical signifies that between eight and 13 participants reported a given theme, and Variant themes had relevance to four to seven participants. Rare categories were endorsed by two or three participants only, are excluded from the table, and are discussed below only when they are of special interest.

Table 3
Cross-Analysis: Client Perceptions of Positive Regard in Psychotherapy

<table>
<thead>
<tr>
<th>Domains</th>
<th>Themes/Categories</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Presence and relevance of PR in treatment</td>
<td>PR present in current relationship</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>PR absent in previous treatment</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>PR is very important to therapy</td>
<td>Typical</td>
</tr>
<tr>
<td>2. Therapist behaviors that convey PR</td>
<td>Nonverbal expressions</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Authenticity and self-disclosure</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Explicit affirmation, reassurance, or positive feedback</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Emotional engagement</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Directiveness</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Nondirectiveness and acceptance of feelings/experiences</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Perspective taking and shifting</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Balancing support and challenge</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Warm and comfortable demeanor</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Flexibility around professional boundaries</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Behavior that differs from other Ts’ habits</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Hugging promotes/would promote PR</td>
<td>Variant</td>
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(continued)
### Table 3 Continued

<table>
<thead>
<tr>
<th>Domains</th>
<th>Themes/Categories</th>
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<td>3. Impact of PR experiences</td>
<td><strong>Combative/judgmental communication</strong></td>
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<tr>
<td></td>
<td>Not believing/understanding</td>
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<td></td>
<td>Excessive boundary-crossing</td>
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<tr>
<td></td>
<td><strong>Strengthens therapeutic relationship</strong></td>
<td>General</td>
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<td></td>
<td>Facilitates personal growth</td>
<td>Typical</td>
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<td></td>
<td>Improves self-esteem and positively impacts</td>
<td>Typical</td>
</tr>
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<td></td>
<td>Social functioning outside therapy</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Buffers against therapeutic ruptures and keeps C coming back</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Feels surprising to C</td>
<td>Variant</td>
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<td>5. Impact of lack of PR experiences</td>
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<td>General</td>
</tr>
<tr>
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<td>C shuts down/therapy less productive</td>
<td>Typical</td>
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<td></td>
<td>Severe consequences for C</td>
<td>Variant</td>
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<td>6. Changes in PR over time</td>
<td>PR increases over time</td>
<td>Typical</td>
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<tr>
<td></td>
<td>PR remains consistent over time</td>
<td>Variant</td>
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<td></td>
<td>Initial PR foundation facilitates greater comfort/trust</td>
<td>Variant</td>
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<td></td>
<td>PR feels more substantial over time</td>
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<td>7. Impact of C/T demographics and therapy variables on PR</td>
<td>Easier to receive PR from female T</td>
<td>Typical</td>
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<tr>
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<td>Older/experienced T conveys PR more effectively</td>
<td>Typical</td>
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<tr>
<td></td>
<td>Age match promotes PR</td>
<td>Variant</td>
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<tr>
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<td>Race/ethnicity does not impact PR</td>
<td>Variant</td>
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<td></td>
<td>Sexual orientation does not impact PR</td>
<td>Variant</td>
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<tr>
<td>8. Suggestions for how to optimize PR</td>
<td>Be attentive and responsive to client as an individual</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Be transparent and communicative</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Take a caring, nonjudgmental stance</td>
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</tr>
<tr>
<td>9. Essential features of the experience of PR</td>
<td>Feeling safe to open up</td>
<td>Typical</td>
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<td></td>
<td>Real relationship/mutuality</td>
<td>Typical</td>
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<tr>
<td></td>
<td>Feeling liked and esteemed</td>
<td>Typical</td>
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<tr>
<td></td>
<td>Understanding, empathy and acceptance</td>
<td>Typical</td>
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<tr>
<td></td>
<td>Therapeutic presence</td>
<td>Variant</td>
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*Note.* N=15. General = category applied to 14 or more cases; Typical = category applied to 8-13 cases; Variant = category applied to 4-7 cases. Rare categories (represented by fewer than 4 cases) excluded from table. PR = positive regard, C = client, T = therapist.
Domain 1: Presence and Relevance of Positive Regard in Treatment

The first domain emerged from participants’ responses to the question of whether, and the extent to which, positive regard was relevant to their experience in psychotherapy. The general theme was that PR was present in the current treatment; in other words, fourteen out of fifteen respondents stated that the therapist they were currently seeing provided them with an active and steady experience of positive regard. Participants typically described positive regard as very important to therapy. In the words of one participant, “it is a critical piece of my therapy, and has made a big difference for me.” Nonetheless, a typical experience was that positive regard had been absent in previous treatment, with many of the participants who endorsed positive regard in their most recent relationship saying that they had had one or more therapists in the past who conveyed positive regard rarely, if at all. Of note, only two participants characterized positive regard as a rare experience across the entirety of their therapy experience; but one of these two, who had an extensive history of psychiatric hospitalization, stated this in the strongest possible terms: “I have only truly felt positive regard from one therapist out of hundreds, and that was about ten years ago.”

Domain 2: Therapist Behaviors that Convey Positive Regard

The interview request to recall instances of therapist behavior that conveyed positive regard invited a broad range of responses, and as such this domain was the most sprawling in nature, encompassing eleven categories with substantial frequencies.

General themes. Participants identified a wide range of therapist behaviors and actions that added to their feeling of positive regard in the psychotherapy relationship, but two themes earned the designation of General within the sample. First, clients mentioned
nonverbal expressions as playing a significant role in their perceptions of positive regard. As might be expected, this theme included body posture, facial expressions, and tone of voice: as one participant said, “I suspect that I don’t experience as much positive regard when I’m on the phone with my therapist because I cannot see her face.” The nonverbal category also covered acts of advocacy and other significant gestures on the client’s behalf. One respondent offered the example of her therapist “trying to get in touch with me and conduct a session when I was admitted to the behavioral health unit,” while another recalled that her therapist “on multiple occasions fought with my insurance company for better mental health coverage; she goes above and beyond.”

The therapist’s authenticity and self-disclosure were also cited as common signifiers of positive regard in the therapy relationship. Instances of authenticity included the use of emotional self-disclosure and unflinching honesty, “telling it like it is without beating around the bush,” as one participant put it; other participants mentioned deriving a sense of positive regard from therapist communications that “show that he is human.” Most participants who mentioned self-disclosure of the therapist’s personal information specified in one way or another the importance of context, in that the therapist’s self-disclosures were experienced as positively regarding when they were “relevant to the therapy.” A few placed no such restrictions on the nature of therapist self-disclosure, deriving a strong sense of positive regard when they were privy to information about a therapist’s life transition (e.g., having a baby, loss of a spouse) and were able to offer support to their therapist.

Typical themes. Seven categories of therapist interventions earned the Typical frequency designation for their ability to convey positive regard. Explicit affirmation,
reassurance, or positive feedback was cited by 11 participants. According to one participant, her therapist’s “stating directly that she likes and cares about me” is an effective way of communicating positive regard. Another said, “I was going through a tough time and was feeling very depressed, and I felt like my therapist was always encouraging; she was positive always. As I was putting myself down she would counteract that.” Another frequently cited theme was the therapist’s emotional engagement in the therapy relationship, which included therapist attentiveness and presence during session, such as “keeping track of everything I have said from week to week” or “refraining from taking notes while I am talking.” Emotional engagement was also indicated by a sense of mutuality in the therapy relationship, as when one therapist “asked for my input on her professional website design, showing she valued my opinion” or when another therapist said “she was inspired by me, and she enjoys our conversations.”

Two categories of therapist behavior that were seemingly opposite in meaning both emerged as typical in the sample: directiveness and nondirectiveness and acceptance of feelings and experiences. On the one hand, participants reported that a therapist’s active stance could serve to foster a feeling of positive regard, for example “gently helping me reorient to what I need when I get off track in session.” Nonetheless, many of the same clients found that an open, accepting stance towards whatever might arise in session to be crucial to their experience of positive regard. One participant whose therapy includes EMDR explained, “EMDR requires a lot of me, and some days I can’t even get there but she’s like, ‘It’s all okay.’ She could say, ‘You need to be concentrating more,’ but she just starts over and says, ‘Let’s try again.’ And then on days when I just
can’t focus [on the EMDR] she’ll just change the session and say, ‘This isn’t going to work today.’ So she’s willing to change her agenda.” Another reflected on her therapist’s nondirective stance towards her past trauma: “My therapist provided positive regard by reassuring me that it didn’t make me a bad person, but she also allowed me to get to my own truth, rather than her interpretation of what happened.”

Interventions around *perspective taking and shifting* were also typically seen by participants as promoting positive regard. In instances of perspective taking, the therapist conveyed empathic understanding of the client’s experience: according to one participant, “she expressed understanding of me as a unique individual”; another participant said his therapist’s willingness to “adopt the mystical language that corresponds to my inner world and imagination, and to really seem to get it” felt like a powerful demonstration of positive regard. Regarding perspective shifting, clients reported that therapists’ ability to offer their own perspective as a helpful corrective or alternative to something they were struggling with often enhanced their feeling of positive regard in the relationship. For example, one respondent said she enjoys the fact that she and her therapist can laugh together about many things, but also that her therapist is “able to question when sometimes things aren’t so funny; she acts as my conscience.”

Relatedly, a large number of respondents voiced the sense that they experienced positive regard when their therapist was able to *create a balance between support and challenge*. This typical theme emerged in response to an interview question about whether participants had ever experienced or could imagine experiencing too much positive regard in therapy, to which respondents consistently responded that moderation was a key component in the delivery of positive regard. Some participants answered in
the hypothetical, since they themselves had never experienced an excess of positive regard: “I don’t think I’ve ever felt too much, but I feel like too much might not be beneficial to the relationship. It would feel kinda false or not genuine....It wouldn’t feel like a normal relationship you know. You want to be positive but realistic.” Respondents who had directly experienced the phenomenon reported a similar reaction: “I have had other therapists that I thought, ‘Oh, get off it; you’re being too gushy.’ I’ve never felt that way from [my current therapist]. She’s very mindful and she doesn’t do anything haphazardly…She doesn’t say things just to say something.” Clients shared the sentiment that sincere and accurate feedback from their therapists felt more positively regarding because it showed faith in their ability to handle feedback. As one client reflected, “In a sense being pointed out if something I’m doing is problematic, that’s also a form of respect for both what I can do, and what I can’t do. Possibly there is such a thing as too much [positive regard]… if it’s not based in reality.”

The therapist’s warm and comfortable demeanor was also a typical signifier of positive regard according to clients in the sample. Informality (“not being overly focused on paperwork or treatment planning”), frequent smiling, and use of humor were cited frequently within this theme. “She jokes with me, makes fun of me in a playful way,” one participant explained. Finally, participants typically saw the therapist’s flexibility around professional boundaries as reflecting their therapists’ positive regard. Hugging, cited as an indication of therapist flexibility with regard to role, was mentioned by several participants and is discussed as a separate, variant theme below. Additional indications of flexibility around boundaries included a relaxed approach to the therapeutic frame (“not being too strict about the session ending time”), availability over e-mail, and willingness
to reschedule if a client’s circumstances dictated the need. As one client reflected, “when she makes exceptions it shows that she is not trapped in her role.”

**Variant themes.** Two categories of therapist behavior that contributed to clients’ impressions of positive regard occurred with variant frequency in the sample. The first finding was that *behavior that differs from other therapists’ habits* was experienced as positively regarding. While some of the examples offered overlapped with other themes, such as flexibility around boundaries and self-disclosure, others seemed specifically to derive from the fact that the clients had never experienced the behavior before in a therapeutic context: for example, one participant “was pleasantly surprised to discover that my most recent therapist listens without writing in a notebook. All of my other therapists would take notes.” The second theme reflected clients’ thoughts that *hugging promotes or would promote positive regard* in the therapy relationship. According to one patient, “giving me a hug afterwards became routine and it always really helped,” and a few other participants reported isolated instances of hugging their therapists that promoted positive regard. Even patients who had never hugged a therapist, though, reported feeling preoccupied by the question of whether hugging could be appropriate. One client reflected, “It feels weird to have a close long-term relationship with someone where you absolutely can’t touch them. And I can’t ask because I’m too scared of rejection.”

**Rare theme.** An additional topic, thematically related to the abovementioned theme of flexibility around professional boundaries, was distinct and dramatic enough to merit its own mention. A rare subset of respondents offered examples in which their therapists were engaged in *dual role relationships* with them (e.g., attending the client’s
wedding, asking the client to babysit). In these cases, the respondents described the naturalness with which the therapist moved between these roles to be a source of positive regard. The most striking example of a dual role relationship was offered by a client who invited her therapist to take a vacation with her, expecting that it would be grist for the mill and nothing more: “After almost a year of talking about it, she went on the bike tour with me…We were both very aware of that it was outside the lines and that it could be easily misinterpreted, but decided that we both had enough integrity to do this and have it not be a fiasco, and it really wasn’t. It has enriched the therapy in so many ways, and I know I’m still her patient.”

**Domain 3: Therapist Behaviors that Convey a Lack of Positive Regard**

Participants provided examples of instances where they perceived a lack of positive regard in therapy, and this content clustered into a smaller set of categories, with only five representative themes emerging. Two of these themes were typical within the sample. The first of these was that *being unresponsive to the client, his or her needs, and his or her sensitivities* was experienced as a failure to show positive regard. Participants inferred unresponsiveness from a variety of behaviors such as note-taking, appearing distracted, and silence from the therapist. Another common example that characterized this theme was feeling that the therapist was not giving due consideration to areas that clients considered hot buttons, as with one participant’s example: “My therapist suddenly decided to cut down the frequency of our sessions because she thought I was doing fine and she was out of town more frequently. But she never talked to me about it. She kept telling me that our therapy wasn’t going to end, but she never really explained what was happening or for how long, and it brought up a lot of the abandonment fears related to
how things ended with my last therapist.” For other participants, unresponsiveness emerged following specific client feedback: “The part of the country where I grew up, we talk slower, and my therapist is from a part of the country where they talk very fast, so I literally could not understand what she was saying. Whenever I asked her to slow down she would for a little bit but then she’d go right back to the same pace.” The second typical category of therapist unresponsiveness was maintaining rigid boundaries. This theme included therapist behavior related to self-disclosure. As one participant recalled, “Once I asked my therapist if she was going to have another baby, and she was really caught off guard and just didn’t want to answer me. I want my therapist to be comfortable, and I don’t ever want anything I say to catch them off guard, so if she could’ve responded in a not-surprised way, it would have been better for me. Otherwise it feels like I have to watch what I say to not make her uncomfortable.” Rigidity also emerged in overly directive or hierarchical behavior from the therapist. One client recalled: “My previous therapist was very structured and very homework driven and almost to the point of legalistic. If I came in and didn’t have my homework done I really felt chastised, or if I was struggling in a certain area and really needed to talk about it, I could tell that she already had an agenda.”

Three variant categories of therapist behavior were described by participants as conveying a lack of positive regard. The first of these, endorsed by six participants, was combative or judgmental communication, with several participants placing a premium on the tone of voice their therapists used in these moments: “I really felt barked at – the attitude and the feeling were accusatory. It was the complete opposite of feeling positive regard.” Other examples related to specific areas in which clients felt judged by their
therapists, as with one client who is diabetic, who reported: “I specifically recall a session where she said to me she knows this person who’s diabetic and who eats candy and eats sweets and she’s fooling herself. Well, you know, I do that, and I was doing that.” The feeling that the therapist was not believing or understanding the client was a second variant theme under this domain, with examples provided by five participants. One participant cited an example of his therapist’s telling him, “Oh, you’re delusional, things like that don’t happen in real life.’ Not understanding, telling me my situation is impossible, or can’t be true.” Furthermore, two clients with sexual minority identifications (one bisexual and one asexual) referenced their therapists’ refusal to believe their stated sexual orientation. Finally, five participants endorsed the finding that excessive boundary crossing by the therapist can be experienced as a lack of positive regard. Most of the examples provided involved inappropriate intrusion by the therapist, including excessive disclosure of the therapist’s personal information, such that “the relationship shifted to where I was listening to her problems. There got to be some boundary issues. And I was like, why am I paying you because we’re talking about you.”

One client described the difficulty of ending treatment with an overly involved therapist: “In a way, she wouldn’t let me go. I saw her for a long time, and I think she was too involved in her part to want to terminate.” Two respondents specifically cited sexual themes as constituting the nature of the boundary violation.

**Domain 4: Impact of Positive Regard Experiences**

Respondents frequently and spontaneously reflected on the impact of their therapist’s expressions of positive regard – on them, on the broader therapy situation, and on their overall functioning. The general theme, endorsed by all 15 members of the
sample, was that positive regard *strengthens the therapeutic relationship*. Participants emphasized the role of positive regard in building a sense of ongoing connection and collaboration in therapy, highlighting the sense of trust, safety, or honesty engendered by their experience of positive regard. One client recalled reacting to a striking display of positive regard from her therapist: “I thought, wow, she was committed to really being there in this relationship, and that meant a lot.”

Therapist positive regard was commonly perceived to have a material impact on promoting client change as well. In this sample, it was typical for participants to report that positive regard from their therapist both *facilitated personal growth* and *improved self-esteem and social functioning outside of therapy*. With regard to the theme of personal growth, clients reported greater ease with self-disclosure, self-exploration, and insight within the therapy setting. As one participant explained, “It makes it feel like I can say some of the irrational things I’m thinking or worrying about and not worrying that I’m damaging my relationship with her because I know she likes me from the rapport we have built up.” Another reflected that the increased openness she feels thanks to her therapist’s positive regard is “really what helps me in the relationship between us so that I can actually get better. Because I’m actually able to go in there and talk.” With regard to functioning outside of therapy, more than half the participants cited examples of how their therapists’ positive regard increased their confidence in themselves and empowered them to make changes in their lives outside of therapy. One participant cited a change in her interpersonal functioning: “It’s because of this support that I get that I’m able to feel good around other people, and carry the negativity I struggle with. I’m not as needy as I was when I was younger.” Another credited a positive career move to her experience of
positive regard in therapy, saying, “I became a social worker because of my work with her. I built up my life again. And that’s mainly because I’ve built up my trust of people through her trust in me.”

Participants also typically reported that positive regard buffers against therapeutic ruptures and keeps them coming back to therapy. Several respondents made reference to the concept of a “foundation of positive regard” that allowed them to have confidence in the overall strength and value of the relationship. As one put it, “Even if the session doesn’t have a lot of progress in it, positive regard is maybe what keeps me in it. Like I walk away and think, ‘Well, it’s still cool, I like talking to her and maybe we didn’t make any progress today but in the grand scheme of things, our therapy relationship is still great.’” This sense of durability is particularly important during therapeutic rupture. One client reflected on her response to a perceived slight from her therapist: “I had had six months of a foundation of positive regard, so I was able to address the issue. The foundation of positive regard helps me be clear and calm, unlike with other therapists where I haven’t felt the positive regard and I’ve been much more combative or had a vehement tone when I’ve told them there was a problem.”

Finally, one variant theme related to the impact of positive regard emerged in some interviews: four participants reported feeling surprised in response to their therapists’ expressions of positive regard. “I think just because my previous therapy situations have been not so positive, it just surprises me every time,” one client said.

**Domain 5: Impact of Lack of Positive Regard Experiences**

Participants identified three consequences of experiencing a lack of positive regard in therapy. The first finding, which was general in the sample, was that a lack of
positive regard caused the participant to feel upset or rejected. Respondents reported feelings including general discomfort and awkwardness, a sense of being “dismissed,” “ignored,” “frustrated,” “invalidated,” “fearful,” “wounded,” and “judged.” While the depth of the negative or vulnerable feeling varied by participant, all seemed to agree that experiencing a lack of positive regard in therapy was harmful in some way. A typical finding, endorsed by twelve participants in the sample, was that these negative feelings cause them to shut down and reduce productivity in the session. As one participant explained, “There’s a sense of, ‘why am I even talking to this person. They’re gonna be dismissive. There’s no place for what I’m saying to land.’” Another client recalled a previous therapist who rarely demonstrated positive regard, “I don’t even remember what her face looks like because she didn’t make enough eye contact with me, and I spent most of my time looking out the window.” For several respondents, this disengagement led to the discontinuation of treatment. Of note, only two participants reported ever raising the issue with their therapists and achieving productive resolution of these ruptures.

Finally, a variant theme suggested that beyond the negative impacts described above, a lack of positive regard in therapy can create severe consequences for the client. Participants reported that the negative feelings that accompanied the failure of a therapist to provide positive regard could often compound their existing problems in ways that felt catastrophic to them. One participant stated, “I really tried to stick it out, but I got to the point that it was really making me worse instead of better”; another put it more bluntly: “I needed therapy for my therapy.” Others reported real-world consequences that they attributed to a therapist action that they viewed as signaling a lack of positive regard. According to one participant, her counselor’s refusal to write a letter so that she could
move out of an unsafe housing situation resulted in her “having to be hospitalized, because the situation I was in was so dangerous.”

**Domain 6: Changes in Positive Regard Over Time**

During the interview, participants were asked to reflect on how, if at all, their experience of positive regard had shifted or changed over the course of therapy. The perception that *positive regard increases over the course of therapy* was typical in the sample. One said, simply, “The positive regard is very strong now. And I think it probably took several years to develop.” For some, the perception of such an increase seemed to be related to an inability to fully trust in their therapist’s positive regard at the outset of treatment. As one participant reported: “For the first several months, I waited for her to change and she didn’t, so now instead of expecting her to change and treat me different, I just have an ability to accept that she may be for real.” A second perspective, that *positive regard remains consistent over time* in the therapy relationship, gained nearly as many endorsements and narrowly missed the cutoff for typical frequency. For the participants reporting this perspective, positive regard has been a constant feature of the therapy relationship. “The way she expresses it is pretty similar now to what it was when we first started our sessions. She says similar things,” one client explained. This consistency, another respondent indicated, is therapeutic: “He’s exactly the same every single week, and I do feel more comfortable with him.”

Two additional variant categories offered a more phenomenological understanding of the shifts in of positive regard over the course of the therapy relationship. The first of these pertained to the idea of “foundational positive regard” referenced above, with nearly half of the sample stating that *an initial foundation of*
positive regard facilitates greater comfort and trust in the therapy relationship over time.

One participant reported a shift in the nature of the positive regard offered by her therapist: “At the beginning when she was trying to get to know me as her patient she didn’t seem as comfortable. She had a level of attentiveness that was more intensely directed at me than it is now, where she curls up in her chair and we’re like two friends hanging out. Now it’s more supporting, like keeping up a level of support, versus building up the rapport at the beginning.” Other participants reported a qualitative shift whereby their experience of positive regard feels more substantial as the therapy progresses. One reflected: “It goes deeper now. She’s actually hearing what I’m saying and taking it in and responding to me. At the beginning it was very much the nonverbal, which laid a foundation for me to open up about stuff. And then later when problems came up and she could acknowledge her misattunement to me, that was taking it to a deeper level.” Another respondent reflected that her growth process seemed to reveal an enriched experience of her therapist’s positive regard: “As I separate from her as I get more comfortable in myself, I feel that I less have to use her way of doing things as a model, and it’s okay, a healthy separation. I am still confident in her positive regard and also my own self-regard, due to a good feeling about myself.”

Domain 7: Impact of Client and Therapist Demographics and Therapy Variables on Positive Regard

Interview participants were invited to reflect on whether demographic characteristics in themselves, their therapists, or within the dyad had any bearing on their experience of positive regard. While the specific characteristics of age, gender, sexual orientation, and race/ethnicity were included in the interview prompt, participants
A QUALITATIVE INVESTIGATION OF POSITIVE REGARD

additionally mentioned a variety of characteristics, including socioeconomic status, marital status, and religion when reflecting on this question. Although the sample was sociodemographically diverse along certain lines (e.g., income, sexual orientation), it should be emphasized that the sample consisted almost exclusively of white women. With this in mind, the results are best understood as capturing the perspectives of white women on the relevance of demographic factors for positive regard. For the most part, participants’ views on which sociodemographic characteristics had relevance for positive regard were fairly idiosyncratic, leading to smaller cell sizes and a large number of rare response categories in this domain. However, a few typical themes did emerge.

Participants typically responded that they found it *easier to receive positive regard from a female rather than a male therapist*; this response was so pervasive that it was only one respondent short of being designated a General theme. The reasons for this preference were varied and in some cases reflected a gender-match preference (given that 13 of 15 participants in the sample were female, this was not insignificant), though both men in the sample also endorsed this theme. Other rationales for this impression included gender-role-based generalizations, including the idea that “men are less calm, soothing, and compassionate” than women and the impression that “a male therapist who is too nice may be perceived as creepy, whereas an overly positive female therapist wouldn’t be perceived that way.” Other participants cited fear of or discomfort with working with a male therapist, based on their personal histories, which they felt would make it hard for them to receive positive regard from such a therapist. Of note, several participants made reference to feeling that their therapists were playing a motherly or grandmotherly role in
connection with their perception of positive regard (e.g., “Having a female therapist of whatever age has been helpful in working out my mother-daughter ‘stuff’”).

Some preferences emerged in the sample regarding the therapist’s age. A typical theme was that an older or more experienced counselor conveys positive regard more effectively than a less experienced or younger counselor. Participants (reporting a mean age of 47.8) substantiated this impression by explaining that they had had more positive experiences with older therapists in the past. While a few respondents were dismissive of younger or less experienced therapists without much explanation, one suggested that more experienced therapists were better able to be responsive to clients by disregarding unhelpful procedures and formalities: “She has twenty years of experience, and so she would just say, ‘We’re not going to do a treatment plan,’ and so we were just able to do what I needed.” By contrast, a variant subset of the sample expressed the sentiment that age match with the therapist promotes positive regard. These respondents stated that they felt more comfortable and better able to relate to their therapists if they were going through similar phases of life. One explained, “When I turned 70 she was about to also and we talked about that in a way that made it a little more personal than if she were just a more distant therapist who wouldn’t acknowledge that we had the same age.” The participants endorsing this view varied significantly in age, such that their preferences did not simply reflect the abovementioned preference for an older counselor.

While some participants shared impressions related to sexual orientation and race/ethnicity – either theirs or their therapists’ – that impacted upon their feelings of positive regard, these viewpoints were not well-represented in this already-small sample. The views that race/ethnicity does not impact positive regard, and that sexual orientation
does not impact positive regard, however, were represented at the variant level in the sample. Participants endorsing this perspective explicitly stated that they could not identify the relevance of these demographics to positive regard, while the remaining respondents did not address these variables in their responses to the general interview prompt about demographics.

Finally, two rare but important views were offered, first on the relevance of therapy setting and second on the relevance of therapeutic modality for clients’ experiences of positive regard. These themes hint at the phenomenology of positive regard in clinical contexts not well represented in the sample. Within the sample, only two participants endorsed experience with treatment in a community mental health or hospital setting, and both of those participants stated that they experienced positive regard at much lower levels than in private practice settings. Both clients cited the short duration of contact with providers as one reason for this experience, with one saying, “I would get changed on such a regular basis—once you got a connection with somebody, they were gone.” A different subset of participants were unanimous on a different point: the only two clients who had experienced psychoanalysis on the couch both reflected that they felt more positive regard when they could see their therapists’ faces during regular talk therapy. However, one of the two added: “I have had the experience while lying on the couch of literally feeling like my head is in her lap....which feels very mothering, and sometimes I imagine that I am lying down with my head in her lap as she strokes my head. There’s something about that that’s very positive regard-y.”
Domain 8: Suggestions for How to Optimize Positive Regard

All participants were asked how their therapists might enhance or improve the experience of positive regard in therapy. With only a few exceptions, clients were largely satisfied with the positive regard offered by their current therapists, and tended to respond to this question with some form of the advice, “do more of what you’re already doing.” Clients did offer three suggestions for enhancing positive regard in significant enough numbers to be captured in the cross-analysis. The first of these, occurring with typical frequency, was to be attentive and responsive to the client as an individual. It was recommended that therapists signal that their clients have their undivided attention by being mindful of nonverbal cues and by asking questions and keeping the focus on the client. Therapists were also advised to display attentiveness and responsiveness by intervening in ways that reflected awareness of the client’s individuality. One participant summarized as follows: “Try to see each person uniquely. Don’t try to peg them into categories. Focus on my strengths and what I can do, not what I can’t do.” Other participants felt that responsiveness could include attention to weaknesses as well: “I have strengths and weaknesses, and my therapist should help me compensate where I’m weak and congratulate me where I’m already strong.”

A second theme, occurring with variant frequency, was that therapists should be transparent and communicative with their clients. Respondents expressed the desire not to be left in the dark in a variety of contexts. One client said, “I don’t really like the silent therapist because you just have no idea what they’re thinking.” Another added, “It would feel more like a human relationship if she gave me more of her feedback and insight.” For others, the preference for open communication related to policies and the therapeutic
frame. One participant whose therapist was cancelling sessions to go out of town with increasing frequency said that she wished her therapist would explain the situation more. “It’s like I’m not sure what’s happening or what’s going to happen. And I don’t like having that feeling. I like to be able to know what’s happening, I wish she would speak about it more.” Another expressed a preference for a lack of ambiguity around the bounds of touch: “I think that they should talk about it during the first couple sessions when they’re talking about other rules like cancellation policies. I think they should just bring up touching. Like, ‘If you ever need a hug you can ask me, I’m open to hugging.’ Or, ‘I don’t hug clients under any circumstances.’ There’s so many different rules around it and therapists having their own feelings about it, I think that it should just be part of like the first session or two. Because if they bring it up first, it’s just way more comfortable.”

One final theme in this domain, occurring with variant frequency, was the suggestion that therapists take a caring and nonjudgmental stance to most effectively communicate positive regard. Respondents endorsing this theme highlighted the human aspect of the therapy relationship, with one saying she felt positive regard when her therapist treated her like “a regular person,” and another explaining that “positive regard gives you the feeling that you are in the presence of your friend. Someone who cares about the outcome, who cares about you, and tries to take into account the broadest possible perspective.” Along these lines, one client emphasized that a therapist’s empathic, nonjudgmental stance was critical – “really trying to put yourself in their shoes and not to come across as judgmental. Trying to keep an open mind – in the way you convey your thoughts or advice or opinion.”
Domain 9: Essential Features of the Experience of Positive Regard

For some participants, a particular feature or impression related to their experience of positive regard was so predominant that it ran throughout the interview like a motif. An additional domain was created to capture the salience of these themes, five of which emerged across the sample, four with typical frequency and one with variant frequency.

The first typical category was that positive regard was associated with feeling safe to open up in therapy. Clients attributed this feeling to high levels of trust and respect in the therapeutic relationship. “For me, trust and positive regard are just synonymous,” one participant explained. Another emphasized the centrality of respect to positive regard: “If there’s not a general atmosphere of respect then it’s very hard for me to make the connection to my own thoughts and to have this sense that they’re going to have somewhere to land and we’re going to be able to go somewhere with it.” A second typical theme was the notion that client and therapist were engaged in a real relationship characterized by a sense of mutuality. One respondent said, “I feel positive regard from my therapist all the time because he treats me like an equal.” Others emphasized the human elements of the therapeutic relationship, with one saying she appreciates that her therapist is “not overly authoritative,” and another highlighting the fact that her therapist is “comfortable and informal with me.” Third, clients described feeling liked and esteemed by their therapist as critical to their experience of positive regard. As one participant reflected: “She communicates the high esteem she holds me in and she brings me back to my essence. It reminds me that my soul is who I am. She reinforces my self-image, my positive self-image, with this positive regard that she has for me. No matter
what I present to her she consistently reminds me of who I really am, what my true self
is.” Finally the fourth typical theme that emerged was that participants experienced
positive regard as being strongly connected to their therapist’s understanding, empathy,
and acceptance of them. One client summarized, “I guess if I really have to pin it down,
at the end of the day I feel positively regarded because I feel like she understands me.”
Several respondents paired the experience of understanding and acceptance together,
suggesting that one depended on the other: “It’s more like understanding, accepting,
being willing to see the individual out of the assembly line.”

Finally, a variant number of participants mentioned therapeutic presence as being
essential to their experience of positive regard in therapy. They described the deep and
abiding sense that the therapist is truly “there” with them. One said, simply, “She’s very
focused. She’s really present.” Another explained, “She is always here for me. It’s the
most important thing to me, the feeling that I really matter. She basically makes me feel
like I am important so that's what helps me in the relationship between her and me so that
I can actually get better.”

**Supplemental Analysis**

In Domains 2 and 3, respondents described a wide range of examples that, for
them, represented markers of therapist positive regard or the lack thereof. Even after the
cross-analysis process identified and consolidated common themes across cases within
the domains, several themes echoed one another, as well as reappearing and resonating
significantly with categories in other domains. The conceptual overlap within and across
domains deepened the research team’s sense of the validity of these findings and
strengthened the impression that certain core attitudes on the part of the therapist, easily
recognized by their clients, serve as signature markers of their positive regard. Three trans-domain clusters offered a compelling way of aggregating, organizing, and understanding clients’ experience of positive regard.

While a few of the categories in these domains represent concrete actions or behaviors on the part of the therapist (e.g. Explicit affirmation, reassurance, or positive feedback; Excessive boundary crossing), the majority of themes identified are better described as representing assumed underlying attitudes on the part of the therapist (e.g., Nondirectiveness and acceptance; Being unresponsive to the client and his/her needs and sensitivities). This observation, and the subsequent widening of the inquiry into positive regard from a focus on concrete behaviors to a more encompassing perspective that includes therapist attitudes, is perhaps an inevitable consequence of CQR methodology, in which abstraction from specific cases allows common themes to be identified. It is also wholly congruent with Rogers’ descriptions of unconditional positive regard, which makes frequent reference to “attitudes” held by the therapist.

This higher-order framework, laid out in Table 4 and described in greater detail below, represents an unanticipated result of this study. Though the identification of dimensions of positive regard was not explicitly named as a goal of this study, these three strands, and the possibility of higher-order organization beyond the themes identified in the CQR analysis, emerged organically from the data. This framework is data-driven while also offering the benefit of conceptual clarity and highlighting possible theoretical implications.

**Cluster 1: Warm authenticity.** The first of these higher-order clusters suggests that *positive regard is experienced through a warm and authentic relationship with the*
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Table 4
*Attitudes Underlying Therapist Expressions of Positive Regard*

<table>
<thead>
<tr>
<th>Cluster Name</th>
<th>Corresponding Categories</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm Authenticity</td>
<td>Authenticity and self-disclosure</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Explicit affirmation, reassurance, or positive feedback</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Emotional engagement</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Warm and comfortable demeanor</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Combative/judgmental communication</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Hugging promotes/would promote PR</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Balancing support and challenge</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Real relationship/mutuality</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Be transparent and communicative</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Feeling liked and esteemed</td>
<td>9</td>
</tr>
<tr>
<td>Flexible Responsiveness</td>
<td>Flexibility around professional boundaries</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nondirectiveness and acceptance of feelings/experiences</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Being unresponsive to client</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Behavior that differs from other therapists’</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Maintaining rigid boundaries</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Excessive boundary crossing</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Be attentive and responsive to client as an individual</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Therapeutic presence</td>
<td>9</td>
</tr>
<tr>
<td>Empathic Acceptance</td>
<td>Perspective taking/shifting</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Not believing/understanding</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Take a caring, nonjudgmental stance</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Feels safe to open up</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Understanding, empathy, and acceptance</td>
<td>9</td>
</tr>
</tbody>
</table>

*Note.* Clusters constructed using themes from Domains 2, 3, 8, 9, and 10.

therapist. The themes organized under this finding, drawn from Domains 2, 3, 8 and 9, include *Authenticity and self-disclosure; Explicit affirmation, reassurance, or positive feedback; Emotional engagement; Warm and comfortable demeanor; Combative/judgmental communication; Hugging promotes/would promote PR; Balancing support and challenge; Be transparent and communicative; Real relationship/mutuality; and Feeling liked and esteemed.* The relevance of many of these
themes to the experience of positive regard is readily apparent by their focus on warmth (e.g. Explicit affirmation, warm and comfortable demeanor, and, in the converse, combative/judgmental communication), while others merit special attention.

Specifically, the frequency (General) with which therapist authenticity and self-disclosure was cited within the sample is striking, and the thematic overlap with the notions of emotional engagement and real relationship/mutuality (both Typical) reinforce the impression that participants find the “realness” of the relationship particularly essential to positive regard. This impression is strengthened by the theme of balancing support and challenge, where participants expressed feeling skeptical of therapists who might express positive regard immoderately. Further support came from Domain 8, in which clients suggested that therapists be transparent and communicative in order to more effectively convey positive regard to their clients.

The emphasis within this cluster on the therapist’s emotional investment in the relationship – not merely that the therapist will be honest with the client in providing feedback, but that she herself has “skin in the game,” so to speak – should be highlighted as well. The inclusion of therapist self-disclosure within this cluster is perhaps the most obvious of several indications that clients look for mutuality as a key indicator of positive regard. It perhaps unsurprising that for many clients, a therapist’s willingness to reveal parts of himself or herself serves as the most powerful evidence of the ability to be truly present and to enter into an authentic human relationship with them.

**Cluster 2: Flexible responsiveness.** The second cluster indicates that therapists communicate positive regard through flexibility and responsiveness to the client. The themes grouped under this finding, culled from Domains 2, 3 and 8, include *Flexibility*
around professional boundaries, Nondirectiveness and acceptance, Being unresponsive to participant, Behavior that differs from other therapists’, Maintaining rigid boundaries, Excessive boundary crossing, Be attentive and responsive to the client as an individual; and Therapeutic presence. Therapists’ ability (or inability) to flexibly accommodate and respond to the needs and concerns of clients was frequently cited as an indication of positive regard (or its absence). Participants felt positively regarded when their therapists were willing to deviate from policies and standard practices as dictated by context or circumstance. Very often, this involved flexibility around boundaries, such as being available over email or extending the session when a client arrives late. By the same token, participants’ mention of excessive boundary crossing suggests that therapists’ ability to identify where clients need boundaries to be preserved can be just as important a marker of positive regard. In being flexible, the therapist acknowledges the client’s uniqueness and acknowledges that one size does not fit all, further reinforcing the sense, discussed above, that they are engaged in a real relationship and not merely a clinical transaction. The fact that participants reported experiencing positive regard when their therapists behaved differently from past therapists is likely related. To the extent that the client had previously conceived of some undesirable aspect of their previous therapy (e.g., writing notes in session, or being resistant to self-disclosure) as being “just the way it is,” starting treatment with a therapist who deviates from this standard is likely to be experienced as a gratifying boundary extension, whether or not it has this significance for the therapist.

Of note, while Cluster 1 (specifically the authenticity component) and Cluster 2 (specifically the flexibility component) share some conceptual overlap with regard to the
therapist’s underemphasizing his or her professional role in interactions with the client, the nature of this emphasis differs. Cluster 1 is primarily focused on the therapist’s manner of relating to the client as a human, setting aside his or her role as therapist; while Cluster 2 pertains to the way in which the therapist works within the parameters of his or her role, which may include mindfully choosing how and when to extend boundaries for therapeutic benefit.

References to the therapist’s responsiveness, a related but slightly different construct from flexibility, were equally pervasive in the data. Participants explained that they felt positive regard when their therapists’ behavior demonstrated a heightened level of attentiveness and engagement with the material the clients brought to session. Some identified a lack of responsiveness in their therapists’ silence in session, or in comments about topics that seemed unrelated to the clients’ concerns. Most frequently, responsiveness was perceived in relation to therapists’ reactions to client feedback, when therapists responded with openness, willingness to reconsider a point of contention, and desire to repair ruptures. Conversely, participants cited negative examples of therapists who had failed to provide positive regard by responding to feedback with defensiveness, rejection, or a seeming inability to recall and implement changes that had been previously discussed.

**Cluster 3: Empathic acceptance.** The third cluster, comprised of themes from Domains 2, 3, 8, and 9, suggests that therapists demonstrate positive regard through an attitude of empathic acceptance. The names of the relevant themes were Perspective taking/shift; Not believing/understanding the participant; Take a caring, nonjudgmental stance; Feels safe to open up; and Understanding, empathy, and
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acceptance. More than half of the participants in the sample voiced the sentiment that they felt positively regarded when their therapists related to them in an empathic manner, conveying a deep understanding of their subjective experience. For many of these clients, the experience of being understood went hand-in-hand with a sense of being accepted. Conversely, several respondents cited empathic failures, in which they felt misunderstood or not believed, as demonstrating a lack of therapist positive regard. Domain 8, in which participants suggested that therapists looking to optimize positive regard should assume a caring and nonjudgmental stance, echoes this perspective by emphasizing the therapist’s acceptance of the client. Finally, in Domain 9, participants described two themes as being fundamental to positive regard – first, the sense that it is safe to open up in therapy without fear of shame or judgment; and second, that a pervasive sense of understanding, empathy, and acceptance characterizes their experience of positive regard.

The repeated pairing of understanding with acceptance in the data suggests, again, a mutually reinforcing relationship between the facilitative conditions of empathy and positive regard. Therapists’ efforts to understand their clients’ experience deeply are themselves illustrative of the esteem in which they hold their clients; furthermore, expressions of affirmation and acceptance are all the more potent in the context of feeling known and understood. The data suggest that, in the minds of clients, positive regard is difficult to disconfound from Rogers’ two other facilitative conditions. It is likely that clinicians who exhibit one of these qualities also make effective use of the others, and that clients experience them as a seamless whole contributing to the overall therapeutic quality of the relationship.
Cluster 3 shares some features with Cluster 1, including a sense of warmth and relatedness; however, they differ in focus. Cluster 1 pertains to the intimate components of the therapist’s relatedness, with a focus on the therapist’s subjectivity. Cluster 3, by contrast, is slightly more remote, with a focus on the therapist’s ability to access and appreciate the client’s subjectivity. Some disambiguation between Clusters 2 and 3 is warranted as well. While Cluster 2 contained the theme on nondirectiveness and acceptance of clients’ feelings and experiences, that category focused more on the therapist’s openness to allowing session material to influence and shift the course of a session. By contrast, “acceptance” in Cluster 3 refers more to an all-encompassing sense that the therapist accepts the client as a person, without judgment. This sense bears significant conceptual similarity to Rogers’ notion of unconditionality.
Chapter 4: Discussion

This qualitative study aimed to elucidate psychotherapy clients’ phenomenological experience of positive regard as offered to them by their therapists. Participants participated in a semi-structured interview protocol that offered a multi-pronged definition of the construct (a feeling you get from your therapist that s/he likes you, accepts you, respects you, and/or has genuine interest in you), and their responses to the prompts in the interview, though reflecting the uniqueness of their diverse experiences, also yielded some key common themes. The most significant findings include the following: 1) Clients view positive regard as an essential and facilitative component of the therapy relationship in that it lays the foundation for self-disclosure, risk-taking, personal growth, and the resolution of ruptures in the therapeutic alliance; 2) while nearly all participants stated that they regularly experienced positive regard in their present therapy relationships, the majority were also able to report on therapy experiences where they felt positive regard was wholly lacking, with significant negative consequences; 3) though all clients endorsed having felt a lack of positive regard in therapy, very few had ever discussed these failures with their therapists, instead tending to withdraw or disengage from treatment; 4) many respondents had in fact chosen to terminate previous therapies where they perceived a lack of positive regard; 5) respondents’ descriptions of therapist positive regard frequently overlapped with the other Rogerian conditions of congruence and empathy; and 6) participants’ descriptions of therapist positive regard yielded three higher-level clusters or thematic strands interwoven throughout the domains described above, suggesting three underlying
attitudes constituent of positive regard – warm authenticity, flexible responsiveness, and empathic acceptance.

The findings are discussed in greater detail, organized by research question, below.

**Question 1: How Prevalent, and How Important, is the Experience of Positive Regard in Psychotherapy?**

The first domain yielded a strong consensus that positive regard is a fundamental ingredient of psychotherapy. All clients reported familiarity with experiencing positive regard, and nearly all clients described it as a critical component of their therapy experience. Furthermore, the vast majority of the sample indicated that their current therapist provides positive regard in a manner that is largely satisfying to them. At the same time, a significant proportion of the sample also reported familiarity with a lack of positive regard, particularly in previous courses of treatment. Indeed, many respondents cited a lack of positive regard in the relationship as a reason they stopped seeing previous therapists. It seems likely that people able to remain engaged enough to be screened for and complete the second phase of a study about positive aspects of the therapy relationship would be motivated by strong positive feelings about their current treatment; thus, satisfied psychotherapy patients are likely overrepresented in this sample. It is therefore telling that all of these patients also could describe experiences or entire courses of therapy in which they did not experience positive regard, with some explicitly mentioning that they terminated treatment when they could no longer tolerate their therapist’s failure to provide positive regard. While most clients stated outright that positive regard is a very important ingredient in their therapy, themes from other domains
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corroborated this notion, especially the fourth and fifth domains, which focused on the impact of experiencing and not experiencing positive regard in therapy. Clients highlighted the role of positive regard in strengthening the therapeutic relationship, maintaining their attendance and motivation in therapy, and facilitating self-disclosure, all critical components of the process of psychotherapy.

These findings are in line with the existing literature, which in previous reviews and meta-analyses over the last two decades have found a generally positive relationship between positive regard and psychotherapy outcomes (Farber et al., in press). Farber and colleagues’ (in press) most recent meta-analysis, which yielded an effect size of $g = 0.36$ as discussed above, demonstrates a statistically significant relationship between positive regard and clinical outcomes and upholds its standing as an important mutative common factor in the psychotherapy relationship.

**Question 1 summary.** Taken together, these findings support the client-centered tenet that positive regard is an essential facilitative condition in psychotherapy. The presence of positive regard likely contributes to client satisfaction and treatment adherence, and its absence most likely contributes to ruptures in the alliance and early termination from treatment.

**Question 2: How do Therapists Effectively Communicate Positive Regard to Their Clients, and Which Therapist Behaviors Convey a Lack of Positive Regard?**

While this study was originally conceived as a tool to elicit a catalogue or taxonomy of specific therapist behaviors that clients find to be particularly potent markers of positive regard (or its absence), the CQR process of abstracting core ideas yielded instead a wide-ranging collection of therapist attitudes that clients interpret as
salient indicators of positive regard (or its converse). Respondents’ experiences of positive regard, diverse though they were, seemed to cohere around a few core attitudes that offered a vivid picture of what positive regard – and its absence – looks and feels like to clients. Three clusters of themes emerged from the CQR cross analysis and may reflect an underlying dimensional structure of positive regard, worthy of investigation in future studies.

Warm authenticity. The first cluster, Warm authenticity, was derived from ten themes united by the core idea that therapists successfully convey positive regard when they relate to their clients in a warm and authentic manner. Of note, warmth and authenticity co-occurred in the data, and participants indicated that warmth in the absence of an impression that the therapist is being truly authentic often rings hollow or is not experienced meaningfully as positively regarding. Respondents differed in their views on how therapists could best convey authenticity: for some, therapist self-disclosure was the most meaningful indicator of their therapist’s “realness”; for others, an ability to balance affirmation with challenging feedback was proof of authenticity; for a small minority, the incorporation of hugging into the therapeutic relationship was a signal that the therapeutic bond was real. Regardless, the themes of this first cluster suggest that clients’ experiences of positive regard are inextricably connected with another facilitative condition – therapist congruence. Positive regard is so vital to clients that they have difficulty trusting in it unless they can be sure that it is deeply felt, and being sure of this requires a sense that the therapist is emotionally invested and truly present in the relationship.

While the dimensional structure of Suzuki and Farber’s (2016) PEPR measure does not include a subscale that corresponds precisely to this dimension of warm
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authenticity, several of the items with a high mean rating for their affirming quality are pertinent to this cluster. The therapist’s warm and comfortable demeanor is captured by several items with higher than average affirming ratings: “My therapist maintains eye contact with me” (M = 4.20 out of 5 for affirming quality) was the seventh-highest rated item out of 43 total items; “My therapist speaks to me in a gentle tone of voice” (M = 4.17) was ranked tenth highest; and “My therapist smiles at me” (M = 3.83) was ranked 20 out of 43. Multiple highly-rated PEPR items reflect the theme of explicit affirmation, reassurance, or positive feedback endorsed by more than half the sample as a key signal of positive regard including behavioral descriptions (“My therapist compliments me on something I feel is a strength of mine,” “My therapist encourages me to take pride in the things I do well,” both Ms = 4.19, ranks 8.5) and direct statements (“You are handling this well,” M = 4.04, rank 12; “That was brave of you,” M = 3.97, rank 14.5; “It’s remarkable how far you’ve progressed,” M = 3.86, rank 19). Furthermore, several statements meet criteria for being explicitly affirming and simultaneously signaling the therapist’s emotional engagement with and feelings of esteem for the client (“I’m proud of you,” M = 3.74, rank 23; “I admire that about you,” M = 3.68, rank 25.5).

A few PEPR items are geared more towards the therapist’s authenticity and emotional presence in the relationship. Of note, these items were generally rated as less affirming by the sample as a whole. While therapist authenticity and self-disclosure was the theme most widely endorsed as a marker of positive regard among the participants in the present study (earning a frequency label of General), the PEPR item tapping that content (“My therapist shares something personal about his/her life”) did not stand out as a particularly potent source of affirmation (M = 3.30, rank 37). One item that resonates
with the emotional engagement/real relationship themes pertinent to this cluster (“My therapist has tears in his/her eyes as I relate a sad story”) was among the lowest-rated items in the inventory as a whole (M = 2.52, rank 41). The other three lowest-ranking items pertained to physical contact in the therapeutic dyad (“My therapist gives me a handshake,” “My therapist hugs me,” “My therapist puts his/her hand on my shoulder”), and also garnered strikingly low ratings (with respective means of 2.55, 2.49, and 2.28).

The low average ratings for items pertaining to touch in the therapeutic relationship are consistent with the present study’s findings. While a number of participants did make a strong case for hugging as being an important indicator of their therapist’s authentic affection for them, these participants constituted a minority in the sample whose perspective was balanced by another subset of participants who cited the therapist’s overstepping of boundaries as a marker of a lack of positive regard. More surprising was the discrepancy in the findings on therapist self-disclosure in the two studies. The participants in the present study, though drawn from the same sample surveyed by Suzuki and Farber (2016), were not randomly selected; thus these discrepant findings could reflect a bias in the present sample towards authenticity and self-disclosure that is not representative in the wider sample or the psychotherapy population as a whole. More likely, however, is the possibility that the phrasing of the PEPR item on self-disclosure lacks sufficient context, given the consistency of report in the current sample that therapist self-disclosure is experienced as positively regarding if, and only if, the relevance to the client’s circumstances is apparent. The multiplicity of PEPR items relevant to this cluster also serves as a useful reminder that self-disclosure is only one
way in which therapists can communicate authenticity in their interactions with their clients.

The question of authenticity in the therapeutic relationship evokes Gelso’s (2002) theory of the real relationship in psychotherapy – defined as the component of the relationship between client and therapist that is relatively uncontaminated by transference – which has significant overlap with Rogerian congruence. A developing literature suggests that the real relationship significantly impacts upon therapy process and outcomes (Gelso, 2009), but that the nature of this relationship may be quite complex, interacting with other relationship components, such as working alliance (Kivlighan, Hill, Gelso, & Baumann, 2016). The results of the present study indicate that therapist positive regard may be an important and relevant variable implicated in the real relationship as well.

However it is expressed, participants in this study overwhelmingly agreed that the therapist’s authenticity, or realness, is what allows them to trust in and derive therapeutic benefit from positive regard. Writings on client-centered theory have typically alluded to a tension between the facilitative conditions of positive regard and congruence. Certainly, authenticity and positive regard can be at odds when the therapist is managing strong negative feelings towards the client: combative and judgmental communication, however authentically expressed, is unlikely to be experienced as affirming. The co-occurrence of warmth and authenticity in the results suggests, however, that in the minds of clients, positive regard and authenticity are usually mutually reinforcing. When paired together, the attitudes of warmth and authenticity serve as core markers of positive regard.
Flexible responsiveness. The second cluster, Flexible responsiveness, was derived from seven themes that suggest that therapists’ attentiveness to clients’ experiences and needs, and their ability to respond in a way that shows they are of primary importance, are core features of positive regard. While flexibility and responsiveness share significant conceptual overlap and cluster together in the data, they are somewhat distinct. Therapist flexibility was typically cited in willingness to deviate from procedural aspects of the therapeutic relationship, such as the allowance of wiggle room around session agendas or ending times, to meet client needs. Therapist responsiveness, on the other hand, was usually communicated by the therapist’s verbal responsiveness (i.e. not being silent in response to the client’s statements in session) and by therapists’ openness to whatever content the client brought to therapy, even if it included negative feedback for the therapist. Therapist responsiveness seemed to act as a signal of positive regard because it indicated to clients that their therapist truly valued what they had to say.

Suzuki and Farber’s (2016) factor analysis of the PEPR scale offers further validation for this cluster, as their dimension of Unique Responsiveness aligns closely with the Flexible responsiveness cluster proposed in this study. In that study, Unique Responsiveness was described as a broad factor: one that “consists of therapist behaviors that include empathic attunement, warmth and prizing, reflective listening, reformulation, interpretation, flexibility, humor, and more.” The authors proposed the label of “Unique Responsiveness” for this subscale “because it seems to describe a therapy relationship in which clients feel that the therapist has been quite attentive and responsive to them as individuals, seeking to enter their world, understand and accommodate their needs and
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commits, celebrate their strengths, and help them think differently about more
challenging areas of life” (p. 13). This factor was found to have the strongest correlation
with BLRI Level of Regard and to be the strongest predictor of positive regard in a
regression when all other variables were controlled for.

Flexible responsiveness in this study is defined somewhat more narrowly,
seeming to represent a subset of the Unique Responsiveness factor. Several items on the
PEPR subscale for Unique Responsiveness correspond to the responsiveness component
of the second cluster in this study and are among the highest-rated items in the measure:
“My therapist shows s/he is listening through her/his body language” (M = 4.26, rank
2.5); “My therapist makes a connection between my current experience and something
that I have discussed in the past” (M = 4.26, rank 2.5); “My therapist remembers the
name or the details of someone or something I spoke of long ago” (M = 4.24 out of 5,
rank 6 out of 43); “My therapist remembers to ask me about someone I was worried
about” (M = 4.05, rank 11); and “My therapist laughs at a funny comment I make” (M =
4.02, rank 13). One highly-rated PEPR item corresponds more to the flexibility
component: “My therapist is understanding if I need to cancel/reschedule” (M = 4.25,
rank 4.5). Additional relevant items on this subscale that were also viewed as affirming
by the sample but garnered slightly lower rankings included an attentive and responsive
gesture (“My therapist hands me a tissue when I begin to cry,” M = 3.32, rank 36), a
statement reflecting nondirectiveness and acceptance (“This is a space for your own
healing and growth,” M = 3.46, rank 33), and two behavioral indications of therapist
flexibility (“My therapist allows the session to go on a few extra minutes,” M = 3.66,
rank 27.5; “My therapist is flexible about fee payments,” M = 3.60, rank 30.5).
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Though Suzuki and Farber (2016) and the present study are the first two to demonstrate a link between responsiveness and positive regard, there is a rich literature on the construct of responsiveness in psychotherapy. Responsiveness has been described by Stiles, Honos-Webb, and Surko (1998) as behavior that is affected by emerging context. “Appropriate responsiveness” is the extent to which therapists’ choice of treatments and interventions in a given moment is shaped by their attention and sensitivity to a client’s verbal and nonverbal behavior. Stiles and colleagues describe responsiveness as both a critical and confounding factor for psychotherapy research, which aims to operationalize and measure fixed variables in order to quantify their impact on psychotherapy outcomes. By its nature, responsiveness entails a dynamism that is, paradoxically, incompatible with the tools of research design but critical for psychotherapy researchers and practitioners to understand. The diversity of participants’ descriptions of their experiences with therapist responsiveness and unresponsiveness in this study supports a conceptualization of responsiveness as an idiosyncratic variable that is nonetheless fundamental to patients’ experience of positive regard. This perspective aids in the interpretation of seemingly contradictory findings in the data from this study – for example, the fact that both nondirectiveness and directiveness from the therapist were cited as markers of positive regard. For a certain client in a given moment, a therapist’s provision of structure and authority may be experienced as particularly containing and nurturing, and feeling taken care of in this way may contribute to feeling positively regarded. In another moment or with a different client, a more receptive and flexible attitude, coupled with the sense that the therapist lacks a preconceived agenda, is more likely to lead to feeling accepted and cared for. Viewed in this way, the wide range of
therapist behaviors that have been identified as markers of responsiveness can be better understood; context is key in inferring responsiveness. The responsive therapist is attuned to clients’ reactions to these different approaches on a moment-by-moment basis and titrates her interventions accordingly; in so doing, she effectively communicates positive regard by letting the client know that his experience as an individual is of utmost importance.

**Empathic acceptance.** The third cluster, Empathic acceptance, was drawn from five themes that collectively underscore the interconnectedness between empathy and positive regard. For the majority of respondents in the sample, the feeling of being understood was closely linked to positive regard, and this feeling typically went hand-in-hand with a sense of being accepted by the therapist. Therapists making these interventions were skilled at both understanding their clients’ point of view (perspective taking) and offering their own perspective (perspective shifting), usually in a direction that contributed to a feeling of affirmation and acceptance. The feeling that it is safe and rewarding to open up and share in therapy is likely bolstered by a therapist’s attitude of empathic acceptance. The repeated emergence of empathy, the third of Rogers’ facilitative conditions, within a dataset focused on therapist behaviors associated with positive regard, again emphasizes the interrelatedness of all three conditions.

Suzuki and Farber (2016) also highlighted the connection between empathy and positive regard, offering evidence of therapist empathy embedded within several items on the PEPR Unique Responsiveness subscale, many of which were highly rated by their sample. The top-ranked item in the PEPR inventory overall embodies the concept of empathic acceptance, particularly the theme of *perspective taking and shifting*: “My
therapist offers a new way of understanding a part of myself that I usually view as a weakness” (M = 4.30, rank 1). Several other highly affirming PEPR items from the Unique Responsiveness subscale evoke the therapist’s empathic capabilities, including “My therapist summarizes what I have said accurately” (M = 4.25, rank 4.5), “My therapist picks up on how I am feeling based on how I look” (M = 3.97, rank 14.5), and “My therapist’s face reflects that s/he is feeling what I am feeling” (M = 3.72, rank 24). Finally, several highly-rated therapist statements convey a nonjudgmental attitude of normalizing, validation, and caring towards clients’ experiences that is likely to facilitate client self-disclosure: “What you are feeling is normal” (M = 3.92, rank 17); “I know how hard you’re working to figure this out” (M = 3.90, rank 18); “I’m glad you shared that with me,” (M = 3.76, rank 21).

Therapist empathy, as one of the more extensively investigated process variables, has been operationalized in a multiplicity of ways. Rogers (1957/1992) defined it as the therapist’s sensing of “the client’s private world as if it were your own, but without ever losing the ‘as if’ quality” (p. 829). Elliott and colleagues (in press), in reviewing the various definitions of empathy across a diverse research literature, delineate conceptual (cognitive) and emotional (bodily) components of empathy, which have been identified as having distinct neuroanatomical correlates, and point out that Rogers’ conception of empathy emphasizes the cognitive component. The authors also offer a three-mode description of therapeutic empathy: 1) the establishment of empathic rapport and support, 2) the ongoing effort to stay attuned to the client’s experience as it unfolds moment-by-moment, and 3) “person empathy,” or the attempt to construct an experience-near understanding of the client’s world by comprehending past and present experiences that
inform the client’s subjective experience. However it is defined, the evidence in favor of empathy as a mutative variable in the psychotherapy process is strong. The most recent meta-analysis on empathy (Elliott et al., in press) generated a study-level random effects weighted \( r \) of .28, a medium effect size that indicates that empathy accounts for approximately 9% of the variance in treatment outcomes. The embeddedness of therapy in positive regard and vice versa suggests that the strength of the relationship between positive regard and therapy outcomes might well be stronger than indicated in Farber and colleagues’ meta-analysis (in press) if the definition of the construct were adjusted to accommodate its significant overlap with empathy. Also suggestive are the not-insignificant correspondences between the tripartite model of empathy above, proposed by Elliott and colleagues, and the three-cluster framework for understanding positive regard emerging from this study. In both models, the first component relates to rapport and connection in the therapeutic dyad, the second component highlights the importance of attunement on a moment-by-moment basis, and the third component is connected by a commitment to understanding clients’ lived experience. These correspondences, though coincidental, suggest commonalities in the underlying properties of these two facilitative conditions that give support to the idea of a global relationship factor.

**Question 2 summary.** Clients endorsed a wide range of behaviors that contribute to their sense of being positively regarded in therapy. Three broad conceptual strands were found interwoven throughout the domains, lending validity to the notion that they are particularly central to the experience of positive regard: first, that positive regard is experienced through a warm and authentic connection with the therapist; second, that flexibility and responsiveness are essential components of positive regard; and third, that
understanding, empathy, and acceptance are key markers of positive regard. It is notable that these three attitudes resonate thematically with the only three suggestions about how to optimize positive regard that were endorsed frequently enough to gain mention in Domain 8. In the suggestion that therapists Be transparent and communicative, respondents reference the importance of authenticity discussed above. In their request that therapists Be attentive and responsive to the individuality of the client, responsiveness is echoed as a core theme related to positive regard. Finally, the suggestion that therapists Take a caring, nonjudgmental stance has significant overlap with the attitude of empathic acceptance highlighted by patients as reflecting high levels of positive regard. Also noteworthy is participants’ spontaneous generation of thematic material related to authenticity and empathy when queried about positive regard, suggesting the substantial overlap and interdependence of Rogers’ three facilitative conditions.

**Question 3: What Impact does Therapists’ Positive Regard, or Therapists’ Failure to Provide Positive Regard, Have on Clients’ Experiences in Therapy, on the Course of Therapy, and on Therapy Outcomes?**

To the extent that positive regard is a facilitative condition in therapy, what precisely does it facilitate? Participants were not queried about this directly but many spontaneously commented on the impact of their therapists’ positive regard, or lack thereof, when describing their experiences in therapy, generating the content of Domains 4 and 5. All 15 participants described positive regard as serving to strengthen the therapeutic alliance, reinforcing its role as a facilitative condition in psychotherapy, essentially a foundation for the other work that therapist and client embark upon together.
Additional themes shed light on the nature of the work clients see as being facilitated: first, therapists’ positive regard facilitates personal growth by enabling clients to disclose and think more deeply about difficult material, indicating that the therapist’s positive regard has the power to dispel shame and fear that can get in the way of therapeutic progress. Shame has been identified as a potent deterrent to client self-disclosure in psychotherapy (Blanchard & Farber, 2015; Hill, Thompson, Cogar, & Denman, 1993; Farber, 2006; Macdonald & Morley, 2001), suggesting that a therapist’s ability to work constructively with it may facilitate the process of psychotherapy. The finding in this study that therapist self-disclosure is experienced as positively regarding (and, therefore, likely to mitigate clients’ feelings of shame), offers additional support for Henretty and Levitt’s (2010) finding that therapist self-disclosure is positively related to clients’ inclination to self-disclose. The converse of this core idea was also endorsed by participants, in that a lack of positive regard caused clients to shut down and become less productive in therapy.

Another typical theme was that positive regard serves to bolster clients’ self esteem and improve their social functioning. Resonant with Rogers’ conceptualization of the self-actualizing tendency and the need to dispel conditions of worth, this finding suggests the power of positive regard to produce meaningful change not only within the treatment room but also in clients’ day-to-day lives. Clients also cited the role of positive regard in mitigating the harm of therapeutic ruptures and keeping them in therapy when they might otherwise decide to terminate, a key finding given the ubiquity of premature termination in psychotherapy. Research on premature termination has primarily focused on client factors that predict dropout (Roos & Werbart, 2013), with the most consistently
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predictive variables being client SES (i.e., race, education, and income; Wierzbicki & Pekarik, 1993). The question of which therapist and relationship factors contribute to premature termination is less-well studied; however, the existing literature supports the proposition that relationship factors play a key role in retaining clients in treatment (Roos & Werbart, 2013). One meta-analysis found strong support for the relationship between therapeutic alliance and dropout in therapy (Sharf, Primavera, & Diener, 2010), and another review identified three studies in which the therapist’s “empathy, warmth and regard” contributed to client continuation in therapy (Roos & Werbart, 2013). These findings suggest that therapist positive regard, through its contributions to the therapeutic alliance, may reduce the likelihood of premature termination.

A lack of positive regard appears to result invariably in therapeutic rupture, as all participants reported feeling upset and rejected in response to these events. Ruptures in the therapeutic alliance, defined by Safran and Muran (1996) as deteriorations in the relationship between therapist and client, can be an invaluable source of data for the therapeutic dyad in their quest to better understand the client’s maladaptive schemas or patterns of interpersonal relatedness. However, this cycle of rupture and repair can only be profitable if clients remain in therapy long enough to work through them. Appropriately, positive regard, particularly a foundation of positive regard that clients can call to mind from earlier in the relationship, may also play a potent role in the repairing of these ruptures as they emerge. Yet the question of how often these ruptures are acknowledged and repaired is an open one. While a majority of clients referenced feeling wounded by a lack of positive regard, only two reported ever raising the matter with their therapists, suggesting the importance of therapists’ attunement and proactive
intervention in circumstances where such injuries seem likely. This finding is consistent with Blanchard and Farber’s (2015) research on lying in psychotherapy, which found that clients commonly withhold negative feelings about therapy from their therapists.

While a lack of positive regard had negative emotional consequences for the entire sample, another subset of clients attributed more severe consequences, such as intense and protracted emotional dysregulation and significant life disruptions, to a therapist’s failure to provide positive regard. These findings resonate with the biosocial theory on the etiology and sequelae of Borderline Personality Disorder (Linehan, 1993), which describes borderline pathology as originating from the interaction between individuals who are biologically predisposed towards heightened emotional reactivity and their invalidating early social environments, which result in chronic emotional dysregulation and maladaptive self-regulatory strategies. Though the particular presenting problems of the participants in the current study are unknown, their reports suggest that positive regard may feel like a lifeline that therapy clients who are particularly emotionally vulnerable cannot do without. Conversely, therapist expressions of positive regard had the impact of feeling surprising to a few respondents, suggesting that a small subset of therapy clients are accustomed to tolerating its absence in therapy, at least in the short-term. However, this category may represent an artifact of the phrasing of one of the interview questions, which probed for “surprising” therapist behavior in an attempt to elicit but avoid priming the specific themes of touch and boundary crossing.

**Question 3 summary.** Therapists’ positive regard is impactful for clients. It was universally acknowledged as a facilitative condition that strengthens the relationship between client and therapist and lays the groundwork for subsequent work in therapy,
including the personal growth that results from increased self-disclosure, risk-taking, and productivity in session; improved self-esteem and social functioning outside the treatment room; and keeping clients motivated to remain in treatment despite occasional ruptures in the alliance. Positive regard plays an important role in the cycle of alliance rupture and repair, with a therapist’s failure to provide positive regard first generating ruptures, and clients’ ability to recall a foundation of existing positive regard in the relationship providing them with the motivation to remain and work through the rupture. While some clients may find their therapist’s positive regard surprising, for others it seems to be an essential condition of therapy, as its absence is experienced as upsetting, rejecting, or even devastating at the margins, resulting in emotional withdrawal or premature termination of therapy.

**Question 4: How, and to What Extent, do Clients’ Experiences with Positive Regard Seem to Shift or Evolve Over the Course of the Therapeutic Relationship?**

The themes of Domain 6 contained participants’ responses to the question of how positive regard evolved or changed over time in their therapy. The typical experience was that participants felt positive regard from their therapists increase over the course of the therapy relationship. Two variant themes endorsed nearly as frequently as this first finding offered slight variations on the same theme: first, that an initial foundation of positive regard facilitates greater comfort and trust in the therapy relationship; and second, that the positive regard feels more substantial over time. Taken together, these three themes suggest that the dominant experience is that positive regard develops and deepens over time. This experience in all likelihood is determined by a multitude of factors. Some clients characterized themselves as “slow to warm up” and had difficulty
receiving positive regard from their therapists early in the relationship, though they recognized in retrospect that their therapists had been offering it from the start. Alternatively, as suggested above in the discussion of empathic acceptance, feeling truly known by one’s therapist is very likely a precondition to a client’s sense of being positively regarded, and this precondition by its nature takes time to develop. Relatedly, from the perspective of the therapist, the subjective experience of positive regard may deepen and intensify as the relationship progresses, allowing for more authentic expressions of regard over time.

This finding notwithstanding, a substantial number of participants reported that positive regard for them felt consistent from the start of the psychotherapy relationship. It is unclear whether this perception stems from client factors, therapist factors, or, more likely, a combination. The constancy of the therapist’s positive regard was described by these clients as an important stabilizing factor in the relationship. The resonance here with Rogers’ construct of unconditionality is noteworthy. Rogers acknowledged that unconditionality was a matter of degree, an ideal to which therapists could aspire while acknowledging their limitations as humans: “the effective therapist experiences unconditional positive regard for the client during many moments of his contact with him, yet from time to time he experiences only a conditional positive regard” (Rogers, 1957/1992, p. 829). Rogers might have added, as anyone who has seen the film of his work with Gloria (Shostrom, 1965) can attest, that the skilled client-centered therapist may manage (borrowing from Winnicott) to convey a “constant-enough” sense of unconditional positive regard that his clients experience it as such.
Whether clients experience positive regard immediately or feel it blossom gradually throughout the early phase of psychotherapy, these initial experiences with positive regard appear to comprise the “foundation of positive regard” theme related to Domain 4 (discussed above under Question 3). Clients evidently recall and draw on representations of their therapists’ regard for them earlier in the relationship as a reference point when navigating critical moments, such as ruptures, later in the therapy.

**Question 4 summary.** The experience of positive regard, for most clients, seems to grow stronger over the course of the therapy relationship. As the therapeutic relationship progresses, clients are likely more able to receive and accept their therapists’ expressions of positive regard; perhaps relatedly, it seems likely that therapists grow more able to offer sincere expressions of positive regard grounded in a deeper understanding of their clients. For a substantial minority of participants, however, positive regard is present at the outset of therapy and is experienced as fairly constant or unconditional. In examining the longitudinal experience of positive regard, whether it evolves over time or remains constant, clients make use of the history of positive regard in the relationship in guiding them through critical moments of therapy.

**Question 5: To What Extent do Client or Therapist Demographic Variables, or Dyadic Demographic Variables, Impact Upon or Relate to Clients’ Experience of Positive Regard?**

In Domain 7, only a few demographic markers emerged with adequate frequency in the sample to be noted as having relevance to positive regard. A majority of participants endorsed the sentiment that they were more likely to experience positive regard from a female, rather than a male, therapist – a finding that is in line with much of
the literature on clients’ preferences for counselor gender (e.g., Pikus & Heavey, 1996). This inclination related in some cases to gender match – since the overwhelming majority of participants were female, and some did specify gender match as important – and in other cases to more intrinsic factors, with some participants stating outright that they believed women therapists to be more nurturing and less judgmental. The majority of participants also expressed the belief that older, more experienced therapists were more effective in communicating positive regard than younger or less experienced therapists. To the extent that veteran therapists have the confidence to do things less “by the book,” this impression may dovetail with the abovementioned connection between therapist flexibility and positive regard. Finally, a subset of participants expressed the view that having a therapist of similar age might enhance positive regard, as they would be better able to relate to the client’s phase of life.

The majority of participants denied that race, ethnicity, or sexual orientation – either their own or their therapists’ – had an impact on their experience of positive regard. This finding runs somewhat counter to suggestions in the literature that positive regard may be particularly essential to work with clients from marginalized or stigmatized populations, such as sexual minorities (Lemoire & Chen, 2005) or racial and ethnic minorities (Farber & Doolin, 2011). One possibility is that because participants generally responded to the demographics question as a matter of “relatability,” social desirability concerns might have hindered them from voicing the idea that they would not relate as easily with a therapist of a different race, ethnicity, or sexual orientation. Though a few queer participants did report problems associated with their therapists’ not believing their stated sexual orientation, other gay and bisexual respondents articulated the sense that
Sexual orientation had no bearing on their experiences with positive regard. Because of the substantial proportion of non-straight-identified participants in the sample, the absence of a significant finding here is unlikely to be due to insufficient representation. Most likely, the intersection of a variety of demographic and personal factors not captured here dictate whether sexual minority clients feel particularly vulnerable and in need of positive regard (of note, cis- or transgender identity status was not queried).

Regarding race and ethnicity, given that the vast majority of the therapeutic dyads described in the sample consisted of white clients with white therapists, the lack of positive findings should be viewed with some skepticism. A separate study focusing on the experiences of racial and ethnic minority clients could offer more comprehensive results on the role of positive regard in the dynamics of racially mixed and matched therapist-client dyads.

The lack of consensus within the sample on the implications of race, gender, age, and sexual orientation for the experience of positive regard in therapy does not tell the full story. The majority of participants provided rich accounts of the extent to which dyadic demographic factors (including ones not specifically queried, such as differences in education level, agnosticism, and marital status within the dyad) were particularly salient for their experience of positive regard; unfortunately, these data were idiosyncratic and could not be coherently abstracted in the cross-analysis. Each client evidently comes to the therapy relationship with his own personally meaningful set of socio-demographic priorities and is sensitive to similarities and differences within the dyad according to these priorities. While there is a risk that the therapist will inadvertently ignore or
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invalidate these identity themes; conversely, there exist ample and rich opportunities to explore these perspectives in a sensitive way that promotes positive regard.

Participants’ reports on positive regard in two special settings – hospitals/clinics and psychoanalysis – though occurring in small numbers, were worth mention. While the vast majority of respondents had only received therapy in private practice, two endorsed experiences in a community mental health or hospital setting. These two participants’ unequivocal statements about the rarity of positive regard suggests that building a strong therapeutic relationship in these settings is particularly challenging, though this suggestion is merely speculative and merits further investigation. Among the hypotheses that might be considered: the demands placed on clinicians working on inpatient units and in community mental health may explain this phenomenon; the shorter courses of treatment and frequent turnover found in these settings might cut short the development of a foundation of positive regard; the restrictions of an institutional setting and the managed care environment could compromise therapists’ ability to be flexible and responsive to their clients’ needs; and larger caseloads, more severe pathology, and concomitant burnout may deplete clinicians’ ability to draw on the necessary inner resources to relate to patients with warm authenticity and empathic acceptance. Alternatively, and again speculatively, client factors rather than therapist factors may determine the lower levels of positive regard reported by participants in our study describing therapy in institutional settings. To the extent that these clients are likelier to be exposed to systemic oppression and trauma, they may themselves be less capable of perceiving and trusting even the best-intentioned therapists’ bids at demonstrating positive regard. Though causality cannot be inferred, the moderator analyses in Farber
and colleagues’ most recent meta-analysis (in press) hint similarly at the differential impact of positive regard across these factors. When moderators were considered individually, the contribution of positive regard to therapy outcomes was stronger in individual (as opposed to group) therapy, conducted in outpatient (as opposed to inpatient) settings, for clients diagnosed with mood and anxiety disorders (as opposed to severe mental illness) – three factors that are more characteristic of private practice than institutional settings.

Regarding the psychoanalytic situation, only two clients had experience with classical psychoanalysis (i.e., use of the couch), but they both stated that they experienced more positive regard when conducting therapy face-to-face than when lying on the couch. Their reports lend added weight to the impression discussed above that clients’ perceptions of positive regard depend on therapists’ nonverbal cues at least as much as their verbal interventions. The finding is also in line with the emphasis on neutrality and detachment traditionally associated with psychoanalysis.

**Question 5 summary.** There was minimal consensus in the sample regarding the relationships among client, therapist and dyadic demographic variables and the experience of positive regard in therapy. Two typical exceptions were that female therapists and older therapists were viewed as more effective in conveying positive regard to their clients, and one variant exception was the sense that a similarly-aged therapist might be more relatable. Outside of these variables, respondents offered idiosyncratic views on which, and to what extent, sociodemographic variables might impact upon their perceptions and needs for positive regard. Two small subsets of participants with special experiences in therapy setting and modality were uniform in
their opinions that positive regard was rare in a hospital/community clinic setting as compared with private practice, and that positive regard was experienced more strongly during face-to-face therapy than when lying on the couch in psychoanalysis.

**Question 6: Do Clients Feel There can be Such a Thing as “Too Much Positive Regard?”**

Participants largely responded to this question in the affirmative. While not all of the respondents endorsing this view could point to specific experiences in which a therapist’s expression of positive regard seemed excessive, they could at least imagine what such an experience would look and feel like. The consensus, catalogued in Domain 2, was that positive regard relies on a balance of support and challenge, and that therapists who were overly complimentary or positive towards their patients could be viewed as insincere and unhelpful. Therapists who challenge their clients offer positive regard both through their willingness to be forthright and through their belief that the client is durable enough to handle and work with honest feedback. This finding gives added weight to the impression of authenticity and positive regard as mutually reinforcing components of the therapy relationship, despite their seemingly contradictory relationship.

**Question 6 summary.** For a majority of participants, positive regard does not consist of immoderate praise and validation. Rather, according to clients, therapists most effectively demonstrate positive regard by having enough faith in their clients to balance their sincere expressions of support against honest feedback that will challenge clients to do the work of therapy. Clients seem inclined to view an excess of positive regard with
suspicion and are predisposed to experience it as trustworthy and affirming when it is delivered in moderation.

**Question 7: What, if Anything, do Clients Wish Might be Different About Their Experience of PR in Therapy?**

While most clients reported being generally satisfied with the level of positive regard they experienced in their current therapy relationship, the themes of Domain 8 offered insight into the markers of positive regard that felt particularly salient to the sample as a whole, and the areas where they thought their therapists might benefit from an adjustment to their approach. More than half of the sample suggested that therapists be transparent and communicative with their clients, and a majority also recommended that they be attentive and responsive to the client as an individual. A smaller subset of respondents proposed that a caring, nonjudgmental stance towards the client would serve to optimize positive regard. These three attitudes mirror the higher-level clusters discussed above. The first suggestion, expressing a desire for transparency and open communication, highlights clients’ wish for the authentic, human relationship encapsulated by the themes of Cluster 1, Warm Authenticity. The therapist who embodies this attitude communicates something along the lines of, “I like you enough to be real with you.” The second suggestion, regarding attentiveness and responsiveness, reflects the wish for a therapist who pays careful attention to what the client says, feels, and needs and who is more concerned about the client as an individual than about considerations such as boundaries, frame, and role. The therapist who fulfills this wish – embodying the qualities of Cluster 2, Flexibility and Responsiveness – seems to be saying to his client, “You are important enough to merit attention and accommodation.” Finally, the third
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suggestion reflects clients’ need to be understood and embraced as they are, an idea that resonates with Cluster 3, Empathic Acceptance. In fulfilling this need, therapists convey the message, “I ‘get’ you, and you are okay just the way you are.” The overall impression is the therapist’s signaling, in a variety of ways, that the patient is a person of worth: someone deserving of the therapist’s affection, attention, accommodation, sincerity, and empathy.

**Question 7 summary.** Participants generated three suggestions for how therapists might enhance positive regard, and these three suggestions largely overlap with the clusters of positive regard behavior proposed above, lending further credence to their validity. The suggestion that therapists be transparent and communicative connects closely to the *Warm Authenticity* cluster. The suggestion that therapists be attentive and responsive to the client as an individual relates to the *Flexible Responsiveness* cluster. Finally, the request that therapists take a caring and nonjudgmental stance towards the client shares thematic overlap with the *Empathic Acceptance* cluster.

**Question 8: Do Clients Experience Positive Regard More Through Their Therapists’ Explicit Verbal Statements, or More Through Non-Verbal Modes of Communication?**

This question derived from Suzuki and Farber’s (2016) findings that PEPR Unique Responsiveness scores were identified as a stronger predictor of overall ratings of therapist positive regard than PEPR Supportive and Caring Statements scores (though both were statistically significant). The interview thus incorporated a prompt related to this matter: when participants were asked about features of their therapists’ behavior that seemed to specifically convey positive regard, a probe differentiating between verbal
and/or nonverbal cues was included as a follow-up if not specifically mentioned by the respondent. While a small number of respondents verbalized an inclination towards one mode or the other as particularly relevant for positive regard, at a group level the findings were null on this point, with most participants replying that both verbal and nonverbal interventions played a role in their experience of positive regard.

The themes of Domain 2 shed further light on this question. Nonverbal expressions of positive regard were cited as a General theme, while explicit affirmation, reassurance, or positive feedback was endorsed as contributing to positive regard with Typical frequency. The unanimity within the sample that nonverbal interventions serve as markers of positive regard, as well as the sense that positive regard is often experienced through a therapist’s underlying attitude, speaks to the impression that positive regard is conveyed implicitly, or through a general approach to the therapy relationship. This suggests that both verbal and nonverbal modes of communication play a role in how therapy clients perceive positive regard, but that nonverbal communication may be more universal.

A more careful examination of the data, however, suggests that these distinctions are somewhat fuzzy. The theme of nonverbal communication was construed quite broadly, ranging from therapists’ body language and tone of voice to instances where the therapist went above and beyond on behalf of the client (e.g., attempting to visit the client in the hospital; advocating for the client regarding insurance coverage). Furthermore, respondents identified a multitude of therapist attitudes and behaviors that represented a combination of the verbal and nonverbal, such as therapist “emotional engagement” and “nondirectiveness and acceptance of feelings/experiences.” Examining the factor
loadings for the PEPR Unique Responsiveness subscale, the highest-loading items (i.e., “My therapist summarizes what I have said accurately” and “My therapist remembers the name/details of someone or something I have discussed in the past”) themselves represent verbal interventions, though not necessarily explicitly affirming statements.

How, if at all, does the PEPR Supportive and Caring Statements factor align with the three-component model of positive regard suggested by the results of this study? The majority of PEPR items comprising that factor best reflect the Warm Authenticity cluster (e.g., “I’m glad you shared that with me,” “I’m proud of you”). This correspondence is primarily tautological, an artifact of the process of generating items for the inventory, which conceptualized positive regard primarily in terms of warmth. A complete review of the PEPR Factor 1 items finds that at least one item seems to fit more appropriately under the Flexible Responsiveness cluster (“This is a space for your own healing and growth”), while a few are most relevant to the Empathic Acceptance cluster (e.g., “That must have been very difficult,” “What you are feeling is normal”). Furthermore, a few statements do not fit clearly into one cluster, as their specific meaning and import could vary depending on the situation and relationship dynamic in which they are delivered (e.g., “That was a good session,” “I think you’re right”). Suzuki and Farber (2016) acknowledged the extent to which the decontextualized and general phrasing of the PEPR Supportive and Caring Statements items likely contributed to their collective loading on a single factor. The qualitative data, on the other hand, give added weight to the impression that warm authenticity, flexible responsiveness, and empathic acceptance can be communicated via both verbal and nonverbal channels, and that drawing neat distinctions between the two is not entirely possible or necessary.
**Question 8 summary.** Both nonverbal and verbal interventions play an important role in the communication of positive regard in psychotherapy. A critical look at the data suggests that the distinction between these modes of expression of positive regard may be less important than indicated by the structure of Suzuki and Farber’s (2016) PEPR inventory.

**Question 9: Do Clients’ Descriptions of Positive Regard Appear to have any Overlap with the Rogerian Constructs of Empathy and/or Congruence?**

This matter was addressed above as part of Question 2, as the emergent higher-order clusters showed a strong relationship to the other Rogerian facilitative conditions. These phenomenological findings are in keeping with the consistently high intercorrelations found particularly among the empathy, congruence, and level of regard subscales on the BLRI since the early development of the instrument (Barrett-Lennard, 2015; Gurman, 1977) and with factor analytic findings that all three subscales typically have high loadings on a single global factor (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Gurman, 1977; Watson & Geller, 2005).

To briefly review: the themes of Cluster 1, with their emphasis on a warm and authentic relationship, have significant overlap with congruence. The frequency (General) with which authenticity and disclosure were mentioned by participants is striking and suggests that patients experience positive regard and congruence as inextricably intertwined. Clients presume, probably accurately, that their own natural inclinations to be more open and personable with therapists towards whom they feel warmly (Henretty & Levitt, 2010), reciprocally guide their therapists’ behavior towards them. Thus, a therapist who is interpersonally warm and self-disclosing, who gives the
impression of being unconstrained by his or her professional role and interested in interacting on a genuine, human level with clients, understandably will be perceived as offering high levels of positive regard in the relationship.

More than half of participants also referenced a relationship between the experience of feeling understood and positive regard, indicating the mutually dependent nature of positive regard and empathy as well. Empathy – the capacity to inhabit and accurately reflect back the lived experience of the client – requires an effortful process on the part of the therapist to enter into the client’s subjectivity. Evidence that the therapist has undertaken this effort on the client’s behalf is likely to be interpreted as evidence of his or her regard for the client, since it demonstrates the therapist’s belief that such an effort is valid and worthwhile. Further, the experience of feeling understood has the effect of increasing the closeness in the dyad, and this connectedness fosters the overall climate of mutual sympathy and warmth in the relationship. The interconnectedness of these variables, particularly of empathy and positive regard, is particularly important for understanding positive regard’s contributions to therapy outcomes, in light of the solid evidence base for the relationship between empathy and outcome.

Question 9 summary. Put simply, the answer to this question is yes. Without being primed to do so, therapy clients spontaneously make reference to congruence and empathy when asked about their experiences with positive regard. It seems clear that therapy clients are predisposed to interpret therapists’ empathic and congruent behaviors as reflective of an overarching attitude of positive regard. The facilitative conditions are likely best understood as intertwined and mutually reinforcing features of the therapy relationship.
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Question 10: Do Clients Identify Instances of Therapist Boundary Extension, Intimacy, and/or Disclosure as Having Any Impact on Their Perceptions of Positive Regard, Whether Positively or Negatively?

This question stemmed from the need to clarify findings from the initial quantitative phase of this study, in which the Intimacy/Disclosure factor was found to be positively related to positive regard in a simple bivariate correlation but revealed to be a negative predictor of positive regard ratings when entered into a regression analysis. This factor contained items reflecting both physical touch (e.g., “My therapist puts his/her hand on my shoulder”) and evidence of therapist self-disclosure (e.g., “My therapist shares something personal about his/her life”) and emotional investment (e.g. “My therapist has tears in his/her eyes as I relate a sad story”). The qualitative data help to clarify how therapy clients conceptualize and react to these different types of intimacy and connection in the therapy relationship. Participants, without being prompted, offered ample evidence that boundary extension, self-disclosure, emotional intimacy, and physical intimacy have a significant impact on their experiences with positive regard, though their level of agreement on the specific impact of these interventions varied.

Respondents were largely unanimous that appropriate self-disclosure, insofar as it relates to therapist authenticity, is a significant marker of therapist positive regard. In being willing to share a piece of themselves with their clients, therapists convey to their clients that they like them enough to be real with them. Conversely, when therapists rigidly adhere to the professional parameters of their role, this puts a strain on positive regard. Beyond disclosure of specific personal details, the data also indicate that self-involving self-disclosures are critical to positive regard. Therapists who are clearly
emotionally engaged in the relationship with their clients, who imbue the relationship with a sense of mutuality, and who are transparent and open in providing feedback to their clients communicate high levels of positive regard.

Another widely shared impression was that therapists’ willingness to be flexible around boundaries communicates positive regard. Though this flexibility relates conceptually to the self-disclosure themes discussed above, it is distinguished by its focus on the mechanics of the therapeutic situation, including session start and end times, cancellation policies, and availability outside of session. In being somewhat relaxed rather than overly rigid around issues related to therapeutic frame and role, therapists demonstrate a level of care and attunement that shows their clients are more than just "patients" to them. Along similar lines, the rare finding that some clients experienced their therapists’ willingness to enter into dual role relationships with them as affirming is noteworthy. Though dual relationships are treated as ethically problematic in the ethical principles and code of conduct for psychologists (APA, 2017), the endorsement of this theme by three respondents within a fifteen-person sample suggests that this practice is more prevalent than many might expect.

While emotional intimacy was overwhelmingly viewed by the sample as an indicator of positive regard, participants were more divided on expressions of physical intimacy. Of note, the topic of hugging, brought up by several participants, was the only mention of physical contact in the data. This was a topic that emerged unprompted – touch of any kind was not addressed in the semistructured interview protocol – with a range of viewpoints and experiences. Some respondents stated that hugs were a regular feature of their therapy that promoted the feeling that their therapist liked them; others
reported wishing for an occasional hug but feeling overwhelmed by anxiety at the
prospect of raising such a taboo topic with their therapist; and still others were definitive
that while they might feel the occasional desire for a hug from their therapist, the reality
of such a transaction could actually be detrimental to their experience of positive regard.
In some cases, therapists’ willingness to extend boundaries in atypical ways was taken as
evidence of the patient’s likeability, though this impression could be undone if the
therapist seemed stiff or awkward in the transaction. These conflictual findings are
perhaps inevitable: while therapists aim to cultivate intimacy and connection to facilitate
their work, and for some clients hugging may seem a natural consequence, the norms
related to physical contact in therapy have grown increasingly conservative, causing
therapists and often clients to be extremely wary of any form of touch. While there is no
easy solution to this conundrum, this study suggests that the issue is very much on
clients’ minds.

Many participants clarified, however, that reasonable limits on the extent of
boundary extension were an essential component of these expressions of positive regard,
and that if taken too far the opposite impression could result. Indeed, a sizeable minority
of participants voiced the opinion that excessive boundary crossing signaled a distinct
lack of positive regard. While only two of these participants specifically referenced
hugging, it is likely that if queried directly a larger proportion of the sample would have
endorsed similar discomfort with the crossing of this boundary. Even some participants
who verbalized a wish to be hugged by their therapists also added that they would not
want this wish to become a reality, suggesting that therapists who uphold these
boundaries serve an important function. Similarly, participants specified that self-
disclosure for its own sake was generally not experienced as positively regarding; in fact, participants voiced the sentiment that when their therapists shared immoderately it signaled a loss of focus and attention on the client.

**Question 10 summary.** The qualitative data shed new light on Suzuki and Farber’s (2016) finding of the negative relationship between Intimacy/Disclosure and positive regard. Therapist interventions that emphasize emotional intimacy and authentic connection in the therapeutic relationship are widely interpreted as fundamental to positive regard; therapists can help to forge this dynamic through appropriate self-disclosure and other sincere displays of warmth and investment in the client. The sense that flexibility around professional boundaries provides evidence of the therapist’s positive regard was also typical in the sample. The introduction of the variable of physical touch generated more controversy. A small but unequivocal subset of participants indicated that hugging specifically was, or hypothetically might be, experienced as evidence of positive regard. Participants endorsing this view acknowledged the traditional prohibition against physical contact in the therapeutic dyad but had found that based on their personal histories the normalization of touch in the therapeutic relationship was healing and affirming. Dual role relationships, though rare in the sample, served as another source of positive regard for some participants. However, other participants emphasized that the therapists’ inability to maintain appropriate boundaries, whether related to touch, self-disclosure or otherwise, could be severely detrimental to positive regard. Clinicians interested in conveying positive regard will aim for attunement to the relevance of boundary issues for their clients and to promote opportunities for an authentic exchange of thoughts and feelings on the matter.
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Limitations

Adherence to the methods of Consensual Qualitative Research – including open, nondirective inquiry; member triangulation and checking; consensus; and validation by an external auditor – bolsters the trustworthiness of the results of this study. Qualitative research seeks to “organize and describe phenomena with depth and richness” with the goal of credibility, rather than testing specific hypotheses and attaining statistical significance. While statistical generalizability is therefore not at issue, the composition of the study sample nonetheless merits a critical eye. From a demographic perspective, the sample consisted predominantly of white female clients paired with white female therapists, representing a significant restriction of range of client demographic perspective and experience. Thus, to the extent that the findings are representative of clients’ experiences with positive regard, it must be acknowledged that these views may not be as applicable to non-white or male therapy clients, or to clients whose therapists’ race and gender differ from their own. Put more succinctly, this study is most credible when understood as representing white female clients’ views and experiences with positive regard.

Furthermore, as noted above, it is possible that selection bias contributed to an overrepresentation of satisfied psychotherapy clients in the sample. The participants consisted of fifteen volunteers drawn from a non-randomly-selected original sample of psychotherapy clients who had initially sought out the opportunity to participate in an online survey nearly a year earlier. Thus, each interview represented the culmination of a lengthy recruitment process, ensuring that only highly motivated participants were included. Though respondents’ motivations can only be inferred, the focus of the study
on positive experiences in the psychotherapy relationship was more likely to resonate with clients who hold strong positive feelings about their therapy experience.

Because the trustworthiness of qualitative research is dependent on the checks offered by the diverse perspectives that comprise the research team, the contributions and inevitable limitations of each research team member’s individual viewpoints must be acknowledged. The size of the team (five members at its peak) and the use of an external auditor offered ample opportunities to provide checks against bias. Nonetheless, qualitative methodology relies on the subjectivity and interpretive abilities of research team members, and as a result the possibility of skewed interpretations of the data must be acknowledged. Furthermore, the semi-structured interview format, though conducted by the principal investigator in as consistent and open-ended a manner as possible, introduces the possibility of error and bias as the content elicited may have varied according to the rapport established with the participant and the particular choices made by the interviewer.

The self-report methodology constrains the scope of this study to what therapy clients are consciously able to report about their experiences with positive regard, and it rests upon the assumption that participants are reporting accurately on their experience. Furthermore, no data was collected on the presenting issues or diagnostic history of our participants, both of which likely impact clients’ experiences, impressions, and needs related to positive regard. Farber et al. (in press) speculated that clients’ personality pathology, especially borderline, antisocial, and narcissistic features, may dictate the ease or authenticity with which therapists are able to access and express positive regard, but the nature of our data does not allow us to shed any light on this issue.
A QUALITATIVE INVESTIGATION OF POSITIVE REGARD

It should further be noted that the study is exclusively focused on the experience of therapy clients, with no data available on the therapists’ perspective. The therapists’ intentions in the relationships and interactions described by participants, as well as their relevance to positive regard in the minds of the therapists themselves, are unknowable. This focus on the subjective experience of the client aligns with the emphasis of client-centered theory but represents a significant limitation to our understanding of positive regard as it is enacted in the therapeutic dyad.

Clinical Implications

This study aimed to elucidate a construct that is both central to clinical practice and under-investigated from an empirical perspective. The open-ended form of inquiry invited a deeper understanding of the complexity of therapy clients’ experiences with positive regard, and the results offer several insights into how positive regard facilitates therapeutic work and into how it can be optimized to benefit the therapeutic process.

Speaking broadly, the data upheld positive regard’s standing as an essential feature of all therapy relationships. This held true across therapeutic modalities and orientations: clients engaged in individual psychodynamic, psychoanalytic, CBT, and EMDR treatment, as well as couples therapy, all cited positive regard – and its absence – as playing a significant role in treatment success or failure. Positive regard was valued by clients in private practice, outpatient community health, and inpatient hospital settings. The trend suggesting that positive regard is less commonly experienced in non-private-practice settings is of special interest for clinicians employed in those settings. Recognizing the systemic and personal factors that operate to the detriment of positive
regard, institutionally-based clinicians may need to redouble their efforts to ensure that positive regard is conveyed and received by their patients.

The universality of positive regard notwithstanding, clinicians contemplating how best to convey positive regard may be influenced by the theoretical underpinnings that inform their work. Practitioners of psychoanalysis, or other approaches that value neutrality and detachment in pursuit of transferential interventions, may be less inclined towards overt expressions of warmth and affirmation. Participants in this study who had experience with psychoanalysis indeed provided the impression that they perceived less positive regard in that form of treatment than in other types of talk therapy. Furthermore, a few participants cited their therapist’s silence in session as evidence of a lack of positive regard, as part of the Being unresponsive to client’s needs and sensitivities theme in Domain 3. Clinicians should accordingly be aware that this approach may be interpreted as a lack of positive regard.

Nonetheless, this impression offers only one additional data point within the context of a sparse and inconclusive literature on positive regard and theoretical orientation. A 2005 study (Watson & Geller) found that process-experiential therapy (an emotionally focused form of client-centered therapy) clients had higher ratings of therapist positive regard than CBT clients, with no other differences found for the other facilitative conditions. Farber and Doolin’s (2011) meta-analysis, too, suggested the presence of a moderator effect for therapy orientation, in that the impact of positive regard on therapy outcomes was highest in psychoanalytic/psychodynamic treatment. However, they also noted that no studies that met their inclusion criteria included patients receiving Cognitive Behavioral Therapy. The more recent and comprehensive meta-
analysis by Farber and colleagues (in press) had more even representation across modalities and replicated this finding when moderator variables were entered individually, though this effect disappeared when all variables were entered into the model simultaneously. Furthermore, an investigation of differences in positive regard by orientation using the original dataset described by Suzuki and Farber (2016) found no significant differences in client ratings of positive regard as measured by the BLRI across treatment orientations (Suzuki, Colvin, & Farber, 2016). Differences in PEPR ratings of therapist likelihood of providing Supportive and Caring Statements and offering Intimacy/Disclosure were noted, with CBT therapists rated as being more likely than psychodynamic providers to offer both of these interventions; however, the two groups did not differ in their likelihood of offering Unique Responsiveness interventions. Suzuki et al. (2016) concluded that while theoretical differences may lead to different clinical choices of how to provide positive regard, these differences do not amount to systematic discrepancies in overall perceptions of positive regard.

With this in mind, a post-hoc, qualitative comparison of the data falling under Domains 2 and 3 was conducted to identify trends or differences along these lines. In particular, the evenly-sized CBT and psychodynamic groups were compared for differences in the frequency of thematic endorsements. No notable group differences emerged in Domain 2, but a few trends were identified in Domain 3, suggesting that certain differences in therapist failures of positive regard may depend on treatment orientation. Specifically, a higher proportion of psychodynamic clients cited Being unresponsive to the client and his/her needs and sensitivities and Maintaining rigid boundaries as markers of a lack of therapist positive regard, while a higher proportion of
CBT clients endorsed the theme *Not believing/understanding the client*. The impressionistic and non-statistical nature of this comparison cannot be overemphasized; however, these findings seem to carry at least some face validity, as the emphasis on nondirectiveness and non-gratification of client wishes in psychodynamic work, as well as the focus on interrogating and changing maladaptive thoughts typical of cognitive behavioral treatment, could reasonably represent stumbling blocks to clinicians in their efforts to provide positive regard.

The reasons that clinicians might wish to optimize their clients’ experience of positive regard, regardless of work setting or theoretical orientation, are many. The data suggest that, from the outset of therapy, clients are attuned to indications of positive regard in their therapists’ behavior, and that a foundation of positive regard developed early in the relationship can pay substantial dividends later on, while the therapeutic dyad works through particularly thorny issues that require high levels of client motivation. Throughout the course of the relationship, the presence of positive regard in the relationship facilitates therapeutic progress by encouraging client self-disclosure, facilitating the resolution of ruptures, and preventing early termination. Positive regard also appears to have significant impact on therapy outcomes, including promoting self-exploration and improving self-esteem and social functioning. The data suggest that therapist positive regard is closely related to other factors that have been more extensively researched and deemed critical to clinical outcomes, such as working alliance, therapist empathy, and client self-disclosure. It is therefore indicated that therapists work actively to convey warmth, respect, and interest to their clients – in a
fashion authentic to their personal style and consistent with their theoretical leanings – from the start of treatment.

Positive regard and its critical role in the change process in therapy are too often underemphasized in clinical training. The process of identifying and implementing modes of expression of positive regard that feel comfortable and authentic to the clinician should begin early in the training process, with clinical programs offering ample opportunities for trainees to discuss their individual inclinations towards the provision of positive regard towards clients. Trainees should be educated about the significance of positive regard and the facilitative conditions for psychotherapeutic process and outcome, and these components of client-centered theory should receive equal weight in didactic instruction on the theoretical underpinnings of clinical intervention. Furthermore, trainees who encounter ruptures and impasses in the course of treatment should attend to the affective quality of the relationship and consider the possibility that the client is experiencing a lack of positive regard. A proactive investigation of this hypothesis is especially important given clients’ hesitancy to articulate their desires for positive regard, or to raise the issue when they feel that those desires have been disregarded. Clinicians who fail to address clients’ need for positive regard run the risk of premature termination.

The wide range of interventions cited by participants as contributing to positive regard is striking, and it affords clinicians significant leeway in considering how best to affirm their clients. The data suggest that three fairly broad constructs are fundamental to the experience of positive regard: Warm Authenticity, Flexible Responsiveness, and Empathic Acceptance. Taken together, the overarching impression is that therapists convey positive regard through a set of attitudes that acknowledge both their clients’ and
their own essential personhood, treating the therapeutic situation as a profoundly human endeavor without losing sight of the fact that the therapist is the professional whose first priority in the relationship is always the care of the client. Though respondents offered a wide and often conflicting set of specific therapist behaviors that served as salient markers of positive regard, the pervasiveness of these three overarching attitudes suggests that they are somehow fundamental to clients’ experience of positive regard. The implications of this finding are both liberating and daunting: On the one hand, there is no single right way for a clinician to offer positive regard; no list of constraining dos and don’ts to ensure that clients will feel affirmed. On the other hand, the provision of positive regard is not subject to rote mastery; rather, it is a dynamic variable that requires clinician sensitivity to complex factors, including dyadic elements, such as the intersection between a therapist’s authentic style and his or her client’s unique set of needs, vulnerabilities, and attitudes. Navigating an appropriate balance of authenticity, responsiveness, and acceptance essentially requires clinicians to “create a new therapy for each patient,” as per Yalom (2010), since the same intervention can be perceived by different clients as strongly facilitative or detrimental to positive regard (e.g., hugging), and since seemingly opposite interventions can be experienced by clients as equally contributory to positive regard (e.g., directiveness and nondirectiveness). Yet the very elements that complicate the provision of positive regard also offer the tools to resolve this conundrum – through open and authentic communication, and flexibility and responsiveness to client feedback, clinicians will learn how best to support their clients. Furthermore, the process of inquiry itself reinforces the sense of acceptance, attunement, and mutuality that underlie the positive regard experience.
Conceptual and Research Implications

Historically, positive regard has been investigated in conjunction with its sister conditions of empathy and congruence. By focusing in on clients’ experiences with positive regard, this study aimed to generate a more precise understanding of how this facilitative condition in isolation is understood and experienced by clients. The data, however, suggest that clients perceive positive regard as inextricably linked with the other facilitative conditions. This finding echoes Rogers’ writings on the facilitative conditions, which emphasized their mutually dependent nature. In practice, as in research, disconfounding them is an artificial exercise. Other elements of client-centered theory found support in the data, including the self-actualizing tendency, the sense that the therapist’s positive regard gradually is internalized and adopted by the client, and the idea of unconditionality as being an important component of the experience of positive regard.

Though unanticipated at the outset, this study also yielded a new proposal for a dimensional structure of positive regard. Because this study was initially motivated by the need to clarify and build upon Suzuki and Farber’s (2016) findings related to the PEPR factor structure, the question bears asking: to what extent does the qualitative three-cluster model proposed in this study relate to the aforementioned dimensional structure of positive regard identified in the quantitative arm of this study (i.e., Factor 1: Supportive and Caring Statements; Factor 2: Unique Responsiveness; Factor 3: Intimacy/Disclosure)? As discussed above under Question 8, the specific items that comprise the Supportive and Caring Statements subscale on the PEPR primarily seem to fit within this study’s Cluster 1, Warm Authenticity. While the qualitative data
corroborate, unsurprisingly, that therapists’ explicitly positively regarding statements can be quite effective in conveying warmth, the real-life examples offered by participants in this study are diverse in context and content, serving objectives beyond merely expressing support and caring. The paucity of strong responses or trends in regard to the question about nonverbal vs. verbal interventions suggest that content, rather than mode of intervention, is the more relevant lens through which most clients understand positive regard, and thus this factor should be reconceptualized in future studies of positive regard.

Most promising in this study is the correspondence between Suzuki and Farber’s (2016) second factor, Unique Responsiveness, and the second cluster proposed by this study, Flexible Responsiveness. In the previous study, Unique Responsiveness was found to be the strongest predictor of client ratings of therapist positive regard. While this factor was wide-ranging in its content, its constituent items relate thematically to the constructs of flexibility and responsiveness presented above; namely, that the therapist has paid careful attention to the client as a unique individual and is able to make interventions that acknowledge his particular set of experiences and needs. These thematically resonant findings give additional validity to the idea that responsiveness is a critical dimension of positive regard.

Finally, as discussed above under Question 10, the qualitative data help to untangle the strands of Suzuki and Farber’s (2016) Intimacy/Disclosure factor and better understand the delicate balance required of clinicians in their communication of positive regard. The PEPR items corresponding to emotional intimacy are most relevant to the Warm Authenticity cluster, while the PEPR items corresponding to physical intimacy are
most relevant to the Flexible Responsiveness cluster, suggesting that in future studies a clearer demarcation is called for, given the generally positive responses to the former and the generally negative responses to the latter. Nonetheless, the CQR process allowed for divergent voices and preferences to emerge, making room for a not-insignificant subset of clients whose preferences do not line up with these generalizations, and hinting at the possibility that a minority of therapists with satisfied clients may be engaging in boundary extension beyond typically accepted clinical rules of thumb.

**Future Directions**

This study suggests several potentially fruitful lines of follow-up investigation. First, given the significant lack of racial and ethnic diversity in the sample, future studies might focus specifically on the experience of racial and ethnic minority clients in terms of positive regard. While our sample tended to underemphasize the impact of race on positive regard in the therapeutic dyad, the extent to which respondents cited “being able to relate” as an important marker of positive regard suggests that there is more to understand about this dimension of treatment.

Furthermore, an analogous qualitative investigation of clinicians’ experiences with providing positive regard could shed useful light on the client perspectives identified here. The breadth of interventions that clients reported as contributing to their impression of positive regard is striking, and it is possible that clinicians are conceptualizing their positive-regard focused interventions more narrowly and with less complexity than the clients in this study, though that hypothesis requires investigation using a similarly open-ended methodology. The study also raised intriguing questions about the extent to which therapy modality and therapeutic setting can impact upon the provision or reception of
positive regard. These questions are perhaps best asked of clinicians themselves. Specifically, a CQR study in which psychodynamic, CBT, and humanistic therapists are invited to reflect upon the manner in which their training and orientation guide and hinder their efforts to offer positive regard could highlight important commonalities and differences. Another study in which hospital-based clinicians who maintain private practices are asked to compare and contrast their experiences providing positive regard in these two settings could be a meaningful follow-up.

Though this study points to strong associations among positive regard and other treatment variables, such as empathy, congruence, working alliance, and outcome, the precise associations among these variables remains unknown. Quantitative studies modeling this relationship using therapist and client ratings of positive regard could add to an understanding of the interrelationships among these variables. The BLRI is a natural choice for ratings of the facilitative conditions; however, a behavioral measure like the PEPR inventory, if properly validated, could offer a useful lens as well. For this reason, a revision of PEPR, with new exploratory and confirmatory factor analyses, incorporating the findings of this study, would be beneficial. This instrument, once validated with client and therapist populations, could provide a user-friendly and behaviorally-grounded way of measuring positive regard; further, it could represent a new tool for direct feedback to clinicians seeking to better understand their clients’ individual preferences with regard to positive regard.

As the first qualitative investigation of psychotherapy clients’ experiences with positive regard, this study offers insight into just how critical this variable is to the treatment relationship. Clients are constantly alert to indications of their therapists’
positive regard, interpreting warm authenticity in their relatedness, flexible responsiveness to their needs, and empathic understanding and acceptance as clear markers of its presence in the relationship. The provision of appropriate positive regard can yield significant returns on clients’ motivation to remain in treatment, disclose openly, and work hard to tackle challenging issues, ultimately deepening the work.
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http://dx.doi.org/10.1080/03069888608253521


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Thanks so much for agreeing to this interview. In this study, we’re trying to learn more about a concept called positive regard. I will read to you the definition for positive regard we’re using in this study: **Positive regard is a feeling you get from your therapist that s/he likes you, accepts you, respects you, and/or has genuine interest in you.** This type of warm, caring feeling may be very important in certain therapy relationships, and it may play a minimal role in others. We are interested in how much positive regard you experience in your relationship with your therapist, what sorts of things s/he does to provide you with positive regard, and whether there are things you might like her/him to do differently to offer you a greater sense of positive regard. This interview is really just like an informal conversation, so please feel free to speak naturally about whatever comes to mind while we’re talking. Do you have any questions about this?

**Question 1:** So I just mentioned that positive regard is something I’m interested in. Can you tell me how that applies to your therapy experience? *(Probe: How much, how often, how does it feel? How important is it in your therapy experience?)*

**Question 2:** Can you tell me about a specific time when you felt a lot of positive regard from your therapist? *(Probe: What was it about that time, do you think, that made the feeling of positive regard hit home for you? Was it something your therapist said/did?)*

**Question 3:** Can you tell me about a specific time when you felt a lack of positive regard from your therapist? *(Probe: What was it about that time, do you think, that made the lack of positive regard hit home for you? Was it something your therapist said/did? Were you able to recover a feeling of PR after that experience, and how did that happen?)*

**Question 4:** In those moments when you’re feeling PR, what are the things that tend to make you feel that? *(Probe: More verbal, non-verbal, experiential, mood-based?)*

**Question 5:** So aside from those usual examples, what about anything that’s less usual that comes up and might make you feel positive regard? In other words, has it ever been that your therapist did something out of the ordinary that helped you feel positive regard? Tell me about it. *(Probe: Has there ever been anything that surprised you? Letting the session run long, calling between sessions, providing a hug, offering a personal disclosure)*

**Question 6:** In what ways has positive regard shifted or changed over time while you’ve been in therapy? *(Probe: Has it become more or less important to you? Have you felt it differently, or with differing regularity?)*

**Question 7:** We’re trying to help therapists be more effective in providing positive regard. With that in mind, what might be useful for your therapist to keep in mind when thinking about providing you with positive regard? *(Probe: Do you think the fact of your therapist’s gender/race plays any role in your thoughts on this? How might these things affect your experience with positive regard in therapy?)*
- **Question 8**: It might be surprising to have me ask this, but have you ever felt like there’s such a thing as “too much” positive regard from your therapist? Or can you imagine feeling that way? Tell me about it.

So to summarize, what you seem to be saying about positive regard is…is this correct, or am I missing anything? I wonder if there’s anything we didn’t cover in this conversation that you’d want to add (are there any other questions I should have asked and didn’t)? We’re at the end of the interview and I really want to thank you for your participation. How was the experience of participating in this study, for you?
## Appendix B – Demographic Questionnaire

### Demographic Information

**ABOUT YOU:** Please provide the information below.

Please enter the Participant Code from the e-mail you received:

Your age (in years):

Your gender:
- Male
- Female
- Other (Please elaborate below)

Your racial identity (select all that apply):
- White/Caucasian
- African American
- Hispanic
- Asian/Pacific Islander
- Native American
- Middle Eastern
- Other (Please elaborate below)

Your language(s):
- I grew up speaking mostly English at home
- I grew up speaking mostly another language at home (please specify):
- I grew up speaking both English and another language equally:

Your country of residence:
- I live in the United States (Please specify which state)
- I do not live in the United States (Please specify your country of residence)

Your residential setting (select your answer from the drop-down menu):

Your sexual orientation:
- Heterosexual/Straight
- Homosexual/Gay/Lesbian
- Bisexual
- Other (Please elaborate below)
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11/19/2015

Qualtrics Survey Software

Your current relationship status (select your answer from the drop-down menu):

Your estimated annual household income (select your answer from the drop-down menu):

Your current occupation or job:

The highest level of education you have completed (select your answer from the drop-down menu):

Thanks so much -- you're nearly done! Just a few brief questions about your therapist await you on the next page. Click the arrow to proceed.

THERAPIST DEMOGRAPHICS

ABOUT YOUR THERAPIST: Please answer the following questions to the best of your ability.

What would you say your therapist's age or age range is (select your answer from the drop-down menu)?

What is your therapist's gender?

☐ Male
☐ Female
☐ Other (Please elaborate below)

How would you describe your therapist's ethnicity or race (select all that apply)?

☐ White/Caucasian
☐ African American
☐ Hispanic
☐ Asian/Pacific Islander
☐ Native American
☐ Middle Eastern
☐ Other (Please elaborate below)

What type of setting does your therapy take place in (select all that apply)?

☐ Private practice
☐ Student health clinic
☐ Community clinic
☐ Hospital
☐ Training institute
☐ Other (Please elaborate below)
What mode or type of therapy are you in, if you know (select all that apply)?
- [ ] Psychodynamic therapy
- [ ] Psychoanalysis
- [ ] Cognitive Behavioral Therapy
- [ ] Humanistic/Existential Therapy
- [ ] Other/Not Sure (Please describe what typically happens in session)

How long have you been in therapy with your current therapist (select your answer from the drop-down menu)?

How often do you see him/her (select your answer from the drop-down menu)?

How many OTHER therapists have you had (select your answer from the drop-down menu)?

How long were you in treatment with these therapists, in total (select your answer from the drop-down menu)?
Appendix C
Informed Consent

Description of the Research
Our research team in the clinical psychology program at Teachers College, Columbia University is studying the experiences of clients and therapists in psychotherapy to improve our understanding of what works in therapy. You are invited to participate in a brief online survey followed by an interview procedure over the phone, in which you will be asked about your experiences in psychotherapy, with a particular focus on things your therapist has done or could do to inspire positive feelings about your relationship. As part of our efforts to ensure accuracy and high-quality research, we will audio-record and transcribe the interviews. The audio files will only be accessed by the research team and will be deleted once the study analyses are complete; the de-identified transcripts will be kept securely and some content may be excerpted for presentation in papers and at professional conferences. The interview will be conducted over the phone by members of our research team, all Master’s or Doctorate-level students in clinical psychology. We will schedule the interview for a date and time that is convenient for you.

This interview protocol was approved by the Internal Review Board (IRB) at Teachers College, Columbia University (protocol # 15-153).

Risks and Benefits
There are risks associated with any research. For this study, the risks are similar to those that you would encounter discussing your therapeutic experience with others. The interview process is focused on positive experiences in psychotherapy, but it may nonetheless bring up difficult topics for some participants. You have the right to decline to answer any question posed to you during the interview. You also have the right to withdraw your consent and stop participation at any point during the interview. If you withdraw consent at any point during the interview, the interviewer will immediately stop the audio recording, notifying you that he/she has done so. We are able to provide information about counseling resources to participants at the end of the interview.

Payments
There will be no payment for participation in this study.

Data Storage to Protect Confidentiality
We have implemented multiple levels of privacy and confidentiality measures to ensure that participant data remains secure and confidential. Your name will not be used anywhere in the online survey or on the audio recording or the corresponding transcript; instead, a participant number will be used to identify you throughout the process of data collection and analysis. The only document linking your participant number with your identity will be saved in a password-protected file on a computer accessed only by the principal investigator of the study, and this computer itself is password-protected and the hard drive encrypted in the event that it is ever accessed by an outside party. The audio and transcript files will be saved on password-protected drives accessible only to members of our research team, and the audio files will be destroyed as soon as the analysis process is complete.
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Time Involvement:
It will take about ten minutes to complete the online questionnaires. It will take approximately fifty minutes to complete the interview.

How Will Results Be Used
Any use of questionnaire data or interview transcripts will be for professional purposes only and in the interests of improving professional standards through research or training programs. Data may be reported in professional publications and conferences. We plan to report group results, such as, "Most psychotherapy clients reported..." De-identified quotations, with personal identifying information removed, may also be reported. By participating in this project, you will be helping to advance knowledge in the field of psychotherapy research.

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
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PARTICIPANT'S RIGHTS

Principal Investigator: Jessica Suzuki

Research Title: Interview on Positive Regard in Psychotherapy

- I have read and discussed the Research Description with the researcher. I have had the opportunity to ask questions about the purposes and procedures regarding this study.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- The researcher may withdraw me from the research at his/her professional discretion.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue to participate, the investigator will provide this information to me.
- Any information derived from the research project that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's phone number is (212) 961-7176.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board /IRB. The phone number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.
- I should receive a copy of the Research Description and this Participant's Rights document.
- For the purposes of research and training,
  I ( ) consent to be audio taped.
I ( ) do not consent to being audio taped.

The audiotaped materials will be accessed only by the principal investigator and members of the research team.

- Audio taped materials
  ( ) may be played in an educational setting outside the research
  ( ) may not be played in an educational setting outside the research

- My signature means that I agree to participate in this study.

Participant's signature: ________________________________ Date: ___/___/____

Name: ________________________________