Characterizing the therapist's responsiveness when using supporting and challenging interventions: a case study

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Escola de Psicologia

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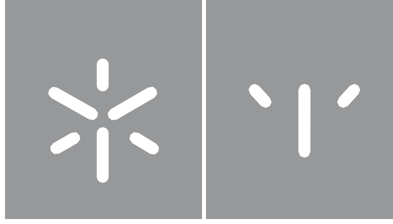

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Characterizing the therapist's responsiveness when using supporting and challenging interventions: a case study

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Trabalho realizado sob a orientação da
Professora Doutora Eugénia Ribeiro
e da
Doutora Dulce Pinto

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Agradecimentos

Aos meus pais e ao meu irmão, primeiramente, por sempre me proporcionarem os meios para eu seguir os meus objetivos e me apoiarem nos bons e maus momentos. Obrigada por se certificarem sempre, que eu nunca me sentia sozinha.

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I hereby declare having conducted this academic work with integrity. I confirm that I have not used plagiarism or any form of undue use of information or falsification of results along the process leading to its elaboration.

I further declare that I have fully acknowledged the Code of Ethical Conduct of the University of Minho.

Caracterização da responsividade do terapeuta quando usa intervenções de suporte ou desafio: um estudo de caso

Resumo

Responsividade apropriada é uma competência importante para um terapeuta, pelo que deve ser treinada e desenvolvida. Ser responsivo de forma apropriada é saber o que o cliente necessita e como é que o necessita em cada momento do processo terapêutico. Intervenções apropriadamente responsivas, por parte do terapeuta, favorecem a validação do cliente, contribuindo, assim, para o desenvolvimento da colaboração terapêutica e melhorando o processo terapêutico. Este estudo de caso teve como objetivo entender se competências terapêuticas especificas, demonstram um padrão de maior ou menor responsividade. Nesse sentido usamos o Sistema de Codificação da Colaboração Terapêutica, o que nos permitiu analisar as respostas do cliente às várias intervenções do terapeuta. Os resultados demonstram que independentemente do tipo de competência específica usada, o terapeuta tende a ser responsivo quando suporta a perspetiva do cliente. Com base nas respostas do cliente, quando o terapeuta desafia a perspetiva, do cliente, tende a ser mais responsivo quando convida o cliente a adotar uma nova ação e menos responsivo quando o confronta ou convida a explorar um cenário hipotético.

Palavras-chave: Colaboração terapêutica; estudo de caso; intervenções de desafio; intervenções de suporte; responsividade apropriada.

Characterizing the therapist's responsiveness when using supporting and challenging interventions: a case study

Abstract

Appropriate responsiveness is an important skill for a therapist and thus should be trained and developed. To be appropriately responsive is to know what the client needs and how he needs it in any given moment during the therapeutic process. Appropriately responsive interventions, by the therapist, favor client's validation, consequently, contributing to the development of the therapeutic collaboration and enhancing the therapeutic process. This case study had the objective of understanding if specific therapeutic skills demonstrate a pattern of more or less responsiveness. In this sense we used the Therapeutic Collaboration Coding System, which allowed us to analyze the client's responses to the therapist's various interventions. The results show that, independently of the type of specific skill utilized, the therapist tends to be responsive when he supports the client's perspective. Based on the client's responses, when the therapist challenges the client's perspective, she tends to be more responsive when inviting the client to adopt a new action and less responsive when confronting or inviting the client to explore a hypothetical scenario.

Keywords: Appropriate responsiveness; case study; challenge interventions; supporting interventions; therapeutic collaboration.

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Responsiveness is an ever-present characteristic in the therapist-client interaction. In fact, accordingly to Stiles, Honos-Webb, and Surko (1998), responsiveness is a characteristic of every human interaction in the sense that when people interact with each other they are constantly adjusting their responses (verbal or non-verbal) in response to the natural development of the situation. Responsiveness in itself is neither good nor bad. However, in therapy, the goal of the therapist is to help the client, not harm him, so Stiles (2013) calls this appropriate responsiveness as both the therapist and the client try to do the right thing.

As Hatcher (2015) puts it, 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 is more than just being empathetic, it's knowing how to access the circumstances and deciding what to do, how and when to do it in order to meet the client's needs at a given time (Stiles, Honos-Webb, & Surko, 1998). In sum, appropriate responsiveness is doing the right thing at the right time but the right thing depends not just on the client's characteristics (e.g., diagnosis, education, values) but also the therapist's characteristics (e.g., skill, theoretical approach) and other factors with relevance to the interaction (e.g., history of the therapeutic relationship, circumstances of the session) (Stiles & Horvath, 2017).

Appropriate responsiveness is an important interpersonal skill that should be trained, and many treatment manuals explicitly instruct therapists to be responsive (Hatcher, 2015; Stiles, Honos-Webb, & Surko, 1998). Trained therapists possess, not just a wider range of helpful means to engage and respond to clients, but also the capacity to use these skills responsively. In fact, Stiles and Horvath (2017) propose that by constantly using appropriate responsiveness the therapist can achieve a strong therapeutic alliance and given that the therapeutic alliance is a modest but highly reliable predictor of success in therapy (Horvath, 2013) it can explain why the appropriateness of the therapist is such a solid predictor of a good process (Meyer & Pilkonis, 2001). Actually, Flückiger, Del Re, Wampold, Symonds, and Horvath (2012) found that the positive relationship between the quality of the alliance and therapy outcome – across varied treatments and outcome measures – is one of the most robust findings in therapeutic process literature. According to Ribeiro, Gonçalves, and Pinto (in press) appropriate responsiveness is integral property of the therapeutic collaboration, that it's one core dimension of the alliance (Horvath & Luborsky, 1993).

In this study we feature marked-guided interventions, which means that each therapist's intervention was analyzed focusing on the therapeutic collaboration and in which the responsiveness is

analyzed moment to moment within the therapeutic interaction (Kramer & Stiles, 2015). This marked-guided interventions highlight noteworthy and productive moments during the therapy process that emerge from the dialogue between the client and the therapist dyad. The theoretical model of Ribeiro, Ribeiro, Gonçalves, Horvath, and Stiles (2013) is, in essence, based on appropriate responsiveness given that it views the therapeutic collaboration as a negotiation between the therapist and the client in a moment to moment basis. These authors propose that the therapeutic collaboration is a developmental process that is based on the dynamic relationship surrounding the therapeutic intervention, where the therapist works within the client's TZPD – Therapeutic Zone of Proximal Development (Leiman & Stiles, 2001), understanding and negotiating with the client about his or her actual difficulties in order to recognize and strengthen the client's own resources and potentiate change. The TZPD can be understood as the distance between the client's actual developmental levels and the potential level he can achieve with the help and guidance of the therapist. The therapist's goal is to work within the client's TZPD (Leiman & Stiles, 2001) gradually expanding the clients TZPD, in order to transform the previous and dysfunctional perspective into a new one that is better suited to the challenges they face. It's important to always bear in mind the client's need to stay as he is, where he feels safe and his or her wiliness to change, and understand that therapist's intervention's that are below or above the client's TZPD will be invalidated by disinterest or intolerable risk, respectively (Ribeiro et al, 2013). In the interest of working within the client's TZPD, the therapist can balance between two types of interventions: supporting and challenging.

Supporting means confirming and elaborating upon the client's own perspective of his or her experiences what would, in theory, foster feelings of safety and comfort on the client. By doing this, the therapist is working closer to the clients actual TZPD level. On the other hand, challenging, is working closer to the clients TZPD potential level and promoting the revision of the client's current perspectives (Ribeiro et al., 2014a). Nevertheless, Ribeiro and Colleagues (2013) propose that, these strategies have to be balanced and responsive to the client's needs at that time because if the therapist gives too much emphasis on safety based interventions, then he may miss opportunities to work on the client's problematic perspective resulting on a lack of improvement of the client's TZPD. In the other hand, if given too much importance to challenge, even when it surpasses the client's TZPD limits, it may arouse excessive anxiety furthering resistance by the client.

In both of these interventions the client may validate or invalidate the therapeutic interventions depending on the level of risk they experience. This level of risk depends on where the intervention is relative to the client's current TZPD. If the intervention was within the client's TZPD level, he/she will give

a validating response which means the client felt understood by the therapist. In the beginning of the therapeutic process, the therapist tends to support the problem because it's important that the client feels that the therapist understands his or her problems and that their views and beliefs are respected. When validating the therapist interventions of supporting the innovation or challenges, the client is accepting the therapist's encouragement to look at his or hers experience from a new, more healthy perspective. An invalidation response is given when the client declines to look at his or hers experiences from a new perspective, because he experiences to much risk, failing to meet the therapist challenge. However, the client can also invalidate when, during a supporting intervention, he feels that the therapist doesn't understand or supports is current perspective or progress. Usually this transpires when the intervention does not respect the client's TZPD. These responses, their frequency and when they occur are important to the therapeutic collaboration because it indicates if the collaboration is evolving or if it is in danger of rupture, which can dictate the future of the therapeutic process. Using this theoretical framework, Ribeiro et al., (2013) constructed the therapeutic collaboration coding system (TCCS) to analyze and track the interaction, on a moment-by-moment basis, between the therapist and the client.

As was referred above, the type of interventions by the therapist and where they stand within the clients TZPD will help or deter the client progress (Leiman & Stiles, 2001; Ribeiro et al., 2013). However, there is a number of ways the therapist can deliver an intervention of support or challenge, which we call subcategories of the therapist's interventions or subcategories for short. To support the client's perspective, the therapist can, for example, reflect on what the client expressed (e.g., "base on what you are saying it seems that those behaviors made you disappointed with yourself…, Am I understanding well?") but he can also use questioning to explore the client's experience (e.g., "What made you behave that way?"). The same can be said for challenging interventions where the therapist can use a number of subcategories, for example, confronting (e.g., do you think you should have done something different?) or inviting the client to adopt to a new action (e.g., what do you believe you could do that may be helpful in those situations?). Responsiveness is an interpersonal skill that can and should be trained in order to potentiate the effectiveness of the therapist so he can better identify, not just if it's a moment to support or if it is a moment to challenge, but how to deliver this intervention (Hatcher, 2015). As Stiles and Horvath (2017) explains, "to infer that techniques do not matter would be missing the point", even when manualized approaches direct for a type of intervention, it is important to understand what the client needs in that instant and use a subcategory in accordance to that. Hill (2014), in her book "Helping skills – facilitating exploration, insight and action", talks about helping skills and when they should be used. According to Hill's three-stage model, some helping skills should be used more than others in specific

moments of the therapeutic process. For example, minimal encouragement is one helping skill that is very useful during the exploration stage where the goal is to actively listen and nonverbally attend to what the client is saying. In the insight stage where the goal is to promote awareness, one of the skills that the therapist can use is interpretation and to explore the idea of change during the action stage, one helpful skill is guidance. According to this model every helping skill, when used correctly should help the therapist achieve a goal that would benefit the client and the therapeutic process. Some of these helping skills can be compared to certain subcategories, of therapist's intervention, contemplated by the therapeutic collaboration model (Ribeiro et al., 2013). It is important to understand if, like Hill (2014) proposes, the therapist can be more responsive when he uses different subcategories in different stages of the therapeutic process or if some subcategories present a general pattern of responsiveness. This can be an important contribution not just in a theory building perspective but can also have implications in therapist's appropriate responsiveness training.

Hatcher (2015) draws attention to the need of further investigation on responsiveness with a focus on the interactions between the particular types of interventions and the therapy process and we intend to help bridge this gap by micro-analyzing the responsiveness across a psychotherapy case and answer the question: What subcategories, of therapist's interventions, show a pattern of responsiveness or non-responsiveness by the therapist?

In sum, we wish to ascertain which subcategories, when used by the therapist reveal that he is being more responsive. We will analyze each subcategory and find if there is a pattern of responsiveness given by the client's response: if he validates, we assume the therapist was responsive and, if he answers with ambivalence or invalidation, we assume that the therapist was not responsive, when he used that subcategory to deliver the intervention.

Method

Participants

Client

The client was a 22 years old male and a full-time college student. He had resorted to the Psychology Service of the university where he was diagnosed with major depressive disorder. He was struggling to deal with a recent break-up with his girlfriend and with conflicts that were emerging within his friend group in which his girlfriend was also a part of. The client was experiencing feelings of sadness and confusion because he felt like his friends were shutting him out and only seeking him when they

needed him (i.e., For him to give them a ride).

The unresolved situation with his ex-girlfriend and the internal debate the client had about whether or not he should pursue a reconciliation, was also taxing for the client.

In the beginning of the first therapy session, the client presented a score of 93 (clinical) on the Outcome Questionnaire (OQ-45). In the end of the therapeutic process his score was 50 points (non-clinical), a difference of 43 points. This means that he made substantial gains and thus met the criteria proposed by Jacobson and Truax (1991) for reliable change (RCI) on Outcome Questionnaire.

Therapy and therapist

The client completed 16 sessions, approximately one hour long, of Cognitive Behavior Therapy (CBT) and the therapist that lead these sessions was a 49 years old woman, with 22 years of clinical experience at the time of the request and with a Ph.D. in clinical psychology. All therapy sessions, apart from the 9th and 12th session because of lack of recordings, were transcribed, and both the client and the therapist gave written consent for these transcripts to be used for research purposes.

One of the objectives during the therapeutic process was to improve the client's social skills to help him deal with conflict situations in order to have a more positive relationship with his friend group and with his ex-girlfriend. Another goal was to strengthen the client's own resources in order to improve his self-confidence and thus be able to seek things that give him pleasure and satisfaction instead of always putting the needs of other before his own and then feeling he was not appreciated.

Researcher Design

This is a descriptive case study and as such it can be very helpful to point us to the direction we should follow in further investigations, even though we can't generalize the results to the population. The results can be used for building theory, meaning that a theory needs to make sense, not just the common features, but also the distinct features of every case (Stiles, 2007).

This research project was led by a 5th year, female student doing her master in psychology. Two coders were involved in the coding process. A researcher, co-advisor of the present study, with a doctorate degree and practice relating to the therapeutic collaboration coding systems and a female student that was in her last year of the master degree in clinical psychology. All the researchers involved in this project were members of the therapeutic relationship research group that belong to the psychotherapy and psychopathology research unit of the University of Minho.

Measures

Outcome measures

Outcome Questionnaire (OQ-45). As stated above, the OQ-45 (Lambert et al., 1996), was used to assess the success of this case. This instrument was adapted to the Portuguese population by Machado & Fassnacht (2014). The OQ-45 is a self-report questionnaire with 45 items on a 5-point Likert scale ranging from never (0) to almost always (4), resulting in a total score ranging from 0 to 180. The higher the score, higher the distress and poor functioning.

The Portuguese version of the OQ-45 has an internal consistency that ranges from .92 and .93, depending on the population, and a test-retest of .79 with a reliability of .80. This questionnaire encompasses the following sub-scales: Symptom distress (α=.89-.92), Interpersonal relation (α=.70-.73), Social role (α=.56-.61).

There are two criteria to determine if there was significant clinical change. The first is the cut-off score of 62, if the client presents a score that falls below 62 it's considered that he belongs to the non-clinic population. The second criterium concerns the reliability of the client's pre and post-test change. The Reliable Change Index (RCI) is calculated as 15 points for the total score. If the client changes by at least 15 points, then it is regarded as having made reliable change.

Therapeutic Collaboration Coding System (TCCS). This coding system was created by Ribeiro et al. (2013) and allows the identification and characterization of different types of collaborative exchanges that can occur between the client and his therapist in relation to the TZPD of the former. This coding system is transcript-based, but videos or audio recordings can be used if possible.

This system analyzes each pair of therapeutic speaking turns. Every therapeutic exchange is characterized by an intervention by the therapist and a response by the client. The therapeutic exchange coding is contextualized in the immediacy of the dialogue and in the context of the session as a whole.

Using a set of pre-stablished rules and categories every intervention by the therapist can be characterized as support (of the problem or the innovation) or challenge and the answers the client gives can be of validation, invalidation and ambivalence. There are 15 different therapeutic exchanges that are defined by the combination between the three main types of therapist intervention's (supporting the problem, supporting the innovation and challenging) and the five client's responses in reference to his TZPD (security, tolerable risk, ambivalence, disinterest and intolerable risk). In total, there are six collaborative exchanges, six non-collaborative and three ambivalent.

In this study was conducted a micro-analyze of the subcategories of the therapist interventions and the type of response they arise from the client. Support interventions include eight subcategories of therapist's interventions that can either be focused on the problem or on the innovation and 11 subcategories the therapist can use to deliver a challenging intervention. The combination of this possibilities sums up to 27 subcategories of the therapist interventions (Table 1).

This system shows good reliability with Cohen's kappa values of .92 for therapist interventions and .93 for client responses.

Table 1

Subcategories of therapist's interventions

Intervention	Description	Example
Interventions for supporting the problem and/or the innovation		
Reflecting	Therapist reflects the content, meaning, or feelings expressed (more or less openly) in client's previous discourse/behavior. He/she can repeat client's words and/or use his/her own words, as long as not adding any new meaning.	*"You feel that A. feels the same thing you do, in those moments, is that it? Am I understanding correctly?"*
Summarizing	Therapist summarizes client's previous discourse or previous interactions, repeating client's words and/or using his/her own words, without adding any new meaning.	*"Ok, and that was what stuck with me from last session when you talked a lot about being disappointed with yourself, disappointed with others but I also got the idea that you feel that you are always there for other people, always available."*
Questioning	Therapist explores client's experience through questions. These questions can be open, allowing the client to elaborate his/her answer in multiple ways; or can be closed, to get more factual or concrete information.	*"Do you have any idea, before we get into detail, about what got you sad or upset this week?"*
Demonstrating interest and/or attention	Therapist openly demonstrates his/her interest and/or attention in client's discourse and/or experience.	*"I imagine that it could be quite painful for you."*
Interventions for challenging		
Interpreting	Therapist proposes a new perspective, using his/her own words but maintaining a sense of continuity in relation to client's own discourse and/or experience.	*"T- The feeling that I have is that, if I'm understanding correctly, you are paying attention... you are cautious in some situations, trying to protect yourself in those situations..."*
Confronting	Therapist questions client's perspective or proposes him/her a new one. There is a clear discontinuity between therapist's intervention/perspective and client's discourse/experience.	*"T- But notice what you told me just now: it's once again about your concern about how she is. And what about how you are?"*
Inviting to adopt a new action	Therapist invites client to act differently, either within session (e.g., inviting client to metaphorically give a name to his/her problem, as it is usual in narrative therapy) or outside the session.	*"T- I was thinking on another possibility that is: when it's really uncomfortable for you maybe it's better to ignore. But when you feel calmer and when you feel that there is room for it, what do you feel about telling them that this situation is uncomfortable for you..."*

Inviting to explore a hypothetical scenario	Therapist invites client to consider cognitive, emotional, and/or behavioral alternatives with regard to the way he/she usually understands and experiences the world.	*"T- You liked to be closer to them, and that could be what, for example...? If the relationship could be closer, how could you see it in the day-to-day? What would be different, what doesn't happen now, or happens less?"*
Changing the level of analysis	Therapist invites client to change his/her experience level of analysis, from a more descriptive to a more abstract level, or vice-versa.	*"T- Do you want to explain that a bit? How is it that for them is a virtue and for you it is a flaw?"*
Emphasizing novelty/reinforcing	Therapist underlines client's indications of change or invites client to elaborate on a new insight about his/her problems or emergent changes.	*"T- This seems to be, in fact, an important discovery this week. This perception that experiences and situations sometimes have two sides, a positive and a negative"*
Tracking change evidence	Therapist asks for evidences regarding client's indications of change.	*"T- What has been helping you staying calmer, more serene?"*
Interventions to support and challenge		
Guiding	Therapist assumes an expert position (e.g., orienting and structuring the session or the therapeutic process, responding to a clarification request from the client about some strategy or procedure, giving client a rational of his/her intervention)	*"In some way we can say that one of the goals of this process can be helping you to recover... to feel a little bit like you used to..."*
Asking for clarification	The therapist asks the client to repeat his/her previous turn or part of it, in order to make clear that he/she has heard it well.	*"Why? I didn't understand..."*
Minimal encouragement	Therapist makes minimal encouragement of client's speech, by repeating client's words, in an affirmative or interrogative mode.	*"C- Going to the gym. T- Going to the gym, hum-hum..."*
Clarifying the previous intervention	The therapist repeats or explains it after a client's request for clarification.	*"T- What do you think that, in this process, has been useful for you? C-Useful? T- What has been helpful? What do you think, about what we have been doing or that I propose, that was useful for you?"*

Procedure

This study is part of a research project financed by the Fundação Bial (178/12) "How collaboration in psychotherapy becomes therapeutic: a study of interactive and psychophysiological processes in good and poor outcome cases". Therefore, the case analyzed in this study was selected from the project database, based on following criteria: given that this project is an integral part of a master degree and thus has time restrains, the therapeutic process had to be finished and the sessions transcribed and coded. Another criterion was the successful outcome, because the literature links appropriate responsiveness, by the therapist, with a high probability of successful therapy outcome (Styles & Horvath, 2017). As the aim of this study was analyzing the responsiveness of subcategories used during therapist interventions, a good outcome was to be expected.

Since this research is part of an investigation project, all the cases in this databased were video recorded and the transcriptions and coding were done prior to the start of this study by members of the therapeutic relationship's team.

From the 16 therapy sessions, two of them (the 9th and 12th) weren't recorded and were disregarded. The remaining 14 sessions were then coded using the TCCS. The first five sessions were coded by two judges, the first was a researcher and the second was a 5th year master's student. The agreement between judges was of 93.78% for the therapist interventions and 90.76% for the client's responses. The last 9 sessions were independently coded by the first judge.

After the codification of all the sessions we proceeded to the identification of the subcategories of the therapist's intervention used in the case. The frequency of each subcategory was calculated in every session. Consequently, the responses of the client to the different subcategories were analyzed in order to see if any subcategory used by the therapist resulted in more validation responses which indicated responsiveness by the therapist or more ambivalence and invalidating responses which signaled non-responsiveness.

A descriptive analysis was done to understand if there was a pattern of responsiveness or non-responsiveness associated to these subcategories. In subcategories that showed evidence of responsiveness or non-responsiveness, the joint proportions of the client's responses, to those interventions, were calculated. This permitted to compare each session and track the evolution of the therapist responsiveness across the case.

Results

Frequency of therapeutic exchanges across sessions

In order to understand the overall responsiveness, every episode was analyzed. The frequency of each intervention by the therapist, the following client's response and the therapeutic exchanges (which refer to the position of each episode in relation to the TZPD limit), across every session, were calculated. Collaborative episodes are within the TZPD, while ambivalence episodes are located in the edge of the TZPD and non-collaborative episodes are outside the TZPD.

In every session analyzed, as shown in Figure 1, most of the therapeutic exchanges are collaborative which means that most episodes occurred within the TZPD. This demonstrates that the therapist tends to be responsive, his interventions are appropriate and validated by the client. There seems to exist an increase of non-collaborative exchanges from the third to the seventh session after which it decreases again. Ambivalence episodes start to increase during session eight and remained the second most prevalent therapeutic exchange until the end of the therapeutic process.

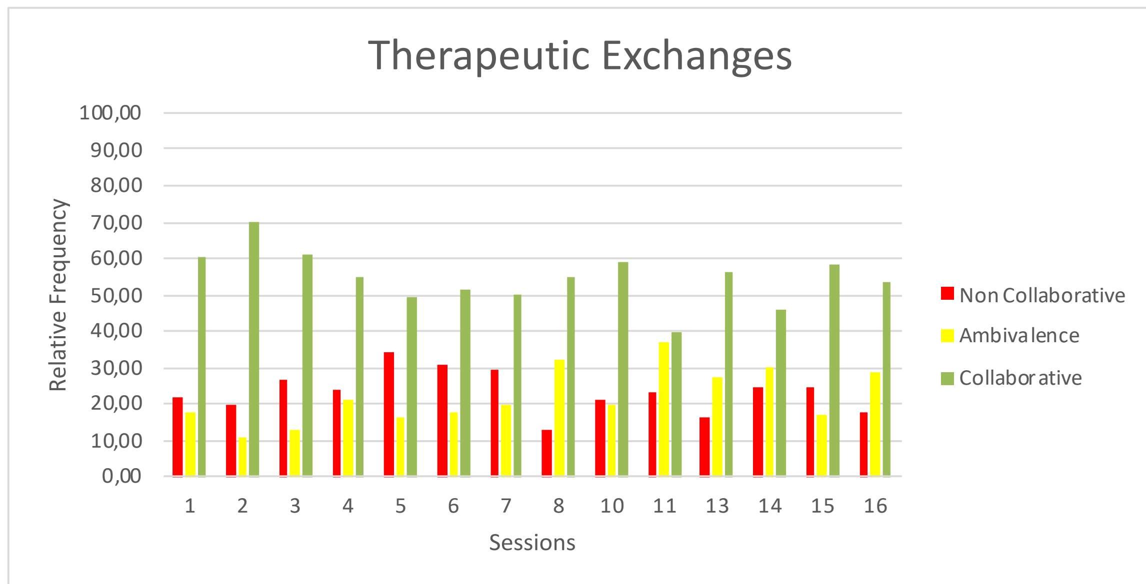

Figure 1 Relative frequency of therapeutic exchanges across sessions.

Percentage of client's responses to each subcategory used by the therapist, across sessions

The client responses were categorized into responsive, if the client validated the intervention, and non-responsive, if the client responded with ambivalence or invalidated that intervention. Table 2 shows the percentage of client's responses to each subcategory used by the therapist to deliver a specific intervention in each session.

Some subcategories were used very few times during the therapy process thus it was stablished the arbitrary value of 5% as a cut off point below which any subcategory with a lower percentage of occurrence during the whole case, were not analyzed in regard to the client's responses. The subcategories eliminated concerning the interventions of supporting the problem were the following: Summarizing (.82%); Demonstrating interest and/or attention (2.13%); Asking for clarification (1.81%) and Clarifying the previous intervention (1.31%). As for Supporting the innovation interventions, the subcategories that were disregarded were: Summarizing (.00%); Asking for clarification (1.22%); Clarifying the previous intervention (.00%) and Minimal Encouragement (2.44%). Some subcategories associated with challenging intervention were also not analyzed because of the low percentage of occurrence, namely: Asking for Clarification (.72%); clarifying the previous intervention (1.81%); Minimal Encouragement (3.96%) and Tracking change evidence (2.26%).

Table 2

Percentage of client's responses to each subcategory

Session number		1		2		3		4		5		6		7		8		10		11		13		14		15		16	
Percentage of client's responses		Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.	Resp.	N. Resp.
Supporting the problem	Reflecting	87.1	12.9	93.2	6.8	81.8	18.2	86.4	13.6	93.3	6.7	84.6	15.4	72.7	27.3	61.5	38.5	90.9	9.1	55.6	44.4	54.5	45.5	77.8	22.2	83.3	16.7	60.0	40.0
	Questioning	69.6	30.4	76.9	23.1	84.4	15.6	70.8	29.2	78.3	21.7	66.7	33.3	65.7	34.3	47.1	52.9	81.3	18.8	50.0	50.0	64.7	35.3	57.1	42.9	77.8	22.2	75.0	25.0
	Guiding	50.0	50.0	100.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	40.0	60.0	0.0	100.0	66.7	33.3	0.0	0.0	0.0	0.0	100.0	0.0	50.0	50.0	0.0	0.0	100.0	0.0
	Minimal encouragement	50.0	50.0	100.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	100.0	0.0	100.0	0.0	66.7	33.3	100.0	0.0	0.0	0.0	100.0	0.0	100.0	0.0	100.0	0.0	0.0	0.0
Supporting the inovation	Reflecting	0.0	0.0	85.7	14.3	100.0	0.0	0.0	0.0	100.0	0.0	75.0	25.0	66.7	33.3	75.0	25.0	33.3	66.7	50.0	50.0	62.5	37.5	66.7	33.3	100.0	0.0	80.0	20.0
	Questioning	0.0	0.0	50.0	50.0	100.0	0.0	0.0	100.0	0.0	100.0	62.5	37.5	0.0	0.0	66.7	33.3	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	0.0	0.0	0.0
	Demonstrating interest and/or attention	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	100.0	0.0
	Guiding	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0
Challenging	Guiding	66.7	33.3	58.3	41.7	16.7	83.3	81.3	18.8	25.0	75.0	28.6	71.4	13.3	86.7	68.8	31.3	61.9	38.1	57.1	42.9	44.4	55.6	33.3	66.7	63.6	36.4	42.9	57.1
	Interpreting	36.4	63.6	52.6	47.4	69.7	30.3	55.0	45.0	41.7	58.3	59.1	40.9	45.5	54.5	63.2	36.8	82.6	17.4	36.0	64.0	57.9	42.1	26.7	73.3	53.8	46.2	41.7	58.3
	Confronting	23.8	76.2	45.8	54.2	30.3	69.7	21.7	78.3	35.7	64.3	21.4	78.6	38.7	61.3	51.9	48.1	43.5	56.5	33.3	66.7	38.5	61.5	31.3	68.8	20.0	80.0	26.7	73.3
	Inviting to adopt a new action	100.0	0.0	75.0	25.0	62.5	37.5	65.2	34.8	61.9	38.1	55.6	44.4	66.7	33.3	66.7	33.3	57.1	42.9	75.0	25.0	50.0	50.0	63.6	36.4	58.3	41.7	100.0	0.0
	Inviting to explore a hypothetical scenario	50.0	50.0	63.2	36.8	33.3	66.7	36.8	63.2	30.8	69.2	40.0	60.0	30.0	70.0	50.0	50.0	42.1	57.9	0.0	100.0	54.5	45.5	0.0	100.0	33.3	66.7	33.3	66.7
	Changing the level of analysis	69.2	30.8	56.5	43.5	19.0	81.0	42.3	57.7	50.0	50.0	53.3	46.7	61.1	38.9	29.4	70.6	52.2	47.8	55.0	45.0	44.4	55.6	52.9	47.1	58.8	41.2	53.3	46.7
	Emphasizing novelty/ reinforcing	57.1	42.9	50.0	50.0	45.0	55.0	50.0	50.0	23.8	76.2	54.2	45.8	50.0	50.0	30.4	69.6	66.7	33.3	33.3	66.7	57.1	42.9	25.0	75.0	60.0	40.0	66.7	33.3

From the subcategories that were further analyzed, there is pattern of responsiveness amid all the subcategories used to support the client. The data obtained indicates that, in this case, the client tends to validate the therapist's interventions when he/she support's the problem or supports the innovation. This pattern of response denotes that the therapist is being responsive when he makes use of these subcategories to support the client, thereby helping him evolve within the TZPD throughout the therapeutic process.

However, when it comes to challenging, the pattern of client's responses points to a larger disparity of therapist's responsiveness among the different challenging subcategories. When the therapist challenges the client inviting him to adopt a new action, he appears to be especially responsive indicating that the client is furthering inside the TZPD level. However, this was not always the case when the therapist invites the client to explore a hypothetical scenario or confronts him, in which the client's responses indicate that the therapist was not being responsive with these interventions being, many times, outside the client's TZPD.

Challenge subcategory with a general pattern of therapist responsiveness

In every session, when the therapist invites the client to adopt a new action, he was likely being responsive. During the entire case, the client validation response rate, for this intervention was always superior to the non-responsiveness (as shown in figure 2). This signifies that the therapist is being responsive more than half percent of the times he delivers this intervention to challenge the client's perspective. In the first session the therapist appears to be responsive every time he invites the client to adopt a new action. However, from the second to the fifteenth session there are moments where the therapist is not being responsive because this intervention is outside the client's TZPD. This is more evident during the 13th session where the therapist is only responsive 50% of the time, when he uses this subcategory to challenge the client. In the last session, however, the therapist is responsive whenever he uses this subcategory.

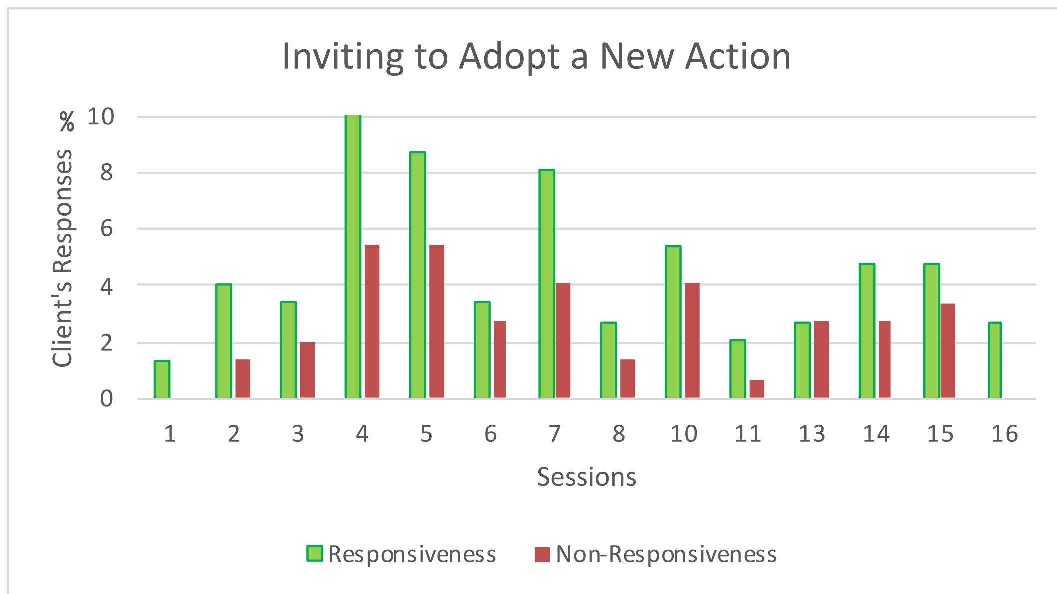

Figure 2 Joint percentage of client's responses to "Inviting to Adopt a New Action" Interventions across sections.

The Case illustration 1 portrays a moment during session 11 when the therapist's invites the client to adopt a new action of trying to self-regulate and analyze the situations before diving into them and getting overwhelmed. This intervention is responsive to the client's needs, at that time, helping the client move forward in his TZPD but not going above the client's limits. When this happens, the client feels safe and validates this intervention.

Case illustration 1 - (session 11)

T. (108) – And that observation that you have been making it's like it's a way to self-regulate that can help you decide "should I get involved, shouldn't I get involved…" and you can do that in home or with your friends… Maybe that's the suggestion I would give you during this vacation in addition to what we discussed earlier about diversifying the people you hang out with… Going out with other people, other groups.

C.- Yes. I can try to go out with other people.

Challenge subcategories with a general pattern of therapist non-responsiveness

The majority of subcategories analyzed seemed to indicate that the therapist is mostly responsive during the entire therapeutic process. However, this was not the case with all the subcategories. The results obtained depicts a clear pattern of non-responsiveness especially in two of the challenge subcategories,

namely: inviting to explore a hypothetical scenario (Figure 3) and confronting (Figure 4).

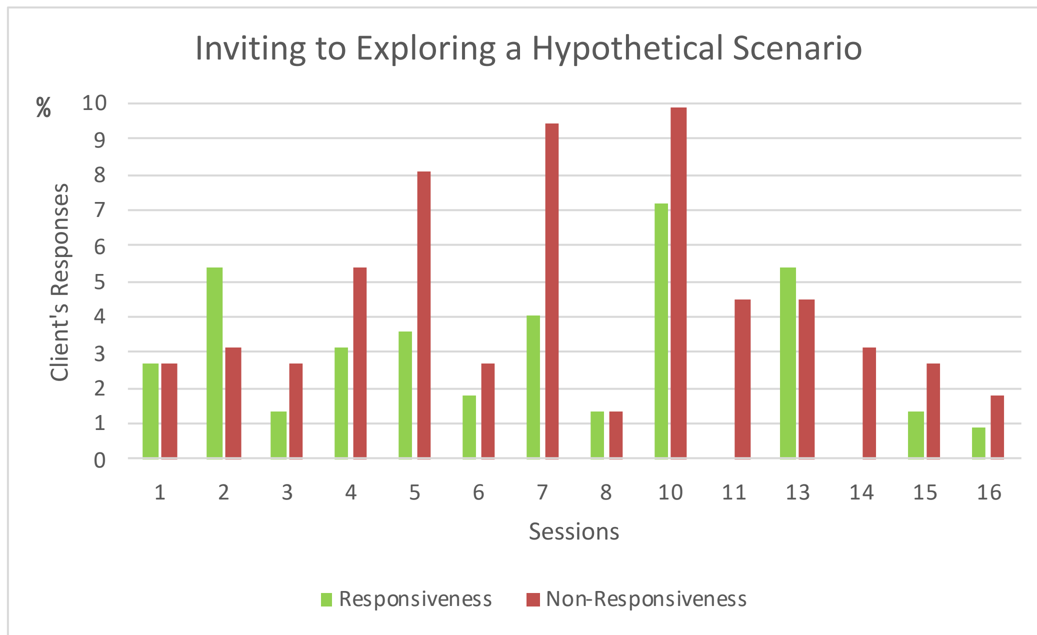

Figure 3 Joint percentage of client's responses to "Inviting to Explore a Hypothetical Scenario" Interventions across sessions.

In the first two sessions, according to the client's response pattern, the therapist was mostly responsive when he invites the client to explore a hypothetical scenario. Nevertheless, from the third session forward, there's a prevalence of non-responsiveness when the therapist makes use of this subcategory (with a mean of non-responsiveness responses of 64.7%). During session 13 there is a slight rise of the therapist responsiveness, but in the next session it changes, and the therapist intervenes outside the client's TZPD 100% of the times that he invites the client to explore a hypothetical scenario.

It is clear that the therapist makes more use of this subcategory to challenge, during the middle of the therapeutic process. After the 5th session, the therapist alternates the amount of times he uses this intervention. Every session in which the therapist invites the client to explore a hypothetical scenario, and the client responds with non-responsiveness, is followed by a session where the therapist decreases this type of intervention.

Case illustration 2 - (session 11)

T. (86) – How do you think that week is going to be (referring to the week of vacations)? What do you like it to happen?

C.– It's going to be peace and quiet... a lot of peace and quiet... will be more relaxed... I, I... I think that's what's going to happen, but at a certain point we won't have anything to talk about, we are going to be annoyed...

In this illustration (case illustration 2), when the therapist proposes the client to imagine his ideal scenario, the client begins to do so by depicting a calm week where he would feel relaxed. Nonetheless, he quickly returns to his initial perspective demonstrating this intervention to be beyond his current TZPD in which returning to his normal perspective feels safer than to imagine an idyllic scenario.

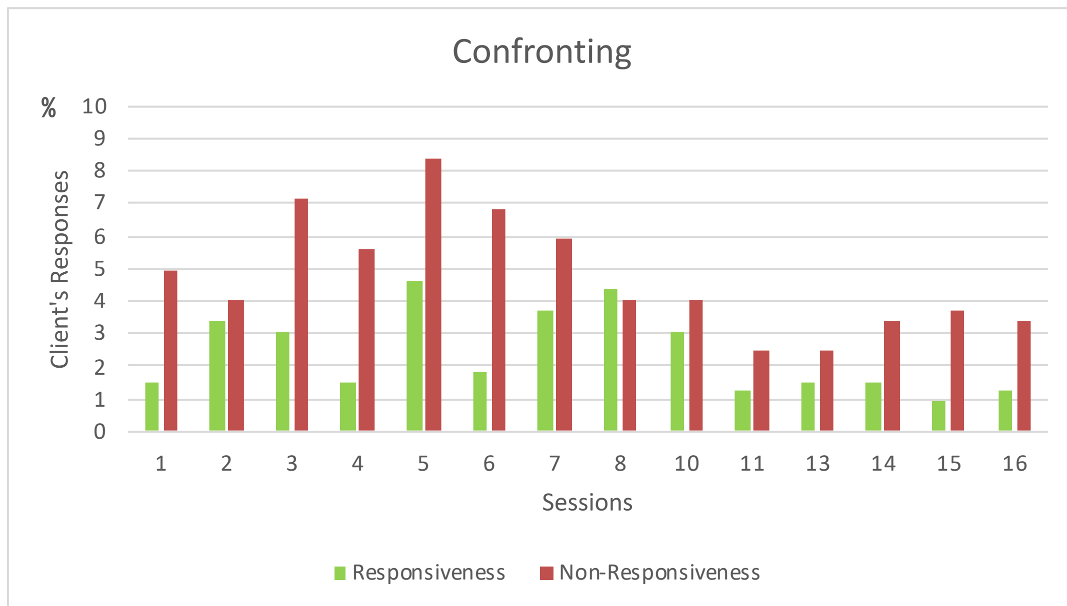

Figure 4 Joint percentage of client's responses to "Confronting" Interventions across sessions.

Confronting, in this case, is mostly outside the client TZPD and his responses point to an overall non-responsiveness by the therapist. The therapist confronts the client much more in the middle of the therapeutic process, being non-responsive most of the time. After the 7th session, however, the therapist began to confront less until the 13th session, after which there was a slight increase. During session 8 there is a slight exception to this pattern on non-responsiveness, with an increase of responsive responses (51.9%) over the non-responsive responses (48.1%).

Case illustration 3- (session 5)

T. (59) – But it's being difficult to move on, right? But it is important for you to find some balance//

C.– Because I can't, I, I can't find a balance right now. And, and, and I forget things, I forgot my mother's birthday... (cries)

During session 5, the therapist confronts the client's perspective that it's too difficult to move on, but it reveals to be too much for the client that, in turn, invalidates this intervention. The client returns to his usual posture focusing on what he can't do and what he is doing wrong instead of trying to think of what he can do to find balance.

Discussion

In this case study, we set up to understand the therapist's appropriate responsiveness in a good outcome case. It is important to note that this dyad worked mostly within the TZPD which means the client typically validated the therapist's intervention as showed by the prevalence of the collaborative episodes throughout the case. These results are consistent with the findings of several authors (Leite, 2012; Ribeiro et al. 2014b) reiterating Tryon and Winograd (2011) statement that if both the client and the therapist are collaborative and work together for the common goal, the outcome is improved.

In some moments the client showed an increase of ambivalence which reflects a mismatch of the therapeutic collaboration were the therapist worked closer to the client's potential TZPD whereas the client returned to where he felt more secure in his current TZPD. Ambivalence can be considered a self-protection mechanism to manage the risk feeling that comes with change. The way in which the therapist addresses these responses can dictate the progress or deterioration of the therapeutic process. Therapist's that are not sensitive to the client's needs (non-responsive) and challenge this ambivalence responses, fail to restore collaboration and contribute to the deterioration of the therapeutic collaboration (Ribeiro et al. 2014a). This seems to support the responsiveness of the therapist in this case, because every session with a spike of ambivalent episodes is followed by a session with higher collaborative episodes.

The therapist, in this case, is seemingly responsive when he supports, both the client's problem as well as the client's new perspective. As argued by Ribeiro and colleagues (2013) when the therapist supports the client perspective, he feels safe. When the therapist supports, he or she is at the client's level, showing empathy towards the client in the sense that he is, in some degree, nonjudgmentally accepting the client's perspective, be that the problematic one when he supports the problem, or the new one when the therapist supports the innovation. This empathetic nature is very important for the client's change (Rogers, 1951). In fact, Hill (2014) uses similar subcategories, or what she calls "helping skills", in the first stage of her three-stage model in which the therapist seeks out to learn about the client and to facilitate the client's concerns and experiences. In fact, in person centered therapy, this support is all that is needed for the client to change (Rogers, 1951).

Challenging can, also, be a very helpful intervention. When the therapist challenges, he or she is working closer to the client's TZPD potential level, trying to help the client revise the current maladaptive perspective to a new, healthier, one (Ribeiro et al. 2013). Challenging can show the therapist's responsiveness to the client's needs when he implements it accordingly with the client's TZPD, as showed in this case when the therapist invites the client to adopt a new perspective. Even though there are moments when this subcategory is used outside the client's TZPD and the client answers with ambivalence or invalidation to this intervention either because of intolerable risk or disinterest, the large majority of this interventions is well

received by the client, expanding his potential TZPD level but still insuring that the client is ready to step outside his comfort zone when trying to adopt a new action and still felling safe when doing it. This demonstrate responsiveness by the therapist because to be successful in encourage the client to take action the therapist needs caution, self-awareness and empathy for their clients (Hill, 2014).

As for confronting and inviting to explore a hypothetical scenario, they appear to be mostly outside of the client's capacity to accommodate a new perspective at the moment of the intervention. Interestingly, in this case, the therapist seems to be responsive, when he invites the client to explore other possibilities different from the usual way of understanding and experiencing, earlier in the therapeutic process. However, this kind of challenging becomes increasingly invalidated by the client which means the therapist isn't being responsive to the client's needs at the time. The same can be said about the therapist responsiveness when he confronts the client clearly opposing the client's usual perspective. Challenging this client in these two ways seems to foster invalidation by the client signaling the non-responsiveness. Given that both subcategories aims for a review of the clients views it can mean that this client is less prepared to challenge his believes and perspectives. Depressed patients, as this case, tend to have positive beliefs about rumination and worry (Westra, 2004) what can increase the ambivalence and the feeling of risk when asked to review these beliefs (e.g T: I think you're too caught up in this way of thinking. So, what if we tried to make this thought a little more flexible, in the sense that it's not "I have to" but rather "maybe today, ok, I can..."; C: But, but what if I, and, and ... I'm going to have to question myself, but what if, and if not ... (2.0) What if do I not find the answer?). Resistance to change is common and entails the client's need to somewhat maintain the status quo in their mental lives, but is also important for the therapist to further understand the client and their struggles (Newman, 1994), which can give an opportunity for the therapist to be more responsive in the future.

Nevertheless, even though the therapist seems to be, mostly non-responsive when he or she confronts or invites the client to explore a hypothetical scenario, the therapist was overall responsive during the therapeutic process, which can largely have contributed to it's good outcome. Even when challenging the client using these two subcategories it seems important to underline some signs that can point to the therapist responsiveness in the long term. The therapist, after the seventh session, starts to gradually decrease the amount of times he confronts the client; this can mean that the therapist understands that challenging the client this way is not well received by the client. The therapist also seems to alternate between challenging a lot while inviting to explore a hypothetical scenario and sessions where he or she doesn't use, this type of challenges, so much. One interpretation for this is that the therapist was responsive to the fact that this type of interventions was mostly outside the client TZPD and during the therapeutic process tried to expand the client's level, retrieving after sessions where this was highly non-responsive.

It seems apparently clear that the appropriate responsiveness of the therapist is a key attribute in the therapeutic process and that some subcategories were more appropriate for the client while others were more non-responsive. Even though we can't generalize the results, they show that maybe not every subcategory used by the therapist is equally responsive. In further studies, if their results point to the same as the results of this study, it could have implications in future theory building as well as in therapist's skill training. It could be very helpful, for a therapist, to understand if some subcategories should be used with more caution and comprehend in which situations, they are more useful.

As for the limitations of this study, it should be noted the lack of data from session 9 and 12 due to the lack of audio and video recordings, that made it impossible to transcribe and code those sessions. This missing data can have impact on the analyzes conducted, for example to include some subcategories that were excluded from further analyzes due to the low percentage of occurrence in the case. In this sense, these results should be interpreted with care.

The definition of responsiveness as the immediate response from the client, as used in this study can also be flawed in the sense that even though the client invalidates or responds with ambivalence may not, necessarily, mean that it was not what was needed in that moment in order to facilitate change. In further investigations it could be important to analyze these interventions not just in the immediate response but also contextualize it in the session.

It would be helpful, in further research, to replicate this study with a poor outcome case to see if there is a pattern of appropriate responsiveness or non-responsiveness associated with any subcategory in a case that doesn't report significant improvement. It also would be interesting to analyze this with different diagnosis and therapeutic models so as to encompass more detailed information to help in theory building.

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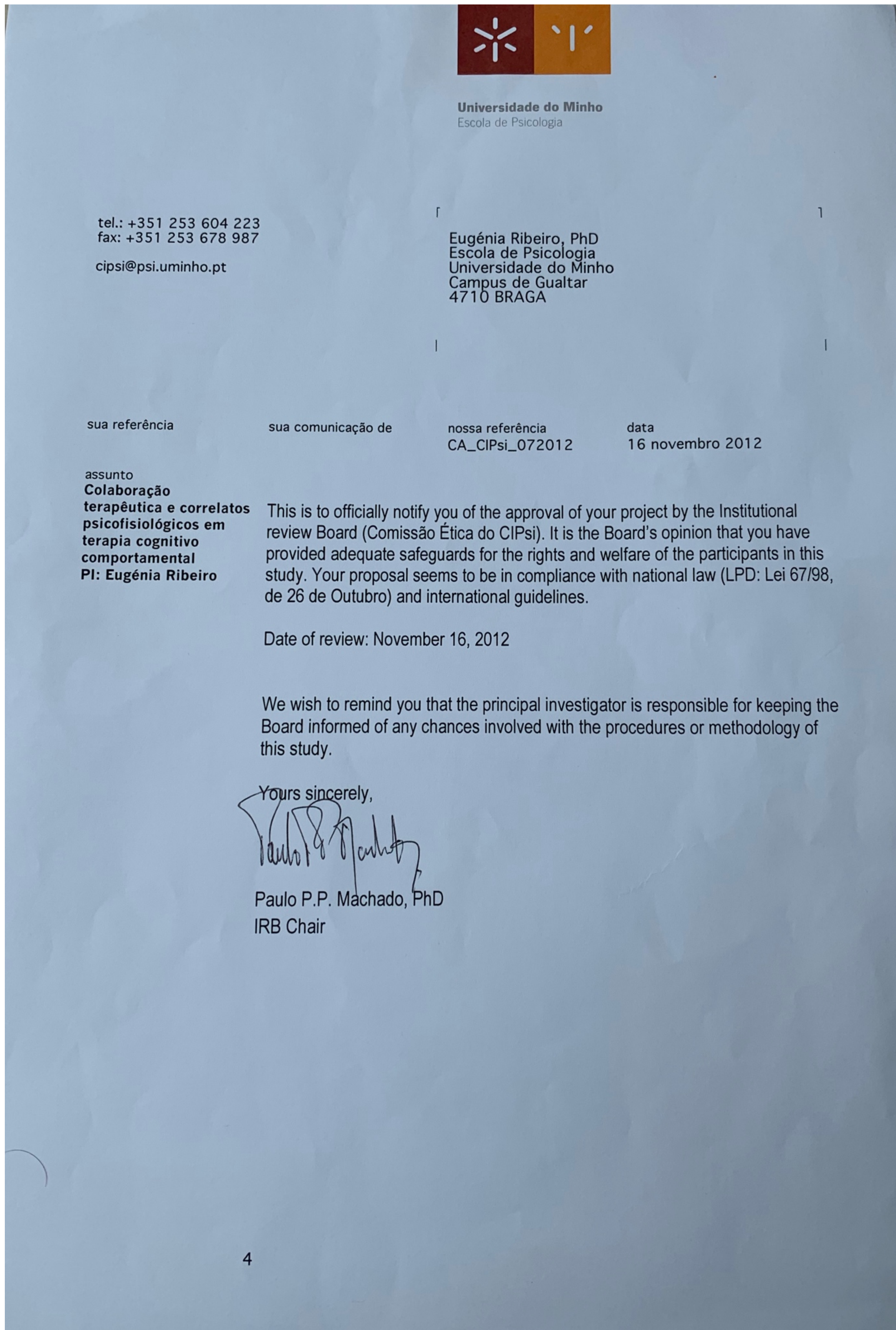
Anexos

Anexo A - Aprovação da Comissão de Ética da Universidade do Minho



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sua referência	sua comunicação de	nossa referência	data
		CA_CIPsi_072012	16 novembro 2012

assunto
Colaboração terapêutica e correlatos psicofisiológicos em terapia cognitivo comportamental
PI: Eugénia Ribeiro

This is to officially notify you of the approval of your project by the Institutional review Board (Comissão Ética do CIPsi). It is the Board's opinion that you have provided adequate safeguards for the rights and welfare of the participants in this study. Your proposal seems to be in compliance with national law (LPD: Lei 67/98, de 26 de Outubro) and international guidelines.

Date of review: November 16, 2012

We wish to remind you that the principal investigator is responsible for keeping the Board informed of any chances involved with the procedures or methodology of this study.

Yours sincerely,

Paulo P.P. Machado, PhD
IRB Chair

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