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Therapeutic Responsiveness as a moment-by-moment process of Alliance: Development of a conceptual-empirical model and an observational system

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Trabalho efectuado sob a orientação da
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THERAPEUTIC RESPONSIVENESS AS A

MOMENT-BY-MOMENT PROCESS OF ALLIANCE:

DEVELOPMENT OF A CONCEPTUAL-EMPIRICAL MODEL

AND AN OBSERVATIONAL SYSTEM

ABSTRACT

The therapeutic alliance has been referred regularly in literature as a common factor across psychotherapy approaches with consistent associations to psychotherapy outcomes. The current challenge claims for researchers to better understand the specific therapeutic actions and interactions between the client and the therapist that account for the development of alliance. I decided to focus on Therapeutic Responsiveness hypothesizing that it has a significant role in the development and quality of alliance.

My main goal was to explore and understand therapeutic responsiveness, which was believed to be a recursive and reciprocal process between the client and the therapist. Because there was not known any reliable way of assessing therapeutic responsiveness, a second goal was to develop a method to observe and analyze it as a moment-by-moment interactive process.

The research project consisted of two studies that examined therapeutic responsiveness based on the observation and analysis of videotaped psychotherapy sessions. Study 1 was a discovery-oriented phase of Task Analysis, which applied conceptual and empirical analyses to intensively study therapeutic responsiveness. Fifteen psychotherapy episodes were used to define a marker whose response points to therapeutic responsiveness, and six entire sessions to explore how therapeutic responsiveness develops. The findings of this qualitative phase of research produced:

(1) a prototype conceptual-empirical model that identifies essential components for therapeutic responsiveness at the micro-analytic level of the conversational interactions between the client and the therapist, (2) an observational tool with detailed criteria for identifying, analyzing, and coding the model components, and (3) a working model that elaborates therapeutic responsiveness at the level of more inclusive relational processes. Based on these empirical findings, the concept of Reciprocal Responsiveness was proposed defining a moment-by-moment process that requires a mutual interaction between the client's needs, the therapist's responses, and the subsequent client's reactions.

Study 2 comprised reliability statistic analyses of the observational tool components, using twelve episodes to calculate the intercoder agreement on coding the therapeutic responsiveness marker – the client's verbal expression of needs – and ten sessions on coding the subsequent therapeutic responsiveness components – the therapist's response and the client's reaction. The findings supported the reliability and, then, the usefulness of the tool.

Contributions of the empirical findings for psychotherapy practice, training and future research were discussed with the purpose of highlight reciprocal responsiveness as a psychotherapy inherent process and a promissory theme to be continuously studied.

RESPONSIVIDADE TERAPÊUTICA COMO

PROCESSO MOMENTO-A-MOMENTO DA ALIANÇA:

DESENVOLVIMENTO DE UM MODELO CONCEPTUAL-EMPÍRICO

E DE UM SISTEMA DE OBSERVAÇÃO

RESUMO

A aliança terapêutica tem sido documentada com regularidade na literatura científica como um factor comum às diferentes abordagens psicoterapêuticas, consistentemente associada aos resultados terapêuticos. O desafio actual reclama a importância de melhor compreender as acções e interacções entre o cliente e o terapeuta que contribuem para o desenvolvimento da aliança. O meu foco de interesse foi a Responsividade Terapêutica que parece tem um papel significativo no desenvolvimento e qualidade da aliança.

O meu objectivo principal foi explorar e compreender a responsividade terapêutica enquanto processo recursivo e recíproco entre o cliente e o terapeuta. Porque não há conhecimento de um modo fiável de avaliar a responsividade terapêutica, um segundo objectivo foi desenvolver um método para observá-la e analisá-la como processo interactivo que ocorre momento-a-momento em psicoterapia.

O projecto de investigação consistiu em dois estudos que examinaram a responsividade terapêutica com base na observação e análise de sessões terapêuticas videogravadas. O estudo 1 consistiu na fase de descoberta da Task Analysis, que permitiu desenvolver análises conceptuais e empíricas ao serviço do estudo da responsividade terapêutica. Quinze episódios terapêuticos foram usados com o objectivo de definir um marcador cuja resposta aponta para responsividade terapêutica e

seis sessões terapêuticas para explorar como a responsividade terapêutica se desenvolve. Os resultados desta fase qualitativa da investigação foram: (1) um modelo conceptual-empírico protótipo que identifica as componentes essenciais da responsividade terapêutica a um nível micro-analítico das interacções conversacionais entre o cliente e o terapeuta, (2) um instrumento de observação que encerra em si critérios detalhados para identificar, analisar e codificar as componentes do modelo e (3) um modelo de trabalho que elabora a responsividade terapêutica a um nível mais inclusivo situado nos processos relacionais. Com sustentáculo nos resultados empíricos, o conceito de Responsividade Recíproca foi proposto para definir o processo que se desenvolve momento-a-momento em psicoterapia e requer uma interacção mútua entre as necessidades do cliente, as respostas do terapeuta e as reacções do cliente.

O estudo 2 envolveu análises estatísticas de fidelidade das componentes do instrumento de observação, usando doze episódios terapêuticos para calcular o acordo inter-codificadores no processo de codificação do marcador de responsividade terapêutica – a expressão verbal de necessidades pelo cliente – e dez sessões terapêuticas no processo de codificação das componentes subsequentes de responsividade terapêutica – a resposta do terapeuta e a reacção do cliente. Os resultados sustentam a fiabilidade e, consequentemente, a utilidade do instrumento.

As implicações dos resultados deste estudo para a prática, formação e investigação futura foram discutidas com o propósito de realçar a importância da responsividade recíproca enquanto processo terapêutico inerente à psicoterapia e tema promissor a ser continuamente estudado.

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LIST OF ABBREVIATIONS

TR	Therapeutic Responsiveness
TA	Task Analysis
C:VEN	Client's Verbal Expression of Needs
T:R	Therapist's Response
C:R	Client's Reaction

INTRODUCTION

There are not lives without commitment, but rather lives

In which commitments are continually refocused and redefined

(Mary C. Bateson)

INTRODUCTION

Therapeutic alliance is a prominently mentioned common factor across various psychotherapies that is strongly associated with outcomes (e.g., Horvath & Bedi, 2002; Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross, 2002; Norcross, 2010). Some authors (e.g., Wampold, 2010) place the emphasis on the therapist's contribution to the alliance. Baldwin, Wampold, and Imel (2007) found that therapists who are better able to form an alliance with different clients generally are the therapists who get better outcomes. Taken into consideration that the variability in therapists' effectiveness can be due to their variability in forming alliances, the question raising is "What are the actions of effective therapists contributing to form positive alliances?".

Psychotherapy approaches all have in common some therapeutic actions, even though they are embedded in the context of the therapist's theoretical orientation and dependent on the delivery of a specific treatment (Anderson, Lunnen, & Ogles, 2010). This way, there can be no alliance without therapeutic actions offering an opportunity for engagement of the client and the therapist in a purposeful and collaborative work oriented to produce client's change. Highlighting alliance as a collaborative process implies both the therapist and the client participation on creating and maintaining mutual actions. This means that conceiving clients as active and collaborators calls for therapists to listen to clients, to privilege their perspectives, attending to their subjective experiences and adjusting flexibly therapeutic actions in response to their needs (e.g., Bohart & Tallman, 2010; Norcross, 2010).

In these terms, alliance seems to be constrained by the therapeutic responsiveness. The Therapeutic Responsiveness is referred in this doctoral dissertation as the recursive and reciprocal interactions that are affected by the therapist's capacity to tailor therapeutic actions in response to the client's needs, regardless of the treatment modality.

The first chapter of this dissertation presents therapeutic responsiveness as moment-by-moment process of alliance highlighting the importance of the therapist's responses and its adaptation to the client's needs occurring on the context of a collaborative and bidirectional work. Therapeutic responsiveness seems to influence the alliance which, in turn, seems to influence the client's change; that is why the chapter begins with a short incursion on common factors perspective in psychotherapy with a specific emphasis on the alliance. Then, the concept of therapeutic responsiveness is introduced as a possible answer to the challenge of better understanding what happens between the therapists and their clients that contribute to the formation and development of the alliance. Some conceptualizations about responsiveness are outlined, namely the concept of Optimal Responsiveness proposed by Bacal (1998b), and the concept of Appropriate Responsiveness proposed by Stiles, Honos-Webb, and Surko (1998).

Optimal responsiveness is defined as the responsiveness of the therapist that is psychologically most relevant and useful for a particular client. Bacal argues that "optimal" does not mean "perfect"; means that the most favourable conditions are provided to produce the best possible result. Thus, optimal responsiveness connotes the facilitation of the client's therapeutic experience. In this perspective, the therapist should pay attention to the client's reactions to his or her responses that feel anything but optimal in order to discover what is most therapeutic for a specific client.

Appropriate responsiveness, as defined by Stiles and collaborators (1998), refers to doing what is required to produce some desired outcome. According to these authors, responsiveness is a behavior resulting from appropriate choices at the level, adjustment, and timing of the interventions, affected by the emerging client's requirements, problems, and characteristics. In a similar manner to the Bacal's proposal, Stiles and collaborators make reference to the mutual features of responsiveness asserting that therapist modify interventions in response to the clients' reactions.

The ensuing section covers the research on how therapists respond to clients starting from one of the referred conceptualizations. It also review on therapists and clients relational variables that might be related to responsiveness taken into consideration the lack of specific research capturing the mutuality that characterizes it. I start by reviewing some studies focused on how therapists respond according to particular client's or process variables. Then, flexibility of the therapist in providing responses to the clients is addressed. Additionally, some studies on client's reactions are presented.

The first chapter concludes with a new proposal: the concept of Reciprocal Responsiveness. I define reciprocal responsiveness as a mutually interactive process between the client and the therapist resulting from the therapist's capacity to flexibly adjust interventions in response to the client's needs, to monitor the subsequent client's reactions, and to continue or reformulate his or her responses according to those reactions.

The empirical study sustaining this proposal was developed using Task Analysis. For this reason, the chapter II presents theoretically this process research method by describing the required steps to identify in-session performances. Following these steps,

it is possible to examine interactions between the client and the therapist at a micro-level by observing, identifying and analyzing the components of therapeutic processes.

The chapter III presents the task-analytic research I carried out aiming to examine therapeutic responsiveness as a reciprocal process involving both the clients and therapists participation on developing responses adjusted to the clients' needs. Because therapeutic responsiveness seems to be a common process across psychotherapies with influence on alliance, a second goal was to develop a method of measuring it moment-by-moment within sessions, based on dyadic interactions.

In light of these two goals I took steps of the discovery-oriented phase of Task Analysis in order to define a marker from which the therapeutic responsiveness occurs moment-by-moment as bidirectional process between the client and the therapist. The main findings were three: a prototype conceptual-empirical model, a working model, and an observational system of therapeutic responsiveness. These results mirror mutual interactions of the dyad between the client's verbal expression of needs, the therapist's responses, and the client's reactions, capturing the mutuality underlying therapeutic responsiveness. The concept of reciprocal responsiveness proposed in this dissertation is supported by these empirically grounded findings.

The chapter IV presents the intercoder reliability estimates that support the usefulness of the Therapeutic Responsiveness Observational System. The trustworthiness of the measure is sustained on intraclass correlation and kappa values.

The findings of the study are discussed on the conclusion chapter. Moreover, limitations of the study, as well as contributions for practice, training, and research are outlined.

CHAPTER I

THERAPEUTIC RESPONSIVENESS AS A MOMENT-BY-MOMENT PROCESS OF ALLIANCE

CHAPTER I – THERAPEUTIC RESPONSIVENESS AS A MOMENT-BY-MOMENT PROCESS OF ALLIANCE

Over the past 30 years, empirical research has established the effectiveness of psychotherapy and begun to suggest what contributes to effective change (Duncan, Miller, Wampold, & Hubble, 2010). The therapeutic factors that work derive from processes or elements that are combined more or less effectively in all psychotherapy approaches.

Several authors (e.g., Duncan, 2010b; Rosenzweig, 1936; Wampold, 2001; Wampold, 2010) argue that various psychotherapies claim similarly good outcomes – the so called *Dodo Bird Verdict* – suggesting that there are therapeutic communalities responsible for the success of psychotherapy. The therapeutic relationship, in general, or the alliance between client and therapist, in particular, is a prominently mentioned common factor.

1. ALLIANCE AS A THERAPEUTIC FACTOR INFLUENCING THE CLIENT'S CHANGE

Alliance is one of the keys factors, if not *the* key, to the change process (Bordin, 1979). The strength of alliance has been reliably and consistently linked to the effectiveness of psychotherapy. Notwithstanding the obvious differences and specific factors among psychotherapies, the alliance appears to be a common factor which has been linked in a consistent way to positive psychotherapy outcomes, regardless of the therapist's theoretical and technical orientation (e.g., Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000; Norcross, 2002; Norcross,

2010), or whether assessed by the therapist, the client, or an independent observer (Horvath, 2001).

Assuming, in a naïve way, the *Dodo Bird Verdict* metaphor of the common factors perspective in psychotherapy can put the researchers and the clinicians in a position that considers alliance as a non-specific factor and neglects the specificities of each theoretical approach. Instead, like other authors (e.g., Castonguay, Constantino, & Grosse Holtforth, 2006; Duncan et al., 2010), I argue that the alliance is viewed as a common factor influencing the quality of psychotherapy, but it is specific to psychotherapy and not an undefined or non-specified variable unrelated to treatment.

Alliance can be different according to the particular interpersonal context in which it develops and the specific features of each psychotherapy approach, depending on the emphasis each one of these approaches put on the commitment, negotiation and collaboration between client and therapist (Ribeiro, 2009). For instance, alliance develops differently in interpersonal and cognitive psychotherapies, even though it influences outcomes in both cases (Hoffart, Borge, Sexton, & Clark, 2009).

Going beyond the traditional distinction between common factors and specific factors, some authors suggest a more inclusive emphasis on *therapeutic factors* contributing to the effectiveness of psychotherapy (e.g., Duncan et al., 2010). This comprehensive view of all psychotherapy approaches is based on research that demonstrates factors contributing to effective client's change. The success of psychotherapy is mainly found in factors that all approaches share in common, although they assume different configurations and they are combined more or less effectively in each approach of psychotherapy. One of these constant factors in psychotherapy is the alliance. Nevertheless, there are individual differences among clients and individual differences among therapists related to their readiness or ability to create and maintain

an effective therapeutic alliance. There are, also, differences in the way that participants in the psychotherapy dyad mutually interact and collaborate. Thus, it is a matter of what makes psychotherapy work, instead of what the diverse approaches have in common.

The concept of alliance has evolved over time. The most often referenced conceptualization currently in the literature originated with Bordin (1979, 1994). Bordin provided a transtheoretical conceptualization of the alliance as the establishment of emotional bonds, an agreement between the client and the therapist about the therapeutic goals and the necessary tasks to achieve these goals. The process of developing alliance is sustained by an ongoing negotiation of goals and tasks, through which the client and the therapist search and endorse change goals that better incorporate the client's needs and the client's struggle with problems. These goals are, then, the target of the therapeutic tasks or interventions.

Bordin's theory provided a useful starting point for the contemporary theory of alliance. Some authors (e.g., Hatcher, 1999; Hatcher & Barends, 2006; Horvath, 2009) refer the need for attention to two main points: (1) that alliance concerns the degree to which the therapeutic dyad is engaged in a purposeful and collaborative work, and (2) that alliance refers to the atheoretical relational, reciprocal and interactive features of the dyad.

There is an increasing consensus among researchers and clinicians in defining alliance as an interactive and collaborative element of the therapeutic relationship (e.g., Castonguay et al., 2006; Hatcher & Barends, 2006; Ribeiro, 2009). The collaborative dimension is associated with the alliance in all psychotherapy approaches and, in this sense, it is universal.

Collaboration can have different meanings. In fact, it is not free of the theoretical assumptions underlying each one of the psychotherapy approaches. Thus, the

collaborative dimension of the alliance has different configurations depending on the way each approach conceives the participation of client and therapist in psychotherapy, as well as the dyadic interaction. It is possible to move toward a transtheoretical position on considering collaboration in psychotherapy, but even in that case it is necessary to define what collaboration is.

Research based on the Bordin's broad viewpoint of alliance has focused on the client or the therapist as the one that promotes collaboration in the therapeutic context. In a different position, I reiterate the proposals by Hatcher (1999), Horvath (2009), and Ribeiro (2009), which argue collaboration as bidirectional and coordinated actions between the client and the therapist, actualized in the moment-by-moment therapeutic conversations. The therapeutic work has a collaborative focus through which attention is given to the here-and-now moment with a particular client in a particular session (Duncan, 2010a).

The negotiated and collaborative work in psychotherapy is facilitated by the reciprocal interaction and positive bond between the client and the therapist. Thus, the dyadic bond is framed within to the collaborative work of psychotherapy (Hatcher & Barends, 2006). In this sense, the relational processes are "contextual" (Horvath, 2009, p. 276) because they play a different role depending on the psychotherapy approach and the particularities of the dyadic interpersonal dynamics throughout the therapeutic process.

Although substantial empirical evidence highlights the importance of a positive alliance for the success of psychotherapy, independently of its configuration regarding the specific theoretical approach, the question of *How the alliance is therapeutic? That is, how it is responsible for good outcomes?* is not often addressed directly.

In order to know how alliance works and how to effectively mobilize this therapeutic factor, some authors (e.g., Castonguay et al., 2006; Horvath, 2005, 2006, 2009) highlight the importance of better understand interactive processes which are associated with the alliance. Research searching for evidence on mechanisms that allows fostering alliance is needed, that is, aiming to identify how to effectively establish, develop and negotiate alliance between the participants of the therapeutic dyad.

In 2001, the American Psychology Association Division 29 Task Force presented research recommendations including to study why the relationship (in particular, the alliance) works, and how clients and therapists' contributions combine to impact outcomes (Ackerman et al., 2001). Nevertheless, while the crucial role of alliance in psychotherapy is by now convincing, relatively little is known about how to create and sustain a positive alliance.

2. THERAPEUTIC RESPONSIVENESS AS A MOMENT-BY-MOMENT PROCESS OF ALLIANCE

One of the current challenges for researchers is to understand what happens in the psychotherapy sessions that contributes to the formation and development of the alliance. Trying to respond to this challenge of better understanding the development of the alliance at a moment-by-moment level and how the therapist can create opportunities to enhance this therapeutic factor, I have focused on the interactive phenomenon of responsiveness that seems to be implicated across the diverse psychotherapy modalities.

Why my interest on studying therapeutic responsiveness? Having the common factors perspective in psychotherapy as background, my interest on therapeutic responsiveness derived from a transtheoretical approach that highlights psychotherapy as a collaborative work through which the interventions are done *with* the client rather than *to* the client.

The framework that inspired my incursion in the responsiveness phenomenon conceives the client as a central and active participant in psychotherapy and as a credible source of his or her own subjective experiences and needs. This way of looking at psychotherapy asserts the importance of the epistemic value of the client's perspective in considering his or her needs, the outcomes, and the relational quality with the therapist. Some authors (e.g., Duncan, 2010a; Duncan & Miller, 2000) talk about this in terms of the importance of the client's frame of reference regarding his or her problems and needs, its' causes and potential change, in other words, the client's theory of change. The therapist is expected to respond to the particular needs informed by that client's theory of change, culminating in a reciprocal interaction of the dyad.

This approach describes a relational model through which any therapeutic interaction can be client-directed, outcome-informed, alliance-focused and discovery-oriented (Duncan, 2010a). It can be client-directed because psychotherapy can be driven by the client's theory of change rather than causal theories or pre-defined techniques. It can be outcome-informed because the client's voice can be privileged on evaluating the therapist's interventions and the inner impact on the client. It can be discovery-oriented because the particular client can inform about what works specifically for him or her. It can be alliance-focused because the interactions of the therapeutic dyad are recursive and require a continued attention.

Reflections endorsing this psychotherapy approach made therapeutic responsiveness my focus of interest. In fact, although the authors did not refer directly the responsiveness phenomenon, they suggested the importance of the therapist's responses to the client's needs, and simultaneously the central role of the client's theories informing about the interventions and the dyadic relational dynamics. Thinking about responsiveness in these terms, it seems to be a therapeutic process intrinsic to any form of psychotherapy, whether it conceives the client as a more central or a more peripheral protagonist in the therapeutic interactions.

Therapeutic Responsiveness is understood as the therapist's capacity to develop interventions oriented to respond to the client's needs, within psychotherapy sessions, regardless of its theoretical orientation. I conceptualize therapeutic responsiveness as a process sustained on a reciprocal interaction between the client and the therapist.

The core and earliest idea underlying my work is that the alliance is affected by the intentional and collaborative therapeutic work that encompasses therapist's responses and its adaptation to the client's needs, as well as the client's reactions to those responses, resulting in an interactive and recursive process. In this sense, I argue that therapeutic responsiveness is a moment-by-moment process of alliance.

Because the literature on therapeutic responsiveness does not seem to have received much attention, the main goal of this chapter is to reflect on the concept and to review studies focused on this therapeutic phenomenon. The chapter will outline some other authors' conceptualizations about therapeutic responsiveness, as well as results of some studies starting from these theoretical perspectives. This literature review is complemented with findings by studies focused on therapist and client's relevant relational variables, which may contribute for the reflection about the responsiveness

phenomenon. In the end, the chapter presents a new proposal for looking at therapeutic responsiveness – the focus of the present dissertation.

3. SOME PERSPECTIVES ON RESPONSIVENESS IN PSYCHOTHERAPY

Some conceptualizations were made regarding the responsiveness in psychotherapy. Different theoretical views resulted in different terminologies. For example, in a psychoanalytic approach, Bacal (1998b) conceptualized on *Optimal Responsiveness* and in a person-centered approach, Stiles and collaborators (1998) conceptualized on *Appropriate Responsiveness*.

3.1. The concept of Optimal Responsiveness

Classic psychoanalysis (e.g., Freud, 1946) establishes interpretation as the therapist's central contribution to the therapeutic experience, aiming to bring insight to the client. Without underestimating interpretation as a key-component of the therapeutic work, some object relations theorists moved beyond the one-person psychology position and started talking about the concept of responsiveness in psychotherapy. In their point of view, the therapeutic experience is the result of the relationship between client and therapist. Thus, psychotherapy develops under relational conditions by which the therapist is oriented to respond to the client's needs and problems.

Viewed from the perspective of self psychology - which can be understood as a derivative of object relations approach - the skillful therapist assists the client in keeping his or her disappointments or discomfort within tolerable limits and helps the client in satisfying his or her unmet needs. In other words, the therapeutic process is developed

according to the principle of optimal frustration and seeking the optimal gratification (satisfaction) of the client's frustrated needs (Kohut, 1971). More specifically, the therapist's role is to play a double game encouraging the client to express his or her instinctual impulses, needs and wishes and, at the same time, gradually refusing its fulfillment. *Optimal frustration* is defined as the sufficient delay in satisfying the client's impulses, needs and wishes in order to increase tension and create tolerable disappointments. The therapeutic process must be developed according to the principle of optimal frustration because it is through it that the growth and development of the self are possible.

According to this perspective, the therapeutic process must allow an optimal level of gratification of the client's frustrated needs. *Optimal gratification* is understood as the satisfaction of the client's needs and wishes, at some point and in some measure. In this sense, the therapist should not give too much or too less, but the sufficient in a specific moment of the therapeutic process in order to allow the optimal frustration and, consequently, the psychological growth of the client.

Kohut (1977) asserts that although the insufficient frustration resulting from an overgratification of some instincts may contribute to it, it is the insufficient gratification that mostly leads to psychological problems. There is an apparent contradiction between this position and the arguments for the therapeutic benefits of frustration (Bacal, 1998a). The central issue is what is "optimal", in the sense of therapeutic heal, leading to the development of the self.

Because the concept of optimal frustration is entangled in theoretical controversies, Bacal (1998b, 1998c) presented a new concept, comprised in a more contemporary interactive perspective. He argues that the concepts of optimal frustration and optimal gratification need to be replaced because not all psychological growth

occurs through frustration (Bacal, 1998a). The underlying idea is that the therapist does not seek to frustrate nor to gratify, but to respond to the client in a useful way.

Bacal (1998b, 1998c) proposed the concept of *Optimal Responsiveness*, understood as the therapist's responsiveness that is the most relevant, useful, and appropriate for the client's particular needs, at a specific moment of the therapeutic process.

Optimal responsiveness requires from the therapist to flexibly relate to the client and to provide responses in order to facilitate the therapeutic process (Fosshage, 1998). The responses should not exceed what is needed or desired by the client nor withhold in a way that could spoil the process (Shane & Shane, 1998). The therapist should be able to provide responses in accordance, insofar as possible, to the particular client's needs. These responses are optimal when they attend to the client's needs and enhance his or her growth.

This theory of responsiveness anchored on the specificity of the interaction involves – on the part of the therapist – appropriate responses to the client's needs, as well as acts of communicating his or her understanding about these needs, and – on the client – an understanding of that responses and acts as therapeutically usable (Bacal, 1998a, 1998b).

Bacal (1998b) argues that optimal responsiveness is to some extent bidirectional. To be effective, the therapist must be aware of the mutual nature of responsiveness. In this sense, the client's responsiveness may be a precondition for the therapist to be free to respond optimally to that client. That is why the client's responsiveness is known as relatedness reactions.

To be more responsive to the client, the therapist should reflect not only the client's needs, but also his or her own needs, experiences and responses, as well as the

dyadic intersubjectivity, that is, the mutual influence of each participant of the therapeutic dyad on the subjective experience of the other, at any point of psychotherapy (Shane & Shane, 1998).

3.2. The concept of Appropriate Responsiveness

In a person-centered approach, Stiles and collaborators (1998) conceptualized on *Appropriate Responsiveness*. In these authors' perspective, the therapist would be appropriately responsive when he or she is doing what is necessary in order to create some desired outcome in the client's experience or to meet a theoretical standard of a psychotherapy approach (e.g., psychoanalytic or cognitive-behavioral theory).

Appropriate responsiveness requires the therapist's interest and attention on the client's requirements and problems. That means that the therapist does not indiscriminately provide responses to the client's requests or satisfy momentary wishes. Instead, the therapist should make decisions incorporating the specific emerging information on the therapeutic context, but also considering the therapeutic goals or theoretical standards. Thus, the therapist should first identify the emerging context affecting his or her own behavior as well as the client's; then the therapist should make appropriate choices at the level of selection, adjustment, and timing of interventions based on the clients' problems and characteristics, as well as on therapeutic goals. At the end, the therapist responds to some variables of the client or the therapeutic context with some interventions.

According to this conceptualization of responsiveness, the different psychotherapies may be equally successful because therapists can respond appropriately to the client´s requirements and problems within their particular theoretical framework.

For that, therapists can responsively use and adapt different techniques and actions of their repertoire as required.

Similarly to Bacal's proposal, Stiles and collaborators make reference to mutual responsiveness, although they highlight the therapist's responsiveness to the client. Therapist and client respond to each other in a way that affects the therapist's work with the client.

4. EMPIRICAL RESEARCH ON THERAPEUTIC RESPONSIVENESS

Based on the concept of optimal responsiveness proposed by Bacal (1998b, 1998c), Estrella (1998) explored the therapists' perspectives concerning the following questions: (a) What subjective and intersubjective experiences contribute to therapists being optimally responsive?, and (b) How do therapists know they have been optimally responsive?

Estrella's research aimed to organize principles by which therapists' optimal responses could be given. The methodology used was semistructured interviews with nine therapists with psychoanalytic orientation and at least five years of clinical practice. The resulting data were qualitatively analyzed. The results of her study established five preconditions contributing to the therapists' feeling of being optimally responsive and three themes by which therapists know that they have been optimally responsive.

In Estrella's study, therapists felt optimally responsive according to (1) their subjective life experiences, including losses and the relationship with their own analyst. Those experiences allowed (2) their identification with the subjective experience of the

client, promoted (3) their attunement and feeling of mutuality concerning the client, as well as (4) the interaction of hope, support and accomplishment, that encouraged (5) their commitment to an ethical psychotherapy approach and, at the same time, their willingness to take risks implementing the interventions.

Therapists confirm that they have been optimally responsive to their clients based on: (1) shifts in the client's affect; (2) external observable signs reflecting changes in the therapeutic process, such as shifts in facial expressions and corporal posture that are associated by therapists to their own empathic understanding; and (3) the access to and development of new behaviors, increased self-disclosure evoked by the client, and more intimacy in the therapeutic relationship.

Estrella's study (1998) focused on the therapists' perspective about what they consider to be optimal responses in a psychoanalytic therapy session, on the basis of their clinical experience. If, on one hand, the results of this research provided some knowledge about the subjective and intersubjective experiences of the therapists contributing to what they consider optimal responsiveness; on the other hand, the research focused only on the therapists' perspective within a specific psychotherapy orientation. Indeed, the author recognizes that the conclusions should be expanded with other studies. Additionally, the study does not provide a universal schema of responsiveness; instead, it indicates some conditions for optimal responsiveness for most of the participants in the study, and in a specific psychotherapy approach.

Departing from the conceptualization proposed by Stiles and collaborators (1998) on appropriate responsiveness, Hardy, Stiles, Barkam, and Startup (1998) studied how therapists respond differentially to clients' interpersonal styles. The participants in their study were one hundred and fourteen clients with depression

assigned to one of five therapists and to either weekly psychodynamic-interpersonal or cognitive-behavioral manualized psychotherapy.

The results of this study indicated that, independently of the psychotherapy approach, therapists' reported intentions and observed behaviors in sessions differed systematically depending on the clients' interpersonal style. Therapists did appear to deliver different interventions depending on this particular clients' variable. Specifically, therapists tended to use more affective and relationship-oriented interventions with clients who had an overinvolved interpersonal style, whereas with clients who had an underinvolved interpersonal style, therapists tended to use more cognitive interventions.

The interpersonal styles groups had approximately equivalent outcomes, suggesting that differences in implementing the interventions in any of the manualized psychotherapies reflect appropriate responsiveness to clients' interpersonal styles.

The research by Hardy and collaborators (1998) aimed to understand if the therapists' responses were specifically adequate to the clients' interpersonal style. Even though two theoretical orientations were considered, the interpersonal style is only one of the clients' variables that are important in psychotherapy. A strong point of this research is the goal of not only identifying therapists' intentions in their perspective, but also to include the observer's perspective in order to classify the interventions. Although the therapists' responsiveness to the clients' interpersonal style was measured through observation, the method selected by the authors implied a defined rating scale which classifies the therapists' responses into a specific framework guiding the observation.

Another study by Hardy et al. (1999), also aimed to examine appropriate responsiveness concerning the clients' interpersonal styles. Sixteen clients with

depression were assigned to one of five therapists in psychodynamic-interpersonal manualized psychotherapy. Significant events in psychotherapy, identified by the clients in recall interviews, were analyzed by five researchers, highlighting the clients' interpersonal styles and the therapists' responses.

The data was organized based on core concepts of attachment theory. Thus, the clients' interpersonal styles were identified according to the attachment classification system of Ainsworth, Blehar, Waters, and Wall (1978), which includes three categories: secure, dismissing-avoidant, and preoccupied-ambivalent. The therapists' interventions linked to the interpersonal styles were analyzed considering in what extent they provided security, worked on the proximal development zone (balancing support and exploration), or promoted the integration of clients' experiences.

The results of this study indicated that therapists tend to respond with reflection and providing support to preoccupied (also called overinvolved) clients, and tend to respond with interpretation and challenging for change to dismissing (also called underinvolved) clients. These results confirmed the early findings achieved by Hardy and collaborators (1998).

The research by Hardy et al. (1999) aimed to understand in more detail how therapists respond to the clients' interpersonal style in a specific psychotherapy approach. The research focused on the researchers' perspective on significant events identified by the clients, not only in order to classify the clients' interpersonal styles, but also to categorize the therapists' responses. The work was inspired on the attachment theory. Similarly to the study of Hardy et al. (1998), this one focused on the therapists' responses to a specific clients' variable.

Although mutual responsiveness was identified by both Bacal (1998) and Stiles et al. (1998), their theories highlight almost exclusively the therapist's responsiveness to

the client. Moreover, the empirical studies parting either from the concept of optimal responsiveness (Bacal, 1998b) or the concept of appropriate responsiveness (Stiles et al., 1998) emphasized only the therapist's side, and some of them focused on the therapist's responsiveness to a specific client's variable (interpersonal style). The other side – the client's responsiveness – still remains unpicked.

Reflecting on the studies by Estrella (1998), and Hardy and collaborators (1998, 1999), I conclude that they highlighted the therapist's side of responsiveness and did not focus on how general and mutual therapeutic responsiveness occurs within the moment-by-moment interaction between the client and the therapist. Moreover, the research so far has been mainly based on theory rather than actual observations of what goes on in psychotherapy. Even when the studies were based on the observer's perspective, as were the studies by Hardy et al. (1998, 1999), they were framed within a specific theory (e.g., psychoanalytic theory, attachment theory).

Given my interest on the mutual nature of responsiveness, and on attending both sides of the therapeutic interaction, I thought it would be important to examine the literature on responsiveness and to review studies focused on therapist and client's relevant relational variables potentially or directly related to responsiveness, but without links to the concepts discussed above. Even though these studies did not spotlight responsiveness, they informed about the therapist or client's side of mutuality, underlying the possibility of some kind of articulation between them.

On the therapist's side, some findings were provided by studies that focused on how therapist respond differentially according to specific client's or process variables. For example, the findings by Connolly Gibbons, Crits-Christoph, Levinson, and Barber (2003) suggested that both cognitive-behavioral and interpersonal therapists tend to use more exploratory techniques, such as asking questions or making clarifications of the

clients' speech, with clients who presented high levels of pretreatment depression. In the same research, the interpersonal therapists tended to use learning statements more than the cognitive-behavioral therapists with clients who reported greater levels of pretreatment interpersonal problems. Despite that, the researchers concluded that the therapists were responsive to the clients' level of interpersonal problems, even though in different manners in the two psychotherapy approaches.

Studies by Connolly Gibbons et al. (2003) and by Elliot, Barker, Caskey, and Pistrong (1981) showed that therapists tend to respond in a different manner depending on the client's perceived empathy. Their findings suggested that with clients who perceived greater levels of empathy, therapists tend to provide more reflexive responses, and more restatements and clarifications as a way of helping the client to expand and clarify his or her thoughts, emotions and behaviors, compared with clients who perceived lower levels of empathy.

Therapists seem to respond in a different manner depending on the client´s level of experiencing, that is, his or her ability to focus, expand and process his or her phenomenological experience. In a study by Hill et al. (1988b) therapists tended to respond in a way that (1) provides support (by expressing approval or paraphrasing the client), (2) explores client´s feelings and behaviors (by doing interpretations, paraphrases or confrontations), or (3) restructure the client´s cognitions (by doing interpretations or confrontations) at the lower client's level of experiencing. Therapists tended to use more interventions aimed at supporting and exploring feelings, and fewer interventions aimed to give information at the higher client's level of experiencing.

Another interesting finding by Connolly Gibbons et al. (2003) revealed that therapists seem to provide different responses to clients considering the level of narrative elaboration in the therapeutic context. In these researchers' study, therapists

tended to implement more interventions aiming to enhance the understanding of the association between thoughts, emotions and behaviors with clients who were better able to elaborate their narratives.

On the therapist's side, some authors elaborate on the therapist's flexibility influencing his or her ability to be responsive to the client (e.g., Beutler, 2002; Connolly Gibbons et al., 2003; Mahoney & Norcross, 1993). Lazarus (1993) argued that the therapist should be an *authentic chameleon* when responding to the client´s needs, which may be different in different moments of psychotherapy.

Taking into account the diversity that characterizes clients and to legitimate their particular needs, it seems crucial for therapist to be flexible in the sense that he or she adapts his or her responses to the client´s needs. Even in manualized psychotherapies, in which the intervention is more systematically defined, the clinical judgment is essential when it comes to the selection and timing of the interventions (Connolly Gibbons et al., 2002; Hardy et al., 1998).

Some authors (e.g., Garfield, 1998; Goldfried & Wolfe, 1998) consider that many psychotherapy manuals do not provide enough flexibility to the therapist for handling the particularities of the intervention with each client. These authors suggest that the therapist should consider the manuals as more generic guidelines for what to do in specific clinical situations, while remaining flexible; instead of looking at them as rules they must follow throughout the interventions. Assuming a different position, other authors (e.g., Connolly Gibbons et al., 2002; Connolly Gibbons et al., 2003) argue that, when the therapist is trained in specific psychotherapy manuals, he or she always has opportunities to flexibly adapt the intervention to the clients' immediate needs. Even if the therapist does not change the technique during the session, he or she may use different styles in the way he or she applies it.

If flexibility is possible in manualized psychotherapies, it is easy to conclude that being flexible and responsive to the client does not mean that the therapist needs to be theoretically eclectic. Stiles and collaborators (1998) argue that responsiveness does not suggest that eclecticism is necessarily preferable to theoretical purity. Thus, within a specific psychotherapy approach or within eclecticism, the therapist can be flexible in order to responsively adapt the intervention to the client's particular needs.

Associated with the flexibility in implementing interventions in response to the client, the therapist can also manifest flexibility in the way he or she relates with the client. Mahoney and Norcross (1993) suggest that the therapist's malleability in using different relational styles with different clients or with the same client at different moments in psychotherapy may be the mark of his or her ability to respond effectively to the client's unique needs.

In the process of flexibly attending to the client's needs, the therapeutic dyad identifies change goals. As Rice and Greenberg (1984) asserted, the dyad participants are goal-setting beings. When the therapist decides to adapt the interventions in order to respond to the client's needs emerging in a specific moment, he or she cannot do it without considering the therapeutic goals that both have negotiated in some degree. Responsiveness implies the therapist to be continuously oriented by the therapeutic goals (Stiles et al., 1998).

The therapist's ability to flexibly adjust the therapeutic process in order to provide responses to the client's needs may require reanalyzing and reformulating the goals in some psychotherapy moments. In this case, changes to the therapeutic goals are meant to be responsive to the emerging manifest needs of the client.

On the other side of responsiveness, clients react and respond differentially to therapist's interventions depending on how they perceive and feel what is happening in psychotherapy, and according to their needs and aims (Rice & Greenberg, 1984).

The client's reactions to the therapist´s interventions can be positive or negative. Hill, Helms, Spiegel, and Tichenor (1988a) developed a system for categorizing client's reactions to therapist's interventions. According to these system, positive reactions include: (a) support-related reactions (the client feels understood, supported, hopeful, or relieved), (b) task-related reactions (the client's thoughts, self-understanding, clear, feelings, responsibility, unstuck, new perspective, educated, or new ways to behave), and (c) reactions underlying the feeling of being challenged. Negative reactions include: the client being worse, scared, stuck, with lack of direction, confused, misunderstood, or presenting no reaction.

I agree with Silberschatz and Curtis (1993), and with Bacal (1998a), when they argue that the client's reactions help to define the pertinence of the therapist's interventions in response to his or her particular needs. In other words, the client's reactions give additional information about the therapeutic intervention, and can determine the appropriateness of the therapist's responses to the client's needs.

Although rare, some studies focused on specific client's reactions to specific therapist's responses. Silberschatz and Curtis (1993) developed an intensive study of two brief psychotherapy cases. They identified client-initiated incidents in psychotherapy, rated the therapist's interventions in response to these incidents, and measured the impact of the interventions on the subsequent client's behavior. The findings suggested that clients respond in an immediate way to the therapist's interventions and that these responses are determined in some degree by the suitability of the therapist's responses to the clients' particular needs. For example, clients tended

to show higher experiencing levels in reaction to therapist's responses disconfirming a central pathogenic belief of the client. In Hill and collaborators' (1988b) study, the highest client's experiencing levels occurred in reaction to the therapist's self-disclosure, which was the intervention with the highest client helpfulness ratings between nine response modes.

Friedlander, Lambert, Escudero, and Cragun (2008) showed that, in family psychotherapy, interventions designed to promote strong alliances through therapist's engagement and emotional connection activated client's engagement and emotional connection and, forward, led to solutions for the family problems.

Watson and McMullen (2005) demonstrated that, in cognitive-behavioral psychotherapy, clients tended to respond more frequently to the therapist's teaching and directive questions with resistance, whereas in experiential psychotherapy the clients tended to respond with resistance to structuring and facilitative interpretations. In both psychotherapies, client's resistance was higher in low-alliance sessions than in high-alliance sessions.

If the therapist is able to accurately perceive the client's reactions, he or she may be able to (re)elaborate intentions, that is, the reasons by which the therapist decides to respond in a specific way, and to develop interventions adapted to the client's needs (Hill et al., 1988a). The therapist implements interventions through intentional actions taking place within and across sessions. The therapist's intentions can be continuously considered or reformulated attending to the particular client's reactions. Thus, on one hand, therapists with different theoretical orientations can have similar therapeutic intentions (Stiles et al., 1996); on the other hand, one particular therapist's intention, within a particular psychotherapy approach, can be operated by different response modes. For example, the therapist can have the intention of exploring the client's

feelings and can do so with equal benefit through an open question, paraphrase, interpretation, or confrontation (Hill et al., 1988b).

The review of the above studies indicated that the therapist responds in several different ways to the client and the client reacts in different manners to the therapist. However, the studies focused on one or the other side of responsiveness.

5. A NEW PROPOSAL: THE CONCEPT OF *RECIPROCAL RESPONSIVENESS*

This literature review highlighted the need for research underlying a bidirectional and reciprocal responsiveness through which the participants in the psychotherapy dyad respond recursively to each other. In addition, it affirmed the need for research based on actual observations of what goes on in psychotherapy.

In the present dissertation, instead of theoretically elaborating the concept of responsiveness, I decided to adopt an empirical research approach, based on an analysis of psychotherapy conversations. My purpose was to capture the interactive and reciprocal nature of responsiveness as a first step in the process of better understanding this complex concept. I decided to develop a research by observing and analyzing the moment-by-moment interaction between client and therapist, independently of the therapist's theoretical orientation. In other words, my intention was to examine responsiveness as a moment-by-moment process based on a bidirectional and reciprocal interaction between the client and the therapist through the observation of what happens within the sessions.

In light of these research goals, the therapist's and the client's sides are similarly important for the understanding of therapeutic responsiveness. Actually, psychotherapy

practice is mutual and shared activity. Through their participation in conversations, a client's and therapist's utterance is linked, in a very complexly organized chain, to other utterances. Consequently, therapeutic responsiveness implies a recursive process by which the actions and statements of each participant in the dyad are mutually affected. This reciprocity is sustained by the way each participant responds to the other and perceives the other's responses, occurring moment-by-moment in psychotherapy.

I propose the concept of *Reciprocal Responsiveness* understood as an interactive moment-by-moment process which requires a mutual interaction between the client's needs, the therapist's responses, and the subsequent client's reactions. The underlying idea is that therapist's responses can be more or less tailored to the client's needs, and the client's reactions can validate or invalidate the therapist's responses.

In order to adopt an empirical approach for observing therapeutic responsiveness, I took steps starting from an inductive and bottom-up analysis of sessions with different theoretical orientations, incorporating the specific therapeutic context in which responsiveness flowed.

Task analysis was the elected research method because it develops through an intensive observation and analysis of processes actually happening in the psychotherapy context. This specific methodology is theoretically explained in the next chapter. Chapter III presents in more detail the proposed concept of reciprocal responsiveness, framed in the conceptual and conceptual-empirical models built through task analysis.

CHAPTER II

TASK ANALYSIS

AS A PROCESS RESEARCH METHOD

CHAPTER II – TASK ANALYSIS AS A PROCESS RESEARCH METHOD

Task Analysis (TA) is a useful method in the study of psychotherapy because it operates by directly observing, identifying and analyzing step-by-step the components of therapeutic processes, and consequently provides a detailed description of what actually happens in psychotherapy. More specifically, TA allows an intensive micro level study of what and how the participants do, moment-by-moment, in psychotherapy sessions. This is an inductive and interactive research method which allows the discovery and validation of therapeutic phenomena through the detailed description and analysis of therapeutic processes (Greenberg, 1976, Greenberg, 1984b; Greenberg, 2007).

Assuming an event-based stance, the researcher breaks down the complex therapeutic phenomena into clinically meaningful client-therapist interactional processes, understood as "when-then" interaction sequences. The event begins with the "when" marker – that is the client presenting a particular problem or action – and develops and ends with the "then" marker – that is the therapist developing therapeutic operations and the subsequent consequences (Greenberg, 1976).

The event-based research provides a specification of the client's and therapist's actions and, also, its context of application. Thus, this research approach is context-sensitive allowing the study of what and when participants do something in psychotherapy, and the examination of when they do this action sequence.

TA has been gaining relevance as a tool for conducting psychotherapy process research (e.g., Rice & Greenberg, 1984; Sicoli, 2005). The process analysis of a task implies the analysis of events having a specific starting-point marker and a process

which develops and ends with a resolution marker. These sequences occur repeatedly, and in a systematically way, in psychotherapy.

TA aims at bridging a detailed and descriptive level with a more general causal level of explanation that considers the processes beginning with the task marker and finishing at the resolution marker. To make this bridge possible, a plurality of methods is implied in TA, including intensive observation, model building, measurement construction, and hypotheses testing (Greenberg, 2007).

Because the goal of TA is to investigate observable therapeutic phenomena rather than theoretical descriptions, conducting a TA is best done by researchers with clinical experience rather than by nonclinical researchers because they understand, in relation of theory and practice, the psychotherapy process.

Task analytic literature suggests that TA procedure includes two general phases: a discovery-oriented phase and a validation-oriented phase (Greenberg, 2007). The first phase of TA aims to formulate a coherent understanding of a specific phenomenon of interest, through a bottom-up approach and a qualitative analysis of therapeutic sessions. The second phase is an empirical validation of the discoveries made in the initial phase using a top-down approach and recurring to hypotheses testing. Next, the stages within each phase of TA are described.

1. Task Analysis: Discovery-phase

The first phase of TA involves the researcher observing and delineating the phenomenon of interest. To rigorously observe, analyze, and categorize that phenomenon, both intensive conceptual and empirical analyses are made, going through seven stages: (1) specifying the task marker, (2) explicating the researcher's rational

map, (3) specifying the task context, (4) constructing the conceptual model, (5) conducting the empirical analysis, (6) synthesizing a conceptual-empirical model and (7) analyzing theoretically the model. At the end of the first phase the researcher has built a conceptual-empirical model, as well as a method of measuring its components.

1.1. Stage 1 - Specifying the task marker

TA begins with identifying and analyzing important sequences that client and therapist follow in therapeutic events. The beginning of these events in psychotherapy is defined by the presence of "markers" that provide a signal indicating the beginning of one specific task. Usually the task marker is some specific observable client's emotional or cognitive problem.

The first stage of TA involves (1) the identification and review of recurrent events containing the task that the researcher aims to study, and (2) the development of a precise definition of the features of the task marker (Greenberg, 1992).

The procedure of identifying and describing the task marker involves an exhaustive study of audiovisual recordings and transcripts of therapeutic sessions. Based on the researcher's judgment, some examples of session segments including the task marker are selected. These segments should contain good examples of the task marker.

Usually TA begins with three examples because this is the minimum number to observe some consistent commonalties. Some examples of session segments, in which the task marker does not exist, are also chosen to serve as contrast. The next step is to identify discernible features of the task marker, comparing task and nontask markers. The process is repeated until the saturation of the data, that is, until no new features

emerge in the analysis (Greenberg, 2007). Based on this observational analysis, the researcher constructs and elaborates a definition of the task marker.

In sum, this stage consists of (1) the observation of one therapeutic task which appears repeatedly within clients across situations or within situations across clients and (2) the elaboration of a definition of the task marker (Greenberg, 1976).

1.2. Stage 2 - Explicating the researcher's rational map

In stage two of TA, the goal is to identify the researcher's perspectives, assumptions and preconceptions. This stage allows making explicit the researcher's standpoint from which his or her study begins, outlining his or her understandings, knowledge and beliefs about the phenomenon under study. The chapter I presents theoretical perspectives about the phenomenon of my interest – Therapeutic Responsiveness.

Although TA aims to construct understandings about a specific therapeutic task starting from observations, the researcher's subjectivity influences the research process in some way. Thus, it is important to explicate the rational map influencing the study of how the task begins, develops, and ends (Sicoli, 2005).

1.3. Stage 3 - Specifying the task context

The development of the task occurs in a specific context. In this stage, the task context is defined through the observation of what the therapist is doing and under what specific conditions these responses occur in psychotherapy. In other words, the goal of this stage is to describe the context in which therapeutic processes are investigated (Greenberg, 2007) and from which the final model is developed.

1.4. Stage 4 - Constructing a conceptual model

A theoretical model is built starting from the researcher's conceptual framework about the components that are believed to be involved in the task development and resolution. Having already observed the task marker, the researcher reflects on what is important to develop and to resolve the task. Then, he or she organizes that information into a diagram, which is drawn to demonstrate the hypothesized sequence of task marker – task development – task resolution. This conceptual model will be the baseline that outlines the researcher's understanding about the task.

The observational process in the following stage will allow the emergence of novelty in the task development and resolution and, the progress from the conceptual to the conceptual-empirical model.

1.5. Stage 5 - Conducting empirical analysis

Stage five involves an intensive observation of therapeutic sessions and a qualitative analysis aiming to achieve a description of the sequence of the task under study. Through an observational process and a qualitative analysis, two purposes of this stage are the follow: (1) to determine the components of the development and resolution of the task, and (2) to develop measures of these components.

Greenberg (2007) suggests a specific procedure in order to conduct an empirical analysis. First, the events are selected and the resolution marker defined. Usually, this procedure starts with three successful tasks, and its comparison with three unsuccessful tasks.

The process that leads from the task marker to the resolution marker is described through the development of categories. Tracking what the client says, speaking turn by

speaking turn, the researcher and a second rater do the categorization working together to consensus. Then, these categories are broken into meaningful segments.

This process is represented into a diagram, showing the necessary steps for the task resolution achievement, that is, the sequence of categories, and the relations among them across time, ending on the resolution marker. The observable features of each of the steps are specified. Through this process, the researcher can compare each process involved in the observed task resolution with the conceptual model.

1.6. Stage 6 - Synthesizing a conceptual-empirical model

Stage six aims to synthesize the conceptual model and the empirical data. The conceptual model is developed or changed in order to integrate the newly observed components in the previous stage. A new diagram is sketched representing all the components from the task marker to the resolution marker. This will be the conceptual-empirical model that integrates what was actually observed with what was expected. This model will represent a theory grounded in observation.

The conceptual-empirical model can be subject of further refinements to make more intensive analysis, as well as to validation in the second phase of TA.

1.7. Stage 7 – Analyzing theoretically the model

In this stage, the goal is to intensively analyze the conceptual-empirical model in order to explain what allows moving from one component to another until the end of the task (Greenberg & J. Pascual-Leone, 2001). Pascual-Leone (2005, p.71) suggested that, in this stage, the researcher do a "meta-subjective analysis" asking him or herself: What mental operations occur when the client (or the therapeutic dyad) moves from one component to another? The answer to this question and the reflexive movement

throughout all the categories within each component will bring the explanation from the moment-by-moment level to a more abstract level.

In this stage, the researcher brings a conceptual meaningfulness to the model through an understanding of how and by which processes the dyad complete the task.

2. Task Analysis: Validation-phase

The results of the discovery-oriented phase of TA are validated and elaborated in the second phase of the TA. The validation-oriented phase of involves two stages: (1) stage 8 - validating the model and (2) stage 9 - relating process to outcome.

2.1. Stage 8 - Validating the model

In this stage, numerous observations are made of psychotherapy sessions in which the task under study is being performed. Then, clinical judges, who are familiar with the conceptual-empirical model, identify the task marker and the resolution marker, as well as "good examples" for each component of the model.

These events are submitted to at least two judges who rate the data using the criteria established for each component of the conceptual-empirical model. If the criteria for a specific component are met, the presence of that component is validated. If not, additional events resembling that component are selected by the clinical judges (Greenberg & Malcolm, 2002). The process repeats until the criteria for all components or the conclusion of the absence of some components have been met.

In the eighth stage of TA, tasks with successful and unsuccessful resolutions are compared on the frequency of occurrence of each component. Statistic analysis can be made to compare these tasks with different resolution quality.

2.2. Stage 9 - Relating process to outcome

In the last stage of TA, the task components or the degree of the task resolution across the therapeutic process is related to outcomes. A hypothesis-testing study can be developed to measure this association.

This stage can increase the understanding of the task occurring along the therapeutic process, and consequently enhance the way of measuring it.

3. Applied Task Analysis

Theoretical influences in TA have come from different disciplines and different schools. Applied to psychology scientific domain, TA was used in several studies that recurred to sessions taken from specific psychotherapy orientations and focused on specific problems leading to specific resolutions.

TA was initially used in Work Psychology to analyze the competencies required for a specific task (Miller, 1955). These were taken within a behavioral perspective.

After that, and clearly distinguished from the behavioral approach, some authors attempted to describe and analyze internal processing. Newell and Simon (1972), and J. Pascual-Leone (1976) are between the first psychologists using TA to construct models of mental functioning by analyzing cognitive problem-solving performances. These are two main references on the analysis of information-processing activities involved in specific cognitive tasks.

In a different theoretical position but aiming to accomplish the same principles, Greenberg (1976, 1984b, 1991) developed an approach based on TA for studying emotional and interpersonal problem-solving performances. In this perspective, the client's performance is regarded as a marker of affective rather than cognitive tasks.

Forwards, the engagement on these affective tasks is oriented to work toward some goal or resolution.

While in cognitive tasks TA was carried out only on one performance by a single person (e.g., the client) at a specific situation, in the analysis of therapeutic processes or affective tasks the context is more complex in that it includes other persons (e.g., the therapist) influencing the task development, facilitating or not the task resolution.

Several authors used TA to study different emotional or interpersonal problems in experiential psychotherapy, namely, interpersonal conflicts (Greenberg, 1984a; Greenberg, 1992), problematic reactions (Rice & Saperia, 1984), unfinished business (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002), emotional distress (Pascual-Leone, 2005), and hopelessness (Sicoli, 2005).

TA has also been used to investigate processes involved in therapeutic alliance. For example, Aspland, Llewelyn, Hardy, Barkham and Stiles (2008), and Safran and Muran (1996) used TA to study alliance ruptures, respectively, in Cognitive-Behavioral Therapy and in Integrative Therapy with features of interpersonal, experiential, and cognitive approaches. Bennett, Parry, and Ryle (2006) used TA to study threats to the alliance in Cognitive Analytic Therapy.

As a process research method, TA allows the researcher investigating the moment-by-moment interactions between the client and the therapist. TA seemed to be an appropriate method to use in a study designed to understand therapeutic responsiveness as a reciprocal and recursive process, because it allows studying psychotherapy in-session conversational performances at a micro-level.

My study aimed to search for components of reciprocal responsiveness and how they are articulated in the therapeutic conversation. In this sense, TA methodology was

adjusted for the study of responsiveness in psychotherapy. Through an intensive observation of what happens in sessions and a systematic analysis of the dyad conversations, TA served my purpose of understand how therapeutic responsiveness develops, moment-by-moment, in psychotherapy. Articulating conceptual assumptions and observational data, TA allowed developing a conceptual-empirical model, as well as an observational system of therapeutic responsiveness. The current research – a TA of therapeutic responsiveness – is outlined in the next chapter.

CHAPTER III

THE CURRENT RESEARCH:

TASK ANALYSIS OF

THERAPEUTIC RESPONSIVENESS

CHAPTER III – THE CURRENT RESEARCH:

TASK ANALYSIS OF THERAPEUTIC RESPONSIVENESS

The current research aimed to explore the concept of Therapeutic Responsiveness (TR) through a discovery-oriented process. The discovery-phase of Task Analysis (TA) for the intensive study of TR involved an interactive procedure linking conceptual and empirical aspects. The articulation between conceptual assumptions and observational data led to the emergence of a conceptual-empirical model, as well as an observational system of TR. This chapter outlines the research goals, method and results.

1. RESEARCH GOALS

My interest in TR generated the following research questions: (a) *How TR operates independently of the psychotherapy approach?* (b) *What characterizes the client's and the therapist's participation on TR?* and (c) *How the therapeutic dyad mutually articulate responsiveness?*

Because in the contemporary literature the mutuality underlying TR is emphasized in theory but not captured empirically, the present study had two main goals:

(1) to explore and understand TR as a bidirectional and reciprocal process, and

(2) to develop a method of measuring it as a moment-by-moment process.

2. METHOD

In order to address the two main goals, the research process involved the seven stages of the discovery-oriented phase of TA. For an ease of reading, the chapter begins by describing two rounds of the discovery-oriented phase of TA. The first round includes the stages from 1 to 4, and the second round includes the stages from 5 to 7. Following these descriptions, each stage is summarized.

2.1. Participants

Sixteen therapeutic dyads participated in the study. Ten dyads participated in the first round of the discovery-oriented phase of TA: six therapists with one client each, and two therapists each with two clients. Six dyads participated in the second round of the discovery-oriented phase of TA: five therapists with one client each, and one therapist with two clients.

2.1.1. Clients.

The inclusion criteria for clients to participate in the research were: (a) the client's agreement for the psychotherapy sessions to be videotaped, (b) client's consent for videotaped sessions to be used as research data, and (c) a diagnosis of a depressive or anxiety disorder.

The clients were screened using the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Patient Edition (SCID-I/P; First, Spitzer, Gibbon, & Williams, 2002) and the clinical judgement of the therapist. The clients were excluded if there was any indication of the following: (a) diagnosis of an Axis II Disorders (e.g., borderline or schizoid personality disorders), (b) any Axis I Disorders (e.g., schizophrenia or

addiction disorders) with the exception of a depressive or anxiety disorder, (c) psychosis, (d) neurological impairment or severe intellectual deficits, and (e) high current risk for suicide.

Ten volunteer clients participated in the first round of the discovery-phase of TA. Clients were all Portuguese, eight female and two male, ranging in age from 20 to 48 years old (M=31). Five were single, three married and two divorced. Four completed university education, five were graduate students, and one had undergraduate education. They each had been given the diagnosis of major depressive disorder.

Six volunteer clients participated in the second round of the discovery-phase of TA. Clients were all Portuguese, three female and three male. Their ages ranged from 20 to 47 years old (M=30). Four were single and two married. Three completed university education, two were graduate students, and one was undergraduate student. Four clients were given the diagnosis of major depressive disorder, and two the diagnosis of anxiety disorder.

2.1.2. Therapists.

In the first round of the discovery-phase of TA there were eight therapists, all Portuguese and female clinical psychologists. Their ages ranged from 23 to 30 years old (M=25). Four therapists were enrolled in a doctoral program; their clinical experience ranged from four to seven years. Four were therapists-in-training with clinical supervision.

In the second round of the discovery-phase of TA there were five therapists, all Portuguese; three male and two female clinical psychologists. Their ages ranged from 25 to 32 years old (M=29). The therapists were enrolled in a doctoral program and raged in clinical experience from three to seven years.

2.1.3. Coders.

Five coders participated in both first and second rounds of the discovery-phase of TA. They were all Portuguese female clinical psychologists concurrently enrolled in a doctoral program. All coders had participated in other studies using qualitative methodologies. Four coders ranged in age from 27 to 29 years old (M=28) and ranged in clinical experience from five to six years. Two had Narrative Constructivist theoretical orientation, one had Cognitive-Behavioral orientation, and one had Integrative orientation. The author was one of the coders. She had ten years of clinical experience and a master degree in Clinical Psychology. Her theoretical influences arose mainly from the Narrative Constructivist and Client-Directed orientations. An expert auditor also participated in the research. She was a 45 years old Portuguese professor with twenty years of clinical practice, and an expertise in psychotherapy process research. Cognitive-Behavioral and Narrative Constructivist orientations were her central theoretical influences.

2.2. Units of analysis

Different units of analysis were considered in the research. Psychotherapy episodes and psychotherapy sessions were used as units respectively in the first and second research rounds.

2.2.1. Psychotherapy episodes.

In the first round of the discovery-oriented analyses, the sample consisted of fifteen episodes taken from ten single sessions, each from a different client. The sessions ranged between session 1 and 18; six in the initial phase (sessions 1-4), three in the intermediate phase (sessions 5-12) and one in the final phase of psychotherapy

(sessions 13-18). The episodes were taken from three different psychotherapies: six from Cognitive-Behavioral Therapy, five from Personal Construct Therapy, and four from Narrative Therapy.

2.2.2. Psychotherapy sessions.

In the second round of the discovery-oriented analyses, the sample consisted of six single sessions, each from a different client. All sessions were taken from the initial phase of finished therapeutic processes; three first sessions and three third sessions. Three of these sessions were taken from Cognitive-Behavioral Therapy and three sessions were taken from Narrative Therapy. In order to cover a greater diversity of TR, sessions from three good and three bad outcome treatments[2] were used. Within each psychotherapy orientation, two clients were given the diagnosis of major depressive disorder and one the diagnosis of anxiety disorder.

2.3. Procedure

2.3.1. Recruiting.

Permission was obtained from a University Counseling Centre to carry out the research with therapeutic dyads in the Centre. Next, both clients and therapists were informed about the implications of their participation in the research, including the video recording of the sessions. They signed an informed consent form[3].

[2] Treatment outcomes were assessed by Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) and Outcome Questionnaire (OQ45; Lambert et al., 1996).
[3] Client´s and Therapist´s Informed Consent may be found in Appendix I.

2.3.2. Selection of the units of analysis.

In the first round of discovery-phase of TA, the *episode* (or event) was elected the unit of analysis. An episode is understood as a "when-then" interaction sequence taken from the complex performance in psychotherapy. It begins with the "when" marker – the client presenting a particular performance pattern – and ends with the "then" marker – the therapist developing interventions and its subsequent consequences. Thus, it allowed studying what and when the dyadic participants do something in psychotherapy, and in response to what. In the first research round, the goal was to search for a TR marker, that is, a discernable signal alerting the therapist that there is an opportunity for him or her to respond. Thus, initially the research focused on the "when" part of the episodes.

The episodes were defined on the basis of the emerging understanding and recurrent data through observation and analysis of several videotaped sessions by the author. Episodes were selected randomly from each of the three psychotherapy approaches: Cognitive-Behavioral Therapy, Personal Construct Therapy, and Narrative Therapy.

In the second round of discovery-phase, the *session* was elected the unit of analysis. The purpose of the second round was to search for the expression of TR. After identifying the marker of TR as the "when" part of the episodes on the first research round, the next goal was to analyze the "then" part. The "then" part of the episodes was related to the therapist´s interventions and its consequences. The research process revealed the complexity of TR (e.g., the therapist can respond at the end of the session to a specific marker expressed by the client in the beginning of the session). For this reason, instead of episode, the whole of the session was chosen to be the unit of analysis.

The sessions were selected by the author from two of the treatment approaches: Cognitive-Behavioral, and Narrative.

2.3.3. Data preparation.

All sessions were videotaped. The author transcribed verbatim the session dialogues used in the study. The identifying information of the client was omitted in the transcripts. The videos were put into the software "Windows Movie Maker" and the transcripts organized into tables. This procedure facilitated the data analysis through the discovery-phase of TA.

2.4. Data analysis: Task Analysis Discovery-phase

In order to explore TR, the discovery-phase of TA consisting of seven stages was developed: (1) specifying a marker of TR, (2) explicating the research's rational map, (3) specifying the context of TR, (4) constructing a conceptual model of TR, (5) conducting an empirical analysis of TR, (6) synthesizing an conceptual-empirical model of TR, and (7) analyzing theoretically the model of TR. In the present study, TA stages were realized in two rounds. The first round included stages from 1 to 4, and the second round included stages from 5 to 7.

Usually TA is developed for describing the observable steps in the resolution of a problem previously studied and defined. In this sense, the problem is the start point to explore how to successfully complete a task resulting on its resolution. Thus, the empirical approach begins in stage 5. The present research did not have a previously defined marker of TR. For this reason, it began defining empirically a start point for the study of how TR operates. Thus, the sequence of the stages in the first round was modified. First, stages 2 and 4 were developed and, subsequently, an empirical strategy

was adopted in order to develop stages 1 and 3. Stage 1 allowed defining a marker that signaled an opportunity for TR, and stage 3 allowed for the contextualizing the features of that marker.

The research was moved to the second round (stages 5-7) in order to develop an empirical analysis of TR, as well as to synthesize an empirical-conceptual model of TR. In the next section the discovery-phase of TA will be outlined according to its seven stages organized into two rounds. For a clearer understanding of the task analytic methodology, results are presented in each step of data analysis.

2.4.1. First round – TA stages 1 to 4.

In the first round of the discovery-phase of TA, the author´s conceptual framework was made explicit and from it a conceptual model of TR was constructed (respectively, TA stages 2 and 4). Then, stages 1 and 3 were simultaneously developed, adopting an empirical approach. In this description, stages are presented in the sequence they were developed.

2.4.1.1. Stage 2 - Explicating the researcher's rational map.

This stage aimed to define the point from which the author began the research process. It is important to explicit the researcher's assumptions and preconceptions because they had influence on the observation and analysis of TR. The researcher's central assumptions are as follows:

a) Client is an active participant in psychotherapy with theories informing about his or her needs, the usefulness of psychotherapy interventions and the quality of dyadic relationship.

b) Alliance is an interactive and collaborative element of the therapeutic relationship in any psychotherapy approach;

c) Collaboration involves bidirectional and coordinated actions between the client and the therapist;

d) Alliance is affected by TR, a recursive moment-by-moment process that requires a reciprocal interaction between the client's needs, the therapist's responses, and the subsequent client's reactions;

These theoretical perspectives were presented in more detail in chapter I.

2.4.1.2. Stage 4 - Constructing a conceptual model of Therapeutic Responsiveness.

Stage 4 involved developing a speculative model that made use of theoretical assumptions and available research (see chapter I). Attempts were made to describe the essential steps that were believed to be representative of how TR occurs regardless of the psychotherapy approach. The question of *What therapist´s interventions are used in order to respond to client's needs?* guided the model building process. The first conceptual model is presented in Figure III – 1. The model highlights two central components: (1) client's needs, and (2) therapist's responses.

In the psychotherapy context, client expresses his or her needs. When the therapist identifies a specific need and decides to focus on it, he or she responds developing need-oriented interventions. Theoretically, these responses can be differentiated into the level of: (1) providing security, that is, promoting a positive and secure relational context; (2) reflecting and understanding thoughts or emotions, that is, elaborating about client's subjective experiences; (3) challenging for change, that is, challenging the client for new resolutions, new perspectives or new behaviors; or finally

(4) integrating client's subjective experiences, that is, constructing meaning for the client's subjective experiences, promoting the client's self organization or endorsing transferability of therapeutic work. In these terms, therapist can help the client to flexibly understand, reflect on, and integrate his or her subjective experiences.

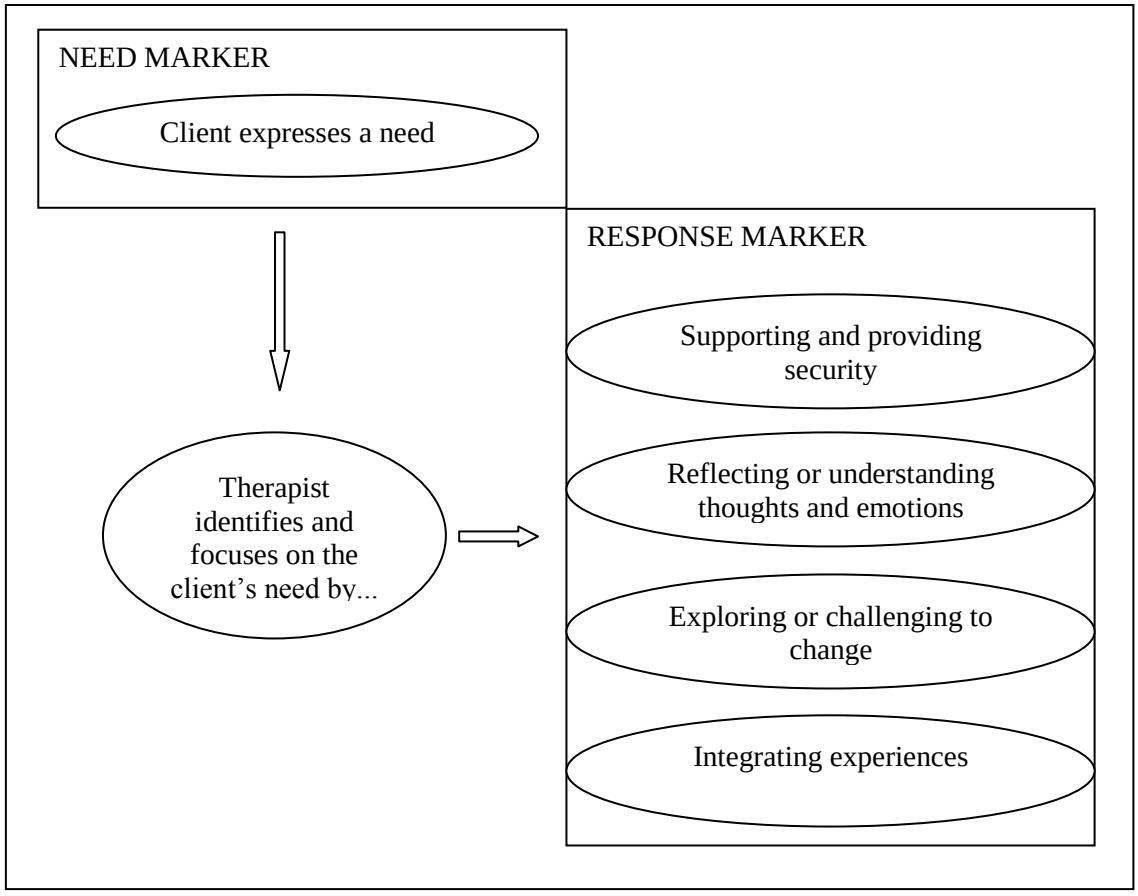

Figure III – 1. The first conceptual model of Therapeutic Responsiveness.

Taking into consideration the inference that is inherent to the therapist's responses in the first conceptual model of TR, more observable conversational actions were included in the final model. Thus, the therapist's responses can be distinguished in terms of response modes (e.g., reflexive, confrontation, questioning, feedback, and acceptance), timing (e.g., immediate response or response informing that a response will

be provided in future sessions), and focus (e.g., the client's subjective experience, the therapist's subjective experience or the therapeutic interaction).

Thinking of TR as a reciprocal process during which the therapist and the client respond recursively to each other induced the introduction of a third component to the model – client's reactions. Thus, in the extended model, first the client expresses a need. Second, the therapist identifies or focuses on that client's need, and provides a specific response. Third, the client reacts to the therapist's response. Client's reactions inform about the appropriateness of the therapist's responses. Figure III – 2 illustrates the final conceptual model of TR.

The central idea underlying this conceptual model is that by identifying the client's needs, the therapist has opportunities to develop need-oriented interventions, and by monitoring the client's reactions, he or she can evaluate the suitability of those interventions. TR occurs as a recursive process that allows both the client and therapist to participate in psychotherapy responding to each other.

2.4.1.3. Stage 1 - Specifying the Therapeutic Responsiveness (TR) marker.

TA stage 1 aimed a functional definition of a marker whose response points to TR. In order to identify a marker of TR, the procedure involved an exhaustive study of videotaped sessions and a purposeful sampling method by which "good examples" of the marker were sought.

Fifteen psychotherapy episodes were selected based on the emerging understanding and recurrent data through observation and analysis of several sessions by the author. Twelve episodes were good discernable examples of the marker. Additionally, three episodes, in which the marker did not exist, were chosen to serve as contrast. These episodes were, then, analyzed by the auditor.

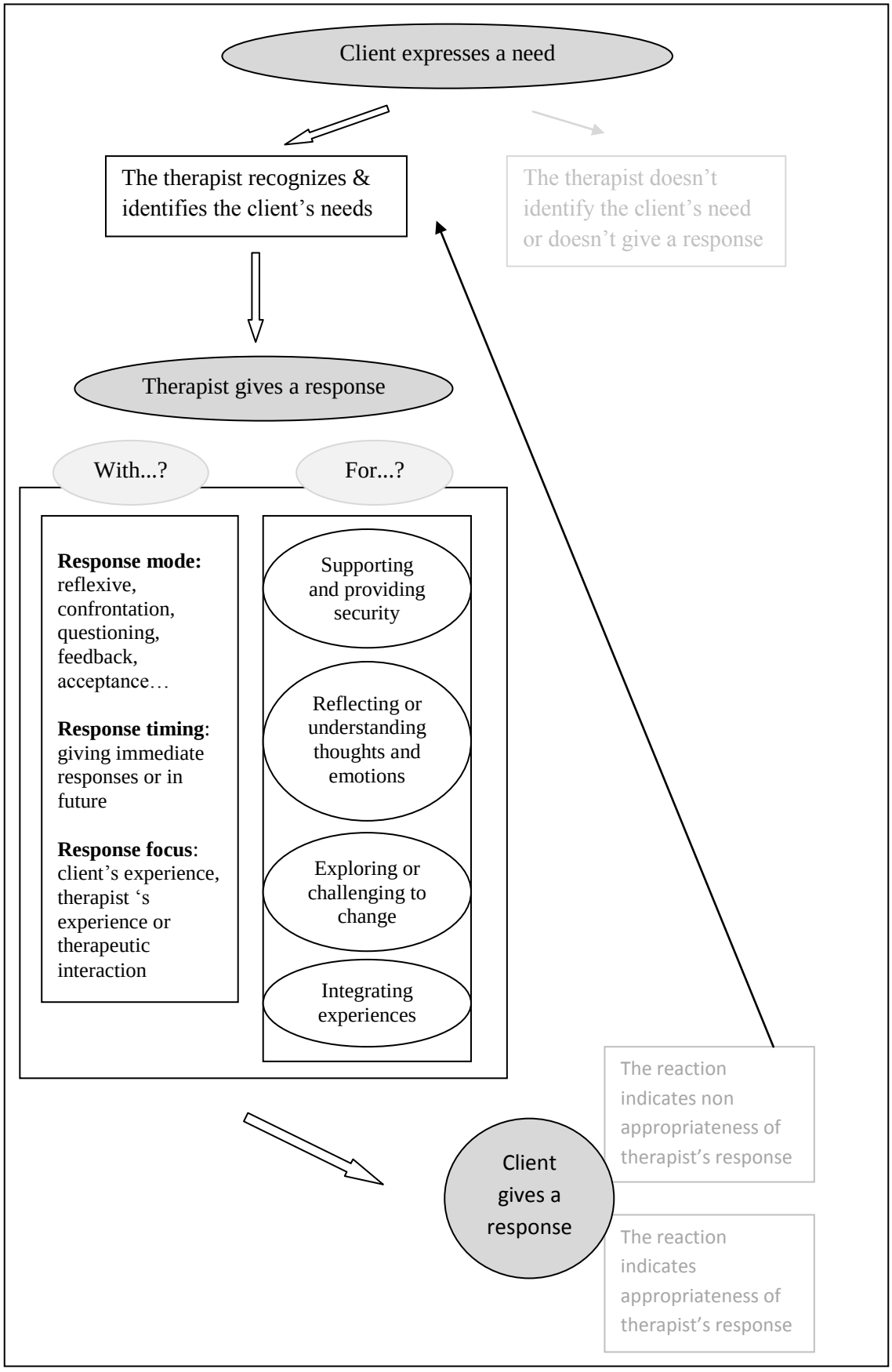

Figure III – 2. The final conceptual model of Therapeutic Responsiveness.

The following steps were taken to generate the sample: (a) selection through observation of episodes with and without TR marker, (b) categorization of episodes with and without TR marker, (c) description of TR marker features, (d) process repetition through observation of other episodes TR marker, (e) auditing of emergent categories, (f) independent coding of episodes, (g) consensus group for refine categories, and (h) auditing of refined categories.

a) Selection through observation of psychotherapy episodes with and without TR marker.

Videotaped sessions from different clients, different therapists and different moments of the therapeutic process were observed. Observing and analyzing these sessions, the author identified conversational sequences underlying in a systematic way needs of the clients. The recurrence of data placed the *Client's Verbal Expression of Needs* (C:VEN) as the marker of TR. C:VEN consisted on an obvious signal indicating an opportunity for TR. The author selected three episodes containing good examples of C:VEN and three episodes containing good examples of no C:VEN.

b) Categorization of psychotherapy episodes with and without TR marker.

An open categorization of the six episodes was made by the author, using indicators of the presence and the absence of C:VEN. This procedure allowed identifying four main categories of C:VEN. These main categories were called as *Axes* of C:VEN. The A Axis is related to clients' wishes or expectations; the B Axis is related to clients' difficulties or problems; the C Axis is related to clients' hesitations or indecisions; and the D Axis is directed related to the psychotherapy, the therapist or the therapeutic relationship.

c) Description of TR marker features.

A description of the specific features of each one of the four axes of C:VEN was made through a careful observation and micro analysis of the six episodes guided by the central question of *From the content of client's talk, what seems to be an expression of needs?*. This process allowed identifying some subcategories within each axis. These subcategories were called as *Types* of C:VEN.

d) Process repetition trough observation of other psychotherapy episodes with TR marker.

More episodes with C:VEN were analyzed. The process of categorizing and decrypting C:VEN was repeated with three more episodes. Because this process allowed identifying more distinctive types of C:VEN, three more episodes were analyzed.

The saturation of data occurred after three additional episodes were analyzed and no more types of C:VEN were found. Thus, the sampling method was finished with the analysis of the fifteenth episode.

Twelve types of C:VEN were identified within the four axes. The A Axis includes three types of needs: (A.1.) Wishes, (A.2.) Motivations, and (A.3.) Expectations. The B Axis includes four types of needs: (B.1.) Emotional Difficulties, (B.2.) Cognitive Difficulties, (B.3.) Behavioral Difficulties, and (B.4.) Interpersonal Difficulties. The C Axis includes two types of needs: (C.1.) Personal Dilemmas, and (C.2.) Doubts. The D Axis includes three types of needs: (D.1.) Wishes Directed Related with psychotherapy (DR), (D.2.) Expectations DR, and (D.3.) Requirements DR. The first set of categories consisting on the axes and types of C:VEN is presented in Table III – 1. Each axis and each type of C:VEN is defined in the table.

Table III – 1. The first set of categories consisting on the Marker of Therapeutic Responsiveness.

Client's Verbal Expression of Needs (C:VEN)			
AXES (4)	**TYPES** (12)	**Definition**	
A Axis Axis of wishes, ambitions, aspirations, motivations, interests, intents, projections, expectations of the client	A.1. Wishes	The client wishing something	
	A.2. Motivations	The client having the intention of something	
	A.3. Expectations	The client believing that something is likely to take effect	
B Axis Axis of obstacles, impediments, objections, criticism or precarious situations, problems experienced by the client	B.1. Emotional Difficulties	The client having a emotional problem	
	B.2. Cognitive Difficulties	The client having a cognitive problem	
	B.3. Behavioral Difficulties	The client having a behavioral problem	
	B.4. Interpersonal Difficulties	The client having an interaction problem	
C Axis Axis of indecisions, doubts, uncertainties, dilemmas of the client	C.1. Personal Dilemmas	The client having two opposite propositions related to the self	
	C.2. Doubts	The client having doubts or uncertainties	
D Axis Axis directly related (DR) to the therapy, the therapist or the therapeutic relationship	D.1. Wishes DR	The client wishing something…	…related to therapy, therapist or relationship
	D.2. Expectations DR	The client believing in something…	
	D.3. Requirements DR	The client calling directly for something…	

e) Auditing of emergent categories.

All categories of C:VEN (axes and types) were reflected and all episodes were analyzed by the auditor. The episodes were analyzed by the auditor as they were being included in the study. Meetings between the auditor and the author were arranged in order to discuss the data. No changes emerged in the first set of categories consisting on the axes and types of C:VEN.

f) Independent coding of episodes.

The first set of categories consisting on the axes and types of C:VEN were presented to four coders. They were trained on coding psychotherapy episodes with C:VEN categories. The same fifteen episodes coded by the author and audited were given to the four coders. They coded independently all episodes.

g) Consensus group for refine categories.

Episodes were coded in the same sequence of the previous analysis by the author – the coders coded independently the first group of six episodes and, then, the following three consecutive groups each one with three episodes. Meetings between the coders and the author were arranged in order to discuss codings and to reach consensus.

Using the independent and the consensual codings, the author made a qualitative analysis with the purpose to better understand why specific clients' utterances were more difficult and less reliable in coding. In order to answer to the questions of *What seems to be not working? What is and is not necessary in the set of categories? How a specific category would work better?*, the author analyzed the data following five steps:

a) Identifying and reflecting on utterances that were coded by more than one coder but consensus defined them as utterances unable of being coded (false negatives);
b) Identifying and reflecting on utterances that were coded by all coders or all but one even though with different categories (no independent agreement);
c) Identifying and reflecting on utterances that were coded by three or more coders with the same category (independent agreement) but different code was established through consensus;

d) Identifying and reflecting on utterances that were coded by at least one coder with more than one category;

e) Identifying and reflecting on utterances that were coded by at least one coder with an axis category but not with a type category.

The consensus discussion and data analysis allowed refining categories and reformulating the description of each category. The four axes of C:VEN remained from the beginning until the end of the analysis. Thus, the C:VEN is coded with one of the four following axes:

a) A Axis or Wanting Axis – Axis of wishes, ambitions, aspirations, motivations, interests, intents, projections, expectations of the client.

b) B Axis or Difficulties Axis – Axis of obstacles, impediments, objections, criticism or precarious situations, problems experienced by the client.

c) C Axis or Hesitations Axis – Axis of indecisions, doubts, uncertainties, dilemmas of the client.

d) D Axis or Direct Requests Axis – Axis directly related to the psychotherapy, the therapist or the therapeutic relationship.

The types of C:VEN changed from twelve to thirteen. Within the Wanting Axis, the *Wishes* category was divided into two categories – *Change-related Wishes* and *Problem-related Wishes*. Data analysis showed that the client's wishes are qualitatively different depending on them being related to his or her problems (e.g., "I want to die") or to the change he or she want to achieve (e.g., "I want to change…").

The *Motivations* category was eliminated because its definition was similar to the definition of *Wishes* category. Having two different categories but with redundant definitions hindered the agreement in coding. Thus, *Wishes* category prevails enclosing the client's motivations (e.g., "My intention now is…" or "I am motivated to…"). The

Expectations category remained as a type of C:VEN. This category includes both positive expectations (e.g., "I believe that if I change…, I will achieve…") and negative expectations (e.g., "If I am not able to… today, I will be not able to… in future"). Realizing these reformulations, the *Wanting* Axis includes three types of needs: (A.1.) Change-related Wishes, (A.2.) Problem-related Wishes, and (A.3.) Expectations.

Within the *Difficulties* Axis, some initial categories were overlapping. The *Emotional Difficulties*, *Cognitive Difficulties* and *Behavioral Difficulties* categories were merged in one category – *Intrapersonal Difficulties*. Data analysis showed that decomposing the complexity of human experience by differentiating emotional, cognitive and behavioral dimensions is an unmanageable task. Also, sometimes the lexical context did not allow identifying the nature of the difficulty (e.g., "I am tired").

Some categories were redefined. For example, the *Interpersonal Difficulties* category was initially related only to interaction issues (e.g., conflict). The category was redefined in order to include also any client's issues or problems related to relationships (e.g., relational insecurity). The *Self-related Difficulties* category was added. Data showed that some client's difficulties were constant lifelong, in contrast with the current intra and interpersonal difficulties. The *Difficulties* Axis includes three reformulated types of needs: (B.1.) Intrapersonal Difficulties, (B.2.) Interpersonal Difficulties, and (B.3.) Self-related Difficulties.

The *Hesitations* Axis includes the same two initial types of needs: (C.1.) Personal Dilemmas and (C.2.) Doubts. Data contained lexical context for both categories.

Within the *Direct Requests* Axis, two categories were added – *Difficulties DR* and *Doubts DR*. Data analysis showed that sometimes the lexical context pointing to aspects related to the psychotherapy, the therapist or the therapeutic relationship could

not be classified as one of the three initial types of needs. Two additional categories emerged to cover client's expressions of difficulties (dissatisfaction, negative emotions or attitudes) and doubts directly related to the therapeutic context and dynamics. Thus, the *Direct Request* Axis includes the three initial and the two new types of needs: (D.1.) Wishes DR, (D.2.) Expectations DR, (D.3.) Requirements DR, (D.4.) Difficulties DR, and (D.5.) Doubts DR.

The final set of categories consisting on the axes and types of C:VEN is presented and contrasted with the first set of categories in Table III – 2. Each axis and each type of C:VEN is defined and exemplified with some lexical expressions in Table III - 3.

Table III – 2. The final set of categories consisting on the Marker of Therapeutic Responsiveness, contrasted with the first set of categories.

Client's Verbal Expression of Needs (C:VEN)		
AXES (4)	**TYPES**	
	1st set of categories (12)	**Final set of categories** (13)
A Axis Wanting	Wishes	A.1.Change-related wishes
		A.2. Problem-related wishes
	Motivations	-----
	Expectations	A.3. Expectations
B Axis Difficulties	Emotional Difficulties	B.1. Intrapersonal Difficulties
	Cognitive Difficulties	
	Behavioral Difficulties	
	Interpersonal Difficulties	B.2. Interpersonal Difficulties
	-----	B.3. Self-related Difficulties
C Axis Hesitations	Personal Dilemmas	C.1. Personal Dilemmas
	Doubts	C.2. Doubts
D Axis Direct Requests (DR)	Wishes DR	D.1. Wishes DR
	Expectations DR	D.2. Expectations DR
	Requirements DR	D.3. Requirements DR
	-----	D.4. Difficulties DR
	-----	D.5. Doubts DR

Table III – 3. The final set of categories consisting on the Marker of Therapeutic Responsiveness – definition and examples of each category.

Client's Verbal Expression of Needs (C:VEN)			
AXES (4)	**TYPES**		
	Categories(13)	Definition	Lexical expressions
A Axis Wanting Axis of wishes, ambitions, aspirations, motivations, interests, intents, projections, expectations of the client.	A.1. Change-related wishes	The client expresses verbally a wish of… that he or she is determined to do, think or feel something... that he or she has motivations for… motives for… interest in… the goal of... something change-related.	"I want to..." "It would be important for me to..." "I wish to achieve…" "I would like to change…"
	A.2. Problem-related wishes	The client expresses verbally... (the same as in A.1.)... something problem-related.	"I want to (die)" "I want to (disappear)"
	A.3. Expectations	The client verbally expresses hope or believing that something is likely to take effect.	"If I... I will..." "I hope that..."
B Axis Difficulties Axis of obstacles, impediments, criticism or precarious situations, problems experienced by the client.	B.1. Intrapersonal Difficulties	The client verbally expresses problems on his or her own emotions, cognitions or behaviors (ways of feeling, thinking or acting that are negative).	"I have the bad feeling ..." "I have a problem with…" "I'm following down..." "I can't do..."
	B.2. Interpersonal Difficulties	The client verbally expresses difficulties or problems related to relationships or negative interactions.	"I can't look at her" "I am aggressive to him" "I can't speak with him"
	B.3. Self-related Difficulties	The client verbally expresses difficulties or problems related to the self, personality, identity.	"I am and I always was" "It is of my personality being..."
C Axis Hesitations Axis of indecisions, doubts, uncertainties, dilemmas of the client.	C.1. Personal Dilemmas	The client verbally expresses the presence of two contrary and conditional prepositions related to identity; personal conflict.	"I am ... but at the same time I am the other..."
	C.2. Doubts	The client verbally expresses uncertainties, incredulities, scepticism, which can underlie indecision or hesitation between different (explicit or implicit) possibilities.	"I do not know…" "On one hand…, but on the other hand…" "I want… (this), but at the same time I want…(that)"
D Axis Direct Requests Axis directly related (DR) to the therapy, the therapist or the therapeutic relationship.	D.1. Wishes DR	The client verbally expresses a wish… that he or she wants or is motivated to experience (to do, to feel, to think, to talk…) something related to...	"I want to bring here…" "I want to talk with you about..."
	D.2. Expectations DR	The client verbally expresses hope on… belief in… believing in something inherent to...	"I believe that therapy will help me" "My hope is that you…"
	D.3. Requirements DR	The client verbally expresses requirements or calls directly to something of...	"You could help me…" "I need your help..."
	D.4. Difficulties DR	The client verbally expresses problems related to...	"I can't do what you are asking to… " "Explain to you… is difficult"
	D.5. Doubts DR	The client verbally expresses doubts, uncertainties or scepticism regarding...	"I do not know if it is worth continuing with therapy"

...the therapy, the therapist or the relationship

h) Auditing of refined categories.

All refined categories of C:VEN were reflected and all episodes were reanalyzed by the auditor. Meetings between the auditor and the author were made in order to discuss the reformulated data. The auditing process reiterated the new set of categories.

2.4.1.4. Stage 3 - Specifying the Therapeutic Responsiveness context.

C:VEN is the start marker of TR occurring in a specific context. Stage 3 aimed to define the context in which C:VEN occurred. The context was defined through observation and analysis of what the client was expressing to and with the therapist. Stage 3 was developed at the same time than stage 1.

The types of C:VEN are mutually exclusive although they can occur concomitantly. In other words, a client's utterance can give context to more than one category but each category is sustained by different parts of that utterance. Thus, the client's lexical expressions were analyzed in association with the thematic context in order to elucidate the presence of different types of C:VEN. Tables III – 4, III – 5, III – 6 and III - 7 present the thematic context of all lexical expressions of A, B, C and D axes, respectively.

2.4.2. Second research round – TA stages 5 to 7.

In the second round of the discovery-phase of TA, an empirical analysis of TR was made (TA stage 5); an empirical-conceptual model was synthesized (TA stage 6) and theoretically analyzed (TA stage 7).

Table III – 4. Thematic context of all lexical expressions of Wanting Axis.

C:VEN - (A) Wanting Axis		
Lexical expressions	**Thematic Context**	**Type**
One thing that I always wanted is…	Wanting freedom	A1
I have to do… It would be important for me to…	Aiming a personal definition	A1
I wish to achieve…	Desiring a purpose for future	A1
I want to… I would like to get... I need to organize… This is a… that I want to… I need to change…	Desiring for self-efficacy	A1
It would be important for me… I would like to decide... I should… I need to decide what I want to… I must… It is very important for me… I want to decide…	Motivation to make decisions with security	A1
I should not... I will have to... I should be more important than others… I would like to... I need to improve...	Wanting to establish priorities	A1
I want to grow...	Wanting to learn with the problem	A1
...is always missing.	Desiring positive reinforcement	A1
I don't have anyone to talk with...	Healing desire	A1
I want to live by myself…	Emancipation desire	A1
I should be...	Wanting to be assertive	A1
I would like to have someone to… I don't have anyone to…	Desiring share subjective experiences	A1
It is the will to continue… It is a great challenge… My will of…	Wanting to participate in a different way on the interactions	A1
I would like to change…	Wanting to change interpersonal passivity	A1
It is better to finish with me... I want to disappear... It is not worth... I want to shoot it...	Suicide ideation	A2
I constantly want to...	Compulsive eating desire	A2
If I try… I will win more with…	Positive expectations about personal persistence	A3
I start to notice that if I... I will... Probably after ... I will... I would be capable of…when…	Positive expectations about acting differently	A3
I believe that... I will be not able to... Because this happened he will…	Negative expectations about others' behaviors	A3
My expectations are…	Negative expectations about work	A3
If I cannot… I will not be able to… If I feel… Imagine how I will…! I will not!	Negative expectations about acting differently	A3

Table III – 5. Thematic context of all lexical expressions of Difficulties Axis.

C:VEN - (B) Difficulties Axis		
Lexical expressions	**Thematic Contexts**	**Type**
… I'm still tired… I still have a strange feeling… I can't sleep... exhausted... I am worry... I am tired... this sadness... I feel nervous… I am distressed… Panic… I can't… I can't breathe… I do not control my thoughts… I have the bad feeling of… I am sad… I can't think… I feel badly… this pressure… I feel guilty…	Felling or thinking badly	B1
Very difficult…involve insecurity… I am afraid… insecure… Even suffering… I suffer with… Lack of…decision ability... I don't feel secure… inside everything is confused…I'm scare of… I will not have courage to…	Decision making difficulties	B1
I have a problem with… I can't… it is being difficult to cope with…I can't… more problems because I am afraid to fail... That fear of… I see myself this way… I don't know where to go. I'm following down and everything came back… I can't… it disturbs… more difficulties… Lack of confidence... I do not feel secure... I am afraid of the future…	Fear of failure /Insecurity	B1
I prefer not to try… I fail… I don't try to do anything because I'm afraid of… I fail... I don't put it in practice... I have difficulties in... I can't do anything… I can´t go anywhere… I always stay… I do not have results…	Failure /Inefficacy	B1
I am fat... image problems... I fell bad...	Negative self- image	B1
… I can't look at her… I can't anymore…I just can't…I kept that tension…yesterday we had a fight… I can't remember… I am aggressive to him… I discharge my anger… It disturbs! I feel exhausted… it's my biggest fear… it hurts… I have problems at home... I am overprotecting... I am nervous... He is not... I feel angry... I do not like... I do not understand why he... My relationship is complicated… My parents and I… they judge me because…	Relational tension or discussions	B2
I can't heal anymore… I can't speak with him about what I feel...	Lack of communication on the relation	B2
…the more difficult is… I don't accept that people… I'm afraid of…	Difficulty on taking a risk on interactions	B2
I can't look them in the eyes… they think that I am not interested… I try… but I can't… I think always about what they are thinking about me…	Social anxiety	B2
I have a certain difficulty in be demanding with them…maybe is a trauma…I feel a certain difficulty... Run away… to not talk… I am not with my friends… I do not go out with them because I… I am not fighting for my marriage…	Interpersonal passivity or avoidance	B2
In general I am and I always was… I remember that I… When I was younger I already was… It is of my personality being...	Insecurity	B3

Table III – 6. Thematic context of all lexical expressions of Hesitations Axis.

C:VEN - (C) Hesitations Axis		
Lexical expressions	**Thematic Contexts**	**Type**
If I knew that I am… it would be a relief. If I knew that I am not, it would be a relief also…. I like…I will assume! But I don't want too… I am one side (gender) but at the same time I am the other...	Self gender dilemma	C1
This is a game between two thought lines… I have… I do not have… On one hand…but on the other hand… I don't know… this is a conflict between two ideas… I have a constant uncertain… it is "security" against "happiness"…	Personal principles dilemma	C1
Just… or… it is strange! Must be the opposite… Maybe, it's gone! But, it's not gone! I don't know!	Uncertain about emotions	C2
…We want to go until the end, but at the same time, we want… it's like a conflict!	Hesitation on taking risks on interactions	C2
This is… or does not? I do not know if… or…	Uncertain about how to behave	C2
I need to make choices… I can't decide… I have doubts…	Doubts about work	C2
I do not know why I… I am not sure… I do not know what to decide…	Doubts in academic decisions	C2

Table III – 7. Thematic context of all lexical expressions of Direct Requests Axis.

C:VEN - (D) Direct Requests Axis		
Lexical expressions	**Thematic Contexts**	**Type**
… all right, but there is… I want to talk… I want to bring here… I was waiting to be with you… I want to talk with you about… I would like to… talk with the doctor one thing that…	Wanting to talk / to heal	D1
I want to do that... I really want... It is important for me...	Wanting to participate in tasks	D1
I believe that therapy will help me… I have a strong belief in relation to therapy… it's an area in which I believe... My hope is that you…"	Belief on therapy efficacy	D2
That (homework) will be difficult…	Expectations about homework	D2
You could help me… I need your help…	Asking for therapist help	D3
Just one thing… What do you think…?	Asking for therapist opinion	D3
Can you explain me how…? What that means? How can I…?... And that is good or bad for me?	Asking for clarification	D3
Excuse me...can I speak about...?	Asking permission to speak	D3
I do not speak about everything because is very difficult for me to speak here… Explain to you how this happens is difficult…	Difficulties in speak about problems with therapist	D4
The problem is that I can't do what you are asking to do…	Difficulties in therapeutic tasks	D4
I am wondering if it's worth putting my feet here… I feel that I can do… Well I don't know… I do not know if it is worth continuing with therapy…	Doubts about being in therapy	D5

2.4.2.1. Stage 5 - Conducting an empirical analysis of Therapeutic Responsiveness.

The C:VEN was defined as the marker of TR in the first round of the discovery-phase of TA. Stage 5 involved an intensive observation and analysis of six sessions with an aim to explore how TR occurs following the C:VEN.

Two coders were trained on coding the C:VEN in psychotherapy episodes, using the set of categories constructed in the first round of the discovery-oriented phase of TA. After being reliable[4], consensus between the two coders was reached in coding the entire six sessions. These sessions allowed coding all categories of C:VEN. All codings reached through consensus were analyzed by the author and afterwards audited.

Starting with the identification of the C:VEN, the empirical analysis involved the following steps: (a) observation, analysis and categorization of psychotherapy sessions, (b) auditing of emergent categories, (c) independent coding of sessions, (d) consensus group to refine categories, and (e) auditing of the refined categories.

a) Observation, analysis and categorization of psychotherapy sessions.

Individual videotaped sessions were intensively observed and analyzed by the author. The conversational sequences following the C:VEN were explored moment-by-moment within the sessions. Data highlighted a recursive process between the C:VEN, the immediate *Therapist's Responses* (T:Rs) and the subsequent *Client's Reactions* (C:Rs).

The process of categorizing and decrypting T:Rs and C:Rs was developed until no more distinctive categories were found. Three sets, each one composed by one good-outcome session and one bad-outcome session, were sequentially analyzed. A

[4] These two coders integrated the second team on coding C:VEN episodes for the reliability analysis of TROS (details are presented in chapter IV).

description of the specific features of each category within the T:Rs and C:Rs was made through a careful observation and moment-by-moment analysis of six sessions.

The procedure was guided firstly by the central question of *From what therapist is saying, what seems to be an immediate response to the preceding C:VEN?*. Thirty three categories of T:R were identified. A constant comparison between categories was made following the questions of *How is this category similar or different to another category?* and *Although different, is this category related in some aspect to that category?*. Establishing a dialectical relationship between the empirical and theorizing data, the inductive categories were parsimoniously reduced to four dimensions: response mode, temporal dimension, focus and intention.

Response modes are understood as the method through which the therapist puts techniques into practice through a specific verbal structure regardless the content of the speech. This response dimension included eighteen categories: (1) Listening/minimal encouragement; (2) Completing the client's idea; (3) Repetition of client's key-words; (4) Validation or acceptance; (5) Questioning; (6) Asking for examples; (7) Exemplifying; (8) Reflexive; (9) Reframing; (10) Interpretation; (11) Summarizing; (12) Paraphrase; (13) Suggestions; (14) Instructions; (15) Education; (16) Information; (17) Confrontation; and (18) Self-disclosure.

Response temporal dimensions are linked to the time in the session in which the therapist responded (immediately after the preceding C:VEN or not) and the moment that therapist refers in his or her response. This response dimension included five categories: (1) Immediate response; (2) Late response to a Previous expressed need in the same session; (3) immediate response signalizing that the need will be addressed in the Next Sessions; (4) immediate response anticipating the next Between-Sessions

period; and (5) immediate response informing that the need will be addressed Later in the session.

Response focuses are related to who is attended to in the response provided by the therapist. The response's focus of attention included three categories: (1) Client's subjective experience; (2) Therapist's subjective experience; or (3) Therapeutic relationship.

Response intentions are the therapist's purposes underlying his or her response. This response dimension included seven categories: (1) Promoting confidence and trust; (2) Giving support; (3) Promoting understand; (4) Challenging for novelty or change; (5) Reinforcing the change process; (6) Promoting the client's disclosure; and (7) Promoting therapy sense of continuity. This dimension is the most subjective of the four response dimensions because it is not observable conversational actions (that is, what is actually observed). The therapist's intention is what is inferred of what is observed, of what the therapist actually says or does.

Similar to what happens regarding the C:VEN, categories of T:R are mutually exclusive. The therapist's speech must be considered for the identification of what kind of response is given by him or her. The response intentions dimension is probably the most difficult dimension to identify so that both the immediate context and the entire therapist's speech in the session must be taken into account. The first set of categories consisting on T:Rs is presented in Table III – 8. Each category of the four T:R dimensions is defined in the table.

The procedure was also guided by the question of *How the client reacts to the therapist's responses regarding the needs expressed by the first?*. Empirical data allowed identifying five categories of C:R, all directly related to the client's needs. Thus, in reaction to a specific T:R, the client: (1) Begins the expression of a new type of

need; (2) Continues the expression of the same type of need; (3) Tries Again the expression of a specific type of need; (4) Ends the expression of a specific type of need; or (5) Confirms a specific type of need.

Table III – 8. The first set of categories consisting on Therapist's Responses.

Therapist's Responses (T:Rs)			
Dimensions (4)	**CATEGORIES** (33)		**Definition**
T:R Mode	1	Listening/minimal encouragement	Therapist is tracking the client's verbal expression of needs (C:VEN)
	2	Completing client's idea	Therapist is tracking the C:VEN, completing some client's idea
	3	Repetition of client's key-words	Therapist is tracking the C:VEN, repeating a client's key-word
	4	Validation or acceptance	Therapist approves, accepts or validates what the client said
	5	Questioning	Therapist makes some open or close question
	6	Ask for examples	Therapist asks the client to give examples in order to illustrate what is being discussed in the session
	7	Exemplifying	Therapist gives the client examples of what they are talking about
	8	Reflexive	Therapist thinks and elaborates about what the client said and talk about it without interpretations
	9	Reframing	Therapist uses C:VEN but in a different conceptual framing
	10	Interpretation	Therapist brings something new to the conversation, gives a new meaning to what the client said
	11	Summarizing	Therapist summarizes session contents, using client's language or a language that is not new in the session
	12	Paraphrase	Therapist makes a small abstract of what the client said
	13	Suggestions	Therapist gives the client suggestions or some guidance
	14	Instructions	Therapist gives the client instructions, saying exactly what he or she should do
	15	Education	Therapist educate the client about the problem or the therapy
	16	Information	Therapist gives the client some kind of information which is not education about the problem or the therapy
	17	Confrontation	Therapist presents some idea which is divergent from the client's one
	18	Self-disclosure	Therapist shares with the client his or her emotional experience, or ideological and conceptual position
T:R Temporal Dimension	1	Immediate	Therapist gives a response immediately after and oriented for a specific type of C:VEN
	2	Late to a Previous expressed need in the same session	Therapist's response is not contingent to the immediately precedent type of C:VEN, but is related to another type of need already referred in the session
	3	Immediate, signalizing that the need will be addressed in Next Sessions	Therapist provides an immediate response after the C:VEN informing that the specific type of need will be taken into account in the next sessions

	4	immediate, anticipating the next Between-Sessions period	Therapist provides an immediate response after the C:VEN by addressing the specific type of need and making a bridge with the next between-session period
	5	informing that the need will be addressed Later in session	Therapist provides an immediate response after the C:VEN by addressing just that the specific type of need will be taken into consideration later in the session
T:R Focus	1	Client's subj. experience	Therapist highlights the client's emotions, thoughts, behaviors or interpersonal life
	2	Therapist's subj. experience	Therapist highlights his or her own emotions, thoughts, behaviors or interpersonal life
	3	Therapeutic relationship	Therapist highlights aspects related to the dyadic relationship
T:R Intention	1	Promoting confidence & trust	The therapist aims at promoting a sense of confidence and trust
	2	Giving support	The therapist aims at providing support to the client
	3	Promoting understand	The therapist aims at promoting the understanding of problems or changes
	4	Challenging for novelty or change	The therapist aims at shaking up the client to something new, challenging the client for a different perspective, a different thought, emotion or behavior
	5	Reinforcing the change process	The therapist aims at strengthening the client's change process, the client's gains or positive results
	6	Promoting the client's disclosure	The therapist aims at helping the client to go on talking in moments that he or she is being more defensive or with more difficulties in expressing his or herself
	7	Promoting therapy sense of continuity	The therapist aims at making links between different real and potential moments of therapy in order to promote a sense of continuity

The Begins category is related to the client speaking about a specific type of need for the first time in the session. The Continues category is coded when the client reacts by expressing the same type of need that he or she was expressing immediately before the last T:R. The Tries Again category is coded when a specific type of need was previously referred by the client in the session and is introduced again by the client after he or she expressed other types of C:VEN. The Ends category is related to the last time that a specific type of need is expressed by the client in the session. The Confirms category is coded when the client merely agrees with the therapist who just spoke about a specific client's need.

The thematic context must be taken into account in order to differentiate the categories of C:R. The first set of categories of C:R is presented in Table III – 9. All categories of C:R are defined in the table.

Table III – 9. The first set of categories consisting on the Client's Reactions.

Client's Reactions (C:Rs)		
CATEGORIES (5)		**Definition**
1 Client **Begins**…	…the expression of a specific type of need…	...when the client expresses a type of need for the first time in the session, by his or her initiative, or after the therapist speak about another type of client's need
2 Client **Continues**…		...when the client expresses the same type of need that he or she was expressing immediately before the last T:R
3 Client **Tries Again**…		...when a type of need was previously referred by the client in the session and is introduced again by the client after he or she expressed other type(s) of needs
4 Client **Ends**…		...when the client expresses that type of need for the last time in the session
5 Client **Confirms** a specific type of need...		…when the client merely agrees with the therapist who just spoke about that specific type of client's need

b) Auditing of emergent categories.

All categories of T:R and C:R were reviewed and all sessions were analyzed by the auditor. Meetings between the auditor and the author were made in order to discuss the data. The auditing process reiterated the first set of categories of the T:R and C:R.

c) Independent coding of sessions.

The first set of categories consisting on T:Rs and the C:Rs were introduced to the same four coders. They were trained on coding psychotherapy sessions with T:R and C:R categories. The same six sessions coded by the author and audited were given to the four coders. They independently coded all episodes.

d) Consensus group for refine categories.

Work meetings between the coders and the author were made in order to discuss codings and reach consensus. Using both independent and consensual codings, the author made a qualitative analysis aiming to better understand why specific therapists' utterances were less sensitive to and less reliable for coding.

The consensus discussion and data analysis allowed refining categories and reformulating the description of each category of T:R and C:R, by answering to the questions of *What seems to be not working? What is and is not necessary in the set of categories? How a specific category would work better?*.

The final set of categories of T:R is presented and contrasted with the first set of categories in Table III – 10. Each category of T:R is defined in Table III – 11. The T:Rs are coded within one of the four dimensions that follow:

a) T:R Mode – Method through which the therapist puts techniques into practice through a specific verbal structure regardless the content of speech.
b) T:R Temporal Dimension – Moment of the session in which the therapist respond (immediately after the C:VEN or not) or the moment that therapist refers in his or her response (connecting the C:VEN with the past or projecting for the future).
c) T:R Focus – Target of the therapist's response.
d) T:R Intention –The purpose underlying the therapist's response.

Response modes were reduced from eighteen to twelve categories. Some categories were reformulated. The *Listening/minimal encouragement*, *Completing the client's idea*, and *Repetition of client's key-words* categories were connected in one category – *Tracking/Listening*. Data analysis showed that the three categories are related to responses tracking what the client is saying.

Table III – 10. The final set of categories consisting on the Therapist's Responses, contrasted with the first set of categories.

Therapist's Responses (T:Rs)				
Dimensions (4)	1st set of categories (33)		**Final set of categories (28)**	
T:R Mode	1	Listening/minimal encouragement	1	Tracking/Listening
	2	Completing client's idea		
	3	Repetition of client's key-words		
	4	Validation or acceptance	2	Approval
	5	Questioning	3	Questioning
	6	Ask for examples		
	7	Exemplifying	4	Exemplifying
	8	Reflexive	5	Reflexive
	9	Reframing		
	10	Interpretation	6	Interpretation
	11	Summarizing	7	Summarizing
	12	Paraphrase		
	13	Suggestions	8	Guidance
	14	Instructions		
	15	Education	9	Education
	16	Information	---	-----
	17	Confrontation	10	Confrontation
	18	Self-disclosure	11	Self-disclosure
	---	-----	12	Nonresponse
T:R Temporal Dimension	1	Immediate	1	Immediate
	2	Late, to a Previous expressed need in the same session	2	Late, to a Previous expressed need in the same session
	3	immediate, signalizing that the need will be addressed in Next Sessions	3	immediate, signalizing that the need will be addressed in Next Sessions
	4	immediate, anticipating the next Between-Sessions period	4	immediate, anticipating the next Between-Sessions period
	5	immediate, informing that the need will be addressed Later in session	---	-----
	---	-----	5	immediate, Linking with previous sessions
	---	-----	6	immediate, Renaming the needs
T:R Focus	1	Client's subj. experience	1	Client's subj. experience
	2	Therapist's subj. experience	2	Therapist's subj. experience
	3	Therapeutic relationship	3	Therapeutic relationship
	---	-----	4	Therapeutic work
T:R Intention	1	Promoting confidence & trust	1	Providing security
	2	Giving support		
	3	Promoting understand	2	Promoting understand
	4	Challenging for novelty or change	3	Challenging for novelty or change
	5	Reinforcing the change process	4	Reinforcing the change process
	6	Promoting the client's disclosure	5	Promoting the client's disclosure
	7	Promoting therapy sense of continuity	---	-----
	---	-----	6	Focusing

Table III – 11. The final set of categories consisting on the Therapist's Responses – definition of each category.

Therapist's Responses (T:Rs)			
Dimensions (4)	**CATEGORIES** (28)		**Definition**
T:R Mode	1	Tracking/Listening	Therapist is tracking the client's verbal expression of needs (C:VEN) , listening the client, completing some client's idea or repeating a client's key-word
	2	Approval	Therapist approves, accepts or validates what the client said
	3	Questioning	Therapist makes a question or asks client to give some information or examples
	4	Exemplifying	Therapist gives the client examples of what they are talking about
	5	Reflexive	Therapist thinks and elaborates about what the client said, and talks about it without interpretations
	6	Interpretation	Therapist brings something new to the conversation, gives a new meaning to what the client said
	7	Summarizing	Therapist summarizes session contents, using client's language or a language that is not new in the session
	8	Guidance	Therapist guides the client giving him or her suggestions or instructions
	9	Education	Therapist educates the client about the problem or the therapy
	10	Confrontation	Therapist presents some idea which is divergent from the client's one
	11	Self-disclosure	Therapist shares with the client his or her emotional experience, or ideological and conceptual position
	12	Nonresponse	Therapist does not provide a response immediately after the C:VEN
T:R Temporal Dimension	1	Immediate	Therapist gives a response immediately after and oriented for a specific type of C:VEN
	2	Late, to a Previous expressed need in the same session	Therapist's response is not contingent to the immediately precedent type of C:VEN, but is related to another type of need already referred in the session
	3	immediate, signalizing that the need will be addressed in Next Sessions	Therapist provides an immediate response after the C:VEN informing that the specific type of need will be taken into account in the next sessions
	4	immediate, anticipating the next Between-Sessions period	Therapist provides an immediate response after the C:VEN by addressing the specific type of need and making a bridge with the next between-session period
	5	immediate, Linking with previous sessions	The therapist gives an immediate response after the C:VEN by addressing the specific type of need and making a link with conversational actions in past sessions
	6	immediate, Renaming the needs	The therapist gives an immediate response after the C:VEN but using specific lexical expressions that gives the client an opportunity to begin expressing the need in a different way (using a different type of C:VEN)

T:R Focus	1	Client's subj. experience	Therapist highlights the client's emotions, thoughts, behaviors or interpersonal life
	2	Therapist's subj. experience	Therapist highlights his or her own emotions, thoughts, behaviors or interpersonal life
	3	Therapeutic relationship	Therapist highlights aspects related to the dyadic relationship
	4	Therapeutic work	The therapist highlights aspects related to the interventions
T:R Intention	1	Providing security	The therapist aims at promoting support and a sense of trust and safety
	2	Promoting understand	The therapist aims at promoting the understanding of problems or changes
	3	Challenging for novelty or change	The therapist aims at shaking up the client to something new, challenging the client for a different perspective, a different thought, emotion or behavior
	4	Reinforcing the change process	The therapist aims at strengthening the client's change process, the client's gains or positive results
	5	Promoting the client's disclosure	The therapist aims at helping the client to go on talking in moments that he or she is being more defensive or with more difficulties in expressing his or herself
	6	Focusing	Therapist aims at helping the client to get back to the topic under discussion

The following example was taken from the first session[5] of a Cognitive-Behavioral Therapy for Depression (case b). The client is speaking about her current doubts regarding her professional competence (C:VEN: Hesitations axis, Doubts) that started in her internship. The therapist responds predominantly with interjections, repeating some client's key-words. He just listens and tracks what the client is saying.

C.[6] – [silence] Self-criticism…? No… I think what I do most is mostly doubting, questioning my…

T. – Questioning…

C. – … my ability…

T. – Your ability?

C. – Yes.

T. – Hum-hum… Hum-hum…

[5] All clients were attended to an assessment session prior to the treatment. Thus the session one matches the second time that the client and the therapist meet.
[6] C. – Client; T. – Therapist.

C. – Ah… I don't know to what degree is that self-criticism.

T. – Hum-hum…

C. – I don't critic myself in the sense of saying "I am…" … During my internship there was stuff that didn't go as I had wished… but I don't blame myself…

T. – Hum-hum…

C. – Because I know I was in a position… that was dragging me down a bit. Actually I questioned myself and I was insecure regarding who I was, what I was doing…

T. – Hum-hum…

C. – I was in a very sensitive and out-of-control place.

T. – Hum-hum…

C. – …with no ability to concentrate, without knowing what to do, if I was able to do …

T. – Hum-hum… Hum-hum…

C. – Deep down, I didn't blame myself for that. I'd ask myself: "Why are you like that? You can't be like that! I'm not going to make it! I have to make it! I don't know if I'm going to make it!"

T. – Hum-hum…

C. – I guess it was more like doubt and questioning me about what I was capable of.

T. – Hum-hum… Hum-hum…

C. – In general, it was more that, than actual self-criticism. It still is.

The *Validation or acceptance* category was replaced by the *Approval* category. Even though the meaning of the two categories is similar, the word *Approval* is illustrative of responses approving what the client said that are explicit and clearly detectable in the therapist's speech. The following example was taken from the third session of a Cognitive-Behavioral Therapy for Anxiety (case d). The client is speaking about her difficulties on role-playing proposed by the therapist (C:VEN: Direct Request axis, Difficulties related to psychotherapy). A moment before this excerpt the client was expressing his social difficulties, namely the difficulty in look at the others' eyes in conversations and the difficulty on making comments in public (C:VEN: Difficulties axis, Interpersonal difficulties). The therapist proposed role-playing. After the second role-playing of comments in public (speaking up), the therapist asked the client how he felt (anxiety degree) and his perceived others' evaluation on the role-playing situation. The client said that he felt anxiety and discomfort on the therapeutic activity (C:VEN: Direct Requests axis, Difficulties related to psychotherapy). The therapist normalizes the experienced level of anxiety and approves the client's conclusion about his ability in transmitting messages to an audience. Then, the client expresses his desire of generalize his behaviors in role-playing to his daily life.

C. – The anxiety was the same as previously, although this last presentation was more organized.

T. – (…)

C. – It seemed to me clumsier, but more structured, and following some logic in the information. I think I managed to get the information through better, that is, the audience managed to understand better what I said, although they also

have noticed that I had some discomfort during the presentation.

T. – (…)

C. – They noticed because of the time I usually took to start talking… ah! Another thing that the audience understood is that, right or wrong, with a good or bad presentation, they understood what I was talking about, more than previously. The presentations can be more or less clumsy; can cause more or less at ease feeling…

T. – Exactly. Because, for example, when you observe your colleagues you also notice that they…

C. – I do, I notice insecurity in some and in others I see a security that impresses me.

T. – We are not all equal!

C. – No we aren't. Of course not… There are many that have a great confidence, a great at ease sense. But the majority has always some anxiety.

T. – (…)

C. – The important thing is that I had the ability to understand and to pass the message.

T. – (…)

C. – Whether I can or cannot do it is relative but clearly adopting these behaviors will be very helpful.

The *Ask for examples* category was included within the *Questioning* category. The first category seemed to be a subcategory of the second. In both categories the therapists asks the client to give some information. The following example was taken from the third session of a Narrative Therapy for Depression (case e). Therapeutic dyad discusses marital problems of the client. The client expresses guilty feelings because he had an extramarital relationship (C:VEN: Difficulties axis, Interpersonal difficulties) and doubts in relation with continuing with the marriage or to divorce (C:VEN: Hesitations axis, Doubts).

C. – (…) I am not making an effort to make my marriage work.

T. – What would that effort imply?

C. – That effort would imply that I wouldn't have lived what I have lived… [Laugh] … Making that effort would be something that is not natural… because the experience I had was something so positive, so good …

T. – Hum-hum… What was it making that effort, explicitly?

C. – Making that effort would be to forget completely what happened…

T. – And what does the guilt say about that? Does it say it is possible to do that?

C. – About that the guilt says I should try to forget… But, on the other hand, there's a force that says "No, I cannot forget something that was so good… I don't even want to forget!"

T. – The guilt thinks you should forget… But does the guilt think that it is possible to forget?

C. – Yes… But it would very hard…

Later in the same session, the therapist makes different questions regarding the possible implications of a divorce in the client's relationship with his son.

C. – It would be very hard to tell my son that I'm going to get separated from his mother… but I also see other kids that have separated parents…

T. – Do you know any close case?

C. – Yes I had a close case. A close relative… Of course it was hard because of his daughters… and… afterwards there are those difficult moments: parties, special occasions...

T. – How is it…?

C. – Hard.

T. – How is it with that close case? How did the parents manage those moments?

C. – The children stayed with their mother… The father decided to live further away, and now he sees the children once a week. Well, I mean: they are people… we are different people, right? That would be impossible for me… For me it would have to be every day, every day… I would have to be present. But in that case he managed to accept things that way. But that wouldn't work for me.

T. – If the guilt wouldn't interfere, how would you think that, for example, how would you negotiate with the mother the frequency of the visits and the special occasions?

C. – Well, there would have to be an understanding between us… and the special occasions would have to be shared. With both on the same place...

The *Reframing* category was included within the *Reflexive* category. In both categories, the therapist thinks and elaborates about what the client said, and talks about it without interpretations. The following example was taken from the third session of a Narrative Therapy for Depression (case a). In the beginning of the session, the client is expressing his tiredness, hopeless and anger (C:VEN: Difficulties, Intrapersonal difficulties). After the therapist tracked and questioned the client, he provides a reflection about the client's difficulties.

C. – So… ah… there is an idea that is still persisting in my head….

T. – Hum-hum…

C. – That is: I am extremely tired… I'm desperate and… at this moment I am worthless… (…) I always used to be in a good mood, but not now. I am irritated all the time… always nervous, always irritated … (…) It is a constant stress… and then this irritability.

T. – Hum-hum…

C. – And I ask myself: Why can't I concentrate? I can't I? …? (…) Sometimes I have a thought and I can't reach the end of a conversation because I lose track of what I was thinking… ant that irritates me a lot.

T. – Hum-hum…

C. – It makes me nervous...

T. – The feeling that I get every time you talk, I don't know if I got it right… but you feel irritated because there are a number of things that you think you should be able to do and sometimes you are not. And you feel irritated about that.

C. – Yes.

T. – It is always something like this that happens, if I understood it correctly…

C. – It is. It's the irritability, you know? If I'm not able to do something I start to get nervous …

T. – Ok.

C. – It is visible suddenly in the way I talk, the way I look, huh… even in the way I am.

The *Paraphrase* category was included within the *Summarizing* category. Both categories are related to responses through which the therapist summarizes (or paraphrases) session contents, using client's language or a language that is not new in the session. On the sequence of the previous example (case a), the therapist summarizes what the client said.

C. – It is. It's the irritability, you know? If I'm not able to do something I start to get nervous …

T. – Ok.

C. – It is visible suddenly in the way I talk, the way I look, huh… even in the way I am.

T. – Ok. F., let's organize this information by pieces, ah… A while ago you were talking about being always very tired, about having things that you were not able to do, and that, in a way, you were a little useless because of that.. And that usually left you irritated afterwards. You also told me that in some way there was a change, that it was different before…

C. – Yes.

The new category of *Guidance* combines the *Suggestions* and *Instructions* categories. Thus, the *Guidance* category is related to responses guiding the client, including suggestions and instructions. In the same case referred to in the Approval category (case d) and in the beginning of the session, the therapists guide the client in order to promote the understanding and the development of a task of role-playing.

T. – Today, we had decided to do that task… a presentation to an audience.

C. – As I did not prepare a thing, it has to be a short verbal presentation. It has to do with leisure.

T. – That's ok.

C. – It has to do with a sport I practice.

T. – What is it?

C. – Kitesurf.

T. – Ok. So the idea is to make two presentations. Actually, it is the same presentation, but in one of them using those safety behaviors we had talked about, and the other would be without those safety behaviors.

C. – Which are…?

T. – Those behaviors of staying in the same place.

C. – Well, in this little room I wouldn't have much space to move anyway.

T. – That is true. But, there is still space, right? So the idea is you have to have.

C. – I'll have to try and make up some space!

T. – You'll have to get it! So, when you're ready… Imagine that the audience is right here, besides me. Do as you want to.

C. – Ok, how long is the presentation? Can it be a 5 minute presentation?

T. – Can you do it? Ok.

C. – Yes, I can. I can't say much more than that, but I think I can. Well…

T. – Well…

C. – I'm going to talk about Kitesurf. We can start by talking about what kitesurf is. Kitesurf is a sport that fits in what we usually cal radical sports (…).

Five initial categories did not change. They are: *Exemplifying*, *Interpretation*, *Confrontation*, *Education*, and *Self-disclosure*. *Exemplifying* is the response mode by which the therapist gives the client examples of what they are talking about. The following example was taken from the third session of a Narrative Therapy for Anxiety (case c). The client is describing how she feels when panic episodes develop (C:VEN: Difficulties, Intrapersonal difficulties). The therapist externalizes the problem trying to follow the sequence of what happens in the panic episodes. At the end of this extract, the therapist helps the client to disclose by exemplifying.

C. – When I have some crisis it's something quite fast. I feel my throat…

T. – Hum-hum, hum-hum…

C. – I enter… totally in crisis.

T. – Hum-hum, hum-hum…

C. – Sweating all over… the hands, the legs… and I lose all sense of control… I lose my strength, I can't talk…

T. – (…)

C. – When I'm about to have a crisis I start getting numb… I get the tingles in my hands… My hands get very wet and cold… First the hands, then the legs… then I feel all the body getting numb e… I can't breathe. It's all very fast.

T. – Hum-hum… The problem's action strategy is very fast… Which strategies does he – the problem – uses to upset you, to initiate a total crisis?

C. – Hum. There are several strategies...

T. – (…)

C. – Because, firstly, I get the thinking that I won't breathe…

T. – Do you think he begins by the thoughts, M.? Do you think that's where he starts acting on?

C. – Yes.

T. – (…)

C. – It's like a movie tape that's going through my brain… and from there… I start getting nervous and… and try to control myself more but…

T. – Hum-hum…

C. – It's from there…hammm….

T. – Hum… <u>It's from there that, for example, the throat symptom may appear?</u>

C. – Yes, Yes. That's it. I feel something in my throat… like someone was here [puts hand around neck] choking, the air can't get through… and then I start to hyperventilate … (…).

Interpretation is the response mode by which the therapist brings something new to the conversation or gives a new meaning to what the client said. The following example was taken from the third session of a Cognitive-Behavioral Therapy for Depression (case f). Therapeutic dyad discusses the difficulties that the client had in performing the research task about university courses during the previous inter-sessions period. The client considers that she cannot reason, cannot think, and therefore cannot search the courses (C:VEN: Difficulties axis, Intrapersonal difficulties). The client also refers her expectation that if she has such difficulties with a task like that one

(secondary), she will have much more difficulties in tasks that are considered more important like actually choosing the course (C:VEN: Wanting axis, Expectations). The therapist starts by questioning the client if she would thing about her secondary tasks differently, offering interpretations about what is expected of people's behaviors regarding priorities. The client accepts those interpretations but when the therapist passes those interpretations to the client's subjective experience, she ceases to accept and tries again the expression of reasoning difficulties (C:VEN: Difficulties axis, Intrapersonal difficulties).

T. – Is there another way to look at secondary tasks?

C. – They are still important, but... I can't do them…

T. – Normally those are tasks that people tend to leave for later.

C. – Yes. In first place we put the primary ones…

T. – Yes.

C. – …the more important ones.

T. – And people tend to commit less in those that are not so important.

C. – Yes.

T. – Hum-hum…

C. – But what does that mean?

T. – This week it could have happened that you were not able to do the task because it was a less important task, but you may have interpreted that in a different way like "I can't reason, I can't do it, I'm useless"…

C. – But I really did feel that I was not capable of reasoning.

Confrontation is the response mode by which the therapist confronts the client with new perspective or a divergent idea. In the same case referred to in the Interpretation category (case f), the therapist confronts the client when she expresses indecision in relation to her volunteer work (C:VEN: Hesitations axis, Doubts).

C. – I was not able to think… I´m not sure, I don´t know what should I do. On one hand, I want to continue doing my volunteer work but I can´t, on the other hand, if I leave, I think I won´t feel ok… and that´s it.

T. – Hum-hum…

C. – I don´t know…

T. – Hum-hum… And not being able to reason relieves you from the decision in that moment. Right?

C. – Relieved me? No! It makes me feel really bad not being able to reason.

T. – Yes, but you… When you reasoned or reached a conclusion… It´s like: "Ok, so I don´t need to make that decision."

C. – No.

T. – No?

C. – I don´t feel that way.

T. – Ok.

C. – Quite the contrary. I feel really bad for not being able to make the decision and… really screwed for not being able to think.

Education is the response mode by which the therapist provides education about the problem or the psychotherapy. The following example was taken from the first session of a Cognitive-Behavioral Therapy for Depression (case b). The therapist is educating the client about the problem and the psychotherapy.

T. – The work that we are going to do now has the goal of investigating why certain things maintain themselves, even being dysfunctional. Right?

C. – [Nodding]

T. – Ah… And, because even when everything is fine they are still there. First f all "which are those things"?

C. – Hum-hum…

T. – I'm going to switch "thing" by "thought" to be clearer. So, certain thoughts sometimes make us feel down.

(…)

T. – When we change our perspective of the same things or the same situations, we start to feel them differently…

C. – Hum-hum…

T. – We also start being capable of positioning ourselves in a different way, and of having different attitudes and behaviors.

C. – Hum-hum…

T. – So, the work here has the scope of knowing… knowing how we interpret things. Cognition comes from knowledge,

that is, how do we acknowledge and interpret the situations, the things… right?

(…)

T. – The thought – the so called automatic thought – is that first thought. It is… it is the one that [snaps his fingers]… something happens and what do you think? Those first thoughts are usually tied to conceptions a little bigger, that people have about themselves, the others and the world. These automatic thoughts are very revealing. We don't give much importance to them, most of the times, but they are linked and grouped into bigger themes… and some of them are not very well adjusted.

C. – Ok.

T. – The result of this [self-report] is usually very productive, in identifying the cognition, the knowledge, about how it works.

C. – [Affirmative nod]

T. – And, of course, in identifying why some of these thoughts maintain themselves, why some conceptions exist…

C. – [Affirmative nod]

T. – How do they work when you're alright…

C. – [Affirmative nod]

T. – Whether it works more at some moments. Anyway…

C. – These self-reports make all sense to me.

T. – Hum-hum, ok.

Self-disclosure is the response mode by which the therapist shares with the client his or her emotional experience, or his or her ideological and conceptual position. In the sequence of the previous example (case b), the therapist discloses his beliefs about psychotherapy.

C. – These self-reports make all sense to me.

T. – Hum-hum, ok.

C. – Ah… Even because it stays in record, so then it's easier to…

T. – Exactly.

C. – … be analysed, right?

T. – Ah… I believe that therapy is not only here. To me, here is actually only one hour a week, right?

C. – Exactly. Hum-hum…

Two categories were eliminated – *Explanation* and *Information*. These categories had hindered the agreement between the coders. Data analysis showed that neither categories could be coded reliably.

Finally, one category was added – *Nonresponse*. When this category is identified as response mode, it is not possible to code any other T:R dimensions. If the therapist does not give a response, it is not possible to identify any response temporal dimension, focus or intention. Nonresponse is coded even in moments in which the therapist say some minimal words or interjections but not sufficient to code any other response mode, followed by a change of topic. The following example was taken from the third session of a Narrative Therapy for Depression (case a). The therapist starts questioning and

reflecting about the fact that the client becomes angry with himself when he fails on accomplish what he previously determined (C:VEN: Difficulties axis, Intrapersonal difficulties). Then, the therapist asks about the consequences of the client's anger, and the client expresses his will of "disappear" (C:VEN: Wanting axis, Problem-related wishes). The therapist does not provide a response oriented to the problem-related wishes, maintaining his focus on the intrapersonal difficulties.

T. – Ok. Why does that "failing you" leaves you irritated?

C. – Because I should have completed it, should have done it.

T. – Hum-hum… Not completing, not doing… what does that mean?

C. – I feel bad when I don't do something that I should have done, right?

T. – Hum-hum…

C. – Now… I feel like a failure in that aspect.

T. – Ok. So, you feel like a failure and then irritates. It seems we have here some kind of chain, right? And what is the irritation followed by?

C. – I want to send everything to hell.

T. – Hum-hum…

C. – I want to disappear…

T. – Ok. What else? The consequences of the irritation…?

C. – Sadness…

T. – Hum-hum… Ok.

C. – And… And… The return of certain kinds of thoughts…

T. – Hum-hum…

C. – "It's not worthy to be here, it would better…"…

T. – Ok. Can we go back to the beginning of the chain? You were saying… we started this chain of cases and consequences in the idea of "What I should have done". The beginning is "I should have done", then "As I didn't do, I failed", "I got irritated about this". Ah… What does this "I should have done" say about yourself?

At the end of this step the response mode dimension included twelve categories: (1) Tracking/Listening; (2) Approval; (3) Questioning; (4) Reflexive; (5) Summarizing; (6) Guidance; (7) Exemplifying; (8) Interpretation; (9) Confrontation; (10) Education; (11) Self-disclosure; and (12) Nonresponse.

The response temporal dimension was composed by six categories. Four of the original categories remained as response temporal dimensions – *Immediate response to a C:VEN; Late response to a Previous expressed need in the same session; immediate response signalizing that the need will be addressed in the Next Sessions; and immediate response anticipating the next Between-Sessions period.* The T:R is *Immediate* when the therapist gives a response immediately after and oriented to a specific C:VEN. The examples presented for all the categories within the T:R mode dimension include responses following immediately the C:VEN.

The T:R is a *Late response to a Previous expressed need in the same session* when it is not related to the immediately precedent type of C:VEN but to another type of need expressed earlier in the session. The T:R is an *immediate response signalizing that the need will be addressed in the Next Sessions* when the therapist provides an

immediate response after the C:VEN informing that the specific type of need will be taken into account in the next sessions. The T:R is an *immediate response anticipating the next Between-Sessions period* when the therapist provides an immediate response after the C:VEN by addressing the specific type of need and making a bridge with the next between-session period. On the third session of a Narrative Therapy for Depression (case e), the client talked about guilty feelings because he betrayed his wife (already referred to illustrate the Questioning category). Then, other types of C:VEN were identified, namely the expression of doubts about continuing with the marriage or to divorce. At the end of the session, the therapist returns to the guilt topic (T:R: Late response to a Previous expressed need in the same session), as the following excerpt shows.

> T. – Today we saw that there is a set of more of less implicit rules about how you should behave in different situations, in particular in what regards your marriage. The guilt is who defines those rules.
>
> C. – [affirmative nod]

Also, the therapist talks about the therapeutic work for the between-sessions period and for the next sessions (C:R: immediate response signalizing that the need will be addressed in the Next Sessions, and immediate response anticipating the next Between-Sessions period).

> T. – I have a proposal to make you. I would like that you would be aware of the moments the guilt comes over the next week

to, to the content of the guilt's voice in those moments, to the arguments or stratagems she uses.

C. – Ok.

T. – And I would like you to take some time to write a contract with the guilt. A bit like what we have done here. Imagine that in "article 1" you write "the guilt forces N. to…", that is, what behaviors does the guilt force you to have?

C. – [Affirmative nod]

T. – The idea is that it would be an unfinished document, an open contract. And then in the next session we can analyze the content of those records. Is that ok?

C. – Yes.

T. – With this contract we will be working, and as something new is discovered, we can add to it. We can work on this progressively.

C. – Ok.

The category of *immediate response informing that the C:VEN will be addressed Latter in the session* was eliminated because it was rarely coded and it can be replaced by the *Immediate* category, when the therapist informs the client, and by the category of *Late response to a Previous expressed need in the same session*, when the therapist provides that response later in the session.

Finally, two categories were added – *immediate response Linking with previous sessions* and *immediate response Renaming the need.* In the first, the therapist gives an immediate response after the C:VEN by addressing the specific type of need and

making a link with conversational actions in past sessions. The following example was taken from the first session of a Narrative Therapy for Depression (case a). The client is talking about his wish of become himself his priority and not the others (C:VEN: Wanting axis, Change-related wishes). The therapist provides an example linking the topic under discussion in the current session and what the client said in the previous session in order to clarify the question he is making to the client.

C. – I think that the fact that I am always helping others, and I'm always available to others is more important than me. I should be that way. I should be more important than the others.

T. – Ok.

C. – But that is not my priority.

T. – Hum-hum…

C. – That is, I drop everything for other people…

T. – "Helping others" is more important than "my agenda". How would it work if those "others" were only some others, and not everybody? That is, in the last session, for example, you were talking about the accident your daughter had. So, in that case your child started to be the priority.

C. – Yes, yes, yes…

T. – What I was trying to picture was: What would happen if those "priority others" started to be only family and some friends, instead of everybody?

The T:R is an *immediate response Renaming the need* when the therapist gives an immediate response after the C:VEN but using specific lexical expressions that gives the client an opportunity to begin expressing the need in a different way (using a different type of C:VEN). This category was defined as a response temporal dimension because it is an immediate response for a specific type of C:VEN yet encouraging the client to reframing it, or to express related needs or related topics. The following example was taken from first session of a Cognitive-Behavioral Therapy for Depression (case b). The client is speaking about her difficulty in accepting compliments from the others (C:VEN: Difficulties axis, Interpersonal difficulties) illustrating this with a past situation with school colleagues. The therapist responds firstly by asking if that difficulty continues in the client's current life. Then, he creates a chance for the client to think about the problem in a different way. Affirming that the client needs compliments from the others, the therapist introduces an opportunity by which the client can express a new type of C:VEN (C:VEN: Wanting axis, Wishes). After the client accepted the challenge, the therapist produces a new opportunity by which the client can express a different type of C:VEN (C:VEN: Difficulties axis, Intrapersonal difficulties).

> C. – There was a situation in which my colleagues were complimenting me and I would laugh and agree "yes, I am nice, and funny"… but when they told me I was pretty or intelligent, I said no: "no, that I don't agree. You have the right to your opinion but I don't agree".
>
> T. – And is it still difficult for you today…?
>
> C. – Accepting… Ah…
>
> T. – …Accepting a compliment?

C. – Yes. Yes.

T. – Hum-hum…

C. – It still is. Even though I am trying to work on that…

T. – Ah-ah…

C. – It still is.

T. – Ah-ah…

C. – It is.

T. – What is the difficulty you feel?

C. – [Takes deep breath] Ahh… I am not starting to have conscience that it's something that is… automatic, it is already…

T. – When was the last time it happened? Someone giving you a compliment… something about your work "You are competent… you're good (effective)"…

C. – Hum… I don't remember. I don't thing I had any compliments [Laugh].

T. – <u>You miss… a compliment!</u>

C. – Yes… I guess that… yes. I mean… for you to know that you are…

T. – Hum-hum…

C. – …or you're trying to evolve, right? There's always… hum… you miss a compliment.

T. – Hum-hum… <u>Do you compliment yourself?</u>

C. – No.

T. – Like: “Today you did this alright”… You, I mean, you talking to yourself.

C. – Hum. No.

T. – Do you criticize yourself?

C. – When I say something to myself it is to say that I did bad. It is.

T. – Like: “Today I wasn’t so good…”…

C. – Yes. I guess so.

T. – That seems… that seems important, doesn’t it?

C. – Yes…

Other example arises from session one of a Narrative Therapy for Depression (case c). The client initiates the session talking about a problematic situation with her boyfriend that had happened the week before the session (C:VEN: Difficulties axis, Interpersonal difficulties). After having given some responses oriented to those interpersonal difficulties, the therapist encourages the client to express other type of C:VEN (C:VEN: Difficulties axis, Intrapersonal difficulties) in order to promote comprehension.

T. – First how it was this week?

C. – Difficult… My boyfriend and I have planned to go out on our birthday but (…). We have so little time to be together and now we just can’t be with each other.

(…)

T. – Hum-hum… M., today we are going to talk precisely about the problem that brought you to therapy. What I really wanted today is… get to know that problem ah… and… also the strategies that problem uses to harm you, the effects the problem has had in your life, ah…Understanding the problem perhaps from another perspective. Ah… and… and maybe starting with the effects of the problem in your life, in the various areas, ah… what impact does he have had, for example, starting with your work? What impact has this problem have?

C. – Ah… I have already had a panic crisis at work …

T. – Hum-hum…

C. – And it is evident that since I'm like this I have been having some difficulties in performing certain tasks…

C. – Ah… for example, being in a closed archive room…

T. – Hum-hum…

C. – …to get some files…

T. – Hum-hum…

C. – …to go someplace where I have to climb up the stairs… or go to a place I don't know…

T. – Hum-hum…

C. – Ah… so, it deprives me… in many ways…

T. – Hum-hum…

C. – … from performing certain tasks…

One more category was added to the initial set of categories in the dimension of response focus. Thus, the final set of categories included: the *Client's subjective experience*, when the therapist highlights the client's emotions, thoughts, behaviors or interpersonal life; the *Therapist's subjective experience*, when the therapist highlights his or her own emotions, thoughts, behaviors or interpersonal life; the *Therapeutic relationship*, when the therapist highlights aspects related to the dyadic relationship; and the *Therapeutic work*, when the therapist highlights aspects related to the interventions.

The examples presented for all the categories within the T:R mode dimension included responses focusing on the client's subjective experience with the exception of three examples that follow. In the example provided to illustrate the Self-disclosure category within the T:R mode dimension (case b), the therapist focus his own subjective experience. The following extract illustrates this T:R focus.

(…)

T. – Ah… I believe that therapy is not only here. To me, here is actually only one hour a week, right?

C. – Exactly. Hum-hum…

In the example provided to illustrate the Guidance category within the T:R mode dimension (case d), the therapist highlights the therapeutic work guiding the client to the understanding and the development of a task of role-playing. The focus on the therapeutic work is evident on the following extract:

T. – Today, we had decided to do that task… a presentation to an audience.

(...)

T. – Ok. So the idea is to make two presentations. Actually, it is the same presentation, but in one of them using those safety behaviors we had talked about, and the other would be without those safety behaviors.

C. – Which are…?

T. – Those behaviors of staying in the same place.

(...)

T. – (...) So, when you're ready… Imagine that the audience is right here, besides me. Do as you want to.

(...)

C. – I'm going to talk about Kitesurf (…).

In the example provided to illustrate the Education category within the T:R mode dimension (case b), the therapist focuses on the therapeutic work educating the client about how the problem is conceive in Cognitive-Behavioral Therapy and how psychotherapy works. The focus on the therapeutic work is evident on the following extract:

T. – The work that we are going to do now has the goal of investigating (…)

(…)

T. – When we change our perspective (…) we start to feel them differently… (…) start being capable of positioning

ourselves in a different way, and of having different attitudes and behaviors.

C. – Hum-hum…

T. – So, the work here has the scope of knowing… (…) Cognition comes from knowledge (…)

(…)

T. – The thought – the so called automatic thought – is that first thought. It is… (…) Those first thoughts are usually tied to conceptions a little bigger, that people have about themselves, the others and the world (…)

C. – Ok.

T. – The result of this [self-report] is usually very productive, in identifying the cognition, the knowledge, about how it works.

(…)

Finally, the therapist can focus the therapeutic relationship, as the following example illustrates. On the sequence of the extract presented below the therapist highlights the therapeutic relationship.

T. – In the psychotherapy, one hour a week, here is the time in which we work together. We both work as a research team.

C. – I… I agree… [Laugh]

T. – You start the field work during the week and then we both here together address the material you bring.

C. – Yes, ok.

T. – The work that the field researcher will develop will give us material to work on together in the next sessions… And even to establish some goals for us, here in the psychotherapy. Is that alright?

C. – Ok, ok.

The response intentions changed from five to six and two initial categories were joined. The category of *Promoting confidence and trust*, and the category of *Giving support* became the category of *Providing security* because both seemed to be related to the purpose of promoting a safety feeling in the client. In the example provided to illustrate the Approval category within the T:R mode dimension (case d), the therapist seems to have the intention of providing the client with security by normalizing the client's feelings and reinforcing the client's ability in transmitting messages to an audience. The extract that follows illustrates this response intention.

(…)

C. – They noticed because of the time I usually took to start talking… ah! Another thing that the audience understood is that, right or wrong, with a good or bad presentation, they understood what I was talking about, more than previously. The presentations can be more or less clumsy; can cause more or less at ease feeling…

T. – Exactly. Because, for example, when you observe your colleagues you also notice that they…

C. – I do, I notice insecurity in some and in others I see a security that impresses me.

T. – We are not all equal!

C. – No we aren't. Of course not… There are many that have a great confidence, a great at ease sense. But the majority has always some anxiety.

T. – (…)

C. – The important thing is that I had the ability to understand and to pass the message.

(…)

The category of *Promoting therapy sense of continuity* was eliminated because it seemed to be more related to the response temporal dimension. This category seemed to be redundant, losing power to be coded.

A new category was added – *Focusing*. The T:R has the intention of *Focusing* when the therapist aims at helping the client to get back to the topic under discussion. Sometimes, the client talks about insignificant things, bypassing the therapeutic conversation and the therapist tries to bring the client to the previous topic under discussion. The following example was taken from third session of a Cognitive-Behavioral Therapy for Depression (case f). The client starts saying that she wants to decide her academic future (C:VEN: Wanting axis, Wishes). When the client expresses doubts about decision making (C:VEN: Hesitations axis, Doubts) and discomfort (C:VEN: Difficulties axis, Intrapersonal difficulties), the therapist provides a response aiming to focus the client on the first type of C:VEN. The client accepts the therapist intervention and returns to that first C:VEN.

C. – (…) I've been doing a countdown of the time remaining for me to decide what I want to do.

T. – Ok.

C. – People had told me that I was doing this and I had not noticed. But this week I felt I was doing it...

T. – And when is the deadline?

C. – At the time of the national exams. June, I think ... But I have to study before, so in May...

T. – Hum-hum... Hum-hum…

C – And those thoughts are always passing through my head.

(...)

T. – hmm-hmm ... So the exams begin in June...

C. – I do not know if I can, right? Also because I don't know what course I want to go, so "What exams can I do?".

T. – Hum-hum…

C. – But I think it is wrong ... I feel bad about it. I cannot imagine...

T. – So ... To get to do the exams you have to choose one area... and then choose a course.

C. – [Nods head] And I think that there are many steps to make in a very short time.

T. – Ok. And what is the first step?

C. – To decide what I want to do. This is the whole step, right?

T. – Hum... And what is the first step to decide? What you have to do to decide?

C. – I have to research.

T. – I'm asking this question because from what I understood your major goal is to make the national exams in June.

C. – Depending on the course that I choose, I may or may not have to do the exam. (...) But what I want is ... I do not want to stay another year doing nothing.

Four initial categories remained as response intentions – *Promoting understanding, Challenging for novelty or change, Reinforcing the change process, Promoting the client's disclosure*.

The T:R has the intention of *Promoting understanding* when the therapist aims at promoting the understanding about problems, wishes problem-related, relation between problems, change or novelty, wishes change-related, problems related to psychotherapy, psychotherapy goals or tasks, wishes related to psychotherapy or the now experience. The following example was taken from the third session of a Narrative Therapy for Depression (case e) and was referred to illustrate the Questioning category within the T:R mode dimension. The therapist is questioning the client in order to promote the understanding about the implications arising from two possibilities: marriage or divorce.

C. – (…) I am not making an effort to make my marriage work.

T. – <u>What would that effort imply?</u>

C. – That effort would imply that I wouldn't have lived what I have lived… (...)

T. – Hum-hum… <u>What was it making that effort, explicitly?</u>

C. – Making that effort would be to forget completely what happened …

T. – And what does the guilt say about that? Does it say it is possible to do that?

C. – About that the guilt says I should try to forget… But, on the other hand, there's a force that says "No, I cannot forget something that was so good… I don't even want to forget!"

(...)

C. – It would be very hard to tell my son that I'm going to get separated from his mother… but I also see other kids that have separated parents…

T. – Do you know any close case?

(...)

T. – How is it with that close case? How did the parents manage those moments?

C. – The children stayed with their mother… (...) For me it would have to be every day, every day… I would have to be present (...)

The T:R has the intention of *Challenging for novelty or change* when the therapist aims at shaking up the client to something new, challenging the client for a different perspective, a different thought, emotion or behavior. In both examples referred to illustrate the Interpretation and the Confrontation categories within the T:R mode dimension, the therapist has the intention of challenge the client for a new perspective about what they are discussing. The examples were taken from the same

session of a Cognitive-Behavioral Therapy for Depression (case f). In the first example, the therapist provides interpretations about the expected behavior when priorities are established, challenging the client to reconsider the reasons why she did not carry out the homework on the previous between-session period.

T. – Is there another way to look at secondary tasks?

C. – They are still important, but... I can't do them…

T. – Normally those are tasks that people tend to leave for later.

(…)

T. – And people tend to commit less in those that are not so important.

C. – Yes.

(…)

T. – This week it could have happened that you were not able to do the task because it was a less important task, but you may have interpreted that in a different way like "I can't reason, I can't do it, I'm useless"…

(…)

On the second example, the therapist confronts the client challenging her to consider that she does not make decisions as a result of believing she is "not able to reason".

C. – I was not able to think… I´m not sure, I don´t know what should I do. On one hand, I want to continue doing my

volunteer work but I can´t, on the other hand, if I leave, I think I won´t feel ok… and that´s it.

(…)

T. – Hum-hum… And not being able to reason relieves you from the decision in that moment. Right?

C. – Relieved me? No! It makes me feel really bad not being able to reason.

T. – Yes, but you… When you reasoned or reached a conclusion… It´s like: "Ok, so I don´t need to make that decision."

C. – No.

T. – No?

(…)

This T:R has the intention of *Reinforcing the change process* when the therapist aims at strengthening the client's change process, the client's gains or positive results. The following example was taken from the third session of a Narrative Therapy for Depression (case e), referred above for the category of Linking with previous sessions within the T:R temporal dimension. The client's problem is related to difficulties in making decisions regarding is marriage but the client speaks about changes in his social life in the following extract. The therapist responds to the client with the intention of reinforce these changes accomplished by the client.

C. – I went back to my routine… but there has been a change.

T. – Hum-hum…

C. – For example, before I was incapable of going out with my friends… now I go out… at least once a week. I go out with the guys, go for a drink…

T. – That is something new, right N.?

C. – It is. Right now it's something new, that I didn't do before. And now I opted…

T. – …to do it.

C. – Yes, to do it.

T. – Hum-hum… Very well N.

C. – In those nights out I meet other people and… it becomes interesting.

The T:R has the intention of *Promoting the client's disclosure* when the therapist aims at helping the client to go on talking in moments that he or she is being more defensive or with more difficulties in expressing his or herself. The following example was taken from the third session of a Narrative Therapy for Anxiety (case c) and was referred above for the Exemplifying category within the T:R mode dimension. In the end of this transcript, the therapist provides an example of a physical symptom with the intention of promoting the client's disclosure about the sequence of what happens in her panic episodes (C:VEN: Difficulties axis, Intrapersonal difficulties).

C. – When I have some crisis it's something quite fast. I feel my throat…

(…)

C. – When I'm about to have a crisis I start getting numb… I get the tingles in my hands… My hands get very wet and cold… First the hands, then the legs… then I feel all the body getting numb e… I can't breathe. It's all very fast.

(…)

C. – It's like a movie tape that's going through my brain… and from there… I start getting nervous and… and try to control myself more but…

T. – Hum-hum…

C. – It's from there…hammm….

T. – Hum… It's from there that, for example, the throat symptom may appear?

C. – Yes, Yes. That's it. I feel something in my throat… like someone was here (…).

The refined categories of T:R were presented above. The categories of C:R were also refined and reformulated. Each category of the final set of categories consisting on C:Rs is presented and defined in Table III - 12.

The consensus discussion and data analysis allowed reiterating the five initial categories related to the C'R. Thus, in reaction to the T'R, the client *Begins the expression of a new type of need* not referred previously in the session; the client *Continues the expression of the same type of need* he or she was expressing before the last T'R; the client *Tries Again the expression of a specific type of need* previously referred in the session but interrupted or followed by other conversational actions; the client *Ends the expression of a specific type of need* when he or she expresses that type

of need for the last time in the session; or the client *Confirms a specific type of need* that the therapist just spoke by merely agreeing.

Table III – 12. The final set of categories consisting on the Client's Reactions.

Client's Reactions (C:Rs)		
CATEGORIES (8)		**Definition**
1 Client **Begins**…	…the expression of a specific type of need…	...when the client expresses a type of need for the first time in the session, by his or her initiative, or after the therapist speak about another type of client's need
2 Client **Continues**…		...when the client expresses the same type of need that he or she was expressing immediately before the last T:R
3 Client **Tries Again**…		...when a type of need was previously referred by the client in the session and is introduced again by the client after he or she expressed other type(s) of needs
4 Client **Ends**…		...when the client expresses that type of need for the last time in the session
5 Client **Confirms** a specific type of need...		… when the client merely agrees with the therapist who just spoke about that specific type of client's need
6 Client speaks about **Change or Novelty**		... when the client says something that clearly departs from the C:VEN highlighting changes or novelties
7 Client **Accepts** the…	…therapist's response (T:R)…	...when the client provides an affirmative answer or changes what he or she was talking before, in reaction to the T:R consisting on changing the conversational topic or presenting the conversational topic in a way that is clearly demarked from the way it was being discussed
8 Client **Does Not Accept** the…		...when the client provides an negative answer or returns to what he or she was talking before, in reaction to the T:R consisting on changing the conversational topic or presenting the conversational topic in a way that is clearly demarked from the way it was being discussed

The final set of categories includes three additional categories – the client *speaks about Novelty or Change*; the client *Accepts the therapist's response*, and the client *Does not Accept the therapist's response.* The first category occurs when the client reacts to the T:R saying something that clearly departs from the C:VEN and highlights changes or novelties in the client subjective experience. Two kinds of C:R are possible

when the T:R consists on changing the conversational topic or presenting the conversational topic in a way that is clearly demarked from the way it was being discussed. On one hand, the client accepts the T:R by providing an affirmative answer, saying something that indicates acceptance of the T:R or changing what he or she was talking about before the T:R. On the other hand, the client does not accept the T:R providing a negative answer, saying something that indicates no acceptance of the T:R or returning to what he or she was talking about before the T:R.

The following example was taken from the first session of a Narrative Therapy for Depression (case a) and was partially referred above for the T:R Nonresponse category within the T:R mode dimension. First, the client is talking about his anger toward the others that do not accomplish what is supposed (C:VEN: Difficulties axis, Interpersonal difficulties). Then, following a therapist's question, the client talks about anger toward him when he fails on accomplish what he previously determined (C:R: Begins the expression of Intrapersonal difficulties) and, following the therapist's questions, the client continues expressing his difficulties (C:R: client Continues the expression of Intrapersonal difficulties).

C. – It irritates me when people fail me.

T. – right [laugh]

C. – Then I really loose it!

T. – Hum-hum… Ok. But why do you get irritated when people fail you? That irritates you, but why? What happens in the meantime? Where is this irritability coming from?

C. – Where do I get this irritability?

T. – [affirmative nod] Does it always follow a circumstance where someones did not do what they were supposed to?

C. – Yes. Even with myself.

T. – Ok. Why does that "failing you" leaves you irritated?

C. – Because I should have completed it, should have done it.

T. – Hum-hum… Not completing, not doing… what does that mean?

C. – I feel bad when I don't do something that I should have done, right?

T. – Hum-hum…

C. – Now… I feel like a failure in that aspect.

When the therapist asks about the consequences of the client's anger, the client expresses his will to "disappear", previously referred by him in the beginning of the session (C:R: client Tries Again the expression of Problem-related wishes). The therapist does not provide a response oriented to the problem-related wishes. The client accepts the T:R of questioning about more consequences of the client's anger (C:R: client Accepts the T:R), answering by expressing sadness (C:R: client Begins the expression of Intrapersonal difficulties) but also trying again for the second time his will to "disappear" (C:R: client Tries Again the expression of Problem-related wishes).

T. – Ok. So, you feel like a failure and then irritates. It seems we have here some kind of chain, right? And what is the irritation followed by?

C. – I want to send everything to hell.

T. – Hum-hum…

C. – I want to disappear…

T. – Ok. What else? The consequences of the irritation…?

C. – Sadness…

T. – Hum-hum… Ok.

C. – And… And… The return of certain kinds of thoughts…

T. – Hum-hum…

C. – "It's not worthy to be here, it would better…"…

For the second time the therapist does not provide a response oriented to the problem-related wishes, maintaining his focus on Intrapersonal difficulties. The client continues expressing Intrapersonal difficulties and he does not expresses his will to "disappear" until the end of the session (C:R: client Ends of the expression of Problem-related wishes).

T. – Ok. Can we go back to the beginning of the chain? You were saying… we started this chain of cases and consequences in the idea of "What I should have done". The beginning is "I should have done", then "As I didn't do, I failed", "I got irritated about this". Ah… What does this "I should have done" say about yourself?

C. – Many times I have my map organized…

T. – Ok.

C. – … but there are things in which I still fail a lot…

Other example was taken from the third session of a Narrative Therapy for Depression (case e). The client is expressing his difficulties in making decisions (C:VEN: Difficulties, Intrapersonal difficulties). The therapist makes a question linking with previous sessions. The client confirms his difficulties in making decisions (C:R: client Confirms the need of Intrapersonal difficulties) and speaks about changes in his social life (C:R: client speaks about Novelty or Change).

C. – [Silence] Honestly, it's this difficulty I have of making decisions… I went back home… but… ah… ah… hmmm… it's difficult …

T. – Does this has to do with what you said in the last session: "watch out… you have already tried once and you didn't make it!"?

C. – Yes.

T. – Hum-hum…

C. – Yes.

T. – Does your coming back home, gave power to that argumentation.

C. – Yes, a lot.

T. – how are you at home now? I mean… did you went back to your routine...?

C. – I went back to my routine… but there has been a change.

T. – Hum-hum…

C. – For example, before I was incapable of going out with my friends… now I go out… at least once a week. I go out with the guys, go for a drink…

T. – That is something new, right N.?

C. – It is. Right now it's something new, that I didn't do before. And now I opted…

T. – …to do it.

C. – Yes, to do it.

T. – Hum-hum… Very well N.

C. – In those nights out I meet other people and… it becomes interesting.

Finally, the following example was taken from the third session of a Cognitive-Behavioral Therapy for Anxiety (case d). The client starts the session expressing difficulties (C:VEN: Difficulties axis, Intrapersonal difficulties); the therapist responds; the client doesn't agree with her (C:R: client Does not Accept the T:R) and continues expressing his difficulties (C:R: client Continues the expression of Intrapersonal difficulties). Then, the client expresses a request to the therapist (C:R: client Begins the expression of Requirements directed related to the psychotherapy), and the client ends this type of need (C:R: client Ends the expression of Requirements directed related to the psychotherapy) on the sequence of the therapist's approval response.

C. – The report shows that I do nothing… I don't think about anything… I have a sad life. But this was also a week of holidays!

T. – So you're supposed not to think or do anything.

C. – No! That not what you're supposed to do. The truth is I do very few things. I did very few things this week.

T. – Hum-hum…

C. – But the one who has to analyze that is you, doctor.

T. – Ok! Yes, of course. So, you were saying that has to d with the phase you're in.

C. – Yes, Yes.

e) Auditing of refined categories.

All refined categories of T:R and C:R were reviewed and all sessions were re-analyzed by the auditor. Meetings between the auditor and the author were made in order to discuss the reformulated data. The auditing process reiterated the reformulated set of categories.

2.4.2.2. Stage 6 – Synthesizing a conceptual-empirical model of Therapeutic Responsiveness.

Based on the conceptual and empirical analyses, a synthesized model diagram was developed. This synthesis was called the prototype conceptual-empirical model. Based on the proposed synthesized model, an observational system was developed so that the components of the model could be reliably measured. The conceptual-empirical model and the observational system of TR are presented in the results section.

2.4.2.3. Stage 7 – Analyzing theoretically the model of Therapeutic Responsiveness.

The discovery-phase of TA allowed a detailed description of TR based on a conceptual analysis combined with systematic empirical observations. After combining the conceptual model of TR and what was actually observed in stage 6, the prototype conceptual-empirical model was submitted to a theoretical analysis.

The analysis allowed moving from a micro-analytic level of the conversational interactions to a more abstract level elaborating about relational processes. The central question guiding TA stage 7 was: *How the refined categories of the three components of TR – C:VEN, T:R, and C:R – can be fit into more inclusive categories related to relational processes?* The result was a working model of TR, which is more manageable to be used in clinical practice and training. The working model is presented in the section that follows.

3. RESULTS

The discovery-phase of TA on TR produced three empirically grounded findings: a prototype conceptual-empirical model, a working model, and an observational system.

3.1. Models of Therapeutic Responsiveness

3.1.1. Prototype conceptual-empirical model.

The prototype conceptual-empirical model construed TR as an interactive and recursive process involving the therapist's capacity and willingness to tailor

interventions in response to the client's needs. The reciprocity between the client and the therapist depends on the way both develop conversational actions that are systematically and reciprocally responsive.

Similar to the conceptual model, the prototype conceptual-empirical model of TR is comprised of three components. The diagram in figure III – 3 shows the key findings regarding the three TR components that have mutual influence and occur recurrently in therapeutic conversations: C:VEN, T:R, and C:R.

At the start point of this model the client expresses verbally some type of need. The C:VEN is a clear marker signaling opportunities for TR. From then on, the path toward TR is nonlinear because there are many ways through which the therapist can respond to the C:VEN. Just as a specific type of C:VEN can be followed by different T:Rs in different conversational sequences, different types of C:VEN can be followed by the same type of T:R. There is also many ways through which the client can react to a specific T:R. Thus, each type of C:VEN is linked to one or more T:Rs, and may be followed by one or more C:Rs. These subsequent C:Rs are powerful sources of information about the appropriateness of the T:Rs, which can be taken into account by the therapist in the next responses to the client. In this sense, the model emphasizes TR as a moment-by-moment recursive process involving a mutual interaction between C:VEN, T:Rs, and C:Rs.

A description of the essential components of the prototype conceptual-empirical model is provided below.

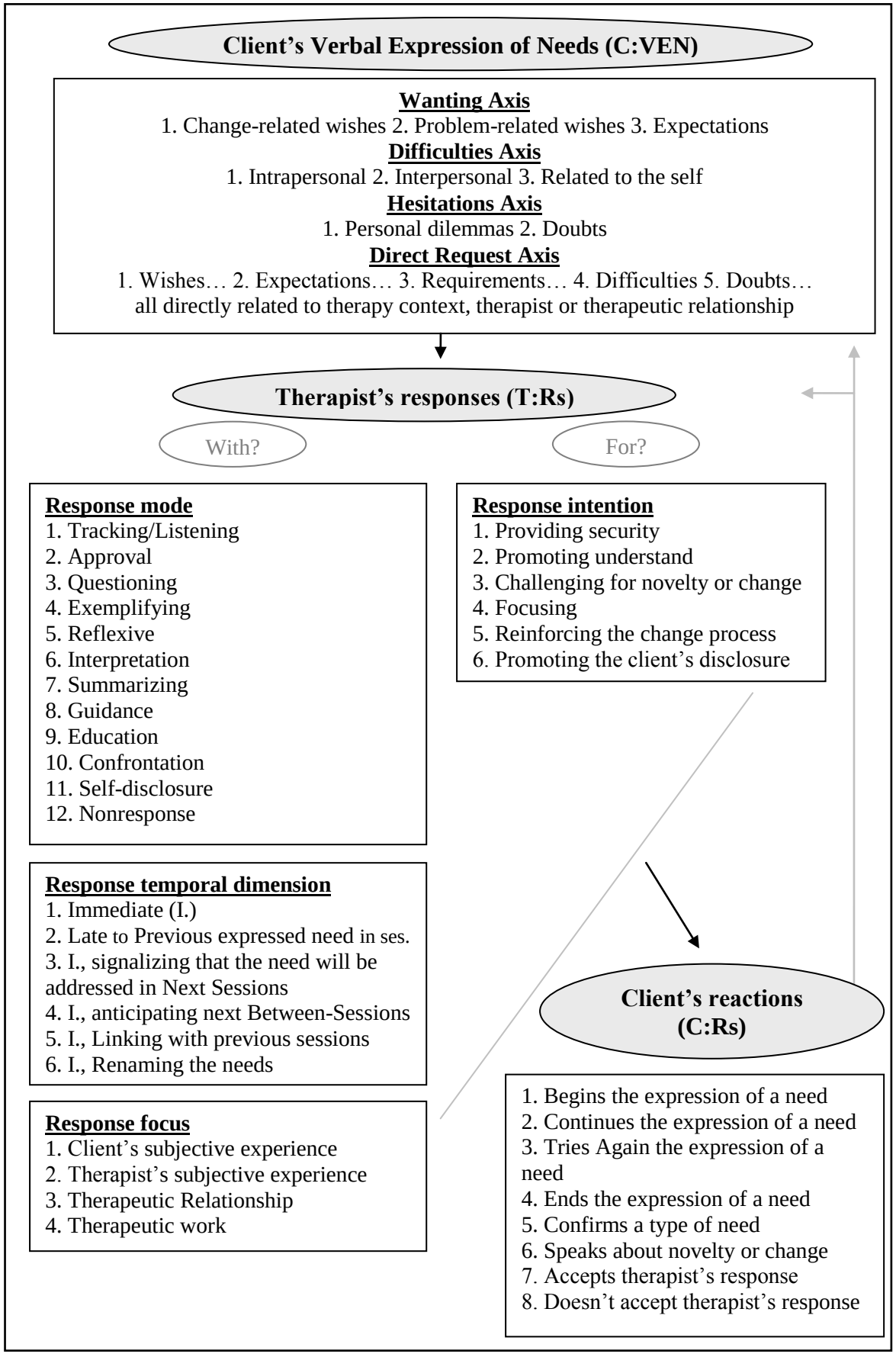

Figure III – 3. The conceptual-empirical model of Therapeutic Responsiveness.

3.1.1.1. The first component: Client's verbal expression of needs.

As the client engages in the therapeutic process, he or she expresses different needs. The prototype conceptual-empirical model provides distinct categories of C:VEN which were not recognized in the conceptual model. Each type into the four axes of C:VEN – Wanting axis, Difficulties axis, Hesitations axis, and Direct Requests axis – was defined in the above section of this chapter.

The distinctive types of C:VEN can occur along with other types on the emerging speech of the client. Nevertheless, each one of the C:VEN types is sustained on specific client's lexical expressions and its thematic context.

3.1.1.2. The second component: Therapist's responses.

The therapist provides moment-by-moment responses more or less adapted to the C:VEN, depending on his or her ability to flexibly adjust the responses to these needs. TR will be optimal when the therapist pays attention to the C:VENs emerging in the therapeutic sessions and respond to them in a way that is therapeutically relevant and useful. The therapist must be flexible in a way that he or she can modify his or her participation in the therapeutic process and intentionally adjust the interventions in responses to the C:VEN.

The prototype conceptual-empirical model of TR classified the T:Rs in four dimensions: response Mode, response Temporal dimension, response Focus, and response Intention. These response dimensions are similar to the ones included on the conceptual model although the categories within each one of the dimensions were reformulated and expanded through the empirical analysis. Each T:R category was defined in the above section of this chapter.

Each category within one response dimension can combine in several ways with categories of the other response dimensions. For example, in one moment, the therapist can respond Late in the session to a need expressed by the client in the beginning, by Questioning, focusing on the Therapeutic relationship, and with the intention of Challenge the client for change or the therapist, also by Questioning, can provide an immediate response to a specific type of C:VEN, Linking with past sessions, focusing on the Client's subjective experience, and with the intention of Promote understanding.

3.1.1.3. The third component: Client's Reactions.

The client reacts to the T:Rs in different ways. The prototype conceptual-empirical model provides distinct categories of C:R not recognized in the conceptual model. Five are directly related to the client's needs: client Begins the expression of a new type of need, client Continues the expression of the same type of need, client Tries Again the expression of a specific type of need, client Ends the expression of a specific type of need client, and Confirms a specific type of need. Three additional categories are: client speaks about Novelty or Change, client Accepts the T:R, and client Does not Accept the T:R. Each C:R category was defined in the above section of this chapter.

In sum, the prototype conceptual-empirical model involves three components which are mutually interactive: C:VEN, T:R, and C:R. Multiple combinations between the C:VEN, T:Rs and C:Rs are possible. These client-therapist conversational combinations result from the therapist's capacity to consider the emerging manifest needs of the client and to flexibly adequate his or her responses according to those needs, as well as to monitor the client's flowing reactions in the therapeutic sessions and to continue, review or change intentionally his or her response to the client. This competence can be labeled as *Reciprocal Responsiveness*.

TR is illustrated in Table III – 13 presenting three excerpts that were taken from the third session of a Narrative Therapy for Depression (case e). The client complaints had to do with marital problems, guilt feelings resulting from an extramarital relationship he had, and doubts in relation with continuing with marriage or to divorce. The client had leave home once in the past while in an extramarital relationship. He abandoned this new woman and returned home after his wife begged for him to do it and to think in her and their son. The third session begins with the therapist summarizing what happened in the previous session: externalization of client's guilt. The therapeutic dyad concludes that the guilt's voice imposes limitations in the client's life.

In the first excerpt, the therapist seems to aim to promote a better understand or to clarify the client's guilt and its implications. Even though the client expresses difficulties in responding to the therapist's request of characterize the guilt, he started doing it after an isolated response of the therapist (T:R: Guidance mode, Immediate, focus on Client subjective experience, intention of Promote the client's disclosure). Thus, the client expresses that guilt is a strong and persistent problem, demands the will of not hurt the others, and implies doubts regarding its implications (C:VEN: Difficulties axis, Intrapersonal difficulties; Wanting axis: Problem-related wishes; Hesitations axis, Doubts). The therapist responds aiming mainly at promote understand about the three types of client's needs (T:R: Questioning, Summarizing, and Reflexive modes, Immediate, focus on Client subjective experience, intention of Promote understand).

The second excerpt presents the client asserting his difficulty in making decisions regarding is marriage (C:VEN: Difficulties, Intrapersonal difficulties). The therapist responds aiming to clarify or promote understand about the client's problem

(T:R: Questioning and Reflexive modes, immediate response Linking with previous sessions and Immediate, focus on Client's subjective experience, intention of Promote understand). The client confirms his difficulties in making decisions (C:R: client Confirms the need of Intrapersonal difficulties) and speaks about changes in his social life (C'R: client speaks about Novelty or Change).

Different types of C:VEN were identified along the session. At the end of the session – the third excerpt – the therapist seems to challenging the client talking about the therapeutic work for the between-sessions period and for the next sessions (T:R: immediate response signalizing that the need will be addressed in the Next Sessions, and Immediate response anticipating the next Between-Sessions period). The client accepts the T'R (C:R: client Accepts the T:R).

3.1.2. Working model.

The theoretical analysis of the prototype conceptual-empirical model resulted in a working model. The working model of TR underlies relational processes that are inclusive of the moment-by-moment conversational interactions of the therapeutic dyad.

The three recursive components of the prototype conceptual-empirical model are also the three components of the working model: C:VEN, T:R, and C:R. According to the working model, the client expresses (1) needs not directly related to and (2) needs directly related to the psychotherapy context, the therapist or the therapeutic relationship. The first kind of C:VEN includes the Wanting, Difficulties, and Hesitations axes of the prototype conceptual-empirical model, and the second is related to the Direct Request Axis.

Table III – 13. Example of coding with the Therapist Responsiveness Observational System.

NARRATIVE THERAPY / DEPRESSION Case e – 3th session	Cl's Verbal Exp of Needs (C:VEN)	Therapist's Response (T:R)				Client Reaction (C:R)
		T:R Mode	T:R Type	T:R Focus	T:R Intention	
(…)	(…)	(…)	(…)	(…)	(…)	(…)
FIRST EXTRACT T. – Throughout time… It made you feel, on one side, a feeling of fulfilled duty, right? "Well, I am here" ah… "I am still here and I am sparing the people I like from suffering, but I can't stop thinking on the other side" ah… It takes pleasure away from the things I keep doing, little daily life things, right? Does that make sense to you?						
C. – It does, it does.						Confirms B1 Intrapersonal Difficulties (guilt is strong)
T. – Hum-hum. Ah… I would like ah… If N. has nothing to add ah… To this or comment, ah… Of exploring some areas that I consider… Well. That it is necessary clarify or, at least, that left me ah… More curious. Ah… And one of them has to do with… With this guilt strategies, right? We have centered a lot on the guilt arguments, on what … On what she says, ah… And… N. can you, when listening to some of this things I have told you, ah… Understand what strategies are behind this argumentation? That is, if you had to characterize this guilt argumentation, ah… What adjectives would you use?						
C. – Well… To characterize the… the guilt argument… well… It isn't easy…	D Axis, D4. Difficulties related to therapy (difficulty in characterize	Guidance	Immediate	Client exp	Promoting client's disclosure	
T. – Put… Put yourself on the role ah… Ah… Imagine, of a lawyer, right? Ah… And the… And enjoy the opposite side argument…						
C. – Hum-hum…						Ends D4

T. –. How do you think? Is it an argument ah…? What are the stronger aspects of the guilt argument?	the guilt)	Questioning	Immediate	Client exp	Promoting understand	
C. – Well, on the whole, all of it is very strong.	B Axis, B1.					Begins B1
T. – Hum-hum.	Intrapersonal					
C. – Very strong guilt… It uses a very strong argument… It leans on feelings. On the feelings, essentially, ah… And… ah...	Difficulties (strong guilt)					
on the will of not hurting anyone, not hurting anyone… ah… so are good… If they aren't good they have to stay, right? So… I have to stay, right? [Laughter]	A Axis, A2.					Begins A2
	Problem-related					
T. – Ok. But ah… On this argument… It builds upon the N's will of not hurting anyone, ah… And, in a way, according to what you have just said, ah… It limits your options to two… that at the end is one, right?	Wishes (will of not hurt others, imposed by the guilt)	Summarizing	Immediate	Client exp	Promoting understand	
C. – [Laughter]						
T. – That is "accept" or "accept".						
C. – [Affirmative nodding with the head]						
T. – Either you accept and things don't even get better, but you accept; or you accept and things even start to get better. Therefore, it isn't multiple choices.		Reflexive	Immediate	Client exp	Promoting understand	
C. – No, there is not many…						
T. – It isn't a multiple choice answer.						
C. – No, there is not… There are not many options…						Confirms A2
T. – It is an answer… It is a short and straight answer. [Laughter]						
C. – It is a little, it is… It is like that…						
T. – Hum-hum. Therefore, and, going back to that metaphor of… Of the lawyer, ah… These are the foundations of the guilt argument. And what are ah…? The bootstraps of the argument? Every good argument has…		Questioning	Immediate	Client exp	Promoting understand	
C. – Yes. Here the bootstrap is capable of… Of exploring a lot the… Let us say, eh… the others.	C Axis, C2.					Begins C2
T. – Hum-hum...	Doubts					
C. – How… What the reaction… What will be the others''	(doubts about the guilt's					

reaction…?	implications)					
T. – Hum-hum…						
C. – …to my attitudes and my decisions?		Tracking/ Listening	0	0	0	
T. – Hum-hum… Centered on the other people reactions.						
C. – Yes. Yes, it will be a lot… A lot regarding the…(…) …reaction that the other people will have…						Continues C2
T. – Hum-hum.						
C. – How they will…? Continue living this way and that… On the future… On the future – a near future – eh… What will be the consequences? I do not know.						
T. – Hum-hum… Therefore, I imagine… The guilt is giving you doubts… appealing to the possible negative consequences that your behavior can… Can have on others, ah… And this speech…? Ah… Does it seem to you that the guilt is…? Is it sincere? Is it balanced?		Summarizing	Immediate	Client exp	Promoting understand	
		Questioning	Immediate	Client exp	Promoting understand	
C. – I have the feeling that it isn't balanced. There is not balance. The guilt is obsessive.	B Axis, B1. Intrapersonal Difficulties (strong guilt)					Tries again B1
T. – Obsessive in what sense?		Questioning	Immediate	Client exp	Promoting understand	
C. – Obsessive because it is centered on only one possibility… on "It is like this and it have to be like this and not other way"!						Continues B1
---------- (…) ----------	----------	----------	----------	----------	----------	----------
SECOND EXTRACT						
C. – [Silence] Honestly, it's this difficulty I have of making decisions… I went back home… but… ah… ah… hmmm… it's difficult …	B Axis, B1. Intrapersonal Difficulties (difficulty in decisions)					Begins B1
T. – Does this has to do with what you said in the last session: "watch out… you have already tried once and you didn't make it!"?		Questioning	Linking w previous sessions	Client exp	Promoting understand	Confirms B1
C. – Yes. Yes.						
T. – Does your coming back home, gave power to that argumentation.		Reflexive	Immediate	Client exp	Promoting understand	

C. – Yes, a lot.						Confirms B1
T. – how are you at home now? I mean… did you went back to your routine...?		Questioning	Immediate	Client exp	Promoting understand	
C. – I went back to my routine… but there has been a change.						Speaks about change
T. – Hum-hum…						
C. – For example, before I was incapable of going out with my friends… now I go out… at least once a week. I go out with the guys, go for a drink…						
T. – That is something new, right N.?		Questioning	Immediate	Client exp	Reinforcing change process	
C. – It is. Right now it's something new, that I didn't do before. And now I opted…						Speaks about change
---------- (…) ----------	----------	----------	----------	----------	----------	----------
THIRD EXTRACT						
T. – I have a proposal to make you. I would like that you would be aware of the moments the guilt comes over the next week to, to the content of the guilt's voice in those moments, to the arguments or stratagems she uses.		Guidance	Antecip. Between-Sessions p	Therapeutic work	Challenging for change	
C. – Ok.						Accepts the T:R
T. – And I would like you to take some time to write a contract with the guilt. A bit like what we have done here. Imagine that in "article 1" you write "the guilt forces N. to…", that is, what behaviors does the guilt force you to have?		Guidance	Antecip. Between-Sessions p	Therapeutic work	Promoting understand	
C. – [Affirmative nod]						Accepts the T:R
T. – The idea is that it would be an unfinished document, an open contract. And then in the next session we can analyze the content of those records. Is that ok?		Guidance	Signalizing Next Sessions	Therapeutic work	Challenging for change	
C. – Yes.						
T. – With this contract we will be working, and as something new is discovered, we can add to it. We can work on this progressively.						Accepts the T:R
C. – Ok.						

Then, two scenarios are possible: (1) the therapist does not provide a response or (2) the therapist provides a response to the C:VEN. When the therapist provides a response, he or she can respond to the C:VEN by: (2.1) Supporting, that is, nurturing and fostering a safety feeling, (2.2) Acknowledging, that is, accepting or recognizing what the client is saying, and replying to the client, (2.3) Negotiating, that is, trying to get an agreement with the client, (2.4) Making connections, that is, associating or integrating experiences, especially different client's needs, (2.5) Redirecting, that is, going forward or emphasizing a different direction, or (2.6) Refusing, that is, capturing the client's request but clearly declining it.

The subsequent C:Rs are predominantly three types: (1) the client engages, (2) the client does not engage, or (3) the client is ambivalent or neutral with the T:R. The client's engagement is defined as the client accepting and viewing the T:R as valuable and meaningful. Thus, the client is engaged with the T:R when there is a clear indication of a sense of being involved in the conversational interchange, coordinating with the T:R. The diagram in figure III – 4 outlines the key findings regarding the three TR components of the working model.

Table III – 14 presents the same three excerpts referred above for illustrating the prototype model, now with the codes of the working model.

3.2. Therapeutic Responsiveness Observational System (TROS)

Based on the empirical-conceptual prototype model, a system for observing and coding TR was constructed. The *Therapeutic Responsiveness Observational System* (TROS) allows observing the conversational actions of the dyad and coding them using the observed relations between the C:VEN, T:Rs, and C:Rs. Inter-coder reliability was established for TROS (details are presented in chapter IV).

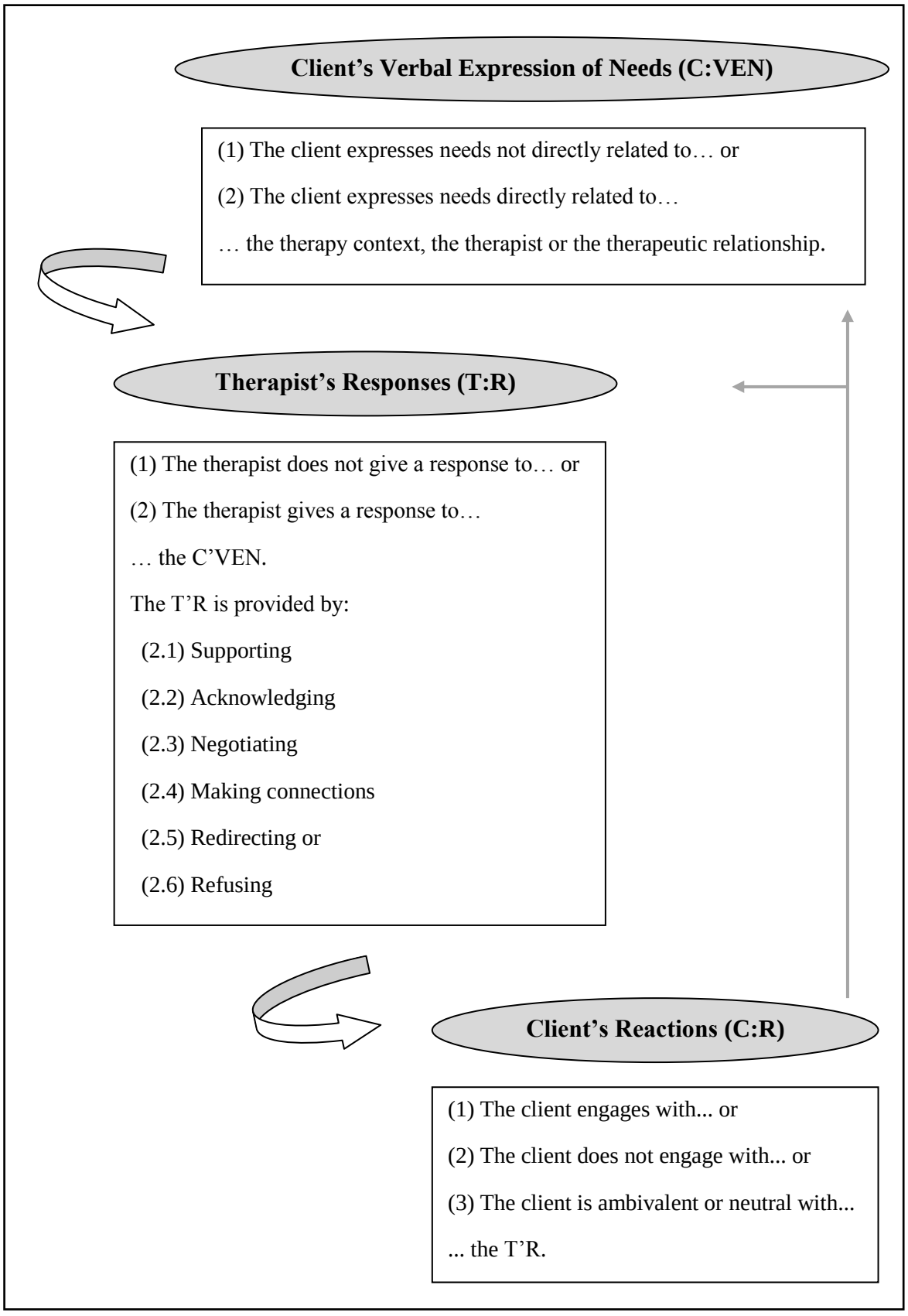

Figure III – 4. The working model of Therapeutic Responsiveness.

Table III – 14. Example of coding with the Therapist Responsiveness Working Model.

NARRATIVE THERAPY / DEPRESSION Case e – 3th session	Cl's Verbal Exp of Needs (C:VEN)	Therapist's Response (T:R)	Client Reaction (C:R)
(…)	(…)	(…)	(…)
FIRST EXTRACT T. – Throughout time… It made you feel, on one side, a feeling of fulfilled duty, right? "Well, I am here" ah… "I am still here and I am sparing the people I like from suffering, but I can't stop thinking on the other side" ah… It takes pleasure away from the things I keep doing, little daily life things, right? Does that make sense to you? C. – It does, it does. T. – Hum-hum. Ah… I would like ah… If N. has nothing to add ah… To this or comment, ah… Of exploring some areas that I consider… Well. That it is necessary clarify or, at least, that left me ah… More curious. Ah… And one of them has to do with… With this guilt strategies, right? We have centered a lot on the guilt arguments, on what … On what she says, ah… And… N. can you, when listening to some of this things I have told you, ah… Understand what strategies are behind this argumentation? That is, if you had to characterize this guilt argumentation, ah… What adjectives would you use? C. – Well… To characterize the… the guilt argument… well… It isn't easy… T. – Put… Put yourself on the role ah… Ah… Imagine, of a lawyer, right? Ah… And the… And enjoy the opposite side argument… C. – Hum-hum…	Needs directly related to therapy	Supporting	

T. –. How do you think? Is it an argument ah…? What are the stronger aspects of the guilt argument? C. – Well, on the whole, all of it is very strong.			Client engages with T:R
T. – Hum-hum. C. – Very strong guilt… It uses a very strong argument… It leans on feelings. On the feelings, essentially, ah… And… ah... on the will of not hurting anyone, not hurting anyone… ah… so are good… If they aren't good they have to stay, right? So… I have to stay, right? [Laughter]	Needs not directly related to therapy		
T. – Ok. But ah… On this argument… It builds upon the N's will of not hurting anyone, ah… And, in a way, according to what you have just said, ah… It limits your options to two… that at the end is one, right? C. – [Laughter] T. – That is "accept" or "accept". C. – [Affirmative nodding with the head]		Acknowledging	
T. – Either you accept and things don't even get better, but you accept; or you accept and things even start to get better. Therefore, it isn't multiple choices. C. – No, there is not many… T. – It isn't a multiple choice answer. C. – No, there is not… There are not many options… T. – It is an answer… It is a short and straight answer. [Laughter] C. – It is a little, it is… It is like that… T. – Hum-hum. Therefore, and, going back to that metaphor of… Of the lawyer, ah… These are the foundations of the guilt argument. And what are ah…? The bootstraps of the argument? Every good argument has… C. – Yes. Here the bootstrap is capable of… Of exploring a lot the… Let us say, eh… the others. T. – Hum-hum... C. – How… What the reaction… What will be the others''			Client engages with T:R

reaction…? T. – Hum-hum… C. – …to my attitudes and my decisions? T. – Hum-hum… Centered on the other people reactions. C. – Yes. Yes, it will be a lot… A lot regarding the…(…) …reaction that the other people will have… T. – Hum-hum. C. – How they will…? Continue living this way and that… On the future… On the future – a near future – eh… What will be the consequences? I do not know. T. – Hum-hum… Therefore, I imagine… The guilt is giving you doubts… appealing to the possible negative consequences that your behavior can… Can have on others, ah… And this speech…? Ah… Does it seem to you that the guilt is…? Is it sincere? Is it balanced? C. – I have the feeling that it isn't balanced. There is not balance. The guilt is obsessive. T. – Obsessive in what sense? C. – Obsessive because it is centered on only one possibility… on "It is like this and it have to be like this and not other way"!			
---------- (…) ----------	----------	----------	----------
SECOND EXTRACT C. – [Silence] Honestly, it's this difficulty I have of making decisions… I went back home… but… ah… ah… hmmm… it's difficult … T. – Does this has to do with what you said in the last session: "watch out… you have already tried once and you didn't make it!"? C. – Yes. Yes. T. – Does your coming back home, gave power to that argumentation.	Needs not directly related to therapy	Making connections	Client engages with T:R

C. – Yes, a lot.
T. – how are you at home now? I mean… did you went back to your routine...?
C. – I went back to my routine… but there has been a change.
T. – Hum-hum…
C. – For example, before I was incapable of going out with my friends… now I go out… at least once a week. I go out with the guys, go for a drink…
T. – That is something new, right N.?
C. – It is. Right now it's something new, that I didn't do before. And now I opted…

---------- (…) ---------- ---------- ---------- ----------

THIRD EXTRACT
T. – I have a proposal to make you. I would like that you would be aware of the moments the guilt comes over the next week to, to the content of the guilt's voice in those moments, to the arguments or stratagems she uses.

Negotiating

C. – Ok.

Client engages with T:R

T. – And I would like you to take some time to write a contract with the guilt. A bit like what we have done here. Imagine that in "article 1" you write "the guilt forces N. to…", that is, what behaviors does the guilt force you to have?
C. – [Affirmative nod]
T. – The idea is that it would be an unfinished document, an open contract. And then in the next session we can analyze the content of those records. Is that ok?
C. – Yes.
T. – With this contract we will be working, and as something new is discovered, we can add to it. We can work on this progressively.
C. – Ok.

TROS can be used as a coding system of transcripts of psychotherapy sessions, but the system highlights the importance of observing the dyadic interactions. Observation provides richer information about the interactive context of the conversations. Verbal signals captured through observation assist the coding procedure. In this sense, verbal signals can be used in order to clarify the dyad conversations. Some examples of verbal signals are: lengthy silence, whispers, deep breaths, laughing, tone of voice, quavering voice, incomplete sentences and interjections (e.g., ahaa… hum… uff…).

Two methods can be used in order to code psychotherapy sessions with the TROS: (1) putting the videotaped sessions in the software "Windows Media Player" and registering the TROS codes in the program as titles and subtitles, or (2) observing the videotaped records and registering the TROS codes into tables together with the transcripts of the sessions[7].

The TROS comprises the same dimensions and categories within the same three components of the prototype model: (1) C:VEN, (2) T:R, and (3) C:R. Ten dimensions are listed and defined separately under each of the three components in Table III – 15. These components and dimensions are common across psychotherapy modalities. Each TROS dimension comprises different categories (Table III – 16). Because each category within each of the three components was defined and illustrated above in the chapter, this section presents pertinent guidelines for observing sessions and coding the therapeutic conversations based on TROS.

[7] Grid for coding psychotherapy sessions with the Therapeutic Responsiveness Observational System can be found in Appendix II.

Table III – 15. Therapeutic Responsiveness Observational System components and dimensions.

Component	Dimension	Definition
Client's Verbal Expression of Needs (C:VEN)	Wanting Axis	The client expresses his or her wishes, ambitions, aspirations, motivations, interests, intents, projections, or expectations
	Difficulties Axis	The client expresses intra, inter or self-related difficulties, obstacles, impediments, objections, criticism, or problems
	Hesitations Axis	The client expresses doubts, indecisions, uncertainties, or personal dilemmas
	Direct Requests Axis	The client expresses wishes, expectations, requirements, difficulties, or doubts, all directly related to the psychotherapy, the therapist or the therapeutic relationship
Therapist's Responses (T:Rs)	Response Mode	Method through which the therapist puts techniques into practice through a specific verbal structure regardless the content of the speech
	Response Temporal Dim.	The specific time in the session in which the therapist respond or the time (occurrence) that therapist refers in his or her response
	Response Focus	Target of the therapist's response
	Response Intention	The purpose underlying the therapist's response
Client's Reactions (C:Rs)	Directly related to client's needs	The client reacts to the therapist's response in a way that is directly related to his or her expressed needs (e.g., client continues expressing the same need he or she was expressing before the therapist's response)
	Not Directly related to client's needs	The client reacts to the therapist's response in a way that is not directly related to his or her expressed needs (e.g., client starts speaking about change)

3.2.1. The first component: Client's verbal expression of needs.

Coding the C:VEN take into consideration the client's lexical expressions and their thematic context on the ongoing conversation. All types (categories) of C:VEN are mutually exclusive.

Table III – 16. Therapeutic Responsiveness Observational System categories.

Component	Dimension	Category
Client's Verbal Expression of Needs (C:VEN)	Wanting Axis	Change-related Wishes Problem-related Wishes Expectations
	Difficulties Axis	Intrapersonal Interpersonal Self-related
	Hesitations Axis	Doubts Personal Dilemmas
	Direct Requests Axis	Wishes… } … Expectations… } directly related to Requirements… } therapy, therapist Difficulties… } or ther. relationship Doubts…
Therapist's Responses (T:Rs)	Response Mode	Tracking /Listening Approval Questioning Exemplifying Reflexive Interpretation Summarizing Guidance Education Confrontation Self-disclosure Nonresponse
	Response Temporal Dim.	Immediate (I.) Late to a Previous expressed need in session I., signalizing that the need will be addressed in Next Sessions I., anticipating next Between-Sessions period I., Linking with previous sessions I., Renaming the needs
	Response Focus	Client's Subjective Experience Therapist's Subjective Experience Therapeutic Relationship Therapeutic Work
	Response Intention	Providing security Promoting understand Challenging for novelty or change Reinforcing the change process Promoting the client's disclosure Focusing
Client's Reactions (C:Rs)	Directly related to Client's needs	Begins… Continues… …the expression Tries again… of a specific need Ends…
	Not Directly related to client's needs	Confirms a specific type of need Speaks about change or novelty Accepts the T:R Does not accept the T:R

When a client's utterance seems to offer context to more than one category, different parts sustain each of the categories (e.g., "I am sad, depressed – Intrapersonal difficulties – I do not know what to decide regarding my job – Doubts – I want to do become a motivated employee – Wishes").

The C:VEN should be related to the client's own experience. Sometimes the client speaks in the first person of plural but clearly includes him or herself in the group (e.g. "Persons like me are… We are…"). On the contrary, sentences describing needs exclusively of others are not coded.

The client's needs are current (e.g., "I want…"; "I am…"; "I have…"; "I do not know…"; "I feel…"). Past sentences without lexical expressions sustaining the presence of current experience are not coded (e.g., "That time, I wanted…", "If it was today, I would…", "I felt…", "It was…") unless they are articulated with lexical expressions pointing out ongoing experience. Even when the client uses direct speech but the subject is past experiences (e.g., "On that day I thought: I am incapable of…"), sentences are not coded unless there is additional indication of continuing needs. Sentences highlighting past needs, but still current, are coded even if they are less intensive (e.g., "On that time I already wanted…"; "I was… and I still am"; "My life was always difficult"). Needs referred for the prior between-sessions period are viewed as they were current.

To be taken as need, the client's current experience must be negative, uncomfortable or unsatisfactory. A sentence by which the client is expressing a specific need whose fulfillment is irrelevant is not coded (e.g., "I do not know if… or… but that is not important for me"; "I want good weather for tomorrow. If not, no problem either"). The C:VEN of any type can be presented using positive or negative sentences (e.g., "I want to…" or "I do not want to"; "I am unsatisfied" or "I am not satisfied").

Within the Wanting axis, the C:VEN regarding Wishes are not always explicit. The client can express wishes in a more explicit manner (e.g., “I want…”; “I would like to…”; “I need to do…”) or in a more implicit manner (e.g., “I am lacking of a friend” underlying the wish of having a friend or “Why she doesn’t trust in me? Why?” underlying the client’s wish of being trusted).

Expectations can be coded when the client expresses hypotheses departing from the present to the future (e.g., “If that occur in next months, I will become…”; “If that happens, I will feel…”) but not departing from the present to the past (e.g., “If it was today instead of one year ago, I would…”). Both change-related and problem-related expectations are coded within the Expectations type.

The client expresses Interpersonal difficulties using the first person of singular (e.g., “I do not like her”), the first person of plural (e.g., “We are always in conflict”) or the third person (e.g., “She does not understand me”; “They want me to be a person that I am not”). In the presence of the Difficulties axis, the coder must analyze if the client’s difficulties are just current or permanent over time in order to decide if they are self-related.

When the client expresses difficulties directly related to hesitations, the Hesitations axis is coded and not the Difficulties axis. Sometimes the C:VEN regarding hesitations begins with lexical expressions suggesting Wanting axis (e.g., “I want…”), however the thematic context suggests the client is oscillating (e.g., “On one hand, I want… but, on the other hand, I do not want… I am confused”). In this case, Hesitations are coded. Hesitating between two opposite sides is coded as Hesitations axis if the two sides are related to the same dimension of the client’s subjective experience (e.g., “I think [one side] but I also think [opposite side]”; “I want to do [one

side] but I also want to do [opposite side]"). A slight hesitation is not coded (e.g., "I do not know. Hamm… It is weird").

Some expressions in the Direct Request axis are similar to the expressions within other C:VEN axes (e.g., Wishes or Doubts). The criteria for coding them are similar; the only difference is the thematic context – intra or extra-therapy context – of the client's lexical expressions (e.g., if the client says "I need to talk with you", Direct Request is coded but if the client says "I need a friend to talk with", Wanting axis is coded). When the client speaks about wishes, expectations, requirements, difficulties or doubts throughout or in relation to therapeutic homework assignments, Direct request axis is coded. Sometimes the client expresses Direct Request axis articulated with needs of a different axis (e.g., "I want to speak with you. I have difficulties in… You are my only hope!"). Delimited speech – lexical expressions and thematic context – for each C:VEN code is requested (e.g., "I want to speak with you… You are my only hope!": Direct request axis; "I… have difficulties in…": Difficulties axis). Finally, both positive and negative expectations related to the psychotherapy, the therapist or the therapeutic relationship, are coded within the DR Expectations type.

3.2.2. The second component: Therapist's responses.

The T:Rs following the C:VEN are coded in four dimensions. All categories in each dimension of T:R are mutually exclusive. Nevertheless, for all dimensions, two or more T:R categories can occur proximally when context is provided by a therapist's utterance.

When the coder is divided between two categories, the most prominent category should be coded. For example, when the therapist provides a reflexive response, even if followed by a small question (e.g., Right?), the Reflexive category must be coded and not the Questioning category; when the therapist is trying to focus the client on a

specific C:VEN, but doing it he or she seems to aim also to promote the client's disclosure, the Focusing category must be coded if this is the most prominent intention of the therapist and not the category of Promoting client's disclosure. The category of Promoting the client's disclosure is the last intention to be judged after the conclusion of no other category within the Intention dimension is present.

The coding process is easier when it begins by identifying the response Mode, and then the other three dimensions: Temporal dimension, Focus, and Intention. The T:R is coded with regard to these four dimensions with the exception of two situations: when Nonresponse and Tracking/Listening categories are coded. When the therapist does not respond to a specific C:VEN, Nonresponse is coded only. If the therapist is tracking what the client is saying using merely interjections (e.g., "Hum, hum… Ok… Hum, hum… Yes"), or even repeating some client's words or completing the client's idea, Tracking/Listening is coded only. One isolated interjection is not sufficient to code Tracking/Listening; instead Nonresponse must be coded.

3.2.3. The third component: Client's reactions.

Coding the C:Rs implies take into consideration the C:VEN as well as the T:Rs. The C:Rs following the T:Rs can be characterized as reactions Directly related to client's needs or reactions Not Directly related to client's needs. All C:R categories are mutually exclusive.

For each T:R, a C:R must be judged. Sometimes it is possible to code one C:R following one T:R (e.g., the therapist responds to a specific type of C:VEN by questioning; the client answers the therapist's question by continuing the expression of the same type of need; the therapist responds then by tracking/listening; the client tries again to express other type of need). Other times, when a specific type of C:VEN is

followed by a T:R containing more than one type of response, the C:R is coded only after that set of T:Rs (e.g., the therapist provides responses to a specific type of C:VEN by summarizing the session's content and by questioning the client; at the end, the client continues expressing of the same type of need). It is possible also to code more than one type of C:R following a specific T:R if there is thematic context (e.g., the therapist responds to a specific type of C:VEN by confronting the client; the client does not accept the confrontation and begins expressing a different type of need).

When the therapist provides an immediate response Renaming the need, or a Late response to a Previous expressed need in the same session (both changing the topic under discussion), the C:R must be coded as client Accepts or client Does Not Accept the T:R. Then, the coder should take into consideration if there is thematic context for coding an additional category. For example if, at the end of the session, the therapist tries to respond to a need expressed in the beginning, and the client does not address again that specific need but talks, for the first time, about difficulties related to the psychotherapy, then there are thematic context to code the C:R with two categories: client Does not Accepts the T:R and client Begins the expression of a new type of need. Also, the C:R must be coded as client Accepts or client Does Not Accept the T:R when the therapist responds to the client by a Confrontation or Interpretation (changing the way the topic is being discussed). For example, if the therapist provides an Interpretation in relation to the client's problem and the client says "Yes. Exactly as you are saying", then the C:R is coded with two categories: client Accepts the T:R and client Confirms a specific type of need.

In judging the client's acceptance of a specific T:R that changes the topic under discussion or the way the topic is being discussed, different aspects must be taken into consideration. Sometimes a positive client's answer clearly indicates acceptance of the

T:R, and a negative answer clearly indicates not acceptance. For example, the client Does Not Accept the T:R when he or she clearly asserts his or her disagreement with the therapist's perspective provided by an Interpretation or Confrontation. Other times, the client not replying the T:R may not mean not acceptance. For example, if the client reacts to a therapist's question saying that "I do not know but that is a good question!", he or she Accepts the T:R although not responding to the question. More, if the client expresses one type of need, the therapist provides a response focusing a different type of need, and the client reacts talking about the one that was introduced by the therapist, then the category of client Accept the T:R is coded; the category of client Does Not Accept the T:R is coded if he or she persists in going on talking about the type of need he or she was talking before the T:R.

CHAPTER IV

RELIABILITY ANALYSIS OF THE THERAPEUTIC RESPONSIVENESS OBSERVATIONAL SYSTEM (TROS)

CHAPTER IV – RELIABILITY ANALYSIS OF THE THERAPEUTIC RESPONSIVENESS OBSERVATIONAL SYSTEM (TROS)

A system for observing the Therapeutic Responsiveness (TR) was developed in the discovery-oriented phase of Task Analysis (details are presented in chapter III). The *Therapeutic Responsiveness Observational System* (TROS) is a coding system of the conversational interactions between the client and the therapist focused on the interchanges between three components: Client's Verbal Expression of Needs (C:VEN), Therapist's Responses (T:Rs), and Client's Reactions (C:Rs). This chapter outlines the inter-coder reliability of each TROS component. The research goals, method and results are presented as follows.

1. RESEARCH GOALS

In this phase of the study, the main goal was to measure the inter-coder reliability of the TROS in order to support the feasibility of the tool.

2. METHOD

Reliability analyses were made to meet levels of acceptable intercoder reliability of the three TROS components. The participants, units of analysis, procedure, and data analysis are presented as follows.

2.1. Participants

Seven therapeutic dyads participated in the reliability analyses. Three dyads participated in the C:VEN reliability analysis: three therapists with one client each. Four dyads participated in the T:R and C:R reliability analyses: two therapists with two clients each.

2.1.1. Clients.

The clients were screened using the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Patient Edition (SCID-I/P; First, Spitzer, Gibbon, & Williams, 2002) and the clinical judgement of the therapist. They each had been given the diagnosis of major depressive disorder. All the clients agreed for the psychotherapy sessions to be videotaped and consented for videotaped sessions to be used as research data.

The clients were excluded if there was any indication of the following: (a) diagnosis of an Axis II Disorders (e.g., borderline or schizoid personality disorders), (b) any Axis I Disorders (e.g., schizophrenia or addiction disorders) with the exception of a depressive or anxiety disorder, (c) psychosis, (d) neurological impairment or severe intellectual deficits, and (e) high current risk for suicide.

Three clients participated in the C:VEN reliability analysis. Clients were all Portuguese, two female and one male, ranging in age from 22 to 47 years old (M=38). Two clients were married and one single. One client completed university education, one was a graduate student, and one had undergraduate education.

Four clients participated in the T:R and C:R reliability analyses. Clients were all Portuguese, two female and two male. Their ages ranged from 20 to 47 years old

(M=28). Three were single and one married. One completed university education, two were graduate students, and one was undergraduate student.

2.1.2. Therapists.

Three therapists participated in the C:VEN reliability analysis, all Portuguese, one female and two male clinical psychologists. Their ages ranged from 29 to 32 years old (M=31). The therapists were enrolled in a doctoral program and their clinical experience ranged from five to seven years.

Two therapists participated in the T:R and C:R reliability analyses. Both therapists were 32 years old Portuguese male clinical psychologists. The therapists were enrolled in a doctoral program and both had seven years of clinical experience.

2.1.3. Coders.

Two coding teams participated in the study by coding the C:VEN in dyadic conversational data. The first team was composed by the same five coders who had participated in the discovery-oriented phase of Task Analysis. They were all Portuguese female clinical psychologists concurrently enrolled in a doctoral program. Four coders ranged in age from 27 to 29 years old (M=28) and ranged in clinical experience from five to six years. The fifth coder was the author who had ten years of clinical experience (details are presented in chapter III). The second team was composed by four coders. Three were Portuguese Clinical Psychology master students, each with 22 years old, two female and one male. The author was the fourth coder of the second coding team.

The first coding team coded also the T:Rs and C:Rs in dyadic conversational data. The author coded the entire ten sessions and the four coders coded ¼ of the material each[8].

2.2. Units of analysis

Because in the discovery-oriented phase of TA psychotherapy episodes were used to examine the C:VEN and sessions were used to examine the T:Rs and the C:Rs, both units of analysis were chosen to establish the reliability of the three TROS components.

2.2.1. Psychotherapy episodes.

For the C:VEN reliability analysis, the sample consisted of twelve episodes taken from twelve single sessions; four from three different clients. The episodes were taken from three different psychotherapies: four from Cognitive-Behavioral Therapy, four from Personal Construct Therapy, and four from Narrative Therapy. Within each psychotherapy approach, one episode was taken from one initial phase session, other from one intermediate phase session, and other more from one final phase session. Additionally, three episodes without C:VEN were chosen to make contrast, one from each psychotherapy approach.

2.2.2. Psychotherapy sessions.

For the T:R and C:R reliability analyses, the sample consisted of ten single sessions. Five of these sessions were taken from Cognitive-Behavioral Therapy and five sessions were taken from Narrative Therapy. Within each psychotherapy approach, the

[8] The author is coder 1 and the others are coder 2 (each of the four coders coded ¼ of the material, thus, all worked as one for the analysis).

first, fourth and eight sessions of one client, and the fourth and eight sessions of other client were chosen.

2.3. Procedure

All sessions used in the reliability analyses were videotaped. The author transcribed verbatim the dyadic conversations. The identifying information of the client was omitted in the transcripts. The videos were put into the software "Windows Movie Maker" and the transcripts organized into tables. This procedure facilitated the coding process.

All coders first read about definitions of TROS categories and were instructed to base their codings on what was actually said by the therapeutic dyads. The first coding team participated in the discovery-oriented phase of Task Analysis by coding, discussing and reaching consensus on the final codings of the C:VEN, T:R and C:R. Coders of the second coding team were trained by using the episodes and sessions already coded in the discovery-oriented phase of Task Analysis. This training allowed the new team to proceed in a similar manner to the first team.

After the training, all coders were asked to independently code the C:VEN in twelve new episodes in teams of five and four, both including the author. All C:VEN codings were introduced in the SPSS Statistics program and reliability on coding C:VEN was calculated for the two teams.

Then, before coding the TR, consensus between two coders was reached in coding the C:VEN in ten new sessions, once they were reliable on coding C:VEN episodes. All codings reached through consensus were then analyzed by the author and afterwards by an auditor[9]. The ten sessions were then independently coded on the T:Rs

[9] The same auditor that participated in the discovery-oriented phase of Task Analysis (details are presented in chapter III).

and C:Rs by the author and a second coder. All T:R and C:R codings were introduced in the SPSS Statistics program and reliability on coding T:R and C:R was calculated.

2.4. Data analysis: Reliability analysis

Across the sample of twelve episodes, 65 segments were coded on C:VEN. After 649 units were coded on C:VEN by consensus across the sample of ten sessions, 2175 segments were coded on T:R and 2175 segments were coded on C:R.

2.4.1. Intraclass Correlation Coefficient.

Intercoder reliabilities for the TROS first component were measured using the Intraclass Correlation Coefficient designated ICC (Shrout & Fleiss, 1979). This way, the frequency of each C:VEN axis, that is, the number of segments coded with Wanting axis, Difficulties axis, Hesitations axis, and Direct Request axis, within each of the twelve episodes were calculated for all coders of the first and second coding teams. Then, the ICC was computed for each coding team using the two-way random effects model.

2.4.2. Cohen's Kappa Coefficient.

A kappa statistic was computed because the ICC allowed to calculate the agreement between coders regarding the number of segments they coded with the C:VEN axes but it did not assure that the codes were placed in the same segments.

Thus, the intercoder reliabilities for the TROS first component were measured using the Cohen's Kappa Coefficient (Cohen, 1960), combining the author's codings

with the codings of each coder of the first and second coding teams (seven pairs of coders). This was done for the C:VEN axes (four) and for the C:VEN types (twelve).

The intercoder reliabilities for the second and third components of TROS were measured using the Cohen's Kappa Coefficient for one pair of coders. A kappa statistic was computed for each of the four T:R dimensions: response modes (twelve), response temporal dimensions (six), response focuses (four), and response intentions (six). The same statistic was done for the set of C:Rs (eight).

3. RESULTS

3.1. Reliability of TROS first component: Client's verbal expression of needs

On the C:VEN axes, IICs[10] of .90 on the first coding team and .89 on the second coding team were obtained for the full sample of twelve episodes.

Kappa coefficients were calculated for six pairs of coders. Kappa statistics could not be computed for one pair of coders because a symmetric two-way table in which the codes of one coder match with the codes of the other was not possible. On the C:VEN axes, kappas raged from .70 to .76 on the first coding team and from .85 to .92 on the second coding team. On the C:VEN types, kappas raged from .75 to .81 on the first coding team and from .86 to .94 on the second coding team. Table IV – 1 outlines all kappa coefficients.

[10] Details on reliability statistics of the first component of Therapeutic Responsiveness Observational System (ICCs and kappas) can be found in Appendix III.

3.2. Reliability of TROS second component: The therapist's responses

Kappa coefficients[11] of TROS second component were calculated for the full sample of ten sessions using the codings of one pair of coders. Table IV – 2 outlines the kappa coefficients of the four T:R dimensions.

Table IV – 1. Cohen's kappa coefficients for the first component of the Therapeutic Responsiveness Observational System.

Coding Team	Coders	C:VEN Axes	C:VEN Types
1	1*2	.76	.81
	1*3	.75	.78
	1*4	.70	.75
2	1*6	.92	.94
	1*7	.89	.92
	1*8	.85	.86

Note. Coder 1 = author; C:VEN = Client's verbal Expression of Needs.

3.3. Reliability of the TROS third component: The client's reactions

Kappa coefficients[12] of TROS third component were calculated for the full sample of ten sessions using the codings of one pair of coders. Kappa of .96 of C:R was obtained (Table IV – 2).

[11] Details on reliability statistics of the second component of Therapeutic Responsiveness Observational System can be found in Appendix IV.
[12] Details on reliability statistics of the third component of Therapeutic Responsiveness Observational System can be found in Appendix IV.

Table IV – 2. Cohen's kappa coefficients for the second and third components of the Therapeutic Responsiveness Observational System.

	2nd and 3th components				
Coders	T:R				C:R
	Mode	Temporal	Focus	Intention	
1*2	.95	.96	.99	.92	.96

Note. T:R = Therapist's response; C:R = Client's Reaction.

In conclusion, this study showed a good reliability of the present version of the TROS. The kappa and interclass correlation values showed that reliability was established for the three components of TROS.

CONCLUSION

Great opportunities come to all,

but many do not know they have met them.

The only preparation to take advantage of them

is simple fidelity to watch what each day brings

(A. Dunning)

CONCLUSION

The dissertation presents a study of Therapeutic Responsiveness (TR) as a moment-by-moment process of alliance in psychotherapy. This section aims to discuss the main findings resulting from an inductive and bottom-up analysis of sessions, based on the observation of conversational interactions between the client and the therapist. Comments on the overall clinical implications are outlined. Finally, limitations of the study and contribution to future research are presented.

The overall goal of the study was to observe and examine TR in clinical sessions in a variety of psychotherapy approaches. First, Task Analysis was used to explore and better understand TR, and to develop a method of measuring TR as a moment-by-moment process. The procedure of the discovery-oriented phase of Task Analysis was used to empirically study how TR operates. Using this method, first a marker signalizing an opportunity for TR was identified and contextualized in dyadic conversations. Then, I conducted an empirical analysis in order to address the question of how TR develops as a bidirectional and reciprocal process.

These steps resulted in a prototype conceptual-empirical model, a working model, and a system for observing TR (TROS), each comprising of three recursive components: client's verbal expression of needs (C:VEN), therapist's response (T:R), and client's reaction (C:R). These final results corroborated the conceptual model confirming its three components and supported the empirical analysis which detailed each of the components. As a result of applying this method I was able to document the following aspects: the TR models I developed capture the reciprocity that I first believed to describe TR; it was discovered that observing and analyzing sessions using the TROS – system through which the prototype conceptual-empirical model of TR is

applied – can provide rich information about the ongoing reciprocal conversational interactions of the dyad as they unfold moment-by-moment in sessions; and the novelty data arising from the empirical analyses framed several categories into each TROS component.

In the second part of the study, reliability analyses were made to establish the trustworthiness of the TROS. The collected data indicated good levels of reliability of the three components of the observational system.

Finally, a theoretical analysis of the prototype model was made moving from a micro level of analysis – interactions – to a more abstract level – relational processes. Working with the full prototype model is very time consuming. Therefore I developed a more parsimonious version based on the same observed data as the full prototype. The result was a working model which was meant to be practical in clinical practice and training.

Based on the main findings, some of the conclusions about the three components of TR are as follows. The C:VEN emerged in the present study as a reliable marker indicating an opportunity for TR. The choice of using verbal expressions was made because what the client says in psychotherapy by using specific lexical expressions informs the therapist about the client's needs. I agree with Duncan (2010a) in highlighting clients as the *best teachers,* credible sources of their own experiences and needs. Listen the client, highlighting his or her epistemic value, provides an opportunity to critically examine the therapist's interventions, supporting what is working and challenging what is not.

The therapist's capacity to listen and capture what the client says in psychotherapy influences his or her capacity to identify the client's expressed needs and to tailor interventions in response to them. The T:Rs are conversational actions expected

to address the client's manifest needs that can be linked to the extra-therapy context – namely client's wishes and expectations, intra or interpersonal difficulties, problems self-related, doubts and personal dilemmas – or linked to the intra-therapy context – namely client's wishes, expectations, requirements, difficulties, and doubts, all directly related to the psychotherapy, the therapist or the therapeutic relationship. Thus, need-oriented interventions are sustained on an intentional and collaborative work that encompasses responses adapted to the client's manifest needs, either processing what occurs in the client's life or what occurs in the here-and-now dyad interactions.

The C:Rs, in turn, provide information about the suitability of interventions. Duncan (2010a) suggests that in the process of *becoming a better therapist*, it is important to track the client's responses to the interventions and tailor the subsequent interventions in accordance with those responses. Doing this, a more systematic process of planning, implementing and evaluating the interventions is possible. It is in this context that I made claims about the importance of collecting the client feedback which is "the compass that provides direction out of the wilderness of negative outcomes and average therapy" (Duncan, 2010a, p. 15).

In sum, the main findings of the present study allowed to address TR as a process sustained on recursive and reciprocal interactions between the C:VEN, the T:R, and the C:R. For this reason, I proposed the concept of *Reciprocal Responsiveness*. What I mean by this term is the therapist's capacity and willingness to meet, in a flexibly way, the manifest needs of the client emerging in the dyadic conversation, to provide responses adjusted to those needs, and to check the client's subsequent reactions. Therefore, TR seems to require two kinds of therapist's skills: competences and metacompetences (Roth & Pilling, 2008). Competences are the therapist's skills to deliver a specific intervention, monitor the client's engagement with the intervention,

and adjust his or her response accordingly. Metacompetences are skills in applying general principles of case formulation and treatment planning in an ongoing strategic decision-making about what to do and where to focus as the case unfolds. Thus, the reciprocal process involving coordinated conversational actions between the client and the therapist is mediated by the therapist's competences and metacompetences.

The way through which the client and the therapist develop these coordinated conversational actions are believed to influence the formation and development of alliance. On the first chapter I highlighted alliance as an interactive and collaborative therapeutic factor influencing the quality of the treatment. This therapeutic factor seems to be common across different psychotherapy modalities, even though assuming different configurations probably depending on how TR occurs, that is, depending on the more or less coordinated reciprocal interactions between the C:VEN, the T:Rs, and the C:Rs.

Placing emphasis on the therapist's contribution to the alliance, I hypothesize that the therapists who apply their competences and metacompetences on developing an interactive and collaborative work with their clients are those who permit the clients to have an active role on creating and maintaining mutual actions. Following this line of reasoning, my hypothesis is that the therapists who are better able to form an alliance with their clients are the therapists who create opportunities for the dyad reciprocal responsiveness, allowing the clients to assume a privileged position in psychotherapy and making use of their important epistemic value.

1. Implications for psychotherapy practice, training, and research

The results of the present study are encouraging and have provided an opportunity to empirically document the clinical richness of the psychotherapy interaction. I believe that the findings of this study provide helpful directions on how to improve clinical practice regardless the therapist's theoretical orientation. Taken into consideration the potential influence of TR in the development and quality of alliance, the TR models seems to be of particular clinical usefulness. By attending, developing, and assessing systematically the TR based on the recursive and reciprocal dyadic interactions, the therapist would be more capable of:

a) appreciating the diversity of needs across clients;
b) listening and being aware of the specific needs of each individual client that emerge moment-by-moment in psychotherapy, yet without losing the therapeutic goals negotiated with the client;
c) communicating his or her understanding about what are the client's needs;
d) deciding intentionally about what to do and where to focus, that is, deciding with regard to the treatment planning and how to deliver interventions in accordance to the client's needs;
e) tailoring the interventions in response to the client's needs, being flexible yet disciplined;
f) developing a positive alliance with the client, which may not only facilitate the implementation of techniques but also provide, in and of itself, opportunities for transformative experiences; and
g) evaluating the reactions of the client to the interventions and reviewing the interventions if necessary.

Because TR is a recursive and reciprocal process, not only the client provides opportunities by expressing his or her needs for the therapist respond, but also the therapist provides opportunities by tailoring interventions for the client participate actively in the therapeutic process, either informing about his or her needs, either reacting or responding to the therapist's interventions. Thus, the TR models highlight the importance of attending to the reciprocal features of TR.

Moreover, the TR models call attention for the importance of the therapist to be aware and better understand the particularities of the moment-by-moment interactions as they unfold and the way that these are affecting the quality of alliance. If necessary, the therapist might ask directly the client what he or she is thinking or feeling about the work they are developing, by discussing and processing with the client what is occurring in the here-and-now moment.

Therapists-in-training should be encouraged to become responsive with their clients. With this respect, they should be trained to value the clients as active participants in psychotherapy, expressing their needs, being involved in the therapeutic collaborative work, and responding or reacting to the interventions. Also, they should be trained to give attention to what the clients say, relying on their capacity to inform about inner experience and needs. This entails listening to clients, incorporating the clients' perspective on their needs into how the interventions are developed, as well as being aware of the clients' reactions because they provide indicators of what is working and what is not, calling for continuing or reformulating the interventions.

Trainees should practice listening skills and be encouraged in the process of knowing how to flexibly adjust interventions attending to the clients' needs. They can evaluate how they progress in this process by reviewing videotapes of their sessions, observing and coding the conversational interactions with TROS, as part of the

supervision process. Supervisors can view their supervisees´ videotaped sessions, code their responsiveness to the client, and discussing with them aspects regarding the opportunities they can create to better interact with the client, to involve the client as an active participant in a collaborative work, and to capture the reciprocal features of TR. Thus, TROS can be a useful tool for supervision despite of the theoretical background or the model under training, and seems to have potential for enhancing clinical effectiveness.

Additionally, TROS can be a useful tool for empirical research. This tool can provide a fine-grained view of the unfolding therapeutic process because it allows to studying observable conversational interactions in context. Recommendations are made for using the TROS in research that aims to analyzing psychotherapy, in particular its relational aspects, in a richly and detailed manner.

2. Limitations of the study and future directions

Some limitations should be noted. Although empirical data placed the C:VEN as the marker from which TR develops, it did not reflect the intensity of each client's need, that is, the needs salience was not captured. The client can express numerous needs, some of them more important or more intense. Future research may well increase the understanding of what occurs between the dyad participants when more salient needs are observed in comparison with less salient needs. Collecting the client, the therapist or both perspectives using recall procedures will probably answer the question of *What are the most salient needs that the client expresses in a specific session?*. In alternative, salience might be understood as the recurrence or persistence of a specific need in the

client's speech. Following this line of reasoning, future research may well examine the needs salience by the observer perspective.

The nonverbal expression and communication occurring also recursively in psychotherapy are not underestimated but the TROS does not measure this facet of the client-therapist interaction. Although some verbal signals are used in order to clarify the dyad conversations, it is unclear how these verbal signals, as well as the nonverbal behaviors of the client, the therapist or both such as eye contact, facial expressions, and body posture, have impact on the way that they respond verbally to each other.

As my conceptualization of TR was based on the idea that specific observable actions are ubiquitous in all forms of treatment irrespective of the theory that undergirds it, neither the prototype model or the measure (TROS) captures some of the concepts that are claimed to be related to the value of the therapist's responses, as for example the concept of core needs. Core needs are understood as continuously unmet needs that dominate the client's life and contribute to psychological problems, which might underlie what the client expresses verbally to the therapist (Flanagan, 2010). The core needs can be inferred through observation of the client and the dyadic interactions. They cannot be directly observed and TROS allows examining client's needs essentially based on actual observations.

The T:Rs are conversational actions following the C:VEN. In the prototype model, the T:Rs are analyzed in terms of mode, time frame, and focus. Because responses are intentional actions, a fourth dimension was added even though I recognize that it is in a different level of analysis. The response mode, temporal dimension, and focus are actually observable actions; instead, response intentions are inferred from those actions. Intentions are what the therapist wants to achieve through his or her actions in the session (Stiles et al., 1996). Thus, the most direct access to the therapist's

intentions is by asking therapists to reveal them. However, in the present study, the therapist's response intentions were judged by trained observers. The possible controversy around this response dimension argues for including both perspectives in future studies of how intentions are implemented.

On the balance, I chose to include this dimension because it offers a potential contribution to fine-grained evaluation of the effectiveness of TR. More research will be needed to bring to bear evidence on the utility of this dimension. In order to validate the prototype model, a new cycle of research is needed using the second phase of Task Analysis – the validation-phase. New data may be observed and analyzed repeatedly until the components of the model, encompassing the intention dimension, are validated or eliminated. The model would be refined, tested, and revised through a series of intensive and sequential analyses of single cases.

In the present study I used the C:R to the T:R to judge the appropriateness of the intervention (e.g., if the client does not accept the T:R systematically, it is assumed that the therapist needs to reformulate his or her interventions). However, from a practical perspective, to determine the quality of the C:Rs without doing inferences seems impossible. In the prototype model, the C:Rs are clearly observable actions, but if the goal is to judge the appropriateness of T:R then collecting the client's perspectives directly (i.e., by asking them) might be a better way. TROS and recall procedures would be complementary and benefit to the better understanding of both what is actually observed and how it contributes for the quality of outcomes in psychotherapy by addressing the quality of the C:Rs and the appropriateness of T:R together.

Thinking about the way that the present study evolved over time leads to some additional limitations and subsequent suggestions for future research. Indeed, a potential limitation of the study is the examination of TR at single sessions. Observing a single

session limits the analysis to what happens in that specific session. Thus, bridges between sessions of the same therapeutic dyad are not observed. Starting from the main findings of this study, it is possible to go one step further with the detailed examination of all the interchanges between the C:VEN, T:Rs, and C:Rs that arise during a treatment. This way, the recursive sequences of conversational interactions between the client and the therapist may be analyzed moment-by-moment throughout the course of treatments. Systematic case studies (e.g., Edwards, 2007, 2010) or focused theory-building case studies (Stiles, 2009) would probably lead to a more broad and coherent understanding about how the C:VEN, T:Rs, and C:Rs articulate across treatment sessions. Like alliance, responsiveness patterns may assume distinctive configurations as they evolve over the length of treatment (e.g., Kivlighan & Shaughnessy, 2000). A detailed and sequential analysis of the dyadic conversational interactions in different phases of psychotherapy might reveal distinctive configurations of TR unfolding across time.

Additionally, studies examining intensively TR in successful and unsuccessful psychotherapies are needed in order to compare TR in poor outcome and good outcome cases. I argue, as many other authors (e.g., Bacal, 1998a, 1998b, 1998c; Silberschatz & Curtis, 1993; Stiles et al., 1998), that the client tend to improve when the therapist develops interventions in accord with the client's particular needs. A new cycle of research using the validation-phase of Task Analysis would increase the understanding of TR, and ultimately enhance the way of measuring it by relating the way that the components of the model are articulated with psychotherapy outcomes. Thus, future researchers might find it useful to attend to whether TR has a different configuration in different phases of treatment, and whether particular patterns of TR are differentially associated with successful and unsuccessful psychotherapies.

TR is understood as a process inherent to psychotherapy regardless of the theoretical orientation of the therapist. Conceiving TR 'as such' as a generic process across psychotherapy modalities, this study examined TR in Cognitive-Behavioral Therapy, Narrative Therapy, and Personal Construct Therapy without making comparisons. I believe that the three components of the prototype model are universal. This does not invalidate the idea that comparisons may be made across treatments and sessions of other psychotherapy approaches may be used aiming to check if TR assumes different configurations in each of them.

Also, it would be interesting to examine TR in treatments for personality disorders taken into account that the clients with personality disorders, particularly with borderline personality disorder, are likely to have a rigid interpersonal functioning (e.g., Benjamin & Karpiak, 2001), which negatively affect the therapeutic alliance (e.g., Bourke & Grenyer, 2010), which in turn can lead to specific challenges on TR.

An additional future direction is due to the potential usefulness of the working model for clinical practice and training. Reliability analyses of the working model would lead to further refinements. Increasing confidence and generality can be expected from refinement of the model using further sessions.

This dissertation presents a research that seems to contribute to expanding the knowledge about the responsiveness phenomena. The study might provide the researchers and therapists with some insight into the reciprocal interactions underlying TR – a process inherent to any psychotherapy with potential contributions for the quality of alliance. The promising findings created opportunities for the improvement of psychotherapy practice and further research. TR remains a fascinating but *endless ocean to browse*.

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