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The facilitative interpersonal skills method: Difficult psychotherapy moments and appropriate therapist responsiveness

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Abstract

The Facilitative Interpersonal Skills (FIS) task is a performance test of therapists' use of common relational skills (e.g. empathy, building expectations). The FIS method includes (a) materials that simulate difficult client moments on video, which are used to collect therapists' responses to these situations; and (b) independent ratings of these responses. Many of the FIS items are informed by psychotherapy processes that have been linked to outcome and facilitative conditions that have been reframed as individual therapist skills (e.g. alliance bond capacity). Overall, the FIS has predicted psychotherapy outcome. A single study is described in which FIS predicted the therapist effect using multilevel modelling of a large sample of clients who were nested within therapists. We also summarise two additional outcome studies that used experimental designs. One future direction is to better understand how therapists form responses to these difficult moments. We conclude that forming an optimal therapeutic response during challenging, emergent in-session situations involves responsiveness (Stiles et al., 1998), or finding a response that fits the clients' needs within any moment.

KEYWORDS

facilitative interpersonal skills, responsiveness, therapist effects, psychotherapy process

1 | INTRODUCTION

The Facilitative Interpersonal Skills (FIS) research method exposes therapists to a simulation of therapy where they respond to standardised, realistic and challenging client verbalisations that are presented with brief video stimulus clips. The FIS method (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009) has been developed as a pan-theoretical and treatment non-specific application, one that is designed to assess therapists' interpersonal skills with general principles that are broad enough to be applicable to most forms of psychotherapy. Related to several significant developments in the research literature, however, FIS methods depart somewhat from examining genuine two-person interactive processes in an attempt to isolate individual therapist skills.

Psychotherapy process research has routinely found that many common relational processes are the strongest predictors of client outcomes, with empathy and the "working alliance" as examples (Elliott, Bohart, Watson, & Greenberg, 2011; Horvath, Re, Flückiger, & Symonds, 2011). Given that these processes are consistent across psychotherapies and that many processes are intercorrelated, research on FIS builds on the strong findings of process–outcome research (see Norcross & Lambert, 2019; Norcross & Wampold, 2019) by adapting several common relational constructs. A more focused look at the therapist contribution to these processes has implicated the role of therapist interpersonal characteristics to the associations between psychotherapy processes and outcomes, which have been supported by several positive findings (e.g. Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Henry, Schacht, & Strupp, 1990; Moyers,

Miller, & Hendrickson, 2005; Nissen-Lie, Monsen, & Rønnestad, 2010). One caveat to research on the therapist role in process findings is that there are methodological difficulties involved in identifying therapists' independent contributions to therapy outcomes.

Relatively recent research on therapist effects has found that it is possible to separate individual therapist contributions to therapy outcomes from other factors, but without necessarily identifying what therapist characteristics are responsible. Identifying therapist effects, findings that individual psychotherapists differ among each other in client outcomes, was made more possible when innovative statistical methods (e.g. multilevel modelling) were applied to large data sets of clients nested by their assigned therapists (Baldwin & Imel, 2013; Wampold & Imel, 2015). Thus, relational process research findings implicate the likely role of positive therapist relational skills, and therapist effects demonstrate that individual therapists are indeed contributing to outcomes; however, researchers have only recently begun to take the next step of developing methods for isolating the therapists' contributions to in-session psychotherapy processes and outcomes.

Relatively recently, methodological strategies have been developed for isolating both the therapist interpersonal skills as independent from therapist interactions with clients. Heinonen et al. (2014) found that self-reported therapist basic interpersonal skills, particularly engaged relational styles, were predictive of client-rated alliances. The measure of therapist skill was collected prior to treatments and thus provided some independence from effects of client interactions during therapy. Schöttke, Flückiger, Goldberg, Eversmann, and Lange (2017) measured therapist interpersonal characteristics through a group format, as well as with expert interviews, and found that group ratings of positive therapist interpersonal dispositions were predictive of client outcomes over the 5-year period after the therapist assessments. It is important to note that the therapists' dispositions rated by Schöttke et al. (2017) had a high degree of conceptual overlap with the items rated with the FIS method (e.g. empathy, warmth, management of criticism and cooperation). Strikingly, the work of Schöttke et al. (2017) and the FIS (see Anderson, McClintock, Himawan, Song, & Patterson (2016, below) occurred in different laboratories (and continents) and different procedural methods (interviews and experimental simulation); nevertheless, the constructs used were highly similar therapist characteristics/skills, and importantly, the results yielded similar prospective predictions of client outcomes!

2 | DIFFICULT MOMENTS: A MARKER-BASED METHOD

Most therapists can generally be warm and empathic, build alliances and encourage clients' expectations. These interpersonal skills may be challenged during difficult moments. In an early review of therapist interpersonal skills, Lambert, DeJulio, and Stein (1978) were likely the first to highlight the difficulty of measuring therapist interpersonal skills. Lambert et al. attributed this measurement problem as partly due to the wide in-session variability and fluctuations of therapist interpersonal skills and associated client impacts from those skills being quite varied. The FIS method assumes that responses to difficult interpersonal moments with clients are especially useful for identifying therapist interpersonal skill, and also may be most impactful to clients. This assumption is supported by foundational work on how therapists can address more problematic relational impasses with clients (e.g. Strupp & Binder, 1984; Safran & Muran, 2000). After researching common relational factors between trained and untrained therapists, Strupp (1998) noted that even highly experienced professional therapists had remarkable variation in how they responded to the most challenging moments presented by clients. Even more, Strupp suggested that clients are highly impacted by interpersonal processes with their therapists, and research indicates that even relatively small amounts of negative interpersonal process are associated with poor therapy outcomes (Henry et al., 1990). The use of markers of difficult moments has played a central role in locating salient emotional experiences of clients (e.g. Greenberg & Safran, 1986; Rice & Greenberg, 1984) and in the development of common therapeutic strategies for addressing these moments, both through pan-theoretical treatment strategies and through brief therapist training (e.g. Eubanks-Carter, Muran, & Safran, 2015; Safran & Muran, 2000).

2.1 | Responsiveness and difficult moments

Although difficult moments may comprise a relatively small fraction of time with a client, therapists' reactions to simulations of difficult moments are a core feature to the method. Understanding what the therapist chooses to do in difficult moments can be broadly understood through a construct known as therapist *responsiveness*, introduced by William B. Stiles and colleagues (see Kramer & Stiles, 2015; Stiles, Honos-Webb, & Surko, 1998). In fact, the measurement issues of interpersonal skills—wide variability of client impacts to various therapist skills—are part of the responsiveness issue. Being appropriately responsive during difficult moments means that the therapist does "the right thing" and demonstrates the ability to quickly assess what the client needs and provides a response that fits. Therapists who demonstrate appropriate responsiveness on the FIS task react to interpersonally difficult client situations with immediacy, but non-defensively, and express comfort in novel fluctuations of challenging interpersonal moments.

3 | FACILITATIVE INTERPERSONAL SKILLS METHODS

In order to isolate therapist contributions, psychotherapy process is simulated and the client contributions are standardised by using a set of different video-recorded client segments. Again, one important reason for standardising the client contribution (instead of sampling from a therapist's actual clients) is that every real client contributes unique variance, which may make it more difficult to

isolate and understand therapists' skill. By using "standard clients" to test therapists' performance, some control for this client source of variance can be applied.

Using standard video stimuli of simulated clients does not completely remove the effect of the client contribution to the therapist response, but merely equalises its effects across all therapists measured in a sample. For that reason, a sample of client stimulus clips is used in the FIS method, and the types of client stimuli are deliberately selected from a variety of interpersonal presentations—specifically, different locations around the interpersonal circumplex (friendly-hostile, controlling-submissive).

The FIS method includes both (a) a performance-based task, in which simulations of difficult clients are presented and the therapist gives verbal responses, and (b) an observational measure for rating the therapist's responses. Both the performance-based task and the ratings involve separate, but related, procedures. Each is considered separately below.

3.1 | Performance task

The FIS task is a performance-based task in which therapists respond to a standardised set of simulated patients as if they were in-session together. The video clips used in the FIS task are about one minute each and were selected from video recordings of actual therapies that contained highly challenging interpersonal situations for the therapist. The most difficult interpersonal markers (i.e. alliance ruptures) were used for the standard client video stimuli because of the assumption that therapists may not have insight into their own level of skill. Each of the selected markers includes some form of interpersonal request from the client, which contributes to these markers' difficulty and even may be experienced as provocative to therapists attempting a response. For example, one simulated client, "Jack", an interpersonally controlling and condescending businessman, complains about his employees who he perceives as not timely and irresponsible. The implied request occurs when Jack concludes that therapy is also a business relationship and that he would not get his "money's worth" if the therapist were ever to be late. The identifying information for each clip was altered to protect confidentiality of the actual clients, and the FIS task videos were re-created by actors. Mostly, the actual clients' language remained unchanged and emotional expression was faithfully reproduced with some coaching. It was hoped that these steps provided each video clip with a realistic context to create a more genuine simulation for the therapist participants taking the FIS task. Thus, during the performance task, participants view these brief client videos, and after each client moment stops, they are asked to speak to each client "as if" they were the therapist. Their verbal responses to these stimulus clips are audio/video-recorded for later evaluation.

3.2 | Illustrations of FIS responses

The following example was given by one of the highest-rated therapists on the FIS in a previous study, which will be described below. The response was to "Suzie", a client who expressed hopelessness, blame and anger at the therapist for the direction of her therapy. The therapist began, "*Wow Suzie, it really sounds like you're feeling very upset and, and a little confused, uh, maybe about the direction that we're taking right now...*". The remainder of this therapist's response focused on helping Suzie find a role in therapy where she could feel comfortable meeting her goals. The therapist concluded by asking the client whether her understanding had fit. Beyond the content, this therapist's tone of voice conveyed warmth and she spoke with confidence. In contrast, a low FIS therapist responded to Suzie in a somewhat halting and unexpressive voice while saying, "*Well, um, I'm sorry that you feel that I can't help you at all, but um, I don't know...*". At this point, the therapist's voice trails off in faint speech that was difficult to hear and understand. The therapist's response concluded with what seemed to be self-conscious laughter. Responses like these are evaluated with the items from the FIS observational ratings, which will be described next.

3.3 | FIS observational ratings

The second part of the FIS method is the observational evaluations that are made by trained raters who follow a manual (Anderson, Patterson, McClintock, McCarrick, & Song, 2019). Table 1 summarises the eight FIS items, which are based on common interpersonal therapy skills. Some of the skills are drawn from psychotherapy process research findings and are established constructs, common across psychotherapies, and have attained considerable empirical support as process measures (e.g. see Norcross & Lambert, 2019; Norcross & Wampold, 2019). Specifically, for individual therapist skill ratings on the FIS measure, observational evaluations are made on verbal fluency, emotional expression, persuasiveness, warmth/positive regard, hopefulness, empathy, alliance bond capacity and alliance rupture-repair responsiveness. The FIS rating manual utilises multiple anchor points to aid in coding each skill on a 5-point Likert scale ranging from optimal performance to deficit. A FIS total score is calculated, averaging performance across the eight skill ratings.

FIS raters are regularly able to achieve high levels of inter-rater reliability. Recent empirical studies utilising the FIS have reported ICCs between 0.85 and 0.91 using teams of three to six raters (Anderson et al., 2019). Munder et al. (2019) found that FIS can be reliably assessed with a subset of clips from just three or four responses from different videos (Munder et al., 2019). Using repeated exposure and practice of the clips, Anderson et al. (2019) found inter-rater reliability with as little as two responses at different time points.

4 | AN EMPIRICAL STUDY: FIS PREDICTS THERAPIST EFFECTS

We provide an example of an investigation in which the therapist FIS method was demonstrated (Anderson et al., 2009). Therapist responses to the FIS task were used with a large sample in order to predict the source of the therapist effect (i.e. the differences

TABLE 1 Facilitative interpersonal skills rating items and descriptions

Item	Description
Verbal Fluency	This item is a rating of the extent to which the participant is verbally comfortable and at ease in communicating.
Hope and Positive Expectations	This item rates expressions of hope, optimism and positive expectations for change.
Persuasiveness	This item rates the participant's capacity to induce the other to accept a view that may be different from his or her own view.
Emotional Expression	This item rates the energy and emotion in the participant's response. This item rates the extent to which the participant's response is delivered with effective expressions of emotion.
Warmth, Acceptance, and Understanding.	This item is a rating of the ability of the participant to care for and accept the other.
Empathy	This item rates the participant's capacity to respond with an expressed understanding of the subjective experience of the client.
Alliance Bond Capacity	This item rates the participant's capacity to provide a collaborative environment, one in which there is recognition of the need to work with the client jointly on problems.
Alliance Rupture-Repair Responsiveness	This item rates the extent to which the therapist appears responsive to the interpersonal issue.

Note: Table Adapted from Anderson et al. (2019).

among individual therapists in their clients' outcomes). The study was unique in that it is the first known study to predict the therapist effect with a specific therapist characteristic. The sample was unique, not only for the large number of clients, but also because Okiishi, Lambeert, Nielsen, and Ogles (2003) had previously found therapist effects at this site, but the source for the differences among the therapists had not been identified.

Anderson et al. (2009) collected new data from this site with the aim of identifying therapist characteristics, including the FIS, that might account for the therapist differences originally reported at the earlier period by Okiishi et al. (2003). Twenty-five therapists (16 men and nine women) were included in the analyses. The mean age of the therapists was 43.9 years (*SD* = 10.9) and most identified as White (96%). Therapists practised from theoretically diverse perspectives, self-identifying their theoretical orientations as cognitive–behavioural (*n* = 8), humanistic (*n* = 8), eclectic (*n* = 5) and psychodynamic (*n* = 4). They were mostly fully trained and credentialed—17 of the 25 therapists were licensed doctoral-level therapists; however, several levels of trainees were also included—two were postdoctoral but not fully licensed; three were predoctoral interns, and three were graduate-level trainees. Therapists had a mean of 11.5 years of clinical experience (*SD* = 10.1).

In order to test therapist effects, a large sample of clients were nested within the 25 therapists. A total of 1,141 clients were treated and thus a mean of 45.6 clients per therapist (range = 13 to 141). All clients completed at least three therapy sessions to be included (mean = 9.09 sessions; *SD* = 8.79; range = 3 to 72). Clients were mostly women (85.5%) and White (85.5%), and had an average age of 23 years.

The FIS was administered at the counselling centre by one of the researchers, who insured that the FIS task was administered in a standard manner, and in the privacy of a private office. After the therapists completed the FIS task, their responses were sent to researchers at different research sites so that raters would be blind to the therapists' identity and their clients' outcomes and scores. After completion of observational ratings of the therapists' FIS, their clients' outcomes were linked to the FIS ratings and additional characteristics that had been collected about the therapists.

Client outcomes were measured through routine administration of the Outcome Questionnaire-45 (OQ-45), a self-report measure of subjective, interpersonal and social components of psychological distress. The OQ-45 was administered before each therapy session. Data were analysed using multilevel linear modelling, which better allows for missing data and for treatments of various duration than traditional statisical analyses. Importantly, multilevel modelling not only compares individual client's rate of change, but also compares them as a set of nested clients within therapists. Finally, multilevel modelling allows for examination of individual therapist predictors (e.g. level of training, theoretical orientation, types of training, gender and age) of the therapist effects, or all individual client changes (slopes) in OQ-45 across all treatment sessions. These slopes of client OQ-45 scores were nested within their individual therapists. In addition to FIS, the therapists' level of training, theoretical orientation, types of training, gender and age were all included as predictors of the therapist effect.

The multilevel analyses found that clients improved, overall, by about one OQ-45 point per session. In addition, a significant therapist effect was found (i.e. individual therapists differed from each other in client outcomes within their caseloads). Furthermore, these therapist

effects were significantly accounted for by ratings from the FIS performance task ($p < .05$), whereas the other therapist characteristics were not predictive of the therapist effects (Anderson et al., 2009).

5 | LIMITATIONS AND FUTURE DIRECTIONS

There are numerous future directions for research using the FIS method, and we will consider a few here.

5.1 | Transferability of FIS into community practice

Practice-based implementation of therapist FIS using existing treatments and within-community settings would make sense. For example, treatments that are already relationship-based might allow for strong interpersonal abilities of FIS therapists to be targeted to maximal efficacy. Common relational skills on the FIS might be acquired through less directive learning and by emphasising general principles that can be practised in real, naturalistic and spontaneous interactions with clients. Specific, deliberate practice strategies (e.g. Rousmaniere, 2019) might be integrated with instruction of relational principles and workshop training for maximum effect (Anderson & Perlman, 2020).

5.2 | Selection of therapists

Therapist FIS could be considered as a more ecologically face-valid task to aid in the selection of persons for counselling and therapist training programmes. The FIS task is also brief and portable, and there is some evidence that FIS scores are predictive of future therapist success with later therapeutic work with clients (Anderson et al., 2016), though studying FIS within real-world decision-making about therapist selection has yet to occur.

5.3 | Construct validity

Use of the FIS observational ratings has notable predictive validity, and the construct validity has ranged from mild to moderate with self-report measures such as social skills and empathy (e.g. Anderson et al., 2016; Anderson et al., 2019; Hill et al., 2016). However, there is a need to develop more comparable, competency-based measures in psychotherapy research that measure performance.

5.4 | Alternate FIS versions in different contexts

Ongoing research is taking place on the use of alternate forms of the FIS. The original FIS scripts have been re-created in 3 different English-language versions, as well as in Norwegian, German, Danish, Portuguese and Chinese. It is unclear how these FIS versions might differ since the impact of interpersonal communication differs among cultures (e.g. Guillemin, Bombardier, & Beaton, 1993). There is also a version of the FIS that is text-only, FIS-Text, which is currently being tested through a text-based therapy application.

5.5 | Responsiveness and experimental studies of therapist immediate reactions to difficult markers in therapy

As noted in the background section, the FIS method selects difficult markers because of the assumption that challenging moments provide a better indication of therapist skill than less challenging moments. Responsive therapists demonstrate the ability to "do the right thing, which may be different each time, providing each client with a different, individually tailored treatment" (Stiles & Horvath, 2017, p.71).

Research on FIS responsiveness (Finkelstein & Anderson, 2018) is addressing the theoretical underpinnings for *how* therapists are responsive during difficult therapy moments. Specifically, the highly difficult FIS video clips are being compared with more ordinary ("benign") clips. Responsive therapists would be expected to quickly shift in *how* they respond when the client's presentation shifts, especially within the moment-to-moment emergent context (Stiles & Horvath, 2017). Research on FIS and therapist responsiveness is also examining therapist physiological reactions during the presentation of provocative and benign FIS clips (Steggles & de Jong, 2018), specifically with measures of heart rate variability and skin conductance. If effective therapists are able to be responsive to their clients during challenging moments, future research could focus on how therapists are able to remain responsive within difficult moments. Our current thinking is that appropriate responsiveness involves facing these difficulties directly while maintining optimal levels of involvement and maintaining their tension, but also balanced with emotional regulation.

5.6 | Therapy illustration of responsiveness

We provide an in-session example of how therapist responsiveness emerges with immediacy of the context of difficult moments. During her initial session, "Alex" (the client), reported a dislike for most people because of what she described as the "bullsh*t" and artificiality of most people, including therapists and professional relationships in general. For prior therapists, "bullsh*t" included professional jargon and communication that she experienced as "sugary sweet", artificial and indirect. Without missing a beat, the therapist retorted, "So, I'm hearing that you want me to call you out on *your* bullsh*t?" Alex laughed and expressed enthusiasm for the fact that the therapist was willing to "play ball". The therapist communicated with responsiveness, not simply by using the client's language or any planned

intervention, but with immediacy and a deeper understanding of what the client was communicating.

The therapist's response also addressed an emergent theme of avoidance and negativity in Alex's relationships, which she usually hid from others with her own interpersonal "mask". By dropping "the mask" of overt professionalism, her therapist emphatically demonstrated her interest in Alex by affirming aspects of her voice and language. In future sessions, the therapeutic relationship became warm and open as Alex increasingly took risks by being vulnerable with her emotions. The therapist could have provided many other fine, competent interventions at this difficult marker–moment, but the use of "bullsh*t" was responsive to the emergent context through immediacy and engagement to the client's need for genuineness. Understanding more about how therapist FIS is expressed as responsiveness within different emergent contexts is an ongoing and important next step.

6 | CONCLUSION

While difficult moments are relatively rare in psychotherapy, practitioners may enhance therapeutic efficacy by mindful consideration of these moments with their own clients. These moments may present golden opportunities for beneficial impact to the client through the therapist's heightened awareness of the emergent context. To be beneficial, therapists likely need to practise their own experiential awareness as to what therapeutic moments are uniquely experienced as difficult. To a large extent, the FIS clips assume that sampling what is difficult for other therapists will also be difficult for any individual therapists. Master therapists are likely to have much more nuanced and individualised notions for what is challenging to them. However, the emergency of difficulty fills any therapist's experience, and appropriate responsiveness involves remaining emotionally and interpersonally engaged. Because of their difficulty and emotional intensity, difficult moments may require a different form of practice from standard interventions. It is encouraging that practice can help, especially when therapists deliberately approach and embrace difficult moments as opportunities for client improvement.

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