

# Inside the consulting room of a highly effective therapist: An analysis of first sessions

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## Abstract

**Aim:** The aim of this study was to capture the most salient aspects of first-session activities by a therapist who consistently had good clinical outcomes.

**Method:** Constructivist grounded theory was used to analyse the first three audio-recorded psychotherapy sessions with two clients.

**Results:** The analysis generated 12 categories organised into three major domains: (a) promoting clients' sense of agency and the collaborative nature of the therapeutic process; (b) supporting clients' exploration of meaningful contents, balancing responsiveness between following clients and introducing new dimensions; and (c) creating a climate of emotional security based on empathic presence, authenticity and positive regard.

**Conclusions:** The results show key aspects of the therapist's performance, such as distinguished clinical skills, responsiveness and strong relational abilities. The results support the literature on highly effective therapists. They also contribute to practice and psychotherapist training. Domains and categories from this study may be the basis for a checklist of some essential features to be included in psychotherapists' deliberated practice programmes.

## KEYWORDS

expertise, first sessions, grounded analysis, psychotherapeutic efficacy, psychotherapy

## 1 | INTRODUCTION

The person of the therapist influences the results of therapy (Johns et al., 2019; Sousa, 2017; Wampold & Imel, 2015). Some therapists consistently obtain better outcomes with clients than their peers (Barkham et al., 2017; Johns et al., 2019; Wampold & Imel, 2015). In some literature, this tendency seems to be independent of therapists' theoretical model, experience, type of intervention or clients' distress level (Barkham et al., 2017; Goldberg et al., 2016; Sousa, 2017; Wampold, 2015; Wampold & Imel, 2015). Recent publications have found that therapists' experience and client distress, particularly in combination, do have an impact on treatment effectiveness (Johns et al., 2019; Wampold & Owen, 2021).

In the last decades, psychotherapeutic outcomes researchers have been interested in the study of exceptionally competent therapists (Miller et al., 2018). However, there is no consensus on how to assess therapists' expertise. For some, client outcome is the ultimate criterion of expertise (Goodyear et al., 2017; Tracey et al., 2014, 2015). Others argue that expertise assessment should reflect multiple criteria, stressing the overall quality of therapists' performances (Hill et al., 2017; Norcross & Karpiak, 2017; Reese, 2017; Rønnestad, 2016).

Research on expert therapists has consistently suggested their distinct development at cognitive, emotional and relational levels (Hill et al., 2017; Jennings & Skovholt, 1999). Cognitively, they are voracious learners who value cognitive complexity and

ambiguity. Emotionally, they are self-aware, nondefensive and attendant to their emotional well-being and how it affects their work. Relationally, they are committed to building a strong alliance (Jennings & Skovholt, 1999). Research has also demonstrated the harmonious interaction between aspects of professional and personal functioning of these professionals and revealed in the way they ethically position themselves towards the profession (Hill et al., 2017; Nissen-Lie, 2018; Norcross & Karpiak, 2017; Skovholt et al., 2016). Expert therapists value their personal development, have a culture of learning throughout their career, actively seek feedback on their performance and tend to constructively doubt themselves (Hill et al., 2017; Jennings & Skovholt, 2016; Nissen-Lie, 2018; Nissen-Lie et al., 2015; Norcross & Karpiak, 2017; Skovholt et al., 2016). They stand out by their distinct clinical skills, great responsiveness to clients' needs, the ability to deal with complexity and ambiguity, and their strong relational orientation (Jennings & Skovholt, 2016). They show an extraordinary ability to form and maintain robust and productive therapeutic alliances (Jennings & Skovholt, 2016) characterised by both relational security and challenging stances (Sullivan et al., 2016). There is also evidence of their striking ability to promote a climate of meaningful collaboration with clients (Nissen-Lie, 2018).

Some investigations point to concrete clinical actions that contribute to positive outcomes: working with clients' expectations, increasing clients' motivation and hope for change and encouraging clients' agency (Oddli et al., 2014, 2021). Enhancing client agency is highly mentioned by reputable expert therapists in qualitative studies. Concrete clinical actions include seeking to guide clients to decide what is and is not in their power to change and increasing clients' awareness of how and why they are inhibiting change (Williams & Levitt, 2007). Eminent therapists also stress stimulating self-curiosity and emotionally engaged explorations, challenging ideas that block growth and integrating new symbolisation (Levitt & Williams, 2010). Clinical wisdom concept is also elaborated. It refers to the use of therapists' sense of their clients and their own experiences of adversity, diversity and intimate relationships to help clients to craft idiosyncratic answers (Levitt & Piazza-Bonin, 2014). Other successful activities include introducing comprehensive explanations about the client's problems and corresponding therapeutic tasks (Hansen et al., 2015; Laska & Federman, 2015; Pereira & Barkham, 2015).

However, to date, there is little empirical research focussed on the study of the concrete clinical actions of highly effective therapists in the early stages of a therapy (Oddli et al., 2014). The literature identifies these very early stages as crucial moments in establishing good proximal outcomes, such as therapeutic alliance and the introduction of expectations about change (Lavik et al., 2018; Zilcha-Mano & Errázuriz, 2017).

The aim of this study was to identify the most salient aspects of conducting first psychotherapy sessions by a highly effective therapist. Specific questions were as follows: (a) What therapeutic activities are practised by this highly successful therapist in the first three initial sessions with these good-outcome clients? (b) How do these

### Implications for practice and policy

- This research has highlighted how the first sessions are essential for good therapeutic results. We believe that the results of this study are the basis for a checklist to be included in the training of psychotherapists, which would include how to think (thinking), know-how (doing) and how to be (being).

therapeutic activities seem to contribute to the success of these psychological interventions?

## 2 | METHOD

We chose a qualitative design methodology. This is well suited to obtaining a descriptive and contextual understanding of themes, as required by our study aims (Patton, 2015). We used grounded theory in its constructivist form (Charmaz, 2014). This method allows for the generation of a theory or explanation about a process emerging from data (Creswell & Poth, 2018; Fernandes & Maia, 2001).

As recommended, we used clinical outcomes as a criterion for the therapist's expertise assessment, as opposed to the reputation criterion (Jennings & Skovholt, 2016; Nissen-Lie, 2018; Tracey et al., 2015). We also drew on naturalistic in-session observation of the therapist's performance, as recommended in prior investigations (Hansen et al., 2015; Hill et al., 2016).

### 2.1 | Participants

The participants were a female therapist based at a university therapy clinic in the United Kingdom and two of her clients. This therapist was rated as a highly effective therapist based on having the highest average rates of improvement on the Patient Health Questionnaire measure of depression (PHQ-9) (Kroenke et al., 2001) across the 11 therapists of the university therapy clinic: 7.9 ( $SD=7.0$ ), compared against an average for all therapists of 6.2 ( $SD=5.8$ ). On the General Anxiety Disorder Assessment (GAD-7) (Spitzer et al., 2006), she had an average improvement score of 8.4 ( $SD=7.3$ ) against a service average of 5.7 ( $SD=5.5$ ). The therapist had 1 year of postqualification clinical experience at the time of the interventions and followed a pluralistic psychotherapeutic approach (Cooper & McLeod, 2010).

The clients that were selected were two of her most successful outcome cases and where all recording data were available. Both clients were male, college students, and presented with depression. We name them 'John' and 'Frank'. John was 21 years old and completed 15 psychotherapy sessions, and Frank was 24 years old and completed 21 psychotherapy sessions (Table 1).

TABLE 1 Clients' clinical outcomes.

	John		Frank	
	PHQ-9	GAD-7	PHQ-9	GAD-7
Assessment session	20 (severe)	9 (mild)	15 (moderately severe)	17 (severe)
Last session	6 (mild)	4 (minimal)	2 (minimal)	1 (minimal)

## 2.2 | Procedures

Audio records of the first three psychotherapy sessions (including assessment session) of each dyad were obtained under a cooperation agreement between universities. Data protection, participant anonymity and informed consent were ensured. The interventions happened in a naturalistic, nonmanualised context and had a limit of 24 sessions.

## 2.3 | Data analysis

Therapy sessions were transcribed by Sílvia Caçador, including nonverbal utterances. The first three sessions with each client were then analysed. Analysis started with the *open coding* process (Charmaz, 2014). The length of text units varied from single utterances to some consecutive turn-takings. We used an open-source software (Taguette™) for coding and code management. The main goal of open coding was to identify the therapist's clinical actions and/or intentions and generate descriptive codes. For the purposes of rigour, we kept a focus on making thick descriptions (Hays & McKibben, 2021) for the open coding phase. We wanted to exhaustively describe all the concrete actions of the therapist, even the most subtle ones. The open coding procedures involved constant questioning and comparisons. 'What is the therapist doing?' 'What seems to be her intention?' 'Is this sequence different from that one?' 'On what?' These 'constant comparison' questions allowed us to constantly move between data and codes. As the open coding work progressed, the coder's sensitivity to coding the sequences increased. At the same time, more data were available to make comparisons between and within cases, allowing refining, merging or ruling out of codes. To maximise this study's rigour and trustworthiness, the open coding process involved intercoder training and discussion procedures. Coding was fully discussed, and other sequences were discussed whenever the need was felt.

By the completion of this process, 121 descriptive codes were obtained across the six sessions. The following sequence illustrates the open coding process:

**Therapist (T):** (...) And how did you construct that, what was that like for you, you're given things? [Code: Encourages client to deepen his internal experience on a relevant topic or event]

**Client (C):** Hum, I think is like momentary... (...) well you deem happiness from it, it's worth it, so is similar to that, that you, if they're buying stuff for you, you get a little bit of pleasure from it then obviously that pleasure goes.

**T:** It doesn't, it's a transient pleasure, is it? [Code: Tentatively clarifies client's experience as perceived by the therapist]

**C:** Hm.

**T:** But it makes sense, doesn't it? Because that's how people showed you that you show affection, how you give pleasure is to give things, that's what you've learned. [Code: Validates client's experience]

The next step was *focussed coding*. This aimed to generate comprehensive conceptual categories based on the descriptive codes (Charmaz, 2014). We captured initial codes that stood out and were associated with the same theoretical construct. At this stage, the analysis began to gain some theoretical direction (Fernandes & Maia, 2001).

Focussed coding relied on both questioning and comparison processes. The following questions guided the analysis: 'What theoretical category does this code(s) represent?' 'What seems to be the theoretical construct to which these code(s) refer?' 'Does this code seem to link to another category?' As relationships of similarity and connections between codes and theoretical constructs emerged, categories and domains were provisionally established.

For example, the category 'Encourages the client to explore his vision of himself, worldview and future projects' resulted from the following codes: 'Encourages exploration of vision about oneself (e.g. characteristics, functioning, coping style and defences)', 'Explores worldview or client's beliefs', 'Explores reactions, traits and beliefs based on what-if scenarios', 'Explores client's perception of attitudes, actions, or circumstances of significant others', and 'Explores client's future or aspirational vision'.

Salient codes and emerging theoretical constructs were discussed with Daniel Sousa for the purposes of overcoming theoretical bias and extending the constant comparison method to a saturation point. This helped to maximise the rigour and trustworthiness of the study. Analysis ended when the *saturation criterion* was met (Charmaz, 2014; Corbin & Strauss, 2015); that is, when the constant comparison method no longer generated new connections or the need to refine established categories.

## 2.4 | Reflexivity

All authors take a broadly person-centred and existential perspective, informed by theoretical constructs from the perspective of common factors in psychotherapy (Rosenzweig, 1936) and by theories of the contextual model (Wampold & Imel, 2015). Sílvia Caçador and Daniel Sousa made a conscious effort to bracket their theoretical assumptions

and maintain a constant self-monitoring stance. These efforts, aided with using the constant comparison method to reach a saturation point, and triangulation of theoretical perspectives, were fundamental strategies to maximise the rigour and trustworthiness of our work.

### 3 | RESULTS

We generated 12 categories, organised into three major domains (Table 2).

#### 3.1 | Domain 1. Promoting clients' sense of agency and the collaborative nature of the therapeutic process

##### 3.1.1 | Encourages clients to explore their vision of themselves, worldview and future projects

Through open questioning and dialogic explorations, the therapist encouraged clients to deepen their reflections on themselves, their worldview and their personal ambitions. This allowed a discovery of the person behind the problems. The following excerpt illustrates the client reflecting on his worldview and the therapist following the client's narratives with curiosity.

TABLE 2 Domains and categories.

<p>Domain 1. Promoting clients' sense of agency and the collaborative nature of the therapeutic process</p> <ul style="list-style-type: none"> <li>1.1 Encourages clients to explore their vision of themselves, worldview and future projects</li> <li>1.2 Highlights and values clients' psychological resources</li> <li>1.3 Establishes clients as 'experts on themselves'</li> <li>1.4 Tries to ensure that therapy focus is meaningful to clients</li> <li>1.5 Promotes expectations about clients' active role in the therapeutic process</li> <li>1.6 Attempts to establish a climate for collaboration and mutual involvement</li> </ul>
<p>Domain 2. Supporting clients' exploration of meaningful contents, balancing responsively between following clients and introducing new dimensions</p> <ul style="list-style-type: none"> <li>2.1 Encourages clients to deepen their internal experience</li> <li>2.2 Picks up clients' subtle cues and promotes focus on those subjects</li> <li>2.3 Tentatively clarifies clients' experiences, establishes connections and provides feedback</li> </ul>
<p>Domain 3. Creating a climate of emotional security based on empathic presence, authenticity and positive regard</p> <ul style="list-style-type: none"> <li>3.1 Discursively manifests her strong therapeutic presence</li> <li>3.2 Uses the self as a therapeutic tool and communicates her inner experience</li> <li>3.3 Expresses empathy and acceptance for clients' internal experiences</li> </ul>

C: (...) I will need to have money, I will need to do things, you know, with the current way things are going in the world it's going to be more and more difficult for me to do what I want to do for enjoyment or fun.

T: Do you think the world has changed, do you think that life is harder for young people now than it used to be?

##### 3.1.2 | Highlights and values clients' psychological resources

Clients' sense of competence to face their life circumstances was strongly emphasised by the therapist. She consistently highlighted and valued clients' psychological resources. For instance:

T: Hum, hum. So again there was this... you had to work out for yourself [C: Hum.], this wasn't, this wasn't kind of a productive thing for you to be doing.

C: Yeah.

T: Yeah. Hum. Hum. I, I, I find that, I feel really glad that you had that insight [C: Hum.] because it feels like it would have been really easy to stay in the room and not come out.

At the same time, clients were encouraged in this process, leading them to reflect on their coping strategies and psychological costs (T: *Can you understand why you did that?*). Those strategies were not always conceptualised as productive or beneficial, but the reflection process led to relevant clarifications about clients' belief systems. This exploration also implicitly emphasised clients' agentic quality.

##### 3.1.3 | Establishes clients as 'Experts on Themselves'

This position was consistently present in the therapist's discourse. It was communicated explicitly and reiterated throughout the sessions.

T: Ok, and what, what for you... because kind of my take on this is that you're the expert in you [C: Yeah.] so I wonder what you think was... was kind of important or pivotal for you about that relationship?

This was also communicated implicitly or in subtle ways. Examples include when the therapist showed interest in clients' rationales about the origins of their problems or when she emphasised the tentativeness of her inputs and encouraged clients to express their agreement.

T: So there was, ok, this, this, this is something that... I have a sense of but I wonder if this makes sense to you.

The centrality of the client's voice was a fundamental feature in the therapist's attitude. Very often and explicitly, the therapist stated the client's central role in directing sessions:

T: (...) What have I not asked? I feel like I've asked you a lot. Is there anything that you feel is important for me to know?

### 3.1.4 | Tries to ensure that therapy focus is meaningful to clients

The therapist sought to capture emerging therapeutic goals from the clients' narratives and encourage their co-elaboration, while introducing or clarifying expectations about therapeutic change, as the following excerpt illustrates:

T: Ok, so you can - perhaps what you would like to get to with those feelings is you've experienced them, they will be, I won't say 'scars', but sometimes scars of relationships are positive as well. Good relationships leave marks too. But you want to be able to take all the marks that relationships have left and process them, the negative as well, in a more positive way.

Therapeutic goal formulation was presented as a dynamic process, oriented towards clients' needs. If the therapist felt that her contribution might have overlapped with clients, she would address the issue directly:

T: Ok, so on that basis then, did you... and I am kind of conscious that I feel... do you feel... hum, how do I wanna word this...? Is there any sense in which you feel that I've imposed those goals onto you? I know they're things that I've picked out...

Throughout the sessions, client goals were systematically revisited by the therapist and used to assess the focus of sessions from the client's point of view.

### 3.1.5 | Promotes expectations about clients' active role in the therapeutic process

The therapist explicitly and implicitly promoted clients' active involvement in the therapy processes. The therapist frequently used discursive formulations that communicated her implicit view about clients' active role in therapy, for instance, 'Are you interested in...?' 'Do you think it would be useful for you...?' and 'Is [this] something that helps you?'

More explicitly, the therapist referred to clients as the main decision-makers in session. For instance:

T: I'd really like - I really like it to be your choice [C: Yeah.] rather than mine because what I deem to be [C: Important, yeah.] important, you might not (...)

The therapist also made educational interventions about the therapeutic processes, placing particular emphasis on the clients' role, particularly when clients showed less involvement. For instance:

T: (...) I'm asking you a lot of questions, probably more than I'd like to be asking. [C: Ok.] The reason I don't like to ask all those questions is that that's all driven by what I'd like to know, rather than what you want to talk about [C: Yeah.]

These kinds of interventions seemed to serve the purpose of helping the client understand what kind of involvement is expected from him and stressing the collaborative stance of the therapeutic process.

### 3.1.6 | Attempts to establish a climate for collaboration and mutual involvement

Therapeutic goals co-formulation and negotiation about expectations for the therapeutic processes were extensively explored in session and seemed to contribute positively to the establishment of a collaborative climate.

The shared and transparent way of conducting sessions seemed to create a sense of relational symmetry and fostered mutual involvement. The therapist frequently resorted to meta-communication about her therapeutic intentions and/or here-and-now relational difficulties. The therapist openly addressed the use of therapeutic monitoring instruments, assuring access to all records. She also systematically resorted to cautious and attempted discursive formulations, for instance, 'It feels as...', 'Sounds if it becomes...' 'To me, perhaps, it feels...'. This hedging language seemed particularly important in removing her from an expert position and urging clients to get involved in a joint process.

## 3.2 | Domain 2. Supporting clients' exploration of meaningful contents, balancing responsively between following clients and introducing new dimensions

### 3.2.1 | Encourages clients to deepen their internal experience

The therapist followed the clients' narratives very closely and responsively. Her interventions derived in a very direct sequence of clients' narratives, and she tried to establish and keep the focus on concrete episodes and on clients' internal experiences. There was a consistent intention to lead clients to elaborate on their emotions and experiences, abandoning abstract or rationalised narratives. The therapist often resorted to open-ended formulations, for instance:

T: Ok. Ok. And I'm wondering - I'm wondering what it is like for a little boy to hear that their mom is leaving...

When clients showed resistance or difficulty in deepening their internal experience, the therapist looked for more guided ways that seemed to be unblocking for clients. For instance:

T: And what, can you, if you had to, if you have to pick a label to label the first feeling that came out when you wake up and feel like that...

### 3.2.2 | Picks up clients' subtle cues and promotes focus on those subjects

The therapist demonstrated a great sensitivity to small verbal and nonverbal cues that could point to potentially relevant issues for the client. For instance:

**T:** Ok, but you're smiling when you speak of him, you look quite – you feel quite fond of him...

Quite often these interventions served as a stimulus for clients being able to address significant themes.

### 3.2.3 | Tentatively clarifies clients' experiences, establishes connections and provides feedback

The therapist often listed significant aspects of the clients' narratives and made tentative clarifications about conflicts, ambivalences, relational patterns or coping styles. These interventions seemed to have a structuring function, possibly making the problematic aspects of clients' experiences more intelligible.

Other times, the therapist introduced alternative points of view or made new connections about clients' narratives. These types of clinical actions seemed to establish a starting point for reassessments and/or co-constructions of alternative visions. The therapist's contributions were very close and complementary to the clients' narratives. However, in some cases, some degree of challenge was carefully introduced. For instance:

**T:** The way sometimes that you talk about lessons you've learned, I don't know if it's the way you described, it sounded like quite punishing to yourself, like 'I'll have to learn that lesson, I'll have to learn that lesson'. I think what I'm not hearing – doesn't mean is not there, but I'm not hearing it – is any compassion for that boy – for that young man – for the man who had those feelings. It's just 'you have to learn and that's that'.

The therapist was very attentive and responsive to the clients' reactions to her inputs, trying to assess whether they were accepted or rejected by clients.

## 3.3 | Domain 3. Creating a climate of emotional security based on empathic presence, authenticity and positive regard

### 3.3.1 | Discursively manifests her strong therapeutic presence

One of the most salient features of the therapist's practice was the way she communicated her presence in the session. Her clients'

speech was permeated by the therapist's short, distinctively expressive interlocutions ('Hum, hum', 'Yeah', 'No') which seemed to introduce a strong sense of presence. Through these discursive mechanisms, she seemed to be creating a sense of attunement and validation, encouraging her clients to continue talking.

Another recurrently used discursive mechanism that seemed to fulfil the same function was the frequent mirroring of the clients' words. For instance:

**C:** I haven't much memory of that cos my dad... It would have always been my dad.

**T:** Always been your dad, hum, hum.

**C:** Because my mom (...)

### 3.3.2 | Uses the self as a therapeutic tool and communicates her inner experience

The therapist's distinctive presence in session involved a conscious attention to her own internal experience. For instance:

**T:** Ok. Hum. [pause] Hum. It actually affected me.

**C:** Yeah?

**T:** Yeah. I, I, I'm, I... Yeah. I'm just trying to process what that's like, but you seem...

This attention to her internal processes seemed to be used as a way of interpreting clients' experiences. The way the clients' narratives echoed for the therapist (e.g. emotions, images or intuitions) was used as a guide for her own empathic process. In session, her authenticity was manifested in multiple disclosures about her experiences of her clients and by meta-communicating about the here-and-now of the therapeutic relationship. For instance:

**T:** I'm even really experiencing it in the way we're interacting today, not that you weren't chilly to me, but I feel as if...

### 3.3.3 | Expresses empathy and acceptance for clients' internal experiences

The expression of empathy for the clients' experiences and difficulties was a central feature in the therapist's practice. She showed understanding of clients and their world through empathic reflections and conjectures. The quality of her empathic ability was mirrored when clients corroborated the therapist's tentative clarifications and in moments of high attunement between the dyad, when they completed each other's sentences.

The expression of empathy was intertwined with validation processes. In an attitude of unconditional acceptance, the therapist validated the clients' experiences, reporting on the plausibility of their feelings and reactions in the context of their life circumstances.

T: (...) But it kinda makes sense. When you think about it in terms of how vulnerable showing emotions has made you or might have made you [C: Yeah, yeah] feels like you became very fearful of it...

All these therapeutic actions seem to have created an environment of emotional safety, in which the clients seemed to feel welcomed, understood and accepted. This facilitated in-depth discussion of problems in the session.

## 4 | DISCUSSION

The aim of this study was to identify and analyse the most salient aspects in conducting first psychotherapy sessions by a highly effective therapist. The data analysis resulted in the formulation of three major domains.

The first relates to promoting the clients' sense of agency and the collaborative nature of the therapeutic process. In psychotherapy, an agentic client is conceptualised as an intentional influencer of the change process, who proactively engages within and between sessions (Huber et al., 2018, 2021). Throughout the analysed sessions, the therapist seemed to contextualise clients' active role in therapy in a broader scope related to the persons' sense of agency in life. This conception is traditionally associated with humanistic approaches (Coleman & Neimeyer, 2015). The contextual model (Wampold & Imel, 2015) and common factor (Laska et al., 2014; Rosenzweig, 1936) approaches also encompass a view of the client as a self-determined and agentic being and therapy as a shared and co-constructed process (Huber et al., 2021).

What can one conjecture about how the promotion of client agency becomes therapeutic? Frank's (1974) classical idea about the remoralising function of psychotherapy is that therapy constitutes a means of returning, to the person, their ability to deal with adversities, find (new) answers and restore their sense of mastery (Coleman & Neimeyer, 2015; Frank, 1974; Mackrill, 2009). It can be conjectured that experiencing themselves as agents of their own therapeutic process increases clients' hope in the possibility of change, launches the process of clients' remoralisation and facilitates the global activation of their psychological resources (Huber et al., 2021). The promotion of client agency can also contribute therapeutically through enhancing the quality of the therapeutic alliance (Huber et al., 2021; Tryon et al., 2018).

The second domain relates to the therapist's intention to support the exploration of meaningful contents, responsively balancing between following the client and introducing new dimensions. We identified two elements of this domain. The first, relating to the role of the therapist (and therapy), was to gently guide the client through the exploration of significant and emotionally charged contents. The second was the therapist's responsiveness in conducting the process.

Regarding the first, some research about significant events in psychotherapy suggests that talking about current and past

emotions, being honest about them, possibly disclosing them for the first time, or approaching them in an experiential way in therapy are considered useful activities by clients. Therapists' actions considered most useful by clients are questioning and incitement to go deeper into behaviours and emotions (Watson et al., 2012). Some directivity and challenge on the part of the therapist is also valued. Clients value the introduction of relevant topics, alternative perspectives, a challenging questioning, clarifications and some feedback on their interpersonal functioning patterns (Antoniou et al., 2017). Research based on session analysis also finds a tendency among therapists who have conducted successful therapeutic processes to skilfully help the client focus on concrete and emotionally charged episodes in the here-and-now of the session (Von der Lippe et al., 2017).

The second aspect relates to how the therapist balances between following the client's narratives and introducing new dimensions. *Appropriate responsiveness* refers to the quality of the therapist's interpersonal skills that allow them to respond adequately to the specifics of the client and the interaction (Hatcher, 2015). Often, as in the case of the present therapist, this kind of responsiveness is characterised by seeming to know what to do, and when, in such a way that the therapeutic work proceeds fruitfully. In other words, it is a delicate balance between leading and following, as described by emotion-focussed approaches (Watson, 2018). The therapist makes moment-to-moment decisions about the type of interventions that may be most beneficial (e.g. questioning the client to delve deeper, providing clarifications and/or alternative readings and respecting resistances) informed by clients' receptivity or characteristics (Hatcher, 2015; Li et al., 2020). It has been hypothesised that the therapist's responsiveness is one of the most decisive elements of therapists' effectiveness (Stiles & Horvath, 2017).

How does the exploration of meaningful content, supported by a responsive therapist, become therapeutic? We can hypothesise that such therapeutic processes allow clients to progressively gain a greater awareness of themselves and their psychological processes. Increasing client awareness can also be seen as a profoundly agentic process (Gorlin & Békés, 2021). Under different designations (e.g. 'awareness', 'insight' and 'emotional processing'), many psychotherapeutic orientations emphasise this process as one of the most fundamental mechanisms of change (Gorlin & Békés, 2021).

The third and final domain refers to the creation of a climate of emotional security based on empathic presence, authenticity and positive regard. This captures a Rogerian view about the 'necessary' conditions in psychotherapy (Rogers, 1957). Within the scope of this discussion, the concept of *therapeutic presence* (Geller & Greenberg, 2002) seems to capture some distinctive aspects of the therapist's attitude in the sessions. Presence in psychotherapy refers to the immersion of the therapist in the present moment of the therapeutic encounter, being with and for the client in an unconditional way, and maintaining a dual attention to the client and therapist's

own internal experiences (Geller, 2017; Geller & Greenberg, 2002). For some, it is understood as a superordinate concept that allows conceptualising of how the intra and interpersonal qualities of the therapist combine in session (Bernhardt et al., 2021). Therapeutic presence is often demonstrated nonverbally, through the therapist's posture, gestures, prosody quality and discursive rhythm (Geller & Porges, 2014). These aspects were quite salient in the present therapist's practice. It has been argued that being present is the first condition for being responsive and empathetic, creating a strong alliance and promoting clients' involvement in therapy (Geller, 2019; Hayes & Vinca, 2017).

Regarding the empathic presence stance, the concept of *embodied empathy* (Bernhardt et al., 2021; Cooper, 2001) also seemed relevant to our analysis. It is a form of therapist's attention to their own internal experience and bodily sensations, which allows them to deeply understand the client. In other words, it is the use of the self as a therapeutic tool. We note that it is not just about listening to their inner experience but also communicating it to clients. Revelations and meta-communications about her inner experience was a quite prominent feature in the present therapist's performance. Arguably, this process allows the therapist to be in a state of authenticity and congruence (Geller & Greenberg, 2002). Research has demonstrated the relationship between a therapist's meta-communication and clients' collaboration (Li et al., 2016). It is hypothesised that the quality of the therapist's presence resonates with the client in such a way that they also become more present, less defensive and more connected: as in a 'resonance circuit' (Macdonald & Muran, 2020). From this perspective, the therapist's empathic presence is an enabling condition for constructing and maintaining robust alliances (Geller, 2017; Hayes & Vinca, 2017).

What can be hypothesised about the therapeutic function of the therapist's presence, manifested through their empathic capacity, authenticity and unconditional acceptance? It seems reasonable to think that this therapeutic function is related to creating an environment of emotional safety for the client. On the one hand, an environment of emotional safety can be therapeutic per se because a sense of positive connection with others is central to human well-being and mental health (Geller, 2017). On the other hand, it can become therapeutic through the alliance. Clients' feelings of emotional security seem to have a positive impact on alliance quality through their collaborative involvement in the relationship and the therapeutic process (Geller, 2017).

#### 4.1 | Limitations and recommendations

A key limitation of this study is the sample size. There would have been advantages in analysing more first sessions of this therapist with other clients and/or analysing first sessions of other therapists with good clinical results. We recommend that the final sample, in

future investigations, should be considered complete only when new session analysis does not generate new relevant categories (Charmaz, 2014; Corbin & Strauss, 2015).

Another major limitation of this study is related to the associational nature of the results. This study design only allowed us to show how this therapist and these clinical actions were associated with good outcomes with these specific clients. As a recommendation, therefore, it would be important to compare clinical characteristics and actions of good-outcome therapists against therapists whose clients had poor outcomes.

Although rigour and trustworthiness were two main concerns, as we stressed through the method chapter, it is not clear how much our findings were influenced by our own biases and assumptions. Our results are relatively consistent with our theoretical starting points: that the client should be considered an active agent in therapy, that the therapeutic relationship is a key healing agent and that therapists should actively strive to deepen emotional processing. It is possible that researchers with an alternate set of assumptions and biases would find something otherwise in this data.

We also recommend that further research should analyse complete therapeutic processes, especially the end of psychological interventions by highly effective therapists. This recommendation stems from the premise that the end of a therapeutic intervention is another decisive step for an effective therapeutic process (Sperry & Carlson, 2014).

#### 4.2 | Implications for practice

This research has highlighted how the first sessions are essential for good therapeutic results, even before a solid therapeutic alliance is established. We believe that the results of this study are the basis for a checklist to be included in the training of psychotherapists. This checklist does not claim to be definitive, or to include all essential categories, but it is a foundation and starting point consistent with findings from other studies. This study identifies three broad categories that highlight three essential dimensions in the training of psychotherapists: how to think (thinking), know-how (doing) and how to be (being). Watching videos of therapy sessions is a privileged method for training and continuous improvement of therapists (Hatcher, 2015). It is suggested that the three major dimensions and their subcategories be considered as a checklist for therapists in training. That is, trainees can watch (or listen to) their therapy sessions, to assess whether these competencies are present in their therapeutic intervention with clients. This specific part of the training is focussed on the first sessions. The same procedure can be applied by more experienced therapists. Research also suggests more experienced therapists do not always have better outcomes (Goldberg et al., 2016). Indeed, therapists may continue making the same mistakes for a long time if we do not find methods to have feedback about our clinical practice. One method is

to have solid indications of what good clinical practices are and how these can be followed, without this being misunderstood as a rigid manual of intervention.

## 5 | CONCLUSION

The results of this investigation support what the literature on highly effective therapists emphasises: the distinguished clinical skills of these professionals, their remarkable responsiveness and strong relational orientation (Jennings & Skovholt, 2016). These qualities seem to allow them to generate relational environments that are both safe and challenging (Sullivan et al., 2016) and build effective collaborative therapeutic relations (Nissen-Lie, 2018), based on promoting clients' agency (Oddli et al., 2014, 2021).

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## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are not openly available due to original consent agreements with participants.

## INFORMED CONSENT

All data protection, participant anonymity and informed consent procedures were ensured.

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