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Bridges and barriers in the psychodynamic treatment of personality disorders: two thematic analyses of therapist responsiveness and non-responsiveness from clinicians' and patients' perspectives

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Abstract

Introduction: Therapist responsiveness promotes favorable treatment outcomes and contributes to a deeper understanding of the mechanisms of change in psychodynamic psychotherapy for patients with personality pathology. At the same time, non-responsiveness may disrupt the clinical process and undermine the conditions for meaningful therapeutic progress. Design: This study examined therapist responsiveness and non-responsiveness in psychodynamic treatments of patients with personality disorders, integrating complementary perspectives from both clinicians and patients within a dual-perspective qualitative design. Methods: 54 clinicians and 54 patients each responded to two open-ended questions describing specific moments of responsiveness and non-responsiveness. Two separate thematic analyses were conducted within a critically realistic framework. Results: Therapists were perceived as responsive when patients felt deeply heard, recognized, and helped to develop greater self-awareness and new perspectives. Non-responsiveness was primarily associated with negative countertransference reactions, misattunement, and misalignments in expectations and shared understanding of the treatment. A substantial proportion of patients reported no experience of non-responsiveness—a finding interpreted in light of specific relational dynamics, social desirability bias, and idealizing transference processes. Conclusions: Therapist responsiveness is a fundamental clinical competence in the psychodynamic treatment of personality disorders, fostering a holding environment in which patients feel safe, accepted, and supported in developing insight and deeper reflective capacities. Training and supervision should focus on enhancing clinicians' attunement, interpersonal sensitivity, countertransference awareness, and metacommunicative skills. Collaboratively negotiating expectations, priorities, and shared understandings of treatment may reduce alliance ruptures. In addition, helping clinicians recognize and work through non-responsive moments may transform perceived failures into opportunities for professional growth and improved patient engagement.

Keywords Therapist responsiveness · Psychodynamic psychotherapy · Psychotherapy process · Personality disorders · Qualitative methods · Thematic analysis

Introduction

The efficacy and effectiveness of psychotherapies for a range of mental health conditions have been consistently established (Campbell et al., 2013); however, the mechanisms underlying good outcomes remain only partially understood. Research has increasingly highlighted the importance of therapists' characteristics—particularly interpersonal competencies—in shaping clinical processes that foster therapeutic change (e.g., Heinonen & Nissen-Lie, 2020; Norcross & Lambert, 2019; Wampold & Flückiger, 2023), especially in the treatment of patients with personality pathologies (e.g., Babl et al., 2022; Kramer et al., 2020). These individuals typically present severe impairments across several psychological domains—including difficulties in self–other representation, emotion regulation,

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reflective capacities, and relational functioning, as emphasized in *Psychodynamic Diagnostic Manual* (PDM-3; Lingiardi & McWilliams, 2025)—which pose significant challenges to mental health professionals and may hinder the development of a strong therapeutic relationship and jeopardize treatment success (e.g., Cristea et al., 2017; Tanzilli et al., 2016, 2018). Working with this clinical population requires clinicians to continuously adjust their interpersonal and technical stance to patients' rapidly shifting affective states, intense transference-countertransference dynamics, and frequent alliance ruptures—clinical demands that highlight therapist responsiveness as a key component of effective individualized therapies (Culina et al., 2023; Fiorentino et al., 2024; Kramer et al., 2020; Levy Chajmovic & Tishby, 2025).

In recent years, clinician responsiveness has received increasing attention in empirical research (Hatcher, 2021; Stiles & Horvath, 2017). In line with foundational formulations and operationalizations of this construct (Hatcher, 2015; Stiles et al., 1998; for a systematic review, see Esposito et al., 2024), responsiveness is understood here as a multidimensional, higher-order interpersonal competence through which therapists flexibly adapt their interventions to the patient's characteristics and the emerging clinical interaction. More specifically, it refers to the quality of a regulatory process through which therapists modulate, moment by moment, the timing, intensity, and focus of relational and technical actions in response to patients' unfolding emotional and cognitive states during clinical sessions. Nevertheless, this capacity does not imply constant activity or immediate patient gratification or relief. A clinician's intervention, whether verbal or nonverbal, may be fully attuned to the patient's emotional state and relational context, even when it is not followed by an immediate positive reaction or an observable shift in the patient. Within this framework, responsiveness and treatment effectiveness are conceptually related but not overlapping constructs (Silberschatz, 2017): the former refers to the extent to which a therapist's actions are contingent on and calibrated to the patient and the interactional field, whereas the latter concerns whether these actions contribute to broader therapeutic gains or changes over the course of treatment. Therefore, responsiveness can be understood as a process condition that, over time, increases the likelihood of positive outcomes, without implying that any single intervention will have an immediately beneficial effect in a deterministic way (Culina et al., 2023; Lauritzen et al., 2023). In some instances, restrained or delayed responses—including silence, opacity, or apparent non-responsiveness—may serve a responsive function when they are intentionally adopted, attuned to the patient's conflicts and developmental needs, and subsequently elaborated within the therapeutic relationship (Levitt & Morrill, 2023). At the same time, similar behaviors can be experienced as distancing or invalidating when they stem from misattunement, defensive withdrawal, or excessive adherence to technical rules rather than from a shared clinical intention (e.g., Lane et al., 2002). Importantly, this process-oriented view also helps clarify the broader conceptual status of responsiveness within psychotherapy research. Therapist responsiveness is not treated as a single or discrete process variable (e.g., empathy, the therapeutic alliance, or general clinician competence), but as a superordinate, context-sensitive capacity that organizes how relational and technical aspects of clinical work are mobilized in light of what unfolds in the here-and-now of the session (Hatcher, 2015). From this perspective, empathy, alliance, supportive interventions, interpretations, and other techniques can all be enacted more or less responsively. Accordingly, although responsiveness is ubiquitous in psychotherapy (Kramer & Stiles, 2015), it is not a 'common factor' in the narrow sense of a specific relational ingredient (such as alliance; Norcross & Lambert, 2019), but rather an extra-specific meta-competence that coordinates the use of the therapeutic relationship and techniques in a patient- and situation-sensitive way (Hatcher, 2015; Kramer & Stiles, 2015; Lauritzen et al., 2023).

Therapist responsiveness is likely grounded in an underlying capacity to understand and regulate minds in interaction (Fonagy & Allison, 2014; Heinonen & Nissen-Lie, 2020). It relies on complex psychological processes, including therapists' ability to understand and reflect on both their patients' and their own mental states, and to adapt their interventions accordingly—a set of skills often described in terms of therapists' reflective functioning and mentalizing abilities, which have been linked to greater therapeutic effectiveness (Cologon et al., 2017; Luyten et al., 2024). From a relational and intersubjective perspective, responsiveness is inherently co-constructed: it unfolds within a shared relational field in which therapists' and patients' experiences are reciprocally influenced, resulting in an interactional process through which patients feel accurately perceived, emotionally held, and helped to make meaningful progress during sessions (Snyder & Silberschatz, 2017; Tishby, 2021).

Building on this conceptualization, responsiveness has increasingly been referred to as a potential mechanism of therapeutic change (Kramer & Stiles, 2015), especially in the treatment of personality disorders (Kramer et al., 2020). From this perspective, responsive interventions may foster the patient's progress through several interrelated pathways. By attuning to patients' specific affective-interpersonal states, therapist responsiveness facilitates emotion regulation and enhances their sense of being recognized and understood. Moreover, responsiveness may support the development and improvement of levels of reflective functioning and

mentalization in therapy—both in clinicians, whose capacity to maintain a mentalizing stance underpins responsive clinical action (Cologon et al., 2017; Luyten et al., 2024), and in patients, for whom being responded to in a timely, attuned, and flexible manner may itself constitute a mentalizing experience. Through these processes, it may contribute to the recognition and collaborative elaboration of relational misattunements as they emerge within the therapeutic relationship, fostering the co-construction of new meanings of the patient's experience and more adaptive ways of being and relating (Tishby, 2021).

It appears crucial to distinguish therapist non-responsiveness from the inevitable—and at times therapeutically productive—experiences of mismatch that commonly characterize psychotherapy, particularly with patients presenting with personality pathologies. Therapist non-responsiveness refers to situations in which the clinician's relational stance or interventions are experienced by patients as persistently poorly attuned, rigid, or negating, and, above all, when such patterns recur pervasively, without being adequately explored and repaired within the therapeutic relationship, potentially rendering these moments clinically problematic or, even, detrimental to treatment (Snyder & Silberschatz, 2017). Temporary misattunement, transient lapses in empathic connection, enactments, and alliance ruptures are frequent features of therapeutic work and, from a responsiveness perspective, are understood as relational events emerging from the ongoing collaborative negotiation rather than as mere treatment failures (Eubanks et al., 2018). When such disruptions are recognized, explored, and collaboratively worked through, they can renew collaboration, deepen understanding of core interpersonal needs and schemas, and provide corrective relational experiences for the patient. In psychodynamic treatments for personality disorders, where recurrent alliance disruptions are common, the active resolution of ruptures is considered a general principle of change and a key context for emotionally corrective experiences (Safran & Muran, 2000). At the same time, clinicians should remain cautious in the face of experiences of "total understanding" or "complete attunement", which should not be uncritically regarded as positive in themselves. Episodes of seemingly perfect mutuality may at times reflect idealizing or fusion-like relational dynamics with patients presenting with personality pathologies, which can mask discrepancies in perceived distance and autonomy and become detrimental to the development of a flexible, collaborative alliance (Tishby, 2021; Levy Chajmovic & Tishby, 2025).

This conceptual and clinical account is broadly consistent with the available empirical literature. Most research on therapist responsiveness has employed quantitative approaches, showing associations with positive outcomes such as improved interpersonal functioning and symptom reduction (Elkin et al., 2014; Snyder & Silberschatz, 2017). Converging evidence also suggests that responsiveness is closely linked with the therapeutic alliance, as these processes mutually reinforce collaboration and trust (Culina et al., 2023; Elkin et al., 2014; Hatcher, 2021). However, this association should not be interpreted as conceptual overlap, but rather as reflecting the possibility that responsive therapist behavior supports the development and maintenance of a strong alliance through reciprocal feedback processes (Watson & Wiseman, 2021). In the context of personality disorders (Culina et al., 2023; Signer et al., 2020), a lack of clinician attunement and affective engagement is often associated with a marked decline in the alliance, characterized by intense ruptures in collaborative processes between patient and clinician, as well as heightened countertransference reactions (e.g., Fiorentino et al., 2024; Kramer, 2021; Levy Chajmovic & Tishby, 2025). Despite these advances, quantitative approaches remain limited in their capacity to capture the subjective complexity of how responsiveness is enacted and experienced in the moment-to-moment unfolding of clinical practice (Kramer & Stiles, 2015).

Qualitative research is particularly well suited to addressing this gap, as it allows exploration of complex, context-dependent processes and the subjective meanings patients and clinicians attribute to these mechanisms (Levitt et al., 2016; Maxwell & Levitt, 2023; Timulak & Keogh, 2017). A qualitative meta-analytic review by Wu and Levitt (2020) has highlighted the central role of responsiveness across therapeutic processes, identifying key principles related to therapist flexibility, relational attunement, and adaptation to patient characteristics. However, this body of studies has primarily focused on general principles and therapist perspectives. How responsiveness and non-responsiveness are subjectively experienced within specific clinical populations — and particularly from both sides of the therapeutic relationship — remains relatively unexplored. Indeed, few qualitative investigations have directly examined therapist responsiveness in psychodynamic treatments of patients with personality disorders, and fewer still have captured the experiences of both members of the therapeutic dyad. Wu and Levitt (2022) employed a qualitative approach using interviews with trainee therapists to investigate the development of responsiveness skills. Other studies have explored challenges to responsiveness (Stige et al., 2024) or clinicians' responsive stance in specific disorders such as depression (Pellens et al., 2025), but they do not provide an integrated account of responsiveness and non-responsiveness as experienced by both members of the therapeutic relationship. More broadly, qualitative syntheses and meta-analytic studies on patients' experiences in psychodynamic psychotherapy have underscored the importance of the

therapeutic relationship, mentalizing processes, and insight-driven change in patients' subjective accounts of treatment (Barrett et al., 2026).

Focusing specifically on psychodynamic treatments for personality disorders, the present study aims to deepen our understanding of how therapist responsiveness — and its failures — are experienced in this clinically complex context. Building on the assumption that responsiveness is a co-constructed feature of the clinical process (Aafjes-van Doorn et al., 2022), the research examines therapists' and patients' subjective experiences of responsiveness and non-responsiveness, treating their accounts as complementary perspectives on shared relational processes, without assuming access to matched dyadic data. In this vein, two thematic analyses were conducted with the following objectives:

(a) to identify themes and potential subthemes characterizing moments of therapist responsiveness from both patient and therapist perspectives;
(b) to identify themes and potential subthemes characterizing moments of therapist non-responsiveness from both patient and therapist perspectives.

Method

Participant sampling

Several psychotherapy associations specializing in the psychodynamic treatment of personality disorders in Genoa, Milan, and Rome were contacted via email to recruit the sample. Therapists were asked to select one patient who met the following inclusion and exclusion criteria: (1) being at least 18 years old; (2) having a diagnosis of a personality disorder according to Section II of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association [APA], 2022); (3) not having a diagnosis of a psychotic disorder and not receiving pharmacological treatment for psychotic symptoms; and (4) being engaged in psychotherapy for a minimum of 2 and a maximum of 12 months. This temporal criterion was adopted to maximize the likelihood of obtaining accurate and detailed information about the initial period of treatment, during which the therapeutic relationship is being established, and experiences of responsiveness and non-responsiveness are particularly salient. The lower bound of two months was set to ensure participants had engaged sufficiently with the therapeutic process to provide meaningful accounts, while the upper bound of twelve months was intended to capture the early consolidation phase prior to deeper, long-term work. Each therapist was required to select only one patient to minimize rater-dependent bias. Clinicians also provided information about their patients' characteristics (e.g., gender, age, diagnosis, and other clinical features), about themselves (e.g., professional background, theoretical orientation, and years of clinical experience), and about the ongoing psychotherapy (e.g., duration and therapeutic approach). Therapists and their patients participated in the study after providing written informed consent. The research protocol was approved by the Ethics Committee of the Department of XXX, Faculty of XXX, University of XXX (Protocol No. 0000773, dated May 12, 2022).

Therapists

The sample consisted of 54 therapists, comprising 24 males (44.4%) and 30 females (55.6%), with a mean age of 47.41 years ($SD = 11.58$) and an average of 15.49 years of clinical experience ($SD = 9.86$). Regarding professional background, 51 therapists (94.4%) were licensed psychologists, and 3 (5.6%) were psychiatrists. All clinicians held a psychodynamic theoretical orientation and had completed formal postgraduate training in psychodynamic psychotherapy.

Patients

The sample consisted of 54 patients, comprising 17 males (31.5%) and 37 females (68.5%), with a mean age of 37.35 years ($SD = 12.36$). The average treatment duration at the time of data collection was 9.36 months ($SD = 6.84$). Patients received the following personality disorder diagnoses: paranoid personality disorder ($N = 1$, 1.9%), borderline personality disorder ($N = 10$, 18.5%), histrionic personality disorder ($N = 7$, 13.0%), narcissistic personality disorder ($N = 10$, 18.5%), avoidant personality disorder ($N = 4$, 7.4%), dependent personality disorder ($N = 10$, 18.5%), obsessive-compulsive personality disorder ($N = 4$, 7.4%), other specified personality disorder ($N = 4$, 7.4%), and unspecified personality disorder ($N = 4$, 7.4%). In addition to DSM-5-TR categorical diagnoses, clinicians characterized each patient's level of personality organization according to Kernberg's (1984) model, as elaborated within the PDM-3 framework (Lingiardi & McWilliams, 2025). The majority of patients presented with a neurotic level of personality organization ($N = 33$, 61.1%), followed by a borderline level ($N = 20$, 37.0%), and one patient with a psychotic level of organization ($N = 1$, 1.9%).

Data collection and material

Data were collected through two separate online surveys, one administered to therapists and the other administered to patients. The use of online surveys within a qualitative research design enabled participants to report their subjective

experiences in a comfortable, relatively anonymous setting, thereby potentially reducing social desirability bias (Braun et al., 2021). Each survey included two open-ended questions designed to explore participants' subjective experiences of therapist responsiveness and non-responsiveness. Specifically, therapists were asked to describe a moment in one of their recent sessions in which they responded promptly, flexibly, and sensitively to the patient's needs or requests, and a moment in which they did not. Similarly, patients were asked to recall comparable experiences from their own perspective. All survey questions, in both Italian and English translation, are reported in Supplementary Material S1 (Appendix A).

Data analysis

Data were analyzed using Thematic Analysis (TA) within a (critically) realistic framework (Braun & Clarke, 2006, 2019; Clarke & Braun, 2018). Unlike constructionist frameworks, this approach primarily employs an inductive and descriptive methodology, staying close to the data and its explicit content rather than being guided by prior theoretical assumptions or seeking latent meanings. Nevertheless, the analytic process was inevitably informed by familiarity with the contemporary literature on therapist responsiveness and psychotherapy process, rendering the analysis at least partially deductive (see also the following paragraph on Reflexivity).

Two separate thematic analyses were conducted: one focusing on narratives of therapist responsiveness and the other on narratives of therapist non-responsiveness. The analysis followed the six-phase procedure outlined by Braun and Clarke (2006):

(1) *Familiarization with the data*. Two coders independently read participants' responses multiple times to become familiar with the dataset, excluding missing or unclear answers and identifying preliminary patterns of meaning.
(2) *Generation of semantic codes*. The coders independently generated semantic codes (i.e., "blocks" that can be sorted into themes) for each answer, reflecting an idea associated with a segment of data. Approximately fifteen responses were jointly examined to establish shared coding criteria.
(3) *Development of potential themes.* Codes were compared, discussed, and refined, and subsequently organized into candidate themes, defined as "patterns of shared meaning underpinned by a central organizing concept."
(4) *Review of candidate themes*. Candidate themes were evaluated across the entire dataset to assess their coherence and relevance to the research questions. Themes were refined, merged, newly generated, or discarded as necessary.
(5) *Review and refinement of themes*. Themes were repeatedly reviewed to ensure a good fit with the data and to reach agreement on the final set that effectively captured both therapist responsiveness and non-responsiveness. This process included consultation with a supervisor with a cognitive-behavioral orientation, which helped ensure that interpretations remained grounded in the data rather than shaped solely by psychodynamic presuppositions. The 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.

Frequency counts for each theme and subtheme are reported in Tables 1 and 2; they were examined to further illuminate convergences and divergences between therapist and patient perspectives. They carry no inferential or quantitative implications and are not intended to establish a hierarchy of theoretical or clinical relevance, nor to privilege certain experiences over others. Similarly, the presentation of themes in order of frequency reflects a purely descriptive organizational choice. The consensus process between the two coders involved independent coding followed by collaborative discussion and negotiation of disagreements—consistent with qualitative approaches to trustworthiness (Williams & Morrow, 2009)—rather than the calculation of formal inter-rater reliability coefficients, which would be inconsistent with the epistemological assumptions of critically realistic thematic analysis (Braun & Clarke, 2006, 2019).

Themes were constructed by integrating therapists' and patients' narratives rather than by participant role, in order to capture shared patterns of meaning that cut across both perspectives in psychodynamic treatment. This analytic choice reflects a theoretical and clinical framework in which both responsiveness and non-responsiveness are understood as emerging from the relational dynamics shared by therapist and patient within the therapeutic context. It bears noting that this approach differs from dyadic analysis in the strict methodological sense: therapist and patient accounts were not analyzed as matched pairs describing the same clinical moment, but rather as complementary perspectives contributed by both members of the therapeutic relationship. Given the inherently subjective nature of responsiveness, therapists and patients do not always converge in their accounts

Table 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
Subjective Experience of Deep Attunement and Trust in the Therapist	7	/
Setting Flexibility	4	3
Insight Promotion	16	38
Understanding of One's Own Functioning and/or Past-Present Connections	11	28
Acquisition of New Perspectives	4	3
Meta-Communication on the Psychotherapy Process and/or the Therapeutic Relationship	1	6

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 2 Themes, subthemes, and frequencies of thematic analysis on therapist non-responsiveness

Therapist non-responsiveness	Patients (*N*)	Therapists (*N*)
Failure to Report the Lack of Therapist Responsiveness	31	4
No Occurrence of the Therapist Being Non-Responsive	24	4
Minimize Therapist's Non-Responsive Behaviors	7	/
Struggle to Engage with the Patient	/	29
Therapist Perception of Inefficacy or Helplessness	/	18
Difficulties in Addressing Meaningful Subjects During Sessions	/	11
Attunement challenges	15	4
Perspectives on the Psychotherapy Process	9	8
Misalignments in Expectations and Shared Understanding of Treatment	6	4
Unrealistic Expectations	3	3
Therapist Interventions	8	8
Judgmental, Premature, or Intrusive Interventions	3	7
Detached or Rigid Interventions	5	1

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

of responsive or non-responsive moments, a finding that reflects the intersubjective complexity of this dimension.

To enhance the trustworthiness of the analysis, illustrative quotations were translated from Italian into English by a bilingual member of the research team and subsequently reviewed by a native English speaker to ensure linguistic accuracy and fidelity to the original meaning of participants' accounts.

Reflexivity

Reflexivity involves recognizing the influence of researchers' characteristics, professional backgrounds, and subjective positions on the TA procedure. Establishing reflexivity is a central component of qualitative research, as "meaning is not fixed within data" (Braun & Clarke, 2019, p. 2) but is actively constructed through interpretation. Throughout the study, all members of the research team engaged in ongoing reflexive dialogue regarding their assumptions and interpretative choices.

The two coders shared a psychodynamic theoretical orientation, which inevitably shaped their sensitivity to certain themes and processes in the data — including countertransference dynamics, rupture and repair processes, and insight-oriented moments — and may have predisposed them to organizing experiences of responsiveness and non-responsiveness within a relational and intersubjective framework. To counterbalance this potential interpretive bias, the analytic process included consultation with an external clinician with a cognitive-behavioral orientation, whose perspective helped interrogate psychodynamic presuppositions embedded in the emerging themes and ensure that the thematic structure remained grounded in participants' accounts rather than shaped by theoretical assumptions. This cross-orientation consultative dialogue contributed to a more critically informed and reflexive analytic process.

The research team also remained attentive to interpretative challenges inherent in analyzing narratives from both members of the therapeutic dyad, such as power asymmetries, differences in access to clinical information, and the non-equivalent narrative positions of therapists and patients. These issues were continuously discussed within the research group and addressed through supervisory consultation.

Results

Two separate thematic analyses were conducted. The first focused on narratives describing moments of therapist responsiveness during psychotherapy, as reported by both patients and therapists. The second examined descriptions of moments of therapist non-responsiveness provided by the members of the same therapeutic dyads.

Therapist responsiveness

The first thematic analysis identified two overarching themes (see Table 1):

(1) *Attunement*, *Closeness*, *and Support*, comprising four subthemes (*Perception of Empathy*, *Understanding*, *and Emotional Containment*; *Support*, *Validation*, *and Focus on Resources*; *Subjective Experience of Deep Attunement and Trust in the Therapist*; *Setting Flexibility*);
(2) *Insight Promotion*, including three subthemes (*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*).

Themes and subthemes are presented below in order of frequency.

Attunement, closeness, and support

Perception of Empathy, Understanding, and Emotional Containment This subtheme was identified in the responses of 22 patients and 12 therapists. Many patients reported that therapist responsiveness was closely associated with feeling deeply heard, accepted, and understood during psychotherapy sessions, without fear of judgment. Several accounts highlighted the emotional quality of these moments, often linked to therapist interventions that fostered heightened awareness and affective processing (see also the theme *Insight Promotion*).

The interpersonal dimension of responsiveness was emphasized as a prerequisite for experiencing moments of attunement and mirroring within the therapeutic relationship. One patient described:

> In the last few sessions, something happened that had never happened to me before. Suddenly, during the session, tears began to run down my face. I don't really understand why. I do know that I start crying seemingly for no reason. This surprises me because it never happened in my previous therapy experiences […] In response to my request to understand what was happening, I felt that he responded with a closeness and availability that was neither anxious nor tense. He listened to me, gave me time, and, above all, welcomed my fear of what was happening.

Another patient underscored the importance of the therapist's empathic stance toward emotionally sensitive issues: "My psychotherapist quickly understood my thoughts about the possibility of becoming a mother. With great delicacy and tact, he explored the topic with me, helping me put into words the emotions and feelings I was experiencing."

From the therapists' perspective, responsiveness was also associated with helping patients share and process painful emotions, thereby reducing anxiety or emotional overload: "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 profound anguish eased his pain."

Support, Validation, and Focus on Resources This subtheme was identified in the narratives of 8 patients and 11 therapists. Therapists described responsive moments as those in which they explicitly acknowledged patients' strengths, capacities, and progress achieved during treatment. One clinician reported:

> The moment when, in the last session, the patient spoke of her difficulty changing some patterns she has now become aware of, and I tried to show her that, while she still faces some difficulties, her responses and patterns 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 by giving an answer as she used to be and is more able to make her voice heard.

Some patients described these interventions as particularly effective when delivered during moments of vulnerability or distress. When offered at the right time, explicit 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. One patient noted:

> My mother asked to come and visit me at my new place, where I now live on my own. 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, he was very clear in stating that it was not appropriate for my mother to visit me, which gave me the opportunity to say no.

Subjective Experience of Deep Attunement and Trust in the Therapist This subtheme emerged exclusively in the responses of 7 patients. Therapist responsiveness was described as the experience of being completely understood and of developing profound trust in the clinician's capacity to respond appropriately to one's needs. In these narratives, therapists were perceived as consistently attuned and able to anticipate patients' internal experiences. One patient expressed this sentiment, stating: "[…] my therapist knows me, knows who I am, understands how my mind works, can anticipate my thoughts, and immediately grasps how I feel when I express a fear or show vulnerability."

Setting Flexibility This subtheme was identified in the responses of 4 patients and 3 therapists. Responsiveness was associated with therapists' flexibility regarding setting-related rules, particularly when such flexibility was perceived as responsive to patients' emotional or practical needs. One therapist described adjusting session scheduling to accommodate a patient's work constraints:

> 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 were beyond her control. By asking her to describe her work situation, I was able to verify that she received her new work shifts on a monthly basis. I thus reassured her that we would always find a suitable time for her sessions and schedule them in advance.

Patients also valued therapists' availability outside standard session formats, such as through brief contacts or additional sessions during periods of heightened vulnerability:

> During the Christmas holidays, I needed to request an unscheduled session because I felt the need to talk about something that was troubling me emotionally. An appointment was promptly arranged, which helped me a great deal, as I had been keeping everything to myself for a long time, and it was taking a real mental toll.

Insight promotion

Understanding of One's Own Functioning and/or Past-Present Connections This subtheme was identified in the responses of 11 patients and 28 therapists and was the most frequently reported within the *Insight Promotion* theme. Therapist responsiveness was associated — from both clinicians' and patients' perspectives — with increased patient awareness of psychological functioning and with the ability to link present experiences to past relational patterns. These moments emerged from free associations or followed therapist interventions that allowed patients to discover new aspects of themselves, including recognizing personal needs, identifying and expressing emotions, addressing interpersonal problems, and reflecting on their attitudes and behaviors. One patient reported: "I was recounting a frustrating episode, and my therapist picked up on my emotions and pointed out that beneath the frustration, there was anger; this helped me better understand what I was actually experiencing."

Therapists described these moments as emotionally intense and meaningful, frequently accompanied by patients' expressions of relief or surprise:

> Free-associating spontaneously, and in apparent contrast to the cheerful mood she had arrived with, the patient began to talk about her relationship with her mother, visibly 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.

In other cases, therapists observed that identifying meaningful internal connections helped regulate patients' distress:

> The patient was stuck in obsessive ruminations and argumentative tangents. He calmed down when we focused on a similarity between his father's and mother's approaches to life's problems—two internalized models that still seem to be in conflict as he tries to reconcile them. In general, when he is in a state of confusion, identifying meaningful connections between different aspects helps him feel relieved, and he appears to benefit from this process.

Acquisition of New Perspectives This subtheme emerged in the responses of 4 patients and 3 therapists. Responsiveness was linked to interventions that enabled patients to reconsider their interpretations or adopt alternative viewpoints. The use of metaphors was explicitly mentioned as a means that facilitated this process. One patient stated:

> […] Generally, he lets me talk and listens to my concerns, then very gently finds the right moment to step in and, with just the right words, says something that manages to both reassure me and broaden my perspective. He often uses a metaphor, borrowing my words or the themes I put forward, and what he says opens up my perspective in ways I hadn't considered.

Meta-Communication on the Psychotherapy Process and/or the Therapeutic Relationship This subtheme was identified in the narratives of 1 patient and 6 therapists. Clinicians described moments of responsiveness when they explicitly addressed the psychotherapy process itself, particularly around emotionally charged transitions such as holiday breaks. One therapist reported:

> We are approaching the 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 (who has a severe alcohol addiction and refuses treatment), and 'who knows what might happen before we see each other again.' I tell him he fears losing me, too, since anything can happen. He becomes emotional and tells me that we need to put everything in order before the new year.

Other clinicians described meta-communication as facilitating the expression of ambivalent or painful emotions related to treatment continuity:

> The patient expressed her misgivings and criticisms about the therapy, fearing that doing so might lead her to discontinue it. Instead, it became an opportunity to share angry, defiant, and long-hidden thoughts — allowing her to feel ready to acknowledge even the more destructive parts of herself that she had been afraid to face.

Therapist non-responsiveness

The second thematic analysis identified five main themes describing moments of therapist non-responsiveness provided by both patients and therapists (see Table 2):

(1) *Failure to Report the Lack of Therapist Responsiveness*, comprising two subthemes *(No Occurrence of the Therapist Being Non-Responsive; Minimize Therapist Non-Responsive Behaviors)*;
(2) *Struggle to Engage with the Patient*, including two subthemes (*Difficulties In Addressing Meaningful Subjects During Sessions*; *Therapist Perception of Inefficacy or Helplessness*);
(3) *Attunement Challenges;*
(4) *Perspectives on the Psychotherapy Process*, including two subthemes (*Unrealistic Expectations*; *Misalignments in Expectations and Shared Understanding of Treatment*);
(5) *Therapist Interventions*, comprising two subthemes (*Judgmental*, *Premature*, *or Intrusive Interventions*; *Detached or Rigid Interventions*).

Failure to report the lack of therapist responsiveness

No Occurrence of the Therapist Being Non-Responsive This sub-theme emerged in the responses of 24 patients and 4 therapists. Many participants reported not having experienced moments of therapist non-responsiveness, stating explicitly: "I have never found myself in the situation described."

Some patients suggested that such moments might have led to treatment discontinuation, while others minimized or dismissed what they described as minor disagreements. A patient expressed this feeling, reporting: "There are no such episodes; at most, some misunderstandings about things I did not fully agree with."

Minimize Therapist Non-Responsive Behaviors This subtheme was identified in the narratives of 7 patients. Some of them perceived and acknowledged therapist non-responsiveness but subsequently 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."

Other patients attributed misunderstandings or a lack of attunement during sessions to themselves, as follows:

> I can't think of any specific moments. In general, my therapist has often said things that bothered me; however, that was only because they touched on the way I see myself — a self-image I struggle to let go of — not because what was said was invalid in itself.

Struggle to engage with the patient

Therapist Perception of Inefficacy or Helplessness This subtheme emerged exclusively in the narratives of 18 therapists. Clinicians described difficulty maintaining responsiveness when experiencing feelings of inefficacy, frustration, or emotional entanglement. They acknowledged the risk of being inadvertently drawn into the patient's emotional state, which could hinder progress and impede the exploration of relevant subjects during sessions. One therapist expressed this issue, stating: "Sometimes, the patient arrives with such a pervasive sense of inadequacy about herself and her relationships that it becomes difficult to maintain an open, receptive listening stance without feeling frustration and sadness."

Some therapists felt inadequate when addressing themes that evoked personal sensitivity or misunderstandings within the therapeutic relationship: *"*Due to a misunderstanding about the session time, I perceived a deep discomfort in the patient that I was unable to address with her.*"*

Difficulties in Addressing Meaningful Subjects During Sessions This subtheme was reported in the narratives of 11 therapists and described challenges in engaging patients who predominantly focused on concrete details, thus hindering access to their emotional states. Many therapists observed that patients tended to report repetitive details and offered rational explanations for their affective problems. One therapist described this pattern, saying: "[…] the patient retreats and immerses himself in his children's problems, obsessively describing, in minute detail, phone calls and messages between them and their mother, between him and them."

Therapists reported feelings of frustration and helplessness and described difficulty maintaining emotional and attentional involvement during sessions. This disengagement was closely related to the reduced capacity to create sufficient space for processing painful emotions and anxieties within the therapeutic process. One clinician, reflecting on this difficulty, noted: "These are the moments when I fail to engage and involve the patient, feeling confused and dazed by obsessive, verbose, pedantic, and hypnotic rambling that leaves the patient helpless and unable to express herself."

Attunement challenges

This subtheme was identified in the responses of 15 patients and 4 therapists. Patients described moments of therapist non-responsiveness characterized by experiences of discomfort, perceived judgment, and feeling unheard, which were associated with the sense that their concerns were not adequately recognized or understood. Several patients reported that, at times, therapists appeared to underestimate the severity of their difficulties or provided responses that shifted attention away from issues experienced as central, thereby contributing to feelings of invalidation. One patient illustrated this experience, stating:

> It happened that I did not feel understood when I was talking about a physical problem or concerns related to physical symptoms, and my therapist kept trying to redirect the conversation to something else; I felt belittled, as though my pain was not being acknowledged.

Additionally, patients reported a sense of emotional disconnection from their therapists when they perceived them as rigid, distant, or judgmental toward themselves or significant others, which further intensified feelings of being unseen and unheard. For example, one patient noted: "There was a time when we were talking about my mother, and I sensed a kind of 'judgment' that the therapist was expressing toward my mother, which bothered me."

From the therapists' perspective, moments of non-responsiveness were also acknowledged, particularly when they found it difficult to empathize with the patient's internal experience. One therapist reflected on such an instance, stating: "During one session, the patient discussed her ambivalence about motherhood; on that occasion, she probably did not feel sufficiently held by me."

Perspectives on the psychotherapy process

Misalignments in Expectations and Shared Understanding of Treatment This subtheme was identified in the responses of 6 patients and 4 therapists. Experiences of therapist non-responsiveness were often linked to misalignments between patients' and therapists' views of the psychotherapy process, including treatment goals, priorities, and modalities (i.e., treatment model and therapeutic approach). Such discrepancies could give rise to misunderstandings, particularly when patients perceive that their expectations or immediate needs are not adequately acknowledged, thereby fostering feelings of being misunderstood or insufficiently supported. Specific aspects of treatment organization, such as managing breaks and vacations, emerged as salient sources of tension. For example, one patient described feeling disregarded when the therapist's suggestion did not adequately consider her current emotional resources: "My therapist's suggestion to schedule vacations with my family while arranging for a

caregiver to look after my mother seemed to overlook my current inability to handle this situation."

More broadly, patients reported feeling misaligned with the focus of sessions, particularly when topics they perceived as emotionally urgent were not addressed. This lack of convergence on what to prioritize during the session sometimes led to confusion and dissatisfaction. One patient articulated this experience as follows: "Sometimes I left the session feeling confused, having not addressed something that felt important to me at that moment, and instead having spent the time on something unrelated to what was causing me anxiety."

Unrealistic Expectations This subtheme was identified in the responses of 3 therapists and 3 patients. Therapists described difficulties in maintaining responsiveness when patients held unrealistic expectations about the therapeutic process or the therapist's role. In particular, some patients expected rapid symptom relief without active personal involvement, which clinicians experienced as challenging to address within a psychodynamic framework. As one therapist noted: "The patient would like me to be able to relieve her of anxiety symptoms without her having to play any active role."

From the patients' perspective, unrealistic expectations sometimes involved anticipating constant agreement, validation, or emotional mirroring from the therapist. When such expectations were not met, patients reported experiences of disappointment or frustration, which could be interpreted as a lack of therapist responsiveness. One patient reflected on this dynamic, stating:

> […] this "provocative" approach of the therapy sometimes leads to certain statements by my psychotherapist with which I simply do not agree; I have always been open about my disagreement, and at those moments, my therapist, by reframing and clarifying what she had said, would bring the discussion back on track.

Overall, it should be noted that "unrealistic expectations" functions here as an interpretive category: the expectations described in this subtheme were not recognized as unrealistic by participants themselves, but rather appeared incompatible with the psychodynamic treatment frame (e.g., rapid symptom relief without active personal involvement, or anticipation of continuous agreement and validation from the therapist).

Therapist interventions

Judgmental, premature, or intrusive interventions

This subtheme was identified in the narratives of 3 patients and 7 therapists. Therapist non-responsiveness was sometimes attributed to interventions perceived as poorly timed, overly directive, or insufficiently attuned to the patient's readiness. In such cases, attempts to explore sensitive material or establish links between past and present experiences were experienced as intrusive or judgmental, eliciting discomfort and resistance. Therapists themselves acknowledged moments in which their interventions may have been premature. One clinician reflected: "The patient spoke at length about her daily work, describing workplace conflicts among colleagues. I may have drawn a connection between her experience and other areas of her relational life too abruptly."

Similarly, patients reported feeling pressured when therapists introduced themes or suggestions that did not resonate with their current concerns. As one patient stated:

> I do not perceive the therapist as responsive when he encourages me to seek or think about a romantic partner, as at this point in my life, I do not feel this need — except perhaps as a way of avoiding future loneliness.

In addition, some patients described rejecting practical advice or suggestions, perceiving them as inconsistent with their expectations of the therapeutic role or disconnected from their emotional experience.

Detached or rigid interventions

This subtheme was identified in the responses of 5 patients and 1 therapist. Participants described therapist interventions perceived as emotionally detached or excessively rigid, which were experienced as lacking responsiveness to the patient's subjective state. Such interventions were often described as technically correct but insufficiently attuned, leaving patients feeling emotionally unsupported. For instance, one patient reported: "In the face of my discouragement, he behaved in a cold, detached manner that may have made therapeutic sense, but it deeply affected me."

Additional examples included prolonged silences or distant responses during moments of heightened vulnerability, as well as rigid interpretations that failed to acknowledge the patient's lived experience of distress.

Therapists also recognized that inflexible adherence to contractual or setting-related rules could be perceived as non-responsive. One clinician reflected on such an instance:

When presenting him with the invoice, the patient realized that I had also charged for two sessions he had missed without notice. I reminded him of the initial agreement, perhaps somewhat abruptly, because I did not expect him to have forgotten it. He asked me to reconsider, saying he had never failed to notify me in advance. I maintained my position rather rigidly.

Discussion

The present study aimed to explore the core aspects of therapist responsiveness and non-responsiveness in psychodynamic treatments of patients with personality disorder diagnoses by analyzing narratives from both therapists and patients. Overall, the findings suggest that responsiveness is characterized by the clinician's capacity to make patients feel heard and deeply understood, while providing opportunities for developing insight and self-awareness. In contrast, non-responsiveness was associated with therapists' perceived inefficacy, misattunement, difficulties in managing countertransference, and misalignments in expectations and shared understandings of the treatment.

The first thematic analysis focusing on moments of therapist responsiveness identified two main themes: *Attunement*, *Closeness*, *and Support* and *Insight Promotion*. Together, they map closely onto central psychodynamic dimensions of clinical work with personality disorders (Fiorentino et al., 2024; Kramer, 2021; Lingiardi et al., 2011). Patients' experiences of feeling listened to, mirrored, and emotionally held point to the successful creation of a holding environment, allowing intense affect and vulnerable self-states to be experienced without fragmentation or distortion (Tishby, 2021). At the same time, therapists' emphasis on helping patients link past and present relational patterns and experiences, develop new perspectives, and engage in meta-communication reflects psychodynamic attention to transference, internal object relations, and insight-oriented interventions (De Smet et al., 2020; Hilsenroth et al., 2005; Tanzilli et al., 2018). In this vein, the themes capture both the emotional (attunement) and cognitive (insight) dimensions of the psychotherapy process, underscoring the importance of these components in shaping patients' perceptions of responsiveness (McCarthy et al., 2017; Snyder & Silberschatz, 2017). These results resonate with Ladmanová et al.'s (2022) qualitative meta-analysis of positive events in psychotherapy, which highlighted the centrality of the therapeutic relationship and patient self-development.

Within the first theme, the subtheme *Perception of Empathy*, *Understanding*, *and Emotional Containment* was particularly prevalent among patients, highlighting the importance of therapists' sensitivity, non-judgmental stance, and attunement to patients' emotional states. These interpersonal capacities overlap with constructs such as empathy, positive regard, and genuineness (cf. Norcross & Lambert, 2019), which have consistently been associated with therapeutic alliance and outcome (Cuijpers et al., 2019). The subtheme *Support*, *Validation*, *and Focus on Resources* underscored the importance of emphasizing patients' strengths and improvements during treatment, rather than focusing solely on difficulties (Lingiardi & McWilliams, 2025). Moreover, it highlighted the value of integrating supportive interventions even within psychodynamic treatment frameworks that have traditionally prioritized expressive techniques such as transference interpretation (Hilsenroth et al., 2005). Taken together, these findings suggest that responsiveness often entails a flexible integration of supportive and expressive interventions, tailored to patients' moment-to-moment needs (Gabbard & Crisp, 2023; Owen & Hilsenroth, 2014), particularly in the treatment of personality pathology (Fiorentino et al., 2024; Lingiardi et al., 2011). Crucially, however, supportive interventions per se should not be conflated with therapist responsiveness. What makes an intervention responsive is not its supportive tone or content in itself, but the extent to which it is contingently attuned to the patient's current affective state, relational needs, and the unfolding clinical moment (Hatcher, 2015; Kramer & Stiles, 2015). Finally, the subtheme *Subjective Experience of Deep Attunement and Trust in the Therapist* described patients' attributions of extremely positive qualities and capacities to their clinicians, along with a subjective sense of being deeply understood. This dynamic can potentially enhance patients' engagement in the treatment process but may also generate unrealistic expectations, requiring careful navigation of transference dynamics (Constantino et al., 2012; De Smet et al., 2020). From a psychodynamic perspective, these experiences are better understood as idealizing transferences and fantasies of perfect mutuality rather than as literal clinical aims of 'complete understanding'.

The second core theme, *Insight Promotion*, was particularly prominent in clinicians and further supports the relevance of insight in psychodynamic psychotherapy (Jennissen et al., 2018). Therapists frequently associated their responsiveness with moments in which patients achieved greater self-understanding, connected present experiences with past relational patterns, or developed new perspectives (De Smet et al., 2020). This result aligns with Fiorentino and colleagues (2024), who observed that therapists perceive themselves as more responsive and helpful during sessions characterized by greater depth of elaboration and the exploration of meaningful topics, such as deep conflicts, significant interpersonal difficulties, or intense distress, consistent with psychodynamic goals of understanding intrapsychic processes. These findings are also consistent with Barrett

et al.'s (2026) systematic review and meta-aggregation of patient experiences in long-term psychodynamic psychotherapy, which identified gaining new perspectives as a key treatment outcome — described by patients as a transformative process of challenging ingrained assumptions and developing greater self-understanding and relational flexibility. The convergence between that review and the present results suggests that insight-driven change and the acquisition of new perspectives represent core experiential dimensions of psychodynamic treatment, as perceived by both patients and therapists across different clinical contexts.

In contrast, the thematic analysis of therapist non-responsiveness revealed a more heterogeneous picture, consistent with prior literature on negative or hindering events in psychotherapy (Burton & Thériault, 2020). Within a psychodynamic framework, themes such as *Struggle to Engage with the Patient*, *Attunement Challenges*, and *Therapist Interventions* (especially *Detached or Rigid Interventions*) suggest that therapists' technical stance, defensive reactions, or negative countertransference limit the capacity for evenly hovering attention and flexible engagement with the patient. Clinicians' feelings of helplessness, frustration, boredom, or confusion may signal unrecognized enactments in the transference–countertransference matrix (Fiorentino et al., 2024), while patients' experiences of feeling unheard, judged, or dismissed indicate ruptures in the holding function of the relationship (Safran & Muran, 2000). Overall, within psychodynamic work with personality disorders, these findings highlight the importance of training therapists to recognize and work through such non-responsive moments as potential opportunities for transformation rather than as failures.

Notably, the high prevalence of the theme *Failure to Report the Lack of Therapist Responsiveness*, especially among patients, suggests that non-responsive moments may often remain implicit or unspoken (Henkelman & Paulson, 2006; Kramer & Stiles, 2015; Stiles et al., 1998). It should be noted that this pattern characterized fewer than half of the patient sample ($N=24$, 44.4%), while the majority of patients ($N=30$, 55.6%) did report some form of non-responsiveness across the remaining themes. However, this tendency supports prior observations that patients may avoid reporting hindering events due to a deferential attitude toward their therapists (i.e., being acquiescent, not expressing their own opinion), self-censorship, or reluctance to confront difficulties (Henkelman & Paulson, 2006; Vybíral et al., 2024), potentially impacting the therapeutic process (e.g., Ladmanová et al., 2022). Beyond these well-documented dynamics, the absence of reported non-responsiveness among some patients may also reflect social desirability bias inherent in written survey formats, fear of destabilizing the therapeutic bond, or idealizing relational dynamics — particularly relevant in patients with personality disorders, for whom idealization of the therapist may represent a characteristic transference configuration (Kernberg, 1984; Lingiardi & McWilliams, 2025). Equally, it cannot be excluded that some patients genuinely did not experience significant moments of non-responsiveness during the observed treatment period, which covered the initial phases of therapy (2 – 12 months). The related subtheme, *Minimize Therapist Non-Responsive Behaviors*, reflects situations in which patients tend to downplay the significance of therapist non-responsiveness or attribute these difficulties to themselves rather than to the therapeutic interaction (Vybíral et al., 2024). From a clinical perspective, these instances of non-responsiveness may indicate a rupture in the therapeutic relationship (Levy Chajmovic & Tishby, 2025). Attending to and acknowledging these events is therefore essential to engage both therapist and patient in a deliberate, collaborative repair process (Muran et al., 2021). When explicitly addressed, these moments can provide the patient with "a new relational or corrective experience" (Muran et al., 2021, p. 364), allowing maladaptive representations of oneself, the other, and oneself-with-the-other to be revised in vivo within the therapeutic dyad, with potential benefits for both the therapeutic course and outcome of treatment (Safran & Muran, 2000; Tishby, 2021).

The theme *Struggle to Engage with the Patient* emerged as a prominent theme among therapists, reflecting how feelings of helplessness, frustration, inadequacy, and boredom can compromise responsiveness (Stige et al., 2024). Previous research has shown that strong emotional responses in clinicians (or countertransference) can hinder their ability to be empathetic and provide timely interventions, potentially impacting session quality (Fiorentino et al., 2024; Fiorini Bincoletto et al., 2025; Norcross & Lambert, 2019). Patients with personality disorders tend to evoke in their therapists reactions that are particularly difficult to manage, challenging the psychotherapy process and highlighting the importance of supervision and self-reflection (e.g., Tanzilli et al., 2016). Clinicians' awareness of their contribution to these non-responsive moments is crucial, as such moments offer valuable opportunities for growth within psychodynamic practice (Levy Chajmovic & Tishby, 2025; Stige et al., 2024; Wu & Levitt, 2022).

The theme *Perspectives on the Psychotherapy Process* indicated that perceived non-responsiveness may arise from misalignments between patients' and therapists' expectations and understandings of the treatment. In particular, the subtheme *Misalignments in Expectations and Shared Understanding of Treatment* further supported the close link between therapist responsiveness and the quality of the therapeutic alliance, including a shared sense of what is being worked on, how it is being addressed, and the perceived bond between patient and therapist (Culina et al., 2023;

Elkin et al., 2014; Hatcher, 2021), especially in the clinical treatment of patients with personality disorders (Fiorentino et al., 2024; Kramer, 2021). Along with the subtheme *Unrealistic Expectations*, these findings suggest that explicitly discussing and negotiating priorities and realistic directions for the work can foster responsiveness and positive treatment outcomes (Slade, 2017), whereas unmet expectations and persistent misunderstandings about the treatment process may exacerbate relational ruptures (Constantino et al., 2012).

Finally, the theme *Therapist Interventions* highlighted the nuanced ways non-responsiveness may manifest in psychodynamic treatment: patients perceived detached or rigid interventions (e.g., silence, aloofness) as non-responsive, while therapists noted intrusiveness or premature interpretations as markers of their own non-responsiveness. Notably, these findings reveal a discrepancy between patients' and therapists' perspectives. This divergence underscores the importance of ongoing reflection, attunement to transference cues, and modulation of interventions in relation to patient characteristics—core competencies in psychodynamic training and supervision (Heinonen & Nissen-Lie, 2020). To further clarify the distinction between responsive and non-responsive therapist behaviours—especially in relation to silence and apparent non-intervention—we provide a brief clinical vignette in the supplementary materials (Supplementary Material S2). This example illustrates how a moment that could at first glance be described as "non-responsiveness" may, in context, function as an attuned and elaborated clinical response.

Taken together, the present findings contribute to a growing body of qualitative research on psychodynamic psychotherapy that foregrounds the subjective experience of both patients and clinicians as a central source of knowledge about therapeutic processes. Our results extend recent systematic syntheses in this area — notably Barrett et al.'s (2026) meta-aggregation of patient experiences in long-term psychodynamic psychotherapy, which highlighted the central role of trust-building, mentalizing, and insight-driven change — by providing a focused account of how responsiveness and non-responsiveness are experienced in the psychodynamic treatment of patients with personality disorders. Convergence with qualitative syntheses focusing on younger populations (Fiorini et al., 2024) further suggests that core experiential dimensions of psychodynamic treatment — including the centrality of the therapeutic relationship and the challenges of engaging with the process — may transcend age and clinical context (e.g., Tanzilli et al., 2021). By integrating complementary therapist and patient perspectives on a clinically complex population, the present study offers a more differentiated account of the relational and technical dimensions that shape — or hinder — the unfolding of psychodynamic work.

Limitations and future directions

The present study has some limitations that should be considered when interpreting the findings. First, therapist responsiveness and non-responsiveness were examined using online surveys with open-ended questions rather than full qualitative interviews. Online qualitative surveys can offer important advantages for qualitative research, including flexibility, reach, and the ability to gather rich accounts from diverse participants, and have been advocated as a rigorous qualitative method when grounded in carefully designed prompts (Braun et al., 2021; Thomas et al., 2024). At the same time, the use of an online survey format entails specific methodological constraints that warrant explicit acknowledgment. Unlike semi-structured interviews, online surveys do not allow researchers to probe ambiguous responses, follow unexpected threads, or request elaboration on clinically significant moments, and online data collection can be affected by issues such as self-selection and variable response quality (Andrade, 2020; Thomas et al., 2024). These features may have contributed to shorter, less contextualized, or more normative descriptions of complex or emotionally charged experiences. Furthermore, the topics under investigation — especially therapist non-responsiveness — are inherently sensitive and potentially shame-inducing for both clinicians and patients. Even within an anonymous written format that may lessen some inhibitions, participants may still underreport, minimize, or rationalize instances of non-responsiveness, in line with broader concerns about bias and non-representativeness in online survey research (Andrade, 2020; Thomas et al., 2024). Future studies should therefore complement online qualitative surveys with interview-based or observational designs that permit interactive clarification and deeper exploration of these clinically salient phenomena; such designs could build on the methodological guidance now available for enhancing the rigor and richness of qualitative data collection (Braun et al., 2021; Thomas et al., 2024).

Second, the sample consisted of psychodynamic therapists and patients with personality disorder diagnoses, which limits the generalizability of the findings. Future comparative qualitative studies should include clinicians with different theoretical orientations and broader clinical populations. Third, although the sample size was adequate for qualitative thematic analysis, replication with larger populations would strengthen confidence in the findings. Fourth, although clinicians characterized each patient's level of personality organization according to Kernberg's (1984) model and the

PDM-3 framework (Lingiardi & McWilliams, 2025), this information is reported solely to contextualize the sample and deepen its psychodynamic characterization. The skewed distribution of personality organization levels — with a predominance of neurotic cases and a limited borderline subgroup — and the modest overall sample size precluded meaningful subgroup comparisons. Future research should examine how therapist responsiveness and non-responsiveness unfold differentially across patients with varying levels of personality organization and distinct personality styles or types, as conceptualized within the PDM-3 framework. Integrating structural severity and personality functioning with process-level analyses of therapeutic responsiveness could clarify whether specific configurations of personality pathology are associated with particular patterns of responsive and non-responsive moments. Such work would deepen the psychodynamic grounding of responsiveness research and inform more finely tuned clinical interventions.

Finally, the decision to integrate therapists' and patients' narratives within unified themes raises some issues. A joint framework may blur role-specific nuances and understate tensions, contradictions, or power asymmetries across perspectives. Therapists and patients occupy structurally different positions within the therapeutic relationship, which may lead to divergent constructions of the same clinical moments that a unified thematic structure cannot fully capture. It should be noted, however, that the narratives analyzed here were provided by members of the same therapeutic dyads, which grounds the thematic integration in a shared relational context. Future research could complement this approach by separately analyzing each group or by employing explicitly dyadic analytic methods to more systematically examine convergences and divergences between perspectives.

Implications for clinical training

The present findings carry several implications for clinical training and supervision in psychodynamic psychotherapy. Although responsiveness represents a core clinical capacity, the present research sought to shed light on the patient's perspective and experience, emphasizing the intersubjective nature of this dimension in the clinical exchange between clinicians and patients (Hatcher, 2021; Tishby, 2021). Our findings indicate that a clinician's ability to foster insight, cultivate new perspectives, and demonstrate attunement and empathy was essential to promote responsive moments in psychodynamic psychotherapy. Conversely, moments of therapist non-responsiveness were mostly characterized by therapists' perceptions of being ineffective or helpless in facilitating the processing of patients' affective and relational dynamics, as well as by mismatches in treatment goals and expectations.

Although responsive behaviors and interventions emerge from the clinical context and are unique to each therapeutic dyad, the findings contribute to identifying crucial elements in the narratives of both clinicians and patients, as well as to a better understanding of the processes underlying therapist responsiveness. Although some discrepancies exist between clinicians' and patients' perceptions of responsive and non-responsive moments, the present findings suggest that therapist responsiveness represents a core competency when working with patients with personality disorders. These patients tend to re-enact their dysfunctional interpersonal patterns within the therapeutic relationship (e.g., through transference-countertransference interactions; Tanzilli et al., 2016, 2018), which can hinder their engagement in clinical work. The clinicians' capacity for emotional attunement and interpersonal sensitivity helps these patients feel heard, accepted, and supported while fostering self-knowledge (Culina et al., 2023; Kramer, 2021; Lingiardi et al., 2018). Thus, supervision and training programs within the psychodynamic framework should explicitly help mental health professionals develop responsiveness as a core clinical competency. Clinicians should learn to employ verbal and nonverbal behaviors that deepen attunement with patients, effectively manage their countertransference reactions—particularly when negative—and foster insight through targeted interventions and metacommunication about the therapeutic process. Moreover, within the context of psychodynamic training, clinicians should be supported in identifying, expressing, and working through their own moments of non-responsiveness, addressing feelings of inefficacy, missed attunement, and unresolved personal reactions that may hinder patient engagement. Structured opportunities for clinical discussions of 'failed' sessions may help therapists use these experiences to enhance their responsiveness rather than defensively avoid them. Finally, both training and supervision should emphasize the collaborative negotiation of shared understandings of treatment with patients, particularly when interpersonal impairments and rigid relational patterns are central. Explicitly addressing shared goals and clarifying expectations can reduce the risk of ruptures stemming from non-responsiveness and strengthen the co-construction of the therapeutic alliance.

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Declarations

Ethics approval This study was conducted in accordance with the principles outlined in the Declaration of Helsinki. It was approved by the Ethics Committee of the Department of Dynamic and Clinical Psychology, and Health Studies, Faculty of Medicine and Psychology, "Sapienza" University of Rome, Rome, Italy [Protocol number 000073, date of approval 12/05/2022].

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Declarations The authors declare that the content and ideas presented in the manuscript are original and have been independently generated by the authors.

References

Aafjes-van Doorn, K., Bar-Sella, A., Zilcha-Mano, S., Luo, X., Silberschatz, G., Kealy, D., McCollum, J., & Snyder, J. (2022). Within-patient perceptions of alliance and attunement: Associations with progress in psychotherapy. *Clinical Psychology & Psychotherapy*, *29*(5), 1717–1727. https://doi.org/10.1002/cpp.2737

American Psychiatric Association (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Andrade, C. (2020). The limitations of online surveys. *Indian Journal of Psychological Medicine*, *42*(6), 575–576. https://doi.org/10.1177/0253717620957496

Babl, A., Berger, T., Eubanks, C. F., Gómez Penedo, J. M., Caspar, F., Sachse, R., & Kramer, U. (2022). Addressing interpersonal patterns in patients with personality disorders partially explains psychotherapy outcome via changes in interaction patterns: A mediation analysis. *Psychotherapy Research*, *32*(8), 984–994. https://doi.org/10.1080/10503307.2022.2036383

Barrett, A., Campbell, C., Luyten, P., Fonagy, P., & Moser, M. (2026). Patient experiences of long-term psychodynamic psychotherapy for mood and personality disorders: A systematic review and meta-aggregation of qualitative studies. *Journal of Counseling Psychology*, *73*(1), 101–115. https://doi.org/10.1037/cou0000844

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2021). The online survey as a qualitative research tool. *International Journal of Social Research Methodology*, *24*(6), 641–654. https://doi.org/10.1080/13645579.2020.1805550

Burton, L., & Thériault, A. (2020). Hindering events in psychotherapy: A retrospective account from the client's perspective. *Counselling and Psychotherapy Research*, *20*(1), 116–127. https://doi.org/10.1002/capr.12268

Campbell, L. F., Norcross, J. C., Vasquez, M. J., & Kaslow, N. J. (2013). Recognition of psychotherapy effectiveness: The APA resolution. *Psychotherapy*, *50*(1), 98–101. https://doi.org/10.1037/a0031817

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research*, *18*(2), 107–110. https://doi.org/10.1002/capr.12165

Cologon, J., Schweitzer, R. D., King, R., & Nolte, T. (2017). Therapist reflective functioning, therapist attachment style and therapist effectiveness. *Administration and Policy in Mental Health*, *44*(5), 614–625. https://doi.org/10.1007/s10488-017-0790-5

Constantino, M. J., Ametrano, R. M., & Greenberg, R. P. (2012). Clinician interventions and participant characteristics that foster adaptive patient expectations for psychotherapy and psychotherapeutic change. *Psychotherapy*, *49*(4), 581–588. https://doi.org/10.1037/a0029440

Gabbard, G. O., & Crisp, H. (2023). Techniques of psychodynamic psychotherapy. In H. Crisp, & G. O. Gabbard (Eds.), *Psychotherapeutic treatments* (2nd ed., pp. 41–63). American Psychiatric Association Publishing.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *JAMA Psychiatry*, *74*(4), 319–328. https://doi.org/10.1001/jamapsychiatry.2016.4287

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcomes. *Annual Review of Clinical Psychology*, *15*, 207–231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

Culina, I., Fiscalini, E., Martin-Soelch, C., & Kramer, U. (2023). The first session matters: Therapist responsiveness and the therapeutic alliance in the treatment of Borderline Personality Disorder. *Clinical Psychology & Psychotherapy*, *30*(1), 131–140. https://doi.org/10.1002/cpp.2783

De Smet, M. M., Meganck, R., Truijens, F., De Geest, R., Cornelis, S., Norman, U. A., & Desmet, M. (2020). Change processes underlying good outcome: A qualitative study on recovered and improved patients' experiences in psychotherapy for major depression. *Psychotherapy Research*, *30*(7), 948–964. https://doi.org/10.1080/10503307.2020.1722329

Elkin, I., Falconnier, L., Smith, Y., Canada, K. E., Henderson, E., Brown, E. R., & McKay, B. M. (2014). Therapist responsiveness and patient engagement in therapy. *Psychotherapy Research*, *24*(1), 52–66. https://doi.org/10.1080/10503307.2013.820855

Esposito, G., Cuomo, F., Di Maro, A., & Passeggia, R. (2024). The assessment of therapist responsiveness in psychotherapy research: A systematic review. *Research in Psychotherapy: Psychopathology Process and Outcome*, *27*(2), 751. https://doi.org/10.4081/ripppo.2024.751

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy*, *55*(4), 508–519. https://doi.org/10.1037/pst0000185

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

Fiorini, G., Westlake, M., Chokhani, R., Javed, M., Norcop, H., & Midgley, N. (2024). Children and young people's experience of psychoanalytic psychotherapy: a qualitative meta-synthesis. *Journal of Child Psychotherapy*, *50*(2), 278–305. https://doi.org/10.1080/0075417X.2024.2349225

Fiorini Bincoletto, A. F., Liotti, M., Di Giuseppe, M., Fiorentino, F., Nimbi, F. M., Lingiardi, V., & Tanzilli, A. (2025). The interplay of epistemic trust, defensive mechanisms, interpersonal problems, and symptomatology: An empirical investigation. *Personality and Individual Differences*, *233*, 112893. https://doi.org/10.1016/j.paid.2024.112893

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372–380. https://doi.org/10.1037/a0036505

Hatcher, R. L. (2015). Interpersonal competencies: Responsiveness, technique, and training in psychotherapy. *The American Psychologist*, *70*(8), 747–757. https://doi.org/10.1037/a0039803

Heinonen, E., & Nissen-Lie, H. A. (2020). The professional and personal characteristics of effective psychotherapists: A systematic review. *Psychotherapy Research*, *30*(4), 417–432. https://doi.org/10.1080/10503307.2019.1620366

Henkelman, J., & Paulson, B. (2006). The client as expert: Researching hindering experiences in counselling. *Counselling Psychology Quarterly*, *19*(2), 139–150. https://doi.org/10.1080/09515070600788303

Hilsenroth, M. J., Bonge, D. R., Blagys, M. D., Ackerman, S. J., & Blais, M. A. (2005). Measuring psychodynamic-interpersonal and cognitive-behavioral techniques: Development of the Comparative Psychotherapy Process Scale. *Psychotherapy*, *42*(3), 340–356. https://doi.org/10.1037/0033-3204.42.3.340

Watson, J. C., & Wiseman, H. (Eds.). (2021). *The responsive psychotherapist: Attuning to clients in the moment*. American Psychological Association. https://doi.org/10.1037/0000240-000

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.

Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work: Evidence-based therapist contributions* (3rd ed.). Oxford University Press.

Jennissen, S., Huber, J., Ehrenthal, J. C., Schauenburg, H., & Dinger, U. (2018). Association between insight and outcome of psychotherapy: Systematic review and meta-analysis. *American Journal of Psychiatry*, *175*(10), 961–969. https://doi.org/10.1176/appi.ajp.2018.17080847

Kramer, U. (2021). Therapist responsiveness in treatments for personality disorders. In J. C. Watson & H. Wiseman (Eds.), *The responsive psychotherapist: Attuning to clients in the moment* (pp. 237–255). American Psychological Association. https://doi.org/10.1037/0000240-012

Kramer, U., & Stiles, W. B. (2015). The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychology: Science and Practice*, *22*(3), 277–295. https://doi.org/10.1111/cpsp.12107

Kramer, U., Beuchat, H., Grandjean, L., & Pascual-Leone, A. (2020). How personality disorders change in psychotherapy: A concise review of process. *Current Psychiatry Reports*, *22*(8), 41. https://doi.org/10.1007/s11920-020-01162-3

Ladmanová, M., Řiháček, T., & Timulak, L. (2022). Client-identified impacts of helpful and hindering events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, *32*(6), 723–735. https://doi.org/10.1080/10503307.2021.2003885

Lane, R. C., Koetting, M., & Bishop, J. (2002). Silence as communication in psychodynamic psychotherapy. *Clinical Psychology Review*, *22*(7), 1091–1104. https://doi.org/10.1016/s0272-7358(02)00144-7

Lauritzen, L. R., Jacobsen, F., Nielsen, C., Lunn, J., Mathiesen, S., Falkenström, B. B., F., & Poulsen, S. (2023). Common factors, responsiveness, and outcome in psychotherapy (CROP): Study protocol for a naturalistic prospective cohort study of psychotherapy in Denmark. *British Medical Journal Open*, *13*(6), e072277. https://doi.org/10.1136/bmjopen-2023-072277

Levitt, H. M., & Morrill, Z. (2023). Silences in psychotherapy: An integrative meta-analytic research review. *Psychotherapy, 60*(3), 320–341. https://doi.org/10.1037/pst0000480

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, *142*(8), 801–830. https://doi.org/10.1037/bul0000057

Levy Chajmovic, M., & Tishby, O. (2025). Therapists' responsiveness in the process of ruptures and resolution: Are patients and therapists on the same page? *Psychotherapy Research*, *35*(1), 42–53. https://doi.org/10.1080/10503307.2024.2303318

Lingiardi, V., Colli, A., Gentile, D., & Tanzilli, A. (2011). Exploration of session process: relationship to depth and alliance. *Psychotherapy*, *48*(4), 391–400. https://doi.org/10.1037/a0025248

Lingiardi, V., & McWilliams, N. (Eds.). (2025). *Psychodynamic Diagnostic Manual – 3rd ed. (PDM-3)*. Guilford Press.

Lingiardi, V., Muzi, L., Tanzilli, A., & Carone, N. (2018). Do therapists' subjective variables impact on psychodynamic psychotherapy outcomes? A systematic literature review. *Clinical Psychology & Psychotherapy, 25*(1), 85–101. https://doi.org/10.1002/cpp.2131

Luyten, P., Campbell, C., Moser, M., & Fonagy, P. (2024). The role of mentalizing in psychological interventions in adults: Systematic review and recommendations for future research. *Clinical Psychology Review*, *108*, 102380. https://doi.org/10.1016/j.cpr.2024.102380

Maxwell, J. A., & Levitt, H. M. (2023). How qualitative methods advance the study of causation in psychotherapy research. *Psychotherapy Research*, *33*(8), 1019–1030. https://doi.org/10.1080/10503307.2023.2181112

McCarthy, K. L., Caputi, P., & Grenyer, B. F. S. (2017). Significant change events in psychodynamic psychotherapy: Is cognition or emotion more important? *Psychology and Psychotherapy: Theory Research and Practice*, *90*(3), 377–388. https://doi.org/10.1111/papt.12116

Muran, J. C., Eubanks, C. F., & Samstag, L. W. (2021). One more time with less jargon: An introduction to Rupture repair in practice. *Journal of Clinical Psychology*, *77*(2), 361–368. https://doi.org/10.1002/jclp.23105

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. Yale University Press.

Owen, J., & Hilsenroth, M. J. (2014). Treatment adherence: The importance of therapist flexibility in relation to therapy outcomes. *Journal of Counseling Psychology*, *61*(2), 280–288. https://doi.org/10.1037/a0035753

Pellens, H., Vanhees, V., Dezutter, J., Luyten, P., & Vanhooren, S. (2025). Therapist responsiveness in the blank landscape of depression: A qualitative study among psychotherapists. *Psychotherapy Research*, *35*(1), 67–83. https://doi.org/10.1080/10503307.2023.2239457

Hatcher, R. L. (2021). Responsiveness, the relationship, and the working alliance in psychotherapy. In J. C. Watson, & H. E. Wiseman (Eds.), *The responsive psychotherapist: Attuning to clients in the moment* (pp. 37–58). American Psychological Association.

Signer, S., Estermann Jansen, R., Sachse, R., Caspar, F., & Kramer, U. (2020). Social interaction patterns, therapist responsiveness, and outcome in treatments for borderline personality disorder. *Psychology and Psychotherapy: Theory Research and Practice*, *93*(4), 705–722. https://doi.org/10.1111/papt.12254

Silberschatz, G. (2017). Improving the yield of psychotherapy research. *Psychotherapy Research*, *27*(1), 1–13. https://doi.org/10.1080/10503307.2015.1076202

Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry*, *16*(2), 146–153. https://doi.org/10.1002/wps.20412

Snyder, J., & Silberschatz, G. (2017). The Patient's Experience of Attunement and Responsiveness Scale. *Psychotherapy Research*, *27*(5), 608–619. https://doi.org/10.1080/10503307.2016.1147658

Stige, S. H., Torrissen, M. H., Danielsen, Y. S., Jakobsen, R., Morken, K. T. E., & Dundas, I. (2024). Training students to become responsive therapists: Implications from a sequential mixed-methods study on situations that therapists find challenging. *BMC Medical Education*, *24*(1), 261. https://doi.org/10.1186/s12909-024-05236-1

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, *5*(4), 439–458. https://doi.org/10.1111/j.1468-2850.1998.tb00166.x

Tanzilli, A., Colli, A., Del Corno, F., & Lingiardi, V. (2016). Factor structure, reliability, and validity of the Therapist Response Questionnaire. *Personality Disorders: Theory Research and Treatment*, *7*(2), 147–158. https://doi.org/10.1037/per0000146

Tanzilli, A., Colli, A., Gualco, I., & Lingiardi, V. (2018). Patient Personality and Relational Patterns in Psychotherapy: Factor Structure, Reliability, and Validity of the Psychotherapy Relationship Questionnaire. *Journal of Personality Assessment*, *100*(1), 96–106. https://doi.org/10.1080/00223891.2016.1272050

Tanzilli, A., Giovanardi, G., Patriarca, E., Lingiardi, V., & Williams, R. (2021). From a Symptom-Based to a person-centered approach in treating depressive disorders in adolescence: A clinical case formulation using the *Psychodynamic Diagnostic Manual* (PDM-2)'s Framework. *International Journal of Environmental Research and Public Health*, *18*(19), 10127. https://doi.org/10.3390/ijerph181910127

Thomas, S. L., Pitt, H., McCarthy, S., Arnot, G., & Hennessy, M. (2024). Methodological and practical guidance for designing and conducting online qualitative surveys in public health. *Health Promotion International*, *39*(3), daae061. https://doi.org/10.1093/heapro/daae061

Timulak, L., & Keogh, D. (2017). The client's perspective on (experiences of) psychotherapy: A practice-friendly review. *Journal of Clinical Psychology*, *73*(11), 1556–1567. https://doi.org/10.1002/jclp.22532

Tishby, O. (2021). Responsiveness in psychodynamic relational psychotherapy. In J. C. Watson & H. Wiseman (Eds.), *The responsive psychotherapist: Attuning to clients in the moment* (pp. 107–132). American Psychological Association. https://doi.org/10.1037/0000240-006

Vybíral, Z., Ogles, B. M., Řiháček, T., Urbancová, B., & Gocieková, V. (2024). Negative experiences in psychotherapy from clients' perspective: A qualitative meta-analysis. *Psychotherapy Research*, *34*(3), 279–292. https://doi.org/10.1080/10503307.2023.2226813

Stiles, W. B., & Horvath, A. O. (2017). Appropriate responsiveness as a contribution to therapist effects. In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others? Understanding therapist effects* (pp. 71–84). American Psychological Association. https://doi.org/10.1037/0000034-005

Wampold, B. E., & Flückiger, C. (2023). The alliance in mental health care: conceptualization, evidence and clinical applications. *World Psychiatry*, *22*(1), 25–41. https://doi.org/10.1002/wps.21035

Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, *19*(4–5), 576–582. https://doi.org/10.1080/10503300802702113

Wu, M. B., & Levitt, H. M. (2020). A qualitative meta-analytic review of the therapist responsiveness literature: Guidelines for practice and training. *Journal of Contemporary Psychotherapy*, *50*(3), 161–175. https://doi.org/10.1007/s10879-020-09450-y

Wu, M. B., & Levitt, H. M. (2022). How to become a responsive therapist: A study of experiences of developing therapists. *Psychotherapy Research*, *32*(6), 763–777. https://doi.org/10.1080/10503307.2021.2009929

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