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Navigating the Complexities of the Psychotherapy Process: A Multi-Method Investigation on the Role of Therapist Responsiveness

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"[…] Comprendo que no existe

El camino derecho

Solo un gran laberinto

De encrucijadas múltiples […]"

Los puentes colgantes, Federico García Lorca

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General introduction[1]

The effectiveness of psychotherapy to treat diverse psychopathologies has been proven (Campbell et al., 2013; Cristea et al., 2017; Leichsenring et al., 2023). However, a comprehensive understanding of the specific mechanisms contributing to therapeutic change remains partially unclear (Norcross & Wampold, 2019b).

The equivalence of different treatment methods suggested that *relational* or *common* factors (e.g., therapeutic alliance), shared across various theoretical orientations, may contribute to explaining how treatments work (Cuijpers et al., 2019). Notably, research underscored the role of the *therapist effects* (Wampold & Owen, 2021), particularly highlighting the importance of therapists' interpersonal skills, including therapist responsiveness (Kramer & Stiles, 2015). This construct refers to the therapist's capacity to meet the patient's needs and to deliver timely and appropriate interventions (Snyder & Silberschatz, 2017; Stiles, 2021).

Therapist responsiveness has been associated with positive treatment outcomes with evidence suggesting it fosters agreement and collaboration (e.g., therapeutic alliance) within the therapeutic dyad (Culina et al., 2024; Elkin et al., 2014). Nevertheless, this complex and multifaceted relationship requires further investigation, also considering the role of other therapist variables such as their emotional responses (or *countertransference*) towards the patient. This is particularly crucial in treating Personality Disorders (PDs), as these patients often exhibit impaired interpersonal functioning, requiring clinicians to manage therapeutic relationships with great care (Kramer, 2021; National Institute for Health and Care Excellence, 2009).

In light of the above, the central aim of this thesis was to examine the impact of therapist responsiveness in relation to the quality of psychotherapy sessions, measured in terms of depth of elaboration (Stiles & Snow, 1984a, 1984b), and its relationship with other critical elements, such as the therapeutic alliance.

Clinicians participating in this project selected one patient in their care with a PD diagnosis. Both therapists and patients responded to two open-ended each on therapist responsiveness. Additionally, they both filled in the *Patient's Experience of Attunement and Responsiveness Scale* (PEAR; Snyder & Silberschatz, 2017), the *Working Alliance Inventory-Short Form* (WAI-SF; Tracey & Kokotovic, 1989), and the *Depth Scale of the Session Evaluation Questionnaire* (Stiles & Snow, 1984b). These tools evaluated therapist responsiveness, therapeutic alliance, and depth of elaboration respectively. Finally, clinicians also completed the *Therapist Response Questionnaire* (TRQ; Betan et al., 2005; Tanzilli et al., 2016) to assess their therapist emotional responses toward the patient.

In this thesis, I adopted a multi-method approach to offer a nuanced perspective on the investigated variables. Conversely, a reductionistic approach can limit the understanding of a complex phenomenon such as psychotherapy (Fried, 2022; Klocek et al., 2024). Specifically, mixed models, thematic analysis, and network analysis were employed.

Study One first aimed to explore the associations between therapist responsiveness, therapeutic alliance, and depth of elaboration from the perspective of sixty-seven patient-therapist dyads. Secondly, I examined discrepancies between patients' and clinicians' evaluations by considering the variability both between and within dyads. Finally, I conducted an exploratory analysis to investigate the effect of therapist responsiveness and therapeutic alliance in predicting session depth while accounting the nested data structure.

In *Study Two* the focus has been on the therapist's perspective. The sample consisted of eighty-four clinicians, and I explored differences in therapist responsiveness and therapist

emotional responses in sessions with various levels of depth of elaboration. I also tested a mediational model, exploring if the positive countertransference pattern mediated the relationship between therapist responsiveness and depth of elaboration.

In *Study Three* I conducted a thematic analysis on descriptions of therapist responsiveness and therapist non-responsiveness moments provided by fifty-four therapists and fifty-four patients. Thematic Analysis was used to identify themes that captured the subjective experience from both perspectives.

Study Four aimed to apply complex systems theories to psychotherapy research by examining the therapeutic process holistically. Data from seventy-seven therapeutic dyads were used to explore the network structure of therapist responsiveness, therapeutic alliance (including its components: *task*, *bond*, and *goal*), and depth of elaboration within psychotherapy sessions.

Before describing the empirical study of my thesis, in the first two chapters I provided the theoretical background. Specifically, in *Chapter 1*, I focused on the evolution of psychotherapy research, tracing the major landmarks of *outcome research* and the rise of *process research*, which aims to understand the mechanisms of change of psychotherapy. I also highlighted the limitations of applying a reductionist approach to this area of study as well as possible solutions. Additionally, within this chapter, I discussed the recognition of therapist effects, with a particular emphasis on the construct of therapist responsiveness. Despite the challenges faced in assessing this variable, its importance in the psychotherapy process is underscored. Finally, I reported available evidence on the role of therapist responsiveness in the treatment of PDs. In *Chapter 2* I provided a thorough description of two key variables: therapeutic alliance and countertransference. I detailed their theoretical evolution and empirical evidence supporting their significance within the psychotherapy process. Furthermore, I examined their relationship with therapist responsiveness warranting

the need for further explorations. Finally, I described the rationale of the empirical investigation I conducted.

In *Chapters 3*, *4*, *5*, and *6* the empirical studies of my thesis have been illustrated. The conclusions, clinical implications and limitations of the findings have been discussed in the final section of the present work.

Chapter 1

Psychotherapy Research and Therapist Responsiveness

1.1 Evolution of Psychotherapy Research

For many decades, early psychotherapy theorists and practitioners aimed at achieving consensus on a definition of psychotherapy (Lutz et al., 2021). A significant milestone in this effort was reached when the American Psychological Association (APA), on the occasion of its *Recognition of Psychotherapy Effectiveness* (Campbell et al., 2013), formally declared psychotherapy as: "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Norcross, 1990). Still relevant today, this characterization highlights the multifaceted nature of psychotherapy, emphasizing its reliance on a range of "ingredients" (e.g., clinical methods, interpersonal stances) and its ambitious goal of modifying numerous aspects of individual functioning.

The origins of psychotherapy can be traced back to the emergence of psychoanalysis at the end of the 19th century, particularly with the introduction of the "talking cure" (Freud & Breuer, 1895). Sigmund Freud, whose research and clinical practice significantly influenced the field (i.e., Freud, 1905, 1923; Freud & Breuer, 1895), was pivotal in shaping early therapeutic approaches. However, in the 1940s, other therapeutic perspectives such as humanistic psychology with the contributions of Carl Rogers, emphasized the *relational* dimension of psychotherapy, including the therapist's warm and empathic stance towards the patient, which research later confirmed as critical to therapeutic success (Rogers, 1957; Rogers & Gendlin, 1967). In the following decade, psychotherapy research developed into

two main fields: *outcome research*, which focused on evaluating the efficacy of various treatments; and *process research*, which sought to understand the mechanisms and components of psychotherapy that promote or hinder therapeutic outcomes.

The following sections explore these key developments in psychotherapy research, focusing on the role of the therapist and their interpersonal characteristics. While these factors were overlooked for many years, recent scholarship has given more attention to concepts such as therapist responsiveness, underscoring the complexity of the psychotherapeutic process and the need for further investigation.

1.1.1 Outcome Research

Around 1950, psychotherapy research entered its first major phase, aimed at demonstrating its efficacy. Eysenck (1952) argued that there was insufficient evidence to support the effectiveness of psychotherapy (and particularly psychoanalysis, which was the dominant therapeutic approach at the time). The author suggested that positive treatment outcomes could result from the natural progression of symptoms (i.e., spontaneous remission), rather than the particular therapeutic intervention. Later meta-analyses (Smith et al., 1980; Smith & Glass, 1977) effectively refuted this position, confirming the efficacy of psychotherapy techniques. However, they failed to establish the superiority of a single approach over others. Consequently, scholars hypothesized that the success of various psychotherapeutic approaches may be influenced by *common* or *non-specific factors* (e.g., the therapeutic alliance, empathy), over and above the *specific intervention* (e.g., *interpretation* in psychoanalysis, *exposure* in the treatment of anxiety disorders) (Cuijpers et al., 2019; Mulder et al., 2017). Subsequently, common factors emerged as critical mechanisms of change,

warranting further investigation into their role in therapeutic outcomes (see the following section on *"Process Research"*).

Efforts to demonstrate the impact of specific psychological interventions faced numerous challenges. Unlike medical research, in which treatments could be compared to a "simple" placebo, psychotherapy research had to rely on comparisons between different types of treatments, or between structured interventions and less structured conditions (e.g., *waiting lists*, *care as usual*). In response to these challenges, the second wave of outcome research focused on *efficacy research*, aimed at assessing the measurable effects of psychotherapy. In line with this, the popularity of *empirically supported treatments* (ESTs), or "clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population," began to grow (Chambless & Hollon, 1998, p.7).

From the 1980s onward, the third generation of outcome research embraced *randomized controlled trials* (RCTs) as the *gold standard* and most well-validated paradigm for assessing psychotherapy efficacy (Goldfried, 2013). RCTs, by randomly assigning individuals with specific psychopathologies to different treatment conditions, allow researchers to attribute symptoms change (e.g., relapse, remission) to the treatment, itself. However, RCTs also present significant limitations when applied to psychotherapy research, as their highly controlled, medicalized approach tends to oversimplify clinical practice, which is inherently complex and heterogeneous (Goldfried, 2013; Shedler, 2010; Westen et al., 2004). As an example, in order to maximize internal validity, RCTs tend to select patients with no comorbidities—a rare scenario in clinical practice—thus sacrificing ecological validity. Consequently, the findings from RCTs can be difficult to generalize to everyday therapeutic settings.

As ESTs continued to proliferate, Seligman (1995) argued for the importance of research conducted in more naturalistic settings, reflecting the realities therapists face in

everyday practice. Thus, *effectiveness research* emerged with the aim of measuring the impact of treatments in diverse and realistic settings. Importantly, effectiveness research includes individuals with comorbidities and employs broader outcome measures, such as quality of life and personality functioning. Moreover, the approach prioritizes the generalizability of the results over internal validity and replicability (as emphasized by more controlled studies). The findings from effectiveness research contribute to the broader concept of *evidence-based practices* (EBPs). Unlike ESTs, which are determined solely by empirical validation, EBPs integrate "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006), taking into account the complexity of the psychotherapy process.

A major goal of contemporary psychotherapy research is to bridge the gap between empirical evidence and clinical practice. However, a persistent challenge is the skepticism and mistrust that many clinicians harbor towards research findings, which hinders their adoption of EBPs in routine care (Lilienfeld et al., 2013; Lutz et al., 2021). Relative to previous waves of outcome research, the current era also reflects a different research agenda. As Paul 1967 articulated, the question is no longer simply, "Do treatments work?" but rather, "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" This shift highlights the importance of individualized, patient-centered care *tailored* to the specificities of each patient's unique situation (Horowitz et al., 1984), as further explored in the subsequent sections.

1.1.2 Process Research

To date, the efficacy of psychotherapy across diverse clinical populations has been widely established (Cuijpers et al., 2013, 2014; Cristea et al., 2017). However, the precise role

played by factors contributing to the success or failure of psychotherapy, and the interactions between these factors, remain only partially understood (Mulder et al., 2017; Norcross & Lambert, 2018). This suggests a need to shift the primary aim of psychotherapy research from evaluating treatment efficacy to identifying *how* treatment works—that is, investigating the underlying mechanisms of change (Cuijpers et al., 2019; Kazdin & Nock, 2003). This revised aim defines the core of *process research*, as succinctly stated by Krause (2024, p. 262): "to discover which factors of therapy influence psychotherapeutic change and elucidate the mechanisms through which change evolves."

Initially, process research, rooted in the pioneering work of Carl Rogers (Rogers & Dymond, 1954; Rogers & Gendlin, 1967), focused on psychotherapy micro-processes (Lutz et al., 2021). In the 1960s, much of this research sought to inform clinical practice by closely observing the interactions between patients and therapists, with the goal of understanding how these interactions contributed to certain therapeutic outcomes (Stiles et al., 1999). As the field advanced, a key debate emerged around whether factors shared across all therapies (i.e., common factors) or factors unique to particular therapeutic approaches (i.e., specific factors) were the primary drivers of change. This debate was fueled by the so-called *dodo bird verdic*t (inspired by Lewis Carroll's [1965] *Alice's Adventures in Wonderland*)**,** which suggested a paradox: while various psychotherapies appeared equally effective, the mechanisms by which they achieved success remained unclear (Luborsky et al., 1975).

Over time, a growing emphasis on common factors led researchers to expand their focus beyond specific therapy techniques to also explore the unique roles played by the patient and therapist, as well as the relationship between them—elements often overlooked in efficacy research and RCTs(Norcross, 2011; Norcross & Lambert, 2019). To address this gap, the Division of Psychotherapy of the American Psychological Association established a series of task forces focused on *empirically supported relationships* (ESR), aimed at identifying

effective components of therapeutic relationships and developing methods for tailoring treatments to patients' individual characteristics (Norcross, 2011). After the third task force, Norcross and Lambert (2019, p.1) noted that "decades of psychotherapy research consistently attest that the patient, the therapist, their relationship, the treatment method, and the context all contribute to treatment success (and failure). We should be looking at all of these determinants and their optimal combinations." In their attempts to quantify the relative contributions of these factors, the authors estimated that the therapeutic relationship accounted for 15% of the explained variance in treatment outcomes, the individual therapist for 7%, the patient for 30%, and the treatment method for 10%, leaving 35% unaccounted for (see Figure 1.1). These findings fueled the debate over the role played by specific versus common factors in psychotherapy, suggesting that a balanced approach—one targeting both groups of factors—may be essential for improving therapeutic outcomes (Crits-Christoph & Gibbons, 2021). Conversely, an exclusive focus on either group of factors would present a false dichotomy, thereby oversimplifying psychotherapeutic dynamics (Mulder et al., 2017). Despite these advances, the central questions of process research—how treatments work and by what mechanisms (Krause, 2024; Mulder et al., 2017)—remain incompletely answered.

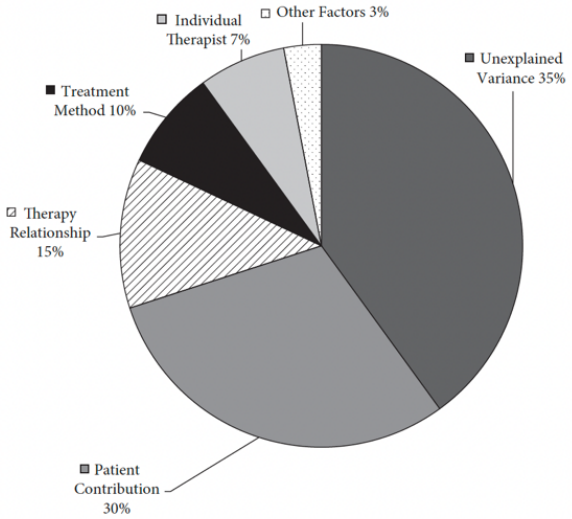
The following sections describe efforts to address the challenges of studying psychotherapy. Specifically, when examining such a complex phenomenon, there is a risk of focusing on isolated variables and overlooking the dynamic interplay between them.

1.1.3 Complexity in Psychotherapy Research

Psychotherapy process researchers have often applied a "reductive" approach (Klocek et al., 2024), exploring isolated factors in the psychotherapeutic process to better understand their unique impact on therapeutic outcomes (Cuijpers et al., 2019). However, as discussed in the previous sections, psychotherapeutic outcomes are influenced by the interaction between

several “ingredients,” including the therapist, the patient, and the therapeutic dyad (Norcross & Lambert, 2019). Capturing this complexity can be challenging when relying on traditional research methodologies (Stiles, 2021; Stiles, 1980).

Figure 1.1 Percentage of psychotherapy outcomes attributed to various factors (Norcross & Lambert, 2019, p. 12).



From an epistemological standpoint, several scientific fields have responded to the limitations of reductionism by approaching complex phenomena (e.g., psychotherapy; Klocek et al., 2024) as systems, thus acknowledging the dynamic interplay between their components (Meadows, 2008). Within psychology, a key shift in this direction was motivated by increasing recognition of the constant mutual influence between the therapist and the patient, emphasizing the need to examine data from both members of the therapeutic dyad. *Multilevel analysis* (including *mixed models*) thus emerged as a means of accounting for this interdependence, allowing researchers to analyze data from nested structures with no assumption of data independence (Gulseren & Kelloway, 2018). This methodological advance

was instrumental in generating insights into the complex, interactive nature of the psychotherapeutic process (Crits-Christoph & Gibbons, 2021).

Another critical approach that arose as a counterbalance to the dominant reductionist framework was qualitative research (Clarke & Braun, 2018). Historically, psychology's alignment with positivism led to the marginalization of qualitative methods, which were viewed as less rigorous than quantitative approaches (Levitt, 2015; Levitt et al., 2022). However, over time, researchers increasingly recognized that scientific rigor, including causal attribution, could also be achieved through qualitative methodologies (Maxwell & Levitt, 2023). One of the strengths of qualitative research is its ability to explore the lived, subjective experiences of individuals, offering a nuanced understanding of the attitudes, feelings, and beliefs of its subjects (Braun & Clarke, 2006; Levitt, 2021). As Levitt (2015) noted, qualitative analysis is particularly well-suited to psychotherapy research because "psychotherapy itself is an intersubjective dialogue—which introduces complexity into analyses because, instead of one truth of what is occurring in any one moment, clients and therapists can have distinct and multiple understandings" (p. 32). Qualitative findings thus complement and strengthen quantitative research by providing rich insight into the psychotherapeutic process (Levitt, 2021).

Network theory also made a significant contribution to psychotherapy research (Borsboom, 2017; Borsboom et al., 2021), offering a compelling alternative to reductionist models, particularly in the context of psychopathology (Lo Buglio et al., 2022; Manfro et al., 2023; Robinaugh et al., 2020). The theory posits that mental disorders arise from the mutual reinforcement and interactions of symptoms, rather than from a single latent dimension or "common cause" (e.g., an underlying depressive disorder causing symptoms such as anhedonia and depressed mood). In *network analysis*, individual symptoms or factors are represented as nodes in a network, with the links between nodes representing their

interconnections (Borsboom et al., 2021). Thus, the model allows for a detailed exploration of the role played by individual factors (e.g., the therapeutic alliance, therapist responsiveness) and their reciprocal relationships in defining overall network effects (Fried, 2022).

1.2 The Therapist Effect

The *therapist effect* refers to the differences in treatment outcomes attributed to individual therapists (Hill & Castonguay, 2017). As Wampold and Owen (2021) provocatively observed, "it is no secret that patients, therapists, and therapist trainers alike believe that some therapists are better than others" (p. 297). In the early days of psychoanalysis, however, this effect was not acknowledged. Therapists were seen as neutral entities whose role was to avoid influencing the patient or the analytic process with their own subjectivity (Freud, 1913). This perspective began to shift in the 1930s, when the influence of the individual therapist was first noted (Rosenzweig, 1936), prompting a recognition of the importance of exploring this aspect of the therapeutic process. However, to date, the role of the therapist has remained largely underexplored compared to other treatment variables (Wampold & Owen, 2021). Most EPBs still overlook the therapist's influence, suggesting that clinicians are interchangeable "providers" of specific treatments (Norcross & Lambert, 2019).

Conversely, growing empirical evidence supports the significance of the individual therapist in shaping treatment outcomes (Wampold & Owen, 2021). Meta-analyses of both RCTs and naturalistic studies have consistently identified a therapist effect, demonstrating small but meaningful impacts on treatment outcomes when compared to other within-treatment variables, such as the therapeutic alliance (Baldwin & Imel, 2013; Crits-Christoph et al., 1991; Crits-Christoph & Mintz, 1991; Johns et al., 2019). However, only a small

portion of RCTs have focused on this dimension, underscoring the need for further research (Wampold & Owen, 2021).

In 1936, Rosenzweig acknowledged the existence of the therapist effect, while noting a lack of clarity regarding the specific characteristics that make an "effective therapist." Since that time, decades of research have empirically validated this effect, challenging the *therapist uniformity assumption* (Kiesler, 1966). Nevertheless, the precise attributes and behaviors that contribute to therapist effectiveness remain only partially understood. Most studies have examined factors such as therapist gender, age, theoretical orientation, interventions delivered, and years of experience (Heinonen & Nissen-Lie, 2020), while far less attention has been given to the therapist's interpersonal qualities, despite increasing evidence that traits such as attachment style, interpersonal patterns, mentalization capacity, and empathy play a significant role in the therapeutic process (Hill & Castonguay, 2017; Krause, 2024; Lingiardi et al., 2018). This gap in psychotherapy research is noteworthy, as it highlights the need for further investigation of the evolution of these interpersonal qualities in the psychotherapy process and their interaction with patient characteristics such as diagnosis, interpersonal problems, age, and gender.

The following sections focus on *therapist responsiveness*—an interpersonal variable that has recently garnered considerable attention due to its potential role in shaping psychotherapy session and treatment outcomes (Kramer & Stiles, 2015).

1.2.1 The Broad Nature of Therapist Responsiveness

In recent years, the concept of therapist responsiveness has gained significant attention. Research has shown that it is closely associated with other critical elements, such as the therapeutic alliance, as well as the therapist effect and positive treatment outcomes (Hill &

Castonguay, 2017; Kramer & Stiles, 2015; Wampold & Owen, 2021; J. C. Watson & Wiseman, 2021).

The term "responsiveness" was first used by Bacal (1985), who coined the phrase "optimal responsiveness" to describe the therapist's capacity to adapt their responses to suit their patient's developmental level and unique needs. Stiles et al. (1998) later expanded this concept, providing the most widely accepted definition (see also Stiles, 2021; Stiles, 2009, 2013; Stiles & Horvath, 2017). According to their framework, responsiveness is a fundamental human capacity, present in all kinds of interactions, including the therapeutic relationship. They differentiated between two forms: *responsiveness to*, which describes the therapist's continuous adjustment of behavior to suit their patient's unique characteristics (see also Norcross & Wampold, 2019c; Wu & Levitt, 2020); and *responsiveness with*, which refers to the specific interventions employed to maintain this adjustment (Kramer & Stiles, 2015; Stiles, 1988). The authors also introduced the notion of *appropriate responsiveness*, acknowledging that, while therapists generally aim to promote therapeutic progress with good intentions, their responses are sometimes inappropriate (Kramer & Stiles, 2015). Notably, the effects of moments of therapist "non-responsiveness" have been underexplored, despite growing recognition of its significance in the context of ruptures and repairs in the therapeutic alliance, as addressed in Section 2.1.4 of the present work (Eubanks et al., 2021; Levy Chajmovic & Tishby, 2024; Muran et al., 2021). Overall, therapist responsiveness is a dynamic behavior that depends on the *hic et nunc* of the ongoing therapeutic exchange. As Stiles et al. (1988) observed, responsiveness "is shaped by the emerging context, including perceptions of others' characteristics and behaviors. Insofar as therapist and client respond to each other, responsiveness implies a dynamic relationship between variables, involving bidirectional causation and feedback loops" (Stiles et al., 1998, p. 439). In line with this, Kramer and Stiles (2015) described that an appropriately responsive therapist does "the right

thing at the right time" (p. 278) in response to the patient's needs (Stiles, 2021; Stiles, 1988). Given their context-dependent nature, responsive behaviors cannot be predefined or prescribed, highlighting the broad and adaptive nature of this construct. Moreover, Hatcher (2015), along with Watson and Wiseman (2021), emphasized that responsiveness is inherently interpersonal, unfolding within the therapeutic relationship.

Another noteworthy conceptualization was proposed by Snyder and Silberschatz (2017), who referred to *attunement and responsiveness*. With this concept, the authors aimed at describing the therapist's ability to deeply understand the patient's emotional state, thereby creating a warm and genuine environment and providing timely interventions. Drawing on *infant research*, the concept of attunement refers to the enhancement of mutual coordination within the therapeutic dyad, even during periods of discord, resembling the relationship between a child and a "good enough" caregiver (Beebe & Lachmann, 1988; Stern et al., 1984; Tronick et al., 1998). A therapist who remains open, warm, and attentive to the ongoing interaction fosters a sense of safety for the patient, facilitating emotional regulation within the relationship (Fosha, 2001). Snyder and Silberschatz (2017) further developed a self-report instrument, the *Patient's Experience of Attunement and Responsiveness Scale* (PEAR), to assess therapist responsiveness from both patient and therapist perspectives (see Section 2.3.1.1 for further detail).

Elkin (2014) made a further significant contribution to the operationalization of therapist responsiveness, defining it as "the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient's current concerns; is clearly interested in and responding to the patient's communication, both in terms of content and feelings; and is caring, affirming, and respectful towards the patient" (p. 53). Based on this definition, Elkin developed the *Therapist Responsiveness Scale* (TRS)—an observer-rated

tool for quantifying responsiveness during treatment (see the following section for a detailed description of this instrument).

These various definitions highlight that therapist responsiveness is closely related to other interpersonal therapist variables, such as empathy, positive regard, flexibility, and genuineness, all of which have been linked to positive treatment outcomes (Elliott et al., 2018; Farber et al., 2018; Kolden et al., 2018; Owen & Hilsenroth, 2014). However, while there are overlaps, responsiveness distinguishes itself by having a clear *behavioral component* (Esposito et al., 2024). Being responsive involves more than being attuned to the patient and understanding their emotions; it also requires knowing "what to do and when" (Hatcher, 2015, p. 4).

In summary, therapist responsiveness is deeply embedded in the interpersonal dynamics of the psychotherapy process, emerging from the real-time interaction between therapist and patient (Hatcher, 2015). While fluidity and complexity are manageable for clinicians in practice, they present significant challenges for psychotherapy researchers attempting to systematically study and quantify these behaviors (Hatcher, 2015; Kramer & Stiles, 2015).

1.2.2 The Responsiveness Problem in Psychotherapy Research

The previous section discussed the broad and multifaceted nature of therapist responsiveness, drawing attention to its various definitions and conceptualizations. While responsive therapists are known to show attentiveness, warmth, empathy, and genuine regard for their patients' characteristics and emerging needs, research has not yet been able to define specifically responsive behaviors (Hatcher, 2021). Responsiveness occurs across all phases of treatment—from the initial selection of an intervention to the moment-to-moment interactions

during a session. Its unpredictable and context-dependent nature poses a challenge to psychotherapy research, particularly in its attempts to isolate clear cause-and-effect relationships between variables (Kramer & Stiles, 2015; Stiles, 2021).

In outcome research, responsiveness complicates the assumptions underlying RCTs, which often overlook the unique dynamics of the therapeutic dyad (Carey & Stiles, 2016). In efficacy studies of ESTs, therapists are typically expected to deliver standardized, manualized interventions without accounting for individual patient differences. However, in clinical practice, therapists responsively adapt their techniques and behaviors to fit the patient's evolving needs, deviating from strict adherence to protocols and introducing elements of unpredictability that would contradict an experimental design (Bohart, 2000). These real-time adaptations, driven by therapist responsiveness, undermine the rigid comparison of therapeutic approaches, potentially contributing to the persistence of the dodo bird verdict (Luborsky et al., 1975). In other words, if a therapist were to adjust their behavior to meet their patients' needs in a clinical trial, the dependent variable (i.e., patient outcomes) would likely influence the independent variable (i.e., the treatment), thereby violating the assumptions of the controlled trial and complicating statistical interpretation (Stiles, 2021).

Process research is similarly challenged by therapist responsiveness, since change in the behaviors of both therapist and patient can lead to misleading interpretations of the results. Kramer and Stiles (2015) illustrated this problem using the example of a therapist who employed more interpretations with patients exhibiting greater impairments in insight, who often achieved worse outcomes compared to patients with stronger insight capacity. A simplistic reading of this result might erroneously conclude that a higher number of interpretations was negatively associated with symptom improvement. However, the finding merely reflected the therapist's ability to responsively tailor their interventions to meet their

patients' needs, rather than the inherent effectiveness (or ineffectiveness) of their chosen technique (Kramer & Stiles, 2015).

Despite the above-described challenges, researchers have attempted to explore therapist responsiveness in meaningful ways (Kramer & Stiles, 2015). For instance, one approach has been to examine how therapists adjust their behavior during treatment in response to specific patient characteristics and behaviors. Norcross and Wampold (2019) extensively reviewed this body of literature, noting that "adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of psychological treatment" (Norcross & Wampold, 2019a, p. 330). Studies have also produced evidence that patient variables such as diagnosis (Connolly Gibbons et al., 2003), gender (Frühauf et al., 2015), and ethnicity (Lee & Horvath, 2014) influence therapist behavior, thereby impacting treatment outcomes. For instance, Hardy et al. (1998) found that therapists systematically adjust their interventions based on patients' interpersonal styles, offering more relationship-oriented interventions for patients with over-involved relational styles and more cognitive-based methods for those with under-involved styles. Similarly, other studies have shown that therapist interventions vary according to personality traits such as assertiveness, coldness (Caspar et al., 2005), hostility (Anderson et al., 2012; Macdonald et al., 2007), and aggressiveness (Boswell et al., 2013). Finally, Despland et al. (2001) demonstrated that therapists adapt their interventions in accordance with the maturity of their patients' defensive patterns, using more expressive interventions (e.g., interpretations) with patients employing more mature defenses, and more supportive interventions with those relying on more immature defenses. While these studies underscore the therapist's ability to tailor their interventions to their patients' specific characteristics, other researchers have aimed at *directly* evaluating therapist responsiveness, itself.

As described above, Elkin et al. (2014) pioneered the development of an observer-rater instrument, the Therapist Responsiveness Scale (TRS), to systematically assess therapist responsiveness within psychotherapy. They defined a responsive therapist as one who is attentive, caring, and validating towards the patient. The TRS is divided into three parts: Part I rates therapist behaviors at 5-minute intervals, using eight items reflecting *positive* therapist behaviors (e.g., making eye contact, using minimal encouragers) and three items reflecting *negative* therapist behaviors (e.g., making critical, judgmental, countering, minimizing, or invalidating comments). Part II consists of evaluative items, assessing the overall atmosphere of the therapy session as "good," "bad," "positive," or "negative," without detailing specific behaviors (Stiles, 2021). Finally, Part III consists of a single assessment of overall therapist responsiveness.

In their study, Elkin et al. (2014) investigated the relationship between therapist responsiveness and patient engagement in psychotherapy, focusing also on drop-out rates (i.e., patients abandoning therapy prior to the fourth session). Their findings showed that two items—one assessing the positive therapeutic atmosphere and the overall responsiveness rating—predicted higher patient engagement and were negatively associated with patient drop-out. Moreover, therapists' negative behaviors were found to predict greater patient drop-out, while no significant results emerged regarding specific positive therapist behaviors. Stiles (2021) offered a potential explanation for these findings, considering the different natures of TRS items: For the descriptive items assessing specific positive therapist behaviors, "more is not always better," as the frequency of such behaviors should match the patient's emerging needs. Therefore, the "quantity" of positive behaviors should change in accordance with the therapeutic moment. Conversely, for negative behaviors, "more is always worse," with the ideal frequency of negative behaviors being zero. Finally, for the evaluative items capturing

global responsiveness, “more is always better.” This may explain why these items were more predictive of patient engagement and lower rates of drop-out.

In a different approach to assessing therapist responsiveness, Snyder and Silberschatz (2017) developed the *Patient's Experience of Attunement and Responsiveness Scale* (PEAR) self-report instrument. The PEAR includes two parallel forms—one for therapists (PEAR-t) and one for patients (PEAR-p)—consisting of 20 and 22 items, respectively. Items are rated on a Likert scale ranging from 0 to 3, capturing perceptions of therapist attunement and responsiveness from both perspectives. Factor analysis of the PEAR-t revealed a two-factor structure: (1) *Therapist Helpfulness* and (2) *Safe Accepted*; while for the PEAR-p, a three-factor structure emerged: (1) *Perceived Helpfulness*, (2) *Felt Empathy*, and (3) *Sensed Accomplishment* (see Section 2.3.1.1 for further detail on this instrument). Preliminary findings have revealed positive correlations between PEAR-p scores and improved treatment outcomes, including psychological and emotional well-being. In contrast, for the PEAR-t, only the Safe and Accepted factor has been found to be significantly related to the therapist’s evaluation of the patient’s overall well-being. These results highlight the differing perspectives of therapists and patients, emphasizing the importance of including both viewpoints when examining therapist responsiveness.

Overall, these studies have demonstrated the possibility of assessing both therapist responsiveness during psychotherapy and its link with positive treatment outcomes. However, further research is needed on the role played by therapist responsiveness in diverse clinical populations and its interplay with other variables in the therapeutic process.

1.2.3 Responsiveness in the Treatment of Personality Disorders

Research has investigated therapist responsiveness in the treatment of various psychopathological conditions (Boswell et al., 2013; Pellens et al., 2023), including

personality disorders (PDs) (Kramer, 2021). PDs are relatively widespread psychopathologies, with estimates indicating a global prevalence of 7.8% in community samples (Winsper et al., 2020), and higher rates in primary care (25%) and psychiatric outpatient settings (50%) (Tyrer et al., 2015). PDs are also moderately stable over time (d'Huart et al., 2023) and associated with significant impairments in functioning, as well as elevated morbidity and mortality. These factors underscore the importance of research focused on the PD patient population (Tyrer et al., 2015).

While psychotherapy is the recommended treatment approach for PDs (Bateman et al., 2015; Cristea et al., 2017; Simonsen et al., 2019), the severe interpersonal difficulties often associated with these disorders (Wilson et al., 2017) can challenge the development of a collaborative therapeutic relationship (Alarcón, 2016; Livesley & Larstone, 2018). Moreover, these interpersonal issues can affect the therapist's ability to remain appropriately responsive, thereby limiting positive treatment outcomes.

Before reviewing the empirical research on therapist responsiveness with PD patients, it may be useful to provide a brief overview of the classification of these psychopathologies in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; (American Psychiatric Association, 2022). The DSM-5-TR includes PDs in Section II, "Diagnostic Criteria and Codes," and Section III, "Emerging Measures and Models." Section II presents a *categorical* approach to PD diagnoses, conceptualizing these disorders as qualitatively distinct syndromes with "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" (APA, 2022, p., 734) (see Table 1.1 for an overview of general PD criteria). In Section II, PDs are categorized into three clusters based on shared characteristics. Cluster A, which includes paranoid, schizoid, and schizotypal PDs, describes individuals who appear odd or eccentric. Cluster B, comprising antisocial, borderline, histrionic, and narcissistic PDs, encompasses individuals

who display dramatic, emotional, or erratic behaviors. Finally, Cluster C includes avoidant, dependent, and obsessive-compulsive PDs, marked by high levels of anxiety and fear.

Table 1.1 General criteria for PD diagnosis according to the DSM-5-TR (APA, 2022, pp. 735–736)

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas: 1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events). 2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response). 3. Interpersonal functioning. 4. Impulse control.
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).

Of note, the DSM-5 Personality Disorders Work Group introduced a hybrid *Alternative Model for Personality Disorders* (AMPD) (APA, 2013), integrating both *categorical* and *dimensional* approaches (for a review, see Bach & Tracy, 2022). In its diagnostic approach, the AMPD evaluates impairments in personality functioning alongside the presence of pathological personality traits. To satisfy diagnostic criteria, the model requires moderate or severe impairment in personality functioning (criterion A) in the domains of the *self* (subdomains: *identity* and *self-direction*) and *interpersonal relationships* (subdomains: *empathy* and *intimacy*). Moreover, the diagnosis of specific PDs (e.g.,

antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, schizotypal) depends on the combination of maladaptive personality traits (criterion B).

Based on these descriptions, it appears likely that individuals with PDs would pose unique challenges to clinicians, potentially hindering the establishment of a collaborative therapeutic alliance (Bateman et al., 2015). Their unpredictable and demanding behaviors (Lingiardi & McWilliams, 2017; Livesley & Larstone, 2018) may test the therapist's capacity to respond appropriately to their evolving needs, making the task of "doing the right thing at the right time" (Kramer & Stiles, 2015, p. 278) particularly difficult. For instance, PD patients may push boundaries by making extra requests (e.g., for additional sessions), engaging in self-harm, or attempting suicide. Moreover, clinicians may struggle to determine the most appropriate response to these behaviors, and they may risk inadvertently accommodating the patient's demands in a way that undermines the therapeutic work. This dilemma becomes even more pronounced when clinicians experience feelings of overwhelm and concern in response to patients' behaviors (Kramer, 2019, 2021; McMain et al., 2015; Tanzilli et al., 2020).

Kramer (2021) described three levels of therapist responsiveness when working with PD patients. The first level, *generic responsiveness*, refers to the therapist's basic stance of attentiveness, care, interest, and respect towards the patient. This form of responsiveness is aligned with the operationalization provided by Elkin et al. (2014). The second level, *disorder-specific responsiveness*, involves tailoring therapeutic strategies to the particular symptoms and challenges of a given disorder. For instance, in *mentalization-based therapy* (MBT; Bateman & Fonagy, 2009), which is commonly used to treat patients with borderline personality disorder (BPD), a responsive therapist would focus on enhancing the patient's capacity for mentalization (McMain et al., 2015). Finally, the third level is *individualized responsiveness*, which involves tailoring the treatment to suit the unique characteristics of

each patient. One method of achieving individualized responsiveness is through case formulation, such as plan analysis (Caspar, 2007). This approach allows for treatment planning based on the patient's specific psychological needs and dynamics.

Research on therapist responsiveness has predominantly focused on BPD, due to its severity and prevalence in clinical settings (Cristea et al., 2017; Leichsenring et al., 2024). In particular, several studies have explored responsive (or individualized) treatment approaches for BPD (Kramer, Kolly, et al., 2014, 2022; Zufferey et al., 2019). For example, Signer et al. (2020) found that responsive interventions based on the *motive-oriented therapeutic relationship* (MOTR), grounded in plan analysis, are associated with increased activation of patients' social-interpersonal patterns and better treatment outcomes compared to standard therapeutic interventions. These findings highlight the importance of tailored, patient-specific interventions for BPD, addressing the psychological processes underlying their symptomatology.

Among studies directly addressing therapist responsiveness in BPD treatment, Culina et al. (2023) found that greater responsiveness—measured using the TRS during the first session—was significantly associated with a stronger therapeutic alliance, as rated by the therapist, over the course of the treatment. However, some relationships between the study variables were not statistically significant. The authors suggested that therapist responsiveness in BPD may need to be evaluated over shorter time frames due to the pronounced emotional instability of these patients, which can elicit intense emotional responses from therapists. Culina and colleagues (2024) explored therapist responsiveness with BPD patients by examining specific therapist behaviors, as captured using the descriptive items of the TRS and their relationships with the therapeutic alliance. Of note, the item "therapist makes affirming, validating, normalizing, optimistic affirmations" emerged as the sole significant predictor of patients' positive evaluations of the therapeutic alliance. This aligns with the findings of

McMain and colleagues (2015), highlighting the importance of therapists adopting a validating approach, especially at the beginning of treatment, to help BPD patients feel accepted and understood while normalizing their (often intense) emotional experiences. Another significant finding was the impact of variability in the item "therapist responds to the patient's verbally expressed feelings" on the therapeutic alliance: when this item showed greater variability within sessions, therapists tended to rate the alliance lower. This may reflect the inherent emotional instability of BPD patients and the inconsistency in their expressions of need.

Overall, these findings suggest the significance of therapist responsiveness—and particularly validating and affirming behaviors—in work with BPD patients. However, the instability and interpersonal difficulties displayed by BPD patients may challenge therapists' ability to maintain a consistent responsive stance. This highlights the need for further research, also with respect to therapists working with patients diagnosed with other PDs. Moreover, research has not yet explored how therapist responsiveness with PD patients might interact with other variables in the psychotherapeutic process. Such research could provide valuable insights to improve therapeutic interventions with these patients.

Chapter 2

Therapeutic Alliance and Countertransference

2.1 Therapeutic Alliance: Theory and Research

The emergence of meta-analytic evidence suggesting the equivalence of different psychotherapeutic approaches (see Section 1.1 of this thesis) prompted discussion about the factors driving treatment efficacy, with some scholars arguing that therapeutic effectiveness was primarily attributable to common or relational factors shared across diverse theoretical orientations, rather than to the specific techniques employed within each approach (Luborsky et al., 1975). This insight led to a surge in empirical research on these common factors, aimed at identifying the mechanisms underlying this phenomenon. Among these factors, the therapeutic alliance garnered significant empirical attention, with numerous studies, including meta-analyses (Flückiger et al., 2018), establishing strong associations between this factor and positive therapeutic outcomes (Cuijpers et al., 2019; Doran, 2016; Norcross & Lambert, 2019). The following sections will trace the historical and theoretical development of this concept and examine key empirical findings highlighting its significance.

2.1.1 Theoretical Background of the Therapeutic Alliance

Similar to many foundational concepts of psychotherapy, the origins of the therapeutic alliance can be traced to the work of Sigmund Freud (1912, 1913). Although Freud did not explicitly use the term, he recognized the need to differentiate between two types of transference: *neurotic* or *infantile* transference, characterized by the patient's distorted projections of past experiences onto the analyst; and *positive*, *unobjectionable transference*,

reflecting the patient's conscious and reality-based *rapport* with the analyst. While Freud initially advocated for interpreting both forms of transference, he ultimately emphasized the importance of not analyzing positive transference, seeing it instead as a source of motivation and a "vehicle for success in psychoanalysis" (Freud, 1912, p.105) that helps the patient overcome resistance.

Building on Freud's ideas, Sterba (1934) introduced the concept of the *ego alliance*, highlighting the therapist's role in fostering a collaborative relationship with the patient's rational and self-observing part. This concept was further elaborated by Fenichel (1941), who referred to it as *rational transference*, and Stone (1961), who termed it *mature transference*. Zetzel (1956) made a significant contribution by coining the term *therapeutic alliance,* describing the patient's capacity to leverage healthy aspects of their ego, rooted in early childhood experiences, to build stable and trusting relationships.

In 1965, Greenson further refined the concept by introducing the notion of the *working alliance*, referring to the patient's ability to consciously engage in the therapeutic process and strive towards therapeutic goals. Greenson identified three key aspects of the therapeutic relationship: the working alliance, the transference, and the "real" relationship. He noted that, while the working alliance and transference might sometimes overlap, leading to interpretive challenges, elements of transference within the alliance must still be addressed. Greenson's seminal work, *The Working Alliance and the Transference Neurosis* (1965), marked the culmination of the first phase of research on the therapeutic alliance, originating with Freud and remaining largely rooted in psychoanalytic theory. This phase sought to establish a unified definition of this construct (De Bei, 2006).

The second phase of research on the therapeutic alliance began in the 1970s and continued into the early 2000s. A significant contribution during this period came from Luborsky (1976), who, building on Zetzel (1956) and Greenson (1965), introduced a two-

stage model of the therapeutic alliance. He described a *type I alliance*, characterized by the patient's initial passive trust in the therapist and the belief in the potential for improvement, and a *type II alliance*, which emerges through active collaboration between the patient and therapist over the course of therapy (Luborsky, 1976).

A further relevant contribution came from Bordin (1979), who expended the concept of the therapeutic alliance beyond its psychoanalytic origins by adopting a *pantheoretical* approach. Bordin argued that the therapeutic alliance is a fundamental element across all forms of psychotherapy, irrespective of the theoretical orientation. He conceptualized the alliance as consisting of three key components: (1) an agreement between the therapist and patient on the *goals* of therapy, (2) an understanding of the *tasks* required to achieve these goals, and (3) the development of a *bond* within the therapeutic relationship. Bordin emphasized that the goals should represent realistic and achievable outcomes, tailored to the patient's condition and available resources. The tasks, in turn, are the specific therapeutic activities or interventions that facilitate the attainment of these goals. For instance, in psychoanalysis, tasks might include free association and the use of the couch, with a primary goal being to increase awareness of unconscious content. Beyond these elements, Bordin emphasized the therapeutic alliance as a dynamic process involving negotiation and adjustment on both conscious and unconscious levels. He also acknowledged the significance of ruptures in the therapeutic relationship, marking a breakdown or deterioration in the agreement between the patient and therapist (Bordin, 1983, 1994).

These various operationalizations of the therapeutic alliance led to the development of tools aimed at measuring this construct, thus advancing empirical research in the field. Among these, the *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989), based on Bordin's theoretical model, remains one of the most widely used (Norcross & Wampold, 2019b). Moreover, this phase of research also saw the emergence of the first meta-analytic

findings, consistently demonstrating the significance of the therapeutic alliance in predicting positive treatment outcomes (Horvath & Symonds, 1991).

The third phase of psychotherapy research on the therapeutic alliance began in the early 2000s. In particular, this stream of research focused on the relationship between the alliance and various factors related to the therapist, the patient, and their relationship (e.g., attachment style, mentalization capacity) (De Bei, 2006). Studies at this time were significantly influenced by relational psychoanalysis (Mitchell & Aron, 1999), which conceptualizes the therapeutic process as a mutual, dyadic exchange between patient and therapist. Within this framework, researchers placed greater emphasis on understanding ruptures in the therapeutic alliance and the processes of repair that follow (Safran et al., 1990). Safran and Muran (2006) described the therapeutic alliance as an emergent property of the patient-therapist relationship that continuously evolves through ongoing negotiation. They highlighted that a strong therapeutic alliance is one of the most influential factors in facilitating therapeutic change.

Ruptures in the alliance are commonly observed and, when appropriately resolved, may offer valuable opportunities for therapists to address patients' maladaptive relational patterns (Eubanks et al., 2019). Two main types of rupture have been identified: *withdrawal* ruptures and *confrontation* ruptures. In withdrawal ruptures, patients retreat from the therapist or therapeutic work, avoiding direct expression of dissatisfaction or disengaging emotionally. In contrast, confrontation ruptures are characterized by patients' open expressions of anger or frustration with the therapist. Different strategies for repairing these ruptures have been proposed, ranging from *direct* strategies, involving explicit acknowledgment and discussion, to *indirect* strategies, with repair occurring more implicitly through shifts in the therapeutic interaction.

Researchers have noted significant parallels between the therapeutic relationship and the mother–child relationship (Safran & Kraus, 2014). In both contexts, fluctuations in the quality of the interaction are considered normal and even beneficial, provided that disruptions are followed by effective repair (Beebe & Lachmann, 1988; Tronick et al., 1998). In a healthy dyad, a "good enough" caregiver can attune to the child's needs following a rupture, accurately recognizing and responding to the child's internal state. In contrast, dysfunctional relationships are marked by a lack of attunement, with caregivers either failing to recognize the child's emotions or responding with inappropriate timing. The process of rupture and repair is crucial for the child's growth and development, helping them internalize these experiences as normal and resolvable.

2.1.2 Empirical Research on the Therapeutic Alliance

Over the years, numerous studies have examined the therapeutic alliance as a crucial mechanism of change in psychotherapy. To facilitate this line of inquiry, several instruments have been developed to reliably and validly assess the alliance from different perspectives (i.e., therapist, patient, external observer). Some of the most notable tools include the California Psychotherapy Alliance Scale (CALPAS; Marmar et al., 1986), the Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986), the Vanderbilt Psychotherapy Process Scale (VPPS; Suh et al., 1986), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The WAI, in particular, is the most widely used tool—due in part to the availability of shorter versions (Tracey & Kokotovic, 1989).

While differences among these instruments complicate the direct comparison of empirical results, various meta-analyses have consistently investigated the relationship between the therapeutic alliance and treatment outcomes, with Horvath and Symonds (1991) finding a correlation of r=.26, and subsequent meta-analyses producing similar results: r=.21

(Horvath & Bedi, 2002), *r*=.28 (Horvath et al., 2011), and *r*=.28 (Flückiger et al., 2019). These associations appear to hold across different psychotherapeutic approaches, offering further support for Bordin's (1979) *pantheoretical* perspective.

Researchers have also explored the nature of this relationship, hypothesizing that a stronger therapeutic alliance may result from—rather than lead to—symptom reduction. However, studies investigating this hypothesis have produced mixed results (DeRubeis et al., 2005; Doran, 2016). Overall, studies have consistently shown an association between the therapeutic alliance and treatment outcomes. Although the strength of this correlation appears modest, with the therapeutic alliance accounting for approximately 8% of the variation in treatment outcomes, this proportion appears comparable to the influence of other significant factors, such as the treatment method employed (Flückiger et al., 2019). These findings suggest that psychotherapy effectiveness may be more accurately understood through the interaction of multiple elements involving the patient, the therapist, and their relationship, rather than the result of a single linear factor (Norcross & Wampold, 2019a).

To better capture the complexity of the therapeutic alliance, researchers have introduced a distinction between *trait-like* and *state-like* alliances (Zilcha-Mano, 2017; Zilcha-Mano & Fisher, 2022). A trait-like alliance may result from the patient's general ability to form collaborative and trusting relationships, including with the therapist. In contrast, a state-like alliance pertains specifically to the dynamic relationship that emerges and evolves during therapeutic sessions. Zilcha-Mano et al. proposed that the state-like alliance is the critical element driving the therapeutic process. However, this warrants further investigation.

Studies have also explored convergence and divergence between patient and therapist ratings of the therapeutic alliance, with a meta-analysis by Tyron et al. (2007) finding that therapists consistently underestimate the quality of the therapeutic alliance compared to their

patients. While some divergence may be expected due to the different roles of patients and therapists, it remains clinically relevant for therapists to have an accurate understanding of their patient's perceptions. Discrepancies in the ratings may indicate unresolved ruptures in the relationship or disagreement concerning treatment tasks and goals (Tryon & Winograd, 2011). Research suggests that, as therapy progresses, convergence between patient and therapist perspectives tends to increase, and this alignment is associated with a reduction in symptomatology (Laws et al., 2017). However, findings on this divergence remain mixed. Fluckinger et al. (2018) found no significant differences between patient and therapist ratings of the therapeutic alliance, contrasting with previous meta-analyses (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Horvath et al., 2011). These earlier studies also noted that alliance-outcome associations were generally weaker when assessed from the therapist's perspective. Notably, there is a gap in the literature concerning the nested nature of patient and therapist evaluations of the therapeutic alliance. Given the dyadic nature of the relationship, it can be problematic to assume the independence of these data points.

Empirical research using instruments such as the Rupture Resolution Rating System (3RS; Eubanks et al., 2015), which assesses the moment-to-moment interactions between patients and therapists, has also provided support for the rupture-reparation framework. In more detail, meta-analytic findings have demonstrated positive associations between effective rupture repair and improved treatment outcomes (Eubanks et al., 2019), emphasizing the importance of identifying and effectively addressing ruptures during the clinical encounter to enhance the therapeutic process.

2.1.3 Therapeutic Alliance with Patients with Personality Disorders

As described in the previous sections, the therapeutic alliance is a relevant treatment factor that can significantly influence patient outcomes (Flückiger et al., 2019). Thus, it is essential to examine the variables that either facilitate or hinder the development of a collaborative and trustful alliance. One such variable is patient personality, which plays a significant role in the treatment of individuals with personality disorders (PDs), in particular. Such patients often present substantial challenges, due to their severe emotional dysregulation and maladaptive interpersonal patterns (for further detail on PDs, refer to Section 1.2.3). As recommended by the NICE guidelines (2009), management of the therapeutic alliance represents a general principle of change in the treatment of patients with PDs. In their meta-analysis, Flückiger et al. (2019) found consistent associations between the therapeutic alliance and outcomes across diverse patient populations. However, for patients with borderline personality disorder (BPD), effect sizes varied significantly, ranging from .00 to .78. This variability likely reflects the emotional instability characteristic of BPD patients and its impact on the perceived quality of the therapeutic alliance.

Although BPD has garnered substantial research attention, other PDs also exhibit interpersonal difficulties that can affect the therapeutic alliance. Bender (2005) outlined specific challenges posed by each PD, while Lingiardi et al. (2005) compared the quality of the therapeutic alliance across different PD clusters, finding that patients in Cluster A (e.g., schizoid, paranoid) often struggled to establish a collaborative bond with therapists, due to difficulties forming trust and connection (Lingiardi & McWilliams, 2017). Patients in Cluster B have also been shown to present notable challenges, with studies reporting significant alliance difficulties, as reported by therapists (Leichsenring et al., 2024; Ogrodniczuk & Kealy, 2013). In contrast, research has shown that therapists generally find it less difficult to build alliances with Cluster C patients. Interestingly, specific PD subtypes can also influence the quality of the therapeutic alliance. For example, Tanzilli and Gualco (2020) identified

three subtypes of narcissistic personality disorder, noting that therapists rated the therapeutic alliance lower with the grandiose subtype.

Despite these difficulties, a robust therapeutic alliance is essential for patients with PDs (Kramer et al., 2020), as it can offer an *emotionally corrective experience*, allowing them to address and modify dysfunctional interpersonal patterns (Eubanks et al., 2021). In this context, the therapist's ability to identify and address ruptures in the alliance is particularly important (Schenk et al., 2021). Colli et al. (2019) observed that therapy with PD patients involved more frequent ruptures, and clinicians working with these patients tended to exhibit greater hostility and less clarity. However, they also employed more supportive, explanatory, and expressive interventions to repair ruptures. While some individual studies have reported differences in the rupture repair process with PD patients (see also Tufekcioglu et al., 2013), meta-analyses have not consistently identified such discrepancies (Eubanks et al., 2019).

2.1.4 Interplay between the Therapeutic Alliance and Therapist Responsiveness

Research has extensively explored the relationship between the therapeutic alliance and treatment outcomes, aiming to identify factors that enhance or weaken this association. Recently, the construct of therapist responsiveness, described in Chapter One of this thesis (see Section 1.2), has garnered increasing attention. Studies have revealed a complex interplay between the therapeutic alliance and therapist responsiveness, suggesting that these variables may partially overlap and reinforce each other through a feedback loop dynamic. As Hatcher (2021) argued, responsiveness may promote a stronger therapeutic alliance, which is likely to enhance treatment outcomes and increase patient engagement in therapeutic tasks, thereby further strengthening therapist responsiveness. Notably, clinicians' capacity to be sensitively attuned, empathetic, and aware of emerging contexts has been shown to be closely associated

with the development of a therapeutic bond characterized by trust and collaboration (Aafjes-van Doorn, 2022; Elkin et al., 2014; Snyder & Silberschatz, 2017). Culina et al. (2023) found that a stronger therapeutic alliance was significantly associated with greater therapist responsiveness in the treatment of BPD patients. Their findings also indicated that therapist responsiveness during the first psychotherapy session could predict the evolution of the therapeutic alliance throughout the course of treatment (Culina et al., 2023). Moreover, with BPD patients, specific in-session behaviors, such as validating and normalizing the patient's experience, have been found to be particularly associated with stronger evaluations of the therapeutic alliance (Culina et al., 2024). Finally, Harrington et al. (2021) underscored the critical role played by therapists in enhancing the therapeutic alliance, particularly with patients with difficulties in this domain. Their findings suggest that therapist responsiveness to patients' unique challenges may lead to significantly improved treatment outcomes.

Notably, within the rupture-reparation framework, disruptions in the therapeutic alliance are considered a common aspect of treatment. If appropriately handled, these disruptions present opportunities to strengthen the therapeutic bond by exploring the patient's interpersonal difficulties (Eubanks et al., 2018; Eubanks et al., 2019). It is crucial to acknowledge that, despite the assumption of therapists' good intentions towards their patients (Kramer & Stiles, 2015; Stiles, 1988) "the term *appropriate responsiveness* implies that there is also *inappropriate responsiveness*" (Snyder & Silberschatz, 2017, p. 609). This suggests that therapists may sometimes fail to adequately respond to patients' evolving needs in moment-to-moment interactions. As described by Muran et al. (2021), therapist responsiveness is closely tied to the concept of rupture repair. Levy Chajmovic and Tishby (2024) empirically examined this connection, finding that a lack of therapist responsiveness was associated with subsequent rupture. Conversely, a responsive therapeutic stance was crucial to effect repair. Of note, their study revealed that therapist responsiveness, as

evaluated by patients, was negatively associated with confrontation ruptures, but not when evaluated by therapists. This discrepancy suggests that, while therapists may be aware that a rupture has occurred, they may not always attribute these ruptures to their lack of responsiveness (Coutinho et al., 2011; Hill et al., 2003). Patients, on the other hand, appear more attuned to therapists' difficulties in managing these critical moments within the therapeutic encounter. Regarding withdrawal ruptures, no significant relationship with therapist responsiveness was observed, based on either therapist or patient ratings. This suggests that withdrawal ruptures may often be linked to subtle disagreements that do not escalate into full-fledged ruptures in the therapeutic relationship.

Overall, research supports the need for further investigation of the complex interplay between the therapeutic alliance and therapist responsiveness. In particular, research should aim at identifying therapist behaviors that either foster or hinder the therapeutic relationship, as such knowledge could yield valuable implications for clinical practice (Stige et al., 2024).

2.2 Countertransference: Obstacle or Resource in Clinical Practice?

While countertransference was originally seen as a significant hindrance to the therapeutic process (Freud, 1912), it is now widely recognized as a valuable tool that therapists can use to better understand their patients (Tanzilli & Lingiardi, 2022). From an intersubjective or relational perspective, the therapeutic process may be understood as a reciprocal relationship in which the therapist's subjectivity is an important source of insights into the *hic et nunc* within sessions. However, if clinicians are unaware of their internal conflicts or unable to effectively manage their emotional reactions, countertransference can become an obstacle to the therapeutic process (Hayes et al., 2019). The following sections

outline the development of the concept of countertransference and efforts to empirically investigate its role in psychotherapy.

2.2.1 From a *Classical* to a *Totalistic* View of Countertransference

Countertransference, a central concept in psychotherapy, was first introduced by Freud, though he did not consistently elaborate on it in his writings. Freud coined the term in 1910 during a speech in Nuremberg, which was later published as "The Future Prospects of Psycho-Analytic Therapy." In this speech, he defined countertransference as the analyst's response to the patient's transference, shaped by the analyst's unresolved neurotic conflicts. In Freud's view, countertransference was a potential obstacle in therapy, primarily due to the risk posed by the analyst's unresolved internal conflicts, or "blind spots." To mitigate this risk, Freud (1912) emphasized the importance of analytic neutrality to minimize the influence of the analyst's personal issues on the treatment process. He also advocated for clinicians to undergo self-analysis—a recommendation that eventually evolved into a standard requirement for psychotherapeutic training. Of note, while Freud occasionally acknowledged the value of the analyst's unconscious in the therapeutic process, he did not assign the same value to countertransference (Stefana & Gamba, 2013). Thus, his original perspective is often referred to as the "narrow" or "classical" view (Kernberg, 1965). Over time, new perspectives emerged, leading to a "broader" or "totalistic" understanding of countertransference, extending beyond the analyst's reactions to the patient's transference.

The year 1950 marked a pivotal moment in the evolution of the concept, as alternative views (diverging from Freud's original perspective) began to emerge. These new perspectives were grounded in the earlier work of authors who had already begun to recognize the potential value of countertransference in the therapeutic process (e.g., Balint & Balint, 1939; Deutsch,

1926). Notably, Sàndor Ferenczi (1919) highlighted the significance of therapists' reactions for gaining insight into patient dynamics. Ferenczi argued that the analyst's strict control over their emotions could potentially undermine the therapeutic process, and he introduced an intersubjective understanding of the therapeutic relationship. This approach, emphasizing the mutual influence between therapist and patient, was subsequently supported and developed by other theorists, as further described in this section. However, despite these early contributions, Freud's perspective remained the dominant framework for many years.

A turning point in the understanding of countertransference emerged with the initiation of treatment for patients exhibiting severe impairment, who were previously deemed unsuitable for psychoanalysis. The intense emotional reactions these patients elicited in their analysts made it evident that countertransference could not be "merely" suppressed. In *Hate in the Countertransference*, Winnicott (1949) introduced a concept that was initially met with resistance by many therapists. He argued that, much like a mother's relationship with her child, the analyst must acknowledge and accept feelings of hate towards patients to avoid being overwhelmed by them. Winnicott referred to this as "objective countertransference," attributing it to patients' real characteristics and behaviors.

Heimann (1950) offered another pivotal contribution by redefining the term countertransference to encompass the entire spectrum of feelings experienced by the analyst towards the patient, which she regarded as the analyst's most valuable tool in the therapeutic process. According to Heimann, these emotional responses provided an intuitive understanding of the patient that could not be fully accessed through conscious and rational means alone. Consequently, efforts to limit and repress countertransference shifted to refining the analyst's ability to discern and utilize their feelings to enhance treatment. In line with these evolving perspectives, Little (1951) and Racker (1953, 1957) underscored the centrality of countertransference in therapy. Racker, in particular, introduced a distinction between

concordant and *complementary* countertransference: in concordant countertransference, the analyst empathically experiences emotions similar to those felt by the patient (i.e., feelings towards the patient's caregivers); in complementary countertransference, however, the analyst identifies with the patient's internal objects, potentially leading to a reactivation of the patient's dysfunctional relational patterns if not carefully managed

Other noteworthy insights came from Melanie Klein's description of *projective identification*, which shares some similarities with Racker's complementary countertransference. In her influential work *Notes on Some Schizoid Mechanism* (1946), Klein described projective identification as an intrapsychic defense mechanism whereby patients deny and split off parts of the self and then project these disowned aspects onto the analyst. This projection exerts pressure on the analyst, who may internalize these projected aspects and feel compelled to enact them. Bion (1962) expanded on Klein's idea, shifting the focus from an intrapsychic to an interpersonal perspective and introducing the *container-contained* model to illustrate the communicative function of projective identification. In his view, the analyst acts as a "container" by lending part of their mind to hold and process the patient's projected material, while maintaining sufficient detachment to observe how the patient utilizes this containment. Bion emphasized the importance of balancing detachment and empathic involvement in this process, suggesting that countertransference could serve as a valuable guide in the analytic process only when this balance is achieved.

Building on these ideas, Ogden (1982) further refined the understanding of projective identification, defining three distinct phases. In the first phase, the patient projects unwanted or rejected aspects of the self onto the other (e.g., the analyst). In the second phase, the recipient experiences a psychological pressure to identify with and potentially enact these projected contents. Finally, in the third phase, the recipient processes and returns the projected material in a modified form, shaped by their own personality and level of psychological

integration. In therapy, the analyst's task is to recognize this mechanism, utilize it as a means of understanding the patient's internal world, and work through the projected material in a manner that supports the patient's growth.

This evolution of the concept of countertransference closely aligned with a significant paradigm shift in psychoanalysis. While classical contributions to countertransference theory were developed within the framework of *monopersonal psychology*, newer insights emerged from interpersonal and relational psychoanalysis. Central to this shift were key contributions from Stolorow and Atwood (1994), as well as Mitchell and Aron (1999), who advanced a *bipersonal paradigm* of psychoanalysis. In this perspective, both therapist and patient are regarded as individuals who contribute their own subjectivity to the therapeutic interaction. This dynamic exchange implies that both parties mutually influence one another, actively co-constructing the therapeutic relationship and creating a context that fosters therapeutic progress. From this relational perspective, countertransference is seen as inevitable, but it becomes essential for therapists to develop the ability to recognize and effectively manage their emotional reactions.

2.2.2 Countertransference in the Empirical Literature

The empirical study of countertransference has presented significant challenges within psychotherapy research, due to the complex nature of the construct. Countertransference encompasses both conscious and unconscious elements, making it difficult to precisely define and measure, especially given the lack of a unified operationalization (Hayes et al., 2019). The most prominent perspectives on countertransference are the *classical*, *integrative* (or moderate), and *totalistic* views. Among these, meta-analytic research has primarily employed the integrative perspective. While both the integrative and the classical view associate

countertransference with the therapist's unresolved conflicts and the patient's personal characteristics, the integrative approach differs by acknowledging that countertransference is a useful tool in the therapeutic process, and not exclusively negative.

In their meta-analytic study, Hayes et al. (2019) found that more prevalent countertransference responses were associated with poorer treatment outcomes. Conversely, more effective management of countertransference correlated with improved outcomes, and fewer countertransference responses were linked to better management. These findings are consistent with the results of earlier meta-analytic research (Hayes et al., 2011). However, Hayes et al. (2019) also identified a gap in the literature with regard to countertransference management.

Several studies have approached countertransference by investigating specific patterns associated with distinct clinical populations (Brøsholen et al., 2022; Dahl et al., 2012; Hennissen et al., 2019; Tanzilli et al., 2020, 2024; Ulberg et al., 2014). The results have shown that countertransference can serve as a valuable diagnostic and therapeutic tool, enabling clinicians to gain deeper insight into patients' psychological functioning through their own subjective experiences (Colli & Ferri, 2015). Notably, research has emphasized the existence of *average expected countertransference reactions* when working with specific clinical populations, alongside *idiosyncratic countertransference responses* that arise from therapists' individual characteristics and conflicts (Tanzilli & Lingiardi, 2022).

A significant focus in this field has been therapist countertransference patterns towards patients with PDs. Studies have shown that these patients often evoke strong and intense emotional responses in their therapists due to their significant self-impairment and interpersonal difficulties, which extend into their interactions with clinicians. Such dysfunctional patterns can negatively impact the therapeutic relationship, underscoring the critical importance of therapists' effective recognition and management of their emotional

reactions to better understand their patients' dynamics and provide more effective treatment (Gabbard, 2001).

Important insights have emerged from studies employing a totalistic perspective of countertransference (sometimes referred to as *therapist emotional responses*), encompassing the entire spectrum of therapist thoughts, feelings, and behaviors towards patients. For this research, the Therapist Response Questionnaire (TRQ; Betan et al., 2005; Tanzilli et al., 2016) has been widely used. As depicted in Table 2.1, the Italian version of the TRQ (Tanzilli et al., 2016) has revealed a nine-factor structure identifying patterns of therapist emotional responses (for further detail, see Section 4.2.2.3 of this thesis).

Betan et al. (2005) identified specific countertransference patterns with each PD cluster, with therapists reporting criticized/mistreated responses when working with Cluster A patients; overwhelmed/disorganized, helpless/inadequate, and sexualized responses when working with Cluster B patients; and parental/protective reactions when working with Cluster C patients. Colli et al. (2014) further explored these associations using the Shedler Westen Assessment Procedure (SWAP-200; Westen & Shedler, 1999a, 1999b). Their findings indicated that BPD elicited particularly intense and negative emotional responses in therapists, such as helpless/inadequate, overwhelmed/disorganized, and special/overinvolved feelings. This finding aligns with the empirical and clinical literature showing the numerous challenges involved in the treatment of BPD patients (Alarcón, 2016; Kernberg, 1967). Furthermore, the study also revealed that paranoid PD often evoked criticized/mistreated reactions, while avoidant and dependent PDs prompted more positive feelings, such as parental/protective responses. Even these positive reactions, however, demanded careful attention from clinicians to prevent over-involvement and a detrimental loss of therapeutic neutrality.

Table 2.1 Countertransference Patterns, Identified by the TRQ (Tanzilli et al., 2021)

Helpless/Inadequate	Feelings of inadequacy, incompetence, hopelessness, and inefficacy.
Overwhelmed/Disorganized	Feelings of being overwhelmed by the patient's emotions and needs, as well as confusion, anxiety, dread, or repulsion.
Positive/Satisfying	Close connection, trust, and collaboration with the patient, along with a good therapeutic alliance.
Hostile/Angry	Feelings of anger, hostility, and irritation towards the patient.
Criticized/Devalued	Feeling criticized, unappreciated, dismissed, or devalued by the patient.
Special/Overinvolved	Perception of the patient as very special, potentially leading to difficulties in maintaining the boundaries of the therapeutic setting (e.g., ending sessions late).
Parental/Protective	Desire to protect and nurture the patient in a parental way, not limited to normal positive feelings.
Sexualized	Sexual attraction or feelings towards the patient
Disengaged	Annoyance, boredom, withdrawal, or distraction during sessions.

Patients' level of personality functioning—as assessed, for instance, in terms of *personality organization* (Kernberg, 1967, 1968)—has also been shown to significantly influence therapists' countertransference responses. Specifically, research has shown that patients with greater personality impairment tend to evoke more intense emotional reactions, and clinicians must employ their interpersonal skills to manage these responses effectively (Dahl et al., 2012; Kramer, 2019; Tanzilli et al., 2024).

The *Psychodynamic Diagnostic Manual, Second Edition* (PDM-2; Lingiardi & McWilliams, 2017) underscores the importance of therapists' subjective reactions in

psychodynamic diagnosis. Unlike traditional the other diagnostic systems, such as DSM and ICD, the PDM-2 considers itself a "taxonomy of people," rather than a "taxonomy of disorders" (p. 2), highlighting the centrality of the individual over a sole focus on symptoms. The manual employs a multiaxial diagnostic system comprised of three axes: *personality syndromes* (P Axis), *mental functioning* (M Axis), and *symptom patterns* (S Axis). Therapist emotional responses are incorporated into the P Axis and the S Axis, to facilitate more accurate and nuanced diagnosis and support tailored treatment planning.

Finally, recent studies have examined the impact of countertransference on the therapeutic process and its relationship with other relevant variables, showing that negative countertransference responses can undermine therapists' ability to remain empathic, attuned, and responsive in clinical work (Ulberg et al., 2014; Tishby and Wiseman, 2022; Hennissen et al., 2023; Pellens et al., 2023). In particular, Hennissen et al. (2023) emphasized the importance of managing feelings of disengagement towards self-critical patients, noting the challenging nature of these emotional reactions. If not adequately monitored and addressed (Tishby & Wiseman, 2014), such reactions can disrupt the development of a collaborative therapeutic environment, thereby hindering effective treatment (Gross & Elliott, 2017; Tanzilli & Gualco, 2020). Despite the useful insights generated by this research, the direct relationship between countertransference and therapist responsiveness remains underexplored, suggesting a need for further investigation.

2.3 The present investigation

As discussed in the first two chapters of this thesis, the study of mechanisms contributing to the effectiveness of psychotherapy still demands substantial attention from researchers. For a long time, one under-researched area has been the therapist's effect on

treatment outcomes (Castonguay & Hill, 2017; Wampold & Owen, 2021) and currently, the role of therapist interpersonal skills (e.g., Lingiardi et al., 2018) remain partially unclear (Mulder et al., 2017; Norcross and Lambert, 2018).

In this thesis I focused on therapist responsiveness to better understand its complex interplay with other key elements of the therapeutic relation and process, such as the therapeutic alliance and the therapist's emotional responses.

In the present project, I collected data from both the therapists' and patients' perspectives. Particularly, I explored individual therapy sessions – that is, the "session's immediate subjective effect on patients' reactions in terms of interpersonal climate, sense of progress and satisfaction" (Stiles et al., 2002, p. 326). Events within each session have an impact on what occurs in other sessions and in the whole treatment, offering valuable insights into the ongoing therapeutic process and, consequently, on long-term psychotherapy outcomes (Lingiardi et al., 2011; Stiles, 1980; Stiles et al., 1988).

Particularly, in the present thesis the depth of elaboration has been considered as an outcome measure and an index of the session quality (Stiles & Snow, 1984b, 1984a). The "curative" effect of exploring deep contents in therapeutic sessions has been emphasized in clinical work (Greenberg & Pascual-Leone, 2006). Good sessions are deep, powerful, valuable, full, and special, and typically foster a sense of safety (cf., Mallinckrodt et al., 2005), creating an environment conducive to the exploration of interpersonal problems, conflicts, and, more broadly, psychological issues related to inner dynamics of the patient (Stiles, 1988; Lingiardi et al., 2011). Notably, several findings (e.g., Mallinckrodt, 1993; Reynolds et al., 1996; Rocco et al., 2017; Samstag et al., 1998), including meta-analytic estimates (Pascual-Leone & Yeryomenko, 2017), have emphasized that attaining higher levels of depth of elaboration is associated with positive treatment outcomes, supporting the need for further investigations into factors that might facilitate or hinder this in-session process.

2.3.1 Objectives of the Studies and Measures

In light of the above, multiple methodologies have been employed in the attempt to address psychotherapy holistically to contribute to enrich the knowledge in this field (Hayes & Andrews, 2020; Klocek et al., 2024; Scheffer et al., 2024a). In what follows I summarized the aims of my studies which have been detailed in *Chapters Three*, *Four*, and *Five* and *Six* of this thesis. Moreover, I illustrated the instruments I used across the studies to avoid redundancy in the following chapters.

Study One) The first study explored associations between therapist responsiveness, therapeutic alliance and depth of elaboration as well as the capacity of therapist responsiveness and therapeutic alliance to predict levels of depth of elaboration. Moreover, I explored discrepancies between patients' and therapists' ratings of the therapeutic alliance, depth of elaboration, and therapist responsiveness. Of note, mixed models have been employed, taking into account the nested data structure.

Study Two) The second study focused on the therapist's perspective. Particularly, differences in therapist responsiveness and therapist emotional responses between sessions characterized by diverse levels of depth of elaboration have been explored. I also investigated if the positive countertransference pattern mediated the relationship between therapist responsiveness and depth of elaboration.

Study Three) In the third study I employed a thematic analysis to examine the subjective experience of both patients and therapists describing moments of therapist responsiveness and therapist non-responsiveness within sessions.

Study Four) The fourth study aimed to use network analysis to explore the interconnections between patients' and therapists' evaluations of therapist responsiveness,

therapeutic alliance, and depth of elaboration. Moreover, the associations with session outcome, conceptualized in terms of depth of elaboration has been explored.

Within the four studies described in the next chapters therapist responsiveness, therapeutic alliance and depth of elaboration have been assessed using the following instrument.

2.3.1.1 Patient's Experience of Attunement and Responsiveness Scale (PEAR; Snyder & Silberschatz, 2017).

PEAR is a valid and reliable instrument to assess attunement and responsiveness in psychotherapy sessions. Two forms have been developed: one for the therapist or PEAR-T (including items such as: *"I was able to provide valuable insight to my client that resulted in him/her achieving greater self-understanding today"*, *"I was able to help my client talk about what was really important or troubling to him/her today"*) and one for the patient or PEAR-P (including items such as: *"My therapist provided valuable insight and helped me achieve greater self-understanding today"*, *"I felt able to take the lead in bringing up whatever I wished to talk about today"*). These subscales consisted originally of 30 items each. As reported by Snyder and Silberschatz (2017), after preliminary analyses, some items were excluded, and exploratory factor analysis (EFA) has been carried out on 22 items for the PEAR-T and 20 items for the PEAR-P. The PEAR-T revealed a two-factor structure, i.e., *Therapist Helpfulness* and *Safe Accepted*, whereas the PEAR-P showed a three-factor structure, i.e., *Perceived helpfulness*, *Felt Empathy*, and *Sensed Accomplishment*. Items are on a 4-point Likert Scale and range from 0 (*not at all) to 3 (very much).* In the studies of the present thesis the Italian translation of the PEAR has been used (see Appendix 1).

2.3.1.2 Working Alliance Inventory – Short Form (WAI-SF; Tracey & Kokotovic, 1989)

WAI–SF has been developed from the Working Alliance Inventory (WAI; (Horvath & Greenberg, 1989). It evaluates the quality of the therapeutic alliance from multiple perspectives (patient, therapist, observer). In the present study, the Therapist (WAI-T) and Patient (WAI-P) versions were adopted. Each of them consists of 12 items, written in jargon-free language and ranging on a 7-point Likert Scale from 1 (*never*) to 7 (*always*). This instrument is based on Bordin's (1979) pantheoretical theory of therapeutic alliance and identifies three dimensions: *bond*, *tasks,* and *goals*. The *bond* refers to the quality of support and collaboration in the therapeutic work, *goals* to the objectives of the treatment, and *tasks* to the ways for their achievement. Each version of the instrument provides a score for each of the three subscales (*bond*, *task,* and *goals*) and an overall working alliance score.

2.3.1.3 Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles & Snow, 1984)

The SEQ is an instrument developed to evaluate different dimensions of psychotherapy sessions (e.g., Depth, Smoothness, Positivity, Arousal). In the present study, it was only used the SEQ-D, for the evaluation of the depth of elaboration from the therapist and patient's perspective. This scale is composed of five items on a 7 point-Likert scale. Each item consists of bipolar adjectives regarding the therapy session (i.e., powerful/weak, valuable/worthless, deep/shallow, full/empty, and special/ordinary). Preliminary results of the Italian validation of the SEQ-D demonstrated overall good psychometric proprieties (Rocco et al., 2017). Cronbach's alpha was .85.

Chapter 3

Study One. Therapist Responsiveness and Therapeutic Alliance in Psychotherapy Process: How to Increase the Depth of Elaboration?

3.1 Introduction and aims

In recent years, a growing number of studies have paid attention to therapist responsiveness (e.g., Kramer & Stiles, 2015; Wu & Levitt, 2020), demonstrating the association between this interpersonal capacity of the clinician and psychotherapy outcomes (Stiles & Horvath, 2017; Wu & Levitt, 2020). Moreover, several investigations have highlighted the link between responsiveness and other dimensions of the patient-therapist relationship (Watson & Wiseman, 2021), particularly the therapeutic alliance (Elkin et al., 2014; Hatcher, 2015; Snyder & Silberschatz, 2017).

Despite the significant strides made by researchers in the study of therapist responsiveness, the complex processes underlying the interactions between this dimension, therapeutic alliance, and depth of elaboration during psychotherapy are not sufficiently clear. In light of these premises, and in order to increase our knowledge to better inform tailored clinical interventions (Kramer et al., 2022), the present study investigates the intricate association between therapist responsiveness, therapeutic alliance, and depth of elaboration during psychotherapy sessions. It sought to verify which dimensions (either independently or in connection with each other) were strongly associated with favorable outcomes. More specifically, my objectives were:

a) Explore the associations between therapist responsiveness, therapeutic alliance, and depth of the session from both patient and clinician perspectives. It is possible to hypothesize that higher levels of therapist responsiveness would strongly relate to better quality of

therapeutic alliance and greater depth of elaboration in session, as perceived by both therapists and patients.

b) Investigate the potential discrepancy between patients' and clinicians' assessments of therapist responsiveness, alliance, and depth of elaboration in psychotherapy sessions, considering the variability both between and within patient-clinician dyads. Based on the sparse empirical literature in this field, which mainly focused on the therapeutic alliance (e.g., (Aafjes-van Doorn et al., 2022; Laws et al., 2017; Zilcha-Mano, 2017), I hypothesized that discrepancies would exist between therapists' and patients' evaluations, with patients providing higher ratings on the investigated variables.

c) Conduct an exploratory analysis to examine the effect of therapist responsiveness and therapeutic alliance in predicting good levels of depth in processing session content, taking into account the nested data structure. Consistent with little literature in this topic (Aafjes-van Doorn et al., 2022; Silberschatz, 2005), I hypothesized that the two dimensions of the therapeutic relationship would be strongly correlated with session depth, taking into account the variance between and within patient-clinician dyads.

3.2 Methods

3.2.1 Participant sampling

A sample of 67 pairs of patients and therapists was recruited from several Italian associations of psychodynamic and cognitive-behavioral psychotherapy and centers specializing in the treatment of personality disorders in Genoa, Milan, Turin, and Rome. Clinicians were asked to identify one of their patients according to the following inclusion/exclusion criteria: (1) at least 18 years old; (2) a personality disorder diagnosis (according to the DSM-5/5-TR or ICD-10/11 international taxonomies; APA, 2013, 2022;

WHO, 1993, 2022, respectively) (3) in treatment from a minimum of 2 to a maximum of 24 months; (4) without psychotic disorder diagnosis, nor treated with drug therapy for psychotic symptoms. Participation was voluntary and completely anonymous to guarantee privacy. To minimize rater-dependent biases (i.e., therapist effects), each clinician was allowed to select only one patient. All the participants provided informed consent. The research protocol was approved by the Ethical Committee of the Department [information blinded for review], Faculty of [information blinded for review], University of [information blinded for review], Prot. n. 0000773 del 12/05/2022.

3.2.1.1 Therapists

This sample consisted of 67 White therapists, including 28 males and 39 females. Their main age was 48 years approximately (*SD* = 12.30; range = 31–71). The average length of their clinical experience was 15.19 years (*SD* = 10.20, range = 2–43). The weekly hours devoted to clinical practice were 30,57 approximately (*SD* = 13.10, range = 6–55). The main clinical-theoretical approach was psychodynamic (*N* = 57), whereas a minority portion is cognitive-behavioral (*N* = 6) and metacognitive-interpersonal (*N* = 4).

3.2.1.2 Patients

This sample consisted of 67 White patients, including 42 females and 25 males. Their mean age was 36 years approximately (*SD* = 12.41, range = 20–65). Forty-four patients had only a DSM-5 personality diagnosis: 2 patients had a Cluster A disorder (diagnosed with a paranoid and schizoid personality disorder, respectively); 11 had a Cluster B personality disorder (5 diagnosed with a borderline personality disorder, 2 with a histrionic personality

disorder, and 4 with a narcissistic personality disorder); 22 had a Cluster C personality disorder (6 diagnosed with an avoidant personality disorder, 11 with a dependent personality disorder, and 5 with an obsessive–compulsive personality disorder); 9 patients presented two or more personality disorder diagnoses (5 had a comorbidity within the Cluster B and 2 a comorbidity within the Cluster C; 2 had a comorbidity between different clusters). Forty-eight patients presented with a DSM-5 psychiatric diagnosis: 1 had a bipolar disorder, 15 had a depressive disorder (5 of whom also presented with a comorbid anxiety disorder), 21 had anxiety disorders, 4 had a obsessive-compulsive disorder, 3 had a feeding and eating disorder, 2 had a post-traumatic stress disorder, and 2 had a somatic symptom disorder. The mean Global Assessment of Functioning (GAF) score was 65 (*SD* = 18.12, range = 30–90). The average length of treatment was about 8.38 months (*SD* = 6.28; range = 2–24).

3.2.2 Measures

3.2.2.1 Patient's Experience of Attunement and Responsiveness Scale (PEAR; Snyder & Silberschatz, 2017).

PEAR is a valid and reliable instrument to assess attunement and responsiveness in psychotherapy sessions. In this study, the Italian version of the PEAR has been used (see Appendix 1). In the present study, both versions of the instrument showed good reliability (cf., Snyder & Silberschatz, 2017), with coefficients ω= .95 (PEAR-P) and ω = .96 (PEAR-T). Moreover, the three PEAR-P subscales showed good internal consistency, obtaining the following coefficients ω= .87 (*Perceived Helpfulness*), ω= 93 (*Felt Empathy*), and ω= 82 (*Sensed Accomplishment*). Similarly, the two PEAR-T subscales showed the following

coefficients ω= 81 (*Therapist Helpfulness*) and ω= 85 (*Safe Accepted*). See paragraph 3.1.3 for further details on PEAR.

3.2.2.2 Working Alliance Inventory – Short Form (WAI-SF; Tracey & Kokotovic, 1989).

The WAI–SF has been developed from the Working Alliance Inventory (WAI; Horvath, 1981, 1989). It evaluates the quality of the therapeutic alliance according to the Bordin's (1979) *pantheoretical* theory of therapeutic alliance and identifies three dimensions: bond, tasks, and goals. In the present study, the Therapist (WAI-T) and Patient (WAI-P) versions were adopted. Specifically, it was used the global index of alliance given that the intercorrelations among all the subscales ranged from .89 to .94. See paragraph 2.3.1.2 of the previous chapter for further details on the WAI-SF.

3.2.2.3 Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles & Snow, 1984).

The SEQ is an instrument developed to evaluate different dimensions of psychotherapy sessions (e.g., Depth, Smoothness, Positivity, Arousal). In the present study, it was only used the SEQ-D, for the evaluation of the depth of elaboration from the therapist and patient's perspective. Preliminary results of the Italian validation of the SEQ-D demonstrated overall good psychometric proprieties (Rocco et al., 2017). Cronbach's alpha was .85. See paragraph 2.3.1.3 of the previous chapter for further details on the SEQ-D.

3.2.3 Procedures

After providing their informed consent, clinicians were asked to choose one patient in their care according to the inclusion and exclusion criteria described above (see "Participants sampling" Section). Both therapists and patients were asked to fill in an online survey (hosted on SurveyMonkey). In particular, therapists and their patients completed the following questionnaires after their weekly psychotherapy session: the *Patient's Experience of Attunement and Responsiveness Scale* (PEAR-T and PEAR-P), the *Working Alliance Inventory – Short Form - Therapist and Patient Version* (WAI-SF-T and WAI-SF-P), and the *Depth scale* of the *Session Evaluation Questionnaire* in both versions (SEQ-D-T and SEQ-D-P).

3.2.4 Statistical Analysis

A priori power analysis using G*Power (Faul et al., 2007) was conducted to estimate the minimum sample size needed for the primary analyses. The results indicated that a minimum of 67 therapist-patient dyads was required to achieve adequate statistical power. Statistical analyses were performed using SPSS 27 for Windows (IBM, Armonk, NY). Descriptive statistics of all the dimensions of the therapist responsiveness (evaluated using the PEAR-T and PEAR-P), the therapeutic relationship (evaluated using the WAI-SF-T and WAI-SF-P), and the depth of sessions (evaluated using the SEQ-D-T and SEQ-D-P) were calculated for the therapist and patient samples. Moreover, to verify the possible impact of clinician and patient gender on the assessment of variables considered in the study, independent sample *t* tests were performed to compare the means of males and females on PEAR-T and PEAR-P subscales, WAI-SF-T and WAI-SF-P global indices, and SEQ-D-T and SEQ-D-P subscales. Bivariate correlations (Pearson's *r*, two-tailed) were carried out to verify the relationship between all the dimension of the study and age of patients and therapists.

Bivariate correlations were also carried out to investigate the associations among therapist responsiveness (assessed using the PEAR-T and PEAR-P), therapeutic alliance (evaluated using the WAI-T and WAI-P) and depth of elaboration during the session (evaluated using the SEQ-D-T and SEQ-D-P). The nested data structure of patient-therapist dyads made necessary to use a linear mixed model to examine the discrepancy between patients' and clinicians' ratings of therapist responsiveness, alliance and depth of elaboration in the psychotherapy session (also taking into account the within-subjects variance per each patient-clinician pair). Finally, a generalized linear mixed model was performed to identify which dimensions of therapeutic relationship predicted depth of elaboration and, as consequence, session outcome. Fixed factors in the model included therapist responsiveness and therapeutic alliance. In addition, these continuous predictor variables were mean centered as well as the continuous outcome variable, while dichotomous variable was coded as 0 (patients) or 1 (therapists). Finally, Cohen's *d* was used to indicate the effect size. It was calculated from the *t* statistic (see Dunlap et al., 1996).

3.3 Results

3.3.1 Preliminary Analyses

Analyses comparing therapist and patient ratings in all PEAR-T and PEAR-P subscales, in the WAI-T and WAI-P global indices, and in the SEQ-D-T and SEQ-D-P subscales showed no significant differences by gender. With regard to the sample of patients, the mean scores obtained by females were not significantly higher than the mean values obtained by males: (a) PEAR-P Perceived helpfulness, $M_{females} = 2.23$, $SD = .58$; $M_{males} = 2.07$, $SD = .53$; $t(65) = 1.10$, $p = .277$); (b) PEAR-P Felt empathy, $M_{females} = 2.50$, $SD = .62$; $M_{males} = 2.31$, $SD = .46$; $t(65) = 1.28$, $p = .205$); (c) PEAR-P Sensed accomplishment, $M_{females}$

= 2.14, *SD* = .66; M_{males} = 1.89, *SD* = .42; *t*(65) = 1.70, *p* = .094); (d) WAI-SF-P global index, $M_{females}$ = 5.57, *SD* = .84; M_{males} = 5.27, *SD* = .93; *t*(65) = 1.32, *p* = .191); (e) SEQ-D-P, $M_{females}$ = 5.59, *SD* = .95; M_{males} = 5.24, *SD* = .73; *t*(65) = 1.61, *p* = .113). Similarly, with regard to the sample of therapists, the mean scores obtained by females were not significantly higher than the mean values obtained by males: (a) PEAR-T Therapist helpfulness, $M_{females}$ = 1.82, *SD* = .40; M_{males} = 1.77, *SD* = .41; *t*(65) = –.56, *p* = .580; (b) PEAR-T Safe accepted, $M_{females}$ = 1.64, *SD* = .29; M_{males} = 1.55, *SD* = .30 ; *t*(65) = –1.18, *p* = .244); (c) WAI-SF-T global index, $M_{females}$ = 4.57, *SD* = .51; M_{males} = .4.38, *SD* = .47; *t*(65) = –1.49, *p* = .141); (d) SEQ-D-T, $M_{females}$ = 4.67, *SD* = .80; M_{males} = 4.97, *SD* = .63; *t*(65) = 1.64, *p* = .105).

All the dimensions included in the study were not significantly related to patient and therapist age. In more detail, patient age obtained the following coefficients: $r_{Perceived\ helpfulness}$ = .11, *p* = .400; $r_{Felt\ empathy}$ = .005, *p* = .970; $r_{Sensed\ accomplishment}$ = .10, *p* = .435; $r_{Alliance}$ = .19. *p* = .119; r_{Depth} = .22, *p* = .08. On the contrary, therapist age obtained the following correlation coefficients: $r_{Therapist\ helpfulness}$ = .14, *p* = .27; $r_{Safe\ accepted}$ = .09, *p* = .49; $r_{Alliance}$ = –. 21, *p* = .09; r_{Depth} = .09, *p* = .49;

3.3.2 Associations Between Therapist Responsiveness, Therapeutic Alliance and Depth of Session from Therapist and Patient Perspectives

The first aim of the present study was to examine the relationships between therapist responsiveness, therapeutic alliance and depth of elaboration in psychotherapy session (assessed using the patient- and therapist- versions of PEAR, WAI-SF, and SEQ-D), considering the perspective of patients and therapists.

Table 3.1 shows the correlations between all the PEAR-P subscales and other variables evaluated by patients. It is important to note that in patients, felt empathy was the

dimension more closely related to the global index of therapeutic alliance; on the contrary, sensed accomplishment was the dimension more strongly associated with session depth.

Table 3.1 Bivariate Correlations Between all the Dimensions of the PEAR-P, Global Index of the WAI-SF-P, and Depth Scale of the SEQ-D-P From Patient Perspective ($N = 67$)

		WAI–SF–P global index	SEQ-D-P
PEAR–P	*M*(*SD*)	5.46(.89)	5.47(.88)
Perceived helpfulness	2.17(.56)	.49***	.51***
Felt empathy	2.43(.57)	.59***	.52***
Sensed accomplishment	2.04(.59)	.44***	.69***

Note. The table lists Pearson's *r* values, two-tailed.

PEAR-P = Patient's Experience of Attunement and Responsiveness–Patient Subscale. WAI-SF-P = Working Alliance Inventory–Short Form–Patient Version. SEQ-D-P = Depth Scale of Session Evaluation Questionnaire–Patient Perspective.

*** $p \leq .001$.

Table 3.2 provides the correlations of all the PEAR-T scales with the global index of alliance and depth of session evaluated by therapists. Overall, consistent with the expectations, therapist responsiveness was significantly and positively related to other variables; notably, the dimension of therapist helpfulness was found to be more strongly associated with alliance and session depth than the dimension of safe accepted.

Table 3.2 Bivariate Correlations Between all the Dimensions of the PEAR-T, Global Index of the WAI-T, and Depth Scale of the SEQ-D-T From Therapist Perspective ($N = 67$)

		WAI–SF–T global index	SEQ-D-T
PEAR–T	*M*(*SD*)	4.49(.50)	4.79(.75)
Therapist helpfulness	1.81(.40)	.38***	.54***
Safe accepted	1.60(.30)	.30*	.26*

Note. The table lists Pearson's *r* values, two-tailed.

PEAR-T = Patient's Experience of Attunement and Responsiveness–Therapist Subscale. WAI-T = Working Alliance Inventory–Short Form–Therapist Version. SEQ-D-T = Depth Scale of Session Evaluation Questionnaire–Therapist Perspective.

* $p \leq .01$. *** $p \leq .001$.

3.3.3 Evaluation of Therapist Responsiveness, Therapeutic Alliance, and Depth of Session in Patient-Therapist Dyads

The second aim of the study was to assess the potential discrepancies between patients and their therapists in assessing therapist responsiveness, quality of alliance, and depth of the session. Considering the nested structure of the data on patient-therapist pairs, the mixed-model analyses were used to assess variability both between- and within-dyads.

Table 3.3 depicts the results of three mixed-model analyses including therapist responsiveness (i.e., the mean scores of both PEAR-T and PEAR-P), therapeutic alliance (i.e., the mean scores of both WAI-SF-T and WAI-SF-P), and depth of session (i.e., the mean scores of both SEQ-D-T and SEQ-D-P) as dependent variables, respectively. In line with expectations, the divergence between patient and therapist evaluations of all the variables included in the study was statistically significant. Examining fixed and random effects in

more detail, it can be shown that there was strong variability within patient-therapist pairs, and more specifically, patients' evaluations of responsiveness, therapeutic alliance, and depth of session ($M_{Therapist\ responsiveness}$ = 3.22, SD = .05; $M_{Alliance}$ = 5.46, SD = .08; M_{Depth} = 5.47, SD = .10) were significantly higher than their therapists' evaluations ($M_{Therapist\ responsiveness}$ = 2.70, SD = .05; $M_{Alliance}$ = 4.49, SD = .08; M_{Depth} = 4.80, SD = .10, respectively).

3.3.4 Prediction of Session Depth from Therapist Responsiveness and Therapeutic Alliance

The third aim of the study was to test the hypothesis that therapist responsiveness and therapeutic alliance would predict depth in processing contents that emerge in the session. Consistent with the expectations, the linear mixed model analysis showed that higher levels of therapist responsiveness and greater quality of therapeutic alliance were significantly associated with better depth of session, $F(1, 131) = 39.81$, $p < .001$ and $F(1, 131) = 5.52$, $p = .02$, respectively. Parameter estimates of this model are reported in Table 3.4.

Table 3.3 Mixed Model Parameter Estimates for the Evaluation of Convergence vs. Divergence in the Therapist Responsiveness (PEAR), Therapeutic Alliance (WAI-SF) and Depth of Session (SEQ-D) in Patient-Therapist Pairs ($N = 134$)

Dependent Variable: *Therapist Responsiveness*							
			Estimates of fixed effects				
						95% Confidence Interval	
Parameter	Estimate	SE	df	*t*	*p*	Lower bound	Upper bound
Intercept	1.71	.05	131.05	33.821	<.001	1.61	1.81
Patient perspective	.51	.07	66	7.469	<.001	.37	.65
Therapist perspective	0[d]						
			Test of random effects				
						95% Confidence Interval	
Parameter	Estimate	SE		Wald Z	*p*	Lower bound	Upper bound
Residual	.10	.03		3.652	<.001	.06	.17
Patient-therapist pairs	.01	.02		.69	.49	.001	.25
Dependent Variable: *Therapeutic alliance*							
			Estimates of fixed effects				
						95% Confidence Interval	

Parameter	Estimate	SE	df	*t*	*p*	Lower bound	Upper bound
Intercept	4.49	.09	129.262	51.109	<.001	4.32	4.66
Patient perspective	.97	.11	66	8.458	<.001	.74	1.20
Therapist perspective	0[d]						

Test of random effects

					95% Confidence Interval	
	Estimate	SE	Wald Z	*p*	Lower bound	Upper bound
Residual	.27	.08	3.504	<.001	.15	.47
Patient-therapist pairs	.08	.06	1.170	.24	.01	.40

Dependent Variable: *Depth of session*

Estimates of fixed effects

						95% Confidence Interval	
Parameter	Estimate	SE	df	*t*	*p*	Lower bound	Upper bound
Intercept	4.80	.10	127.425	47.987	<.001	4.60	4.99
Patient perspective	.67	.13	66	5.230	<.001	.41	.92
Therapist perspective	0[d]						

Test of random effects

					95% Confidence Interval	
	Estimate	SE	Wald Z	*p*	Lower bound	Upper bound
Residual	.32	.09	3.382	<.001	.18	.57
Patient-therapist pairs	.13	.08	1.512	.13	.03	.46

Note: [d] This parameter is set to zero because it is redundant.

PEAR = Patient's Experience of Attunement and Responsiveness. WAI-SF = Working Alliance Inventory-Short Form. SEQ-D = Depth Scale of Session Evaluation Questionnaire.

Table 3.4 Mixed Model Parameter Estimates for the Prediction of Session Depth From Therapist Responsiveness and Therapeutic Alliance ($N = 134$)

Fixed effects

Parameter	Estimate	SE	*t*	*p*	95% Confidence Interval		*d*
					Lower bound	Upper bound	
Intercept [a]	2.23	.31	7.08	<.001	1.61	2.85	1.23
PEAR	.97	.15	6.31	<.001	.66	1.27	1.10
WAI-SF	.20	.09	2.35	.02	.03	.37	.41

Test of random effects

	Estimate	SE	Wald Z	*p*	95% Confidence Interval	
					Lower bound	Upper bound
Intercept	.08	.05	1.513	.130	.02	.29
Patient-therapist perspective	.21	.06	3.525	<.001	.12	.36

[a] The intercept reflects the variability of patient-therapist pairs.

PEAR = Patient's Experience of Attunement and Responsiveness. WAI-SF = Working Alliance Inventory-Short Form. SEQ-D = Depth Scale of Session Evaluation Questionnaire.

3.4 Discussion

The present study sought to investigate the associations between therapist responsiveness, therapeutic alliance, and depth of processing content that emerges in the context of psychotherapy, considering not only the distinct perspectives of patients and clinicians, but also the dyadic patient-clinician interaction. Overall, this research shows that clinicians' interpersonal ability to accurately tailor and personalize their interventions to patients' characteristics is crucial to establishing and maintaining a good therapeutic alliance, characterized by increased intimacy, reciprocity and collaboration (e.g., Culina et al., 2023; Hatcher, 2021; Heinonen & Nissen-Lie, 2020). Furthermore, it appears that the mutual interconnection between therapist responsiveness and the alliance allows for a significant improvement in the good quality of therapeutic sessions (e.g., Harrington et al., 2021), enhancing their potential impact on the outcomes of successful psychological treatments (Norcross & Wampold, 2019c; Stiles, 1980)

The first aim of the study was to explore whether specific dimensions of therapist responsiveness (perceived by patients and therapists separately) were significantly and consistently associated with alliance and depth of elaboration in the psychotherapy session. The results substantially confirmed my hypothesis, suggesting that patients' good experience of attuned and responsive therapists plays a relevant role in fostering a good relational climate and promoting clinically meaningful elaborative processes during the psychotherapy session (e.g, Kramer & Stiles, 2015; Snyder & Silberschatz, 2017; Watson & Wiseman, 2021).

Looking in more detail at the correlation picture shown in Table 3.1, it is possible to note that in patients higher levels of *felt empathy* and *perceived helpfulness* of PEAR-P were significantly correlated with better therapeutic alliance. Consistent with the empirical literature in the field (Aafjes-van Doorn et al., 2022; Elkin et al., 2014; Snyder &

Silberschatz, 2017), these findings confirm that the therapists' ability to empathically perceive patients' emotional experience, as well as presumably to convey this attunement through specific therapeutic techniques (e.g., active-listening, helping in more difficult areas of life, and increasing insight) has a considerable effect in consolidating patients' perceptions of a stable therapeutic relationship, in which they can feel trustful, secure, and stimulating to cope with their difficulties. In addition, higher levels of *sensed accomplishment* were correlated with greater depth of content processing that emerged during a treatment session. This result seems to support that patients' perception of being helped to overcome their problems and being able to achieve a sense of well-being through clinicians' authentic connection increases deeper exploration processes (Hatcher, 2015). Furthermore, it is important to highlight that in previous research, the dimension of *sensed accomplishment* has been found to be more correlated with treatment outcome measures (Snyder & Silberschatz, 2017). In the present empirical investigation, this dimension of PEAR-P—related to the patient's sense of progress and change during therapy—was also found to be strongly connected to session depth, which is a measure of ongoing treatment effectiveness (Stiles, 1980).

Observing the correlations shown in Table 3.2, it is found that in therapists the dimension of *therapist helpfulness* was more strongly related to therapeutic alliance and depth of elaboration than *safe accepted*. According to therapists' perspective, to create a stable, flexible, and open relational "environment", which allows patients to work through their painful or unacceptable emotions, distressing thoughts, or relational conflicts, it is essential to maintain an "appropriate responsiveness" defined as "… the therapist's ability to achieve optimal benefit for the client by adjusting responses to the current state of the client and the interaction" (Hatcher, 2015, p. 747; see also Stiles & Horvath, 2017).

The second aim of the study was to examine the levels of divergence between patients' and clinicians' assessments of therapist responsiveness, therapeutic alliance, and depth of

elaboration, taking into account the variance between and within patient-clinician pairs. The empirical literature in this field is scarce and empirical findings are not exhaustive. However, in line with the few studies, mainly focused on alliance (e.g., Aafjes-van Doorn et al., 2021; Laws et al., 2017; Pellens et al., 2023; Zilcha-Mano et al., 2017), and with my hypothesis, this research found a statistically significant divergence among patients' and therapists' ratings on all the variables included in the mixed model analysis. The findings revealed that the mean values of therapist' evaluations were lower when compared with the mean values reported by patients (see Table 3.3).

This discrepancy may be linked to different variables of the patient, the therapist, or the therapeutic relationship. A number of clinical and empirical contributions have shown that specific patient characteristics (such as maladaptive personality traits, immature defensive style, insecure attachment, poor mentalization or, recently, epistemic mistrust) may impact on clinicians' (self-perceived) capacity of being optimally sensitive and effectively customizing interventions to fit patients' requirements (Despland et al., 2001; Fonagy & Allison, 2014; Kramer & Stiles, 2015; Meyer & Pilkonis, 2001; Talia et al., 2014; Wiseman & Egozi, 2021). Moreover, responsiveness markedly influences patients' experience of good-enough collaboration with patients to promote new insights and changes in treatment (Flückiger et al., 2019; Lingiardi et al., 2011; Norcross & Wampold, 2019c, 2019b)

Clinicians' perceptions of responsiveness, alliance, and depth of elaboration may be also influenced by their particular characteristics (such as defensive stance or failure to maintain empathy, etc.) or relational variables (such as countertransference) (e.g., Norcross & Wampold, 2019b). In particular, recent research has shown that, when faced with intense and negative countertransference reactions, characterized by helplessness, hostility, criticism, confusion, frustration, or disengagement, there can be a significant decrease in clinicians' ability to be empathetically attuned and responsive, along with difficulty in establishing a

strong therapeutic alliance with patients and, therefore, potential stagnation of therapeutic process (Lingiardi, 2022; Pellens et al., 2023; Tanzilli et al., 2018a, 2018b). Indeed, these maladaptive relational dynamics in the treatment context greatly interfere with therapists' ability to understand patients' moment-by-moment goals on a basis, to encourage the processing of feelings or thoughts (sometimes very distressing) related to their conflicts or motivations for psychotherapy, and continually negotiate and adjust their interventions to patient characteristics (Aafjes-van Doorn et al., 2022). Some studies have found that, at times of resistance or impasse, the clinician's (misattuned) use of confrontation or interpretation, rather than reformulation, clarification, or validation of patients' experiences, risks reinforcing emotional detachment with patients and impeding processing and treatment progress (Owen & Hilsenroth, 2014; Snyder & Silberschatz, 2017; Stiles et al., 2002)

The third aim of the study was to investigate whether therapist responsiveness and therapeutic alliance were related to depth of elaboration in a clinically meaningful and statistically systematic way. Overall, the results confirmed my hypotheses; however, contrary to expectations, the contribution of responsiveness in predicting deeper exploration of patients' intrapsychic and interpersonal problems in session was greater than the impact of therapeutic alliance (see Table 3.4). Indeed, the effect size of these variables (verified using the d of Cohen; Cohen, 1988) showed that the proportion of variance explained by therapist responsiveness was larger ($d_{\textit{therapist responsiveness}} = 1.10$ vs. $d_{\textit{therapeutic alliance}} = .41$) than that of alliance.

Even though these are preliminary results, they seem very promising since they seek to shed light on the interconnections between therapist responsiveness and therapeutic alliance. From a clinical point of view, it appears clear that therapists' attunement and responsiveness can create a sense of psychological safety within the therapeutic relationship that enables patients to remember and explore painful experiences previously warded off, thus permitting

a greater understanding of these events, and the opportunity to work through them (e.g., Aafjes-van Doorn et al., 2021; Silberschatz, 2005). From a theoretical perspective, the results essentially suggested a reciprocal interaction, in which therapist responsiveness, alliance and depth of elaboration in session are engaged in virtuous "feedback loops" (cf., Hatcher, 2021).

The present research has some limitations. First, it is a naturalistic study conducted in different clinical settings and based on a cross-sectional design. Moreover, it lacks a measure of treatment outcome. Further empirical investigations should develop a longitudinal design, including some instruments to evaluate the efficacy/effectiveness of psychotherapy. Moreover, in the future, it might be useful to combine data provided by patients and therapists with data on the therapeutic process obtained from the perspective of an external observer or supervisor, to contain any bias due to the use of self-report instruments.

Despite these limitations, this empirical investigation offered the opportunity to increase our knowledge on therapist responsiveness, seeking to better understand the processes underlying the relationship between this dimension and other variables of therapeutic process, and helping to overcome the so-called "problem" of therapist responsiveness for psychotherapy research (Kramer & Stiles, 2015).

Chapter 4

Study Two. Exploring the Outcomes of Psychotherapy Sessions: How do Therapists' Responsiveness and Emotional Responses to Patients with Personality Disorders Affect the Depth of Elaboration?[2]

4.1 Introduction and aims

Despite the well-established effectiveness of psychotherapies across diverse clinical populations (Cuijpers et al., 2013, 2014; Cristea et al., 2017), it is important to acknowledge that not all patients benefit from psychological treatment, with some even reporting unhelpful or harmful effects (Castonguay, Boswell, Constantino, et al., 2010; Mohr, 1995; Scott & Young, 2016). Notably, treating individuals diagnosed with personality disorders presents a significant challenge for clinicians. This population's highly impaired interpersonal patterns (Wilson et al., 2017) demand highly sophisticated therapist interpersonal skills and planning of individualized interventions (Caligor et al., 2015; Kramer, 2021; Kramer, Eubanks, et al., 2022). Evidence highlights depth of elaboration as a key marker of psychotherapy session quality (Stiles et al., 2002) possibly offering a more nuanced understanding of underlying mechanisms of change related to long-term treatment (in)effectiveness (Gelo & Manzo, 2015; Kramer et al., 2020b; Orlinsky & Howard, 1968). However, there remains limited knowledge regarding the influence of therapist and relational variables on this dimension of session outcomes, particularly in the treatment of patients diagnosed with personality disorders.

[2] Part of the content presented in this chapter has been described in the following published article: Fiorentino, F., Gualco, I., Carcione, A., Lingiardi, V., & Tanzilli, A. (2024). Exploring the outcomes of psychotherapy sessions: how do therapists' responsiveness and emotional responses to patients with personality disorders affect the depth of elaboration?. *Frontiers in Psychology*, 15, 1390754. https://doi.org/10.3389/fpsyg.2024.1390754

With these premises in mind, the present research aimed to:

a) examine differences in therapist responsiveness and countertransference patterns in sessions with higher or lower levels of depth of elaboration, regardless of the duration of treatment. Based on the clinical and empirical literature (Harrington et al., 2021; Pellens et al., 2023; Stiles et al., 2002; Tishby & Wiseman, 2014), it was expected that poorer clinician responsiveness and more intense and negative patterns of therapist emotional responses would have a greater impact on the shallower sessions, net of the effect of the length of therapy; conversely, higher levels of responsiveness and more positive countertransference reactions would significantly affect sessions characterized by a greater degree of depth;

b) through exploratory analysis, to investigate whether the therapist's positive emotional responses would mediate the relationship between clinician responsiveness and depth of session processing. Despite the paucity of studies in this field of investigation (Pellens et al., 2023; Tanzilli et al., 2016; Tanzilli, Majorana, et al., 2018; Ulberg et al., 2014), positive countertransference would be a significant mediator that could partially account for the effect of clinician responsiveness on good session quality.

4.2 Materials and Methods

4.2.1 Participant sampling

The sample of therapists was recruited from several Italian associations of psychodynamic and cognitive-behavioral psychotherapy and centers specializing in treating personality disorders in Genoa, Milan, Turin, and Rome. They were contacted *via* email and asked to identify one patient in their care according to the following inclusion/exclusion criteria: (1) at least 18 years old; (2) a personality disorder diagnosis (according to the DSM-5/5-TR (APA2013, 2022) or ICD-10/11 [WHO, 1993, 2022]) (3) without psychotic disorder

diagnosis, nor treated with pharmacological therapy for psychotic symptoms; (4) in treatment from a minimum of 2 to a maximum of 12 months. This temporal criterium was established to maximize the likelihood of obtaining accurate information on the first phase of treatment. To minimize rater-dependent biases (i.e., therapist effects), each therapist was allowed to select only one patient. In addition, to ensure a random selection of patients, clinicians were asked to consult their appointment calendars to identify the last patient they had seen who met the study criteria. Despite acknowledging the role of the patient's perspective, in the present study, only the therapist's point of view was considered to focus on their contribution to session outcome in terms of depth of elaboration. Participation was voluntary and completely anonymous to guarantee privacy. All the clinicians provided informed consent. The research protocol was approved by the Ethical Committee of the Department of Dynamic and Clinical Psychology, and Health Studies, Faculty of Medicine and Psychology, Sapienza University of, Protocol number 0000773, date of approval 12/05/2022.

4.2.1.1 Therapists

This sample comprised 84 White therapists, 38 males and 46 females. Their main age was 46 years approximately (*SD* = 10.36; range = 30–65). The average length of their clinical experience was 14.34 years (*SD* = 9.62, range = 2–43). The weekly hours devoted to clinical practice were approximately 30.26 (*SD* = 13.10, range = 6–55). The main clinical-theoretical approach was psychodynamic (*N* = 73), whereas a minority portion was cognitive-behavioral (*N* = 10).

4.2.1.2 Patients

This sample 84 White patients, 59 females, and 25 males. Their mean age was 35 years approximately (*SD* = 11.97, range = 20–65). Forty-four patients had only a DSM-5 personality diagnosis: 1 patient had a Cluster A disorder (diagnosed with a paranoid personality disorder); 18 had a Cluster B personality disorder (5 diagnosed with a borderline personality disorder, 4 with a histrionic personality disorder, and 9 with a narcissistic personality disorder); 14 had a Cluster C personality disorder (2 diagnosed with an avoidant personality disorder, 7 with a dependent personality disorder, and 5 with an obsessive-compulsive personality disorder); 16 patients presented two or more personality disorder diagnoses (8 had a comorbidity within the Cluster B and 4 a comorbidity within the Cluster C; 4 had a comorbidity between different clusters); 35 patients had personality disorder with or without other specification. The average length of treatment was about 8.38 months (*SD* = 6.44; range = 2–12).

4.2.2 Measures

4.2.2.1 Patient's Experience of Attunement and Responsiveness Scale – Therapist Version (PEAR-T; Snyder and Silberschatz, 2017).

PEAR is an instrument developed to assess clinician attunement and responsiveness in psychotherapy sessions from therapist (PAER-T) and patient (PEAR-P) perspectives. The Italian translation (see Appendix 1) of the therapist version (PEAR-T) was employed in the present research. As in the study of Snyder and Silberschatz (2017), the PEAR-T scale (ω = .78) and its subscales therapist helpfulness (ω= 80) and safe accepted (ω= 75) demonstrated good reliability. See section 2.3.1.1 of the present thesis for further information on the PEAR.

4.2.2.2 Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles and Snow, 1984b; Rocco et al., 2017).

The SEQ-D is an instrument designed to assess the depth of elaboration in psychotherapy sessions. The items represent bipolar adjectives describing specific features of the session (i.e., powerful/weak, valuable/worthless, deep/shallow, full/empty, and special/ordinary). In the present study, SEQ-D showed good psychometric proprieties in terms of reliability (Cronbach's α is .75). See section 2.3.1.3 for further details on SEQ-D.

4.2.2.3 Therapist Response Questionnaire (TRQ; Betan et al., 2005; Tanzilli et al., 2016).

The TRQ is a 79-item clinician-report questionnaire developed to evaluate the therapist's emotional responses (e.g., countertransference) in terms of thoughts, feelings, and behaviors toward the patient. The items are written in a jargon-free language to be understandable to clinicians of different theoretical orientations. The clinicians assess each item on a 5-point Likert scale, ranging from 1 (*not true*) to 5 (*true*). The factor structure of the Italian version showed 9 countertransference patterns: (a) helpless/inadequate, indicates feelings of inadequacy, incompetence, and inefficacy; (b) overwhelmed/disorganized, describes confusion, anxiety, and intense feelings of being overwhelmed by the patient's emotions and needs; (c) positive/satisfying, describes an experience of close connection, trust, and collaboration with the patient; (d) hostile/angry, describes feelings of anger, hostility, and irritation toward the patient; (e) criticized/devalued, describes a sense of being criticized, dismissed, or devalued by the patient; (f) parental/protective, captures a wish to protect and nurture the patient in a parental way; (g) special/overinvolved, indicates that the patient is very special, so much so that the clinician may show some difficulties in maintaining the

boundaries of the therapeutic setting; (h) sexualized, describes the presence of sexual attraction toward the patient; and (i) disengaged, describes feelings of annoyance, boredom, or withdrawal in sessions.. The Italian validation of the TRQ demonstrated excellent psychometric properties. In this study, the nine TRQ dimensions showed good/excellent internal consistency (Streiner, 2003), obtaining the following Cronbach's alpha: criticized/devalued (α = .78), helpless/inadequate (α = .90), positive/satisfying (α = .82), parental/protective (α = .72), overwhelmed/disorganized (α = .77), special/overinvolved (α = .70), sexualized (α = .81), disengaged (α = .81), and hostile/angry (α = .84).

4.2.3 Statistical Analysis

Data analyses were performed using JAMOVI version 2.4.11, with the application of jAMM statistical package (including the GLM mediation model module) (Gallucci, 2021) First, a multivariate analysis of covariance (MANCOVA) was used to investigate differences between two groups of psychotherapy sessions with poorer vs. greater degree of depth of elaboration (assessed with the SEQ-D) in therapist responsiveness (assessed with the PEAR-T) and specific patterns of clinician emotional reactions (assessed using the TRQ), after controlling for the impact of treatment duration. Notably, depth levels of psychotherapy sessions were distinguished by considering the median value of the SEQ depth scale in the total sample ($N = 84$). Thus, in MANCOVA, the groups of sessions with high or low depth of elaboration were used as the independent variable, all the therapist and relational dimensions as dependent variables, and psychotherapy length as a covariate.

Then, following the approach of Baron & Kenny (1986), a mediation analysis was carried out to test the potential mediator role of positive countertransference pattern in the relationship between therapist responsiveness (i.e., the average of the scores of the two

dimensions of the PEAR-T) and depth of elaboration (considered as a continuous variable) in the psychotherapy sessions. In this model, the effect of therapy duration was also controlled for. This mediation analysis was conducted using the bootstrap percentile method. It was employed to construct the 95% confidence intervals to assess the statistical significance of these effects (Hayes, 2017). These bootstrap 95% confidence intervals (with 5000 samples) were calculated to evaluate if they included zero.

4.2.4 Procedures

Clinicians were asked to choose one patient in their care according to inclusion and exclusion criteria (see "Participants sampling" for the description). After a psychotherapy session with the selected patient, they completed an online survey (hosted on SurveyMonkey), including: the PEAR-T, TRQ, and SEQ-D.

4.3 Results

4.3.1 Therapist Responsiveness and Countertransference Patterns Affecting Depth of Elaboration in Psychotherapy Sessions

The first aim of the study was to investigate the differences between psychotherapy sessions characterized by different degrees of depth of elaboration (evaluated with the SEQ-D) on therapist responsiveness (evaluated with the PEAR-T) and various countertransference patterns (evaluated using the TRQ).

One-way MANCOVA was used to determine whether psychotherapy sessions with lower vs. higher levels of depth of elaboration (distinguished based on the median value of SEQ depth scale of 4.80) were significantly affected by specific dimensions of clinician

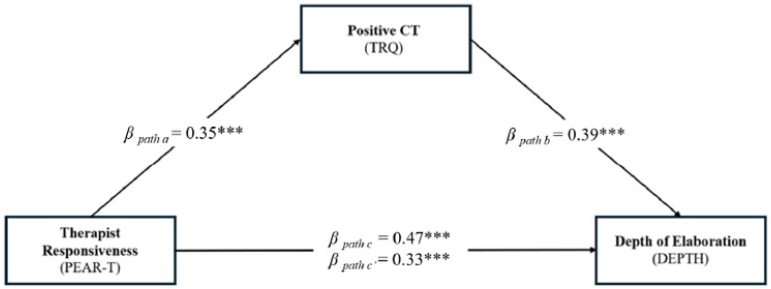
responsiveness and distinct patterns of therapist emotional responses, after removing the impact of treatment duration (Table 4.1). The results showed significant main effects for session groups, Wilks's $\lambda = 0.65$, $F(11, 71) = 3.51$, $p < .001$, $\eta^2 = 0.35$, while no significant effect was found for treatment duration, Wilks's $\lambda = 0.89$, $F(11, 71) = .82$, $p < .621$, $\eta^2 = .113$.

Notably, the deeper sessions differed significantly from the shallower sessions with respect to the higher levels of therapist helpfulness and positive countertransference. Moreover, these sessions, characterized by great depth of elaboration, showed significantly lower levels of helpless/inadequate, disengaged, and hostile/angry therapist responses than the shallower ones.

4.3.2 Therapist Responsiveness, Positive Countertransference, and Depth of Elaboration in Psychotherapy Sessions: A Mediation Model

The study's second aim was to examine the mediation role of positive countertransference in the relationships between therapist responsiveness and depth of elaboration in psychotherapy sessions, controlling for the effect of treatment duration (Figure 4.1). The results are also reported in Table 4.2. Overall, the mediation analysis showed that therapist responsiveness had a significant indirect effect on the depth of elaboration through the pathway of positive countertransference, ß=.1378 (95% C.I. .09746, .062026), z=2.691, p=.007. Notably, the clinicians' positive response partially mediated the relationship between therapist responsiveness and depth of sessions, accounting for 29% of the total variance.

Figure 4.1 A Mediation Model Examining the Direct and Indirect Effect of Therapist Responsiveness On Depth of Elaboration in Psychotherapy Sessions Through Positive Countertransference (*N*=84)



Note. PEAR-T = Patient's Experience of Attunement and Responsiveness Scale – Therapist Version. TRQ = Therapist Response Questionnaire (Tanzilli et al., 2016). DEPTH = Depth Scale of Session Evaluation Questionnaire (SEQ). The figure includes completely standardized path coefficients (*betas*) obtained using a series of multiple regressions to construct the mediation model.

*** $p \leq .001$.

Table 4.1

Differences Between Groups of Psychotherapy Sessions with Different Levels of Depth of Elaboration on Therapist Responsiveness and Countertransference Patterns After Controlling for Treatment Duration ($N = 84$)

	Deeper sessions ($N = 46$)		Shallower sessions ($N = 38$)		$F(1, 81)$	η^2
	M	*SD*	*M*	*SD*		
PEAR -T[a]						
Therapist helpfulness	2.90	.41	2.63	.34	10.62**	.116
Safe accepted	2.62	.28	2.53	.29	1.70	.021
TRQ[b]						
Criticized/devaluated	1.36	.29	1.54	.62	3.41	.040
Helpless/inadequate	1.61	.58	2.18	.93	10.58**	.116
Positive	3.21	.64	2.66	.51	19.76***	.196
Parental/protective	2.79	.73	2.81	.80	.02	.001
Overwhelmed/disorganized	1.65	.45	1.60	.53	.23	.003
Special/overinvolved	1.47	.41	1.40	.52	.57	.007
Sexualized	1.37	.60	1.24	.45	1.01	.012
Disengaged	1.50	.48	1.94	.76	9.57**	.106
Hostile/angry	1.60	.49	1.91	.69	4.70*	.055

Note. [a] PEAR-T = Patient's Experience of Attunement and Responsiveness Scale – Therapist Version. [b] TRQ = Therapist Response Questionnaire (Tanzilli et al., 2016). * $p < .05$. ** $p < .01$. *** $p < .001$.

4.4 Discussion

The primary aim of the present study was to examine differences in therapist responsiveness and countertransference patterns between sessions with distinct degrees of depth of elaboration in the treatment of individuals with personality disorders, regardless of the duration of treatment. The results partially confirmed my hypothesis (Table 4.1), showing that clinicians tended to exhibit higher levels of attunement and responsiveness in "good" sessions, characterized by greater depth of elaboration (Hatcher, 2015; Elliott et al., 2018). It is important to note that significant differences were observed in the dimension of *therapist helpfulness* but not in that of *safe accepted.*

This finding suggests the crucial role of therapists' interpersonal skills, particularly their ability to be close to the patient and make them feel helped and supported during sessions (Timulak, 2010; Heinonen and Nissen-Lie, 2020; cf., Liotti et al., 2023). Additionally, therapists' perceptions of providing timely interventions and noticing patients' relief, success, and progress appear to correlate with valuable exchanges (Hatcher, 2015; Kramer and Stiles, 2015; Elliott et al., 2018; Wu and Levitt, 2020). Notably, this relational skill can be especially relevant for therapists treating individuals with personality disorders who show maladaptive interpersonal patterns that can hinder their engagement in the therapeutic work (Culina et al., 2023; Kramer, 2021). These results are in line with previous qualitative studies, which emphasize the importance of the therapist's sensitivity to the moment-to-moment state of the patient (Levitt and Piazza-Bonin, 2011; Kleiven et al., 2022; Ladmanová et al., 2022). Levitt and Piazza-Bonin (2011) also highlighted the relevance of therapist empathy, honesty, and validation, Kleiven and colleagues (2022) found that helpful therapist actions, such as *"actively helping the clients to notice and stay with difficult experience,"* were related to a greater likelihood of engaging in profound topics.

Table 4.2

Indirect and Total Effects in the Mediation Analysis Including Countertransference pattern as Mediator in the Relationship Between Therapist Responsiveness and Depth of Elaboration in Psychotherapy Sessions ($N = 84$)

				95% C.I.				
Type	Effect	Estimate	SE	Lower	Upper	β	z	p
Indirect	PEAR-T ⇒ Positive CT ⇒ DEPTH	0.35886	0.13337	0.09746	0.62026	0.1378	2.691	.007
Component	PEAR-T ⇒ Positive CT	0.78085	0.22463	0.34058	1.22111	0.3544	3.476	< .001
	Positive CT ⇒ DEPTH	0.45958	0.10814	0.24764	0.67153	0.3888	4.250	< .001
Direct	PEAR-T ⇒ DEPTH	0.86690	0.23810	0.40022	1.33357	0.3328	3.641	< .001
Total	PEAR-T ⇒ DEPTH	1.22576	0.24687	0.74190	1.70962	0.4706	4.965	< .001

Note. PEAR-T = Patient's Experience of Attunement and Responsiveness Scale – Therapist Version. DEPTH = Depth Scale of Session Evaluation Questionnaire (SEQ). CT = Countertransference Pattern of Therapist Response Questionnaire (Tanzilli et al., 2016).

Castonguay and colleagues (2010b) pointed out the detrimental effect of clinicians' failure to attune to the patient's needs and communication, particularly concerning issues that can trigger strong reactions such as interpersonal conflicts, further underscoring these therapist capacities. Furthermore, the present study suggested that patient's feeling safe was not directly associated, from the therapist's perspective, with the exploration of meaningful subjects in psychotherapy sessions. Snyder and Silberschatz (2017) indicated that the dimension of safe accepted (and not therapist helpfulness) was strongly related to the patient's evaluation of the treatment outcome; therefore, the result from this empirical investigation may confirm that such a dimension is more closely associated with a broader inclusive representation of the treatment, rather than the evaluation of the individual session.

Looking at the specific and nuanced findings provided in Table 4.1, some relevant considerations need to be addressed on countertransference patterns. Consistent with my hypothesis, the results revealed significant differences in therapists' emotional responses between sessions with higher and lower levels of depth of elaboration, regardless of treatment duration. Specifically, only the positive countertransference pattern was significantly more prevalent in "good" sessions, whereas helpless/inadequate, disengaged, and hostile/angry responses recurred more in "bad" sessions characterized by lower levels of depth. Contrary to the study by Rocco and colleagues (2021), which did not identify any relationship between self-report countertransference evaluations and depth of elaboration, the present study highlighted such a connection, suggesting considering the role of therapist constellations of thoughts, behaviors, and feelings (that is, their emotional responses) in influencing session quality (Rosenberger and Hayes, 2002; Ulberg et al., 2014; Abargil and Tishby, 2022).

The presence of positive therapist responses in deeper sessions supports the conceptualization of countertransference as a potentially valuable tool for gaining meaningful insights into the patient's needs and not as an obstacle to the session process (Gabbard, 1998;

Tishby and Wiseman, 2014; Tanzilli and Lingiardi, 2022; Pellens et al., 2023). Positive countertransference encompasses affiliation and emotional closeness (Tanzilli et al., 2016). Interestingly, research showed that it is linked with the therapeutic alliance, further supporting its connection with an atmosphere of collaboration and trust in therapeutic work (Ulberg et al., 2014; cf., Tanzilli and Gualco, 2020).

Regarding the clinician's negative emotional responses, the study revealed that sessions with lower levels of depth of elaboration were strongly characterized by a greater degree of helpless/inadequate, disengaged, and hostile/angry countertransference patterns. These findings underscore the negative association between these intense and difficult-to-manage therapist reactions and the exploration of meaningful issues (Tishby and Wiseman, 2014; Abargil and Tishby, 2022). They are aligned with previous studies that have emphasized the potentially harmful effect of negative countertransference reactions, particularly when they are not effectively managed (Ulberg et al., 2014; Hayes et al., 2018; Tanzilli et al., 2018). Feelings of hostility, boredom, or helplessness can divert the therapist's focus away from the patient's emotional state (Rosenberger and Hayes, 2002; Gross and Elliott, 2017; Rocco et al., 2021) thereby interfering with the fundamental condition necessary for an emphatic and attuned elaboration process (Hennissen et al., 2023; Pellens et al., 2023). These specific therapist emotional reactions have been observed in the treatment of patients with personality pathologies, who often manifest maladaptive interpersonal patterns, such as devaluating and dismissing attitudes (Colli et al., 2014; Tanzilli et al., 2017). Therapists working with these patients may experience significant difficulties in reaching a high depth of elaboration in the therapeutic process. Finally, it should be acknowledged that these reactions of detachment or irritation might indicate underlying ruptures in the therapeutic alliance (Safran et al., 1990; Safran and Kraus, 2014). Therapists' awareness of their own feelings toward patients, as well as empathic resolution strategies, are essential tools for preserving the

quality of the therapeutic relationship and facilitating in-depth exploration of the patient's inner dynamics (Eubanks-Carter et al., 2015; Tishby and Wiseman, 2022).

The second aim of the present study was to examine the mediating role of positive countertransference in the relationship between therapist responsiveness and session depth. Consistent with the hypotheses, this study provided preliminary confirmation of this mediation model (Table 4.2). Therapist responsiveness and attunement were found to be systematically associated with greater depth of elaboration (cf., Harrington et al., 2021), but positive countertransference played a key role by shedding light on some mechanisms through which therapists promote a profound elaboration of content in psychotherapy sessions. Presumably, therapists' subjective experience of a positive relationship with patients, characterized by intimacy, affective closeness, cooperation, and trust, enables them to be attuned and responsive to patients, promoting the working through of meaningful topics (cf., Hatcher, 2015; Snyder and Silberschatz, 2017). This study seems consistent with previous research that has shown how the clinician's positive, hopeful, and genuine emotional reactions were able to influence the quality of the therapeutic process (see Tishby and Wiseman, 2022), while negative reactions toward the patient can produce severely detrimental effects (Ulberg et al., 2014).

The present study has some limitations. First, the sample size might limit the generalizability of the findings, suggesting the need to replicate the present study on larger samples. Second, due to the research design's cross-sectional nature, it is not possible to establish causal relationships between the dimensions investigated in the study. Different study designs (i.e., longitudinal) should be employed to overcome this limitation. Third, the data collection method from a single informant (i.e., the clinician) might be vulnerable to biases. Further research should consider other perspectives, such as that of the patient or external observer. Fourth, the present study only considered patients with a personality

disorder diagnosis, limiting the generalizability of these findings and suggesting the need to replicate this study within different clinical populations. Moreover, most of the clinicians were psychodynamic, and their theoretical orientation may have influenced the study results. Future research should investigate the effect of the therapist's clinical background on the dimensions of therapeutic relationship and process investigated in this study to shed light on possible associations underlying the quality of psychotherapy sessions and, potentially, treatment outcomes. Finally, treatment outcomes were not considered in the present study, indicating a need for further research to address this gap.

4.5 Conclusions

The present study emphasizes the importance of acknowledging therapists' contribution to the individual session outcome considering the effect of their interpersonal capacities that develop during the clinical encounter. Particularly, treating patients with personality disorder diagnoses (Hatcher, 2015; Johns et al., 2019; Heinonen and Nissen-Lie, 2020), who may potentially impact therapeutic work with challenging behaviors, seems to require especially timely and appropriate responsiveness from the clinician in order to achieve greater session quality (Kramer, 2021; Kramer, Flückiger, et al., 2014; Signer et al., 2020). It further suggests the need to identify moments of misattunement during clinical work - giving particular attention to the therapist's perception of being helpful - and to address negative countertransference reactions (e.g., detachment, inadequacy) that can hinder a profound elaboration of the content of the psychotherapy session. On the contrary, the value of the therapist's capacity to be attuned and responsive to the patient's needs, along with the presence of trustful and collaborative feelings to facilitate the exploration of meaningful content, is advocated (Kramer and Stiles, 2015; Snyder and Silberschatz, 2017).

Chapter 5

Study Three. Bridges and Barriers in Psychotherapy: Insights from Thematic Analyses of Therapist Responsiveness and Non-Responsiveness within Therapeutic Dyads

5.1 Introduction and aims

Different studies have acknowledged the importance of the therapist contribution to psychotherapies effectiveness (Hill & Castonguay, 2017; Wampold & Owen, 2021) and therapist responsiveness has recently emerged as a promising variable (Hatcher, 2021; Kramer & Stiles, 2015; Stiles & Horvath, 2017). However, also the presence of moments of miscoordination needs to be acknowledged since they normally occur even in optimally functioning dyads (Fosha, 2001; Levy Chajmovic & Tishby, 2024; Muran et al., 2021).

To date, most studies that investigated the role of therapist responsiveness in the psychotherapy process adopted a quantitative approach. Although they can provide meaningful insights for understanding therapist responsiveness, quantitative studies may also face limitations in capturing the subjective experiences of participants (Maxwell & Levitt, 2023; Timulak & Keogh, 2017). Qualitative methods seem well-suited to address this gap, offering insights into individuals' attitudes, emotions, and beliefs and providing an in-depth description of complex phenomena (Levitt et al., 2016), such as therapist responsiveness.

Further research is needed to examine how responsive and non-responsive moments are experienced during treatment, in the way they emerge from the narratives of patients and therapists. Moreover, as therapist responsiveness is shaped by ongoing interactions between patient and therapist perspectives (Aafjes-van Doorn et al., 2022; Coutinho et al., 2011; Levy Chajmovic & Tishby, 2024), the present study has considered both viewpoints.

In light of the above, in this qualitative research, two processes of thematic analyses were carried out with the following objectives:

(a) To identify themes (and potential sub-themes) that characterize moments of therapist responsiveness from both patient and therapist perspectives within therapeutic dyads.

(b) To identify themes (and potential sub-themes) that characterize moments of therapist non-responsiveness from both patient and therapist perspectives within therapeutic dyads.

5.2 Method

5.2.1 Participant Sampling

Several associations of psychotherapy specialized in the treatment of personality disorders located in Genoa, Milan, Turin, and Rome, were contacted via email to recruit the sample. Therapists were asked to choose one among their patients who satisfied the following inclusion/exclusion criteria: (1) being at least 18 years old; (2) having a diagnosis of personality disorders according to Section II of the DSM-5/5-TR [APA, 2013, 2022]; (3) being in treatment from a minimum of 2 to a maximum of 12 months. This temporal criterion was requested to maximize the likelihood of obtaining accurate information on the first phase of treatment; (4) not having a diagnosis of a psychotic disorder, nor being treated with drug therapy for psychotic symptoms. Each therapist was asked to select only one patient to minimize the possibility of rater-dependent bias. The research protocol was approved by the Ethical Committee of the Department of Dynamic and Clinical Psychology, and Health Studies, Faculty of Medicine and Psychology, Sapienza University of Rome, Prot. n. 0000773 dated 12/05/2022. All participants provided informed consent.

5.2.1.1 Therapists

54 therapists participated in the study comprising 53 psychologists and one psychiatrist. The sample included 24 males (44.4%) and 30 females (55.6%), with a mean age of 47.41 years (SD = 11.58) and 15.49 years of clinical experience (SD = 9.86). The theoretical orientation of the therapist who took part in this study was psychodynamic.

5.2.1.2 Patients

54 patients participated in the study, encompassing 37 females (68,5%) and 17 males (31.5%), with a mean age of 37.35 years (SD = 12.36). The average treatment length was 9,36 months (SD = 6,84). According to their clinicians, patients had the following personality disorder diagnoses: paranoid personality disorder (N = 1), borderline personality disorder (N = 10), histrionic personality disorder (N = 7), narcissistic personality disorder (N = 10), avoidant personality disorder (N = 4), dependent personality disorder (N = 10), obsessive-compulsive personality disorder (N = 4), other specified personality disorder (N = 4), unspecified personality disorder (N = 4).

5.2.2 Data Collection and Material

In the context of an online survey, four open-ended questions (see Appendix 2 for the original Italian text and its English translation) were administered to each therapeutic dyad – two questions to the therapist and two to the patient – aimed at exploring the subjective experiences regarding therapist responsiveness from both clinician and patient perspectives.

Specifically, therapists were asked to recall a moment when they perceived themselves as being responsive to patients in one question and a moment when they perceived not have being responsive. Similarly, patients were asked to describe a moment when they perceived their therapist as responsive in one question and a moment when they did not perceive this. These questions were included in an online survey and, to minimize potential compilation biases, (i.e., the "alone effect,") they preceded the administration of questionnaires investigating variables concerning the therapeutic relationship and the psychotherapy process, including therapist responsiveness. The surveys received 107 responses from therapists and 101 from patients. After removing invalid responses (e.g., surveys not started, unreadable, or incomprehensible answers), the first and second authors selected responses from therapeutic dyads where both patient and therapist provided valid answers to each open-ended question. Notably, using online surveys for qualitative studies offers advantages such as reaching a larger number of participants and allowing respondents to comfortably report their subjective experiences with reduced social desirability bias (Braun et al., 2021).

5.2.3 Data Analysis

The present study analyzed data following the Thematic Analysis (TA) procedure and embracing a (critically) realistic framework (Braun & Clarke, 2006; Clarke & Braun, 2018). This approach differs from a constructionist framework by primarily relying on an inductive and descriptive methodology. This is a more data-driven approach: it stays close to the data and its explicit content rather than being guided by specific ideas or searching for underlying assumptions, as seen in more deductive and latent approaches. However, the analysis was inevitably influenced by the research team's awareness of updated literature on therapist

responsiveness and psychotherapy process, as well as their personal experiences as clinicians, making the analysis at least partially deductive (see also *Reflexivity*).

Two separate thematic analyses were conducted: one focused on answers about therapist responsiveness and the other on answers about therapist non-responsiveness. A step-by-step procedure was followed (Braun & Clarke, 2006): (1) *Familiarization with the Data*: Two coders (i.e., FF and EI) familiarized themselves with the data by reading the answers of the participants several times, removing any missing or not understandable answers, and searching for shared meanings and patterns across the dataset; (2) *Generation of Semantic Codes*: The same two coders independently started to generate semantic codes (i.e., "blocks" that can be sorted into themes) for each answer reflecting an idea associated with a segment of data. The coders analyzed together almost fifteen responses to reach a consensus on how to address the text concerning the research questions; (3) *Development of Potential Themes*: The coders discussed the generated codes, compared each other's codes, and revised them. They began to sort codes into candidate themes, defined as "patterns of shared meaning underpinned by a central organizing concept" (Braun et al., 2014); (4) *Review of Candidate Themes*: Candidate themes were checked against the data to determine if they appropriately answered the research questions. Themes were either deleted, newly generated, or combined; (5) *Review and Refinement of Themes*: Themes were repeatedly reviewed to ensure a good fit with the data and reach an agreement on the final set that effectively captured data on both positive and negative therapist responsiveness, also through consultation with a supervisor and another member of the research team (AT and GLB). Such a review process ensured both internal homogeneity (i.e., coherence within themes) and external heterogeneity (i.e., clear differences between themes); (6) *Writing up*: In the final phase, all themes and subthemes were coherently mapped and contextualized in light of the literature on psychotherapy research.

To further increase the trustworthiness of the analysis (Williams & Morrow, 2009) direct quotes were translated from Italian to English and included in the Results Section to provide clearer insight into the coders' process and the interpretation of the text. Moreover, the frequencies of participants contributing to each theme and sub-theme were examined and reported (see Table 5.1 and Table 5.2).

5.2.4 Reflexivity

Reflexivity involves recognizing the influence of coders' competencies, characteristics, and subjectivity on the TA procedure. Establishing reflexivity serves as a valuable resource in qualitative analysis since it inevitably contributes to shaping the process as "meaning is not fixed within data" (Braun & Clarke, 2019, p.2). All researchers involved in this study acknowledged their perspectives and experiences during the whole procedure. The research team consisted of five psychologists and one psychiatrist, all sharing a psychodynamic theoretical framework and possessing specific experience in psychotherapy research, including the field of therapist responsiveness. Both coders are currently attending relational psychoanalytical training schools.

5.3 Results

The first thematic analysis was conducted on descriptions of moments of therapist responsiveness during psychotherapy provided by both patients and therapists. The following themes and sub-themes were identified (see Table 5.1 for frequencies): (1) *Insight promotion* (*Understanding of One's Own Functioning and/or Past-Present Connections*; *Acquisition of New Perspectives*; *Meta-Communication on the Psychotherapy Process and/or the*

Therapeutic Relationship); (2) *Attunement, Closeness, and Support* (*Perception of Empathy, Understanding, and Emotional Containment*; *Support, Validation, and Focus on Resources*; *Complete Understanding and Trust*; *Setting Flexibility*).

The second thematic analysis was conducted on descriptions of moments of therapist non-responsiveness provided by both patients and therapists, yielding the following themes and subthemes (see Table 5.2 for frequencies): (1) *Therapist Interventions* (*Judgmental, Premature, or Intrusive Interventions*; *Detached or Rigid Interventions*); (2) *Failure to perceive the therapist's non-responsiveness* (*Any occurrence of the therapist being non-responsive*; *Stepping Back After Noticing Therapist's Non-Responsive Behaviors*); (3) *Struggle to Engage with the Patient* (*Difficulties to Address Meaningful Subjects During Sessions*; *Therapist perception of inefficacy, helplessness, and/or collusion with the patient*); (4) *Attunement challenges;* (5) *Perspectives on the Psychotherapy Process* (*Unrealistic Expectations*; *Disagreements on Treatment Goals, and/or Modalities*).

Themes and subthemes are described in detail in the next paragraphs ordered based on their frequencies.

Table 5.1 Themes, subthemes, and frequencies of Thematic Analysis on therapist responsiveness

Therapist Responsiveness	Patients (N)	Therapists (N)
Attunement, Closeness, and Support	42	36
Perception of Empathy, Understanding, and Emotional Containment	22	12
Support, Validation, and Focus on Resources	8	11
Complete Understanding and Trust	7	/
Setting Flexibility	4	3
Insight Promotion	16	38
	11	28

Understanding of One's Own Functioning and/or Past-Present Connections	4	3
Acquisition of New Perspectives	1	6
Meta-Communication on the Psychotherapy Process and/or the Therapeutic Relationship		

Note. The number of responses under each theme/subtheme represents the total count of participants' answers classified within that theme/subtheme. A single participant's response may fall under multiple themes/subthemes.

Table 5.2 Themes, subthemes, and frequencies of Thematic Analysis on therapist non-responsiveness

Therapist non-responsiveness	Patients (N)	Therapists (N)
Failure to perceive the therapist's lack of responsiveness	31	3
Any occurrence of the therapist being non-responsive	24	4
Stepping Back After Noticing Therapist's Non-Responsive Behaviors	7	/
Struggle to Engage with the Patient	/	29
Therapist perception of inefficacy, helplessness, and/or collusion with the patient	/	18
Difficulties to Address Meaningful Subjects During Sessions	/	11
Attunement challenges	15	4
Perspectives on the Psychotherapy Process	9	8
Disagreements on Treatment Goals, and/or Modalities	6	4
Unrealistic Expectations	3	3
Therapist Interventions	8	8
Judgmental, Premature, or Intrusive Interventions	3	7

Detached or Rigid Interventions Perception of distance and rigidity	5	1	

Note. The number of responses under each theme/subtheme represents the total count of participants' answers classified within that theme/subtheme. A single participant's response may fall under multiple themes/subthemes.

5.3.1 Therapist responsiveness

5.3.1.1 Attunement, Closeness, and Support

5.3.1.1.1 Perception of Empathy, Understanding, and Emotional Containment

This sub-theme was identified in the responses of 22 patients and 12 therapists. Many patients reported that perceiving their therapist as responsive was closely tied to feeling truly heard, accepted, and understood during psychotherapy sessions, free from the fear of judgment. Some underscored these emotional aspects in connection with therapist interventions and heightened awareness (see also Theme *Insight Promotion*). The interpersonal dimension underpinned the possibility of sharing intense moments of attunement and mirroring with their therapist was emphasized, as exemplified by one patient "*In the last few sessions something happens that has never happened to me in previous therapies. Suddenly during the session, tears start to fall from my face. I don't understand so much the reason. I do know that I start crying seemingly for no reason. This surprises me because in my previous therapy experiences this never happened […] To my request to be able to understand what happens, I felt that he responded with a closeness and availability that was not fearful or tense. He listens to me, gives me time, and welcomes above all my fear of what is happening"*. Moreover, some therapists felt responsive when helping the patient reduce anxiety or preoccupation by sharing painful emotions "*At the end of the year, the*

patient was very distressed because he could not cope with his relationship with his widowed father, the chance to share and process some deadly anguish diluted his pain".

5.3.1.1.2 Support, Validation, and Focus on Resources

This sub-theme was identified in the responses of 8 patients and 11 therapists. Some clinicians offered support by explicitly recognizing the patient's characteristics, including their diagnosis, qualities, capacities, and progress made during the psychotherapy process, as reported by one therapist: *"The moment when, in the last session, the patient spoke of her difficulty in changing some of the mechanisms that she has now realized to use, and I tried to show her that while it is certainly true that there she still meet some difficulties, her responses and mechanisms are not quite the same as they used to be. Even though it still does not seem enough to her, [..] and it is true that she still cannot give the "answers she would like" in some situations, she is no longer intimidated from giving an answer as perhaps she used to be and is more able to make her voice heard."* Some patients found these interventions particularly helpful when they occurred during times of vulnerability and when they were facing difficult situations. If delivered at the right moment, interventions characterized by overt suggestions or opinions were not perceived as intrusive or judgmental but rather as helpful in providing the support needed to make decisions, set boundaries, and promote self-affirmation as reported by one patient, "*My mom asked me to visit her in the new house that I live in by myself. I was supposed to organize her trip, but after a few days of reflection, I realized that this was putting a lot of pressure on me. My therapist helped me understand the dynamic, that is, my need to establish boundaries […]. In particular, she was very clear in formulating that it was not appropriate for my mom to visit me, allowing me the opportunity to say no*".

5.3.1.1.3 Complete Understanding and Trust

This sub-theme was identified in the responses of 7 patients. They linked their perception of therapist responsiveness to the feeling of being completely understood and experiencing blind trust in the therapist's ability to respond to their needs. Patients could perceive the therapist as constantly capable of being attuned to guide them through every kind of circumstance. One patient expressed this sentiment, stating, "*[…] my therapist knows me, knows how I am, has understood my mental mechanisms, can anticipate a thought of mine or understand immediately how I feel after expressing a fear or weakness".*

5.3.1.1.4 Setting Flexibility

This sub-theme was identified in the responses of 4 patients and 3 therapists. Therapists who showed flexibility regarding setting rules were perceived as responsive by some patients. For instance, if appropriate, they tried to meet the patient needs through specific actions, such as rescheduling appointments "[Therapist] *The patient expressed anxiety concerning the difficulty in keeping the day and time of the session due to changes in the schedule of the facility where she works, changes that are independent of her will. By asking her for a description of the work situation, I was able to verify that she would know her new work shifts every month. I was thus able to reassure her that even for sessions we would be able to find spaces for her, scheduling in time"*. Moreover, patients appreciated clinicians' availability outside traditional psychotherapy settings (i.e., via messages or phone calls) and the possibility of additional sessions during moments of exceptional vulnerability, "*During the Christmas holidays I needed to ask for an unscheduled additional session since I*

felt the need to expose a new emotional/social issue that was plaguing me. Promptly an appointment was scheduled which helped me a lot since I was already keeping everything to myself for a long time and this was mentally straining me".

5.3.1.2 Insight Promotion

5.3.1.2.1 Understanding of One's Own Functioning and/or Past-Present Connections

This sub-theme was identified in the responses of 11 patients and 28 therapists. Increased awareness of patients psychological functioning and/or their ability to make connections between current life events and past experiences were connected to the perception of therapist responsiveness from clinicians and patients perspectives. These moments emerged from free associations or followed therapist interventions that allowed patients to discover new aspects about themselves, including personal needs, identifying and expressing emotions, addressing interpersonal problems, and reflecting on their attitudes and behaviors. As one patient reported: "*I was recounting an episode of frustration and the therapist read my emotions and defined that behind the frustration there was anger; it made me better understand what I was experiencing".* Frequently feelings of surprise, relief, and commotion, often shared with the therapist, accompanied these moments, as reported by one clinician "*Associating spontaneously and in apparent contrast to the state of good humor with which she had arrived, the patient began to talk about her relationship with her mother, being moved by the apparently insurmountable misunderstandings between them. She expressed her pain, a long-lasting pain, for a mother who was in many ways unreachable and incomprehensible. I felt I knew her more, sensing her struggle and loneliness".*

5.3.1.2.2 Acquisition of New Perspectives

This sub-theme was identified in the responses of 4 patients and 3 therapists. Therapists were perceived as responsive when they allowed patients to view things from a different angle. Therapist interventions helped patients realize that their initial thoughts and perceptions could have been different, broadening their previous viewpoints or sometimes actually flipping their perspectives. The use of metaphors was explicitly mentioned as a means that facilitated their ability to gain new outlooks, as stated by one patient "*[…] Generally he lets me talk, listens to my concerns then very gently manages to find a moment to insert himself and with the right words says something that has the power at the same time to reassure me but also to broaden my perspective. He often uses a metaphor, borrowing my lexicon or the themes I put forward, and what he says to me expands the boundaries of the vision I had".*

5.3.1.2.3 Meta-Communication on the Psychotherapy Process and/or the Therapeutic Relationship

This sub-theme was identified in the responses of 1 patient and 6 therapists. Some therapists reported feeling responsive to their patients when they engaged in discussions about the psychotherapy process itself. Specifically, holidays, such as summer break emerged as a challenging moment within the therapeutic process. By focusing discussions on its impact on the therapeutic relationship, patients were able to explore significant topics such as anxiety and fear regarding the coming separation. One therapist stated, *"We are before the holiday (Christmas) break, and the patient is afraid of losing me. He recently lost his mother in an extremely painful way. […] I ask him if he is afraid for this vacation, and he tells me yes, without his mother, with his brother (psychotic with alcohol addiction who won't get*

treatment), and "who knows what will have happened when we see each other again." I tell him that he is afraid of losing me too, since anything can happen. He gets emotional and tells me that next year we have to get everything in order." Other therapists reported addressing the patient's fears and painful emotions regarding the treatment process: "[*The patient] expressed her misgivings and criticisms on the psychotherapy fearing that it would result in a discontinuation and a turning away from it. Conversely, it was an opportunity for fruitful sharing of angry, defiant, solemnly concealed thoughts. This allowed the patient to feel a willingness to embrace even the more destructive part of her that she is afraid of".*

5.3.2 Therapist non-responsiveness

5.3.2.1 Failure to perceive the therapist's lack of responsiveness

5.3.2.1.1 Any occurrence of the therapist being non-responsive

This sub-theme was identified in the responses of 24 patients and 4 therapists. Many patients and a few therapists did report they did not experience moments of non-responsiveness during psychotherapy. For instance, one therapist simply stated "*Not present*" when asked to recall a moment of therapist non-responsiveness without providing further explanation. In one case, a patient mentioned that perceiving a lack of responsiveness from the therapist could have led to the termination of psychotherapy. Others acknowledged minor issues but did not recognize them as instances of non-responsiveness. A patient expressed this feeling, saying, "*There are no such episodes; at most some understanding of events that I did not fully agree with*".

5.3.2.1.2 Stepping Back After Noticing Therapist's Non-Responsive Behaviors

This sub-theme was identified in the responses of 7 patients. They initially reported moments of perceived therapist non-responsiveness but later minimized their concerns. For instance, one patient remarked, "*There hasn't been any!!! Sometimes she's a little tougher but I always know she's doing it for my sake, she's not insensitive*". Patients also attributed misunderstandings or a lack of attunement during sessions to themselves rather than to the therapist attitudes or behavior. As noted by another patient, "*I can't think of any moments. In general, I have had the doctor give me cues that bothered me, very often, however, it was only because they affected a way, I think about me that I can't get rid of (not because the cues weren't valid in themselves)".*

5.3.2.2 Struggle to Engage with the Patient

5.3.2.2.1 Therapist perception of inefficacy, helplessness, and/or collusion with the patient

This sub-theme was identified in the responses of 18 therapists. Some therapists found it challenging to maintain responsiveness and attunement when facing feelings of inefficacy and helplessness toward their patients. They acknowledged the risk of inadvertently colluding with the patient emotional state, which may have hampered progress and impeded the exploration of relevant subjects during sessions. One therapist expressed this issue, stating, *"Sometimes it happens that the patient comes in the office with such a sense of inadequacy for herself and her ways of approaching relationships that it is difficult to activate a listening modality not as much frustrated."* Moreover, some therapists felt inadequate when addressing themes that evoked personal sensitivity or when addressing misunderstandings within the therapeutic relationship: "*Due to a misunderstanding regarding the time of the session, I caught a deep discomfort of the patient that I was unable to process with her*".

5.3.2.2.2 Difficulties to Address Meaningful Subjects During Sessions

This sub-theme was identified in the responses of 11 therapists. They encountered challenges in being responsive when dealing with patients who predominantly focused on concrete aspects, thus hindering access to their emotional sides. Many therapists observed that such patients often engaged in conversations characterized by repetitive and recursive details and gave concrete and rational explanations of their emotional problems. One therapist described this pattern saying, "*[...] the patient withdraws and throws himself headlong into his children's problems, obsessively describing phone calls and messages between them and their mother, between him and them*". Consequently, therapists experienced boredom and struggled to stay engaged during sessions, leading to a sense of not having space in the therapeutic relationship. Another therapist reflecting on this mentioned, "*moments when I fail to engage and involve the patient, feeling confused and dazed by obsessive, verbose, pedantic and ipnoinducent argumentation that also leaves the patient with a feeling of helplessness and expressive uselessness*".

5.3.2.3 Attunement challenges

This sub-theme was identified in the responses of 15 patients and 4 therapists. Patients recounted instances of non-responsiveness during sessions, where they experienced discomfort, perceived judgment, and felt unheard, which are connected to the belief that their concerns were not adequately understood. Some patients reported that therapists occasionally downplayed the severity of their problems or offered responses that sidestep their core issues. One described this feeling, stating, "*It happened to me that I did not feel understood when I was talking about a physical disorder or concerns related to physical disorders and the*

doctor was trying to bring the focus to something else, at which time my feeling was that I was belittled and not understood in pain". Moreover, patients reported a sense of disconnection from their therapists when they perceived them as being emotionally rigid or distant which further exacerbated the feelings of being unheard. On their side, therapists acknowledged instances where they struggled to empathize with their patients. One therapist reflected on such an occasion, stating, "*During one session the patient talked about her desire/not desire for motherhood, probably on that occasion the patient did not feel sufficiently welcomed*".

5.3.2.4 Perspectives on the Psychotherapy Process

5.3.2.4.1 Disagreements on Treatment Goals, and/or Modalities

This sub-theme was identified in the responses of 6 patients and 4 therapists. The perception of therapist non-responsiveness was also linked to the patient and therapist having different ideas on the psychotherapy process. This could create disagreements when patients felt their expectations were not met, fostering a sense of being misunderstood. For instance, the management of the summer break was an important issue as reported by one patient, "*My therapist's request to schedule vacations with my family while entrusting the caregiver with my mom's care seemed to me to disregard my current inability to handle this situation*". Moreover, a lack of alignment on the most relevant topics to address during sessions was mentioned as a factor that can leave patients feeling unseen. One patient expressed this by saying "*Sometimes I felt confused at the end of the session not having addressed a topic that was sensitive to me at that moment but having talked about something else outside of what was causing me anxiety at that moment*".

5.3.2.4.2 Unrealistic Expectations

This sub-theme was identified in the answers of 3 therapists and 3 patients. Therapists reported difficulties in being responsive when realizing patients had unrealistic expectations from the therapeutic process. For instance, one noted, "*The patient would like me to be able to take away her anxiety symptoms, almost without her having to actively do anything*". Some patients expected to agree with every statement of the therapist or to be mirrored in every moment, experiencing the disappointment of their expectations when this does not occur: "[..] *this "provocative" approach of therapy sometimes comes to certain statements of my psychotherapist, which I just do not agree with; I have never omitted my disagreement with what she said, and at this point, the doctor by reshaping and explaining her last statement brought the discussion back into the ranks*".

5.3.3.1 Therapist Interventions

5.3.3.1.1 Judgmental, Premature, or Intrusive Interventions

This sub-theme was identified in the responses of 3 patients and 7 therapists. Some therapist interventions lacked responsiveness due to poor timing, causing discomfort and leading patients to perceive the clinician as too intrusive or judgmental. Particularly, therapists occasionally attempted to address sensitive topics and drew connections between past and present events when patients were not ready or did not feel the need to do so. For example, one therapist reflected, "*The patient spoke at length about her daily work, describing workplace injustices that occur between colleagues. I may have offered a connection of this experience of hers to other areas of her relational life too abruptly*". A patient also shared this feeling, stating, "[I do not perceive the therapist as responsive] *When sometimes the search/need for a partner is urged, while, at the moment, I do not feel this need*

except in terms of avoiding possible future loneliness". Additionally, some patients rejected suggestions, or practical advice, perceiving these interventions as unrelated to the therapist's role.

5.3.3.1.2 Detached or Rigid Interventions

This sub-theme was identified in the responses of 5 patients and 1 therapist. They noted that some therapist interventions seemed detached from the patient's feelings and experiences and felt like mere techniques rather than appropriate responses to their needs. For instance, one patient expressed, "*In the face of my discouragement he behaved in a cold and detached manner that maybe therapeutically makes sense, but inside he touched particularly*". Additionally, examples of such detached interventions included silent responses or aloof reactions when patients felt vulnerable, as well as rigid interpretations that failed to acknowledge their subjective experience of suffering. Furthermore, inflexible responses to requests for setting adjustments were also perceived as non-responsive. For example, one therapist said, "*Giving him the invoice, the patient realizes that I also counted two sessions where he had missed, to his remonstrances I remind him of the initial contract, perhaps a little dryly because I did not expect him not to remember the initial agreements. He asked me to change the arrangements because he never forgot to inform me. I stand firm in my position somewhat rigidly*".

5.4. Discussion

The present study aimed to identify core aspects of therapist responsiveness and non-responsiveness within 54 therapeutic couples by performing two thematic analyses. Overall,

these findings suggest that moments of therapist responsiveness are characterized by the capacity to make patients feel understood and heard during treatment, as well as offering opportunities for gaining new knowledge about themselves. In contrast, various elements were identified as contributing to the perception of therapist non-responsiveness including therapist perception of inefficacy, misattunement, and discrepancies in treatment goals and expectations. However, it must be acknowledged that more than half of patients (thirty-one out of fifty-four) struggled to report moments of therapist non-responsiveness.

First, the thematic analysis of moments of therapist responsiveness identified two core themes: *Attunement, Closeness, and Support* and *Insight Promotion*. Notably, these themes respectively reflected the more emotional (attunement) and more cognitive (insight) dimensions of the psychotherapy process, supporting the relevance of both components in fostering the perception of therapist responsiveness within the therapeutic dyad (McCarthy et al., 2017; Snyder & Silberschatz, 2017). This aligns with the findings of Ladmanová et al. (2022), who identified two areas of positive events in psychotherapy, related to the *therapeutic relationship* and *patient's self-development*.

Specifically, the subtheme *Perception of Empathy, Understanding, and Emotional Containment* was highly prevalent among patients, highlighting the importance of therapists creating a safe environment, maintaining a non-judgmental attitude, and being attuned to patient needs. These interpersonal capacities have been also linked to constructs such as *positive regard* (Farber et al., 2018; Rogers, 1957), *empathy* (Elliott et al., 2018), and *genuineness* (Kolden et al., 2018), which are widely described in clinical literature as core aspects of therapeutic work associated with positive treatment outcomes (Cuijpers et al., 2019; Norcross & Lambert, 2019). The subtheme *Support, Validation, and Focus on Resources* underscored the importance of emphasizing positive aspects and improvements during treatment, rather than solely concentrating on the patient's issues (Lingiardi &

McWilliams, 2017). It is noteworthy that this subtheme emerged from narratives of therapeutic dyads engaged in psychodynamic-oriented treatments that typically tend to prioritize expressive interventions (i.e., transference interpretations, elaboration) instead of supportive ones (i.e., validation) (i.e., Hilsenroth et al., 2005). Therefore, these findings have further endorsed the integration of diverse techniques based on the actual needs of the patient (Gabbard & Crisp, 2023; Owen & Hilsenroth, 2014). Finally, the subtheme *Complete Understanding and Trust* described the attribution of extremely positive qualities and capacities to the therapist. This dynamic can potentially enhance the patient's engagement in the treatment process, as noted by De Smet et al. (2020) who found that patients talked about the therapeutic relationship as a "*non-judgmental safe haven*". However, this perception may also lead to unrealistic expectations and eventual client dissatisfaction (Constantino et al., 2012).

The second theme identified by the analysis of moments of therapist responsiveness was *Insight Promotion* supporting the relevance of insight within the psychotherapy work (Jennissen et al., 2018; Timulak & McElvaney, 2013). This theme was most prevalent among therapists who linked their responsiveness to patients' self-knowledge, connections between past and present, or the development of new perspectives (De Smet et al., 2020). Moreover, this finding is in line with the study of Fiorentino et al. (2024) who found therapists perceived themselves as more responsive and helpful in sessions characterized by greater levels of depth of elaboration, that is when it is possible to address meaningful topics such as conflicts or interpersonal difficulties.

The second thematic analysis, focusing on therapist non-responsiveness, revealed a varied picture. This aligns with Burton and Thériault (2020) who noted that findings on negative events in psychotherapy are less consistent than those on positive moments. First, the theme *Failure to perceive the therapist's lack of responsiveness* was highly prevalent, especially

among patients. This is noteworthy since it can be assumed that moments of non-responsiveness normally occur within the therapeutic relationship such as in other kinds of interactions (Kramer & Stiles, 2015; Stiles, 1988). The tendency to not report hindering events in psychotherapy has been previously observed (Henkelman & Paulson, 2006; Paulson et al., 2001; Vybíral et al., 2024). According to Rennie (1994), clients may have a *deferential* attitude toward their therapists (i.e., being acquiescent, not expressing their own opinion), hide their feelings, and avoid addressing difficulties, potentially impacting the therapeutic process (Locati et al., 2016). This was further evident in the subtheme *Stepping Back After Noticing Therapist's Non-Responsive Behaviors*, where patients initially recognized instances of non-responsiveness but ultimately blamed themselves (i.e., Vybíral et al., 2024) or minimized the issue. A lack of responsiveness can signify a rupture in the therapeutic relationship (Levy Chajmovic & Tishby, 2024), and recognizing such ruptures is essential for initiating a reparation process involving both therapist and client (Muran et al., 2021). Rupture reparation can give the patient the possibility of "a new relational or corrective experience" (Muran et al., 2021 p.364). Notably, it is associated with good treatment outcomes (Eubanks et al., 2018), and, conversely, unresolved ruptures are related to negative outcomes and dropout (Coutinho et al., 2011).

The theme *Struggle to Engage with the Patient* was highly prevalent among therapists, indicating that feelings such as helplessness, inadequacy, frustration, and boredom could interfere with their ability to be responsive. Stige et al. (2024) also found that therapists struggled in the clinical work when they felt they were not competent enough to help the patient. Notably, research has found that therapist emotional responses (or countertransference) can hinder the possibility of being emphatic, providing timely interventions, and potentially impacting session quality (Fiorentino et al., 2024; J. A. Hayes et al., 2018; Tishby & Wiseman, 2022). Moreover, patients with personality disorders can evoke

particularly strong reactions in their clinicians (Rossberg et al., 2007; Tanzilli et al., 2017) challenging the psychotherapy process. It is noteworthy that therapists' awareness of their contribution to non-responsive moments can serve as a valuable resource to help them address difficulties in clinical work (Levy Chajmovic & Tishby, 2024; Stige et al., 2024; Wu & Levitt, 2022).

The theme Perspectives on the Psychotherapy Process signals that patients may perceive a lack of responsiveness when not feeling on the same page with therapists. Notably, the subtheme Disagreements on Treatment Goals and/or Modalities offered further support to the relationship between therapeutic alliance - which encompasses agreement on goals and tasks, as well as the quality of the bond (Bordin, 1979) - and therapist responsiveness (Culina et al., 2024; Elkin et al., 2014; Hatcher, 2021). Along with the subtheme Unrealistic Expectations this finding suggests that explicitly addressing and sharing priorities and realistic treatment goals can promote positive treatment outcomes (Slade, 2017), while they can be hindered by unmet expectations (Constantino et al., 2012; Curran et al., 2019). Lastly, the theme Therapeutic Interventions revealed that while patients often perceived detached or rigid behaviors (such as silence) as non-responsive, therapists generally considered themselves non-responsive when they provided intrusive or premature interventions.

5.5 Limitations

The present study has several limitations. First, therapist responsiveness and non-responsiveness were examined through a single open-ended question each, which may have influenced participants' ability to provide detailed descriptions or identify multiple events. At the same time, online surveys are widely used in qualitative research as they allow to reach larger samples than interviews and partially overcome desirability bias (Braun et al., 2021).

However, research employing in-depth interviews could be useful to further explore this topic. Second, this sample consisted of psychodynamic therapists and patients with personality disorders. Future studies should qualitatively investigate therapist responsiveness across therapists with different theoretical orientations and other clinical populations. Third, the research team had a psychodynamic background and expertise in psychotherapy research and therapist responsiveness, which may have influenced data analysis and result interpretation. A qualitative analysis conducted by teams with diverse backgrounds could offer additional insights into the understanding of therapist responsiveness.

5.6 Conclusion

This is the first qualitative study aimed at identifying the core aspects of therapist responsiveness and non-responsiveness as described by both members of therapeutic dyads. These findings indicated that the therapist's ability to foster insight, cultivate new perspectives, and demonstrate attunement and empathy were fundamental to responsive moments in therapy. Conversely, moments of therapist non-responsiveness were heterogeneous, including therapist perceptions of inefficacy and mismatches in treatment goals and expectations. Notably, several patients found it challenging to describe non-responsive moments, highlighting the need for further research. Although responsive behaviors arise from the emerging context and are unique for each therapeutic dyad, the present findings contribute to the understanding of therapist responsiveness by identifying recurrent elements in the narratives of both therapists and patients. Additionally, considering both perspectives revealed some discrepancies in the perception of therapist responsiveness that should be acknowledged by clinicians in their work.

Chapter 6

Study Four. Therapeutic Process as a Complex System: A Network Analysis of Therapeutic Alliance, Responsiveness, and Depth of Elaboration

6.1 Introduction and aims

Several psychotherapeutic approaches have proven to be effective for a range of mental health conditions (Cristea et al., 2017; Cuijpers et al., 2023). Yet, it is poorly understood how therapies work (Cuijpers et al., 2019). Some scholars have suggested that the so-called "common factors," which include interpersonal variables inherent to the therapeutic relationship regardless of the theoretical orientation, play a pivotal role in promoting clinical change (e.g., Norcross & Lambert, 2019). However, much research on psychotherapy may have been affected by a reductionist approach, which risks oversimplifying complex phenomena by isolating the relationships between individual elements (Cuijpers et al., 2019; Fried, 2022). This indicates a need for frameworks to capture the complexity of the therapeutic relationship and psychotherapy process.

Recent developments in psychology have seen the introduction of "network approaches," a paradigm shift supported by insights from complex systems theories (Borsboom et al., 2021). Network approaches applied to psychopathology posit that symptoms (e.g., depressed mood) are not passive indicators of latent variables (e.g., major depressive disorder). In contrast, symptoms actively cause and reinforce each other, generating feedback loops that render them self-sustaining in an "alternative stable state." Such a complex entity is essentially what is recognized as a mental disorder (Borsboom, 2017; Scheffer et al., 2024b). Notably, complexity characterizes not only symptoms but also the therapeutic process.

By applying the principles of traditional network approaches to the therapeutic process, interpersonal variables, such as the sense of bond between therapist and patient, should not be viewed as merely passive indicators of a latent variable like the therapeutic relationship. Rather, these relational variables actively interact and reinforce each other, contributing to the formation of what is known as the "therapeutic process." Thus, the therapeutic process could be better conceptualized as a "complex system," in which the order at the macro-level depends on the interdependence among variables at the micro-level (Fried, 2022). The clinical implications of adopting network approaches involve identifying the interactions among variables, such as symptoms, to guide clinical intervention (Eaton et al., 2023). By translating this concept to the therapeutic process, understanding the network structure of the psychotherapy process can help clinicians promote feedback loops that foster a stable state of "collaborative work." Even though some authors (Burger et al., 2023; Hayes & Andrews, 2020; Klocek et al., 2024) have suggested that psychotherapy processes should be studied as a complex system, to my knowledge, network analysis has not been applied to factors that characterize the psychotherapy process and the therapeutic relationship while considering both members of the therapeutic dyad.

In the present study, I focused on therapeutic alliance, therapist responsiveness, and depth of elaboration, due to their crucial role in the psychotherapy process. The therapeutic alliance, the most studied among the "common factors", is significantly associated with positive treatment outcomes facilitating therapeutic changes (Flückiger et al., 2019). Bordin (1979) defines the therapeutic alliance as the mutual agreement between patient and therapist on the *goals* of the therapeutic work, the necessary *tasks* for achieving them, and the interpersonal *bond* reflecting trust and collaboration. Therapist responsiveness refers to the therapist's ability to attune to the patient emotional state and to provide interventions tailored to their needs (Snyder & Silberschatz, 2017). This pervasive and multi-faceted variable has

gained increasing attention reflecting the complexity of emerging interactions within the therapeutic relationship (Hatcher, 2021). Lastly, depth of elaboration is a dimension that reflects the quality of the psychotherapy session (e.g., outcome), specifically, the possibility of reaching profound and meaningful subjects such as interpersonal or emotional difficulties and conflicts (Stiles et al., 2002). However, there remains a dearth of research that has comprehensively examined the interplay among these variables. In light of the above, enhancing our comprehension of the relationships between common factors that characterize the psychotherapy process, and the therapeutic relationship can provide valuable insights into the underlying mechanisms that facilitate therapeutic change (Cuijpers et al., 2019). The aims of the current study were: (a) examine the network structure and interconnections among therapeutic alliance, therapist responsiveness, and depth of elaboration, as evaluated from both patient and therapist perspectives within therapeutic dyads; (b) investigate the associations with session outcome, conceptualized in terms of depth of elaboration.

6.2 Methods

6.2.1 Participants

77 therapeutic dyads were recruited from Italian psychotherapy associations. Each clinician selected one patient based on the following criteria: (1) ≥18 years old; (2) diagnosed with a personality disorder according to the Section II of the DSM-5/5-TR (APA, 2013, 2022) (3) treatment length ranging from 2 to 24 months; (4) without a diagnosis of psychotic disorder or receiving drug therapy for psychotic symptoms. Participation was voluntary and anonymous to ensure privacy, with participants providing informed consent. The present study received approval from the local ethics committee under protocol number n. 0000773 dated 12/05/2022. Therapists, 40,3% male and 59,7% female had a mean age of 46,78 years

(*SD* = 12,12) and 14,71 years (*SD* = 9,91) of clinical experience. The most common theoretical orientation was psychodynamic-psychoanalytic (85,7%), followed by cognitive-behavioral (7,8%) and metacognitive-interpersonal (6,5%). Patients, mostly females (72,7%) with a mean age of 35,29 years (*SD* = 12,09) underwent treatment averaging 8,12 months (*SD* = 6,40).

6.2.2 Measures

6.2.2.1 The Working Alliance Inventory – Short Form (WAI-SF; Tracey & Kokotovic, 1989)

WAI-SF is a 12-item questionnaire evaluating therapeutic alliance in psychotherapy. Items are on a 7-point Likert Scale ranging from 1 (*never*) to 7 (*always*). This instrument encompasses three subscales: *bond*, *task*, and *goals.* In the present study, patient and therapist versions were employed (in section 2.3.1.2 further information on WAI-SF are provided).

6.2.2.2 Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles and Snow, 1984; Rocco et al., 2017)

The SEQ assesses various aspects of psychotherapy session quality, including Depth, Smoothness, Positivity, and Arousal. In this study, only the SEQ-D (Depth) was employed to evaluate the depth of elaboration from both the therapist and patient perspective. See section 2.3.1.3 for further details on SEQ-D.

6.2.2.3 Patient's Experience of Attunement and Responsiveness Scale (PEAR; Snyder and Silberschatz, 2017)

The PEAR evaluates therapist attunement and responsiveness in psychotherapy sessions on a Likert scale ranging from 0 (*not at all*) to 3 (*very much*) from both the therapist (PEAR-T) and the patient (PEAR-P) perspectives. In this study the Italian version of the PEAR has been used (see Appendix 1). More details on this measure are reported in section 2.3.1.1.

6.2.3 Network estimation

In the network framework, the "nodes" are the variables of interest, while the "edges" are the statistical relationships between them. I was employed a Gaussian Graphical Model (GGM) and used pairwise partial correlations to infer the network structure. An adaptive least absolute shrinkage and selection operator (LASSO) was modeled, forcing weak connections to 0. The Extended Bayesian Information Criterion (EBIC) was employed to control the sparsity, and the tuning parameter was set to 0.5. The following centrality metrics have been computed: strength, closeness, and expected influence (see Supplementary Methods). To test the robustness of the estimates, it has been evaluated the accuracy of edge-weights and assessed the stability of centrality indices through the correlation stability coefficient (CS) (Supplementary Methods). CS values above .25, .50 and .70 indicate acceptable, good, and excellent stability properties, respectively (Epskamp, van Borkulo, et al., 2018). The analyses were conducted using the programming language R (R Core Team, 2023) and the packages *bootnet* and *qgraph* and by following relevant literature (Burger et al., 2023; Epskamp, Borsboom, et al., 2018).

6.3 Results

6.3.1 Demographic and clinical characteristics

77 patient-therapist couples were included in this study. Demographic and clinical information are shown in Table 6.1. There was no missing data in this dataset.

Additional Information on Participants.

Table 6.1 Patients Personality Disorders and Clinical Diagnosis (*N*=77)

Diagnosis	**N (%)**
Personality Disorders	
Paranoid	3 (3.9)
Schizoid	0
Schizotypal	1 (1.3)
Antisocial	0
Borderline	12 (15.6)
Histrionic	9 (11.7)
Narcissistic	16 (20.8)
Avoidant	8 (10.4)
Dependent	14 (18.2)
Obsessive-Compulsive	9 (11.7)
Other Specified Personality Disorder	7 (9.1)
Unspecified Personality Disorder	6 (7.8)
Schizophrenia Spectrum and Other Psychotic Disorders	0
Bipolar and Related Disorders	2 (2.6)
Depressive Disorders	26 (33.8)
Anxiety Disorders	38 (49.4)
Obsessive Compulsive and Related Disorders	13 (16.9)
Trauma – and Stressor – Related Disorders	14 (18.2)

Dissociative Disorders	3 (3.9)
Somatic Symptom and Related Disorders	6 (7.8)
Feeding and Eating Disorders	7 (9.1)
Disruptive, Impulse-Control, and Conduct Disorders	4 (5.2)
Substance-Related and Addictive Disorders	1 (1.3%)

6.3.2 Network analysis

The network structure is shown in Figure 6.1. The most central therapist node was *task,* while the most central patient node was *goal* (Figure 6.2). Visual inspection revealed that the patient nodes were closely interconnected with each other. A range of interconnections were
also observed among the therapist nodes. Two interconnections emerged between the nodes of the patient and the therapist–namely, *task (patient)* was connected to *task (therapist),* while *bond (patient)* was connected to *bond (therapist)*. Regarding depth, *depth (patient)* was directly connected to *responsiveness (patient)*, *goal (patient)*, *bond (patient)* and *task (patient),* while *depth (therapist)* was directly connected to *responsiveness (therapist)*, which, in turn, was directly connected to *task (therapist)* and *bond (therapist)*. The CS for strength was .36 (Figure 1 in Appendix 3). The bootstrapped confidence intervals of the estimated edge weights are shown in Figure 2 in Appendix 3.

Figure 6.1 Network structure.

Legend Figure 6.1. BOND_P: bond (patient); BOND_T: bond (therapist); DEPTH_P: depth (patient); DEPTH_T: depth (therapist); GOAL_P: goal (patient); GOAL_T: goal (therapist); PAER_P: responsiveness (patient); PEAR_T: responsiveness (therapist); TASK_P: task (patient); TASK_T: task

(therapist). The associations are either positive (colored black) or negative (colored red), with thicker lines representing stronger associations.

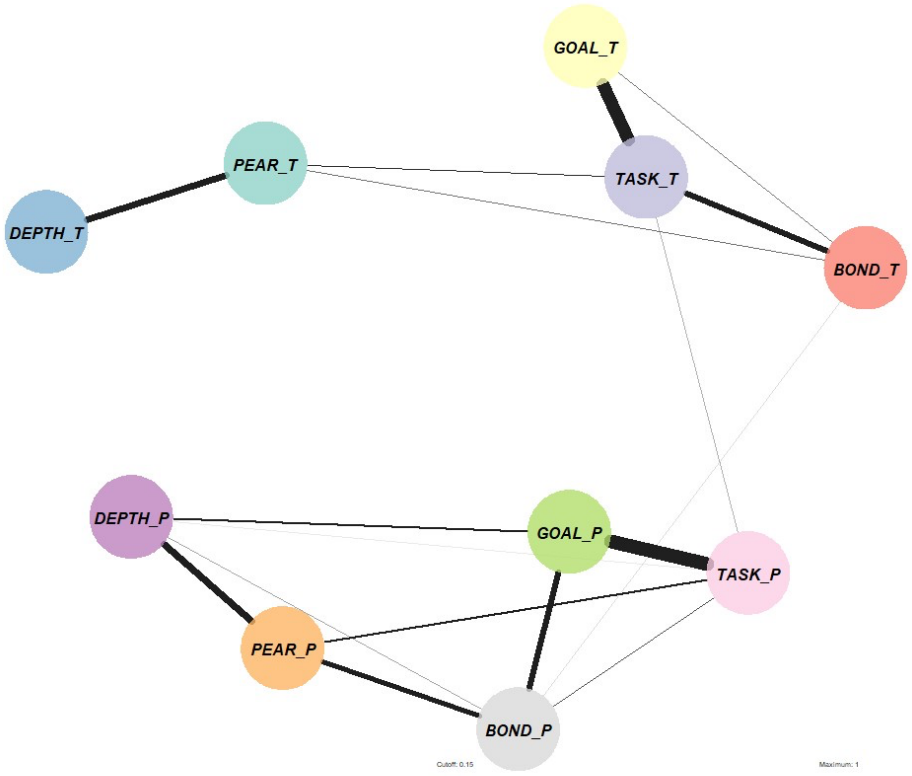
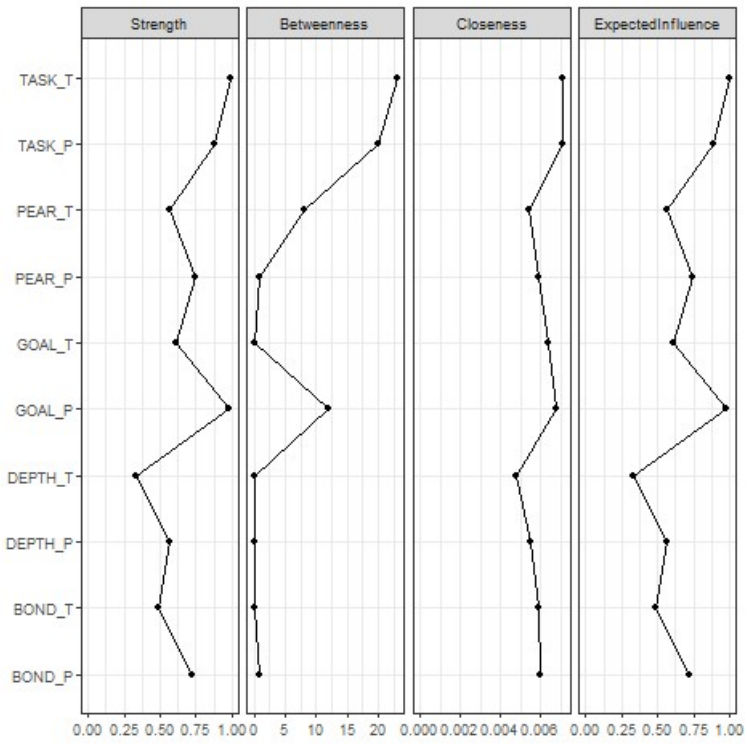


Figure 6.2 Centrality indices of the study variables, shown as standardized z-scores.

Legend Figure 6.2: BOND_P: bond (patient); BOND_T: bond (therapist); DEPTH_P: depth (patient); DEPTH_T: depth (therapist); GOAL_P: goal (patient); GOAL_T: goal (therapist); PAER_P: responsiveness (patient); PEAR_T: responsiveness (therapist); TASK_P: task (patient); TASK_T: task (therapist).



6.4 Discussion

This study applied network analysis to variables that characterize the psychotherapy process, particularly, examining the interconnections among therapeutic alliance, depth of elaboration, and therapist responsiveness in therapeutic dyads. The findings show that these variables are highly interconnected, suggesting overcoming simplistic approaches to embrace holistic frameworks that consider interdependence and interconnectedness among the members of the dyad in the psychotherapeutic process, which can be conceptualized as a "complex system."

It is possible to observe several intra-individual interconnections respectively within patient and therapist variables, stemming from their distinct perspectives and points of observation. Moreover, there are discernible connections between the two members of the dyad, highlighting the presence of reciprocal and mutual exchanges in the psychotherapy

process. These results support previous studies highlighting the relationship between responsiveness and depth of elaboration (Harrington et al., 2021). Indeed, the therapist's ability to foster an environment of safety and trust, wherein patients feel genuinely heard and understood, appears linked to the possibility of exploring meaningful experiences during sessions (Kleiven et al., 2022). In turn, addressing profound subjects may reinforce the therapist's sense of efficacy, thereby enhancing the likelihood of attuning to the patient's needs and delivering timely interventions. In this vein, it is possible to observe that all the included nodes of the patient were directly connected to the depth of elaboration as evaluated by the patient, suggesting that it should not be considered an "isolated" factor; instead, the present findings emphasize that depth of elaboration is a process inherently intertwined with a range of non-specific factors (i.e., bond, task, goal, and therapist responsiveness) that contribute to shaping a given psychotherapy session. This has crucial clinical implications, as both relational and therapist interpersonal variables may act as mechanisms of change that are directly or indirectly connected with depth of elaboration, a marker of session outcome (Stiles & Snow, 1984b, 1984a). Moreover, improving depth of elaboration may, in turn, foster therapeutic alliance and therapist responsiveness, promoting a feedback loop of collaborative work in the therapeutic dyad. Future studies adopting longitudinal designs are needed to clarify the direction of these relationships.

Furthermore, I observed that task (patient) was directly connected with task (therapist), and bond (patient) was directly connected to bond (patient), highlighting the need to both agree on the most appropriate modalities to reach specific therapeutic goals (i.e., task) and foster a warm sense of connection between the members of the therapeutic dyad (i.e., bond). In essence, this underscores the significance of both the interpersonal dynamics within the therapeutic relationship alongside the practical operational factors, thereby supporting the multifaceted nature of the therapeutic alliance. Finally, goal was a highly central node in the

patient, highlighting the importance of the patient's perception that their objectives in psychotherapy are acknowledged, shared, and understood by the therapist.

6.5 Limitations

This study has several limitations that need to be acknowledged. First, this is a cross-sectional study. Future research using time series data (Epskamp, 2020) could provide insights into the idiographic network structure specific to each therapeutic dyad, promoting the identification of tailored intervention strategies. Second, I did not include variables about specific factors (e.g., intervening on maladaptive cognitions in cognitive psychotherapies) in the network structure. However, this choice was consistent with my study rationale and aims, which focused on common factors, as they are shared across all theoretical orientations. Nevertheless, future studies applying network analysis to specific factors are recommended. Third, all the participants were recruited from psychotherapy centers located in Italy. Fourth, the predominant therapeutic orientation among the therapists was psychodynamic, introducing a potential source of bias. Finally, to date in the network literature there are no analytic methods specifically designed to address nested, dyadic and/or dependent data. In order to overcome this gap, in this study I addressed the therapist-patient dyad as the primary unit of analysis. Moreover, while the observations within each dyad are interdependent, the evaluations were provided by different individuals (i.e., therapist or patient), which helps mitigate concerns about complete dependance between observations.

6.6 Conclusion

This is the first study to apply network analysis to the common factors in psychotherapy while including both members of the therapeutic dyads. These findings reveal a range of interconnections among variables within and between the two members of the therapeutic dyad, suggesting that the psychotherapy process can be understood as a complex system. Moreover, it is underscored the clinical relevance of the therapist responsiveness and the need to fully consider patients goals, while aligning tasks and fostering therapeutic bond as these are intertwined with depth of elaboration in the patient. This study opens the field to future replication studies and investigations using longitudinal designs.

Chapter 7

Conclusions

The main aim of this thesis was to shed light on the role of therapist responsiveness in psychotherapy sessions focusing on its interconnections with other critical elements such as therapeutic alliance and therapist emotional responses. With this purpose in mind, I employed diverse methodological approaches — including mixed models, thematic analysis, and network analysis — to capture the complexity of the phenomena under investigation.

While the effectiveness of psychotherapy across different clinical populations — including personality disorders (PDs) — has been well established (e.g., Cristea et al., 2017), further research needs to better understand *how* treatments work (Norcross and Lambert, 2019). As I discussed in detail in *Chapter 1*, empirical evidence supports the therapist's effect on treatment outcomes (Wampold & Owen, 2021). Specifically, therapist responsiveness — the ability to resonate with the patients' emotional states and provide timely interventions — has been identified as a crucial factor linked to positive treatment outcomes (Kramer & Stiles, 2015; Snyder & Silberschatz, 2017). Moreover, as outlined in *Chapter 2*, this therapist interpersonal capacity is strictly associated with significant variables including therapeutic alliance (Culina et al., 2023; Elkin et al., 2014). However, their specific interplay as well as their relationship with other factors (e.g., the therapist's emotional responses and depth of elaboration) require further investigation.

Therapists who participated to this project selected one patient in their care with a personality disorder (PD) diagnosis. They both provided data referring to a single psychotherapy session completing two open ended questions on therapist responsiveness and they both filled in the *Patient's Experience of Attunement and Responsiveness Scale* (PEAR; Snyder & Silberschatz, 2017), the *Working Alliance Inventory-Short Form* (WAI-SF; Tracey

& Kokotovic, 1989), and the *Depth Scale of the Session Evaluation Questionnaire* (Stiles & Snow, 1984b) to assess therapist responsiveness, therapeutic alliance, and depth of elaboration respectively. The clinicians also completed the *Therapist Response Questionnaire* (TRQ; Betan et al., 2005; Tanzilli et al., 2016) to evaluate their countertransference patterns. In *Chapters 3*, *4*, *5* and *6*, I illustrated the empirical studies of this thesis. In *Study One,* data were collected from sixty-seven therapist-patient dyads. The findings revealed a strong association between therapist responsiveness, therapeutic alliance and the depth of elaboration. Notably, therapist responsiveness emerged as the most significant predictor of sessions depth, highlighting its crucial role in enhancing the quality of psychotherapy sessions. Moreover, clinicians tended to underestimate their perceptions of being attuned and able to develop a collaborative and deep relationship with their patients. Raising awareness of this discrepancy is essential, as convergent perceptions between therapists and patients are linked to positive treatment outcomes (Laws et al., 2017).

Eighty-four therapists participated in *Study Two.* My primary aim was to compare therapist responsiveness and therapist emotional responses in psychotherapy sessions with diverse levels of depth of elaboration. I found that deeper sessions were associated with greater therapist responsiveness and more positive countertransference responses. In contrast, sessions characterized by poor therapist responsiveness exhibited hostile/angry, disengaged, and helpless/inadequate countertransference responses. These results underscore the critical role of the therapist's interpersonal skills highlight the importance of recognizing and managing negative emotional responses (Hayes et al., 2019).

In *Study Three* fifty-four therapeutic dyads answered two open-ended questions each describing moments of therapist responsiveness and therapist non-responsiveness. I employed thematic analysis to explore their subjective experience of such moments, revealing that therapists were perceived as responsive when patients felt heard and accepted, and when they

increased their self-knowledge. Conversely, therapist non-responsiveness was linked to various situations, such as therapists feeling ineffective, experiencing misattunement, or disagreeing on treatment expectations and objectives. Notably, patients found it challenging to identify moments of therapist non-responsiveness. This is the first study to have qualitatively examined descriptions of therapist responsiveness and non-responsiveness from both members of the therapeutic dyad evidencing the significance of specific therapist behaviors.

Finally, *Study Four* stems from the attempt to apply complex systems theories in the field of psychotherapy research by capturing the therapeutic process globally. This empirical investigation aimed to explore the network structure and interconnections between therapeutic alliance, therapist responsiveness, and depth of elaboration as evaluated by seventy-seven therapist-patient dyads. Network analysis revealed that the patient nodes were closely interconnected with each other and several interconnections also emerged among the therapist nodes. Particularly, the bond (therapist) was connected to the bond (patient), and the task (patient) was connected to the task (therapist). Moreover, depth was connected to all the variables in the patient, and, in the therapist, depth was closely connected to responsiveness. These results offered further support to the relationship between depth of elaboration and therapist responsiveness. Notably, task and goal need to be carefully addressed because they enable mutual interaction between clinicians and patients.

Notably, mixed models, thematic analysis, and network analysis revealed converging findings highlighting the critical importance of the therapists' interpersonal capacities in successful psychotherapy sessions. This result supports the intersubjective nature of clinical exchange in agreement with the Third Task Force on Evidence Based Psychotherapy Relationship (Norcross & Lambert, 2019). Specifically, the pivotal role of the therapist capacity to demonstrate care, attentiveness, and attunement to patients' needs while delivering

appropriate interventions underscores the importance of promoting tailored treatment (Elkin et al., 2014; Hatcher, 2021). On the other hand, these findings also revealed threatens to therapist responsiveness including a lack of agreement on the treatment's tasks and goals as well as by therapist's negative emotional responses towards the patient if not carefully managed (Hayes et al., 2011; Laws et al., 2017; Tishby & Wiseman, 2014; Tryon & Winograd, 2011). Therefore, therapists should actively notice gaps between their perspective and the patients' experience monitoring potential ruptures in the therapeutic process and fostering collaboration within treatment. While these findings require further validation, they support the importance of promoting therapists' self-reflection and awareness of potential risks during psychotherapy (Stige et al., 2024; Wu & Levitt, 2020, 2022). This is particularly important for novice therapists, who may struggle more with responsiveness. Training should include learning to recognize cues that enhance their interpersonal capacities, enabling them to tailor interventions to patients' states, needs, and goals regardless of theoretical orientation (Wu & Levitt, 2022). Additionally, supervision may play a crucial role in helping therapists manage their responses to patients, examine relational dynamics, and address potential obstacles to responsiveness. By integrating these practices, therapists can strengthen their capacity to deliver effective and attuned care.

However, this research has some limitations which could be addressed in future studies. First, the reliance on self-report instruments introduces potential bias, such as social desirability or recall bias. Although the inclusion of both patient and therapist perspectives represents a significant strength of this thesis, the exclusive use of self-report questionnaires and open-ended questions may have hindered the possibility of capturing certain aspects of the psychotherapy process and the therapeutic relationship. For instance, the high number of participants who struggled to report moments when they perceived their therapists as non-responsive in *Study 3* could be partially attributed to a deferential attitude (Rennie, 1994), or

more in general, a difficulty to report hindering moments of the therapy (Henkelman & Paulson, 2006; Paulson et al., 2001; Vybíral et al., 2024). Overall, to address this gap, future research should include the use of observer-rated instruments such as the Therapist Responsiveness Scale (Elkin et al., 2014) which could provide additional validation, and a more comprehensive understanding of the findings presented in this thesis. Secondly, the present studies have a cross-sectional study design, not allowing any causal inference on the relationship between the investigated variables nor to observe how they change across treatment. Future studies could use longitudinal study design focusing on how therapist responsiveness interact with therapeutic alliance, therapist emotional responses and depth of elaboration over the course of psychotherapy to better elucidate its role in treatment and patterns of change and influence between variables. As shown by Culina and colleagues (2022), longitudinal investigations can shed light on the role of therapist responsiveness. For example, longitudinal studies could examine if the discrepancies in the patients' and therapists' evaluations of therapist responsiveness and therapeutic alliance predict the level of the depth of elaboration of the following sessions (i.e., session outcome). Moreover, qualitative studies utilizing in-depth interviews and analytical software may provide meaningful insight to explore the narratives of therapist responsiveness in multiple therapeutic sessions. Additionally, the impact of therapist responsiveness on treatment outcomes could be explored through Randomized Controlled Trials (RCTs). By comparing different psychotherapeutic treatments, it could be possible to explore if therapists with specific theoretical background tend to be more responsive towards their patients highlighting its impact on treatment outcomes. Also, the sample size of the present studies can limit the generalizability of the results. Future research should replicate these findings on larger samples. Finally, the present studies have been conducted on patients with PDs. Given the heterogeneity of this clinical population, to further improve generalizability, future studies

may also focus on specific PDs or include samples with diverse psychopathologies to explore potential differences in the interaction between therapist responsiveness and other key factors of the patient-therapist relationship and of the psychotherapeutic process. However, despite the specificity of this population, the present findings partially align with studies conducted on other clinical samples, such as individuals with depressive disorders (i.e., Elkin et al., 2014) or specific PDs, particularly borderline personality disorder (see for example Culina et al., 2023, 2024), providing further support, for instance, to the reciprocal influence between therapist responsiveness and therapeutic alliance. Additionally, the centrality of intersubjectivity in the clinical encounter, along with the importance of an attentive, caring, and empathetic attitude towards the patient, which emerged from the present study, has been consistently highlighted in research across various clinical populations (Norcross & Wampold, 2019a). However, the specific aims of the present studies should be replicated in different population.

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Appendix 1

PATIENT'S EXPERIENCE OF ATTUNEMENT AND RESPONSIVENESS SCALE (PEAR; SILBERSCHATZ, 2009; SNYDER & SILBERSCHATZ, 2017)

TRADUZIONE ITALIANA DI ANNALISA TANZILI, FLAVIA FIORENTINO E VITTORIO LINGIARDI ©

DIPARTIMENTO DI PSICOLOGIA DINAMICA, CLINICA E SALUTE,
FACOLTÀ DI MEDICINA E PSICOLOGIA – SAPIENZA UNIVERSITÀ DI ROMA

Le seguenti affermazioni fanno riferimento ad alcuni modi in cui clinici e pazienti si sentono, pensano, comunicano e interagiscono tra loro in psicoterapia.

PEAR-P (per il/la paziente):
Considerando l'ultima seduta con il/la suo/a terapeuta, indichi il grado di accordo con le affermazioni di seguito.

Scala Likert:
0 = per niente d'accordo
1 = poco d'accordo
2 = moderatamente d'accordo
3 = molto d'accordo

N.	Item	Punteggio
1.	Oggi il/la mio/a terapeuta mi ha proposto un punto di vista interessante e mi ha aiutato a raggiungere una maggiore comprensione di me stesso/a	
2.	Oggi sono stato/a capace di tirar fuori tutto quello di cui volevo parlare	
3.	Mi è sembrato che oggi il/la mio/a terapeuta fosse contento/a di lavorare con me	
4.	Oggi il/la mio/a terapeuta mi ha aiutato a parlare delle cose che sono per me davvero importanti o che mi preoccupano	
5.	Oggi le osservazioni del/la mio/a terapeuta mi hanno permesso di vedere le mie motivazioni e i miei comportamenti sotto una luce più positiva	
6.	Oggi ho fatto progressi nell'affrontare i problemi che mi hanno portato in terapia	
7.	Oggi il/la mio/a terapeuta ha saputo capirmi (rispetto ai miei pensieri, ai miei sentimenti, ai miei obiettivi e così via)	
8.	Quello che oggi il/la mio/a terapeuta ha detto e fatto mi è stato d'aiuto	

9.	Oggi il/la mio/a terapeuta mi è sembrato/a a suo agio di fronte a tutte le mie reazioni	
10.	Oggi ho provato sollievo rispetto allo stato di tensione in cui mi trovavo	
11.	Oggi il/la mio/a terapeuta ha riconosciuto i miei punti di forza e i miei progressi	
12.	Oggi sono riuscito/a a entrare più profondamente in contatto con i miei sentimenti e a emozionarmi	
13.	Oggi mi sono sentito/a accolto/a dal/la mio/a terapeuta	
14.	Oggi mi sono sentito/a rassicurato/a e incoraggiato/a rispetto a come sto	
15.	Oggi sono riuscito/a a entrare in contatto con i miei sentimenti e ad essere veramente chi sono	
16.	Oggi ho sentito che al/la mio/a terapeuta importasse davvero di me	
17.	Oggi mi sono venute delle idee per relazionarmi agli altri con modalità nuove o comunque migliori	
18.	Oggi ho sentito di avere una relazione autentica e personale con il/la mio/a terapeuta	
19.	Oggi il/la mio/a terapeuta ha mostrato davvero empatia per i miei bisogni e sentimenti	
20.	Oggi ho fatto progressi nella direzione di una maggiore capacità di controllo sul mio umore e sul mio comportamento	

PEAR-T (per il/la terapeuta):
Considerando l'ultima seduta con il/la suo/a paziente, indichi il grado di accordo con le affermazioni di seguito.

Scala Likert:
0 = per niente d'accordo
1 = poco d'accordo
2 = moderatamente d'accordo
3 = molto d'accordo

N.	Item	Punteggio
1.	Oggi sono stato/a in grado di proporre un punto di vista interessante al/la mio/a paziente che lo/l'ha aiutato/a a raggiungere una maggiore comprensione di sé stesso/a	
2.	Oggi il/la mio/a paziente è stato/a in grado di tirare fuori tutto quello di cui voleva parlare	
3.	sono stato/a in grado di aiutare il/la mio/a paziente a parlare delle cose che veramente erano importanti per lui/lei o che lo/la preoccupavano	
4.	Oggi le mie osservazioni hanno permesso al/la mio/a paziente di vedere le sue motivazioni e i suoi comportamenti sotto una luce più positiva	
5.	Oggi il/la mio/a paziente si è sentito/a rispettato/a da me	
6.	Oggi il/la mio/a paziente ha fatto progressi nell'affrontare i problemi che lo/la hanno portato/a in terapia	
7.	Oggi il/la mio/a paziente è stato/a critico/a nei miei confronti	
8.	Quello che oggi ho detto e fatto è stato di aiuto al/la mio/a paziente	
9.	Oggi mi sono sentito/a a mio agio di fronte a tutte le reazioni del/la mio/a paziente	
10.	Oggi il/la mio/a paziente ha provato sollievo rispetto allo stato di tensione in cui si trovava	

11.	Oggi il/la mio/a paziente si è sentito/a sicuro/a con me	
12.	Oggi il/la mio/a paziente non si è sentito/a compreso/a da me	
13.	Oggi mi sono sentito/a legato/a al/la mio/a paziente	
14.	Oggi ho riconosciuto i punti di forza e i progressi del/la mio/a paziente	
15.	Oggi il/la mio/a paziente è riuscito/a a entrare più profondamente in contatto con i suoi sentimenti e a emozionarsi	
16.	Oggi il/la mio/a paziente si è sentito/a criticato/a o disapprovato/a da me	
17.	Oggi il/la mio/a paziente si è sentito/a accolto/a da me.	
18.	Oggi il/la mio/a paziente si è sentito/a rassicurato/a e incoraggiato/a da me	
19.	Oggi il/la mio/a paziente è riuscito/a ad entrare in contatto con i suoi sentimenti e ad essere veramente chi è	
20.	Oggi ho proposto al/la mio/a paziente modalità nuove o comunque migliori per relazionarsi con gli altri	
21.	Oggi il/la mio/a paziente ha fatto progressi nella direzione di una maggiore capacità di controllo sul suo umore e sul suo comportamento	
22.	Oggi il/la mio/a paziente sembrava insicuro/a rispetto a come mi sentivo verso di lui/lei	

Appendix 2

The question included in the survey completed by the therapists to examine therapist responsiveness:

- Descriva brevemente un momento di una delle ultime sedute con il/la paziente in cui si è sentita/o capace di rispondere a un'esigenza o a una richiesta del/la paziente con prontezza, flessibilità e sensibilità (briefly describe a moment in one of your last sessions with the patient where you felt able to respond to a need or request of the patient with promptness, flexibility, and sensitivity)

The question included in the survey completed by the therapists to examine therapist non-responsiveness:

- Descriva brevemente un momento di una delle ultime sedute con il/la paziente in cui le sembra di non essere riuscita/o a rispondere a un'esigenza o a una richiesta del/la paziente con prontezza, flessibilità e sensibilità (briefly describe a moment in one of your last sessions with the patient where you feel you were unable to respond to a need or request of the patient with promptness, flexibility, and sensitivity).

The question included in the survey completed by the patients to examine therapist responsiveness:

- Descriva brevemente un momento di una delle ultime sedute con il suo/la sua terapeuta in cui ha sentito che lei/lui è stata/o capace di rispondere a una sua esigenza o richiesta con prontezza, flessibilità e sensibilità (briefly describe a moment from one of the last sessions with your therapist where you felt they were able to respond to a need or request of yours promptly, flexibly, and sensitively).

The question included in the survey completed by the patients to examine therapist non-responsiveness:

- Descriva brevemente un momento di una delle ultime sedute con il suo/la sua terapeuta in cui ha sentito che lei/lui non è stata/o capace di rispondere a una sua esigenza o richiesta con prontezza, flessibilità e sensibilità (briefly describe a moment in one of the last sessions with your therapist where you felt they were not able to respond to a need or request of yours promptly, flexibly, and sensitively).

Appendix 3

Centrality metrics:

Strength: the sum of the absolute values of all connection weights of any given node);

Closeness: the inverse sum of the shortest paths between any given node and all the other nodes,

Betweenness: how many shortest paths that pass through any given node);

Expected influence: the sum of the connections weights of any given node, with their sign (Opsahl et al., 2010; Robinaugh et al., 2015)

Correlation stability coefficient (CS): the maximum proportion of the sample that can be dropped while retaining a correlation of at least 0.7 between the recalcualated indices and those of the complete original sample (Epskamp et al., 2018).

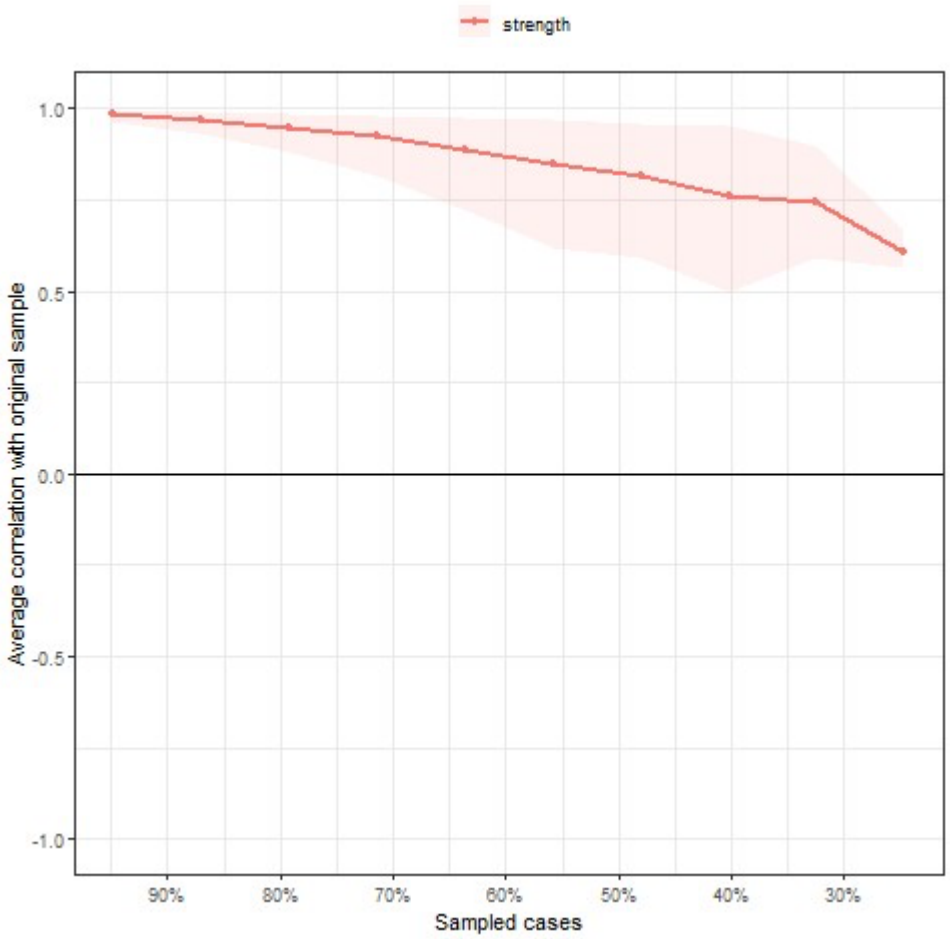

Figure 1. Average correlation between centrality indices of network subsamples and the original sample. Lines indicate means and areas indicate the range from the 2.5th quantile to the 97.5th quantile.

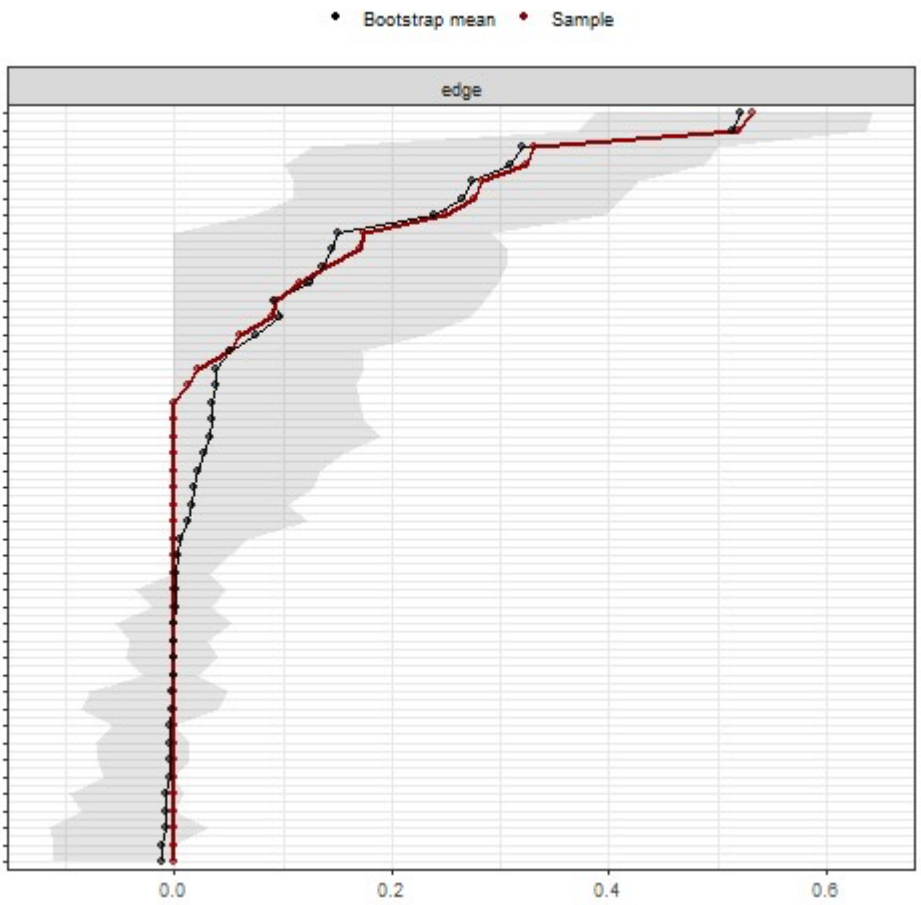

Figure 2. Bootstrapped confidence intervals of estimated edge weights

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