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The Responsiveness Problem in Psychotherapy: A Review of Proposed Solutions

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Abstract

Background: Therapist responsiveness is defined as therapist behavior being influenced by emerging context. Responsiveness is ubiquitous and creates serious problems for a ballistic, cause-effect understanding of how psychotherapy works. This conceptual literature review examines ways psychotherapy researchers have constructively engaged the responsiveness problem.

Method: We noted classical approaches to the responsiveness problem, and, we reviewed all available citations of the formulation of the problem by Stiles, Honos-Webb and Surko (1998), focusing on proposed solutions. We identified $N = 58$ studies that cited the 1998 paper and engaged with the responsiveness problem.These, along with additional engagements with the responsiveness problem identified by us and by colleagues were reviewed.

Results: We distinguished six categories of ways researchers have addressed the responsiveness problem: (a) demonstrating effects of responsiveness, (b) measuring responsiveness quantitatively, (c) describing responsiveness qualitatively, (d) using evaluative measures, (e) developing responsive clinical interventions, and (f) extending responsiveness concepts to related domains.

Conclusions: There are ways to engage the responsiveness problem that are scientifically productive. However, appropriately engaging the problem may require some psychotherapy researchers to ask different questions than they have previously asked.

Key-Words: Responsiveness; Randomized Controlled Trial; Process-Outcome; Literature Review; Psychotherapy Research

The Responsiveness Problem in Psychotherapy: A Review of Proposed Solutions

This article is a conceptual literature review addressing the following question: In what ways have researchers engaged with the responsiveness problem in psychotherapy research? Responsiveness refers to behavior being influenced by emerging context, for example, therapist interventions being influenced by clients' changing characteristics and behavior. Responsiveness is not a problem for psychotherapy practice, but it is a problem for psychotherapy research because it undermines many conclusions based on linear reasoning and linear statistics (Stiles, 2009; Stiles, Honos-Webb, & Surko, 1998).

By *engagement*, we mean active attempts to find a solution to the problem, not merely acknowledging the problem. Since a 1998 formulation of the problem in this journal (Stiles, Honos-Webb, & Surko, 1998), over 15 years of psychotherapy research have accumulated, and we thought it was time to examine this literature to see how psychotherapy researchers have engaged with the responsiveness problem and tried to solve it. We reviewed and classified reported strategies of engagement, drawing on a systematic search of articles that have cited the 1998 formulation as well as our and colleagues' knowledge. We begin by describing responsiveness and illustrating the responsiveness problem.

What is responsiveness and why is it a problem?

Responsiveness denotes behavior being affected by events on all time scales, immediate, short-term, and long-term. Responsiveness is a problem because it defeats most psychotherapy research designs that depend on cause-effect reasoning, including correlational process-outcome research and experimental intervention studies (Stiles, 2009b, 2013 ; Stiles et al., 1998). Therapists deliver therapy by responding to client requirements and characteristics as they

emerge in the therapy process using the principles and tools of their approach. A therapist who takes into account what a client presents – by specifically responding to emerging client requirements – injects unpredictable irregularities into research designs. Therapists are responsive even before therapy starts, as they choose and shape treatment based on available information. In therapy studies, therapists are not "implacable experimenters" (Wachtel, 1973, p. 331) who behave independently of interpersonal cues from the client; rather, they adapt their approach to what the client presents. Responsiveness in psychotherapy is a ubiquitous characteristic of the therapist-client dialogue.

Responsiveness is not necessarily benign. People may respond to each other's behavior with intent to cause harm. However, therapists generally have benign goals, and they act to advance those goals in ways consistent with their theoretical and personal principles. This can be called *appropriate responsiveness*. So, appropriate responsiveness means doing the right thing. In general, we suggest, therapists and clients try to do the right thing at the right time.

Therapist responsiveness impacts many results in psychotherapy research, including process-outcome links and outcome effects. Consider the following illustration of how responsiveness is a problem in therapy process-outcome research: Psychodynamic therapists facing clients with low insight capacities may need to repeat and rephrase interpretations more frequently than therapists facing clients with high insight capacities, yet the latter may have better outcomes than the former. That is, correlations between frequency of therapist use of interpretations and symptom change may be negative (clients given more interpretations have poorer outcomes), even if interpretations are an effective ingredient of that therapy's process (Stiles, 2013). The adjustment between client and therapist, that is, responsiveness, explains this result, which seems paradoxical from the perspective of traditional ballistic (cause-effect)

reasoning (Stiles et al., 1998). In process-outcome research, the responsiveness problem applies to behaviors that participants can adjust up or down volitionally, in response to client requirements, including most therapist interventions. If it is impossible to do too much of a specific behavior, so that more of this therapist behavior is always better, then the responsiveness problem is partially avoided (Stiles, 1996), as discussed later.

In outcome research, randomized controlled trials (RCTs) are seriously impaired by responsiveness (Carey & Stiles, in press; Stiles, 2009b, 2013) because it leads to unspecified variation in the independent variable (the treatment). In RCTs, it is implicitly assumed, by treating named treatments as levels of an independent variable, that psychotherapeutic interventions are pure and consistent in the same sense as pharmacological interventions. Responsiveness teaches us that even within one condition of a study, each client's treatment, indeed, each minute of each treatment is different because it is affected by client behavior and other changing contextual characteristics. Of course, no two things in the universe are ever exactly alike; however, any two instances--indeed, any two minutes--of any named psychotherapy are hugely more different than are two tablets of a named drug. If the implementation of treatment X is substantially different on each occasion, then it is unclear what we mean by saying that treatment X is more efficacious than some other treatment. Similarly, it is misleading to assume that a psychiatric diagnosis is a homogeneous and pure concept (Budd & Hughes, 2009). Some approaches claim to standardize treatments by elaborating detailed manuals for the intervention. However, a close examination of the manuals shows that they do not specify an unvarying script for the therapist; rather, they emphasize clinical judgment, building rapport, interpersonal sensitivity, and appropriate use of a flexible repertoire of strategies and techniques. Indeed, correct application of treatment manuals explicitly demands

appropriate responsiveness (Stiles et al., 1998). Thus, far from removing responsiveness, therapy manuals actually instruct therapists to be responsive, that is, to adjust their intervention to the requirements of the client and the circumstances. Manuals may be useful for clinicians, but they do not solve the responsiveness problem.

We argue that appropriate responsiveness goes beyond injecting noise and ambiguity into RCTs: it works specificially to defeat differential treatment effects. Therapists attend and respond to indications of improvement or deterioration, such as changes in clients' emotional state, significant relationships, or functioning at work, and they use such information to adjust their interventions, session by session and minute by minute. In effect, then, information about outcome, or its detectable precursors, feeds back to improve the delivery of the treatment. In terms of research design, the dependent variable alters the independent variable in ways that tend to make the treatment more effective. Responsiveness thus grossly violates independence assumptions and simultaneously tends to optimize outcomes in all theoretical approaches, as therapists make appropriate use of whatever techniques their approach offers.

More globally, the paradigm of empirically supported therapies (EST; Chambless, Baker, Baucon, Beutler, Calhoun, Crits-Christoph et al. 1998; Chambless, Sanderson, Shoham, Bennett Johnson, Pope, Crits-Christoph et al., 1996), like other attempts to develop selective lists of evidence-based treatments, relies on the assumption that therapeutic interventions are specified independently of the patient being treated, so that researchers comparing treatments can assess which intervention works best for which types of problem. That is, EST researchers attempting to answer the question of "what works?" ignore the responsive nature of treatment, and this confounds the experimental intervention (Bohart, 2000 ; Budd & Hughes, 2009; Elliott, 2010 ; Haaga & Stiles, 2000 ; Lampropoulos, 2000). This description of EST has led Bohart (2000),

among others, to describe a “paradigm clash” between therapeutic approaches that are consistent with the EST paradigm and approaches which are not.

The problem of responsiveness is not a new idea to process-outcome and outcome research in psychotherapy. For example, Paul (1967, p. 111) was describing responsiveness at the level of treatment choice when he suggested that the right question for outcome research is: "*what* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* circumstances?" This has led a number of researchers to advocate studies consistent with the principles of Aptitude-Treatment Interaction (Beutler, 1991, 2002; Shoham-Salomon & Hannah, 1991; Snow, 1991), which suggest that patient characteristics and readiness for change interact (statistically) with treatment characteristics to predict therapeutic change. However, when this argument is thought through, it would yield “nearly one and one-half million potential combinations of therapy, therapist, phase, and patient types” (Beutler 1991, p. 227); to study them all would be a literally impossible task! And of course, this involves only responsiveness regarding initial treatment choice. Responsiveness at the level of session-by-session treatment planning, in-session decisions about treatment tactics, and moment-by-moment adjustments of timing, phrasing, and tone yield possible combinations many orders of magnitude larger. These arguments highlight the importance of proposing viable and creative solutions to the responsiveness problem in psychotherapy research.

Is Appropriate Responsiveness a Common Factor?

As we have been describing it, responsiveness is not a technique or a specific agent of change. It is not a specific behavior, insofar as it requires responses that vary depending on the emerging circumstances. Instead, it is a generic and ubiquitous principle of interpersonal

regulation and attunement. Although responsiveness is common, it is not a factor in the sense intended by the concept of common factors in psychotherapy (Norcross & Wampold, 2011). Rather, appropriate responsiveness describes the observation that clinicians, in their daily work, tend to optimize their interventions by adjusting to circumstances.. They try to do the right thing at the right time, considering the client, the context, and their therapeutic approach. In this sense, appropriate responsiveness is part of being an expert who intuitively discriminates seemingly similar situations and decides how to intervene differentially across time (Dreyfus, 2004). For this reason, the responsiveness problem is not a problem for clinical practice; on the contrary, appropriate responsiveness is the essence of good practice. Rather, responsiveness is a problem for researchers who are trying to model and study what clinicians do (Stiles, 2013). We note that appropriate responsiveness could also conflict with strictures on practice imposed by administrators, researchers, or manuals (Kramer, 2009).

As explained, responsiveness is not a specific behavior; however, it is possible to redefine the word to describe dimensions of therapist behavior. For example, the way people (e.g., therapists) respond may vary in the degree to which it is appropriate. Degree of appropriateness of the responsiveness, that is, the extent to which the therapist does the right thing, might vary from session to session (i.e., a process variable) or from therapist to therapist (i.e., an individual difference variable). Redefined in this way, variation in appropriate responsiveness may explain why evaluative common factors – such as the therapeutic alliance, empathy, group cohesiveness and others (Norcross & Wampold, 2011) – account for so much outcome variance and treatment techniques so little (Wampold, 2001). Evaluative common factors describe the extent to which the therapist (or the dyad) did the right thing at the right time, whereas technique variables describe only what was done, regardless of whether it was the

right thing to do. We return to this point in a later section on evaluative variables.

Design of Our Review

We reviewed ways that researchers and theorists have actively engaged with the responsiveness problem in psychotherapy research, and we sorted the approaches we found into conceptual categories. We distinguished engagement with the responsiveness problem from mere acknowledgment of the problem. Engagement encompassed explicit methodological strategies, but also theoretical elaborations and ideas about how the problem may be solved. Acknowledgment of the responsiveness problem referred to merely citing the responsiveness problem, for example, as an explanation of null or unexpected findings, as a limitation of the research design, or as a contribution to a particular observed phenomenon, without suggesting ways to address or avoid the problem.

Our review encompassed, first, longstanding approaches that predated the Stiles et al. (1998) formulation and have continuing currency. These included for example, the discipline of conversational analysis (e.g., Labov & Fanshell, 1977; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008), which qualitatively describes the process of interpersonal responsiveness as its primary focus. Another example was the use of evaluative process measures, such as ratings of the alliance, which incorporate appropriate responsiveness to some degree. Second, we systematically searched for and examined articles that had cited the Stiles et al. (1998) formulation to identify more recently developed strategies. Finally, we circulated a draft manuscript to a few willing colleagues, asking them to suggest other work that had engaged with the problem. Our goal was not to compile an exhaustive bibliography of studies that have taken responsiveness into account but to distinguish and enumerate categories of ways that

investigators have engaged with the problem.

Method

We began with our knowledge of ways researchers have engaged responsiveness, as noted above. Seeking additional strategies of engagement, we searched for all citations of the article by Stiles et al. (1998), using google citation search. This literature search, completed in the third week of October 2014, yielded $N = 218$ items. The 218 items included published journal articles, book chapters, dissertations and interviews. These items were downloaded and/or purchased. Items that were unavailable to both co-authors were excluded, as were items that were not in English, German or French. At this first stage, $n = 40$ items were excluded.

The remaining $n = 178$ contributions were reviewed by the first author, who judged whether each met the criterion of engagement with the responsiveness problem. The judgments by the first author were subsequently discussed with the second author.

We judged that $n = 120$ contributions acknowledged the responsiveness problem (i.e., cited the argument), but did not fully engage with it in the sense of proposing a theoretical elaboration or method for addressing the problem. This left $n = 58$ items, which we considered as having constructively engaged with the responsiveness problem. Some of these ($n = 8$), though clearly engaged with the responsiveness problem, did not suggest a specific solution. We have cited them in this article's introduction. We classified the remaining $n = 50$ contributions according to the strategy of engagement and used the strategies as headings in our Results section.

Results

Our results classify ways of engaging with the responsiveness problem. We distinguished six ways that psychotherapy researchers have engaged with the responsiveness problem: (a) demonstrating effects of responsiveness empirically, (b) measuring responsiveness quantitatively, (c) describing responsiveness qualitatively, (d) using evaluative measures, which incorporate responsiveness, (e) developing clinical interventions that are explicitly responsive, and (f) extending responsiveness concepts to other, related domains. These six ways of engagement may be further characterized by three dimensions: (1) qualitative versus quantitative approach, (2) evaluative versus descriptive assessment, and (3) generic versus idiographic characterization of responsiveness.

These categories and dimensions are not mutually exclusive (some research engages responsiveness in more than one of these ways), and we do not claim that they are exhaustive. We acknowledge that there may be categories that we have overlooked and that we have not cited all studies that have used the listed strategies.Within each of these categories, we briefly describe lines of research we encountered in our review, drawing particularly on the 50 contributions that cited the 1998 formulation of the problem.

Empirical demonstrations of effects of responsiveness

One type of engagement we encountered was investigating how therapy participants are responsive to each other. These fell into two categories: investigating responsiveness to patient personality features and investigating responsive regulation of treatment duration.

Therapist responsiveness to patient personality features. A design in which a specific patient characteristic precedes a therapist intervention addresses the responsiveness problem, in that it takes into account both the patient and therapist contributions to process and outcome. For

example, Hardy, Shapiro, Stiles and Barkham (1998) analyzed patient relationship involvement in cognitive-behavioral vs psychodynamic-interpersonal interventions and found an interaction effect. In psychodynamic therapy, the therapist offered more affective interventions for relationally over-involved patients (compared to under-involved patients). In cognitive-behavioral therapy, therapists did the same and in addition, they offered more cognitive-behavioral interventions to under-involved patients (compared to over-involved). Relatedly, in their review, Meyer and Pilkonis (2001) suggested that for insecure attachment styles, such as dismissive attachment, specific interpersonal therapist reactions are elicited, such as active intervention facilitating connection. For secure attachment styles, no such customizing of the therapeutic intervention might be elicited ; however, the therapist appropriateness to patient attachment might be the strongest predictor of good process (i.e., strength of the therapeutic alliance). Kiesler (1996) demonstrated that clients' interpersonal behavior tends to elicit specific complementary therapist responses, following predictions of the interpersonal circumplex model.

Macdonald, Cartwright and Brown (2007) tested the hypothesis that patient interpersonal hostility/reactance influences therapist negative interpersonal behavior in assessment interviews for alcohol problems. More subtle interpersonal hostility was investigated by Anderson, Knobloch-Fedders, Stiles, Ordonez and Heckman (2012) using a speech act analysis. Subtly hostile interaction episodes were associated with relatively more disclosures for the patient, and with relatively more interpretations (and relatively few questions or reflections) for the therapist. Despland, de Roten, Despars, Stigler and Perry (2001) demonstrated that psychodynamic therapists used more interpretations facing clients with mature defense mechanisms and more supportive interventions facing clients with immature defense mechanisms; this adjustment to defenses was associated with the quality of the process (i.e., therapeutic alliance). Flückiger and

Znoj (2009) showed that therapists non-verbally counter-modulated clients' generic mood states (i.e., depressed, anxious) in a minute-by-minute fashion, which was related with the quality of the sessions. This effect was not found for the more global therapist responses to client mood. Caspar, Grossmann, Unmüssig and Schramm (2005) showed that facing clients with low assertiveness, therapists – who were interpersonal therapists uninformed of the specific relationship variables measures in this study – used motive-oriented therapeutic intervention strategies (see below) to a greater extent, compared to therapists facing clients who were cold and vindicative, where the therapist's use of motive-oriented relationship interventions was rare. This study defined responsiveness for each client individually, using idiographic information. Lee and Horvath (2014) examined an interaction model in cross-cultural counselling in one dyad and found a decline in therapist responsiveness to cultural issues exposed by the client, over the course of treatment. This decrease in responsiveness was not observed for general clinical issues unrelated to the client's culture. This differentiated pattern is consistent with the view that therapists are responsive to distinctive features within each client-therapist dyad.

In a study on therapist response modes, Connolly Gibbons, Crits-Christoph, Levinson and Barber (2003) found that therapists used more clarifications treating clients with greater depression (compared to less depression), more learning-type interventions treating clients rated as telling complete (i.e., high-quality) narratives (compared to incomplete narratives), and more clarification treating clients who rated the therapist as more empathic (compared to less empathic). For cognitive-behavioral treatment for panic disorder, Boswell, Gallagher, Gorman, Sauer-Zavala, Bullis, Shear and colleagues (2013) showed that the within- and between variability of therapist adherence to the protocol decreased over the course of treatment. This was particularly the case for clients with higher levels of self-reported interpersonal

agressiveness. Analyzing interaction sequences - such as client's narrative, followed by therapist's response mode, followed by client's narrative – Goates-Jones (2004) found no effect of the quality of the client's way of telling his/her story (i.e., internally vs externally focused narrative) on therapist's response categories. However, an increased level of the client's internal narrative followed the therapist asking open questions or making reflections. Responsiveness may be more obvious in certain types of client-therapist dyads: Frühauf, Figlioli, Oehler and Caspar (in press) showed that impression management tactics (e.g., supplication, self-promotion) by clients in the intake interview were present particularly when a male client was treated by a female therapist. Finally, using qualitative analysis of transcripts involving three clients being treated by Carl Rogers, Bohart and Byock (2003) concluded that the client's framework of understanding and construing influences what he/she perceives from the therapist response (see Bohart, 2007, for a discussion).

These studies demonstrate that certain interpersonal variables, such as client attachment, relational involvement, interpersonal agressiveness, assertiveness, perceived therapist empathy, cultural issues, supplication, defense mechanisms, general mood, and subtle hostility, influence the therapist's intervention choice. Conversely, the client's framework influences his/her readiness to integrate a particular therapist response. As discussed in the introduction, these conclusions are compatible with the Aptitude-Treatment Interaction paradigm (Beutler, 1991, 2002).

Duration of therapy as a responsive regulatory process. The four studies in this category addressed responsiveness to client requirements with respect to treatment length, as observed in naturalistic settings of psychotherapy (Baldwin, Berkeljon, Atkins, Olsen, & Nielson, 2009; Barkham, Connell, Stiles, Miles, Margison, Evans, & Mellor-Clark, 2006; Shapiro, Barkham,

Stiles, Hardy, Rees, Reynolds, & Startup, 2003; Stiles, Barkham, Connell, & Mellor-Clark, 2008). This responsive regulation model suggests that the effect of treatment is not necessarily predictable from the dose of therapy delivered (as suggested by the dose-effect model, which predicts a negatively accelerated curve of change over time), but reflects negotiations (explicit or implicit) between the client and the therapist, to arrive at a "good enough level" of gains. When clients reach a good enough level, treatment ends, so treatment length varies, but clients tend to have similar outcomes. In this context, responsiveness refers to adjustment of therapy length, expectations, focus, and therapeutic effort in response to contextual information, such as the client's improvement rate (Barkham et al., 2006). The studies all suggested that outcomes tended to be similar regardless of treatment duration. As an implication, insofar as each client may progress at his/her own pace until reaching a "good enough level", fixing the number of sessions by administrative fiat interferes with a central responsive regulation processes in therapy.

Quantitative assessment of responsiveness in therapy

Elkin, Falconnier, Smith, Canada, Henderson, Brown, and McKay (2014) undertook the important effort of designing a quantitative measure of therapist responsiveness using observer ratings, the Therapist Responsiveness Scale. Three levels of abstraction are included in the rating, described as dimensions of therapist responsiveness: (1) Based on 5-minute segments, specific therapist behaviors considered to be responsive were rated (e.g., makes eye contact, uses work-encouraging comments, demonstrates interest in the client's perspective, makes effort to understand the client's perspective, responds to expressed feelings, makes inferences on unexpressed feelings, makes normalizing, affirming, validating statements), along with items describing negative therapist behaviors (e.g., disrupts the flow of the session, makes judgmental, critical, invalidating comments, lectures client). (2) Based on the entire sessions, global items

describing the quality of the interaction between therapist and clients were rated (e.g., appropriate level of emotional quality and intensity, respectfulness, compatible levels of discourse), including negative items (e.g., client displays hostile behavior). (3) In addition, they gathered a one-item, global rating of overall responsiveness. Regression analyses showed that early engagement in therapy, measured by client ratings of the relationship, was predicted by factor scores based on global ratings of responsiveness, called positive therapeutic atmosphere and by the one-item overall rating of responsiveness. Early treatment termination was predicted (negatively) by the same two global scales as well as by a factor based on negative therapist behaviors in the first two sessions of the therapy.

The Elkin et al. (2014) study demonstrated that it is feasible to assess responsiveness using observer ratings. However, the main predictors of early engagement and early termination were based on global ratings rather than on specific behaviors within the client-therapist dialogue. These global ratings run into a conundrum common to other evaluative measures, such as therapist competence, alliance, and empathy: the measure itself incorporates responsiveness. This conundrum is elaborated in a later section on evaluative measures.

Interestingly, the one factor based on specific behaviors that predicted early termination consisted of negative behaviors (disrupts flow, lectures, critical/judgmental). If it is assumed that the optimal level for such behaviors is zero and that many therapists are at or near zero then more is always worse, and this predictor avoids, at least from a statistical viewpoint, potential problems related to responsiveness. Elkin et al. did not report distributions, but Anderson et al. (2012) suggested that negative behaviors are very rare. An appropriately responsive therapist would not do any of them, so there is a floor on the distribution.

In a different sort of quantitative assessment of therapist responsiveness, Mazzi, Del Piccolo and Zimmermann (2003) proposed that Markov-chains test sequences might help identify hidden patterns of client-therapist interaction sequences. Using time series to maximize the ratio comparing signal to noise, such an approach might help to disentangle relevant (signal) patterns from irrelevant (noise) patterns in observed interactions. In research using this approach, non-verbal client-therapist sequences were modeled using time-series panel analysis (Ramseyer, Kupper, Caspar, Znoj & Tschacher, 2014). It was shown that client-therapist non-verbal synchrony was related with the global assessment of alliance of a therapy session.

Qualitative descriptions of responsiveness in therapy

Qualitative descriptions engage responsiveness by detailing how therapist and client (or any people) respond to each other in interactions. Arguably, this is the most straightforward form of engagement, heir to methods of narrative description of interpersonal interaction tracing back to the beginning of human language. Although qualitative description has obvious advantages with respect to realism, it encounters more problems than do quantitative and statistical approaches with respect to precision and generality.

Conversational analysis as the study of responsiveness. The discipline of conversational analysis has sought precision by developing highly detailed systems of transcription (Sacks, Schegloff, & Jefferson, 1974) and intensively studying moment-by-moment nuances in interaction. Intended for conversations of all sorts, several inverstigators have applied conversational analysis to psychotherapeutic interactions (Labov & Fanshell, 1977; Muntigl & Horvath, 2014; Peräkylä et al., 2008).

For example, Peräkylä (2004) studied the process of making interpretations in

psychoanalytic therapy. The authors described two ways in which the analyst actively works to create a match between the different domains of experience by shaping the description of the client's experience to display the similarity of the experiences linked by the interpretation. One way was the choice of words within the interpretations themselves, while the other way was in the sequence of elements in the discussion preceding the interpretation. Muntigl and Horvath (2014) examined extended episodes of disaffiliation – or lack of collaboration – between clients and therapists. They compared clients with confrontation versus withdrawal styles of disaffiliation and showed the distinctly different ways in which these styles were associated with relational ruptures and attempted repair. Sutherland, Peräkylä and Elliott (2014) examined compassionate self-soothing dialogue, a two-chair task intervention used in emotion-focused therapy. They showed how therapists and clients collaborate to move from the ordinary frame of therapeutic conversation to a self-soothing frame and back again by using combinations of therapist instructions, sequencing actions in the interaction, explanations and justifications, assigning pronouns to distinguish among the client's internal addressees, corrections of clients' talk, and verbal acknowledgments. The material in these studies was intricately responsive, and the research reports classified and described principal patterns.

Of course, many researchers who are not specifically conversational analysts have offered or advocated qualitative descriptions of responsive patterns in conversations. As one who cited the Stiles et al. 1998 formulation, Auletta (2012) underlined the importance of dialogical analyis for the study of therapist responsiveness via the analysis of respective speech turns.

Responsiveness demonstrated in case studies. One subcategory of the case studies which cited the (1998) formulation has focused on illustrating the effectiveness of responsive interventions (e.g., describing processes in good outcome cases). For example, Dattilio, Edwards

and Fishman (2010) commented on the use of case studies in clinical psychology and advocated a mixed methods -quantitative and qualitative - paradigm that includes case studies within randomized controlled trials. While following treatment manuals, effective clinicians must at the same time maintain a responsive flexibility to the client's personality, motivation and needs. Anderson, Ogles, and Weis (1999) contrasted two examples of therapists working with the therapeutic relationship, one who provided a manual-based intervention, the other who provided a creative client-responsive intervention. At one point in therapy, the latter therapist made a seemingly offhanded comment on the client's sweater which indeed helped the alliance-building in a creative way. With the aim of describing the meaning-construction process in psychosis, Dilks, Tasker and Wren (2008) used grounded theory and found several ways clients may engage in constructing meaning which helped them in the dialogue with the therapist. Creating meaning is here a circular process implying client and therapist contributions. Dilks, Tasker and Wren (2012) demonstrated that the dialogical process of therapist providing scaffolding fostered this positive therapeutic process. Elliott (1983) developed comprehensive process analysis of a significant event in therapy which is an intense analysis of client and therapist speech turns and their mutual influences, using a particular case. The analysis starts with identifying an immediate client utterance to which the therapist speaking turn was a response, then working backwards to analyzing context factors which influenced the therapist response.

A second subcategory of case studies has addressed the generality problem by using a theory-building qualitative research strategy (Stiles, 2009b, 2010). Even though each observation is made only once on a case, and thus cannot be generalized, the rich clinical material offers many theory-relevant observations, which together may lend significant support to the theory. The theory then supplies the generality by specifying its own scope, or range of convenience.

Craig (2010) argued that theory-building case study research is particularly appropriate for addressing the fundamental problem, posed by therapist responsiveness - the mutual adjustment observed on a moment-by-moment basis within a particular interaction.

Several studies have used a theory-building case study approach to build the assimilation model (Stiles, 1999a), which segments outcome into a sequence of developmental stages, each associated with specific client tasks and understood at the same time as a micro-outcome. Honos-Webb and Stiles (2002) suggested that each assimilation stage might call for specific (responsive) therapist interventions. For example, material at the assimilation stage of unwanted thoughts/avoidance (stage 1) might call for experiential focusing, whereas material at the new understanding/insight stage (stage 4) might call for psychodynamic interpretation. Beginning with these hypotheses, Meystre, Kramer, de Roten, Despland and Stiles (2014) conducted a theory-building case study that assessed which links were most effective at each of a client's stages of assimilation. For example, for accessing and elaborating unwanted thoughts, explicit and subtle guidance, and emphasizing feelings and focusing on the present experience were associated with increments at particular assimilation stages. Meystre et al. (2014) then produced a modified set of hypotheses that incorporated the case observations and emerged ready for the next case study. In another theory-building study using a version of task analysis on pooled data from 6 cases, Meystre, Pascual-Leone, de Roten, Despland and Kramer (in press) micro-analyzed inpatient psychodynamic therapies and elaborated a detailed list of responsive interventions. For example, to responsively foster progress at the new understanding/insight assimilation stage, the therapist used psychodynamically informed confrontative interventions, whereas responsive interventions at the lower, unwanted thoughts/avoidance assimilation stage drew from a different set of interventions.

In other theory-building case studies, Stiles, Leiman, Shapiro, Hardy, Barkham, Detert and Llewelyn (2006) applied dialogical sequence analysis (DSA) to the very first exchange of a psychotherapy with a client. They showed how a responsive therapist facilitated the client's transition across stages in the theoretical assimilation sequence. Tikkanen and Leiman (2014) applied DSA to a network meeting for a pediatric neurological assessment, involving two therapists, the mother and the father. They showed how a shared formulation of the problematic pattern helped to resolve a therapeutic impasse; all participants contributed responsively to the formulation. Drawing on a case previously analyzed within the assimilation model (i.e., the case of Lisa; Honos-Webb, Stiles, Greenberg, & Goldman, 1998), Stiles (1999b) suggested that the symptoms of depression might reflect the active suppression of "continuity-benevolence assumptions" (p. 268; e.g., that "life is just and worth living") because they were opposed by external cirumstances that could not otherwise be reconciled with deeply held personal beliefs. The results of these studies were used to elaborate the assimilation model.

In our view most (arguably all) clinical cases represent responsive solutions to the clients' problems. In this sense, the foregoing section is incomplete, noting only a selection of studies that explicitly addressed responsiveness, omitting case studies that engaged responsiveness implicitly.

Task analysis as a detailed examination of the responsive process. Task analysis combines qualitative and quantitative research strategies into a multi-step research endeavor guided by a specific question, such as "how did the patient manage to do this?" (Rice & Greenberg, 1984; Greenberg, 2007). Its strategy is to select a number of interactions (instances of the task) and then to examine in great detail the responsive dialogue between the client and the therapist. An example of such a task is the resolution of lingering unresolved emotions as a result

of interpersonal trauma. The first step of task analysis is rooted in qualitative analysis (called the discovery phase), aiming at the elaboration of a theoretical model to be tested, the second step uses more traditional hypothesis testing of this theoretical model (the validation phase). Task analysis has been used, for example, to study the step-by-step resolution of initial global emotional distress in experiential psychotherapy (Pascual-Leone, 2009) and the detailed process of attaining interpersonal forgiveness in couple's therapy (Woldarsky Meneses & Greenberg, 2014). The first example of task analytic research yielded in the discovery phase an eight-step sequence between global distress (the initial problematic state) and the experiential acceptance of the emotion (the complete resolution of an emotion episode). The validation phase corroborated this sequence and suggested that the typical productive movement towards emotional resolution in experiential psychotherapy is not linear, but follows a zigzag "two steps forward one step back"-type iterative process. Even though the focus of task resolution might lie within an individual person (i.e., resolution of global distress), it is assumed that the therapist actively contributes to the various steps of the resolution (Pascual-Leone, Greenberg, & Pascual-Leone, 2013). This can be achieved using two methodological pathways: (a) studying the micro-exchanges as task and thus dealing directly with responsiveness (e.g., studying the productive client-therapist exchanges when resolving lingering unresolved emotions; example found in Greenberg & Malcolm, 2002), (b) studying the pre-selected client processes which were impacted by the therapist responsiveness, which is an indirect way of taking into account responsiveness (e.g., studying emotion episodes and describing patterns of emotional change in the client; example found in Pascual-Leone, 2009). Finally, task analysis can be understood as a form of theory-building case studies (Pascual-Leone et al., 2013; see section above) and can be used to unpack responsive processes in therapy.

Evaluative measures of therapy process and of therapist characteristics

Evaluative process measures reflect appropriate responsiveness. Unlike descriptive process variables, such as therapeutic techniques, which therapists can adjust voluntarily, evaluative measures do not assess distinct categories of behavior but rather the product of both therapists and clients doing the right thing at the right time (Stiles & Goldsmith, 2010). That is, evaluations of psychotherapy process reflect appropriate responsiveness by the participants. Conversely, evaluative measures implicitly incorporate responsiveness. A strong therapeutic alliance, for example, can be understood as an achievement, a result of appropriate responsive processes taking place in the interaction between client and therapist (Newman & Stiles, 2006; Stiles & Wolfe, 2006; see the illustration above by Anderson and colleagues, 1999). If therapists and clients do the right thing at the right time, the alliance tends to be strong. If they do not (i.e., if their responsive actions are not so appropriate to the person and circumstances), the alliance tends to be weak.

Evaluative process variables are very popular in psychotherapy research, probably because they correlate with outcome variables. The list of "relationship variables that work" accumulated by the APA Taskforce of empirically supported psychotherapy relationships (Norcross, 2001; Norcross & Wampold, 2011) included mainly evaluative variables: therapeutic alliance, group cohesion, and empathy (demonstrably effective); goal consensus, collaboration and positive regard (probably effective); and congruence/genuineness, successfully repairing alliance ruptures and effectively managing counter-transference (promising). Scale respondents (self-report or external raters) evaluate the strength of the alliance, cohesion, empathy, effective feedback, and other aspects of good process by implicitly judging whether participants were appropriately responsive.

Evaluative measurement is perhaps psychotherapy research's most common approach to engaging the responsiveness problem, and it long predates the Stiles et al. (1998) formulation. On the other hand, the engagement is implicit and imprecise. Building and maintaining a strong alliance entails different behaviors depending on the people and circumstances, so saying that an alliance is strong does not describe participants' specific behaviors. Thus enthusiasm generated by the positive, replicable correlations with outcome should be tempered by the central drawback that evaluative measures do not actually specify the behaviors they measure. They do not yield concrete guidelines about how, when, facing whom, and why to implement a specific intervention.

Therapist competence and skill as appropriate responsiveness. Therapist competence and skill is another evaluative variable that, we suggest, incorporates responsiveness. That is, competence for a therapist includes knowing when to use an intervention and how to deploy it. Ratings of competence and skill are then, in part, judgments about how appropriately responsive the therapist's behavior was: Did he or she do the right thing at the right time? For example, the competence rating scale for supportive-expressive dynamic psychotherapy comprises items like “Therapist and patient work as a team to help the patient with better self-understanding” (Barber & Crits-Christoph, 1996, p. 84). Such items clearly reflect appropriate responsiveness, and, like evaluative process ratings, they fail to specify what the therapist actually does in order to, in this example, work as a team or help the client with better self-understanding.

Explicitly responsive clinical strategies

Every psychotherapy is responsive, insofar as all therapists (and clients) respond to the emerging contingencies at all time scales: during treatment assignment, treatment planning,

forming alliances, choosing interventions, and adjusting tone and timing during the process. In this section, we selectively note a few of the treatments in which responsiveness has been a central and explicit consideration in the design of the intervention (however, other treatments also engage responsiveness; e.g., see Carey, 2011; Mansell, Carey, & Tai, 2012).

Pluralistic therapy as a responsive clinical framework. Partly to address the responsiveness problem at the level of treatement choice, Cooper and McLeod (2007, 2011) proposed a framework they describe as "pluralistic counseling and psychotherapy," which explicitly incorporates responsiveness to client preferences for how the treatment will be conducted. It assumes that features of many therapeutic approaches promote positive outcome but that the relative importance of these features depends on the individual clinical situation. Within this pluralistic framework, McLeod (2012) studied the clients' preferences for one or another therapy and proposed that the design of the treatment can be a collaborative, fundamentally responsive process of therapy, drawing on multiple documented approaches, similar to the negotiation of treatment goals. This responsive elaboration of client preference may contribute to the alliance and outcome in therapy.

Individualizing treatment using Plan Analysis and Plan Formulation: Fostering responsive interventions. Two treatment approaches that have systematized responsiveness at the level of treatment planning are Plan Analysis within the context of Grawe's Psychological Therapy (Caspar, 2007; Grawe, 2004) and Plan Formulation (Silberschatz, 2012, 2013). Both approaches use a systematic and individual-based case formulation method which informs therapist intervention choice. Plan Analysis, developed by Grawe and Caspar (Caspar & Grosse Holtforth, 2009, 2010), allows the analysis of verbal and non-verbal behaviors and experiences from an instrumental perspective. An individualized hypothetical structure of a client's conscious

and non conscious, intrapsychic and interpersonal instrumental strategies is inferred. Based on such a case conceptualization, an individualized, motive-oriented therapeutic relationship is proposed (Caspar, 2007). Problematic client behaviors are traced back to acceptable motives which are then satisfied. Grawe, Caspar and Ambühl (1990) have compared therapies based on such individualized formulations with therapies without and showed that several process variables (e.g., collaboration), and some outcome variables, were better in individualized treatments, compared to treatments without this component. Client predictors at intake presented weaker correlations with outcome in the individualized conditions, which may be interpreted as a demonstration of therapist responsiveness washing out initial client influences on outcome. A study by social psychologists (Thommen, Ammann, & von Cranach, 1988) demonstrated that therapists using individualized treatment planning based on Plan Analysis used more situation-specific information to make a decision for intervention, compared to client-centered therapists who referred to stable norms and interventions styles across situations. Kramer, Berger, Kolly, Marquet, Preisig, de Roten, Despland and Caspar (2011) and Kramer, Rosciano, Pavlovic, Berthoud, Despland, de Roten and Caspar (2011) showed links between the individualized motive-oriented therapist intervention variable, when taking into account the client's idiosyncrasy, and symptom change in clients with personality disorders. In a randomized controlled trial for a short-term treatment for borderline personality disorder, Kramer, Flückiger, Kolly, Caspar, Marquet, Despland and de Roten (2014) have demonstrated that the alliance-outcome link was greater for treatments that included the individualized motive-oriented relationship and intervention principles, compared to treatments that did not explicitly include them. Within the context of Grawe's model, activation of individually defined client resources, together with other mechanisms of change such as the activation in the process of the presenting

problem are explicitly fostered. Flückiger and Grosse Holtforth (2008) have demonstrated that therapies in which the therapists systematically paid attention to individual resources and activate them in the therapy process had better outcome and process characteristics, such as clients' experiences of attachment and mastery, compared to treatments without this resource-component (see also Gassmann & Grawe, 2006).

The Plan Formulation method is a similar way of individualizing intervention, which predates the Stiles et al. (1998) formulation of the responsiveness problem (Silberschatz, 2013; Weiss, 1993). For example, Silberschatz, Fretter, and Curtis (1986) categorized therapist interpretations in three cases of brief psychodynamic psychotherapy as transference versus non-transference and rated them for suitability with respect to the client's Plan. In each case, suitability of the interpretation correlated significantly and positively with client productivity (rated using the Experiencing Scale; Klein, Mathieu-Couglan, & Kiesler, 1986).), whereas type of interpretation did not. In a more recent study, Silberschatz (2012) similarly showed that adjusting treatment to the individual client predicted outcome.

Individualizing therapy using a case formulation method operationalizes the responsiveness problem and guides the responsive interaction between client and therapist. Client and therapist contributions to process and outcome are conceptualized from an idiographic perspective. The clinical purpose is to give clinicians concrete guidelines on how to optimize therapy by tailoring responsive interventions.

Marker-guided interventions: Moment-by-moment responsiveness. Marker-guided treatments focus on responsiveness within the client-therapist interaction. Markers are recognizable categories of events in the client process, such as a *self-evaluative split* (a seeming

division between two parts of the client's experience, the experiencing part and a separate internal "voice" that evaluates the experiencing part). Marker-guided interventions thus emphasize significant and productive moments in the therapy process that emerge in and through the dialogue between the client and the therapist. The approach specifies markers that may be opportunities for particular sorts of therapist responses to be effective. The treatment design thus describes types of emerging contingencies and types of effective responses to them (see also Knobloch-Fedders et al., in press).

Rice and Greenberg (1984) defined the moment of marker appearance as when the client enters a problem space at that moment, that is, a therapeutic space where the problem is activated and therefore asks for a resolution. The latter may obey by generic rules and laws, to be discovered by systematic analysis of the problem space, using task analysis (see above). Greenberg (2002) and others have developed emotion-focused therapy (EFT) which identified a number of such process markers, each with an associated resolution model that includes step-by-step interventions from the moment of the marker appearance to the complete resolution of the associated task. For example, lingering unresolved feelings in the context of unfinished business with a significant other may be resolved by proposing to the client a form of Gestalt-therapy based two-chair dialogue, with a series of very specific steps to be accomplished along the way by both the therapist and the client. Also, EFT deconstructs the global relational constructs of empathy and working alliance in specific responsive terms, by analyzing working alliance as a task with multiple stages (Elliott, Watson, Goldman, & Greenberg, 2004).

Constantino, Boswell, Bernecker and Castonguay (2013) applied marker-based intervention theory to integrative therapy and identified five relevant markers to be attended to by specific therapist responses: client's low expectations of outcome, high levels of change

motivation, important self-strivings, symptom progression within an identified "red" domain (i.e., manifested by no change or deterioriation) and rupture of the therapeutic alliance.

Training in the therapeutic alliance as a responsive process. Formally training therapists to build and maintain an effective therapeutic alliance helps the trainers to make explicit some of the responsiveness which goes into the evaluative measures described previously. After observing that ruptures in the therapeutic alliance are particular opportunities for responsive interventions, a model of the resolution of such alliance ruptures was developed and tested. Safran, Muran, Demaria, Boutwell, Eubanks-Carter and Winston (2014) designed a program of therapist training in negotiating the therapeutic alliance and showed in a study that this training yielded an increase in therapist experiencing and enhanced attendance to inner feelings. Therapist attendance to inner feelings might be an important mediator of processes and outcome in psychotherapy. A similar study focusing on the effects of alliance-fostering training for therapists demonstrated moderate to large increases in the alliance pre- to posttraining, however with only small changes in client’s symptoms (Crits-Christoph, Connolly Gibbons, Crits-Christoph, Narducci, Schamberger, & Gallop, 2006).

Despite somewhat mixed findings related to alliance-fostering training for psychotherapy, it seems sensible to train therapists in their perception and handling of alliance difficulties and ruptures. Such a specific training focus contributes explicitly to a responsive intervention style, by focusing on the alliance.

Providing feed-back as a responsive process. Studies by Lambert (2010) have engaged the responsiveness problem from a global perspective, by explicitly feeding back information on the client state and symptoms in case of predicted deterioration to the therapist. It has been

demonstrated that therapies in which such feedback-loops were incorporated presented a reduced deterioration rate (by 20%), compared to therapies without such explicit feed-back loops (Shimokawa, Lambert, & Smart, 2010).

Extension of responsiveness concepts to related domains

Responsive e-therapy. A particularly modern chapter of engagement with the responsiveness problems represents responsive e-therapy (i.e., internet therapy). In two studies, Richards and colleagues (Richards & Timulak, 2012; Richards, Timulak, & Hevey, 2013) have demonstrated how therapist responsiveness is possible within the context of e-therapy. In a comparison between classical CBT-based e-therapy and a therapist-delivered CBT-based e-therapy (i.e., including client-tailored interventions), the authors showed advantages for the threapist-delivered e-therapy on client-reported measures related to helpful events in therapy. Several other e-therapy programs have "responsive" components where therapeutic dialogues are tailored to the client utterances (for example Meyer, Berger, Caspar, Beevers, Andersson, & Weiss, 2009).

Responsiveness in clinical supervision. Friedlander (2012) suggested that appropriate therapist responsiveness may be mirrored in the supervisor's responsiveness. Supervisor responsiveness describes the accurate attunement to the supervisee's moment-by-moment needs in terms of guidance for specific skills or knowledge (concerning a particular client). It may involve explicitly teaching responsive interventions to supervisees. Caspar (1997) has outlined ideal conditions for psychotherapy training and has described process monitoring as a clinical tool fostering responsive feed-back loops in the training process.

Responsiveness as tool to increase civility at the workplace. Finally, Osatuke, Moore,

Ward, Dyrenforth and Belton (2009) engaged with the responsiveness problem to understand an organization troubled by lack of civility in the workplace. These authors argued that responsiveness within the intervention overrides intervention-outcome links not only in psychotherapy, but also in organizational development. Specific interventions may be designed to increase civility, that is, to foster interpersonal respect in the workplace, but it is the responsive implementation, taking into account individuals' moment-by-moment requirements that makes these specific interventions so powerful. Efficacy is attributed to the "extreme flexibility" (p. 401) of the intervention.

Conclusions: "What Works?" Won't Work, But "How Does It Work?" Will

We have reviewed several ways that investigators have engaged with the responsiveness problem: demonstrating the phenomenon of responsiveness, describing responsiveness quantitatively, describing it qualitatively, incorporating it in evaluative measures, incorporating it explicitly in interventions, and extending understanding of it gained in psychotherapy to nearby domains. We have identified three generic dimensions underlying solutions to the responsiveness problem: a) the nature of the methodology (qualitative vs quantitative), b) the quality of the variable (evaluative vs descriptive), and c) the nature of the characterization (generic vs idiographic). Various combinations of the latter result in creative solutions to the responsiveness problem. None of these approaches, however, directly addresses the "what works?" question that has been central to a generation of comparative outcome and process-outcome researchers. As one way to put it, the responsiveness critique is that a psychotherapeutic intervention (the "what") is not a coherent entity but a fluid, adaptive process that stands in the way of the straightforward answers everyone would like.

Responsiveness appears in the present review as an underlying principle of human interaction that characterizes all psychotherapy approaches. We suggest that it may be an fruitful avenue of reflection for scholars and researchers interested in psychotherapy integration. Reviewed solutions to the responsiveness problem cut across theories of pathology and intervention and extend to internet therapy, psychotherapy training and other domains where human interaction is at the core.

Responsiveness is relevant across approaches and settings.Although it is a problem for researchers, it is a core operating principle for clinicians. The responsiveness problem might help researchers to engage in fruitful dialogues with clinicians to identify new research designs that are relevant for clinical practice.

Our review shows numerous ways that the phenomenon of responsiveness can be unpacked, its details observed, and its mechanisms explained. In acknowledging the responsive nature of its object of study, psychotherapy research may have reached a new stage of maturity addressing solveable research puzzles with increasingly sophisticated methods (Knobloch-Fedders et al., in press), working toward consensual principles. Human responsiveness may be a candidate for such a principle.

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