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Interpersonal Competencies: Responsiveness, Technique, and Training in Psychotherapy

Robert L. Hatcher

Graduate Center – City University of New York

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Address correspondence to Robert L. Hatcher, Wellness Center, Graduate Center-City University of New York, 365 Fifth Avenue #6422, New York, NY 10016. Email: robert.hatcher@gmail.com

Phone: 212-817-7029; FAX 212-817-1602

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Abstract

Professional practice in psychology is anchored in interpersonal or relational skills. These skills are essential to successful interactions with clients and their families, students, and colleagues. Expertise in these skills is desired and expected for the practicing psychologist. An important but little-studied aspect of interpersonal skills is what Stiles and colleagues (1998, 2009, 2013) have called appropriate responsiveness. In treatment relationships, appropriate responsiveness is the therapist's ability to achieve optimal benefit for the client by adjusting responses to the current state of the client and the interaction. This article was designed to clarify this aspect of responsiveness, showing its links to empathy, illustrating how responsiveness has been detected in controlled clinical trials, discussing how educators and supervisors have worked to enhance students' responsiveness, and considering how appropriate responsiveness has been assessed. The article also discusses the development of skills underlying appropriate responsiveness, and the role of stable differences in talent in training of professional psychologists. Notwithstanding other pessimistic reports on psychologists' expertise, demonstrable expertise may exist in the effective, responsive use of these skills in treatment settings. Appropriate responsiveness may be a variety of executive functioning, organizing and guiding the use of many specific competencies. As such it may be a metacompetency, with implications for the design of competency schemes. Key to all of these considerations is the distinction between therapeutic techniques and their responsive use, which involves astute judgment as to when and how to utilize these responses to best effect in the treatment situation.

Interpersonal Competencies: Responsiveness, Technique, and Training in Psychotherapy

Interpersonal or relational skills are the bedrock of professional practice in psychology. Successful interactions with clients and their families, students, and colleagues are based on these skills. Contemporary competency models (e.g., Fouad et al., 2009; Hatcher et al., 2013) feature relational skills prominently throughout, and interpersonal expertise is a goal and an expectation for the practicing psychologist. Interpersonal skills, used responsively to aid clients, are central to psychotherapy and have been most studied in this domain. This article focuses on the organizing role of interpersonal responsiveness in psychotherapy, and discusses the relationship between responsiveness and empathy, technique, and other, more specific interpersonal skills. Methods for assessing responsiveness are reviewed. The development of interpersonal skills, and training to enhance and shape these skills, are considered, as are evidence of the effectiveness of training and some of its unforeseen consequences. There are limits on therapists' knowledge that in turn limit responsiveness, and these are considered. Finally, some implications for the design of competency models are discussed.

Treatment is Interpersonal

Psychotherapy is a special form of interpersonal interaction (Norcross & Lambert, 2011). There is much evidence that therapists' interpersonal skills have significant effects on treatment outcomes. Therapists' empathy and the therapeutic alliance each make a contribution to client improvement of between 6% and 12% (Norcross & Lambert). Goal consensus, and the therapist's positive regard, acceptance, congruence, and genuineness, also enhance outcome (Norcross & Lambert, 2014). These important skills are just a part of the complex set of related interpersonal skills of the psychotherapist. For example, empathy may be shown to clients in a many different ways, with varying effects on the client, the relationship, and treatment outcome

(Elliott, Bohart, Watson, & Greenberg, 2011). However, research has not addressed how the skillful therapist makes appropriate, nuanced choices about how and when to express empathy.

Responsiveness

Responsiveness: Organizer of social skills. Responsiveness is a characteristic of human interactions involving a continual adjustment of responses based on the evolving nature of the interpersonal situation (Stiles, 2009, 2013; Stiles, Honos-Webb, & Surko, 1998). Responsiveness occurs at every level of exchange, and on a widely distributed time scale. In the treatment setting, the therapist's goal of helping the client relies on the therapist's responsive interventions that are shaped by the therapist's perception of the client and their interaction. Responsiveness can be understood as "knowing what to do when" to advance the therapeutic work, as in the decision noted above regarding how to use empathic responding with a client. Stiles calls this "appropriate responsiveness" (2013, p. 34). Because responsiveness characterizes how the person's interpersonal skills are organized and used to achieve meaningful goals in relationships, it could be considered a super-ordinate or meta-competence (Hatcher & Lassiter, 2007; Roth & Pilling, 2008). In everyday interaction, knowing how to respond is largely an implicit or intuitive process, a result of long-term experiential learning in relationships with others. Responsiveness may be continually informed by new experiences with others, and enriched by strengthening and modifying existing interpersonal skills. Deliberate or effortful learning of new interpersonal skills, or unlearning of established ways of interacting, can also modify both the "what to do" and the "when" of responsiveness. This process is one way to characterize training in psychotherapy technique, which adds new skills, together with guidance on when and how to use them, to the trainee's interpersonal skill set. These skills become part of the trainee's overall responsiveness repertoire or meta-competence.

Stiles and colleagues (1998, 2009, 2013) have stressed that responsiveness is disruptive to the assumption that the presence or quantity of techniques such as interpretations or focus on negative self-image will be associated with good outcomes. Because therapists use these techniques responsively – as much or often as needed to achieve treatment goals – some clients will need more, some less to achieve the same level of outcome. As a result, researchers typically find no consistent relationship between the amount or frequency of these interventions and outcome. On the other hand, some commonly studied variables actually incorporate evaluations of responsiveness, and these do predict outcomes. The prime evaluative variable is the alliance in therapy, which reflects the therapist's effective use of interpersonal skills, techniques, and other factors to engage the client in treatment.

Empathy: A core feature of responsiveness. Empathy is a core component of responsiveness, because it involves the perception of the other that is required for the moment-to-moment adjustments needed for optimal effects in treatment. Definitions of empathy vary in their breadth, but there is general agreement that it involves or is closely connected to three main functions: (1) an affective response based on sensing or feeling another's emotional state, (2) a conceptual or perspective-taking process of understanding the other's situation and frame of reference, and (3) an emotion-regulation aspect, which helps the person tolerate the emotional discomfort or arousal that may result from experiencing the other's feelings and situation (Eisenberg & Eggum, 2009; Elliott et al., 2011). Descriptions of empathy in the conduct of psychotherapy give evidence of its role in appropriate responsiveness. Elliott and colleagues describe communicative attunement with the client, "an active, ongoing effort to stay attuned on a moment-to-moment basis with the client's communications and unfolding experience," (p.135), as well as person empathy, the sustained effort to understand the client and the client's

experiences and history. These two aspects of empathy provide information to the therapist that is essential to determining what responses or actions would be best to take with the client.

In addition, responsiveness is implicit in Elliott et al.'s (2011) extension of the idea of empathy to a more complex, higher-order conceptualization. They comment that “therapists need to know when – and when not – to respond empathically. When clients do not want therapists to be explicitly empathic, truly empathic therapists will use their perspective-taking skills to provide an optimal therapeutic distance ... in order to respect their clients’ boundaries” (p. 48). This distinction helps separate empathy as a technique (i.e., explicit expression of empathy) from responsive use of technique, which involves using the information gathered by the therapist through empathy to judge when and how it would be best to use the technique.

Theory and research in the area of emotional intelligence (EI) have potential to contribute to our understanding of the components of responsiveness (Mayer, Roberts, & Barsade, 2008; Roberts, MacCann, Matthews, & Zeidner, 2010). Mayer and colleagues’ ability model for EI describes skills essential to empathy such as the perception of emotion, and also includes emotional understanding (relationships between emotions and situations) and the regulation and management of emotions in relationships, features that seem related to responsiveness.

Interpersonal Skills, Technique, and Responsiveness

The relationship between interpersonal skills, technique, and responsiveness is complex. It may be useful to think of the therapist as a socially skilled person whose training has refined and augmented these skills, all of which may be used responsively for the client’s benefit. This approach emphasizes that trained therapists possess a wide range of potentially helpful means, including technique, to engage and respond to clients, together with a capacity to use these skills responsively. The baseline interpersonal skills and responsiveness that a new, untrained doctoral

student brings to training may be considerable. These skills can be quite helpful to clients, as suggested by studies of untrained or novice counselors (Anderson, Crowley, Himawan, Holberg, & Uhlin, in press; Christensen & Jacobson, 1994; Strupp & Hadley, 1979).

Building on these baseline skills, training offers specific techniques and tactics designed to help clients. Some behaviors may be proscribed, such as confrontation or interpretation. Training may also recommend a standard template for the session, as in some CBT protocols (e.g., Boswell et al., 2013). Although training is certainly intended to enhance the outcomes of treatment, it may also constrain the therapist's responsive use of a variety of potentially helpful skills that are not emphasized or may be proscribed by the treatment approach.

Interpersonal Skills and Common Factors

Techniques are one group of interpersonal skills that can be used responsively in therapy. Many other interpersonal skills fall in the category of common factors – features shared widely across psychotherapies of all types. Among the many common factors with a strong interpersonal quality are positive relationship, therapist warmth, respect, empathy, acceptance, genuineness, safe environment, feedback, reassurance, therapeutic alliance, instilling hope, and mitigation of isolation, all of which must be deployed with appropriate responsiveness for good effect (Lambert, 2013; Lambert & Ogles, 2014; Swift & Derthick, 2013). These interpersonal factors play an important role in the outcome effects attributed to common factors overall, estimated to be in the range of 30% (Lambert, 1992) to 49% (Cuijpers et al., 2012; Lambert, 2013). Although the size of the contribution of interpersonal factors to these effects is not known, they loom large in the list of common factors, which also includes advice, affective re-experiencing, cognitive learning, rationale, facing fears, modeling, reality testing, and quite a few others (Lambert & Ogles, 2014), each requiring responsiveness and interpersonal skill for good effect.

How Responsiveness Affects use of Technique

Several research studies have demonstrated how therapists modify their work in therapy in response to client features despite expectations of adherence to treatment protocols that may restrain therapist responsiveness. These findings have emerged from controlled trials, where therapists are screened and carefully trained to adhere to a particular approach. They suggest that therapist responsiveness often trumps even the most rigorous screening and training efforts.

For example, Imel, Baer, Martino, Ball, and Carroll (2011) demonstrated significant variation in adherence to motivational enhancement therapy (MET) techniques both within and between therapist caseloads in a trial of MET with a mixed sample of substance abuse clients. They found that therapists were less adherent to MET with clients showing greater motivation prior to the treatment session, as would be expected if therapists were working responsively, since MET would be less relevant to already-motivated clients.

Boswell and colleagues (2013) showed how therapists trained in a panic disorder treatment protocol varied considerably in their levels of adherence within their individual caseloads. They found lower levels of adherence for clients who had higher scores on a trait-level measure of interpersonal aggression/hostility. This finding suggests that these therapists encountered challenges with their clients that their manualized techniques and protocol did not address, and that they turned to other approaches to deal with the situation. The fact that the researchers found no differences in proximal outcome (changes in panic levels after the session) based on adherence level is an indication that these off-protocol techniques were used responsively as described by Stiles and colleagues (1998).

A study by Zickgraf and colleagues (2015) showed that, when faced with resistant behavior in a manualized cognitive-behavioral treatment for panic disorder, experienced

therapists utilized off-protocol techniques to one degree or another in an effort to move the treatments forward. These authors recognized the disruptive effects on adherence to manualized treatment protocols caused by therapist responsiveness to patient resistance (though without referencing Stiles, 2009, 2013). They also recognized that resistance is to be expected, and that manuals should make room for responses to such events, noting that “optimizing patient outcomes is the goal of any clinical intervention. In some cases, this goal may conflict with the need to maintain treatment adherence during a research trial.” These authors advocated identifying evidence-based techniques to deal with resistance for inclusion in treatment protocols. This valuable approach would give therapists a wider range of approved and efficacious options for responsiveness, and give license to those who might otherwise eschew responsiveness in favor of adherence to the original treatment protocol. However, it would not necessarily address what to do when these additional techniques fail, and it would only partially address the broader issue of how to choose among and use these skills. Overall, these findings demonstrate that expected technique may be modified or set aside when the therapist senses that the goals of treatment would be better served by use of other responses.

Some examples of responsiveness involve within-protocol variations that are sensitive to client differences. For example, Hardy, Stiles, Barkham, and Startup (1998) reported that therapists utilized different techniques depending on client interpersonal styles. In psychodynamic therapy, clients with overinvolved styles received more affective and relationship-oriented interventions as compared to those with underinvolved styles, and in CBT, those with underinvolved styles received more cognitive interventions than overinvolved clients, with each approach showing generally equivalent outcomes. None of these techniques were proscribed, but they were chosen responsively.

Detecting and Evaluating Responsiveness

Evaluating responsiveness is a considerable challenge because by its nature its operation varies across different interactions and dyads. A therapist may be more effectively responsive with one client than another, or in one session or another with a particular client. Responsiveness is not directly related to specific therapist actions or techniques, such as expression of empathy or use of exposure. These are among the tools of responsiveness; responsiveness itself is knowing whether, how, and how much to use these and other tools to move the therapy toward an optimal outcome. Nevertheless, more effectively responsive therapists may well make greater use of some tools such as promoting hopefulness, or show greater presence of some attitudes, such as respectfulness. But for some clients, in some sessions, these responses may be counterproductive and thus not used. At the same time, despite the variation across clients, individual therapists have typical or mean levels of responsiveness. Two studies illustrate different approaches to assessing responsiveness.

Elkin and colleagues (2014) examined psychotherapy sessions for therapists' use of positive actions intended to engage the client in therapy. They rated many specific techniques and activities, such as making eye contact and using minimum encouragers. In addition, several more direct indicators of responsiveness were rated, including "appropriate level of emotional quality and intensity" and "compatible level of discourse" (p. 57). A factor analysis grouped the latter items together with two attitudinal features, reflecting respectfulness and therapist caring. As expected from the appropriate responsiveness viewpoint, the specific positive activities (e.g., minimum encouragers) did not relate to the outcome criterion (early termination), because their use would vary depending on what the therapist felt would best further the treatment (Stiles,

2009). On the other hand, the factor reflecting appropriate responsiveness did. Thus there is some indication that raters can detect appropriate responsiveness in treatment sessions.

In another approach, Anderson and colleagues employed their Facilitative Interpersonal Skills performance task (FIS; Anderson, Patterson, & Weiss, 2007) in several studies (Anderson et al. in press; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). The FIS was designed to assess a trait-level ability to “perceive, understand, and communicate a wide range of interpersonal messages” (Anderson et al., 2009, p. 759) and to be persuasive to clients. The FIS involves eight two-minute segments portrayed on film by actors, extracted from the therapies of four clients presenting different interpersonal challenges. Participants were asked to respond as if they were the therapist at set times for each episode. The recorded responses were rated on “verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus” (p. 759). These criteria include the use of techniques (e.g., problem focus, warmth) as well as signs of therapist interpersonal facility that are likely associated with responsiveness (e.g., verbal fluency, persuasiveness, alliance-bond capacity). In several studies, ratings of therapist responses to the FIS were strong predictors of therapy outcome (Anderson et al., in press; 2009). A particular strength of the FIS is that it assesses responsiveness with challenging episodes from challenging clients, pushing the limits of therapists’ skills and creating a broader distribution of scores.

Further work on assessing responsiveness would be helpful, keeping in mind the distinction between particular types of interventions and the ability to combine the use of these methods responsively to enhance the therapy process.

Interpersonal Skills: Individual Differences, Development, and Training

Individual differences in therapists' interpersonal skills. Research on therapists' contributions to psychotherapy outcome shows that differences between therapists account for about 5% to 8% of variance in outcomes (Baldwin & Imel, 2013). Interpersonal skills in general, and responsiveness in particular, likely play a large role in these differences. Research indicates that some therapists may be more skilled at facilitating the therapy process than others.

The studies by Anderson and colleagues (in press; 2009) underscore the role of facilitative interpersonal skills in treatment outcome, and demonstrate that differences between therapists in these skills are related to significant, meaningful differences in client outcomes. These findings raise important questions. What is known about the development of interpersonal skills? Is further development of skills possible?

Development of interpersonal skills. Although research is lacking on the early development of the specific interpersonal skills involved in psychotherapy, the research literature on the development of prosocial behavior and social skills may shed some light. Prosocial behavior is voluntary behavior intended to benefit another, and is based on the capacities for empathy and sympathy that first emerge in early childhood (Eisenberg, Spinrad, & Morris, 2013). Eisenberg, Egum, and Spinrad (2015) point out that prosocial behavior involves socio-cognitive skills, including understanding others' emotions from cues they offer, affective perspective-taking which involves "the ability to make inferences about how another person likely feels" (p. 4), and cognitive perspective-taking, which requires understanding another's thoughts or their situation. These skills are closely related to the empathic processes discussed above as central to the interpersonal skills involved in psychotherapy. The ability to tolerate the personal distress associated with empathy for another's distress, and the strength of other-

oriented moral reasoning are also important aspects of prosocial behavior. The overlap of prosocial behavior as studied by developmental psychologists with the interpersonal skills of psychotherapists is certainly not complete, although psychotherapy could be considered a particularly specialized form of prosocial behavior.

The overall trend is for prosocial skills to increase from childhood to young adulthood. As children mature, early prosocial behavior typically becomes more sophisticated and accurate, less egocentric, more tailored to the situation, socially appropriate, and capable of extending beyond the immediate experience with the other (Eisenberg et al., 2015, 2013). An important finding is that individual differences in prosocial skills are evident from the start of development, and show considerable stability over its course (Eisenberg et al., 2015). In addition, there is evidence of significant genetic effects in prosocial behavior that contribute to these individual differences and their stability (Eisenberg et al., 2015). Similar stability has been reported in studies of the development of social skills and social competence, which, in addition to cooperation, include self-control, responsibility, and assertion (Lamont & Van Horn, 2013; see also Berry & O'Connor, 2010). These individual differences appear to affect the individual's capacity to enhance their social skills. Berry and O'Connor (2010) reported significant positive effects on social skills development when children experienced "high-quality teacher-child relationships" between kindergarten and sixth grade. Children with relatively higher social skills benefitted more from high quality teacher relationships than those with lower skill levels, who nevertheless were better off than those with lower quality teacher-child relationships. These findings suggest that there is a talent aspect to social skills that varies across individuals, like musical or athletic talent. Thus, although development and learning may enhance the individual's skills, the degree of talent may constrain the rate and level of obtainable skills.

Training for Appropriate Responsiveness

Stable, long-term differences in the development of social or interpersonal skills may result in significant differences in the abilities needed to foster a productive therapeutic process among students entering graduate programs. Training is intended to strengthen or build on a student's talent and on the capability for flexible, judicious, and responsive interaction that has developed during earlier life. If the individual's talent and baseline capabilities are too low, training may not be effective. A similar conclusion was reached by Nissen-Lie and Orlinsky (2014). An important question is whether the baseline talent necessary for satisfactory training is widespread, so that many people have the potential to perform adequately as therapists, or whether there is a steep talent gradient, such that only portion can learn and perform well. Anderson and colleagues' (2009) study suggests that differences in appropriate responsiveness persist despite training, a finding consonant with the developmental studies noted above. How is appropriate responsiveness affected by training? Can those low in this capacity develop stronger levels of appropriate responsiveness? These are questions in much need of further study.

Training in professional skills focuses primarily on techniques. Appropriate responsiveness, rarely mentioned explicitly, may be an implicit goal of this training. Training in facilitative interpersonal skills, which are important tools of responsiveness, are a good example.

Training for interpersonal skills. Clinicians and researchers have described some elements of the processes involved in responsiveness, such as facilitative skills. This has naturally led to efforts to develop methods for training students in these elements. Many graduate programs offer preparation for clinical work under the rubric of helping skills. Helping skills are therapist behaviors that are thought to promote good client outcomes, (Hill & Knox, 2013). These skills include exploratory skills, such as open questions, restatements, and reflection of

feelings; promoting insight through interpretation and immediacy; and action skills designed to help clients make changes in their behaviors (Hill, 2009). Trainees practice these skills in role plays and with volunteer clients. Hill and Knox report that this training shaped student behaviors in the expected ways, and increased their comfort with the therapeutic role.

Many of these helping skills can be seen as tools that expand the options for appropriate responsiveness. For example, the use of reflection can surely be facilitative to clients and the therapy process. However, the choice of what to reflect and when to reflect it versus doing something else, such as asking a question, offering a warm supportive comment, or simply listening further, relies on an active, responsive understanding of the client in the moment.

Accordingly Hill and Knox (2013) were careful not to confuse mastery of these helping skills with the broader and more elusive capacity for appropriate responsiveness. They resisted setting criteria for success or failure in training in these skills, noting that the goal of the training was not the skills themselves so much as to learn “when and why to use skills, and to observe client reactions and adjust their approach based on clients’ unique needs” (p. 779). They concluded that “the goals of training are to provide therapists with an armamentarium of skills upon which they can rely, and which they can astutely use, in the inevitably dynamic and varied clinical situations they will encounter” (p. 779). How students learn to use these skills astutely is not a clear focus of the training, however. Does singling out these skills lead to better overall responsive processes? Might the training in some ways interfere with responsive processes?

Similar to Hill and Knox (2013), Barber, Sharpless, Klostermann, and McCarthy (2007) note the distinction between training for adherence, which involves learning to utilize specified techniques (and avoiding some other specified behaviors), and training for competence, which involves learning the appropriate, responsive application of these techniques. Citing Stiles and

colleagues (1998), they note that “competent application requires that techniques be wisely applied while the idiosyncratic context of the patient is simultaneously considered” (p. 494). They conclude that “competent therapists are flexible in their judicious implementation and nonimplementation of therapeutic techniques” with “a great deal of judgment and clinical acumen” (p. 494). Again, with the focus on learning and adhering to specific techniques, how are these therapists aided in learning their flexible and judicious implementation?

Training for appropriate responsiveness: Supervision. Given the indications that trained professionals have some skill in identifying responsive process (Anderson et al., 2009; Elkin et al., 2014), clinical supervision is likely a particularly valuable venue for training in appropriate responsiveness. Friedlander (2012, 2015) has highlighted this role for supervision. Three main elements are evident in her account. First, the supervisor helps the supervisee to consider the specific needs of the client and the particular flow of the session. Second, the supervisor helps the supervisee to consider alternative responses to the client and their possible effects. Third, by enacting responsiveness with the supervisee, the supervisor can demonstrate its value and make how it is done explicit. In these ways, attention can be given to the larger picture of appropriate responsiveness. Here the trainee and supervisor can work together to help the trainee to master, not just the techniques, but how the therapist can use his or her judgment to put the techniques together to foster positive change. Helping the trainee to keep this overarching goal in mind while reviewing therapy process would seem to be a valuable feature of supervision that is difficult to obtain otherwise. This is also a strong feature in Falender and Shafranske’s (2014) examples of competent supervision, although more explicit discussion of responsiveness as a competency might be helpful.

Training for appropriate responsiveness: Specialized supervision. An approach that includes skills training and supervision has been designed to heighten therapists' awareness of interpersonal processes, especially those that indicate problems in therapist responsiveness. Alliance-focused therapy (AFT) was developed by Safran, Muran and colleagues (Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011; Safran et al., 2014). Growing from Strupp and colleagues' work on negative process (cf. Binder & Strupp, 1997), AFT focuses on detecting and responding to indications of strains in the alliance that may be considered to be failures in appropriate responsiveness. The goal is to interrupt the cycle of negative responding that has been identified as especially toxic to effective treatment. AFT highlights the fundamentally relational nature of therapy, training students to monitor the interaction, to attend to their often unwitting contribution to the interaction, and to recognize and utilize their own feelings to perceive the interpersonal situation with the client (Safran et al., 2014). In addition, therapists are taught to emphasize metacommunication (noting and discussing implicit relational communications with the client) as technique for engaging the client in resolving the strain in the alliance, along with deep exploration of client feelings regarding the relationship. Application of these techniques is intended to be explicitly responsive, based on the clinician's judgment of what would work best at the current moment. Initial results from this approach showed expected changes in therapist behaviors and practices (Safran et al., 2014). Although designed as a standalone treatment, this approach, as an aid to responsiveness, might be usefully combined with other treatment methods (e.g., CBT). As useful as these techniques may be, it is important to distinguish between appropriate responsiveness and techniques to aid responsiveness.

Hazards of Training for Facilitative Skills - Rigidity

Hill and Knox (2013) recognized that training designed to promote responsiveness risks becoming a prescription for specific techniques, becoming ends in themselves, making their unresponsive use more likely, and leading to poorer outcomes. The same question arises for any training in technique. Some interesting findings point to the consequences that follow when therapist responsiveness is limited by overly-rigid application of technique. Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) showed that single-minded adherence to cognitive techniques can aggravate disruptions in the therapeutic alliance, leading to poor outcomes. Some therapists in their study responded to clients' concerns about the therapy by focusing on specific cognitive techniques that assumed that the client's complaints were based in irrational thinking in need of examining and correcting. This unresponsive approach further compromised the alliance and limited subsequent outcomes. A study conducted by Owen and Hilsenroth (2014) had similar implications. These researchers created a measure of therapist flexibility based on the variation in degree of adherence to psychodynamic technique over time within cases. They found that lower flexibility was related to less successful outcomes, and accounted for these results using the responsiveness concept. Henry, Strupp, Butler, Schacht, and Binder (1993) reported on the effects of the controlled training protocol in the classic Vanderbilt II Study, which was designed to enhance therapists' capacity to deal with negative process in therapy. The training encouraged greater therapist activity, giving them more opportunities to express (unawares) more hostility to their difficult clients. Further, therapists reported that they felt constrained by their need to follow the treatment manual, reducing their use of other techniques such as support and optimism. These issues arise not just with manualized treatments, but with any treatment approach that has preferred and proscribed techniques, such as psychoanalysis.

It is possible that rigidity as an unwanted side-effect of training may be dealt with by recognizing the importance of responsiveness in treatment, which includes being open to indicators that whatever technique is being used is not functioning effectively or optimally in the current situation. Similar issues are dealt with in the education research literature under the rubric of learning transfer. Schwartz, Chase, and Bransford (2012) describe the problem of overzealous transfer or OZT, the insufficiently flexible application of learned solutions to problems, without being open to the nuances of the current situation. This is a general issue for learning transfer, and not unique to professional psychologists. They recommend approaches to help deal with OZT, involving actively seeking feedback either from the situation or from other professionals. They cite professional designers, whose methods include continually seeking feedback from their clients. They note that “this can help block the kinds of OZT that fail to take into account new features, needs and opportunities that would be missed if they simply used their previously acquired assumptions of what a good solution would be” (p. 211).

These findings regarding the hazards of rigidity point to the value of building explicit attention to the role of flexibility and responsiveness into therapist training. Training in how to choose among techniques and put them together on the fly in a treatment session is a greater challenge that has received limited attention so far (e.g., Friedlander, 2012), even though therapists continually exercise independent judgment in just this area, often incorporating techniques not included in their training.

Effects of Training

An abiding question is whether training in the elements of appropriate responsiveness has positive effects on the ensemble of therapist actions and attitudes that together constitute appropriate responsiveness. Does the training help the therapist to be a better conductor – can he

or she put the instruments together into an orchestra? Are some therapists destined to be less responsive than others? The field's faith in the value of training is based on decades of observation but very little actual research. Hill and Knox (2013) presented an extensive review of research on the effects of training and supervision in psychotherapy, concluding that there was very limited evidence to demonstrate their effects, particularly regarding client outcomes. A host of definitional and methodological problems has made adequate study of this topic extraordinarily difficult, and longitudinal studies relating training to client outcomes over time are notably scarce. However, attempting to address some of the problems identified by Hill and Knox, a recent longitudinal study of early training effects by Hill and colleagues (2015) indicated significant changes in client-rated alliance and real relationship and ability to manage countertransference during 12 to 42 months of supervised clinical training. Clearly, more research of this sort is sorely needed.

Limits of Responsiveness – Supplementary Feedback

Although appropriate responsiveness is likely enhanced by good training, there are limits to therapists' ability to gather valid information necessary for appropriate responsiveness. Lambert and colleagues have shown that clinicians have great difficulty identifying when psychotherapy clients are on a deteriorating course in treatment. For example, Hannan et al. (2005) showed that therapists identified just 0.5% of clients as deteriorating, whereas 7.3% showed strong evidence of decline. Lambert and colleagues (Shimokawa, Lambert, & Smart, 2010) have developed and studied a client progress tracking method that helps therapists supplement their own judgment about treatment progress with cumulative client progress data that indicates whether the treatment is on track, based on actuarial data from many cases. When cases are not improving as expected, the system recommends use of supplementary measures of

treatment alliance, social support, treatment motivation, and life stressors. Interestingly, their method leaves the question of how to use the data up to the therapist. Because receiving the data improves outcomes for deteriorating cases, as well as for those doing relatively well, it seems likely that responsiveness is enhanced by extending therapists' awareness of clients' improvement status, alerting them to the need to modify their approach. But specifically how therapists use the data remains an area of great interest and is expected to be a focus of future study. Further, this research does not explain why client deterioration was missed in the first place. Were some therapists able to detect early signs of deterioration and address them before a significant downward path began? Did therapists of all abilities miss these problems? Or was deterioration especially frequent among the clients of less able therapists, those whose relative lack of competence, interpersonal or otherwise, might further blind them to their failure to help their clients (Kruger & Dunning, 1999)?

Is Expertise Possible?

In 1992, Shanteau published a widely-cited claim that clinical psychologists have not demonstrated expertise, defined as increased quality of performance with experience. Much of the research on this issue deals with predictions (e.g., danger to others, recidivism), and it is remarkable that there are no longitudinal studies of psychologists' effectiveness across their careers in terms of maintaining and enhancing client outcomes. Much of the extant, and largely pessimistic, literature on this topic is based in group studies of therapist outcomes that overall show no correlation between experience and client improvement (Tracey, Wampold, Lichtenberg, & Goodyear, 2014; Spengler & Pilipis, 2015). However, these cross-sectional studies are not informative about the issue at hand, which is whether and how it is possible for a psychologist to maintain and improve client outcomes. A lack of change in mean outcomes

associated with experience is likely a composite result, with some clinicians doing worse over time, some not changing, and some producing better outcomes. It would be of great interest to study these groups over time, with the goal of identifying how those psychologists who become more effective over time – if any – achieve this result, and to contrast them with those who become less effective or simply maintain their initial competence.

Tracey and colleagues (2014) cite lack of quality feedback to the clinician as the main reason for pessimism about the possibility of improving outcomes. They suggest that most psychological interventions are low-validity environments. Kahneman and Klein (2009) identified these environments as failing to “provide adequately valid cues to the nature of the situation,” (p. 520). Without these cues, or in the presence of misleading cues, it is difficult for practitioners to learn the “rules of the environment,” (p. 521) and from these to make appropriate judgments. In the absence of valid cues, judgments tend to be based on unreflective intuitions that are influenced by heuristics and biases, with unreliable or misleading results. Basically, the less valid the information, the more likely that inaccurate intuitions rule the day. The list of these potential heuristics and biases is long.

However, Kahneman and Klein (2009) suggest that most professionals have what they call “fractionated expertise” (p. 522), with expert skill in tasks that involve reliable, useable data, and less skill in tasks that have more elusive data. The interpersonal scene in psychotherapy seems likely to be such an area of expertise. For those with sufficient ability and good training, relevant feedback may in fact be available, perceived, accurate, and useful, both for skillful performance, and for enhancing future performance.

Conclusions and Implications for Competency Models and Training

Viewing psychotherapy as an interpersonal exchange, I have suggested that it can be considered a specialized form of prosocial interaction. From this perspective, the therapist's formal training refines and extends the helpful interpersonal talents and social skills that have developed over the years prior to training. The therapist learns how to use techniques to interact helpfully with clients, aided by advanced concepts of client problems and sophisticated treatment models. Therapists do not implement these methods mechanically; therapists' use of these techniques is influenced by their always-active judgment of how best to conduct the session with the particular client. This judgment involves what Stiles and colleagues (1998, 2009, 2013) have called appropriate responsiveness. Responsiveness is integral to all interpersonal interaction, as each member of a dyad adjusts his or her responses to the other, each guided by his or her particular goals for the interaction. In the context of therapy, responsiveness is appropriate when it is effectively dedicated to the goal of helping the client. This means that the therapist exercises flexible and astute judgment in the conduct of the session, anchored in perception of the client's emotional state, needs, and goals, and integrates techniques and other interpersonal skills in pursuit of optimal outcomes for the client. Appropriate responsiveness involves knowing what to do and when to do it.

The concept of responsiveness by itself is primarily descriptive – people's responses are typically sensitive to the responses of others. By characterizing the therapist's responsiveness as "appropriate," Stiles and colleagues move the concept to another level, where it serves an overarching, integrating, and guiding role that shares some features with the concept of executive functioning. Jurado and Rosselli (2007), while acknowledging the variety of definitions of executive functioning, note agreement on its core features:

In a constantly changing environment, executive abilities allow us to shift our mind set quickly and adapt to diverse situations while at the same time inhibiting inappropriate behaviors. They enable us to create a plan, initiate its execution, and persevere on the task at hand until its completion. Executive functions mediate the ability to organize our thoughts in a goal-directed way and are therefore essential for success in school and work situations, as well as everyday living (p. 214).

Other contributors have begun to integrate affect into the largely cognitive model of executive functioning, including control and use of emotional responses in pursuit of goals (Schmeichel & Tang, 2015). These features seem to characterize appropriate responsiveness, which however seems to emphasize the role executive functioning in interpersonal interactions.

As a type of executive function, appropriate responsiveness brings order and direction to the competencies involved in conducting psychotherapy. Such over-arching competencies are often called metacompetencies, a concept that has been used in several early formulations of psychologists' competencies. Hatcher and Lassiter (2007) used the concepts of metaknowledge and metacompetency to refer to the person's awareness of the extent and nature of their knowledge and competence, and to the ability to be flexible, creative, and open to new ways of thinking (p. 53). Roth and Pilling's (2008) competency scheme for CBT also makes use of the metacompetence concept, in which they include features of appropriate responsiveness such as "capacity to use clinical judgment when implementing treatment models," "capacity to adapt interventions in response to client feedback," and "capacity to use and respond to humor" (p. 139). They also list a number of CBT-specific metacompetencies, such as "capacity to formulate and to apply CBT models to the individual client" (p. 139).

By excluding metacompetencies, more recent competency models (e.g., Fouad et al., 2009; Hatcher et al., 2013) make it difficult to address the capacity for appropriate responsiveness directly, although some relevant indicators are embedded in specific competencies such as intervention and assessment. However the thrust of these models is that competence is the sum of many discrete competencies, whereas the substance of the current discussion is that the capacity to integrate and orchestrate the use of these discrete competencies is a critical factor in its own right.

Many important questions remain about the trainability of appropriate responsiveness. Limits in innate talent may constrain the effectiveness of training (Nissen-Lie & Orlinsky, 2014), as may the nature of the trainee's formative interpersonal experiences prior to graduate training. The question of how to enhance appropriate responsiveness has barely been addressed by the field. Friedlander (2012, 2015) suggested that supervision is a critical venue for modeling appropriate responsiveness. In addition to the helping skills approach discussed above, other curricula have sought to bolster some of the capacities that contribute to appropriate responsiveness, such as sensitivity to one's own and other's emotions, affect tolerance, and perspective taking (e.g., Hen & Goroshit, 2011). Curricula in United Kingdom clinical programs include training in reflective practice with components related to appropriate responsiveness (British Psychological Society, 2010).

Hand in hand with training is the issue of assessment of appropriate responsiveness. There appear to some promising avenues to evaluating appropriate responsiveness (Anderson et al., in press; 2007; Elkins et al., 2014), but here again much further work is in order. Assessment of appropriate responsiveness and of baseline interpersonal and facilitative skills at application or admission to doctoral training would help guide training, and provide points of comparison for

assessing student progress and the effectiveness of the program's training. If these assessments proved to yield valid predictions of student success in training, they could become a means for admissions screening in the future.

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