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Novice Therapist Responsiveness: Description and Development

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NOVICE THERAPIST RESPONSIVENESS: DESCRIPTION AND DEVELOPMENT

A Dissertation Presented

by

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ABSTRACT

NOVICE THERAPIST RESPONSIVENESS: DESCRIPTION AND DEVELOPMENT

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There is increasing empirical evidence that psychotherapy is very effective when therapists tailor interventions in ways that fit their clients' difficulties and needs (Kramer, 2009; Snyder & Silberschatz, 2017), a concept that has been named "therapist responsiveness" in the psychotherapy literature (Bacal, 1985; Stiles, Honos-Webb, & Surko, 1998). However, the question of how therapists learn to be responsive rarely has been addressed in research (Hatcher, 2015). The central question of this study was, "How did you learn how to be responsive to clients as a novice therapist, and in what ways are you responsive?" Eleven graduate student therapist trainees were recruited. Phone interviews were conducted in a semi-structured style to ask novice therapists from clinical and counseling psychology Masters-level and doctoral programs to describe their experiences. A grounded-theory approach was used to create themes from the qualitative data. The analysis showed that trainees learned to improve their responsiveness to clients by: (1) becoming more aware of cues related to psychotherapy processes, in client-therapist dynamics, and clients' identities and contexts; (2) managing their own emotions

and engaging in self-care; and (3) adopting mindsets that facilitated trying new relational or therapy approaches while also considering professional boundaries. The implications of these findings to help training programs improve teaching about responsiveness and optimize supports for trainees' providing responsive treatment were discussed.

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CHAPTER 1

INTRODUCTION

Researchers have described therapist effects as "an ignored but critical factor" in psychotherapy research (Wampold & Imel, 2015, p. 158). However, meta-analytic research about therapy outcome has found that therapist effects account for 5% of the variance in client outcome (Baldwin & Imel, 2013). This amount is considerable, especially when recognizing that therapy orientation effects have been estimated to account for about 1% of variance in client outcome (Laska, Gurman, & Wampold, 2014). One line of investigation to explore therapist effects has been the study of therapist responsiveness. The use of the term "responsiveness" in this study refers to adjustments by the therapist to better fit clients' needs, which can range from subtle shifts, such as modifying communication style, and more explicit changes, such as using different therapy approaches. In the literature, Bacal (1985) defined therapist responsiveness as a therapist's ability to understand a client's concerns, and then to convey this understanding through an optimal response by choosing specific treatments, interventions, or other actions. Optimal responses depended on the client's context, and Stiles, Honos-Webb, and Surko (1998) proposed that therapists may demonstrate *responsiveness to* a client's age, gender, ethnicity, socioeconomic status, diagnosis, or

personality. Responsiveness has increasingly become a focal point in psychotherapy research (Hatcher, 2015; Kramer & Stiles, 2015), and was the focus of this study.

Greater interest in therapist responsiveness arose when researchers proposed that responsiveness influenced the findings of randomized controlled trials and outcome research. There was a concern that therapists would "inject unpredictable irregularities" (Kramer & Stiles, 2015, p. 278) into randomized controlled trials by not providing homogenous treatment. This would mean that treatment names, such as cognitive-behavioral therapy (CBT), have no stable meaning, because clients receive individually tailored treatments that incorporate elements of other approaches (Stiles, 2013). Therefore, it would be difficult to conclude that one treatment (such as CBT) is more efficacious than another. Indeed, several studies have demonstrated that even in randomized controlled trials, treatments being provided also contained techniques from prototypes of other therapy approaches (Ablon & Jones, 1998, 2002; Ablon, Levy, & Katzenstein, 2006). For example, therapists who used an interpersonal approach included elements of cognitive-behavioral therapy in their treatment for depression, perhaps because therapists were being responsive to their patients' needs for more directiveness on ways to institute changes (Ablon & Jones, 2002). Furthermore, researchers have suggested that responsiveness may explain the lack of consistent links between theoretically important therapy process components, such as interpretations, and positive therapy outcome (Stiles, 1988; Stiles et al., 1998). For example, a study might find that the correlation of frequency of interpretations and symptom change is negative, even if

interpretations are an effective ingredient of the therapy process (Stiles, 2013). This correlation would be misleading because it does not take into account how therapists may use fewer interpretations with clients who display high insight capacities when compared to clients with low insight capacities. Researchers have discussed how this responsiveness is inherent in therapy because clinicians draw on techniques and interventions from various approaches based on their perceptions of what their clients need (Ablon et al., 2006). Therefore, psychotherapy research would benefit from more studies about how treatment is adapted and implemented responsively by therapists.

Existing research has explored more general moment-to-moment ways in which psychotherapists are responsive to their clients, beyond changing one's theoretical approach. One way is by selecting and delivering interventions based on clients' characteristics, such as clients' level of emotional engagement and self-awareness (Bacal, 2007; Edwards, 2010; Hardy et al., 1999). For example, therapists have been found to demonstrate responsiveness by focusing on providing interpretations when clients can recognize their own interpersonal styles (Connolly Gibbons, Crits-Christoph, Levinson, & Barber, 2003; Daly & Mallinckrodt, 2009; Lee & Horvath, 2014). Therapists also can be responsive by increasing eye contact if there is a perceived client need for attentional support, or by inferring unexpressed feelings to facilitate detached clients' emotional expression (Elkin et al., 2014). Further examples of responsive therapist behaviors was reviewed later in this introduction.

One area that still needs more investigation is novice therapists' beliefs about whether they provide responsive treatment, because much of what has been written about responsiveness has been based upon research on experienced therapists (e.g., Levitt & Williams, 2010; Daly & Mallinckrodt, 2009). There has been evidence that novice therapists have more difficulties than experienced therapists in being responsive to clients' words or nonverbal behavior. In one study, trainees were shown to have difficulty planning appropriate responses when challenged by hypothetical provocative statements by clients (Lutwak, 1993). In another study, novice therapists only responded to an average of 5% of clients' statements about the nature of the therapeutic relationship in psychotherapy sessions, whereas experienced therapists responded to an average of 57% of these statements (Church, 1993). Instead of addressing these client statements directly, novices changed the topic, transformed the negative tone of the statements to a positive tone, or became defensive. After these missed opportunities, clients appeared to become more frustrated and even hostile, which seemed to impede the development of trust within the therapeutic relationship. Other research has shown expert therapists often made inferences or abstract comments about the meanings underlying clients' nonverbal behavior, but novice therapists' comments focused on the precise words or nonverbal actions of the clients (Cicchetti & Ornston, 1976).

This body of research provided evidence that when compared to experts, novice therapists more often miss opportunities to be responsive. However, the question of how to enhance the learning of responsiveness barely has been addressed in research (Hatcher,

2015). Investigating the learning process of trainees may yield insights about how to improve the responsiveness of therapists.

The purpose of this study was to examine how novice therapists describe their experiences of learning to be responsive to clients, particularly focusing on features they believe warrant responsiveness, obstacles and supports to becoming responsive, and how they think that they develop responsiveness skills. In the following sections, quantitative and qualitative research that captures the construct of responsiveness was reviewed. Following that, research on the training of novice therapists, obstacles to novices' learning and applying responsiveness, and effects of learning responsiveness was summarized.

What is Therapist Responsiveness?

Psychotherapists have long recognized the principle of adjusting and selecting interventions according to clients' needs. Freud (1912) wrote about how therapists manage their clients' discomfort when unconscious emotional impulses are brought into conscious awareness. Through a process of "optimal frustration" (Kohut & Seitz, 1963), therapists keep their clients' discomfort at tolerable levels, yet refuse to gratify their unhealthy impulses, in order to promote the development of healthy ego. Bacal (1985) relabeled this process as "optimal responsiveness" (p. 216), noting that therapists want their clients to engage in difficult work, but do not intend to frustrate them to the point that they disengage. Therapists seek to understand clients' concerns and then use a variety of verbal or nonverbal responses to facilitate continued engagement in the work.

Responses may include empathic listening, interpretations, or direct challenges; the type of response that could be considered "optimally responsive" would depend on their clients' developmental capacity and relational needs at the moment. Stiles et al. (1998) conceptualized responsiveness in greater detail by naming additional characteristics to consider. Their definition consisted of *responsiveness to* a client's age, gender, ethnicity, socioeconomic status, diagnosis, or personality, followed by *responsiveness with* specific treatments, interventions, or other actions. In other words, "a therapist responds *to* some client characteristic *with* some intervention" (p. 440). By closely examining therapists' interventions with quantitative and qualitative methods, researchers have described how therapists make adjustments in these ways.

Examining Therapist Responsiveness

In this section, research was presented that described the ways that responsive therapists adjusted their treatment. Recently-developed preliminary measures of therapist responsiveness also were detailed, providing early answers to how to measure responsive behaviors.

Attachment style. Responsive therapists have been shown to modify their treatment according to their clients' characteristics, such as client attachment style. For instance, researchers (Hardy et al., 1999) examined helpful events during interpersonal therapy for 16 professional and managerial employees, diagnosed with major depressive disorder. They showed that therapists delivered primarily interpretations of relational patterns to clients with a dismissing style, believing that these underinvolved clients

would benefit from active therapist interventions. In contrast, therapists focused on reflections for clients with a preoccupied style, to provide acceptance and holding. Other researchers also have found that when treating clients with an anxious and avoidant style, therapists often responded to their clients' needs for closeness and security by providing reassurance or self-disclosure (Daly & Mallinckrodt, 2009; Hardy et al., 1999; Huang, Hill, & Gelso, 2013). In those studies, as clients felt more secure in therapy, they often developed new skills, necessitating therapists' adjusting their interventions to facilitate continued growth. When their clients started to initiate discussions about interpersonal interactions and used language filled with rich imagery and emotion, therapists were found to respond by providing more interpretations or challenges, recognizing their clients' readiness to deeply explore potentially maladaptive cognitive or behavioral patterns (Daly & Mallinckrodt, 2009; Levitt & Williams, 2010; Muntigl, Knight, Horvath, & Watkins, 2012; Timulák & McElvaney, 2013).

Symptoms and diagnosis. Therapists also may respond to their clients' diagnoses with tailored approaches and interventions targeting their clients' needs. For example, researchers have shown that for clients who rate higher on depressive symptoms, therapists tend to focus on validation and used more active interventions such as clarifications and questions (Connolly Gibbons et al., 2003; Fosha, 2004; Honos-Webb & Stiles, 2002). These therapist responses were determined through therapist self-report or coding of therapist statements by research assistants, and the researchers discussed how

these active interventions seemed designed to stimulate clients with greater depressive symptoms to deeply engage in exploring the details of their life experiences.

For clients with PTSD, case studies (Edwards, 2010; Lord, 2008) showed how therapists often began treatment by helping clients to articulate their fears of burdening their therapists with their pain. Therapists talked about how a gentler narrative approach, with a low focus on emotions, usually was employed to encourage clients to talk about their traumatic memories in a way that felt safe. However, over time, if re-experiencing symptoms persisted and a gentler approach did not seem effective, therapists sometimes took risks in moving to reliving traumatic memories to try to resolve symptoms more rapidly.

In a review of therapists' treatment of clients at a psychiatric hospital who engaged in self-cutting behavior, Doctors (1999) noted the common theme of the importance of therapists' use of validating statements to acknowledge painful emotions, and then to respond to implied, non-concrete meanings of the cutting behavior, often related to loss or fear of abandonment. Therapists' attempts to control the symptom presented the risk of interpersonal conflict that could be traumatizing.

In these examples, validation and exploration were common interventions, and yet they were tailored to the specific concerns and needs that often are associated with these particular diagnoses. The psychopathology literature is replete with examples of treatments being adapted for specific diagnoses (for more case examples, see Sperry, Carlson, Sauerheber, & Sperry, 2015).

Culture. In addition to diagnosis, therapists have been shown to modify their treatment according to clients' cultural characteristics, such as racial identity and socioeconomic status (Bernal & Sáez-Santiago, 2006; Falconnier & Elkin, 2008; Huey & Pan, 2006; Pan, Huey, & Hernandez, 2011; Thompson, Cole, & Nitzarim, 2012). Commonly, cultural adaptions of therapy involved explicitly including cultural values in treatment, and they have been shown to have an overall positive effect (for a meta-analytic review, see Griner & Smith, 2006). For example, in a theoretical paper, Bernal and Sáez-Santiago (2006) suggested that in culturally responsive therapy for Latino/a clients, therapists could recognize that clients may try to invite their therapists to socialize with them and their family, reflecting the cultural value of *personalismo*. Anticipating this expectation, therapists could let their clients know the limitations of their role, in order to avoid unfulfilled expectations. An empirical example of how to incorporate culture-specific values in treatment effectively was described in studies comparing standard treatment to culturally-adapted treatment for Asian Americans (Huey & Pan, 2006; Pan et al., 2011). 15 clients for this study were recruited from undergraduate courses, and each client met diagnostic criteria for simple phobia. The cultural adaptations included greater emphasis on confidentiality, development of emotional control, and increased therapist directiveness, consistent with common Asian values and contemporary research on East Asian populations (Pan et al., 2011). Culturally-adapted treatment was found to be more effective than standard treatment in reducing fear and avoidance.

Another area of consideration for therapists to be responsive would be economic concerns such as clients' finances, work, or unemployment. Thompson et al. (2012) conducted a qualitative study with 16 low-income clients, and participants reported appreciation of therapists who could connect their concerns related to finances, disability insurance, and housing to their presenting problems such as low self-esteem. Inquiring about potential stigma that the client suffered in their life experience also was seen as helpful. Clients found therapists unhelpful when they seemingly made no effort to acknowledge or thoughtfully address social class. Status differences were not upsetting in isolation, but clients felt most respected and connected when these differences were addressed through conversations initiated by the therapist. Falconnier and Elkin (2008) found evidence that better scores on therapist approach measures for economic concerns were associated with fewer depression symptoms or better functioning at termination, even across different socioeconomic groups.

Therapists' behaviors. Taking a broader approach, two scales have been put forward to assess responsive treatment (Elkin et al., 2014; Snyder & Silberschatz, 2017). Elkin et al. (2014) proposed a list of general therapist behaviors that could be considered responsive, which resulted in the development of a preliminary scale to measure therapist responsiveness. The authors' measure reflected their definition that responsive therapists need to be attentive, respectfully acknowledge and understand their clients' current concerns, and then take action specifically to facilitate client engagement. Client engagement was operationally defined as a higher client-rated working alliance and (lack

of) early termination. In the application of this scale, research assistants observed videotapes of the first two sessions of therapy and rated therapists' verbal and nonverbal behavior in treatment.

Elkin et al.'s (2014) scale had three parts: two subscales (on therapists' behaviors, and their style) and one single-item measure (a general impression of responsiveness). Scores for the measure were rated by independent external raters. The first subscale included eight positive items, including the observed therapists' behaviors of making inferences regarding unexpressed content or feelings, and making affirming, validating, normalizing, and/or optimistic statements. Several negative items also were included, including lecturing the client or making countering remarks. To assign ratings using this first subscale, research assistants watched for the occurrence of these specific positive or negative therapist behaviors in 5-minute segments of the therapy videotapes. The second subscale assessed specific aspects of the therapists' responsiveness, such as therapists' having an appropriate level of emotional intensity, providing single ratings for each aspect across the entire session. Scores for each item on these two subscales were submitted to a principal axis factor analysis that identified four factors: attentiveness, early empathic responding, negative therapist behavior, and positive therapeutic atmosphere. Finally, the scale included an individual global item that attempted to tap into raters' impression of therapist responsiveness for the entire session. Regression analyses showed that higher ratings in quality of the therapeutic alliance and (fewer instances of) early termination were predicted by the factor of global positive therapeutic

atmosphere and the single-item measure of responsiveness. Greater occurrence of negative therapist behaviors predicted more cases of early termination. The results for the other factors (such as moment-to-moment attentiveness) did not have a significant relationship with the engagement variables, perhaps indicating that general positive therapeutic atmosphere, including an overall conveying of care and respect, may be more easily remembered by clients than moment-to-moment actions. In addition, Elkin et al.'s research had some limitations to consider. Their research could be built upon by measuring therapist behaviors beyond the first two sessions, and by recruiting clients with more diverse presentations; all clients in their study were included because they were experiencing a current episode of Major Depressive Disorder.

Snyder and Silberschatz (2017) developed the Patient's Experience of Attunement and Responsiveness (PEAR) Scale to assess (from both clients' and therapists' perspectives) the extent to which therapists were perceived to be helpful overall, empathic, and supportive of clients' goals in session. The client-rated scores, measured after sessions, were found to be moderately correlated with improved treatment outcome, as well as clients' overall sense of psychological and emotional well-being. For therapist-related scores, the ratings of whether the therapists thought that their clients felt safe and accepted were significantly correlated with improved treatment outcome. This research was limited by a smaller sample size (38 therapist-client dyads) with assessments at varied points in the course of therapy. Overall, these promising measures may advance research on therapist responsiveness.

In summary, these studies emphasized that therapist responsiveness is shown when therapists adjust their interventions according to their clients' characteristics, skills, and readiness to address problems. Aspects such as therapists' conducting their sessions at an appropriate emotional intensity and avoiding negative behaviors also were found through Elkin et al.'s (2014) scale as ways to show responsiveness that were meaningfully related to clients' early termination. However, all of these studies, and indeed, most of the extant literature, focused on experienced therapists. The next section will review the few studies that included novice therapists, as well as studies that discuss to what sources trainees attribute their improvements in using and adjusting techniques. While many of these studies did not precisely address responsiveness, they suggested areas for further investigation.

Processes for Training Responsiveness

Several studies have supported the idea that responsiveness can be developed during psychotherapy training, through the processes of developing technical skills (Hill et al., 2015), learning from a supervisor (Friedlander, 2012; 2015), and completing coursework (Orlinsky & Rønnestad, 2005). This section will review research on how training helps novices develop technical skills and apply those skills responsively.

Development of basic technical skills. Several researchers have demonstrated that trainees tend to naturally provide empathy (even perhaps overemphasizing it), then learn exploration skills, and gradually become more comfortable in challenging or providing interpretations for clients (Dennhag & Ybrandt, 2013; Hill et al., 2015; Hill,

Sullivan, Knox, & Schlosser, 2007; Jacobsson, Lindgren, & Hau, 2012). In qualitative research, novices have reported that after training, they could better understand clients' emerging emotions and needs, facilitate specific emerging insights, and explore tacit meaning and non-verbal cues (Pascual-Leone, Rodriguez-Rubio, & Metler, 2013). In a quantitative meta-analysis of 14 studies, Hill and Lent (2006) found that helping skills training programs were effective for increasing the use of empathy or exploration skills (e.g., reflections, open questions, restatements). After one or two years of training, beginning therapists showed gains in using clinical skills such as reflection of feelings, open questions, interpretation, and challenge, and the ability to be flexible in their use of these skills. Overall, there is positive evidence for the effectiveness of psychotherapy training programs in teaching broad technical skills and using these skills responsively by understanding clients' emerging needs and non-verbal cues.

Supervision. Researchers have proposed that trainees learn responsiveness through supervisors' instruction about their trainees' clients and by modeling responsiveness to their trainees' needs (Friedlander, 2012, 2015; Hill et al., 2015). For example, supervisors said that they have discussed with trainees how too much support of their clients in session may be seen as "cheerleading", and too little may be seen as too distant and clinical (Friedlander, 2012). Supervisors talked about how they have aided their trainees in modulating their level of support according to their clients' moment-to-moment needs. With regards to clients' shifting presentations, Edwards (2010) described how, with supervision, novice therapists could be guided to make adjustments to their

interventions based on their clients' level of symptomology as well as degree to which clients were emotionally engaged in session. Additionally, novices have reported that supervisors have modeled responsiveness directly in the supervisory relationship. For example, research has found that supervisors responded to trainees' affect by becoming more directive and supportive when trainees presented with anxiety because their clients are experiencing crises (Hill et al., 2015). In other situations, supervisors reportedly allowed trainees to struggle with processing clients' difficult clinical issues, instead of offering immediate solutions, which modeled for trainees the value of sitting in silence with clients who are struggling with a problem emotionally.

Coursework, presentations, and case studies. Instruction through classwork, watching video recordings of their provision of therapy, and receiving feedback from instructors were listed by novice therapists as helpful for understanding the application of therapy skills (Aladağ, Yaka, & Koç, 2014; Hill et al., 2015; Orlinsky & Rønnestad, 2005). In addition, researchers argued for case studies and presentations to be integrated into psychotherapy training in an organized way, because they provide opportunities for novice therapists to learn more about therapy process (Mackrill & Iwakabe, 2013). Reading, listening to, watching, or discussing case presentations allowed novices to learn about diverse cases without having the direct experience.

These studies have indicated sources for learning responsiveness, such as supervision, presenting cases, and coursework. Despite these supports, trainees have been found to experience anxiety, self-criticism, and other obstacles that hinder their ability to

be responsive to clients (Aladağ et al., 2014; Kannan & Levitt, 2015; Rønnestad & Orlinsky, 2005; Skovholt & Rønnestad, 2003). In the next section, these obstacles to responsiveness, and the negative behaviors that may result, are discussed.

Obstacles to Practicing Responsiveness

Researchers have suggested that trainees may find it difficult to be responsive to clients because they feel "flooded with impressions, images, feelings, ideas, worries, and hopes" (Skovholt & Rønnestad, 2003, p. 49). Additionally, novices may focus too much on their own sense of comfort or appearing competent, which could inhibit their ability to meet their clients' needs (Zeddies, 1999). Several studies indeed have shown that developing therapists experienced more anxiety and defensiveness than expert therapists, and these reactions resulted in behaviors that impeded responsiveness.

Anxiety. Researchers have demonstrated that therapist trainees experience strong anxiety (Aladağ et al., 2014; Hill et al., 2007; Skovholt & Rønnestad, 2003), and that self-reported in-session anxiety was higher for novices than for expert therapists (Rønnestad & Orlinsky, 2005). Beginning therapists reported worries about being "too sympathetic" and allowing clients to complain for whole sessions, about not being able to help clients delve into more substantive self-disclosure, or about pushing "too hard" at times (Hill et al., 2007). Anxious thoughts named by trainees included: "Should I have said that? Or should I have said something more?" Anxiety may distract trainees, leading to rumination, self-criticism, and doubts about how to direct clients, which has been empirically linked to decreased ability to concentrate on their clients in session and

persistent self-doubt about their clinical skills (Kannan & Levitt, 2015; Skovholt & Rønnestad, 2003). Anxious feelings may be followed by unresponsive behaviors in treatment.

Unresponsive therapist behaviors. Research has shown that novice therapists had trouble processing difficult situations with clients, reacting with defensiveness to therapists' poor interventions and frustrations about client resistance rather than being responsive to their clients (Church, 1993; Williams, Judge, Hill, & Hoffman, 1997). In one study, supervisors noted negative behaviors by trainees, including being overactive, shaken, or distant; offering opinions too much; and breaking silence with questions (Williams et al., 1997). In another study, novice therapists, when compared with experienced therapists, more frequently had negative reactions, even defensive ones, when their clients made indirect or direct references to the therapeutic relationship (Church, 1993). Therapists in this study changed the topic, transformed the negative tone of the statements to a positive one, or became defensive. The author suggested that novices may have felt threatened by their clients' statements.

Despite trainees' initial struggles, research has demonstrated that they improved over time in overcoming these obstacles. After training, novice therapists rated themselves higher in confidence when providing therapy and in effective management of their anxiety in sessions (Hill et al., 2015). They expressed that because they were less distracted by their own anxieties, more present in the therapy room, and focused more on the client.

All in all, the previous sections reviewed how beginning therapists have learned responsiveness skills, from the perspectives of trainees themselves, as well as their supervisors. Obstacles to providing responsive treatment and reports of non-responsive treatment also were summarized. These topics mirrored the research questions of this study.

Purpose of the Study

The overarching goal of this qualitative study was to expand the understanding of therapist responsiveness as it pertains to novice therapists. The central question of this study was, "How did you learn how to be responsive to clients as a novice therapist, and in what ways are you responsive?" Specific areas of interest were: (1) what novice therapists know and how they think about the construct of therapist responsiveness; (2) features they believe warrant responsiveness; (3) sources for learning responsiveness across training; and (4) what trainees believe gets in the way or helps them to be optimally responsive. Novice therapists were interviewed, instead of supervisors, because trainees can provide more information than can their supervisors on in-session experiences with clients, on novices' specific behaviors, as well as on their internal thought processes. This study provided a foundation to allow programs to develop a responsiveness-centered training curriculum.

CHAPTER 2

METHOD

Participants

Researcher. In the reporting of qualitative research, it is typical for investigators to provide information about their preconceived beliefs. Having transparency can help readers have a better perspective of the researchers' lens while performing the study. The primary investigator was a University of Massachusetts Boston graduate student, who identified as Asian-American. He conducted an extensive literature review on the subject of therapist responsiveness and had 2.5 years of clinical experience, and from those experiences, he expected that features such as clients' symptoms, diagnosis, and culture would be features that warrant responsiveness. Additionally, based on those experiences, he believed that supervision and increased experience with clients would be cited as main sources of influence during novices' training, and that anxiety and self-doubt would be discussed as primary obstacles to being responsive to clients. To reduce the influence of such expectations, the interview protocol relied upon open-ended questions, to avoid prompting toward the expected answers. Follow-up questions about specific topics only occurred after the open-ended questions were asked. All interviews were transcribed by the primary investigator. The investigator identified himself primarily as a humanistic, cognitive-behavioral psychotherapist.

Participants. Eleven graduate student therapist trainees were interviewed for this study, and this number was determined by the saturation of the analysis. They included seven trainees in clinical psychology doctoral programs and two trainees in counseling psychology doctoral programs from across the United States. Additionally, one trainee was in a Clinical Neuropsychology doctoral program and one trainee was just starting her Counseling Psychology doctoral program, but had attained a Masters Degree in counseling. Participants were between the ages of 25 and 34 years old (Mean = 28.55, *SD* = 3.30). Trainees ranged from a minimum of one full year of supervised clinical experience (with 40 direct contact hours) and a maximum of six years of supervised clinical experience in graduate school (2,117 direct contact hours). Most of the trainees were female (63.6%; men = 36.4%) and White (*n* = 7). Other races represented by participants were Latina (*n* = 1), Asian (*n* = 1), Asian-Latino (*n* = 1), and White-Middle Eastern (*n* = 1). The estimated number of supervision hours that trainees had received ranged from 36 to 641 hours. When asked about theoretical orientations, participants listed the following orientations as being among their most influential so far in their training: cognitive-behavioral (*n* = 7), psychodynamic/interpersonal (*n* = 5), dialectical behavioral therapy (*n* = 3), humanistic (*n* = 3), and multicultural (*n* = 3).

Procedure

Recruitment. Prospective participants were recruited by e-mail, posting on psychological association and psychology graduate student listservs, meeting at psychological research conferences, and through a snowball sampling technique of

participants suggesting other potential contacts for interviews. Participants were informed that their identities would be anonymized for the supervisor and other members of the dissertation committee, with the exception that anonymity with the primary supervisor may be breached if concerns about professional reporting arose, and then the appropriate responders may be involved too. Participants were instructed to avoid disclosure of information about clients' identities as well as information about therapy clients who were actively in crisis (clients' active suicidality, active homicidality, abuse). Theoretical sampling (Glaser & Strauss, 1967) was used to gather a range of participants (see Appendix A for Demographic Form). Glaser (1978) defined theoretical sampling as the process of data collection in which the researchers seek to recruit participants who can provide data from different perspectives and who can usefully add to the understanding of the theory in development. For this study, some diversity in the following areas was sought: (1) theoretical orientation; (2) years of supervised experience providing psychotherapy (at least one full year, with maximum of six years within graduate school); (3) ethnicity; (4) gender; (5) graduate schools (more than one location); (6) type of program (clinical, counseling); and (7) type of degree (MA, PhD, PsyD). Complete representation across all of these areas did not occur. When making decisions about which types of diversity to prioritize, diversity across these four central theoretical orientations was seen as centrally important: Psychodynamic/interpersonal, cognitive-behavioral therapy, humanistic/existential, and multicultural/feminist.

Retrospective recall interviews. The primary investigator conducted all of the interviews. Interviews were semi-structured in format and conducted in an exploratory style of interaction, utilizing open-ended and non-directive questions to limit biasing the opinions and responses of the participants. All interviews were approximately one hour long and conducted over the phone. The interviews were recorded and later transcribed. The overarching question of the interview was: "How did you learn how to be responsive to clients as a novice therapist, and in what ways are you responsive?" The protocol questions clustered around six foci: 1) "Defining the Process", which asked about how participants described the process of being responsive to a client; 2) "Features that Warrant Responsiveness", which asked the participants whether there were any client factors to which they seek to be particularly responsive; 3) "Sources for the Learning of Responsiveness", in which the participants were encouraged to think about how they learned to be more responsive; 4) "Supports and Obstacles", which prompted participants to talk about factors that got in the way of being responsive to clients, and how therapist trainees overcame these obstacles; and 5) credibility questions, as participants were directed to give the interviewer feedback on the interview process (see Appendix B).

Saturation. Data was gathered to the point of saturation, the point at which new data appeared to be redundant and failed to lead to new categories in the hierarchy. Saturation can be seen as enhancing generalizability or external validity. To obtain saturation is to suggest that the model constructed can be considered a fair representation of the experiences of novice therapists as a group.

Analysis

Grounded theory analysis. The data was analyzed using a version of grounded theory analysis (Glaser & Strauss, 1967) developed by Rennie, Phillips, and Quartaro (1988). Grounded theory method has been utilized in psychological research to explore subjective experience and facilitate the development of theories. It is an inductive process in which the researcher is guided by the analysis of data to develop an understanding of phenomena grounded in empirical research. Each interview transcript was read and divided into "meaning units" by delineating sections of the interview that conveyed a single point that relates to the interview question (Giorgi, 2009) and summarized into concise labels that remain close to the participants' language. These meaning units and labels were entered into the computer program NVivo to assist in organizing them into larger categories as the hierarchy is developed.

Constructing the hierarchy. The primary investigator transcribed the interviews and created the meaning units and meaning unit labels for each interview's transcript, which then were uploaded into NVivo. He compared the meaning units and formed the initial sub-categories by grouping units based on perceived similarities. Coding of meaning units was not exclusive, so in some cases, meaning units were sorted into multiple categories based on their relevance to the meaning they contain. These sub-categories formed the base level of the theoretical model. Afterwards, sub-categories were compared with one another and commonalities between them led to the development of higher order categories. This process of analysis was continued, resulting

in a multi-level hierarchical model, at the top of which was the core category, the central interpretation of the data.

Trustworthiness/Quality/Credibility Checks

Checks on the investigators' understanding were conducted throughout the processes of data collection and analysis; these checks are believed to improve the credibility of qualitative research (Elliott, Fischer, & Rennie, 1999). Several methods were used to check with the original informants and the other investigator about the accurate representation of their accounts, as well as the quality of the categories and themes that emerged from the data.

Memo-ing. Memo-ing (Strauss & Corbin, 1998) was used to help the primary investigator keep track of his perspectives and to make sure that the analysis was grounded in the data. Memo-ing is a continual process of recording hypotheses and associations regarding the data and the analysis process, allowing investigators to be consciously aware of their individual perspectives and to limit the effect of a priori theories on the data. Memos were used to record thoughts and feelings, as well as theoretical ideas and analytical decisions.

Consensus. The construction of the hierarchy and model was an iterative group process, requiring that consensus be reached between the primary members of the research team (Max Wu and Heidi Levitt) through the process. Because Max Wu conducted the interviews, his experience was privileged in cases of differences in interpretations between investigators about the content of the meaning units. However,

Heidi Levitt's experience with qualitative research, particularly in constructing hierarchical models with qualitative data, was privileged in cases of differences regarding the development of a clear and useful hierarchy.

Participant check on data collection and findings. Several credibility checks were incorporated into the research process to ensure that the data was grounded in the experiences of the participants. First, the participants were asked to reflect upon the interview protocol and process at the end of the interview hour. This allowed participants to share information that might not have been brought forth and to provide feedback to the interviewer. Second, participants agreed to complete a feedback form after the data was analyzed. After developing the initial iteration of the hierarchy, the primary investigator sent the feedback questionnaire via e-mail that described the themes that came forward in the data gathered, as well as the overarching theme. The form allowed participants to rate how well each theme represented their experiences on a scale of 1-7, with 1 being "not at all" and 7 meaning "very much". Ten of the 11 participants provided feedback using this questionnaire. This feedback was used to clarify and refine the findings.

CHAPTER 3

RESULTS

These results presented the findings from the combined analysis. The 11 interviews were divided into 490 meaning units, which were organized into a hierarchy that included six levels of categories (see Table 1). The "core category" was located at the top of the hierarchy and included six "clusters" based upon 21 "categories," which rested upon 62 "subcategories." After describing each of the six clusters and their categories, the core category that was derived from them was presented. The following terms, based upon the trend of consensual qualitative research (Hill, 2012), were used to refer to the number of participants whose interviews contributed to a cluster or category: all = 11; many = 8-10; most = 6-7; some = 4-5; few = 2-3; and one (see Table 1 for counts for each category). The numbers cannot be used to assess the validity of the finding, because even though each trainee was asked how they learned responsiveness, the semi-structured nature of the interview meant that not all participants were asked the same sub-questions. Instead, the numbers provided an indication of the number of interviews in which an idea was salient. In addition, please note that the terms "participants," "novices," "trainees," and "therapists" were used interchangeably.

Table 1: Cluster, Category Subcategory Titles, and the Numbers of Participants That Contributed Meaning Units to Each

Clusters	Categories
Cluster 1: How to Use Processural Cues to be Responsive: Skills in the Moment-by-Moment Process of Psychotherapy Orientations are a Foundation for Responsiveness (11)	Category 1.1: Developing empathic and exploratory skills is a foundation for responsiveness because therapists learn to listen and notice more about clients (8)
	Category 1.2: Learning about theoretical orientation processes through observing, listening to, or reading about others' therapy helps novices develop models for responsive application of techniques in service of goals (10)
	Category 1.3. Through clinical experience, therapists learn the importance of responsively changing pace by slowing down to explore clients' concerns or emotions, and speeding up when clients show readiness to change (10)
Cluster 2: How to Use Relational Cues to be Responsive: Responsiveness is Developed Cyclically by Establishing Acceptance and Strong Rapport, which Facilitates Clients' Disclosure of Difficult Content in the Therapeutic Relationship, which Then Guides Future Efforts to be Responsive (11)	Category 2.1: Therapists learn to make adjustments to facilitate positive rapport and client engagement, which leads to more client disclosure and more content to which to be responsive (11)
	Category 2.2: Therapists learn from personal reflection and clinical experience to make responsive adjustments to emphasize clients' sense of safety, to encourage disclosing about difficult issues (such as trauma) or emotions (8)
	Category 2.3: Learning more about, observing, or commenting on client-therapist interpersonal dynamics helps therapists be responsive to how clients are reacting to them, and vice versa (8)
Cluster 3: How to Use Identity Cues to Be Responsive: Conceptualizing and Exploring the Interactive Effects of Both Group (e.g., Cultural Identities and Mental Health Diagnoses) and Individual Client Differences (e.g., Clients' Contexts) Locates Work Within Their Clients' Frame of Reference (11)	Category 3.1: Novices learn through coursework, personal reflection, and exposure to diverse populations to identify factors such as their clients' cultural identities, diagnoses, and contexts as reasons for adjusting their treatment in session (8)
	Category 3.2: Novices need to learn how to fully explore clients' context, such as physical health, living situation, social support, and cultural identities, but also avoid putting undue emphasis if not congruent with clients' perspectives (5)
	Category 3.3: Novices reconsider relationship and treatment goals in light of salient identity or contextual factors, prioritizing working within clients' frame of reference to reach goals and maintain the alliance (10)
Cluster 4: How to Attend to Client Agency to be Responsive – Typically, Therapists Conceptualizing Their Clients As the Ones Directing the Change Process Can Increase Their Attunement and Clients' Motivation, But They May Need to Provide More Guidance When Clients Are Stuck (11)	Category 4.1: Learning to allow clients to lead conversation or set the pace builds clients' initiative and comfort in sharing, and is especially important to clients of different cultural backgrounds, those who have experienced trauma, or children (8)
	Category 4.2: Collaborating on setting goals or choosing topics for sessions facilitates meeting clients' needs, and clients become less defensive and more willing to work on goals (8)
	Category 4.3: Therapists learn from personal therapy, supervision, and clinical experience that seeking clients' feedback increases responsiveness because therapists' understanding of clients' personalities and situations improves (7)
	Category 4.4: Being flexible with scheduling appointments or session agenda can be responsive to client needs, but therapists need to focus on high-risk behaviors and avoid reinforcing maladaptive client patterns (6)

Table 1 (continued): Cluster, Category Subcategory Titles, and the Numbers of Participants That Contributed Meaning Units to Each

Cluster 5: How to Develop Emotional Self-Awareness to Be Responsive: Novices Need to Develop Awareness of Their Own Thoughts and Emotions, Manage These Emotions, and Process with Peers and Supervisors to Learn to be Responsive (11)	Category 5.1: To be responsive, therapists learn to tolerate their anxiety, guilt, and self-doubt from trying new things and not pursuing symptom relief as quickly (9)
	Category 5.2: Novices' learning to identify and manage their personal reactions (emotional, cognitive, physical) to clients in session leads to being responsive (8)
	Category 5.3: Novices' taking initiative to seek feedback about mistakes or anxious moments in therapy facilitates learning responsiveness; vulnerability by peers or supervisors increases novices' comfort in sharing (10)
	Category 5.4: To be responsive to clients' emotions, novices learn to hide or express their own emotions according to clients' needs (9)
	Category 5.5: Novices' self-care leads to better responsiveness because it reduces negative emotions and exhaustion and leads to greater focus on clients (7)
Cluster 6: How to Take Risks to Learn to Be Responsive: Therapists Navigate the Paradox of Being Authentic in Delivery while Needing to Adjust Their Natural Relational Styles to Learn to Better Guide Clients Responsively (11)	Category 6.1: Trial-and-error in clinical experiences and role plays, including trying new interventions, is needed to learn responsiveness, and can be fostered by accepting mistakes as part of the process (10)
	Category 6.2: To learn responsiveness, novices experiment with facial and emotional expressions that are different from their own typical behavior (5)
	Category 6.3: Therapist authenticity is important to facilitate responsiveness, because it increases focus on clients and models genuineness, which fosters clients' sharing, but therapists also need to have professional boundaries to avoid being manipulated by clients (7)
Core Category: Novice Therapists Indicated that Deliberate Responsiveness Training Should Include: (a) Structured Education on How to Flexibly Adjust Interventions Based Upon Key Processural, Relational, and Identity Cues; (b) Examination of how Oneself and the Client can Promote or Inhibit Change; and (c) Conceptual Shifts to Encourage Experimenting With and Integrating a Range of Relational Styles and Therapy Approaches	

Cluster 1: How to Use Processural Cues to be Responsive: Skills in the Moment-by-Moment Process of Psychotherapy Orientations are a Foundation for Responsiveness

This theme described how responsiveness improved after novices sharpened their listening and observational skills through learning about psychotherapy processes and orientations. Developing these skills helped novices learn to identify clients' needs and apparent readiness to change, which led to adjustments such as slowing or quickening the pace of therapy. Meaning units from the interviews of all 11 participants were included within the four categories in this cluster.

Category 1.1: Developing empathic and exploratory skills is a foundation for responsiveness because therapists learn to listen and notice more about clients.

Varied experiences such as improvisational acting backgrounds, personal relationships, and intake sessions helped novices develop empathic and exploratory listening skills that would encourage clients to develop new awareness. These experiences created opportunities for trainees to suspend judgment and ask people more detailed questions, which cultivated greater curiosity. Trainees then brought this skill and curiosity into their sessions by asking clients similarly detailed questions, as described in the following interview excerpts:

> If I have a friend who's struggling with a family issue, … I can maybe listen more about it, rather than … being irritated or impatient about [it]. (P-1)
>
> There's a principle [in improvisational acting] … "Yes, and...". … If you're in an improv team, and it's, "Oh my goodness! My grandfather is on the moon with

> Bob Dylan!", as a team partner, you don't say, "That's impossible! Bob Dylan can't go to the moon." You say, "No way! And what else?" Like, so, *that* practice of curiosity and openness and really listening to … and responding to what's being said and not what you wish had been said, it's absolutely something that I try to keep bringing into the session room, and I don't always succeed, but I think is really important. (P-08)

By being patient and curious, these novices were attentive to clients and provided space for clients to share deeply.

Some therapists elaborated about how an effortful aspect of learning responsiveness was not only reacting to what was said, but also attending to clients' emotions and non-verbal behaviors to better guide the therapy process. Some therapists talked about how they acted upon this awareness by asking their clients whether non-verbal behaviors, such as shrugged shoulders or tensed muscles, indicated any unsaid thoughts or feelings. Therapists' learning how to explore these cues involved greater time getting to know their clients, out-of-session processing, and gradually asking more specific questions in session. One participant explained how she recognized a client's patterns through individual and group therapy sessions:

> In individual sessions with me, she was very verbal…. But in group settings, she… was often silent…. Um, the longer I got to know her in the individual setting, the more I got to understand … her body language. … Especially in the beginning of our work in group together, it seemed like she was just tuning out

…. [Over time], I started to have a sense of, *"No, if she's looking down, and not making … eye contact, she's … really distressed and connecting what's being said to something in her personal experience."* … And I would directly inquire and try to find out where the connections were to what was happening in group. (P-08)

Increasing awareness of client behaviors set an important groundwork for responsiveness because it helped therapists to notice and explore the meanings underlying these behaviors.

Category 1.2. Learning about theoretical orientation processes through observing, listening to, or reading about others' therapy helps novices develop models for responsive application of techniques in service of goals.

Exposure to several different theoretical orientations was cited as helpful because trainees gained a toolkit to adapt to their clients based on in-session processes, such as relational or emotional processes. A few trainees noted, for example, that their psychodynamic supervisors drew their attention to the relational process to identify cues to which to respond, such as countertransference. Furthermore, some novices appreciated learning different theoretical orientations and relational approaches in classes or in their research so that they could have more options for how to respond to clients. Observing experienced clinicians through videos, engaging in role plays, or co-facilitating group therapy helped demonstrate how to adapt therapy, and when to use particular interventions or approaches. One trainee talked about how his supervisor's interweaving of elements of multiple theoretical orientations helped him to be patient and responsive in his provision of therapy. He utilized a psychodynamic conceptualization to select

dialectical behavioral therapy (DBT) skills to teach his client, and to identify moments to focus on processing the therapeutic relationship with the client:

> She was very psychodynamically-oriented even though she had done DBT for like a decade. …. She definitely thinks from as many angles as possible…. we ended up talking about…. psychodynamic concepts like… transference… that are probably undergirding a lot of the behavioral features.… That informs, you know, which... DBT skills we ended up selecting…. [I then saw a client who praised me as] projecting onto both me and his dad. … because I'm one of the few males of color who… function as some kind of authority figure in his life…. I ended up exploring that … instead of going with whatever plan I had going in. (P-04)

This novice's understanding of the client's transference, with his supervisor's help, allowed him to delay his previous plan to teach dialectical behavior therapy skills because he recognized the importance of discussing their interpersonal dynamics.

Although learning processes from different therapy orientations provided a necessary foundation for responsiveness, some therapists wished that they had explicitly learned about responsiveness in their training, so that they could have developed the framework for how to tailor interventions to client needs. One therapist shared that it would have been constructive to learn during training to conceptualize the goals of responsiveness as adjusting therapy in ways that built up the mental, emotional, and physical health of clients. This conceptualization could allow for novices to brainstorm freely and flexibly about how to utilize specific therapy approaches and interpersonal

functioning to aid clients.

Category 1.3: Through clinical experience, therapists learn the importance of responsively changing pace by slowing down to explore clients' concerns or emotions, and speeding up when clients show readiness to change.

Many trainees talked about how they responsively changed the pace of therapy according to clients' needs. If their clients seemed to need to explore situations or emotions more deeply, then some therapists adopted a slower pace by speaking in shorter sentences, pausing more, talking slowly, and checking in with their clients more frequently. One therapist described his rationale for slowing down the pace of a therapy session:

> If the client is going through a really tough time, … I would want to [ask] in greater detail about what's going on. I think of it as slowing the pace a bit, like putting less... fewer things on the agenda [to talk about]…. If it's a client that I've worked with for a while, and I know … just because they're tearful, that doesn't mean I have to slow down or we should stop ... then that's a decision I might make there. But if it's a newer client, or if I've never seen this particularly happen with them, I might decide I want to slow it down a bit, ask them ... to describe for me what they're feeling … to give them an opportunity to recognize that something shifted. (P-07)

This therapist learned over time that it was difficult for clients to remember previously-discussed matters when clients' emotions were more overwhelming and symptoms were

more severe, and so he adjusted by helping clients gain awareness about their emotions and reminding them of skills.

Alternately, when novices noticed their clients were able to tolerate emotions (through cues such as leaning forward or displaying contemplative facial expressions), they worked at a faster pace in sessions by challenging clients' defenses or teaching new skills. One therapist explained how she gently began to push the pace forward:

> She [talked about really awful things] … happening in her life …. And she would say …, "But you know, it's fine..." and … she'd have this really, really phony smile on …. At first when I would see that … , I would … smile and nod, and [just] convey an understanding …. [Over time], I would actually start saying, "We don't *have* to talk about how it's not fine, but my sense is that it doesn't feel fine to you." And then she would say, "No, it's not, but you know... that's just Life!" … [I was] incrementally … problematizing that defense of hers … She felt miserable, but she just couldn't bring it to a verbally-conscious place. …. So my sort of giving her permission to do it at her own pace, and to ... *titrate* her … deeper affect allowed her to bring more of it in. (P-08)

Here, the therapist gradually facilitated the client's emotional expression over time, maintaining a slow pace and still seizing opportunities to encourage the client to discuss her feelings.

When asked to share feedback on this cluster on a 7-point Likert scale that indicated how well this theme represented their experiences, with 1 being "not at all" and

7 meaning “very much,” trainees gave high ratings, with a mean response of 6.65 and a standard deviation of 0.47. All ratings ranged from 6 to 7. In their feedback, a few participants emphasized the importance of learning to recognize and respond to non-verbal behavior. Many therapists talked in greater detail about how learning multiple theoretical orientations helped them have more options for techniques in session, but that it took time to be comfortable pulling from multiple orientations to tailor treatment to the needs of their clients (see Cluster 6 for more on this challenge).

Cluster 2: How to Use Relational Cues to be Responsive: Responsiveness is Developed Cyclically by Establishing Acceptance and Strong Rapport, which Facilitates Clients’ Disclosure of Difficult Content in the Therapeutic Relationship, which Then Guides Future Efforts to be Responsive

For this cluster, participants described the development of responsiveness to clients in session as a cyclical process across time, as well as the central role of the therapeutic relationship in guiding this process. All therapists said that they made efforts to responsively facilitate greater client trust and engagement in therapy, which led to increased client disclosure; this, in turn, could increase therapists’ responsiveness. Through classes, supervision, and client experience, many novices became more attentive to interpersonal dynamics in session and learned how to comment on these dynamics in constructive ways. Meaning units from all 11 participants’ interviews were represented in the three categories within this cluster.

Category 2.1: Therapists learn to make adjustments to facilitate positive rapport and client engagement, which leads to more client disclosure and more content to which to be responsive.

Most novice therapists explained how learning to build positive rapport with their clients was essential for responsiveness. A few therapists reflected on personal experiences of how their doctors, therapists, family members, and friends made them feel more comfortable disclosing about problems by being attentive, supportive, and curious. Therapists learned from these experiences, as well as their clinical work, to tailor treatment by speaking in ways that set clients at ease (such as using metaphors, discussing shared interests, or utilizing nonverbal, visual activities), which facilitated clients' self-disclosure. One novice talked about adjusting his conversation with a client who was frustrated about being in therapy and hesitant to reduce substance use. The therapist pivoted the conversation to talk about the positive aspects of substance use to align with the client's perspective:

> [My supervisor and I] had a client who was essentially forced to go to treatment and really just didn't care about cutting down [substance use] …. So when … we'd start talking about some of the negative aspects of use, he would start to get really … angry. … Instead, we … started to talk about some of the good aspects of his use… just as a way to… engage him in the conversation.… Then we kind of jumped into, what are some of the things that are not so great about it…and …. he opened up more after that …. about some of the negative aspects, which [was] … a precursor to him thinking more about those things. (P-02)

The therapist was able to build rapport by helping the client feel understood, allowing for exploration of the client's ambivalence and deeper concerns. In another instance, a therapist spoke of developing a shared language in her work with a client to help her communicate about emotions:

> When she got really depressed, she [closed]… blackout curtains in the bedroom…. And there would be times later in the treatment when maybe she wouldn't come in for a session. And then the next week I'd say, "So were you drawing the blackout curtains?" and that was a way that we could communicate without having to actually address what was too scary for her to address, which was the reason she hadn't come into the session…. It's me saying to her, "I know that you're in pain right now, or my sense is that you're in pain right now. A) am I right about that, and B) if I am, can I peek in the curtains?" …. I think my ability to sort of develop that language with her helped her feel understood and known by me. (P-08)

By using this metaphor from the client's life to connect with her, the therapist found a gentle way to approach and encourage exploration of hurt. Similarly, many therapists talked about ways to personalize treatment to their clients by using language that helped clients express themselves or creating in-session activities or between-session assignments that engaged their clients' interests.

Category 2.2: Therapists learn from personal reflection and clinical experience to make responsive adjustments to emphasize clients' sense of safety, to encourage disclosing about difficult issues (such as trauma) or emotions.

Some therapists talked about how they responded to clients who were more guarded or nervous by making greater efforts to present themselves as patient and non-judgmental. For example, several novices adjusted therapy for clients with a history of traumatic experiences (especially interpersonal trauma) by asking simpler questions, providing more emotional support, and inviting those clients to express criticism about therapy. One therapist described how she learned from experience to decrease her focus on therapy techniques to instead concentrate on building a trusting relationship with her client as the appropriate response to her client's need:

> My agenda was to learn Trauma-Focused CBT, … and [my client] wasn't having it. Like she wouldn't do homework; she wouldn't follow protocol. She got very angry and, like, very silent if I tried to do the thought records and the fear hierarchy and the things that you do in TF-CBT. ... [I decided to change] the goals … completely. It wasn't the goals of … completing the modules with TF-CBT; it was … "Let's survive this session and not feel like this is the worst thing *ever* to have to come here." …. I think that she just was feeling very self-destructive, and being able to be destructive towards me and tell me how she hated the therapy and how poor it was, and then me having to sort of sit there and feel that... was relieving to her, because she didn't have to carry it around herself. (P-06)

Some therapists talked about how they learned the importance of seizing opportunities to strengthen the therapeutic alliance by being supportive of their clients' emotional expressions. Therapists tended to validate and normalize feelings because they sought to reassure clients that their reactions were acceptable, which encouraged further sharing of emotions.

> If the client is, maybe, ashamed or not happy that they're having that reaction… like, "Oh, I can't believe I'm so upset," or, "This shouldn't affect me this much." Some … trying to rationalize away, then I will [say], "*No*, it makes sense that you're feeling this. Like, just listening to you, ... my fists are clenching. (P-09)

While it was generally said to be helpful to validate emotions, a few therapists added that there were situations when emotions were overwhelming for their clients, so they might help clients learn to regulate them. For example, one therapist talked about working with a client who experienced anger that often led to self-harm or hostile behavior toward others. In this example, the therapist validated the emotion and helped the client process it in a constructive manner, simultaneously conveying respect and care, to encourage future client disclosure:

> The best example [of processing emotions comes from when] I've worked with kids … in an inpatient setting. I think … sort of reminding them, "Yeah, this is really overwhelming. How can we... feel a little more grounded?" …. And I think [I was] a little more "solution-focused" …. Not to help them fix their feeling necessarily, … but solution-focused with respect to, "This show of emotion is not … helpful for what you're working towards. So how can we... how can we work on letting you feel this, but not react in a way that's going to be harmful for

> you?" You know, not engaging in … self-harm. Not going and breaking the other client's toy, like things like that. … "How can we be with this emotion and not engage in a way that's … counterproductive?" (P-09)

Though therapists responded to clients' emotions with different reactions such as simply being present, validating, or processing, the common thread was that therapists learned that they needed to convey that their clients could feel safe in expressing what they were feeling.

Category 2.3: Learning more about, observing, or commenting on client-therapist interpersonal dynamics helps therapists be responsive to how clients are reacting to them, and vice versa.

Participants learned about therapist-client dynamics by participating in class discussions, reviewing group sessions with a co-leader, and writing summaries about sessions. These experiences helped therapists process their behaviors, their clients' moment-to-moment reactions, and how they were affected by their clients. One participant described an example of how she learned to respond to her countertransference:

> I think that there's this balance in training between teaching protocols and teaching technical skills, and helping the trainee be aware... "Who is this patient for you? And what is it that you're bringing into the session that is really triggering this patient, or that is really triggering you?" And so, understanding how two humans in a space affect each other and what they're bringing out in

> each other has been really helpful for me … because … if I have this sense of awareness because I've … processed that in a group supervision, that "This patient reminds me of my sister really much, and that's why I'm feeling very protective of her" … . That helps me be more responsive, because then I'm aware of what it is that *I'm* bringing into the room. (P-06)

Rather than overreact, the therapist was able to respond with clinically appropriate support, because of this self-awareness. Many therapists described how they worked to cultivate a strong therapeutic bond with clients and learned to notice signs of connection and disconnection with their clients. One therapist described her beliefs about how connection and disconnection could both lead to responsiveness:

> There's two types of responsiveness: the one that is really sort of very easy, comes easy, feels very natural and very effortless, and you're just there in the moment and it feels very real, very connected. And then there's the responsiveness of there's a huge rupture, or there's an obstacle, or there's a problem, and you expend a lot of effort being responsive, because you need to adjust, you need to change the plan, you need to go to Plan B, you need to be creative and flexible. (P-06)

Some therapists said they learned that when they had a strong alliance with their clients, responsiveness felt easier and less effortful, and therefore less explicit discussion of problematic dynamics was needed. However, when therapists noticed signs of disconnection or rupture, therapists learned that they needed to non-defensively acknowledge and discuss their clients' anger or frustration toward them to be responsive, to show that those emotions were acceptable,

and then proceed to more deeply explore the clients' concerns. One therapist described how she took responsibility for not being attuned to a client's wishes, and how it strengthened their relationship in a way that increased responsiveness in future sessions:

> I made a connection between something that was happening with her "boyfriend" guy and something … about how she worked with her parents, … and she actually stopped me, and she said, "… I want to talk about… [my boyfriend], and... it's frustrating … when you keep bringing up ... my family." So this [was] sort of a lesson for me in responsiveness where … I had failed her. … [I admitted,] … "I'm sorry. You're right. … This is what you want to be talking about, and I've been … trying to derail you, frankly." …. I acknowledged how she was feeling, … I validated my part in it…. And, we were able to … talk about … what she had not been getting from me, then … I [was] … able to respond to her in a more attuned way. (P-08)

Some therapists commented how their clinical experience and support of supervisors helped them learn how to be patient and deescalate any possible conflicts with their clients by speaking openly about their concerns and acknowledging their own responsibility when applicable.

When sharing feedback on this cluster, participants agreed that deepening the therapeutic relationship was a key mechanism for responsiveness (Mean = 6.40, *SD* = 0.84, Range = 5-7). Establishing and keeping positive rapport was said to be very important, because otherwise clients might not implement changes that they discussed in

session into their daily lives. A few therapists noted that they were careful and thoughtful about the balance and timing of validating or challenging clients, depending on the perceived strength of the therapeutic alliance.

Cluster 3: How to Use Identity Cues to Be Responsive: Conceptualizing and Exploring the Interactive Effects of Both Group (e.g., Cultural Identities and Mental Health Diagnoses) and Individual Client Differences (e.g., Clients' Contexts) Locates Work Within Their Clients' Frame of Reference

For this cluster, a three-step sequence represented the process of learning responsiveness to identity cues in order to make adjustments to in-session therapy. Meaning units from all 11 novices were included in the three categories of this cluster.

Category 3.1: Novices learn through coursework, personal reflection, and exposure to diverse populations to identify factors such as their clients' cultural identities, diagnoses, and contexts as reasons for adjusting their treatment in session.

Early in their training, novices learned to identify factors such as their clients' cultural identities (e.g., race, sexual orientation), diagnoses, and contexts (e.g., social support network, stability of clients' living situations) as reasons for adjusting the therapy relationship and interventions in session. Many therapists cited completing coursework, engaging in personal reflection, immersing themselves in diverse cultures on trips, providing therapy to varied clients, and hearing about others' experiences as means of increasing their awareness of cultural concerns that could impact therapy. In the

following examples, novices talked about how their personal background, including cultural identities and education, helped them to identify group and individual differences for which to adjust therapy.

> The LGBT community and racial and ethnic minorities have much higher rates of all sorts of trauma and mental health issues, and [I was part of those] social networks when I was growing up. … And so, … I am drawn to those problems. (P-04)

> I have a Masters degree in Sociology. … The Sociology training, … [has] been helpful. … [because] I think about [people's] identities and where they're situated, [and] how... proximal and distal sociocultural factors could be affecting their presenting concern. … So for example, like social class differences, … regional differences, … and ... local culture…. So trying to … dig a little deeper into my clients' backgrounds, not just … class, religion, race... but like, *"Okay, let's really get into the nuances, and here are how these factors could be interacting with one another."* (P-09)

Most novices talked about how their initial step in responding to identities was becoming aware of differences, variability, and intersectionality within identities, which could guide the questions they asked their clients.

Category 3.2: Novices need to learn how to fully explore clients' context, such as physical health, living situation, social support, and cultural identities, but also avoid putting undue emphasis if not congruent with clients' perspectives.

Second, some novices described learning to fully explore clients' experiences and avoid oversimplifying clients' situations. They said that completing coursework, observing other therapists, and clinical experience helped them learn to consider how identity factors could influence their clients' communication, behavior, and values. For example, one participant talked about a client experience with someone whose seemingly emotionally and psychologically abusive partner had ended their romantic relationship. The therapist admitted that because she believed the end of the relationship to be a positive outcome, she initially did not take the time to explore the meaning of the relationship and its loss with her client:

> [I] didn't even think about … what … this [relationship] brought to her. … Her coming from a different culture, like, [perspectives about] marriage and raising kids. … The sense of self that comes from that, the importance of that …. So, … that was an adjustment for me …, *"Okay, here's how I think about these things, and this … is … not how this person thinks about them*." … [Then thinking] generally, ... "*People with this cultural background may feel this particular way, and then, what does that actually look like for [my client]?"* Just holding that awareness and [also]…, *"Okay, this may or may not apply, or it might apply and look differently than I expect, probably."* So let's figure that out together. (P-09)

This novice learned that she needed to explore her client's experience so that she could understand the client's perspective and respond with appropriate empathy and processing. She also made sure to adopt an open mindset that all clients, regardless of their cultural characteristics, needed to be treated as individuals with their own unique situations and needs. A

major caveat that some novice therapists noted was that when discussing how clients' cultural identities related to problems, they took a tentative tone and showed a willingness to discuss these connections further. As one novice therapist described:

> I try to be responsive to anything if I think it may be contributing to the client's presenting problem, without trying to make *that* the root of all of their problems. …In our discussions in class, a lot of therapists … fall into the trap of thinking that LGBTQ issues are the only reasons for a lot of the presenting problems, where these problems happen in heterosexual individuals just as easily. … A lot of it is just letting the client tell their own story … and maybe bringing it up, then, as "Have they ever thought about it in X way?" And if they haven't, then exploring that, but not only focusing on that. (P-03)

This therapist emphasized that learning responsiveness included developing respect for client's autonomy by not insisting on exploring identities if their clients did not believe they were relevant.

Category 3.3: Novices reconsider relationship and treatment goals in light of salient identity or contextual factors, prioritizing working within clients' frame of reference to reach goals and maintain the alliance.

Third, therapists learned to reconsider relationship and treatment goals in light of identity or contextual factors. This learning occurred via supervision, video review, clinical experience, and personal reflection. Overall, many therapists said that exploring clients' broader context (physical, familial, societal, etc.) led to adjustments in the therapeutic process such as creating

appropriate treatment goals and interventions that would meet the needs of the clients. Some therapists spoke about learning to slow down the pace and adjust treatment goals according to personality and intellectual ability. Novices said that through clinical experience and supervision, they learned to respond to clients who needed more time to process (those who were distractible, less verbal, or had diminished intellectual capacity) by speaking less, checking in with clients regularly, or focusing on more specific goals. In the following example, a novice therapist talked about adjusting her communication with clients based on their intellectual ability:

> I had some clients who were illiterate or reading-challenged and I think one of the greatest cultural learning curves for me was sometimes, I would just anticipate that a client would … have … a higher verbal comprehension or … processing speed than maybe they actually had. … I might need to actually not just hand a client an assessment, but actually go through word-by-word. And … it took me a while to learn how to do that and still show respect and … deference to a client's intelligence. (P-10)

This therapist demonstrated in this example how she changed her method of conducting the assessment to make sure her clients understood, and learned to balance an appreciation for her clients' intelligence, in order to nurture a supportive therapeutic connection.

Generally, therapists prioritized working within clients' frame of reference to reach goals and maintain the therapeutic alliance. For example, rather than making assumptions about clients' needs based on the diagnosis, being responsive to a diagnosis meant exploring clients' specific symptoms and contextual factors, and adjusting therapy goals based on those details.

One therapist reported that she responded to a client's diagnosis of Post-Traumatic Stress Disorder by exploring the impact of these symptoms on the client's daily functioning, which led to identifying social support as a concern. She then decided to specifically target problematic beliefs about safety and trust that led the client to avoid others. When other symptoms seemed more pressing, she chose different strategies to target those symptoms.

In other cases, therapists adjusted the delivery of interventions after reconsidering the goals for the therapeutic relationship. For example, some therapists made efforts to discuss positive aspects of their clients' cultural identities, especially for clients with marginalized identities. Establishing a safe and supportive space set the stage for a stronger alliance and greater client disclosure. One therapist talked about how reflecting upon her extended family's experiences with discrimination motivated her to integrate aspects of her clients' identities into treatment:

> My grandparents came to the States after World War II [and] speak Polish, but not to me, … because when they came to the States, they experienced discrimination …, and they didn't want that for me. So we had our Polish traditions …, but we kept them behind closed doors, … and I always thought that was so sad. … I think I'm pretty sensitive to [culture and language] and …, if it's important to [clients], how can we incorporate it into your treatment. … If they have a religion …, [I might look for] … healthy views of how religion can help cope with severe mental illness … and looking to modify some of the beliefs that are not so helpful. (P-05)

By incorporating strengths related to clients' cultural identities, therapists could empower clients and affirm their uniqueness, which could increase clients' motivation and engagement in healthier therapy goals.

In feedback on this cluster, participants indicated a high level of agreement that this fit with their experience (Mean = 6.20, *SD* = 1.11, Range = 4-7). They talked about how they might adjust the therapy goals to decrease symptoms of disorders in relation to clients' cultures, and emphasized how group identities could offer them strategies that bolster their resilience as untapped strengths of the clients that could be leveraged. One therapist (who gave a rating of "4") noted that that no matter how open therapists presented themselves, some clients may prefer therapists who are more in line with their culture and may not feel safe disclosing information. This could be discouraging for novices and hinder the development of therapist responsiveness.

Cluster 4: How to Attend to Client Agency to be Responsive – Typically, Therapists Conceptualizing Their Clients as the Ones Directing the Change Process Can Increase Their Attunement and Clients' Motivation, But They May Need to Provide More Guidance When Clients Are Stuck

In this cluster, all 11 novice therapists talked about how they learned to consider clients' agency in relation to responsiveness. They considered the conditions when it was helpful to give clients a more active role within the therapy process, or when therapists could benefit clients by being more directive. Four categories comprised this cluster.

Category 4.1: Learning to allow clients to lead conversation or set the pace builds clients' initiative and comfort in sharing, and is especially important to clients of different cultural backgrounds, those who have experienced trauma, and children.

Most novices discussed the importance of being humble and treating clients as experts of their own lives, which they learned from classes and clinical experience. Clients of different cultures than their therapists seemed to benefit from this therapist focus because the relationship was more equal, encouraging open communication. Novices also stated that children seemed to benefit from this therapist focus. When clients brought up topics that were unfamiliar to therapists, trainees expressed curiosity, giving their clients the opportunity to explain. This dynamic set the stage for later responsiveness because clients felt respected and more comfortable providing input, as the following therapists described:

> When my client started discussing her [polyamorous] relationship, I was very open about the fact that I had *no* idea how her relationship worked, and that I was counting on her to explain things to me. I think she responded really well to that. I believe she had been to therapists in the past who, kind of, tried to act as the expert on relationships, and I was not going to try that at all, because I had no idea at all what was going on in her relationship. And I think that she appreciated that. (P-03)

Therapists sought to empower their clients to express themselves, so that they could understand their clients better and make adjustments to therapy based on their clients' input. A few therapists explained how increasing client agency looked different with clients who needed a safer therapeutic space, such as clients who had experienced trauma. Novices learned to allow clients to set the pace of conversations, often slower than the therapists were comfortable with, to provide clients a safe space to share when ready. Novices needed to learn to shift their mindset and realize that appropriate support was to work at their clients' pace, which could include utilizing silences well, instead of continuing to offer verbal interventions, as shown by the following trainee:

> I had a patient that … wouldn't talk…. We spent probably three months [where] most of the time [was] in silence. And just sort of adjusting my expectations [of] a … helpful session was really meaningful. … I think as a trainee therapist, ... you're so focused on doing *something* … I was just … being very, very *effortful*. And it was only when I … was just okay with … just [sitting] there …, that things started shifting. To create a therapeutic space for *her*, specifically…. She doesn't need to do something; she doesn't need to be a specific person. … Because she came in with a very severe history of abuse, … that was really important to be able to have some sense of agency. (P-06)

This therapist learned that reframing her mindset about successful therapy sessions helped her to be patient and invite her client to speak when ready, which allowed the client to express herself.

Category 4.2: Collaborating on setting goals or choosing topics for sessions facilitates meeting clients' needs, and clients become less defensive and more willing to work on goals.

Many novice therapists shared about how they worked with their clients to choose discussion topics and set treatment goals. This collaboration was especially important when clients were unmotivated or resistant, such as clients who struggled with depression or substance use. For example, some therapists discussed realistic expectations for reducing substance use with their clients and established mutually-agreed-upon goals. Giving clients agency in shaping their therapy goals helped therapists be attuned to clients' perceived capacities for change, based on considerations such as intellectual ability or emotional readiness.

Therapists learned through their clinical experience that being responsive in this way improved clients' engagement in therapy and motivation to change. A key attitudinal shift mentioned by a few therapists was that they needed to be patient and have a long-term perspective on change, which could include future therapy. Novices needed to learn and accept that if they pushed for change before their clients were ready, then their clients likely would not make any progress. This learning process is illustrated by the following example:

> [I let] them start where they feel comfortable…. If they're not comfortable, then they're going to minimize things, … versus them … being more open and willing to discuss it. And … meeting them where they're at and figuring out, "Okay, what would be something that you want to work on? What would feel good to you?"

…. So it's really listening to what they want to do. … and not trying to force them to pick a different goal. (P-05)

Most therapists discussed how clients, when given some autonomy in choosing therapy goals or topics for sessions, showed more initiative in working on goals and disclosed more about their problems.

Category 4.3: Therapists learn from personal therapy, supervision, and clinical experience that seeking clients' feedback increases responsiveness because therapists' understanding of clients' personalities and situations improves.

Most therapists talked about how they learned from personal therapy, supervision, and clinical experience to seek their clients' input and feedback about their interventions and interpretations to improve responsiveness. A few therapists talked about reflections from personal therapy in which they observed how they were given autonomy about type of theoretical approach used in session and how their therapists were flexible in changing approach.

Novices learned over time that they needed to learn to be comfortable letting go of adherence to one therapy approach or intervention, and be open to changing their interpretations as well. The following therapist spoke about his thought process as he learned to make adjustments to therapy according to his clients' feedback:

I … try to foster an … experimental attitude in my clients, where like, "Look, we're experimenting, we can try this, and you can try this on your own time. If you don't like it … or it seems really hard for you to do, then you don't have to

keep doing it. It might just not be a method that works best for your personality, but we'll keep working until we find something that works best for you." (P-11)

Over time, therapists learned to provide clients a space to express their reactions and feelings, and to be non-defensive if adjustments needed to be made. This helped novices become comfortable in seeking clients' feedback, which improved responsiveness because clients were encouraged to express their needs, guiding further adjustments to therapy.

Category 4.4: Being flexible with scheduling appointments or session agenda can be responsive to client needs, but therapists need to focus on high-risk behaviors and avoid reinforcing maladaptive client patterns.

Although most therapists agreed that making changes after client feedback often was helpful, some novices remarked that there were times when they needed to be more directive and not immediately adjust to client input, particularly when clients were avoidant or high-risk. If clients seemed to be demonstrating a pattern of avoidance, some therapists chose not to follow their clients' lead in discussing new topics. One therapist talked about a client whose goals were to process grief, practice anger management, and refine interpersonal skills, yet who would instead fixate on academic grades and one professor specifically. The therapist adjusted by validating the concern, but then helped the client draw connections to broader interpersonal challenges. This therapist expressed the challenge of balancing validation while redirecting the conversation back to goals:

> Occasionally, clients will come in and will take the conversation in a direction that maybe seems a bit tangential with respect to what their goals are for therapy. So: if some crisis has happened, they're very upset, they come in and want to talk about someone in their life, or something, … [then] being responsive looks like balancing validation - so, validating what it is they're experiencing in the moment - and creating a space where they feel *heard*, and safe expressing themselves, while also trying to … tie that material into the larger scope of therapy. (P-09)

To respond to clients who presented with high risk factors, therapists often needed to be even more directive in leading the conversation and addressing safety concerns. If therapists believed that risk factors needed to take precedent, they often promised to return to their clients' desired topic later, as shown in the following example:

> One of my clients [had] a very complex presentation, he had anorexia binge-purge subtype - restricting, binge-eating, and purging …. He was also cutting, and he was also wanting to come out to his parents. I was like, "Dude, this is *not* the right time to do that. Gosh, let's keep you alive, and let's talk about that later." And that was a really hard thing to not let him prioritize in a subsequent session. I mean, the first session he needed to disclose, … I tried to provide a very positive response… But other times when he wanted to bring it up, I felt really bad ... in saying, "We have to wait until the end of the session, and if there's time, we can talk about it." (P-04)

In this way, therapists were able to fulfill their clinical duties while also empowering clients to continue to shape the focus and direction of therapy.

When providing feedback on this cluster, novices had a mean response of 6.50 (*SD* = 0.71) on a 7-point Likert scale, indicating that they highly agreed that this fit with their experiences. Ratings for this category ranged from "5" to "7." In the feedback, some novices emphasized that learning to give clients autonomy and provide a collaborative relationship in therapy were some of the most important processes in learning responsiveness. They added the importance of learning conditions under which to be client-led or more directive. One therapist underscored that if clients and therapists did not have the same cultural background, then the therapists' humility and curiosity were especially crucial to convey.

Cluster 5: How to Develop Emotional Self-Awareness to Be Responsive: Novices Need to Develop Awareness of Their Own Thoughts and Emotions, Manage These Emotions, and Process with Peers and Supervisors to Learn to be Responsive

All 11 novice therapists emphasized the importance of learning how to identify and manage their personal emotions when clients raised difficult issues and experienced distress. Identifying their own emotions helped novices potentially recognize how their clients were feeling, which led to improved responsiveness in discussing those emotions, especially if previously unnamed. Learning to manage their own emotions helped many therapists attend to issues in session that might elicit their own anxiety, and allowed them to better attend to their clients' needs. There were five categories within this cluster.

Category 5.1: To be responsive, therapists learn to tolerate their anxiety, guilt, and self-doubt from trying new things and not pursuing symptom relief as quickly.

Many therapists talked about how learning to be responsive involved overcoming their own distracting emotions. Most novices experienced self-doubt and anxiety when they considered asking challenging questions or making adjustments to a treatment protocol and were uncertain about how their clients would react, as demonstrated by the following therapist:

> When I first started, ... if I asked about feelings and emotions, I had a lot of anxiety when stuff like that would come up, because that felt … like we were getting off track [from cognitive-behavioral treatment]. … And I think now, especially through [learning] DBT, something that is changing in my thinking is… when a client ... experiences a lot of emotion that I can attend to, ... it might be even more useful [because we can discuss emotions occurring in the present moment]…. I've … [become] more comfortable with [focusing on clients' emotions]. (P-07)

In this instance, the therapist's learning dialectical-behavioral therapy helped him to attend to clients' emotions more effectively, which reduced his anxiety. Some other therapists learned to cope with difficult emotions by realizing they could be the outcome of responsive therapy, as in this case of a therapist accepting the pain of her client, which meant sitting in silence during sessions:

> You know, it's a funny thing ... sometimes feeling shitty is the good outcome of being responsive. … being able to contain some of the fear and some of the pain and some of the suffering, *that's* being responsive. I think I spent a lot of time feeling really bad about what was going on, and ... that I was carrying the weight of everything that was happening with her. … She spent a lot of sessions that we had completely silent. And … part of that was the pain of termination and separation, and having to … let that go, but … *I* felt really bad. But that was the outcome of actually being there for someone in the way that they needed me to. (P-06)

Novices were better able to manage emotions such as frustration and anxiety when they reminded themselves that incremental gains were important, that progress could not be rushed, and that there were gains besides symptom relief, such as improved self-awareness, or a stronger therapeutic alliance that could prepare clients for future continued therapy. In the following excerpt, a therapist commented on how clinical experiences and supervision helped in adopting a more patient mindset to providing therapy:

> [One] professor really opened my eyes to the idea of "Maybe sometimes you can just *be* with the client. And maybe it's therapeutic to just go where they want to go. And if we don't get to the *action* that we desire, … it's okay." It was such a relief… Because … if I had just gone off of what … textbooks were saying, … I would have felt really discouraged, because sometimes there wasn't … behavioral change. … Sometimes it was really more of an attitudinal shift, or a way of

> thinking …. [It shifted my therapy approach] because … it … gave me the freedom to just say, "… The most therapeutic thing is just to be open-ended and allow them … to … process what they've been through." (P-10)

Therapists learned to attend to what their clients were expressing and to be attuned to clients' needs from moment to moment, instead of being frustrated by deviations from their treatment plans or agendas, which improved their responsiveness.

Category 5.2: Novices' learning to identify and manage their personal reactions (emotional, cognitive, physical) to clients in session leads to being responsive.

Many novices spoke about becoming attentive to their own reactions in session. Therapists cited personal reflection, class discussions, and supervision as experiences that aided their processing of feelings, thoughts, and bodily sensations. One novice described how she noticed her reactions to clients in session, which led her to consider her clients' potentially unsaid thoughts or feelings:

> This is another thing that may be important, ... listening with all your senses: ... am I holding tension in my body somewhere? And if so, what does that mean about what's happening in the moment? How I feel about them, how I think they feel about me… listening with ... that sense of my own. … Watching what's happening with [the client's] body, watching what's happening with my body, where they are in the space, all of that. You know, what is the sound of their voice, not just the words that are coming out. (P-08)

Novices' expanded awareness of their own emotions guided them to check in about clients' thoughts and feelings or reflect upon whether their own emotions mirrored patterns in their clients' interpersonal relationships. This quote was by the same therapist:

> [Supervision] helped me think more about what was being enacted between she and I ... what kind of character was I replicating from her history? And what did it mean that I became less interested in her when I was … more frustrated with her when I was just following her lead? … So [my frustration] gave me a lot more information to work with about her. … I had a … supervisor who … started the thought process of, *"… What is happening between us that relates to her outside life?"* So that helped me sort of understand better what was happening between us, and then the week after, I could be more responsive to where she was in the moment. (P-08)

In this case, the novice therapist benefited from supervision to explore the therapist-client relationship more broadly. The novice's acknowledgment that she was feeling frustrated and exploration of her countertransference led her to conceptualize the relational patterns of her client. This reflection helped the therapist understand what the client's relational needs might be in the moment. Similarly, a particularly difficult emotional process that some novices noted was learning how to overcome irritation and dislike of clients, because those feelings could distract therapists. Focusing on being non-judgmental and curious about reasons for clients' noxious beliefs or behaviors, focusing on shared identities or hobbies, as well as reframing these moments as opportunities for learning, were several helpful ways to overcome irritation with

clients. These processes were learned in supervision, clinical experience, and personal reflection. One novice therapist described how he shifted his mindset to be appreciative of opportunities to work with challenging clients:

> I think it's just a process of becoming more self-aware, of witnessing yourself as therapists, as seeing therapeutic work for us to grow just as much as our clients. … When we have challenging clients, it's not something that we should … begrudge. It's something that we should … welcome as if it was a treasure, because we might not have the best outcomes or whatnot, but for sure, we're going to learn a lot about our weaknesses and a lot about our blind spots. (P-11)

These therapists cultivated an openness in their thinking that encouraged them to persist in their efforts to understand their clients better, which helped them overcome irritation and frustration and be responsive to those clients and future clients.

Category 5.3: Novices' taking initiative to seek feedback about mistakes or anxious moments in therapy facilitates learning responsiveness; vulnerability by peers or supervisors increases novices' comfort in sharing.

Some novices talked about how they overcame self-doubt and anxiety by processing their self-critical emotions with supervisors and peers and remembering past successful experiences with clients. A culture of vulnerability and support in training was described by some therapists as helpful for facilitating their disclosure. In some training programs, trainees were encouraged by supervisors and peers to share about challenging in-session moments or specific instances they considered to be mistakes. In contrast, a

few interviewees talked about having to take the initiative to seek feedback about anxious in-session moments because they did not receive such feedback from their supervisors or during classes. Whether it happened spontaneously in their program or not, trainees seemed to agree that focus on these vulnerable in-session moments led to greater learning and improved responsiveness. Sharing of perceived mistakes was also modeled by supervisors and peers, which served to normalize these anxiety-provoking experiences, as expressed by the following therapist:

> There was one trainee who said … , "Yeah, like, I've had that experience too, where I just get … *anxious* and I feel like I'm tip-toeing around the client, and I just learned, like, I kind of just have to … *do it*, and see that it doesn't lead to catastrophe. It actually could be really helpful." (P-07)

Novice therapists developed the ability to be self-reflective without being self-critical, which increased their motivation to keep improving their clinical work, including their responsiveness to clients, instead of being impeded by guilt or shame. Reduced self-criticism also enhanced novices' ability to use supervision effectively, because they were more willing to bring questions about confusing or challenging moments.

Category 5.4: To be responsive to clients' emotions, novices learn to hide or express their own emotions according to clients' needs.

Many therapists thought deeply about how best to engage with their clients' emotions, particularly when considering whether masking or expressing their own emotions would be helpful. They learned through clinical experience and supervision that overarching goals through

this process were to help support their clients' emotional expression and efforts to change. Therapists took special care to present themselves as calm and non-defensive in spite of potentially anxiety-provoking client disclosures such as critical feedback, suicidal intent, or substance use, so that they could provide support and explore their clients' underlying concerns. One novice elaborated upon how she needed to be non-defensive to build alliance with a client, and how she learned to manage her affect by focusing on the client's problems and then seeking support from a supervisor afterwards:

> I had … [a] patient who … yelled at me and said, "You ask too many questions!" and I said, "You know, it's really my way of trying to understand you and your experiences." And then ... he went along with all the questions and was fine. … I may look like calm on the outside, but … it doesn't feel good to be yelled at, ever. And I think that's where it can be helpful... [to remember I'm treating] veterans who, based on my questions, their PTSD was triggered … and in my mind, I'm reminding myself, "This is the PTSD talking." … And then having good support after, … [from] my supervisor, … getting validation like, "Whoa, that was tough, and yet it sounds like you handled it well." (P-05)

This novice learned from clinical experience and processing with her supervisor that hiding her emotions and working to maintain connection with the client were the most effective ways to respond to convey her support for a client who was emotionally reactive.

Through clinical experience, therapists learned to wait to build a stronger therapeutic alliance before expressing more in-session emotions. After building a stronger relationship, most

therapists expressed concern when their clients were engaging in problematic response styles, such as prejudiced statements, avoidance of emotions, or resistance. With reserved clients, however, therapists might disclose their reactions more gently, building more safety and trust within the therapeutic relationship. Then, when clients signaled readiness to engage with emotions, such as by exhibiting contemplative expressions or verbally disclosing emotions, many therapists were inclined to share their own feelings, such as sadness, in reaction to their clients' disclosures. When revealing their emotions to clients, trainees learned to say just enough to encourage clients to explore their own emotions, while being careful so that their clients did not focus on resolving their therapists' emotions instead. One novice talked about how she disclosed her emotions about a client's situation to validate and deepen her client's experience, and how supervision aided her in developing the confidence to do so:

> I'll use [emotional disclosure] sometimes if the client is … ashamed. … I will use it as a "*No*, like, it makes sense that you're feeling this. Like, just listening to you, ... my fists are clenching; I'm feeling really angry at this person," as they're talking. … [Clients are] able to trust me and feel more comfortable with me. And then, … [I'm] … broadening my understanding of their inner experiences, so that I can ... tailor my interventions more for them. … I'm careful that I use my sharing *just enough* to where we can feel connected, but not to where it shifts it to … now about *me* more than … about [the client]. … [My] first supervisor … and [I] … would watch [video of] sessions…, and, ... just her feedback …, "… It's okay to have these types of emotions, and to [express them]." (P-09)

This supervisor encouraged the novice to express emotions, which then helped her client disclose more emotions and inner experiences, allowing the therapist to then understand the client better and be responsive.

Category 5.5: Novices' self-care leads to better responsiveness because it reduces negative emotions and exhaustion and leads to greater focus on clients.

Many novices talked about learning to engage in self-care to reduce emotions related to fatigue or burnout that might arise, which could reduce their responsiveness in session. Unresolved personal issues could distract therapists or lead to reduced empathy for clients' problems, but processing these issues with supervisors and peers and increasing self-awareness, through mindfulness or other strategies, could help novices understand and be aware of how to guard themselves against these negative effects. A few therapists described how their responsiveness to clients could be impeded by fatigue or personal issues, and how mindfulness and self-care were ways they learned to overcome emotions to attend to their clients. This was explained by one novice:

> I think it's harder to be more responsive and be more present in the room if *you're* having a tough day or you're not feeling well or you've got stuff at home. Your mind is kind of distracted. … You may get clients really giving you more of those kinds of statements like, "No, that's not really it; it's *this*." … I think you're *distracted*…, so you're … not paying as close attention to … that interpersonal process in the room. … I think [what helps is] being mindful, being

> aware of those things when they happen, and trying to remind yourself to be present in the room. (P-05)

This example underscored how therapists need to be present and energized so they can be attuned to their clients, and how engaging in consistent self-care can help novices overcome emotions that can impede client attunement.

In feedback for this cluster, trainees showed a high level of agreement, with a mean response of 6.60 (*SD* = 0.52). Ratings ranged from "6" to "7." Participants indicated in their feedback that developing emotional self-awareness, learning how much to share one's own emotions as a therapist, and processing strong negative reactions to clients were very challenging processes. A few therapists cited how supervisors normalized the struggles of processing negative emotions and modeled how to explore these emotions in-session. One therapist said that processing one's own reactions to clients could be more fully explored in personal therapy than in supervision.

Cluster 6: How to Take Risks to Learn to Be Responsive: Therapists Navigate the Paradox of Being Authentic in Delivery while Needing to Adjust Their Natural Relational Styles to Learn to Better Guide Clients Responsively

In this cluster, all 11 novices described how they benefitted from deliberately pushing beyond personal discomfort to practice new therapy approaches or express emotion in a new style. Novice therapists learned to try different ways of responding to clients to discover what was effective. They also gradually learned how to incorporate their own personalities and styles

into their delivery of treatment, even when trying novel therapy approaches and interventions. Three categories were organized under this cluster.

Category 6.1: Trial-and-error in clinical experiences and role plays, including trying new interventions, is needed to learn responsiveness, and can be fostered by accepting mistakes as part of the process.

Some therapists said that they benefitted from adopting an experimental attitude to try new interventions and therapy approaches in training, and that developing this mindset could be facilitated by engaging in role plays, mock sessions with supervisors and other trainees, and through supervision and clinical experience. Novices who viewed responsiveness as a "trial-and-error" process over time, which would include mistakes, built up resilience to self-criticism because of their strong desire to learn and improve their provision of therapy. A few novice therapists talked about how self-criticism impeded trying new approaches or interventions, and how remembering successful clinical experiences or receiving support from supervisors helped to increase their confidence to keep experimenting. The following therapist explained how normalizing difficulties in therapy interactions and encouraging curiosity were crucial to learning responsiveness:

> [Others can best learn responsiveness] by doing it and failing. And then seeing what your failure is and being able to, frankly, yeah, be curious about where you failed and humble and try something different. … It's important to be able to

> forgive ourselves when we are not responsive … and, like, just be okay with doing something, learning how to be more responsive next time. (P-08)

Novices' growing to accept when interventions were ineffective, without dwelling on self-criticism, promoted persistence and continued efforts to learn new ways to respond to clients.

Category 6.2: To learn responsiveness, novices experiment with facial and emotional expressions that are different from their own typical behavior.

Some therapists spoke about how they learned to adjust their facial expressions or amount of emotional expression to fit the needs of their clients, which was difficult because that required them to behave differently than their typical style. One therapist talked about the need to speak more openly about his own emotions when he believed clients could benefit from noticing the effect they had on others. The therapist said that this increased emotional expression was not his personal style, but that he was encouraged by supervisors and other trainees to consider this practice as his own "exposure therapy" that would likely improve his responsiveness to clients' emotional needs. In contrast, another novice therapist, believing that she needed to learn to reduce her emotional expression to some clients feel more comfortable, worked on controlling her eyebrows:

> Especially when clients are, um, choosing to disclosure things about trauma, sexual assault, really difficult topics maybe for them to speak about, I have to be careful that, obviously I might not have as much control over *what* I'm feeling

> and my reactions, but definitely what I'm *showing* the client, in terms of if I act surprised, or if I show shock or dismay or something like that, then they might … choose NOT to disclose in the future. … I... actually …. went home and I watched myself in the mirror. So, I really focus on keeping my eyebrows down, as opposed to letting them rise and showing shock, or letting my eyelids open. ... And then the rest of the affect, like the mouth and the nose, the rest of the face, kind of follows that. (P-10)

This was a striking example of how a novice observed that she tended to show strong reactions to clients' disclosures of difficult topics, and realizing how that could reduce future disclosure, she actively practiced changing her facial expressions. Therapists learned to make these adjustments to show support and promote their clients' insight or disclosure.

Category 6.3: Therapist authenticity is important to facilitate responsiveness, because it increases focus on clients and models genuineness, which fosters clients' sharing, but therapists also need to have professional boundaries to avoid being manipulated by clients.

Although novices emphasized the importance of trying new things, most talked about the tension between maintaining their genuine selves, while also relating comfortably with clients. Several participants spoke of the challenges of avoiding an overly professional "therapist" persona, including one novice who utilized video recording and noticed how her voice changed when delivering therapy:

> We're trying so hard to be therapists and to utilize all these skills that we've [learned]…, that ... it's really clunky at first when we actually try those things on, and so being able to see what that looks like and synthesizing what we feel and what we can see, to be more comfortable and more genuine. … I noticed [in my early clinical work that] … I kind of have the "therapist voice." It was funny because I would watch the videos and like, *"Wow, that doesn't sound like me at all."* …. I was being really calm and … a little condescending…. And so, …[thinking about] how I can... be myself a little bit more. … Like, I will joke … [or cuss] with clients when it's appropriate. … [It's] just lots of little experiments of … using a certain word or certain way of relating, and seeing if it makes the client tense up or if it makes them seem more open and comfortable. (P-09)

Most therapists expressed a desire to incorporate elements of their personality, such as humor, when they delivered therapy. When they were relating authentically and naturally in session, they found that clients seemed to be more genuine and disclose more about their problems, which increased responsiveness.

However, some therapists added that they were mindful about becoming too casual or playful with clients, which could distract from focusing on therapeutic goals. At times, boundaries needed to emphasized to set limits with clients to promote changes away from maladaptive patterns in their lives. One therapist talked about the difficulty of wanting to express his genuine warm feelings toward a child client, but realizing that it could lead to overattachment:

> I ended up needing to be much more patient with him, and also be very careful with also the warmth that I ended up conveying, because … I didn't want him to become overly attached. … Delineating boundaries was really important early on. … [If he distracted me with a joke, I had to strike a balance between] showing him that I thought it was funny, and then re-directing him back to the task [in session] … And with the same vocalization, intonation, and often with the same words. I think, "Yeah I think that's funny, … but we're not here to … play around and pretend to be monkeys. We're supposed to talk about things" … [Just finding] a balance between being supportive and also being very direct with him. (P-04)

This novice explained how considering overattachment as a client concern helped him to think about the limits of how much genuine warmth to express, and also staying somewhat neutral and professional so that they could focus on important content. Another therapist talked about how she learned that with some clients, it could be more effective to more gradually show her genuine self, depending on how her clients related to her. She described her work with individuals in correctional setting who lied or asked uncomfortable personal questions:

> I was … much less likely to share any kind of personal details about myself. … I think my baseline was to be … genuine, but less warm …. [Some] people would blatantly *lie* … [and] some of these people presented as incredibly charming and warm …, but then would also maybe ask questions about myself that I wasn't comfortable answering. … It's sort of like, *"What is the function? What is what*

> *I'm doing serving?"* …. I want to have clear boundaries … to give them a sense of what they can expect … [from a] professional, talk about what we need to talk about, and ... not be manipulated. (P-09)

This novice underscored how therapists need to be continually mindful about how their clients are relating to them, and for some clients who pushed boundaries by asking personal questions of their therapists, being professional by not answering the questions and not showing as much warmth could set clear limits and model adaptive communication styles.

When sharing feedback for this cluster, participants strongly agreed that the process of taking risks was very important for learning responsiveness (Mean = 6.7, *SD* = 0.48, Range = 6-7). One trainee spoke about the challenge of trying new things frequently and tolerating uncertainty in this learning process. Another novice explained that being authentic as a therapist was necessary to help clients feel that they were in a safe, nonjudgmental space.

Core Category: Novice Therapists Indicated that Deliberate Responsiveness Training Should Include: (a) Structured Education on How to Flexibly Adjust Interventions Based Upon Key Processural, Relational, and Identity Cues; (b) Examination of how Oneself and the Client can Promote or Inhibit Change; and (c) Conceptual Shifts to Encourage Experimenting With and Integrating a Range of Relational Styles and Therapy Approaches

The core category is the central theme that the investigators identified to organize their understanding of the phenomenon of novice therapists' responsiveness. It described how responsiveness was developed in clinical training or life experiences: increasing awareness of cues in client-therapist dynamics and clients' identities and contexts; fostering trainees' awareness of clients' agency and management of their own emotions; and encouraging novices to adopt mindsets that facilitate trying new relational or therapy approaches.

Novice therapists described three main types of cues that helped them to learn responsiveness: processural, relational, and identity cues (see Clusters 1, 2, and 3). Processural cues included signs of clients' readiness for change or suitability for techniques or interventions from specific theoretical orientation approaches. Relational cues were those that were connected to building rapport and safety within the therapeutic alliance. Lastly, identity cues comprised group and individual client differences such as cultural characteristics and clients' contexts. These results suggested incorporating a psychotherapy process course into training curricula that is focused upon how to respond to in-session cues in order to utilize relational styles or interventions responsively to strengthen the alliance, and help clients reach goals.

Novices explained their need to foster their clients' agency and manage their own emotions when providing therapy (see Clusters 4 and 5). They considered the conditions under which it was helpful or not as effective to display or share their emotions with clients. Typically, they hid internal emotions to keep the focus on their clients and explore clients' issues in more detail, and they expressed more emotions to encourage greater disclosure to clients who were hesitant to share emotions or unsure about them. Further, they talked about learning to tolerate

anxiety, self-doubt, and self-criticism when they tried new interventions or emotional expressions in session. They especially noted the difficulties of how to stay responsive while feeling irritation or dislike toward their clients. These emotions were seen as major obstacles to responsiveness, because novice therapists' desired responses might be blocked by their own anxiety in attempting to cope with those emotions. Some therapists talked about taking initiative to be vulnerable and review challenging sessions with supervisors and peers to overcome shame and learn from mistakes.

Lastly, trainees said that adopting certain attitudes and ways of conceptualizing assisted in developing responsiveness (see Cluster 6). Helpful therapist attitudes focused on constantly learning and taking a curious, almost playful "trial and error" approach to therapy that was open to improvisation and experimentation. After perceived mistakes, novices tended to be resilient when they were humble and curious about what might have gone wrong. Trainees also discussed how conceptualizing their clients as the ones directing the change process led to responsive adjustments in therapy, such as talking about expectations for therapy, collaborating on goals, or providing space for feedback about interpretations.

In providing feedback for the core category, most participants said that it was a strong framework for training and captured their experiences well (Mean = 6.65, *SD* = 0.67, Range = 5-7). A few trainees emphasized their belief that clinical experience was the greatest influence on their learning responsiveness. The one trainee who gave a "5" rating expressed concern about the difficulty of learning flexibility through the structured curriculum of a class, citing that in vivo exposure to clients was essential. Another trainee

specified that she did not consider role plays to be helpful because people were unlikely to behave authentically when being monitored so closely in an artificial exercise.

CHAPTER 4

DISCUSSION

This study uniquely contributed to the literature by providing a basis for a structured, intentional training of responsiveness that attempted to integrate multiple elements in a novel way. These elements were derived from empirically-based categories featured in this study. Research in the extant literature has provided support for individual elements being important in training (e.g., cultural training, Bardone-Cone et al., 2016; learning multiple therapy orientations, Castonguay, 2000; therapeutic alliance-focused training, Constantino, Morrison, Coyne, & Howard, 2017), without combining these elements together.

The goals of this study were to increase understanding of novice therapists' beliefs about responsiveness, methods of how they learned responsiveness, and obstacles to mastery. This study's focus on the student perspective allowed for deeper exploration of their experiences, including how self-awareness facilitated the development of responsiveness, and the challenges and rewards of experimenting with interventions in which they were not yet confident. This study also provided a holistic perspective because it drew from students' experiences across varied types of learning.

As a result of this study's deepening the understanding of novices' beliefs and experiences, recommendations for teaching responsiveness could be generated regarding didactic content, practicum experiences, and optimal supports for novices. Creating a structured, intentional training can guide training programs to methodically consider responsiveness within their curricula and to centralize it, instead of having it be implicit. Psychotherapy training has tended to focus on techniques, with responsiveness as more of an implicit goal of training, rather than an explicit focus (Hatcher, 2015; Kramer & Stiles, 2015). An impediment to centralizing responsiveness, though, is that we have developed a rhetoric in which we teach therapy in the form of techniques and fixed step-by-step (often manualized) therapist behavioral performance (Boswell & Castonguay, 2007; Callahan & Watkins, 2018; Hatcher, 2015). Clinical training that focuses on a protocol-based approach can help graduate students efficiently learn many empirically-supported interventions, but also runs the risk of trainees not understanding the rationales for interventions and when to make adjustments to the therapy process (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013) More emphasis is needed on helping trainees learn to develop strong therapeutic alliances with their clients (Constantino et al., 2017; Elmore, 2016; Eubanks-Carter et al., 2015; Safran et al., 2014).

Another potential barrier to centralizing the teaching of responsiveness is the alarming disappearance of intellectual diversity within the field of clinical psychology (Heatherington et al., 2012; Levy & Anderson, 2013). The cognitive/ cognitive-behavioral orientation crossed the 50% mark for faculty in APA-accredited clinical

psychology programs in the early 1990s and has continued to rise, which could diminish flexibility in interventions and marginalize other viewpoints (Norcross, Sayette, & Pomerantz, 2018). Despite the overwhelming volume of meta-analytic research that has accumulated showing equivalence in orientations (e.g., Wampold & Imel, 2015), clinical psychology doctoral training programs gradually have *reduced* the number of faculty who teach non-CBT approaches to therapy to the point that all other approaches combined are still a small minority in clinical science programs and all other PhD university programs (20% and 33%; Heatherington et al., 2012). Just as a strength of CBT approaches have been the development of protocols, other psychotherapy orientation cultures have had strengths and histories in teaching relational and process models of therapy (Hill & Corbett, 1993) and so with this reduction, there is a concern that these conceptualizations of therapy are fading out.

This shift means that it is increasingly unlikely that students will develop a depth of understanding of multiple psychotherapy orientation cultures, come to understand the values embedded therein, identify the ways in which systems in psychology have supported this shift, and see how psychotherapy orientation cultures lead to distinctive ways of understanding both responsiveness and psychotherapy outcome on whole (e.g., Laska, Gurman & Wampold, 2014; Levitt, Pomerville & Surace, 2016). This structural bias in educational contexts may lead to assumptions that facilitate the continued waning of intellectual diversity and cross-orientation conceptualization and responsiveness skills.

Insights from the current study suggested that to centralize the teaching of responsiveness, interventions should be deliberately taught by graduate programs in relation to readiness, process, relational, and identity cues within a rhetoric of flexible collaboration with clients. These implications are in accordance with the literature about psychotherapy training and important aspects of responsive psychotherapy. In Clusters 1, 2, and 3, novice therapists spoke about how they needed education about interventions to use, and about identifying processural, relational, and identity cues that signified when to utilize interventions. Boswell and Castonguay (2007) and Castonguay (2000) encouraged programs to train novices in multiple theoretical approaches to therapy to help them notice processural cues. Relational cues within the therapeutic relationship were seen as valuable as a focus for training by Friedlander (2012, 2015) and Eubanks-Carter, Muran, and Safran (2015). Identity cues were discussed in several studies focused on multicultural training to help novices adjust therapy based on clients' identities and backgrounds (Bardone-Cone et al., 2016; Benuto, Casas, & O'Donohue, 2018; Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014).

In Clusters 4 and 5, trainees stated that adopting a mindset guided by increasing client agency and that improving their self-reflection helped to facilitate responsiveness. Client agency has been emphasized in the literature (Bohart & Tallman, 2010; Gordon, 2012; Hoener, Stiles, Luka, & Gordon, 2012; Williams & Levitt, 2007) as a concept that requires more attention by therapists in order to better respond to clients' needs and improve client outcomes. Increasing self-awareness was supported in the literature

(Boswell & Castonguay, 2007; Rousmaniere, 2017; Pieterse, Lee, Ritmeester, & Collins, 2013) so that novices could learn to identify and cope with their own emotions as they treated clients.

In Cluster 6, novices discussed learning to be comfortable with an experimental approach to the provision of therapy, which enabled them to try new interventions and approaches. The literature agreed with how novices could be supported through training experiences to develop comfort with experimentation by overcoming self-criticism (Kannan & Levitt, 2015; Messina et al., 2017; Salter & Rhodes, 2018) and practicing authenticity (Hill et al., 2015; Levendosky & Hopwood, 2017; Salter & Rhodes, 2018) as well as managing professional boundaries (Bischoff, 1997; Hill et al., 2015; Knapp & Slattery, 2004; Salter & Rhodes, 2018).

The clusters of findings and the core category of this study implied that deliberate responsiveness-centered training should: (1) identify markers that alert trainees of the process (or obstacle) that is confronting each client in each moment (i.e., cues related to therapy orientation processes, the therapy relationship, and clients' culture and identity); (2) conceptualize change as an individualized process that unfolds within clients and develop trainees' understanding of how client agency and therapists' self-awareness might support that change; and (3) help trainees become comfortable experimenting with adjustments and modifying interventions accordingly.

A Responsiveness-Based Curriculum: Identifying Competencies and Methods

To aid in applying this study's findings into recommendations for training, the six clusters of findings were translated into six types of responsiveness competencies. Across all levels of training from novice to expert, researchers (Falender & Shafranske, 2010) have called for the establishment of competency standards, encouraging instructors and supervisors to teach competency-based principles that are shown to be associated with positive treatment outcomes. Competency has been defined as the "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226). Competency implies performance at an acceptable level, which varies by the developmental level of trainees, and establishes a minimal expectation that can be built upon throughout training (Fouad et al., 2009). Clearly defining competency standards provides a delineation of the basic foundation for the essential clinical knowledge, skills, attitudes, and values needed for successful provision of psychotherapy, which can guide and structure training, as well as help in assessing readiness as trainees gain increasing levels of independence in clinical practice (Falender & Shafranske, 2010; Fouad et al., 2009).

Table 2 listed the six types of responsiveness competencies that were developed based on the six clusters of results of this study. Related specific skills, distinctions, and processes that demonstrated the competencies then were described in the second column of Table 2. These skills, distinctions, or processes were identified by reviewing the

hierarchy of findings of this study and organizing recommendations and experiences that were identified as helpful, as described by the participants. For example, Cluster 1 described the responsiveness competency of how to use processural cues tied to therapy orientations and interpersonal skills to guide in-session change. The categories contained within this cluster highlighted the importance of learning to explore and empathize with client experiences, noticing content related to therapy orientation processes, and responsively adjusting pace, and so these activities were listed as skills, distinctions, and processes that demonstrated the competency of how to use processural cues to guide in-session change.

Strategies connected to teaching these skills, distinctions, and processes were defined in the third column of Table 2. These strategies were identified by adding approaches suggested by the findings within the hierarchy and then supplementing them with those culled from the extant literature. As an example, novices in this study described sources for learning about different theoretical orientations, including watching videos of experienced clinicians, engaging in personal psychotherapy, and learning from supervisors, so these strategies were added to Table 2. Learning how to conduct assessments was a recommended method from the literature and to help draw trainees' attention to aspects of the therapy relationship and to learn how to explore clients' experiences more deeply (Hill et al., 2015; Smith & Egan, 2017), and eight participants of this study agreed. As a result, this learning strategy was added to Table 2 as well.

Courses that could facilitate teaching these skills, distinctions, and processes were named in the fourth column of Table 2. These courses were derived from the findings and participant feedback from this study, as well as the literature. For example, the trainees in this study talked about how they benefitted from learning basic interpersonal skills in the early stages of training. The competency of relational cues could be mentioned in a foundational therapy skills course and then be a focus of therapy orientation courses and practicum courses. In addition, based on Castonguay's (2000) recommendation that curricula gradually expose trainees to multiple theoretical orientations, the recommended courses included a psychotherapy theories course and additional theoretical orientation courses.

Based on the core category of this study, and support from the research literature, I proposed that a structured responsiveness-centered curriculum should include the following three elements: (1) psychotherapy process education on client cues across different therapy orientations; (2) consideration of client agency and novice self-examination; and (3) conceptual shifts by novices that support experimentation and growth. In the following sections, findings from this study on the development of responsiveness in trainees were considered in light of the existing literature about formal psychotherapy training, with respect to each of these three elements. Areas of agreement or difference between the findings of this study and the existing literature were highlighted. Instances when the results of this study extended findings in the literature also were discussed.

At the end of each section of this discussion, this study's and the literature's contributions to the competency-based responsiveness-centered curriculum were described (Table 2). Lastly, future research directions were considered.

Psychotherapy process education on client cues. This section reviewed this study's and the literature's findings to generate recommendations for psychotherapy process education. Process education focuses upon teaching students to guide therapy in relationship to processes unfolding within the session. This responsiveness was described in the findings to be facilitated by teaching basic interpersonal skills, exposing trainees to multiple theoretical orientations, attending to the therapeutic alliance, and drawing awareness to identity cues as ways to develop responsiveness.

Models of responsiveness training. Three models of responsiveness training that can help trainees learn to respond to multiple types of cues were reviewed. Findings of this study were considered in relation to these models of training, producing recommendations for how to structure and focus competency-based responsiveness training (see Table 2).

Event-focused module training. In Clusters 1, 2, and 3, trainees in this study emphasized that learning to identify and practice responding to cues about psychotherapy process, therapeutic relationship dynamics, and clients' identities was a foundation for being a responsive therapist. These cues could be the foci of specific training modules in clinical training.

Constantino, Boswell, Bernecker, and Castonguay (2013) suggested teaching trainees within modules focused on the following specific categories of events in therapy: (1) low therapy outcome expectations; (2) change ambivalence; (3) self-strivings; (4) alliance ruptures or repair; and (5) outcomes monitoring. For example, in a module focused on responding to clients' having low expectations for the effectiveness of therapy, trainees could be informed of the significance of addressing these expectations due to their negative impact on treatment processes (e.g., therapeutic alliance) and outcomes. Then, instructors could teach novices how to reiterate or revise their therapeutic rationale or treatment plan in a sensitive, collaborative manner. Novices could be taught how to focus on expectancy-enhancing interventions, with flexible consideration of what approaches make most sense for a given client and context, rather than rigidly teaching structured techniques (Constantino et al., 2013). Within each module, instructors taught trainees to consider strategies tailored to the context of those events, guided by client needs and principles of change, rather than prescribing specific techniques.

By utilizing the structure of event-focused module training, trainers could center didactic modules and supervision on teaching central lessons about cues related to the psychotherapy process, therapeutic relationship dynamics, and clients' identities (cues described in Clusters 1, 2, and 3 of this study's findings) to help novice clinicians understand how these elements interact with each other. Accordingly, Table 2 detailed how attending to these cues should be central competencies that are focused upon

throughout responsiveness training, and instructional modules were listed as a recommended method to learn to attend to these cues.

Micro-process review training model. In Cluster 1, some participants noted how clients' non-verbal micro-process behavior was clinically important but difficult to notice in session. In addition to instructional modules, the literature indicated specific methods to teach the identification of and reaction to cues, focusing on supervision. Several researchers (Cutts, 2012; Tsang, Bogo, & Lee, 2011) have recommended taping of sessions, transcription, and critical review of micro-processes in therapy to help trainees notice markers for moments to be responsive and understand the effects of specific therapist responses. Supervisors can guide trainees with focused reflection questions to develop specific intentions for moment-to-moment decisions in session, and the capacity for intentionality over time because of repeated consideration of the motivations for their clinical decisions. Supervisors might ask trainees about client information that led to the interventions that trainees chose and help trainees consider alternate responses (Friedlander, 2012; Gersten et al., 2013). Questions could include: "What was your purpose in saying what you did?"; "On what information did you base your decision to say what you did?"; "Would you change what you said in any way?"; "What is it you would be trying to accomplish?" (Gersten et al., 2013, p. 77-78, 84).

In Cluster 1, some participants explained that clients' verbal and nonverbal behaviors were clinically important, but they experienced uncertainty about how to respond. Some of the literature that comprised the micro-process review training model

(Cutts, 2012; Tsang, Bogo, & Lee, 2011) recommended video recording and review to aid trainees in noticing clients' verbal and non-verbal behaviors and consider how to thoughtfully respond to these behaviors. Based on the findings from this study and the literature, I have recommended video review of sessions whenever possible to help trainees observe and respond to clients' verbal and non-verbal behaviors (see Table 2). Assigning exercises that use process measures to develop skills in understanding the influence of interventions at a micro-process level can be helpful as well. This learning method was added to Table 2.

Assessment model. While participants in this study did not usually bring up assessment as a salient source of learning responsiveness when asked open-ended questions, eight of 10 participants who provided feedback reported that using assessment measures was helpful when specifically prompted to answer whether there were ways that using assessment measures had influenced their responsiveness to clients. A common theme was that measures were beneficial for therapists in order to identify and discuss distressing symptoms or topics that clients seemed hesitant to talk about.

In the research literature, trainees have reported that completing assessments about clients was helpful to draw attention to aspects of the therapy relationship such as working alliance and transference after sessions (Hill et al., 2015). Smith and Egan (2017) found that trainees viewed psychological assessment clinically useful when it was taught in the context of understanding clients holistically, rather than just to determine their psychiatric diagnoses. In Smith and Egan's study, the course was mandatory and

completed by mostly second- and third-year doctoral students, and both trainees and clients positively rated the assessment process.

Taken together with the findings of the assessment model literature, this study's participant feedback provided support for trainees taking a course in assessment early in training, and thus, Table 2 included assessment as a recommended method and course to learn to attend to processural cues.

Processural cues. Both this study's and the literature's findings suggested that responsiveness-centered training should include exposure to multiple theoretical orientation processes as well as grounding in interpersonal skills.

Learning multiple theoretical orientations. The findings of Cluster 1 in this study conveyed the importance of exposure to multiple theoretical orientation processes to help trainees notice different types of information in session. Novices elaborated on sources for learning about different theoretical orientations, including watching videos of experienced clinicians (from research, classes, or group supervision), engaging in personal psychotherapy, and learning from supervisors.

Experientially learning and applying treatments associated with each of the major psychotherapy orientations has been recommended by multiple researchers to help novices understand how the process of therapy evolves in a moment-by-moment way that functions in relation to ones' theory of change (Boswell & Castonguay, 2007; Castonguay, 2000). Castonguay (2000) encouraged programs to expose trainees to multiple theoretical approaches to therapy early in training. He suggested that students in

their second or third years of training apply treatment protocols associated with each major orientation to at least one or two clients, after reading treatment manuals associated with these approaches. Then, students could identify a primary theoretical orientation in their third or fourth year of graduate school to help them develop expertise in case formulations and treatment plans. Castonguay worried that a superficial understanding of numerous approaches could lead to a lack of clinical depth and a lack of understanding that responsiveness is guided by orientation values. Lastly, after becoming familiar with case formulating and treatment planning within one approach, trainees could be invited to explore other orientations again to consider integrating aspects of other approaches into their primary approach.

Both this study and the literature pointed to the importance of exposing trainees to multiple theoretical orientation processes. The learning methods suggested by this study's participants, including watching videos of experienced clinicians (from research, classes, or group supervision), engaging in personal psychotherapy, and learning from supervisors, were listed within Table 2. Based on Castonguay's (2000) recommendation that curricula gradually expose trainees to multiple theoretical orientations, I recommended that processural cues could be mentioned in a foundational skills course, a psychotherapy theories course, and an assessment course, and that focused learning could follow in therapy orientation courses and practicum courses.

Building interpersonal skills. The trainees in this study reported that they benefitted most from learning basic interpersonal skills in the early stages of training

(leading to the recommendation of a foundational skills course in the responsiveness curriculum to help trainees learn how to be responsive to processural cues; see Table 2). Cluster 1 was based upon trainees' description of how various personal and professional experiences led to increased patience, empathy, and attentiveness to clients' non-verbal behavior. These experiences included coursework, supervision, and research that focused on the development of listening or observational skills. This is consistent with Hatcher's (2015) summary of research about enhancing responsiveness, in which he described several basic interpersonal skills as teachable: therapist warmth, empathy, acceptance, and behaviors such as instilling hope and reducing client's sense of isolation. Castonguay (2000) also included teaching basic clinical and interpersonal skills (diagnosis, empathy, and warmth) as the earliest phase within a model of several phases of training. These skills were included in the model to get trainees accustomed to the "therapeutic encounter" (Boswell & Castonguay, 2007). In traditional therapy education, having a foundational interpersonal skills course was shown to give trainees a focus for their early therapy experiences and greater confidence with clients (Hill et al., 2007).

Five of 10 trainees who provided feedback said that they took a basic helping skills course that focused on developing therapeutic attitudes, skills, and abilities such as empathy, congruence, tracking process, and relationship formation. Two of the five, however, were unsure about whether the course influenced their development of responsiveness, citing reasons such as the class being too easy because they believed that they entered their program with a high level of interpersonal attunement. Of those who

did not take a helping skills course, three trainees said that they would not have wanted such a course. One said that supervision should be sufficient. These concerns could be extrapolated to thoughtfully consider how to structure a foundational therapy skills course early in training. Focusing on marker-driven process cues and relational cues while explicitly naming the responsiveness framework might be more valuable to challenge trainees and stimulate growth. Trainees in this study especially benefitted from developing active listening skills and learning what to ask clients, as well as noticing and exploring clients' nonverbal behaviors, so these should be key components of the course. These skills were therefore listed in Table 2 because of the significance of acquiring these skills in order to demonstrate competency in responding to processural cues.

Relational cues. This study's findings in Cluster 2 indicated the importance of classes, individual and group supervision, and personal reflection to engage in focused discussion about interpersonal dynamics between therapists and clients. Friedlander (2012, 2015) described how supervisors can model responsiveness to relational cues for trainees in their direct interactions with them, such as by discussing a conflict within the supervisory relationship, and then engaging in meta-communication about what helped resolve the conflict. This discussion could draw explicit connections to how that process could apply to clinical work with clients. Eubanks-Carter et al. (2015) developed alliance-focused training (AFT) to enhance therapists' abilities to improve the therapeutic alliance. Goals of AFT are to help therapists gain self-awareness, detect ruptures in the alliance, tolerate difficult emotions in self and clients, and communicate with clients with

interpersonal sensitivity. There is evidence that AFT helped novice therapists to reflect on their relationships with their clients, more deeply sharing personal feelings and reactions (Eubanks-Carter et al., 2015; Safran et al., 2014). Despite these promising findings, Constantino et al. (2017) noted that 90% of clinical and counseling psychology graduate programs surveyed in the United States and Canada relied on informal alliance training within the context of supervision-as-usual, rather than making the alliance a specific focus of training. Constantino et al. (2017) admitted graduate program curricula might be quite full, but they urged programs to consider adding some alliance-training elements, such as teaching trainees with an alliance-repair manual or focusing on the alliance during video review in individual and group supervision.

Taken together, this study's findings and the literature resulted in recommendations for classes, individual and group supervision, and personal reflection to be structured in a way that highlights relational dynamics to trainees. An additional method named in this study's findings, but not mentioned in the literature, was providing group therapy. Focused teaching of an alliance-repair manual within a course or supervision was recommended by the literature. I also recommended that supervisors thoughtfully model responsiveness in their relationship with trainees and then utilize metacommunication to draw novices' attention to the relational process. Video review within supervision should focus on the therapeutic alliance. Learning to provide group therapy also was recommended. Relational cues could be mentioned in a foundational skills course and psychotherapy theories course, and then concentrated learning could

ensue in therapy orientation courses and practicum courses. These recommendations were listed within Table 2.

Identity cues. The findings of Cluster 3 of this study affirmed the value of the learning to attend and respond to identity factors through coursework, supervision, personal reflection, and exposure to diverse populations (through clinical experience or trips). Several studies (Bardone-Cone et al., 2016; Benuto, Casas, & O'Donohue, 2018; Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014) have called attention to trainees' needs in multicultural trainings that can help them to tailor therapy to clients' identities and backgrounds. Trainers should foster a supportive learning environment, which could include appropriately sharing relevant personal experiences, so that novices are comfortable sharing life experiences, feelings and beliefs, while also asking questions and expressing concerns (Bardone-Cone et al., 2016; Benuto et al., 2018). Supervisors should facilitate exploration or education on specific cultural issues, discuss culturally appropriate interventions, develop self-awareness, and challenge trainees (Benuto et al., 2018; Soheilian et al., 2014).

Benuto et al. (2018) conducted a systematic review of 17 training outcome studies of cultural competency trainings. Training methods included lecture, discussion, case scenarios, cultural immersion, role play, contact with diverse individuals, self-reflection about interactions with clients, journaling, and service learning. Readings were considered helpful by trainees, particularly if discussion was included. Factual knowledge about different cultural groups also were reported to be useful, as were guest speakers.

However, notably, results from the review did not point to specific methods or content producing strong effects on client outcomes. Topics included in training curricula were racism and discrimination, worldviews, cultural identity, general concepts about culture, biases, information about specific cultures, and information about the clinical/client interaction as it related to cultural competency or diversity.

Bardone-Cone et al. (2016) outlined a cultural training sequence utilized within a clinical psychology program that incorporated a multicultural orientation and self-reflection, a cultural immersion experience, courses about multiculturalism and supervision, and an annual multicultural case conference. Within their first year, trainees participated in a multicultural orientation to learn about major aspects of identity and completed a cultural genogram about their family background. In their second year, trainees participated in a cultural immersion experience to gain exposure to a specific aspect of diversity. These experiences could include eating lunch with individuals at a homeless shelter or attending a rally of a political party seen as opposite to the party with which one identifies. Then, in their third or fourth year, students took a course on multiculturalism in clinical psychology. Additional activities for fourth year or more advanced students were a multicultural case conference and a course on supervision which included discussion of supervision related to diversity.

Both this study's findings and the literature emphasized the needs for a supportive learning environment that can be fostered with appropriate supervisor self-disclosure, supervision that encourages self-reflection and enhanced knowledge, and clinical or

immersion experiences that expose trainees to diverse individuals. Table 2 has incorporated these recommendations. Additionally, as reviewed previously, Bardone-Cone et al. (2016) provided a model for a cultural training sequence that included a multicultural orientation in the first year and a course on multiculturalism in the third or fourth year. Based upon this reflection of these findings in relation to the literature, Table 2 included a recommendation for a supportive program environment that includes self-disclosure (e.g., of cultural journeys). In addition, identity cues could be discussed in a foundational skills course and therapy orientation courses, and concentrated learning could occur in a multicultural psychology course, sociocultural psychology course, and practicum courses. These recommendations for courses also were included in Table 2.

Considerations of client agency and novice self-examination. This section reviewed this study's findings and the literature to show how a responsiveness-centered curriculum can consist of teaching novice therapists how to support clients' agency and engage in self-examination, personal psychotherapy, and self-care. In order to centralize clients' roles as the agents of change in therapy, therapists needed to become aware of their own needs and how they might infringe upon clients' processes.

Client agency. The findings of Cluster 4 showed how participants learned to see clients as the drivers in the change process and radically reconstrue their role as supporting clients' desired process of change. Trainees noticed that with this adjustment in their mindset, clients became more engaged in therapy, which facilitated more disclosure, better therapist attunement to clients' needs, and increased responsiveness.

An appreciation of client agency can be difficult to foster in this era of manualized treatments and scripted brief treatments. Client agency has been defined as clients' actively making and enacting choices about therapy (Hoener et al., 2012). To teach therapists these sentiments, Bohart and Tallman (2010) underscored training novices to think of psychotherapy as a "collaborative endeavor" (p. 96). Gordon (2012) stated that shifting to this collaborative mindset of therapy with clients as an active agent would be a "new philosophical starting point" (p. 15) that needs to be embraced to improve client outcomes. Clients have reported that when they felt they were responsible for the work of therapy and being a self-healer, they expressed positive feelings of personal accomplishment and empowerment (Hoener et al., 2012). Williams and Levitt (2007) stated that by moving agency into the foreground of therapists' thoughts, they would be better attuned to facilitating clients' agency from moment to moment in therapy.

Bohart and Tallman (2010) recommended that supervisors could help trainees value client agency by teaching them to believe that all clients have an innate ability to change. Novices needed to learn to recognize clients' strengths, resources, and self-healing abilities. Training should emphasize trainees' development of effective, supportive listening, rather than being primarily diagnosticians or interventionists. In addition, trainers could discuss the importance of therapist silence and asking for client feedback to encourage client involvement, so that clients could become more effective problem solvers on their own.

In a responsiveness-centered curriculum, trainees might be guided by supervisors to choose interventions based on considerations of how to increase clients' engagement and responsibility in therapy. This could mean allowing clients to typically lead the conversation, and making strategic decisions on when therapists should become directive. It may require learning humanistic skills that facilitate agency and client self-direction so that directiveness becomes a deliberate stance rather than a default (e.g., Elliott, Watson, Goldman, & Greenberg, 2004). Attentiveness to client agency as a type of responsiveness competency that should be a focus, and the importance of supervisors in guiding trainees to consider client agency, was highlighted in Table 2. Attention to client agency was recommended as important to mention in a foundational skills course and psychotherapy theories course, and that it could be an emphasis in practicum courses within the responsiveness curriculum, because it is a more advanced concept that is easier to learn while trainees engage in clinical work.

Novice self-examination. The findings of Cluster 5 of this study highlighted the importance of supervisors and peers to facilitate trainees' self-reflection and management of self-critical emotions such as self-doubt, guilt, or frustration and try to minimize the impact of those emotions in sessions. This study expanded on the literature through more detailed exploration of trainees learning how to consider whether sharing their emotions with clients was helpful or unhelpful, depending on cues from their clients and case conceptualizations.

The importance of self-examination in training curriculum has been well-supported by the literature. As trainers, Boswell and Castonguay (2007) discussed the importance of training to encourage novices' self-reflection and experiential learning through exposure to feared objects or situations, rather than a purely didactic focus. In a similar vein, based on his own personal experience, Rousmaniere (2017) suggested that therapists should engage in focused deliberate practice, which may include watching their own clinical videos and paying close attention to their internal emotional states. In Rousmaniere's description of his personal experience, increasing awareness of his emotions gradually built acceptance of these emotions and helped him to develop emotional endurance for his work as a therapist. He proposed that therapists could become aware of internal experiences by first building experiential self-awareness of thoughts, feelings, bodily sensations, anxieties, hopes, fears, and more, and then noticing experiential avoidance: the desire to avoid unpleasant feelings such as anxiety, fear, doubt, sadness, anger, and guilt. The development of these skills, he believed, would help therapists to be attuned to their clients' painful experiences.

In addition, Pieterse et al. (2013) wrote about ways to increase self-awareness during training. They suggested a course specifically focused on developing self-awareness, which could include self-reflective group discussions, in which students would aim to challenge themselves and peers with questions, within the context of safe, trusting relationships. The authors talked about the importance of instructors, supervisors, and peers in helping trainees manage reactions, often including anxiety to new self-

discoveries, while making sense of the experiences in the trainees' lives. Self-reflection might be further encouraged through reflective writing assignments, such as journaling or class papers (Hill et al., 2007; Rousmaniere, 2017).

The literature and this study's participants both recommended that supervisors and peers take active roles in shaping trainees' capacity for self-reflection. Specific emphasis on discussing when trainees could share their own emotions with clients in clinically helpful ways was endorsed based on the results of this study. While Pieterse et al.'s (2013) suggestion of a mandatory course on self-awareness might be difficult to implement, self-reflection was mentioned as a method for developing many of the responsiveness competencies in Table 2.

Personal psychotherapy. While few trainees in this study brought up personal therapy as a major influence on learning responsiveness with open-ended prompts, seven of 10 participants who provided feedback had experienced personal therapy and described some benefits. They reported that therapy was helpful to understand the therapeutic process from the client's perspective, increase self-awareness, and experience another therapist's interventions and approach. Trainees noticed both helpful and unhelpful behaviors by their therapists, which they could emulate or avoid in their own clinical practice.

Personal psychotherapy is a required part of many psychotherapy training programs (Edwards, 2018). In Edwards' review of the literature about the rationale for requiring personal psychotherapy, she found that the personal therapy was believed to

assist trainees in having more empathy with clients, although there was risk that trainees might experience distress when issues similar to their own issues were being discussed in personal therapy, making it more difficult to treat clients. Evidence for immediate or long-term benefit of personal therapy was weak, but students tended to believe it was essential to their personal growth and clinical competence. In Murphy, Irfan, Barnett, Castledine, and Enescu's (2018) meta-synthesis of 16 qualitative research studies on mandated psychotherapy during training, novice therapists reported positive effects such as working on personal issues, which validated the model of therapy as effective for change, because they experienced therapy from the client's perspective. Novices talked about greater senses of authenticity and self-acceptance, which led to gains in competence and confidence in their own abilities. The authors cautioned that personal therapy should be considered a method of experiential learning, rather than having a curative function. Trainees should be able to enter therapy at any time when they are ready, and free to set the frequency, length, and intensity of therapy for themselves. Trainees also should be given the opportunity to explore alternative methods for personal development to replace or supplement personal therapy requirements. This could reduce the negative effects of mandatory therapy on removing trainees' autonomy, which could undermine trainees' engaging fully in the therapeutic process.

Based on these findings from this study and the literature, personal psychotherapy could be considered as an option to aid trainees in developing self-awareness and

understanding the therapeutic process. Personal therapy was added as a recommended method to improve responsiveness competencies in Table 2.

Self-care and stress management. In Cluster 5 of this study's findings, trainees stated how self-care was instrumental in improving their provision of therapy by reducing the impact of difficult emotions such as stress and anxiety. Detecting early signs of distress, emotional exhaustion, lower work morale, or burnout helped to avoid potential obstacles to effective therapy.

Training in self-care has been recommended in the literature as a useful addition to therapist training to reduce the impact of difficult therapist emotions (Christopher & Maris, 2010; Norcross & Guy, 2007; Shapiro, Brown, & Biegel, 2007). Self-care could be tracked with journaling, logging, or writing. Trainees' keeping a written record could improve adherence, although caution is advised that maintaining the record does not lead to self-care becoming a burdensome responsibility (Norcross & Guy, 2007).

A course in stress management or mindfulness also may be helpful as part of training curriculum. In one study (Shapiro et al., 2007), a stress management course resulted in trainees' experiencing increased levels of mindfulness and self-compassion, decreased perceived stress, anxiety, and rumination. In another study (Christopher & Maris, 2010), after completion of a semester-long mindfulness course, trainees reported that practicing meditation reduced their discomfort with silence, and that they became less preoccupied with themselves, dwelled less on past moments in therapy, and worried

less about their next steps in sessions. They were more present and attuned to clients' experiences and nonverbal communications.

In summary of the recommendations from this current study and the literature, a responsiveness-centered curriculum should include helping trainees to intentionally plan and engage in regular self-care, which could include mindfulness. While it might be cumbersome to require a stress management or mindfulness course as suggested by Shapiro et al. (2007) and Christopher and Maris (2010), a central task of practicum seminars and supervision could be to learn how to manage stress and engage in mindfulness to reduce the impact of novices' stress, anxiety, and fatigue on their provision of therapy. Managing interference from therapists' emotions could be mentioned in a foundational skills course and in therapy orientation courses, and then focused learning could follow in practicum courses. All of these recommendations were listed in Table 2.

Conceptual shifts by novices that support experimentation and growth. In this section, this study's findings and the literature were examined to demonstrate how responsive interventions could be facilitated by overcoming self-criticism, developing authenticity as a therapist, and managing professional boundaries. Recommendations for how to foster trainees' development in these ways, based on suggestions from this study's findings and the literature, were generated.

Overcoming self-criticism. In the findings from Cluster 6 of this study, trainees expounded upon the benefits to overcoming self-criticism. They described becoming

more confident in trying new relational styles and interventions, which enabled greater responsiveness to clients. Novices stated that their supervisors and peers normalizing their mistakes and affirming their efforts led to decreased shame.

Kannan and Levitt (2015) found that self-criticism was common in novice therapists and underscored the benefits of supervisors drawing attention to these processes, which trainees may wish to hide in supervision. Supervisory factors that helped novices share self-criticism were a sense of safety, permissibility and normalization of clinical errors (Kannan & Levitt, 2015). Support from supervisors helped novices overcome the stress of self-criticism by increasing self-awareness, self-efficacy, and skills (Kannan & Levitt, 2015; Messina et al., 2017, Salter & Rhodes, 2018). On the other hand, felt criticism from supervisors was connected with more frequent difficulties in clinical work, such as avoidant coping, anxiety, and difficulty learning and being creative (Messina et al., 2017; Salter & Rhodes, 2018).

This study's findings and the literature agreed that supervisors and peers could actively work to reduce the impact of trainees' self-criticism by providing emotional support and disclosing their own past clinical mistakes. This recommendation about training program environment is within Table 2.

Developing authenticity. Trainees in this study, in Cluster 6, detailed their learning to incorporate their genuine selves into their therapeutic style so that they could relate authentically to clients, which encouraged openness from their clients. In the literature, trainees have reported that having more client experience helped them be open

and authentic, rather than putting on the "professional mask" of being a therapist (Hill et al., 2015, p. 194). Supervisors could also help by modeling their genuine engagement in therapy to clients, which trainees reported as helpful (Hill et al., 2015; Levendosky & Hopwood, 2017; Salter & Rhodes, 2018). Salter and Rhodes (2018) specified that supervisors' guidance about the role of personality in therapy was named by therapists as being useful for learning to be authentic.

Clinical experience, supervision, and video review of sessions were cited by trainees in this study and the literature as primary learning methods, and so recommendations for this competency in Table 2 included these methods.

Managing professional boundaries. Trainees in this study explained in Cluster 6 how they learned to balance warmth and professional boundaries through clinical experiences primarily, while also noting how their supervisors modeled this balance and stimulated trainees' self-reflection. Trainees reported that working with parents, children, and individuals in correctional settings helped them to think differently about appropriate boundaries for each population, so they wished to encourage novices to gain clinical experience with diverse populations and settings.

Several researchers found in qualitative studies that, through clinical experience, trainees became better at establishing and maintaining boundaries, on aspects such as time or emotional investment in clients (Bischoff, 1997; Hill et al., 2015; Salter & Rhodes, 2018). Therapists often experienced an instance of failing to meet client expectations but still being viewed as helpful, which helped them realize they did not

need to work so hard to achieve change (Bischoff, 1997). Supervisors and peers also helped to normalize and validate clinical experiences, supporting beginning therapists to be confident enforcing boundaries (Bischoff, 1997). Supervision should be thorough, not just a list of "do's and don'ts." Supervisors needed to explain the reasons for guidelines, teach trainees how to apply guidelines, and encourage trainees to discuss unclear situations with them (Knapp & Slattery, 2004).

Based on this study's findings and the literature, supervisors and peers could help trainees learn to manage professional boundaries by normalizing difficulties to increase trainees' self-efficacy, and by explaining the rationale for boundaries and modeling behaviors. Working with diverse populations, or in diverse settings, was cited by this study's participants as helpful. Balancing personal authenticity while taking risks to learn could be mentioned in a foundational skills course and in therapy orientation courses, and then concentrated learning could occur in practicum courses. These recommendations were within Table 2.

Study Limitations and Strengths

A limitation of this study was the lack of diversity with regards to race, gender, and type of graduate training program. Most novice therapists were White (eight of 11 participants), female (seven of 11), and in Clinical Psychology programs (also eight of 11). Therefore, caution should be exercised before generalizing these findings to different therapists and types of training programs. Another possible limitation was the focus on novice therapists in this study. The focus of this paper was on training responsiveness for

students in graduate school and on internship. Trainee therapists may not be aware of elements of responsiveness that more experienced therapists might know and yet, novice therapists provide an important perspective because they are closest to the training needs of new therapists. More research could be conducted on therapists who are more advanced in their career. Interested readers can look at Skovholt and Jennings (2004) to learn more about expert therapists. Lastly, the retrospective recall nature of the interviews was a potential limitation. Methods of learning responsiveness may have been overlooked and forgotten by trainees.

However, strengths of this study were that this sample was diverse in theoretical orientation (e.g., humanistic, CBT, psychodynamic, and multicultural), years of clinical experience (ranging from one to six years), and location of training program within the United States. The credibility of this study was enhanced by several credibility checks conducted by the investigator: asking questions to check on the interview process, using consensus coding, and seeking participant feedback about the findings. Saturation of the categories in the hierarchy was achieved and new categories did not appear when the final two interviews were added, which suggested that the analysis was comprehensive.

Future Directions

Future research could investigate how to assess responsiveness and whether the structured components of responsiveness training suggested by this study are effective as competencies for evaluating or improving responsiveness.

There are no widely-used scales to measure therapist responsiveness, but as described in the introduction of this study, two scales have been put forward to assess responsive treatment (Elkin et al., 2014; Snyder & Silberschatz, 2017). Assessment of responsiveness utilizing these scales could occur at baseline admission and reassessed at later points to measure student progress and the effectiveness of the training program (Hatcher, 2015). The skills, distinctions, and processes that demonstrated responsiveness competencies, as defined in this study, could be utilized as the basis for items on a responsiveness scale. Rating sheets using items from the scales could be developed for the clinical assessments of trainees' responsiveness for session review (tape or video) as a feedback tool as well. A self- or supervisor-assessment measure also can be created in which the competencies listed in Table 2 are evaluated.

In this qualitative study, participants reported improving their responsiveness to clients over time. However, it remains unproven whether client outcomes are improved when therapists are trained to be more responsive. Much of the training literature has demonstrated that training components (such as multicultural training and personal psychotherapy) were seen as helpful through self-report by trainees, without clear evidence of impact on client outcomes (Bardone-Cone et al., 2016; Benuto et al., 2018; Callahan & Watkins, 2018; Murphy et al., 2018; Soheilian et al., 2014). Future research with quantitative measurement would be needed to examine the influence of utilizing this study's recommended learning methods and courses on responsiveness or client outcomes as compared to a "training as usual" model.

Conclusion

Though responsiveness is a key therapy tool, it has not been an explicit focus of therapy training. Here, new data on the development of responsiveness in novice trainees was integrated with existing literature on formal therapist training tools to support specific components of a responsiveness-centered curriculum (see Table 2).

There was substantial agreement between trainees' beliefs and the literature about important elements to teach novices so that they can provide effective, responsive psychotherapy. This implied that these elements are vital and should be part of an intentional competency-based responsiveness-centered curriculum. Video review was recommended often (Cutts, 2012; Friedlander, 2012; Gersten et al., 2013; Tsang et al., 2011), as well as exposure to multiple theoretical orientation processes (Boswell & Castonguay, 2007; Castonguay, 2000). A supportive environment with supervisors and peers was cited as helpful, for meta-communicating about relational cues (Friedlander, 2012, 2015) and for appropriate disclosing of personal experiences to facilitate novices' asking questions and expressing concerns (especially as it pertains to cultural discussions; Bardone-Cone et al., 2016; Benuto et al., 2018).

The literature (e.g., Bohart & Tallman, 2010; Gordon, 2012; Hoener et al., 2012; Williams & Levitt, 2007) as well as novices in this study also agreed on the value of client agency in providing responsive treatment. This underscored the need to intentionally structure training in a way to help novices choose interventions based on how to increase clients' engagement and responsibility in therapy.

Regarding novice self-examination, both researchers (Pieterse et al., 2013; Hill et al., 2007) and novice therapists in this study discussed supervisors' and peers' role in actively shaping trainees' capacity to manage self-critical emotions through validation and normalization to reduce impact of those emotions and encourage continued experimentation with new relational styles and interventions. Both the literature and novices in this study agreed on the importance of others' helping trainees to intentionally plan and engage in regular self-care (Christopher & Maris, 2010; Norcross & Guy, 2007; Shapiro et al., 2007). In addition, supervisors and peers have encouraged trainees to incorporate their genuine selves into therapeutic style (Hill et al., 2015; Levendosky & Hopwood, 2017; Salter & Rhodes, 2018), while maintaining professional boundaries (Bischoff, 1997; Hill et al., 2015; Salter & Rhodes, 2018).

The findings of this study uniquely contributed to the literature by specifying methods for learning responsiveness. Working with diverse populations and settings was cited by novices in this study as helpful for developing appropriate professional boundaries, extending the advantages of multicultural training to the development of professional boundaries (e.g., emotional investment, ending sessions on time; Bischoff, 1997; Hill et al., 2015; Salter & Rhodes, 2018). Novices in this study also extended the literature by noting that self-awareness was important for considering whether sharing their own emotions with clients would be helpful or unhelpful for the therapy. It may be helpful for supervisors to have an awareness of the experiences of supervisees as well. In particular, trainees spoke about how, when providing therapy, they were in a tenuous

position of having to utilize interventions in which they did not yet have confidence, while needing to remain genuine and connected and able to listen to clients so they can fine-tune the interventions.

In terms of differences between the findings of this study and the literature, few participants mentioned learning assessment or personal psychotherapy as a salient source of learning responsiveness when they were asked open-ended questions, although they tended to endorse them as helpful when prompted to consider them. This is somewhat in contrast to research in which trainees reported the helpfulness of participating in personal psychotherapy (Murphy et al., 2018) and learning assessment for improving their provision of therapy (Hill et al., 2015; Smith & Egan, 2017; although these were not identified spontaneously as helpful factors in these studies either). More research about the effects of learning assessment and participating in personal psychotherapy would help elucidate whether they are ways in which novices could best learn responsiveness, or whether other methods might be more helpful.

The central contribution from this study was to develop an empirically and theoretically-driven curriculum for responsiveness training. The amalgamation of methods of training, grounded in novices' experiences, can advance the literature and provide a model for training programs to consider. Continued research into the effects of the training model put forward, or aspects of the model, and their influence on responsiveness competencies would be a future research direction. Responsiveness-

centered training offers exciting potential to stimulate trainees' growth, both personally and professionally.

Table 2: Competency-Based Responsiveness-Centered Curriculum

Type of Responsiveness Competency	Skills that Demonstrate Competency: Distinctions and Processes to Learn	Methods to Learn Competency	Courses to Integrate this Content
Processural Cues for Guiding In-Session Change [see Cluster 1 of Results]	• Empathize with clients • Explore clients' experiences deeply • Notice content related to theoretical orientation in-session processes (such as relational process, transference) • Adjust pace, notice clients' moment-to-moment shifts in affect (especially non-verbal cues) and readiness to change	Personal reflection (experiences, relationships), clinical experience (individual and group therapy), learning different theoretical orientations (watching videos, courses), role plays, supervision, personal psychotherapy, video review of sessions, exercises that use process measures Examples: instructional modules (Constantino, Boswell, Bernecker, & Castonguay, 2013); peer- and supervisor- supported video-tape review, focused on noticing and reacting to specific processural cues (Cutts, 2012; Friedlander, 2012; Gersten, Mears, Baldwin, Roerts, Gaertner, & Bartley, 2013; Tsang, Bogo, & Lee, 2011); assessment (Hill et al., 2015; Smith & Egan, 2017)	Mentioned in foundational skills course, psychotherapy theories course, assessment course Concentrated in therapy orientation courses, practicum courses
Relational Cues for Strengthening the Relationship [see Cluster 2]	• Build positive rapport • Use metaphors, discuss shared interests, use nonverbal activities • Support client's sense of safety (demonstrate patience and non-judgmental stance; validate, normalize, and regulate emotions) • Comment on client-therapist dynamics	Personal reflection (experiences, relationships), clinical experience (individual and group therapy), class discussions, writing summaries about sessions, supervision Examples: teaching trainees with an alliance-repair manual and focusing on alliance in video review (Constantino, Morrison, Coyne, & Howard, 2017); supportive environment with supervisors and peers (Friedlander, 2012, 2015)	Mentioned in foundational skills course Concentrated in therapy orientation courses, practicum courses
Identity Cues for Heightening Attunement [see Cluster 3]	• Increase awareness of contextual factors, individual, and group identities, variability within identities, and intersectionality between identities • Fully explore clients' backgrounds and effects on clients (e.g., communication, behavior, values) • Consider relationship and treatment goals in light of identity or contextual factors	Coursework, personal reflection (traveling, personal identities), clinical experience (exposure to diverse populations), supervision (video review) Examples: guest speakers (Benuto, Casas, & O'Donohue, 2018); immersion experiences (Bardone-Cone et al., 2016); appropriate disclosure of personal experiences from supervisors, faculty, and peers (Bardone-Cone et al., 2016; Benuto et al., 2018)	Mentioned in foundational skills course, therapy orientation courses Concentrated in multicultural psychology course, sociocultural psychology course, practicum courses

Table 2 (continued): Competency-Based Responsiveness-Centered Curriculum

Type of Responsiveness Competency	Skills that Demonstrate Competency: Distinctions/Processes to Learn	Methods to Learn Competency	Courses to Integrate this Content
Client Agency for Empowering Clients [see Cluster 4]	• Collaborate on setting goals or choosing topics for sessions • Allow clients to lead conversation or set the pace • Seek clients' feedback • Consider being more directive if clients are high-risk or avoidant	Classes, clinical experience, supervision, personal psychotherapy Examples: supervisors' encouragement to choose interventions based on how to help clients increase or maintain engagement or responsibility in therapy (Bohart & Tallman, 2010; Gordon, 2012; Williams & Levitt, 2007)	Mentioned in foundational skills course, psychotherapy theories course Concentrated in practicum courses
Management of Interference from Therapists' Emotions [see Cluster 5]	• Develop awareness of therapist's own thoughts, emotions, physical sensations • Cope with anxiety, guilt, and self-doubt • Recognize incremental gains or gains besides symptom relief • Overcome irritation and frustration with clients • Be vulnerable in seeking feedback about mistakes and anxious moments in therapy • Learn to hide or express therapist's own emotions according to clients' needs • Engage in regular self-care	Class discussions, personal reflection, clinical experience, supervision, personal psychotherapy Examples: self-reflective group discussions (Pieterse, Lee, Ritmeester, & Collins, 2013); reflective writing assignments focused on self-awareness and strategic sharing with clients (Hill et al., 2007; Rousmaniere, 2017); a stress management and/or mindfulness course (Christopher & Maris, 2010; Shapiro, Brown, & Biegel, 2007); written records of self-care and regular reminders of trainees' mindfulness or self-care skills from supervisors (Norcross & Guy, 2007)	Mentioned in foundational skills course, therapy orientation courses Concentrated in practicum courses
Balance of Personal Authenticity while Taking Risks to Learn [see Cluster 6]	• Accept mistakes and difficulties in therapeutic interactions • Develop curiosity • Reduce self-criticism • Convey enough emotion to validate client • Avoid conveying too much anxiety to client • Learn to express genuine self authentically as therapist • Learn rationales for appropriate professional boundaries with clients	Classes (mock sessions), clinical experience (with diverse populations and settings), supervision (video review), role plays, personal reflection Examples: school or work culture of safety, permissibility and normalization of clinical errors (including self-disclosure by peers, instructors, or supervisors about own clinical mistakes; Kannan & Levitt, 2015, Messina et al., 2017; Salter & Rhodes, 2018); self-reflection about authentic openness or boundaries with clients through discussions with peers and supervisors (Bischoff, 1997; Hill et al., 2015; Knapp & Slattery, 2004; Levondosky & Hopwood, 2017; Salter & Rhodes, 2018)	Mentioned in foundational skills course, therapy orientation courses Concentrated in practicum courses

APPENDIX A: DEMOGRAPHIC FORM

Novice Therapist Responsiveness Project 2017

1. Age: _____
2. Sex: _____
3. Please indicate which groups most accurately describes your racial identification:

   ☐Alaskan Native/Native American; ☐Black; ☐Latino(a)/Hispanic;

   ☐Asian/ Pacific Islander/Native Hawaiian; ☐White; ☐Other:

   _____
4. Please indicate the areas that most accurately describe the origin of your ethnic identification:

   ☐Africa; ☐Asian; ☐Australia and the Pacific Islands; ☐Caribbean;

   ☐Europe; ☐Middle East/North Africa; ☐Native or Indigenous American;

   ☐North American/Pan-ethnic American; ☐South and Central America;

   Other:_____
5. Sexual Orientation: _____
6. Gender Identity in Most Contexts (e.g., male, female, transgender):

   _____
7. Scientific Field of Study within Psychology: _____
8. Type of Degree: _____
9. Highest Degree Obtained in Psychology: _____

10. Years (and hours) of supervised practice providing psychotherapy:

    Years: _____ Hours: _____

11. How many different clinical supervisors have you had so far?

    _____

12. How many hours of supervision have you received? _____

13. How many direct contact psychotherapy hours have you experienced with clients from different cultures (e.g., age, race, ethnicity, sexual orientation, socioeconomic status, nationality, language) than your own?

    _____

14. Which psychotherapy orientations have been most influential for your approach (e.g., psychodynamic/interpersonal, cognitive-behavioral therapy, humanistic/existential, and multicultural/feminist)? Can you rank order their influence, from 1 = Most influential, to 4 = Least influential? If there are equally influential ones, please use the same numbers. If they are not influential at all, please rank it as zero (0).

____ Psychodynamic/interpersonal
____ Cognitive-behavioral
____ Humanistic/existential
____ Multicultural/feminist
____ Other (please list) _____

15. Which psychotherapy approaches have you practiced in session?

_____

_____

16. Please indicate whether you've experienced the following:

A course in this approach:	Supervision in this approach:
☐Psychodynamic/interpersonal	☐Psychodynamic/interpersonal
☐Cognitive-behavioral	☐Cognitive-behavioral
☐Humanistic/existential	☐Humanistic/existential
☐Multicultural/feminist	☐Multicultural/feminist

17. How would you describe the approach that you use?

_____

_____

18. Within which settings have you practiced psychotherapy?

☐Hospital; ☐Community Mental Health Center; ☐University Counseling Center;

☐School; ☐Private Practice;

☐Other(s): _____

Thank you!

APPENDIX B: INTERVIEW PROTOCOL

Introduction: Thank you for meeting with me today. This study will focus upon the following central question: ***How did you learn how to be responsive to clients as a novice therapist, and in what ways are you responsive?***

Stiles, Honos-Webb, and Surko (1998) conceptualized responsiveness as both *responsiveness to* features such as a client's age, gender, ethnicity, socioeconomic status, diagnosis, or personality, in addition to *responsiveness with* specific treatments, interventions, or other actions; "a therapist responds *to* some client characteristic *with* some intervention" (p. 440).

That said, I am interested in anything you have to share that relates to *your* experiences and understanding of this term. Anything related to these issues would be interesting to me.

1) Defining the Process
    - How would you define the process of being responsive?
    - Can you **describe the process** of being responsive to a client? – a **vignette or story**?
        - Can you describe your **thoughts or beliefs** when you are being responsive?
        - Can you describe your **feelings or emotions** when you are responsive?
    - How do you think you or others could **best learn this process**?

2) Features that Warrant Responsiveness:

- **What client factors are you responsive to?**
- Probes only after initial response: e.g., diagnosis, personality, history, culture, presentation
    - Why or why not? If so, how? **How did you learn that?**

3) Sources for the Learning of Responsiveness:

- **How did you learn how to be more responsive?**
- Probes only after initial response: e.g., supervisors, classes, personal therapy, teaching, experience as a therapist, experiences with friends and/or family, conducting or participating in research
    - Why or why not? If so, how? **How did you learn that?**

4) Obstacles and Supports:

- **What obstacles get in the way of showing responsiveness?**
- Can you **describe an experience** when obstacles got in the way, and you were not responsive to a client? – a **vignette or story**?
- **How did you learn to overcome these obstacles? What helped you?**
- Probes only after initial response: difficult emotions, lack of knowledge, lack of experience

5) Personal Background:

- Is there anything about your personal background (cultural identities, etc.) that impacts how you are responsive to clients?

6) Credibility Questions

- **Is there anything else that we haven't discussed that feels relevant to your experience of responsiveness or that you find interesting? If so, can you describe it now?**
    - Do you have any feedback for me regarding this interview process? Is there anything that you might like to have been done differently or that you think might be helpful with future interviews? If so, do you think this kept you from describing any part of your experience? If so, can you describe it now?
    - Do you think there was anything you couldn't tell me because I am (e.g., Asian, a man, a psychology graduate student, etc.)? Or that you think others might not tell me in future interviews? If so, what? What might help people feel more comfortable?
    - Are there any new thoughts or thoughts that you find most interesting after engaging in this interview? If so, what are they?
    - At the end of this interview, if you were going to summarize in a sentence or two now what thoughts would you communicate to others on the topic of responsiveness in psychotherapy, what would you say?
- Other recommendations for future participants?

APPENDIX C: FULL HIERARCHY DOWN TO INITIAL CATEGORY LEVEL

Core Category: Novice Therapists Indicated that Deliberate Responsiveness Training Should Include: (a) Structured Education on How to Flexibly Adjust Interventions Based Upon Key Processural, Relational, and Identity Cues; (b) Examination of how Oneself and the Client can Promote or Inhibit Change; and (c) Conceptual Shifts to Encourage Experimenting With and Integrating a Range of Relational Styles and Therapy Approaches

Cluster 1: How to Use Processural Cues to be Responsive: Skills in the Moment-by-Moment Process of Psychotherapy Orientations are a Foundation for Responsiveness

- Category 1.1. Developing empathic and exploratory skills is a foundation for responsiveness because therapists learn to listen and notice more about clients.
    - Sub-category 1.1.1. Learning to have greater patience, empathy, and flexibility improves therapist responsiveness in session
    - Sub-category 1.1.2. Therapists' increasing curiosity about others' situations and focusing on listening improves their R in session
    - Sub-category 1.1.3. Therapists' exploring client' non-verbal behaviors leads to responsiveness because clients can express unsaid thoughts or feelings
- Category 1.2. Learning about theoretical orientation processes through observing, listening to, or reading about others' therapy helps novices develop models for responsive application of techniques in service of goals.
    - Sub-category 1.2.1. Exposure to different theoretical orientations helps therapists be flexible in using different interventions and responding to clients' emotions and in-session relational process
    - Sub-category 1.2.2. Learning techniques from different theoretical orientations facilitates responsiveness because it gives therapists options for how to react to different client situations
    - Sub-category 1.2.3. Watching or reading about experienced clinicians can help provide examples of what therapists want to emulate or avoid
    - Sub-category 1.2.4. Responsiveness is a helpful framework and concept, but novice therapists were not explicitly taught it
- Category 1.3. Through clinical experience, therapists learn the importance of responsively changing pace by slowing down to explore clients' concerns or emotions, and speeding up when clients show readiness to change.
    - Sub-category 1.3.1. Slowing down pace is helpful for exploring clients' concerns and emotions more deeply
        - Sub-sub-category 1.3.1.1. Therapists can slow down the pace to focus on exploring their clients' emotions
        - Sub-sub-category 1.3.1.2. Therapists slow down pace to explore clients' concerns in more depth

    - Sub-category 1.3.2. Therapists can speed up pace if clients show engagement and can tolerate emotions

Cluster 2: How to Use Relational Cues to be Responsive: Responsiveness is Developed Cyclically by Establishing Acceptance and Strong Rapport, which Facilitates Clients' Disclosure of Difficult Content in the Therapeutic Relationship, which Then Guides Future Efforts to be Responsive.

- Category 2.1. Therapists learn to make adjustments to facilitate positive rapport and client engagement, which leads to more client disclosure and more content to which to be responsive.
    - Sub-category 2.1.1. Building positive rapport often increases clients' comfort level and disclosure
    - Sub-category 2.1.2. Developing an open, non-judgmental attitude about clients is conducive to learning new things about clients because they feel accepted and share more
    - Sub-category 2.1.3. Therapists' communicating in ways that are more comfortable for clients (metaphors, symbolic language, and discussing their interests) is responsive because it gently expresses curiosity, allowing for slowly building trust
    - Sub-category 2.1.4. Therapists' tailoring session content (e.g., type of homework assigned, humor, personal examples, play) specifically to clients helps to keep their interest and encourage deeper thinking
- Category 2.2. Therapists learn from personal reflection and clinical experience to make responsive adjustments to emphasize clients' sense of safety, to encourage disclosing about difficult issues (such as trauma) or emotions.
    - Sub-category 2.2.1. Focusing on safety by being patient, appropriately warm, and nonjudgmental is responsive for clients with trauma history or attachment concerns
    - Sub-category 2.2.2. Therapists' validation and acceptance, conveyed verbally or nonverbally, is responsive to build a safe space for clients to express emotion, though therapists may need to regulate extreme emotions
- Category 2.3. Learning more about, observing, or commenting on client-therapist interpersonal dynamics helps therapists be responsive to how clients are reacting to them, and vice versa.
    - Sub-category 2.3.1. Focused discussion about interpersonal dynamics helps therapists notice moment-to-moment interactions with their clients
    - Sub-category 2.3.2. Being responsive leads to therapists' positive internal feelings of warmth and connectedness with clients, which leads to more responsiveness
    - Sub-category 2.3.3. Patience and non-defensiveness are optimally responsive to clients' anger, frustration, or concerns about therapists'

competence, to validate clients' feelings and demonstrate therapists' support

Cluster 3: How to Use Identity Cues to Be Responsive: Conceptualizing and Exploring the Interactive Effects of Both Group (e.g., Cultural Identities and Mental Health Diagnoses) and Individual Client Differences (e.g., Clients' Contexts) Locates Work Within Their Clients' Frame of Reference

- Category 3.1. Novices learn through coursework, personal reflection, and exposure to diverse populations to identify factors such as their clients' cultural identities, diagnoses, and contexts as reasons for adjusting their treatment in session.
    - Sub-category 3.1.1. Therapists' immersing themselves in diverse cultures on trips, providing therapy to varied clients, engaging in coursework, and personal or hearing about others' experiences helped therapists identify cultural concerns that could impact therapy
        - Sub-sub-category 3.1.1.1. Learning to identify cultural factors and associated needs helped therapists be responsive to culture
        - Sub-sub-category 3.1.1.2. Personal experiences or hearing of others' experiences of discrimination taught therapists to be responsive in validating and supporting diverse clients
    - Sub-category 3.1.2. Developing knowledge of disorders helps therapists identify what to be responsive to, such as choosing approaches to target symptoms
- Category 3.2. Novices need to learn how to fully explore clients' context, such as physical health, living situation, social support, and cultural identities, but also avoid putting undue emphasis if not congruent with clients' perspectives.
    - Sub-category 3.2.1. Being responsive means exploring how identity factors can influence communication, behavior, and values
    - Sub-category 3.2.2. Therapists' working to understand clients' contexts increases responsiveness because it improves the therapeutic alliance, which facilitates more trust and disclosure
    - Sub-category 3.2.3. To be responsive, therapists may want to prioritize responding to cultural identities and feelings of marginalization, but avoid putting undue emphasis on a cultural characteristic if not congruent with client's perspective or valued identities
- Category 3.3. Novices reconsider relationship and treatment goals in light of salient identity or contextual factors, prioritizing working within clients' frame of reference to reach goals and maintain the alliance.
    - Sub-category 3.3.1. Therapists can be responsive to clients who need more time to process (distractible, less verbal, or displaying diminished intellectual capacity) by slowing down pace (changing the way or amount that they speak) or adjusting therapy goals

    - Sub-category 3.3.2. Therapists can be responsive to diagnosis by adapting therapy to clients' current symptoms and presentation, which could include selecting different strategies or adjusting interpretations
    - Sub-category 3.3.3. Therapists can be responsive to culture by being non-judgmental, affirming, avoiding assumptions, and exploring the importance of clients' culture
    - Sub-category 3.3.4. Therapists can consider whether cultural or contextual factors impact clients' motivation to pursue goals and be responsive by addressing potential challenges or recommending supports or resources

Cluster 4: How to Attend to Client Agency to be Responsive: Typically, Therapists Conceptualizing Their Clients as the Ones Directing the Change Process Can Increase Their Attunement and Clients' Motivation, But They May Need to Provide More Guidance When Clients Are Stuck

- Category 4.1. Learning to allow clients to lead conversation or set the pace builds clients' initiative and comfort in sharing, and is especially important to clients of different cultural backgrounds, those who have experienced trauma, or children.
    - Sub-category 4.1.1. Treating clients as experts facilitates responsiveness because therapists can better understand their clients, especially if situations are unfamiliar to them, and clients' guardedness decreases
    - Sub-category 4.1.2. Giving clients the opportunity to lead the conversation is responsive when clients need to feel validated and safe
    - Sub-category 4.1.3. Allow clients to set the pace at which they are comfortable disclosing, to give clients agency (especially if clients have trauma history)
- Category 4.2. Collaborating on setting goals or choosing topics for sessions facilitates meeting clients' needs, and clients become less defensive and more willing to work on goals.
    - Sub-category 4.2.1. Collaboratively setting goals with clients is a responsive process because it increases rapport, increases client engagement, and decreases client resistance
        - Sub-sub-category 4.2.1.1. Being responsive includes adjusting goals to clients' intellectual and emotional capacities, such as simplifying language or skills to help clients understand, or addressing intellectualized defenses
        - Sub-sub-category 4.2.1.2. Collaborating on realistic goals is responsive to decrease clients' resistance and build clients' self-efficacy
            - Initial category 4.2.1.2.1. Collaborating on realistic goals helps decrease clients' resistance

                - Initial category 4.2.1.2.2. Collaborating on goals helps build clients' self-efficacy and initiative while trying novel behaviors
            - Sub-sub-category 4.2.1.3. Adopting a patient, long-term approach to clients' therapy (including future therapy) helps therapists to be responsive to clients' wishes and set realistic goals for current therapy
        - Sub-category 4.2.2. Allowing clients to choose topics for sessions is responsive when therapists sense clients' need to build initiative and be more engaged in therapy
- Category 4.3. Therapists learn from personal therapy, supervision, and clinical experience that seeking clients' feedback increases responsiveness because therapists' understanding of clients' personalities and situations improves.
    - Sub-category 4.3.1. Presenting interventions or interpretations and seeking client feedback facilitates responsiveness through better understanding clients' needs, abilities, and obstacles
    - Sub-category 4.3.2. Therapists' explaining rationale behind their interventions can be responsive to gauge openness or address clients' frustrations
- Category 4.4. Being flexible with scheduling appointments or session agenda can be responsive to client needs, but therapists need to focus on high-risk behaviors and avoid reinforcing maladaptive client patterns.
    - Sub-category 4.4.1. It is responsive to flexibly schedule with clients with busier schedules if building clients' communication skills
    - Sub-category 4.4.2. Focusing on high-risk behaviors (e.g., suicidality, homicidality, problematic substance use) is responsive when therapists are non-judgmental and showing concern for clients' well-being
        - Sub-sub-category 4.4.2.1. Therapists need to respond to high-risk behavior by addressing it even when it is not clients' priority, to show care for clients' livelihood
        - Sub-sub-category 4.4.2.2. Therapists can respond to high-risk behavior with non-judgmental attitudes and exploring the underlying distress instead of being afraid of severity of problems
    - Sub-category 4.4.3. It is responsive to adhere to session agenda or interrupt clients when they bring up new issues, to try to make progress on initial goals and reduce avoidance of difficult topics

Cluster 5: How to Develop Emotional Self-Awareness to Be Responsive: Novices Need to Develop Awareness of Their Own Thoughts and Emotions, Manage These Emotions, and Process with Peers and Supervisors to Learn to be Responsive

- Category 5.1. To be responsive, therapists learn to tolerate their anxiety, guilt, and self-doubt from trying new things and not pursuing symptom relief as quickly.

    - Sub-category 5.1.1. Being optimally responsive in being client-centered, slowing down pace, or changing goals can lead to internal frustration, so novice need to learn to be patient
    - Sub-category 5.1.2. Novices learn to overcome their anxiety from challenging clients and asking difficult questions by being focused on potential client gains
    - Sub-category 5.1.3. Self-doubt, which arises from facing unfamiliar situations or making a mistake in therapy, can impede responsiveness, but can improve responsiveness by motivating novices to seek clients' feedback
- Category 5.2. Novices' learning to identify and manage their personal reactions (emotional, cognitive, physical) to clients in session leads to being responsive.
    - Sub-category 5.2.1. Therapists' noticing their emotions in response to their clients can help them understand how others might feel about their clients
    - Sub-category 5.2.2. Therapists need to manage irritation and dislike of clients, which can impede responsiveness by distracting from what the client is saying and meeting their needs
        - Sub-sub-category 5.2.2.1. Therapists' irritation and dislike of clients impedes responsiveness because therapists have less empathy and have decreased focus on clients' problems
        - Sub-sub-category 5.2.2.2. Therapists can manage frustration with their clients by trying to understand reasons behind clients' behaviors or appreciating the challenge of working with certain clients
        - Sub-sub-category 5.2.2.3. Focusing on shared identities or hobbies between therapists and clients can help create a bond that facilitates managing irritation with clients
    - Sub-category 5.2.3. Therapists can be responsive to their bodily sensations as signs of their thoughts and emotions in reaction to clients
    - Sub-category 5.2.4. Therapists' considering their own thoughts in reaction to clients provides information to which to be responsive
- Category 5.3. Novices' taking initiative to seek feedback about mistakes or anxious moments in therapy facilitates learning responsiveness; vulnerability by peers or supervisors increases novices' comfort in sharing.
    - Sub-category 5.3.1. Novice therapists need to be vulnerable and seek feedback about mistakes to learn responsiveness
    - Sub-category 5.3.2. Others (supervisors, peers) discussing mistakes, struggles, or anxiety normalizes difficulties which helped novices process those feelings and situations and reduce self-doubt and anxiety, so they could learn and be responsive in future sessions
    - Sub-category 5.3.3. Clear questions and feedback by others about therapists' in-session thoughts, emotions, and behaviors foster learning

responsiveness by providing suggestions and support, which encourages experimentation and reinforces effective interventions
        - Sub-sub-category 5.3.3.1. Supervisors and peers help therapists learn responsiveness by guiding processing about therapists' behaviors, thoughts, and emotions during sessions
        - Sub-sub-category 5.3.3.2. Specific suggestions and feedback from others about the effects of therapists' behavior, positive behaviors, and client features to which to be responsive helps novices learn to be responsive
            - Initial category 5.3.3.2.1. An approachable, supportive supervisory style facilitates comfort for trainees, which helps learning responsiveness, and a distant or critical style increases anxiety, which is an obstacle to learning responsiveness
            - Initial category 5.3.3.2.2. Feedback can help broaden my perspective on client features to which to be responsive
            - Initial category 5.3.3.2.3. Direct, honest feedback about the effect of therapists' behavior on clients is helpful for learning responsiveness
            - Initial category 5.3.3.2.4. Feedback about positive behaviors reinforces responsiveness and reduces self-doubt and self-criticism
- Category 5.4. To be responsive to clients' emotions, novices learn to hide or express their own emotions according to clients' needs.
    - Sub-category 5.4.1. Responsiveness can mean therapists hiding internal emotions (frustration, anxiety, panic) to be client-centered and explore difficult client experiences
    - Sub-category 5.4.2. Responsiveness can mean therapists expressing emotions when supporting clients' emotional expression or promoting clients' changes
        - Sub-sub-category 5.4.2.1. Therapists' expression of own emotions is responsive when it helps clients explore their emotions or supports positive change, but not if client feels need to support therapist
            - Initial category 5.4.2.1.1. Therapists' complimenting their clients' progress, effective coping, and positive behaviors is responsive support
            - Initial category 5.4.2.1.2. Therapists' matching their clients' emotions, body language, or voice can increase responsiveness because it helps understand their feelings

                - Initial category 5.4.2.1.3. Therapists' self-involving self-disclosures about emotions are responsive to validate and encourage their clients' emotional expression
            - Sub-sub-category 5.4.2.2. Responsiveness can mean appropriately sharing frustration about clients to them or challenging them to interrupt clients' maladaptive emotional or behavioral patterns
                - Initial category 5.4.2.2.1. Therapists' challenging or sharing frustration about clients is responsive to interrupt clients' maladaptive behavior and avoid weakening of therapeutic alliance
                - Initial category 5.4.2.2.2. Therapists' gently challenging or sharing their frustration is responsive when it helps clients feel safe and share their emotions
- Category 5.5. Novices' self-care leads to better responsiveness because it reduces negative emotions and exhaustion and leads to greater focus on clients.
    - Sub-category 5.5.1. Therapists need to reduce or prevent anxiety, burnout, or exhaustion by engaging in self-care or intentionally managing their schedules, because those emotions would impede responsiveness
    - Sub-category 5.5.2. Therapists' processing personal issues outside of session reduces risk of decreased responsiveness to clients, and processing can be facilitated by supervisors' or peers' validation and self-disclosure
        - Sub-sub-category 5.5.2.1. Therapists' personal issues (such as homelessness or divorce) can lead to decreased empathy or focus on clients, which reduces responsiveness
        - Sub-sub-category 5.5.2.2. Others' modeling self-disclosure of personal issues and validating their effect on therapy facilitates novice therapists' sharing personal issues
        - Sub-sub-category 5.5.2.3. Novice therapists' worry about negative evaluations leads to not sharing personal issues, which inhibits learning how to process them so that therapists can still be responsive in session
    - Sub-category 5.5.3. Practicing mindfulness helps me stay focused on clients, which facilitates responsiveness

Cluster 6: How to Take Risks to Learn to Be Responsive: Therapists Navigate the Paradox of Being Authentic in Delivery while Needing to Adjust Their Natural Relational Styles to Learn to Better Guide Clients Responsively

- Category 6.1. Trial-and-error in clinical experiences and role plays, including trying new interventions, is needed to learn responsiveness, and can be fostered by accepting mistakes as part of the process.
    - Sub-category 6.1.1. Gaining clinical experience leads to chances for trial-and-error, which is needed because therapy is more than applying theories

    - Sub-category 6.1.2. Therapists' adopting attitude to be experimental, curious, and constantly learn facilitates developing responsiveness
    - Sub-category 6.1.3. Practicing and discussing possible scenarios and reactions by clients helps novices learn responsiveness
    - Sub-category 6.1.4. Seeking feedback from clients and supervisors after trying new approaches in session helps develop responsiveness
    - Sub-category 6.1.5. Therapist self-criticism about past mistakes impedes trying new things, and it can be reduced with successful experiences and supervisor support
- Category 6.2. To learn responsiveness, novices experiment with facial and emotional expressions that are different from their own typical behavior.
    - Sub-category 6.2.1. To be responsive, therapists learn to express emotions more or less than their personal style, to fit different needs of clients, such as for more support or a slower pace
    - Sub-category 6.2.2. To be responsive, therapists try to match their external facial expressions to their internal emotions, and adjust if mismatched
- Category 6.3. Therapist authenticity is important to facilitate responsiveness, because it increases focus on clients and models genuineness, which fosters clients' sharing, but therapists also need to have professional boundaries to avoid being manipulated by clients.
    - Sub-category 6.3.1. Being responsive makes therapists feel more relaxed and comfortable, which facilitates more responsiveness because they are more focused on clients
    - Sub-category 6.3.2. Having an affected, overly professional therapist persona reduces responsiveness because clients feel sense of distance, which can lead to resistance
    - Sub-category 6.3.3. Therapists' being their genuine selves helps to relate authentically to clients, but professional boundaries are needed to maintain focus on clients' concerns and avoid being manipulated by clients
        - Sub-sub-category 6.3.3.1. Therapists being their natural selves helps clients be more genuine, which facilitates responsiveness
        - Sub-sub-category 6.3.3.2. Therapists need to balance being warm and genuine with having professional boundaries, to maintain focus on therapeutic goals

REFERENCES

Ablon, J., & Jones, E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy. *Psychotherapy Research, 8,* 71-83. https://doi.org/10.1093/ptr/8.1.71

Ablon, J. S., & Jones, E. E. (2002). Validity of controlled clinical trials of psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry, 159,* 775-783. https://doi.org/10.1176/appi.ajp.159.5.775

Ablon, J. S., Levy, R. A., & Katzenstein, T. (2006). Beyond brand names of psychotherapy: Identifying empirically supported change processes. *Psychotherapy: Theory, Research, Practice, Training, 43,* 216-231. https://doi.org/10.1037/0033-3204.43.2.216

Aladağ, M., Yaka, B., & Koç, I. (2014). Opinions of counselor candidates regarding counseling skills training. *Educational Sciences: Theory & Practice, 14,* 879-886. Retrieved from https://www.estp.com.tr/

Bacal, H. (1985) Optimal responsiveness and the therapeutic process. In A. Goldberg (Ed.) *Progress in self psychology* (Vol.9, pp. 202-226). New York: Guilford Press.

Bacal, H. A. (2007). Discussion of Judy Pickles's case presentation from the perspective of psychoanalytic specificity theory. *Psychoanalytic inquiry, 27,* 125-138. https://doi.org/10.1080/07351690701312629

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). New York: Wiley.

Bardone-Cone, A. M., Calhoun, C. D., Fischer, M. S., Gaskin-Wasson, A. L., Jones, S. C. T., Schwartz, S. L., … Prinstein, M. J. (2016). Development and implementation of a diversity training sequence in a clinical psychology doctoral program. *The Behavior Therapist, 39,* 65–75. Retrieved from https://www.abct.org/Journals/?m=mJournal&fa=TBT

Benuto, L. T., Casas, J., & O'Donohue, W. T. (2018). Training culturally competent psychologists: A systematic review of the training outcome literature. *Training and Education in Professional Psychology, 12,* 125–134. https://doi.org/10.1037/tep0000190

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology, 34,* 121-132. https://doi.org/10.1002/jcop.20096

Bischoff, R. J. (1997). Themes in therapist development during the first three months of clinical experience. *Contemporary Family Therapy, 19,* 563-580. https://doi.org/10.1023/A:1026139206638

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83–111). Washington, DC: American Psychological Association. doi:10.1037/12075-003

Boswell, J. F., & Castonguay, L. G. (2007). Psychotherapy training: Suggestions for core ingredients and future research. *Psychotherapy, 44*, 378–383. https://doi.org/10.1037/0033-3204.44.4.378

Callahan, J. L., & Watkins, C. E., Jr. (2018). The science of training II: Prepracticum and practicum training. *Training and Education in Professional Psychology, 12*, 231–244. https://dx.doi.org/10.1037/ tep0000209

Castonguay, L. G. (2000). A common factors approach to psychotherapy training. *Journal of Psychotherapy Integration, 10*, 263–282. https://doi.org/10.1023/A.1009496929012

Christopher, J. C., & Maris, J. A. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling & Psychotherapy Research, 10*, 114–125. https://doi.org/10.1080/14733141003750285

Church, E. (1993). Reading the transference in adolescent psychotherapy: A comparison of novice and experienced therapists. *Psychoanalytic Psychology, 10*, 187-205. https://doi.org/10.1037/h0079462

Cicchetti, D. V., & Ornston, P. S. (1976). The initial psychotherapy interview: A content analysis of the verbal responses of novice and experienced therapists. *The Journal of Psychology, 93*, 167-174. https://doi.org/10.1080/00223980.1976.9915809

Connolly Gibbons, M. B., Crits-Christoph, P., Levinson, J., & Barber, J. (2003). Flexibility in manual-based psychotherapies: Predictors of therapist interventions in interpersonal and cognitive-behavioural therapy. *Psychotherapy Research, 13*, 169-185. https://doi.org/10.1093/ptr/kpg017

Constantino, M. J., Boswell, J. F., Bernecker, S. L., & Castonguay, L. G. (2013). Context-responsive psychotherapy integration as a framework for a unified clinical science: Conceptual and empirical considerations. *Journal of Unified Psychotherapy and Clinical Science, 2*, 1-20. Retrieved from https://www.unifiedpsychotherapyproject.org/journal/

Constantino, M. J., Morrison, N. R., Coyne, A. E., & Howard, T. (2017). Exploring therapeutic alliance training in clinical and counseling psychology graduate programs. *Training and Education in Professional Psychology, 11*, 219–226. https://doi.org/10.1037/tep0000157.supp (Supplemental)

Cutts, L. A. (2012). A case study exploring a trainee counselling psychologist's experience of coding a single session of counselling for therapeutic intentions. *Counselling Psychology Quarterly, 25*, 263-275. https://doi.org/10.1080/09515070.2012.716192

Daly, K. D., & Mallinckrodt, B. (2009). Experienced therapists' approach to psychotherapy for adults with attachment avoidance or attachment anxiety. *Journal of Counseling Psychology, 56,* 549-563. https://doi.org/10.1037/a0016695.supp (Supplemental)

Dennhag, I., & Ybrandt, H. (2013). Trainee psychotherapists' development in self-rated professional qualities in training. *Psychotherapy, 50,* 158-166. https://doi.org/10.1037/a0033045

Doctors, S. R. (1999). Further thoughts on "self-cutting": The intersubjective context of self-experience and the vulnerability to self-loss. *Psychoanalytic Review, 86,* 733-744. Retrieved from https://npap.org/psychoanalyticreview/

Edwards, D. J. (2010). Using systematic case studies to investigate therapist responsiveness: examples from a case series of PTSD treatments. *Pragmatic Case Studies in Psychotherapy, 6,* 255-275. https://doi.org/10.14713/pcsp.v6i4.1047

Edwards, J. (2018). The extant rationale for mandated therapy during psychotherapy and counselling training: A critical interpretive synthesis. *British Journal of Guidance & Counselling, 46,* 515-530. https://doi.org/10.1080/03069885.2017.1334110

Elkin, I., Falconnier, L., Smith, Y., Canada, K. E., Henderson, E., Brown, E. R., & Mckay, B. M. (2014). Therapist responsiveness and patient engagement in therapy. *Psychotherapy Research, 24,* 52-66. https://doi.org/10.1080/10503307.2013.820855

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229. https://doi.org/10.1348/014466599162782

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004) *Learning Emotion-Focused Therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

Elmore, A. (2016). Empirically supported treatments: Precept or percept? *Professional Psychology: Research and Practice, 47*(3), 198–205. https://doi.org/10.1037/pro0000078

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *JAMA: Journal of the American Medical Association, 287,* 226–235. https://doi.org/10.1001/jama.287.2.226

Eubanks-Carter, C., Muran, J. C., & Safran, J. (2015). Alliance-focused training. *Psychotherapy, 52,* 169-173. doi:10.1037/a0037596

Falconnier, L., & Elkin, I. (2008). Addressing economic stress in the treatment of depression. *American Journal of Orthopsychiatry, 78,* 37-46. https://doi.org/10.1037/0002-9432.78.1.37

Falender, C. A., & Shafranske, E. P. (2010). Psychotherapy-based supervision models in an emerging competency-based era: A commentary. *Psychotherapy: Theory, Research, Practice, Training, 47,* 45–50. https://doi.org/10.1037/a0018873

Fosha, D. (2004). Brief integrative therapy comes of age: A Commentary. *Journal of Psychotherapy Integration, 14,* 66-92. https://doi.org/10.1037/1053-0479.14.1.66

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., … Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology, 3*(Suppl), S5–S26. https://doi.org/10.1037/a0015832

Freud, S. (1912). The dynamics of transference. In J. Starchey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99–108). London, United Kingdom: Hogarth Press.

Friedlander, M. L. (2012). Therapist responsiveness: Mirrored in supervisor responsiveness. *The Clinical Supervisor, 31*, 103-119. https://doi.org/10.1080/07325223.2012.675199

Friedlander, M. L. (2015). Use of relational strategies to repair alliance ruptures: How responsive supervisors train responsive psychotherapists. *Psychotherapy*, *52*, 174-179. https://doi.org/10.1037/a0037044

Gersten, A. H., Mears, G. F., Baldwin, C. L., Roberts, S., Gaertner, D., & Bartley, J. L. (2013). The development of intentionality: Training and supervision implications. *The Clinical Supervisor, 32,* 70–89. https://doi.org/10.1080/07325223.2013.780877

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh, PA, US: Duquesne University Press.

Glaser, B.G. (1978). *Theoretical sensitivity*. Mill Valley, CA, US: Sociology Press.

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Co.

Gordon, R. (2012). Where oh where are the clients? The use of client factors in counselling psychology. *Counselling Psychology Review, 27,* 8–17. Retrieved from https://shop.bps.org.uk/publications/publication-by-series/counselling-psychology-review.html

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, research, practice, training*, *43*, 531-548. https://doi.org/10.1037/0033-3204.43.4.531

Hardy, G. E., Aldridge, J., Davidson, C., Rowe, C., Reilly, S., & Shapiro, D. A. (1999). Therapist responsiveness to client attachment styles and issues observed in client-identified significant events in psychodynamic-interpersonal psychotherapy. *Psychotherapy Research, 9*, 36–53. https://doi.org/10.1093/ptr/9.1.36

Hatcher, R. L. (2015). Interpersonal competencies: Responsiveness, technique, and training in psychotherapy. *American Psychologist, 70*, 747–757. https://doi.org/10.1037/a0039803

Heatherington, L., Messer, S. B., Angus, L., Strauman, T. J., Friedlander, M. L., & Kolden, G. G. (2012). The narrowing of theoretical orientations in clinical psychology doctoral training. *Clinical Psychology: Science and Practice, 19,* 364–374. https://doi.org/10.1111/cpsp.12012

Hill, C. E. (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena*. Washington, DC: American Psychological Association.

Hill, C. E., Baumann, E., Shafran, N., Gupta, S., Morrison, A., Rojas, A. E., . . . Gelso, C. J. (2015). Is training effective? A study of counseling psychology doctoral trainees in a psychodynamic/interpersonal training clinic. *Journal of Counseling Psychology, 62,* 184 –201. https://dx.doi.org/10.1037/cou0000053

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology*, *40*(1), 3–24. https://doi.org/10.1037/0022-0167.40.1.3

Hill, C. E., & Lent, R. W. (2006). A narrative and meta-analytic review of helping skills training: Time to revive a dormant area of inquiry. *Psychotherapy: Theory, Research, Practice, Training, 43*, 154 –172. https:// dx.doi.org/10.1037/0033-3204.43.2.154

Hill, C. E., Sullivan, C., Knox, S., & Scholler, L. Z. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy: Theory. Research, Practice, Training, 44,* 434–449. https://doi.org/10.1037/0033-3204.44.4.434

Hoener, C., Stiles, W. B., Luka, B. J., & Gordon, R. A. (2012). Client experiences of agency in therapy. *Person-Centered and Experiential Psychotherapies, 11*, 64–82. https://doi.org/10.1080/14779757.2011.639460

Honos-Webb, L., & Stiles, W. B. (2002). Assimilative integration and responsive use of the assimilation model. *Journal of Psychotherapy Integration, 12*, 406-420. https://doi.org/10.1037/1053-0479.12.4.406

Huang, T., Hill, C., & Gelso, C. (2013). Psychotherapy engagers versus non-engagers: Differences in alliance, therapist verbal response modes, and client attachment. *Psychotherapy Research, 23*, 568-577. https://doi.org/10.1080/10503307.2013.807378

Huey Jr, S., & Pan, D. (2006). Culture-responsive one-session treatment for phobic Asian Americans: A pilot study. *Psychotherapy: Theory, Research, Practice, Training, 43*, 549-554. https://doi.org/10.1037/0033-3204.43.4.549

Jacobsson, G., Lindgren, T. E., & Hau, S. (2012). Rites of passage: Novice students' experiences of becoming psychotherapist. *Nordic Psychology*, *64*, 192-202. Retrieved from https://www.tandfonline.com/loi/rnpy20

Kannan, D., & Levitt, H. M. (2015). Self-criticism in therapist training: A grounded theory analysis. *Psychotherapy Research, 27,* 201-214. https://dx.doi.org/10.1080/10503307.2015.1090036

Knapp, S. & Slattery, J. M. (2004). Professional boundaries in nontraditional settings. *Professional Psychology: Research and Practice,* 35, 553-558. doi:10.1037/0735-7028.35.5.553

Kohut, H., & Seitz, P. F. (1963). Concepts and theories of psychoanalysis. In J. M. Wepman & R. W. Heine (Eds.) *Concepts of personality* (pp. 113-141). New Brunswick, NJ, US: Transaction Publishers.

Kramer, U. (2009). Individualizing exposure therapy for PTSD: The case of Caroline. *Pragmatic case studies in psychotherapy*, *5*, 1-24. https://doi.org/10.14713/pcsp.v5i2.966

Kramer, U., & Stiles, W. B. (2015). The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychology: Science and Practice*, *22*, 277-295. https://doi.org/10.1111/cpsp.12107

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy*, 51, 467-481. https://doi.org/10.1037/a0034332

Lee, E., & Horvath, A. O. (2014). How a therapist responds to cultural versus noncultural dialogue in cross-cultural clinical practice. *Journal of Social Work Practice*, *28*, 193-217. https://doi.org/10.1080/02650533.2013.821104

Levendosky, A. A., & Hopwood, C. J. (2017). A clinical science approach to training first year clinicians to navigate therapeutic relationships. *Journal of Psychotherapy Integration*, *27*, 153–171. https://dx.doi.org/10 .1037/int0000042

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, *142*, 801-830. https://dx.doi.org/10.1037/bul0000057

Levitt, H. M., & Williams, D. C. (2010). Facilitating client change: Principles based upon the experience of eminent psychotherapists. *Psychotherapy Research*, *20*, 337-352. https://doi.org/10.1080/10503300903476708

Levy, K. N., & Anderson, T. (2013). Is clinical psychology doctoral training becoming less intellectually diverse? And if so, what can be done? *Clinical Psychology: Science and Practice*, *20*, 211–220. https://doi.org/10.1111/cpsp.12035

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review*, *33*(7), 883–900. https://doi.org/10.1016/j.cpr.2012.09.008

Lord, S. A. (2008). Therapeutic work with trauma, revictimization, and perpetration: Bearing witness, offering hope, embracing despair. *Psychoanalytic Social Work*, *15*, 110-131. https://doi.org/10.1080/15228870802103671

Lutwak, N. (1993). Conceptual level and therapeutic responsiveness among counselor trainees. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues, 12*, 353–363. https://doi.org/10.1007/BF02686815

Mackrill, T., & Iwakabe, S. (2013). Making a case for case studies in psychotherapy training: A small step towards establishing an empirical basis for psychotherapy training. *Counselling Psychology Quarterly*, *26*, 250-266. https://doi.org/10.1080/09515070.2013.832148

Messina, I., Gelo, O. C. G., Sambin, M., Bianco, F., Mosconi, A., Fenelli, A., Curto, M., Gullo, S., & Orlinsky, D. (2017). Trainees' self-evaluation of their development as psychotherapists: An Italian contribution to an international collaborative study on psychotherapy training. *Journal of Clinical Psychology and Psychotherapy, 25*, 338-347. https://doi.org: 10.1002/cpp.2165

Muntigl, P., Knight, N., Horvath, A. O., & Watkins, A. (2012). Client attitudinal stance and therapist-client affiliation: A view from grammar and social interaction. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *15*, 117–130. Retrieved from https://www.researchinpsychotherapy.org/index.php/rpsy

Murphy, D., Irfan, N., Barnett, H., Castledine, E., & Enescu, L. (2018). A systematic review and meta-synthesis of qualitative research into mandatory personal psychotherapy during training. *Counselling & Psychotherapy Research*, *18*, 199-214. https://doi.org/10.1002/capr.12162

Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: A guide to psychotherapist self-care*. New York: Guilford Press.

Norcross, J. C., Sayette, M. A., & Pomerantz, A. M. (2018). Doctoral training in clinical psychology across 23 years: Continuity and change. *Journal of Clinical Psychology*, *74*(3), 385–397. https://doi.org/10.1002/jclp.22517

Orlinsky, D. E., & Rønnestad, M. H. (2005). Current development: Growth and depletion. In D. E. Orlinsky & M. H. Rønnestad (Eds.). *How psychotherapists develop: A study of therapeutic work and professional growth* (pp. 117-129). Washington, DC, US: American Psychological Association.

Pan, D., Huey Jr, S. J., & Hernandez, D. (2011). Culturally adapted versus standard exposure treatment for phobic Asian Americans: Treatment efficacy, moderators, and predictors. *Cultural Diversity and Ethnic Minority Psychology*,*17*, 11-22. https://doi.org/10.1037/a0022534

Pascual-Leone, A., Rodriguez-Rubio, B., & Metler, S. (2013). What else are psychotherapy trainees learning? A qualitative model of students' personal experiences based on two populations. *Psychotherapy Research*, *23*, 578-591. https://doi.org/10.1080/10503307.2013.807379

Pieterse, A. L., Lee, M., Ritmeester, A., & Collins, N. M. (2013). Towards a model of self-awareness development for counseling and psychotherapy training. *Counselling Psychology Quarterly, 26*, 190-207. https://doi.org/10.1080/09515070.2013.793451

Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology?. *Canadian Psychology/Psychologie Canadienne, 29*, 139-150. https://doi.org/10.1037/h0079765

Rønnestad, M. H., & Orlinsky, D. E. (2005). Comparative cohort development: Novice to senior therapists. In D. E. Orlinsky & M. H. Rønnestad (Eds.). *How psychotherapists develop: A study of therapeutic work and professional growth* (pp. 143-157). Washington, DC, US: American Psychological Association.

Rousmaniere, T. (2017). *Deliberate practice for psychotherapists: A guide to improving clinical effectiveness*. New York: Routledge.

Safran, J., Muran, J. C., Demaria, A., Boutwell, C., Eubanks-Carter, C., & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research, 24,* 269–285. https://doi.org/10.1080/10503307.2013.874054

Salter, M., & Rhodes, P. (2018). On becoming a therapist: A narrative inquiry of personal–professional development and the training of clinical psychologists. *Australian Psychologist, 53,* 486-492. https://doi.org/10.1111/ap.12344

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1,* 105–115. https://doi.org/10.1037/1931-3918.1.2.105

Skovholt, T. M., & Jennings, L. (2004). *Master therapists: Exploring expertise in therapy and counseling*. Needham Heights, MA: Allyn & Bacon.

Skovholt, T. M., & Rønnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30,* 45-58. https://doi.org/10.1023/A:1025125624919

Smith, J. D. & Egan, K. N. (2017). Trainee and client experiences of therapeutic assessment in a required graduate course: A qualitative analysis. *Journal of Personality Assessment, 99,* 126-135. https://doi.org/10.1080/00223891.2015.1077336

Snyder, J., & Silberschatz, G. (2017). The Patient's Experience of Attunement and Responsiveness Scale. *Psychotherapy Research, 27,* 608–619. https://doi.org/10.1080/10503307.2016.1147658

Soheilian, S. S., Inman, A. G., Klinger, R. S., Isenberg, D. S., & Kulp, L. E. (2014). Multicultural supervision: Supervisees' reflections on culturally competent supervision. *Counselling Psychology Quarterly*, *27*, 379–392. https://doi.org/10.1080/09515070.2014.961408

Sperry, L., Carlson, J., Sauerheber, J. D., & Sperry, J. (Eds.). (2015). *Psychopathology and psychotherapy: DSM-5 diagnosis, case conceptualization, and treatment (Third edition)*. New York, NY: Routledge.

Stiles, W. B. (1988). Psychotherapy process-outcome correlations may be misleading. *Psychotherapy: Theory, Research, Practice, Training, 25,* 27-35. https://doi.org/10.1037/h0085320

Stiles, W. B. (2013). The variables problem and progress in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training, 50,* 33-41. https://doi.org/10.1037/a0030569

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5,* 439-458. https://doi.org/10.1111/j.1468-2850.1998.tb00166.x

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA, US: Sage Publications Inc.

Thompson, M. N., Cole, O. D., & Nitzarim, R. S. (2012). Recognizing social class in the psychotherapy relationship: a grounded theory exploration of low-income clients. *Journal of Counseling Psychology, 59*, 208-221. https://doi.org/10.1037/a0027534.

Timulák, L., & McElvaney, R. (2013). Qualitative meta-analysis of insight events in psychotherapy. *Counselling Psychology Quarterly*, *26*, 131-150. https://doi.org/10.1080/09515070.2013.792997

Tsang, A., Bogo, M., & Lee, E. (2011). Engagement in cross-cultural clinical practice: Narrative analysis of first sessions. *Clinical Social Work Journal*, *39*, 79 –90. https://dx.doi.org/10.1007/s10615-010-0265-6

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge.

Williams, D. C., & Levitt, H. M. (2007). Principles for facilitating agency in psychotherapy. *Psychotherapy Research, 17*, 66 – 82. doi:10.1080/10503300500469098

Williams, E. N., Judge, A. B., Hill, C. E., & Hoffman, M. A. (1997). Experiences of novice therapists in prepracticum: Trainees', clients', and supervisors' perceptions of therapists' personal reactions and management strategies. *Journal of Counseling Psychology*, *44*, 390-399. https://doi.org/10.1037/0022-0167.44.4.390

Zeddies, T. J. (1999). Becoming a psychotherapist: The personal nature of clinical work, emotional availability and personal allegiances. *Psychotherapy: Theory, Research, Practice, Training*, *36*, 229-235. https://doi.org/10.1037/h0087730