DEPARTMENT OF PSYCHOLOGY

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"You Feel They Have a Heart and are Not Afraid to Show it": A Qualitative Investigation of How Clients Experience the Therapeutic Relationship in Emotion-focused Therapy

MAIN THESIS

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Midway on our life's journey,

I found myself in dark woods,

the right road lost.

Dante Alighieri (1320/1997)

I came in contact with a space of feelings within me that had never been opened before. It was very scary to let it out. I said to him that it felt like I fell through the earth and into a huge, dark room. I don't think that I would have been able to open up in that way, even though I was prepared for it beforehand, had it not been for the safe relationship with the therapist.

Participant in the study

Preface

I consider it a great privilege to be able to study such a fascinating field of inquiry as psychotherapy. I have been fortunate in getting access to conducted and transcribed interviews to investigate clients' experiences in therapy under trusting, encouraging and competent guidance by my main supervisor, Aslak Hjeltnes. I would like to express my sincere gratitude to him. It has been a rich and rewarding process. Also, I would like to thank my co-supervisor, Per-Einar Binder, for his warm presence and very helpful comments. He has been an inspiration for me throughout my education. My thanks also go to the others in the research group for providing the data that made this thesis possible: Elisabeth Schanche, Jan-Reidar Stiegler, Signe Hjelen Stige and Didrik Hummelsund.

Finally, I would like to thank my family for their unremitting support. My love and appreciation for them are beyond words.

Abstract

Objective: To explore how clients with depression and destructive self-criticism experience the therapeutic relationship in Emotion-focused Therapy (EFT) including helpful and hindering aspects. *Methods:* 18 clients who had completed treatment with EFT were interviewed using a semi-structured guide to explore their experiences of the relationship with their therapist during treatment. Transcripts were analyzed by use of a hermeneutic-phenomenological thematic analysis. *Results:* We identified four main themes: (1) Forming a trusting relationship, (2) Collaborating to find new ways to change painful feelings, (3) Alliance ruptures and needs for repair when working with distressing emotions, and (4) The relationship as a transformative experience. *Conclusions:* Participants described the importance of the establishment of trust in the relationship for them to open up to vulnerability and painful feelings. A close and secure relationship enabled participants to immerse themselves more fully in interventions designed to transform these distressing emotions, and provided important corrective experiences. However, some of the participants' concerns in therapy were not always fully recognized or disclosed. Implications for clinical practice and research are discussed.

Keywords: emotion-focused therapy, therapeutic relationship, thematic analysis, hermeneutical-phenomenological, qualitative, depression, self-criticism

Table of Contents

Introduction

How is it to meet and seek help from another human being when you are vulnerable and in the midst of suffering? What is it like to open up and show your feelings to a person when being vulnerable have been harmful for you in the past? Is it possible to change your emotions and how your experience yourself by having a new relational experience that contradicts your worst fears and expectations? For many clients with psychological problems, the process of meeting a stranger who you are supposed to show your inner pain to involve considerable fear and insecurity. Many leading clinicians and theorists in the field of psychotherapy have considered the therapeutic relationship to be the main vehicle for client change (Greenberg, 2007; Mitchell, 1993; Rogers, 1965/2012; Stern et al., 1998; Sullivan, Perry, & Gawel, 1955/2003; Yalom, 1980). By operationalizing constructs of relational aspects in therapy, a good amount of scientific research finds that the quality of therapeutic relationship is indeed a powerful predictor of client outcome (Ardito & Rabellino, 2011; Horvath, 2000; Lambert & Barley, 2001; Norcross & Wampold, 2011). The majority of these studies have been quantitative in nature. However, with some notable exceptions (Israel, Gorcheva, Burnes, & Walther, 2008; Levitt, Butler, & Hill, 2006; Mortl & Von Wietersheim, 2008; Orlinsky & Howard, 1967; Timulak, 2007), there is unfortunately a considerable lack of empirical research investigating clients' actual experiences of the therapeutic relationship in psychotherapy.

Thus, the aim of this study is to contribute to that literature by conducting a phenomenological study of how clients experience the impact and significance of the therapeutic relationship when undergoing Emotion-focused Therapy (EFT). In the present article, we explore clients' first person experiences of the therapeutic relationship after undergoing treatment. Participants were drawn from a larger clinical trial of EFT for major depression and self-criticism (Stiegler, Molde, & Schanche, 2018).

Why Does Psychotherapy Work?

Decades of research has shown that psychotherapy works (Lambert & Ogles, 2004; Wampold, 2007; Wampold & Imel, 2015). Estimates indicate that approximately 80% of those getting psychological treatment will be better off in terms of mental health compared to not having treatment (Wampold & Imel, 2015). Psychotherapy is equal in its effectiveness compared to psychotropic drugs for a number of psychological disorders, and the effects last longer (Wampold, 2007). These findings do, however, raise important and complex questions regarding which components of psychotherapy account for such change (Kazdin, 2009; Silberschatz, 2017).

At present, meta-analyses have consistently failed to uncover meaningful differences between different evidence-based treatment approaches. This has been considered as indicating that other variables than the technical and theoretical aspects of therapy are needed to account for the variance in outcome (Benish, Imel, & Wampold, 2008; Imel, Wampold, Miller, & Fleming, 2008; Leichsenring & Leibing, 2003; Miller, Wampold, & Varhely, 2008; Spielmans, Pasek, & McFall, 2007; Wampold et al., 1997). Other factors that have been delineated include expectancy effects, extra-therapeutic factors such as social support and spontaneous remission, as well as common factors (Lambert & Barley, 2001). Common factors are those variables that are present in all treatment approaches, mostly relating to aspects of the relationship between therapist and client such as the working alliance and the conditions that affect the quality of the relationship including warmth, empathy, and genuineness (Wampold, 2015). Common factors consistently account for a greater variance in outcome than techniques and interventions (Lambert & Barley, 2001; Wampold, 2015). There is thus a consensus in current psychotherapy research that the nature and quality of the therapeutic relationship is of paramount importance for desirable outcomes. Indeed, Lambert and Barley (2001) argue that it is *the* most significant curative factor in psychotherapy.

Conceptualizing the Therapeutic Relationship

What do we mean by the term the "therapeutic relationship"? It is a challenge to distinguish conceptually between different constructs and components of the therapeutic relationship such as the working alliance, therapist factors, transference-countertransference processes, facilitative conditions, and other common factors as there are often considerable overlap. However, for simplicity, in this context the paper will use the term "therapeutic relationship" to refer to the following aspects based on a tripartite model by Gelso (2014): 1) Transference-countertransference configurations, 2) the working alliance and 3) the real relationship.

Transference and countertransference. The constructs of *transference* and *countertransference* have had a long and controversial history ever since Freud's original formulations (Freud, 1940/2011). Transference can be described as clients' experiences of the therapist that are influenced by the clients' past, including emotions and behaviors stemming from earlier significant relationships that are displaced onto the therapist (Gelso, 2014, p. 121). Conversely, countertransference are the therapists' reactions to the client that are influenced by their own inner conflicts from the past (Gelso, 2014, p. 123). Although normally associated with psychoanalytic and psychodynamic therapies, a meta-review of qualitative and quantitative studies indicated that transference occurs in a range of different theoretical approaches and its frequency seems not to be any less for nonanalytic therapies (Gelso & Bhatia, 2012). However, within humanistic traditions in psychotherapy, more attention has been given to the working alliance and real relationship.

The working alliance. The *working alliance* refers to an ongoing process where both parties negotiate a common understanding of the purpose of treatment. Bordin (1979) provided a three-component conceptualization of the working alliance: Agreement (implicit or explicit) on the goals and tasks of therapy, and an emotional bond characterized by mutual

trust and confidence (Bordin, 1979; Hatcher & Barends, 1996). Thus, the working alliance relates to the actual work of therapy. Research that has operationalized the working alliance have found that its quality (e.g. degree of agreement) yields a moderate, stable positive effect on outcome (Flückiger, Del Re, Wampold, & Horvath, 2018; Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000).

The real relationship. It has been argued that the most fundamental component of the therapeutic relationship is what has been termed *the real relationship* (Gelso, 2014). Gelso (2010), based on Greenson (1965, 1967), have defined the real relationship as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, 2010, p. 13). The definition consists of two key components: genuineness and realism. Genuineness refers to both persons being authentic in a relationship, while realism (or realistic perceptions of the other) is defined as "experiencing and perceiving the other in ways that befit the other rather than in ways that fit what the perceiver wishes for, needs, or fears" (p. 13). The magnitude of genuineness and realism in the dyad together with their valence (positive or negative) can be a way of determining the strength of the real relationship (Gelso, 2014). The real relationship is differentiated from the working alliance (Bordin, 1979), which emphasize the collaborative component of the relationship where the therapist and client explicitly or implicitly agree on the goals and methods of therapy. Although an emotional bond is included in Bordin's concept, Gelso argues that the component is narrow in that it mainly refers to a working bond (Gelso, 2010, p. 9). In a working bond, participants in the relationship trust each other in that they are willing to fulfil their respective roles toward a common goal. The real relationship, in contrast, tries to capture a broader sense of an emotional connection that is not necessarily based on the tasks and goals of therapy, although it may profoundly influences its success (Gelso, 2010). As such, it is part of all human encounters.

Because real relationships thus defined are idiosyncratic and co-constructed, the measurement of this concept has been a challenge. However, psychometrically valid measures based on both therapist and client self-report have been developed (Gelso et al., 2005; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010). When comparing studies examining the contribution of the real relationship and working alliance to treatment outcome side by side, the results have so far revealed that the quality of the real relationship accounts for more outcome variance than the quality of the working alliance (Coco, Gullo, Prestano, & Gelso, 2011; Fuertes et al., 2007; Gelso, 2010; Marmarosh et al., 2009). The effect of the component of genuineness on outcome has also received empirical support in a meta-analytic review finding small to moderate effects on treatment outcome (Kolden, Klein, Wang, & Austin, 2011).

The Therapeutic Relationship in Emotion-focused Therapy

In EFT, a particular emphasis on creating a safe and caring therapeutic relationship is a fundamental component of the model, which is based on a Rogerian humanistic-experiential perspective (Elliott, 2004). Indeed, the task of developing an empathic relationship characterized by affective attunement and presence is central to the hypothetical mechanisms of change in EFT, and considered to have ultimate priority over and beyond specific psychotherapeutic interventions (Greenberg, 2014). In Greenberg and Watson's (2006) view, the therapeutic relationship serves two functions: 1) Interpersonal regulation of affect, and 2) Providing a safe atmosphere for inner exploration and transformation of emotions.

Interpersonal regulation of affect. First, the relationship should ideally be developed in such a way that it promotes regulation of affect. Many psychological disorders are characterized by difficulties in emotion regulation (Kring, 2008). However, by providing a soothing, affectionate bond by meeting the client with a therapeutic stance of full presence in the moment, affect can be interpersonally regulated. The therapist's whole being is thus

implicated as his or her attunement to the client, including pace, rhythm, facial expression, tone of voice, mirroring, posture and other forms of non-verbal communication, is involved in creating an emotionally safe climate (Greenberg, 2014). The Rogerian conditions of congruence (or genuineness), unconditional positive regard, and empathy (Rogers, 1957) are similarly fundamental for the client to feel liked, safe, recognized, understood and respected. The co-creation of such a bond is considered as curative in itself, as it disrupts clients' experience of isolation and loneliness due to their inner pain. With time, the interpersonal regulation is internalized into intrapersonal regulation in that that the client is able to self-soothe and self-regulate emotions (Greenberg, 2014, p. 351). The process is similar to interpersonal regulation of an infant's affect by a caregiver (Stern, 1998).

Providing a safe atmosphere for inner exploration and transformation of emotions. Second, the therapeutic relationship in EFT is meant to provide a foundation for deeper transformational work with emotions. A safe relationship with the therapist constitutes a therapeutic environment that makes the client feel secure enough to engage in self-exploration, and to approach and tolerate difficult emotions (Greenberg, 2014). It is important to validate and encourage clients' expression of emotions such that fear of criticism does not hinder them in revealing the depth of their emotions (Greenberg, 2007). The trust gained by revealing oneself to an empathic other being who really understands strengthens the emotional bond such that it also facilitates subsequent specific work with emotions (Greenberg, 2007, p. 352). Examples of specific emotion work are different marker-based interventions like processing unresolved feelings with a significant other in an empty chair dialogue, encouraging internal attention when the client externalize their problems, and enacting dialogues between two split parts of the self (e.g. inner critic and experiencing self) to promote integration (Greenberg, 2007; Greenberg, Rice, & Elliott, 1996).

Another important objective in EFT is for the client to approach, feel and express primary adaptive emotions with their associated needs instead of clients being stuck in secondary maladaptive emotional reactions (Pascual-Leone & Greenberg, 2007). By empathic exploratory probing or questions about clients' emotional awareness, the therapist can guide the client to accept, approach and utilize emotions for their benefit (Greenberg, 2007).

The working alliance in EFT: Collaboration. In addition to the development of a safe bond, EFT emphasizes establishing collaboration as to what will be the objectives of therapy. In EFT there is more focus on getting a common understanding of the underlying pain behind the client's symptoms and resolve that, rather than change behavior. This requires an empathic understanding of the client's life world and hopefully results in a sense of two people together collaborating on an emotional problem to be solved (Greenberg, 2014). With the therapist's explicit focus and attunement to emotion, the client implicitly learns to attend to inner processes. In addition, the therapist conveys a rationale for the usefulness of working with avoided or under-regulated emotions in order to help the clients. If the client understands the relevance of such work and feel safe in the relationship, an agreement on the goals of tasks of therapy can be made: to explore inner feelings (Greenberg, 2007, 2014).

The real relationship in EFT: Genuineness and presence. In EFT, a fundamental therapeutic stance is that of presence. Presence is a state where the therapist is fully immersed in the here-and-now together with the client from moment-to-moment with the intention of tuning into, and being with and for the client with undivided attention (Geller & Greenberg, 2002; Greenberg, 2007, 2014). In order to be fully present, the therapist is required to be genuine and convey genuineness in a facilitating, transparent manner. Genuine, present contact fosters a positive real relationship that may lead to memorable, intersubjective moments of meeting (Stern et al., 1998). In such instances, each person in the dyad is aware of the other experiencing the same as oneself in the moment. It is a shared experience that

disrupts any sense of isolation. Such co-experiencing can be characterized as what Buber termed I-Thou encounters, where two persons recognize themselves and the other as subjects immersed together authentically in a shared, holistic experience (Buber, 1958). Clients having such encounters with their therapist often experience a confirmed self-experience and increased self-acceptance, in addition to building a deeper bond with the therapist (Greenberg, 2007, 2014).

Empirical Research on the Therapeutic Relationship in EFT

In general, research supports the components that EFT emphasizes in developing a therapeutic relationship. For instance, studies have found client-centered therapy (also called person-centered therapy), which bases itself on the Rogerian conditions, to be an effective psychological treatment for different populations and psychological disorders (Cooper, Watson, & Holldampf, 2010). Support for one of its facets, genuineness, has been reported above. Another component, empathy, has been established as predictive of outcome with a moderate effect (Bohart, Elliott, Greenberg, & Watson, 2002; Elliott, Bohart, Watson, & Greenberg, 2011). In a recent study, therapist empathy was found to have both a direct and indirect effect on outcome, the latter being through increased client affect regulation towards the end of treatment (Watson, 2018; Watson & McMullen, 2018). Also, a meta-analysis found that both empathy and genuineness had a moderate positive relationship with the therapeutic alliance (Nienhuis et al., 2016). Furthermore, one study of both process-experiential therapy and cognitive-behavioral therapy found that clients' experience of the Rogerian conditions correlated highly with working alliance quality, that empathy and presence correlated with increased self-esteem and decreased interpersonal problems, and that therapist acceptance predicted decreases in depressive symptoms (Greenberg, 2007; Watson & Geller, 2005).

Successfully negotiated collaboration is also supported in predicting client outcome (Greenberg & Horvath, 1994). A study by Horvath and Greenberg (1989) found that clients'

reported perceptions of the relevance of the tasks they did in therapy and the quality of the collaboration predicted outcome more than empathy. However, the authors argue that successful task collaboration was a consequence of the therapist's ability to empathically understand the client (Greenberg, 2014; Horvath & Greenberg, 1989).

Aim of the Study

Although there exists a good amount of quantitative research investigating aspects and predictors of the therapeutic alliance in psychotherapy in general and EFT in particular, there is in comparison a scarcity of qualitative studies exploring clients' own first-person experiences of how they perceive the therapeutic relationship. Existing qualitative studies that have investigated this question consistently find that that clients appreciate an understanding, warm and involved therapist (Israel et al., 2008; Levitt et al., 2006; Mortl & Von Wietersheim, 2008; Orlinsky & Howard, 1967; Timulak, 2007; Toukmanian & Rennie, 1992; Watson, 2018). However, systematic literature searches of existing research could not identify any prior empirical qualitative studies investigating this question in the context of EFT. This indicates an important gap in the literature. Important insights have indeed been gained from structured questionnaires, ratings by external observers and randomized controlled trials. However, other relevant forms of knowledge can only be acquired by exploring clients' idiosyncratic experiential worlds (Binder, Holgersen, & Moltu, 2012). Exploring how clients experience relational processes can for instance serve to investigate the relevance of specific interventions, provide sources for new research questions, and in general discover phenomena not easily investigated by quantitative methods (McAleavey & Castonguay, 2015). This strategy also relate positively to the mental health user movement (Elliott, 2010). Moreover, predefined operationalizations have the risk of reducing complex and multi-faceted phenomena to simplistic notions. Watson (2018) has asked the field to reconsider if interpersonal attitudes and climates are actually suitable to isolate as variables for statistical

testing, or whether such reductionism is less helpful when investigating the nature of interpersonal interactions. The present study will heed the call from Bohart and Wade (2013) to conduct more research investigating subjective experiences, and follow similar recommendations from Fuertes and Nutt Williams (2017) to explore questions from the clients' perspective. The aim of this study was to explore how clients experience the impact and significance of the therapeutic relationship in EFT. The research question was as follows: What do clients with depression and destructive self-criticism experience as helpful or hindering aspects of the therapeutic relationship when undergoing Emotion-Focused Therapy?

Method

Setting

The following data were gathered from a larger clinical trial in Bergen, Norway (Stiegler et al., 2018) primarily designed to investigate the effect of two-chair dialogue in the treatment of depressed clients. Using a multiple baseline design, the study involved two phases. The first phase would emphasize empathic attunement based on a Rogerian perspective (Rogers, 1965/2012). The therapists subsequently implemented chair dialogue interventions in the second phase (Stiegler et al., 2018).

Participants

The participants, all native Norwegians, were recruited from the aforementioned trial involving a public treatment program designed to treat mental health conditions that resulted in sick leave (Stiegler, 2017). Eligible patients generally suffered from mild to moderate severity of anxiety and/or depression and had to meet criteria for mental health difficulties as assessed by an intake interview. As this particular trial had a specific focus on the reduction of destructive self-criticism, participants had to display moderate to high self-criticism to be included as measured using Self-Criticizing/Attacking and Self-Reassuring Scale (Gilbert,

Clarke, Hempel, Miles, & Irons, 2004). Of 24 participants, twenty-one completed the treatment. See Stiegler et al. (2018) for further details. Out of 21 completers, 18 participants (13 women, aged 20-63, mean age 38.2 years**)** accepted to be interviewed post treatment (Stiegler, Binder, Hjeltnes, Stige, & Schanche, in press).

Methodological Approach

The aim of the present study was to investigate how participants experienced the therapeutic relationship during the process of undergoing Emotion-focused Therapy. We conducted in-depth, semi-structured, qualitative interviews were conducted applying a hermeneutic-phenomenological approach to thematic analysis. This approach seeks to interpret (hermeneutical) and explore lived experience (phenomenological) by systematically investigate people's descriptions and reflections on own subjective experiences and life worlds (Binder, Holgersen, & Nielsen, 2010). Thematic analysis is a method which flexibly analyzes similarities and differences in participants' described experiences through a process of interpretation involving identifying key themes (categories) that could represent psychological dimensions of lived experience (Braun & Clarke, 2006, 2012). In this study, the dialectical process between participants' responses and interpretations of transcribed text sought to uncover descriptive knowledge about psychological phenomena and processes occurring in the context of a therapeutic relationship.

The hermeneutic-phenomenological approach to thematic analysis recognizes that researchers will inevitably shape the participants' recollected experiences due to the nature of the interview context. Also, although the lived experiences of the participants are investigated and analyzed as empirical data, the researchers' own background, preconceptions, basic interpretations, and assumptions will invariably be involved in the process of constructing meaning from the clients' responses (Binder et al., 2012; Heidegger, 1927/2010). Although as a potential source of bias, the researchers' background and theoretical foundations also

provide a set of tools to identify and investigate relevant phenomena that can be integrated and/or compared to existing findings and theoretical frameworks. This co-construction of meaning requires the researchers to interpret the utterances with as much reflexivity as possible (Finlay & Gough, 2003).

Data Collection Method

Interviews were conducted by five clinical psychologists between August and September, 2015, approximately 3 months after treatment termination. Based on a semi-structured interview guide, the interviews explored participants' motivations for and experiences in therapy, experiences about the therapeutic relationship, and experiences with chair dialogue interventions (see appendix for the full interview guide).

The interviews were audio recorded and transcribed verbatim by eight graduate students instructed to include descriptions of salient non-verbal communication (pausing, sighing, laughter etc.) (Stiegler et al., in press).

Data analysis

The transcribed material was analyzed by use of thematic analysis based on Braun and Clarke's (2006) protocol: 1) The candidate familiarized himself with all material by preliminary reading. 2) The candidate examined the material in detail and coded relevant units of meaning based on the research question using Nvivo 11 (QSR International, 2015) computer software. 3) The candidate constructed tentative themes by sorting identified units of meaning in categories in collaboration with the supervisors. 4) The tentative themes were reviewed, modified and redefined to create a coherent narrative between them. 5) The newly modified themes were consensually discussed with the supervisors for final agreement. The candidate was responsible for analyzing the data and writing the scientific report for this study.

Ethics

The study was approved by the Norwegian Regional Committees for Medical and Health Research Ethics (Stiegler et al., in press). The participants were given written information about the study, and voluntarily signed an informed consent form before treatment. Experienced therapists conducted the interviews post-treatment being vigilant to the participants' well-being during the interviews. The data was handled and stored safely in accordance with protocols from the Norwegian Regional Committees for Medical and Health Research Ethics. The identities and names of the participants were not visible for the candidate and transcribers, preserving anonymity.

Results

We identified four main themes, constituted by in all 10 sub-themes. The main themes are as follows: 1) Forming a trusting relationship, 2) Collaborating to find new ways to change painful feelings, 3) Alliance ruptures and needs for repair when working with distressing emotions, and 4) The relationship as a transformative experience.

1. Forming a Trusting Relationship

The first main theme, «Forming a trusting relationship», centers around clients' experiences of their initial contact with the therapist in the process of developing a therapeutic collaboration. Many participants reported that being met by a validating, warm and present therapist created a safe space where they could open up and reveal their vulnerability and personal struggles. Conversely, some participants felt that some of their needs in therapy were not sufficiently recognized and met by the therapist in the first stage. We identified three sub-themes: "Connecting with a warm and present therapist", "Being met and seen as a person", and "Making sense of inner pain through interaction with a therapist who understands and deeply cares".

a) Connecting with a warm and present therapist. The first sub-theme concerns participants expressing how meeting an interested, caring and present therapist helped them to form a trusting emotional connection in the beginning of the therapy. One participant described how she experienced the first encounter with the therapist:

> She was nice, smiling, and comforting. I had her attention and got to explain. She asked sensible questions which enabled me to talk about the things I needed to talk about. The best way to put it is that she was there for me.

This quality of "being there for me" was highlighted as an important experience by several participants. They emphasized the significance of being met by a genuine person who related to them in an honest and authentic way, without any sense of judgment. One participant described how she experienced these qualities in her therapist:

> Certain people have that kind of skill independent of profession. Some people are genuine, and you notice they are not judging and have tolerance for different viewpoints. They have presence and a warm gaze. You feel they have a heart and are not afraid to show that they have it. And that they care.

Furthermore, an important aspect of this encounter includes how participants experienced an atmosphere of equality and mutual respect in the relationship. One participant described that she did not feel that the therapist acted in an authoritative manner, but that through familiarity with each other, she gradually experienced a natural sense of trust in the therapists' authority:

> There was no sense of authority in our contact. The authority was built through getting to know him and the trust in him. I experienced being met with respect and with the attitude that my situation was supposed to be in focus. So this was somewhat unexpected.

Here, the participant described a relationship with an egalitarian quality. It was not only about meeting a professional, but encountering another human being. And the therapist appeared to establish authority through showing personal competence and trustworthiness, and not through professional title or role in itself.

Finally, two participants emphasized that the manner in which the therapist remembered information between sessions served as an important confirmation of the therapist's good intentions and genuine interest in their everyday lives outside the therapy. One participant described:

> I noticed that he quickly learned the names of the important people in my life. Coming to a session where he had complete overview of the whole gallery in his mind made it possible to get to work faster. It confirmed that he actually listened to me. That is important to me - to be remembered.

b) Being met and seen as a person. The second sub-theme includes experiences of being recognized and seen as a person by an emotionally attuned therapist. The participants described that the experience of having their inner pain and difficulties listened to and validated in the sessions helped them to take the risk of opening up and show their vulnerability.

In addition to having one’s struggles validated, the following quote also describes an important experience of being recognized and having an emotional impact on the therapist. The participant recognized an emotional resonance in the therapist when sharing her pain, which strengthened her sense of trust in the relationship:

> I was listened to. I felt that when I cried, she almost sat there and cried together with me. I felt there was a strong connection which made it easy for me to open up. Even though I was prepared to talk about my problems, still, it became even easier. ... Safety

> to open up, and there was something about how the therapist acted ... I feel I have been receiving a lot from her. She was there for me. It has been very close and nice, and very supportive. Very safe.

This description of the therapist's attunement to the client's emotional state may not only reflect an experience of the therapist "being there for me", but also "being there with me". This atmosphere of presence and closeness enabled the participant to more easily open further up about her difficulties afterwards.

Although most clients described feeling seen and validated by their therapist, some reported that they also had interpersonal needs and personal expectations for the therapy that were not fully recognized or sufficiently addressed by the therapist. For instance, two participants experienced the empathic responses of the therapist as excessive, and described that they had hoped for a more challenging therapist:

> I thought the first session was a bit awkward. I felt I got too much sympathy for my problems. I had perhaps hoped that I got someone who could be somewhat harder with me. After the first session I thought 'Oh my God, this is not helpful at all'. I had not intended to have one sitting next to me and patting me. That is not what I need.

One possibility is that this experience of receiving too much empathy could make participants feel that their strengths and resources were not fully recognized. With the therapist adopting a "soft" stance the clients may have perceived that the therapist treated them as being weak and more vulnerable than they experienced themselves to be.

Furthermore, six participants expressed that they expected a more structured treatment from the start. For instance, they described that they wished for homework and assignments between the sessions. Also, participants missed specific feedback and techniques such as

concrete advice on how to manage anxiety, negative thoughts, and difficult situations occurring between sessions. One participant described:

> I needed a technique or a recipe or a safety net I could cling to when the anxiety was at its worst – whether it was a breathing exercise or to walk ten steps back and forth. It is so scary to be paralyzed and terrified by anxiety, and then one is supposed to dive into it without... I can dive into it if someone promises to catch me when I get back up again – if I can hold on to that technique and know what I am doing when I am shaking ... I just become so desperate just sitting down and notice that I am in such pain.

This quote illustrates how some participants described that they needed practical ways to manage distressing emotional states between the therapy sessions. Other participants had similar descriptions with regards to needing strategies to meet other specific challenges in everyday life including instances of escalating negative thoughts that became overwhelming. These descriptions indicate that their therapists were not always able to pick up how vulnerable the participants felt and their fear of being overwhelmed during the therapy. This suggests that these participants needed an outer support structure to feel safe.

c) Making sense of inner pain through interaction with a therapist who understands and deeply cares. The third sub-theme describes the participants' experiences of making sense of their own pain and difficulties in life through their interactions with the therapist. The participants described that they developed new ways of understanding themselves and their past experiences through being properly understood, and their story taken in by and reflected back from the therapist. Some participants described that being understood in a manner where another grasped the emotional essence of their problems was something they had never experienced before. As this participant explains, it was important that the therapist took her perspective: “She was really good at putting herself in my

situation and to understand what the issue was. She could say things that made me break down." Here, the participant describes how small, but precise remarks by the therapist could result in spontaneous feelings in her. In particular, several participants who felt that they struggled with expressing their problems and going into multiple directions during the sessions appreciated the manner in which the therapist actively endeavored to help them to concretize and follow their story. For one participant, this involved having the therapist help her to formulate inner thoughts out loud for the first time: "She expressed things I struggled to say in words – thoughts I have thought a thousand times but never expressed. Afterwards I could more easily express myself." Another participant describes a collaborative process where they together got a clearer grasp and mutual understanding of her problems and the associated feelings:

> She grasps the meaning and says 'you become sad now, but that is because you think like so and so', and then I say: 'Yes, yes, yes!' We talked back and forth and made more concrete what I was actually thinking. She was very good with suggestions: 'Do you think like this and this now?' And I thought: 'Yes!' … I felt that she was with me the whole time even though I was talking in every direction.

In addition, how the therapist helped the participants to explore and make sense of their experiences strengthened this sense of being understood at a deeper human level. One participant described that: "She understood before me where the problem lay and got me to think about things I was not aware of." Not only, then, did the participants feel that their story was understood by the therapist, but they also gained new perspectives and additional meaning to their painful experiences.

2. Collaborating to Find New Ways to Change Painful Feelings

The second main theme, “Collaborating to find new ways to change painful feelings”, describes participants’ experiences of working to change difficult emotions in collaboration with the therapist. The findings in this category highlight the importance of having established a safe relationship in order for participants to dare open up to painful feelings. As those feelings were expressed and brought out into the open, participants described how the therapists’ acceptance of those feelings provided them with a new way to relate to their feelings as less dangerous and scary. This section also described the participants’ positive and negative experiences of the therapist eventually taking up a more leading role during emotional work and themselves letting go of control in the therapy sessions. Three sub-themes emerged: “The relationship provided me safety to explore frightening and painful feelings”, “My feelings became more real, important and normal to me”, and “Letting go and allowing the therapist to lead the way”.

a) The relationship provided me safety to explore frightening and painful feelings. The first sub-theme describes how participants experienced the different ways the therapist reacted to their feelings and actively offered a secure relationship. In turn, the safety and trust in the relationship itself enabled them to dare to open up to difficult and disavowed feelings, despite the sometimes intense and extremely challenging nature of these emotional experiences. One participant described:

> I came in contact with a space of feelings within me that had never been opened before. It was very scary to let it out. I said to him that it felt like I fell through the earth and into a huge, dark room. ... I don't think that I would have been able to open up in that way, even though I was prepared for it beforehand, had it not been for the safe relationship with the therapist.

This quote illustrates how participants described their experience of trust and safety in their relationship with their therapist as an important precondition for entering distressing and

frightening emotional states during the therapy sessions. Another participant pointed out that how the therapist reacted to the expression of vulnerable emotions helped establish a sense of trust in that it was safe to show these feelings, making the participant more fully engaged in and committed to experiencing and expressing their own feelings:

> You feel that you can participate a bit more than you otherwise would because you have that trust. If I am really sad, she does not look at her watch, or try to say 'you have to pull yourself together'. I had quite a trusting relationship with her.

Here, the participant expresses that the therapist's full presence, seriousness, and the perception that the therapist did not judge him in response to the expression of feelings was important for building trust. Despite feeling impatient at the start of treatment and having expectations of more direct work with emotions, another participant realized in retrospect that it was essential for him to build such a trusting connection before going into such work: "I see now that it was necessary to spend such a long time to build trust. If not, then I don't think I would have dared to let go and participate in the manner that I did." Importantly, here the participant explicitly states that the trust that had been established was essential for her to dare involving herself fully in the therapy process. Furthermore, the safe connection with the therapist provided the participants with a sense of not being alone with their pain. One participant mused: "I think it had something to do with not being alone with your emotions – that somebody are there and sees it." This quote indicates an earlier sense of separation and loneliness that this participant experienced from being disconnected from her feelings and other people. However, the encounter with the therapist gave her a new experience of not being alone with her suffering.

b) My feelings became more real, important and normal to me. The second sub-theme describes how participants experienced the reactions and attitude of the therapist when disclosing their distressing emotions. Several participants regarded their own emotional

reactions as embarrassing or irrational, or had a sense of not being entitled to feel them. One participant stated: “I had an idea of what the problem was, but you got to allow yourself to feel it. That it is okay and important what I feel. This therapy actually allowed me to feel.” For this participant, the therapy helped her to be able to allow herself to approach and accept feelings she had not felt before.

Participants found the manner in which the therapist contextualized their emotional reactions as very important, allowing them to realize that it was understandable that they felt in a particular way in response to difficult circumstances rather than due to some personal deficit, fault or abnormality. Having one’s emotions contextualized as natural and understandable allowed participants to view themselves differently – as being part of a common humanity who suffers.

> My feelings were normalized – it is not just me who thinks and feel in these ways. When you feel there is nothing wrong with you, it becomes less scary.

Other participants described not only the importance of having their emotions contextualized and normalized, but also the way the therapist conveyed that there was nothing wrong with them as persons: “I felt that what I said wasn't stupid even though I felt it initially. She told me that this was normal, and that I was normal.” In another example, one participant described that she was embarrassed that she felt so much inner pain as she had not experienced any obvious and dramatic traumas such as severe abuse in the past. However, after the therapist’s acknowledgement of the realness of her pain, she too gradually started to accept her problems and herself as she was.

In addition to being helped to view themselves as normal, participants highlighted how they experienced the therapist’s explicit validation of their emotions and their importance In particular, they commonly emphasized the significance of the therapists' compassionate

recognition and interpretation of non-verbal expressions. This was also helpful in enabling participants to verbalize and become more aware of their feelings with their bodily expression.

> He somehow picked up on my facial expressions and told me like 'Now I see that you are sad' such that it helped me put the feeling into words. Then I would confirm whether it was correct or not, and many times it was. It was just that I was not able to express it first by myself. ... He validated what I said by saying for instance 'I perfectly understand that you are angry right now, just get it out, say what you really think'. He also noticed my body language - something I cannot observe myself – including shifts in posture. This helped in thinking about how I felt.

The participants also regarded the therapist's expressed acceptance and understanding of their emotions as helpful for being able to have a more compassionate attitude toward themselves. As one remembered: "She mirrored me such that it amplified my emotions – here was a person who felt sorry for me ... After the session I felt safe and a sense of "okay, now I have got to feel this" without embarrassment". Here, the therapist's affective mirroring and compassion served to lessen the participant's shame about feeling vulnerable emotions.

However, some participants expressed that they withheld some of their genuine thoughts from the therapist, or felt a need to excuse themselves for their thoughts as they found those too embarrassing. In particular, severely harsh self-critical thoughts could be too difficult to disclose to the therapist:

> I felt that I held some back from my therapist. You know, my thoughts are worse than what I am able to express. I can't get a complete accordance between what I say to myself in my thoughts and what I say aloud. On their way out, I realize how bad they are and I hold back. Almost sort of embarrassing. Also to admit how bad it is.

c) Letting go and allowing the therapist to lead the way. The third sub-theme describes participants' different experiences of when the therapist gradually took on a more leading role in the therapy, and for them to let go of control. Many appreciated the manner in which the therapist took a more instructive lead when working actively to change distressing emotions. Participants frequently described that the manner in which the therapist closely followed their process and supported them to maintain focus was very helpful.

> I thought it was good that she lead on, asking questions such as 'that voice said such and such, what would you say back?' I thought that was very helpful. It felt good that she held the threads together for me and was in control. She picked up everything I said.

However, it was also common that participants would have difficulties answering the therapists' questions or lose focus. Fortunately, multiple participants felt that the therapist was sensitive in picking up difficulties and moments where they felt stuck, and adjusting the process accordingly. This included slowing down, taking a break or shift the conversation to a different topic.

> I sometimes said that I lost focus and she said 'Oh, don't worry about that, it is my job to keep up the thread and guide us back if we get off track'. I thought 'Yes! Then I don't have to think so much about how often I fall out of conversations'. It was relaxing that I did not have to lead on as much.

For this participant, it seemed that being aware that the therapist had responsibility for the unfolding processes presumably freed up her attention to more significant matters than worrying about not being present, thereby ironically enabling greater presence in the relationship and during the therapeutic task. However, there were also instances where participants felt that the therapist was not sensitive enough in giving them time and space to

stay with their inner experience. On such an occasion, a participant deemed the therapists' involvement as disruptive to the process: “It was a couple of times where I felt there was too much leading. There was no space for that which wanted to come out from within.”

Participants' had different experiences regarding letting go of control to the therapist. Some found it helpful, enabling them to connect deeper with their emotions: “It was therapeutic that she was in control, as I am so used to be in control myself. It permitted me to stay with the feelings.” One participant perceived the act of giving up and regaining control as an important, though difficult process that more easily allowed feelings to come up:

> I had no control and at that time. I really felt like a patient. … The last few sessions, I felt I got the control back and I was now supposed to work on my own. I felt in a different way that I let go of the control to someone else, just releasing myself to the emotions.

This quote could suggest that the participant felt that the surrendering of control was in a certain sense forced as opposed to freely submitting to the process. The notion of feeling “like a patient” could indicate that the participant experienced being reduced from a person in to the role of the patient. Giving up control by submitting instead of freely letting go because it felt safe to do so seemed to create a situation where the participant felt alone and helpless when she were to be in control herself after termination.

> When I was in the patient role, you get the feeling that the control was outside yourself. A psychologist was in control. … And then when the sessions were up I had a kind of panic about ‘Oh, now I am left to myself’.

3. Alliance Ruptures and Needs for Repair when Working with Distressing Emotions

The third main theme, “Alliance ruptures and needs for repair when working with distressing emotions”, describes how participants experienced challenges in the therapeutic

relationship, including misunderstandings, disagreements and/or concerns that were not sufficiently addressed during the process of therapy. This included disagreements on how to understand the participants' problems and how to address them such that they became obstacles in treatment. In some cases, the participants and their therapists worked out these difficulties. However, in other cases, difficulties with expressing such concerns to the therapist prevented resolution and common understanding. Two sub-themes described are as follows: "When experiential worlds collide – disagreements about goals, values and tasks", and "Difficult to be open about challenges in the therapeutic relationship".

a) When experiential worlds collide – disagreements about goals, values and tasks. This sub-theme reviews participants' experiences of misunderstandings and being in disagreement with the therapist, including the understanding of the problem and the therapeutic task. It also describes how some participants felt that there was not always enough room to talk about that which felt most pressing for them in a given session. In one instance of disagreement a participant found the focus on self-criticism by the therapist as insufficiently relevant, and as a consequence felt misunderstood:

> I think she perceived me to be cruel to myself, but I am really not. So we misunderstood each other a bit. … I thought it was a bit unfair as I was not that hard on myself. But we worked it out – we found out how I was.

Although this participant disagreed with the therapist about the severity of her self-critical tendencies, they eventually found a common understanding together. In another case of misunderstanding, the therapist's emphasis on the importance of self-care was in discord with the client's goals, leading the client to feel that the therapist's suggestions did not make sense:

> I talked to my therapist about it, because I felt for each thing she helped me figure out I got an even bigger question which I wondered about. We talked a little about that I had to strive less. However, at the same time it felt unnatural for me. I thought: 'I have to get back to work, I can't just sit on the sofa and notice that the anxiety is tearing me apart and I get more hopeless about the future'. I can't sit there and just think 'but I am going to the therapy in five days'. I felt I had to do something. I couldn't just be passive and watch. It is difficult to not work too. What am I supposed to do? Just sit down and be afraid?

In this case, it is possible that the participants experienced the therapist as insufficiently open in attending to the totality of the participant's life world containing existential questions about goals and values. The client's need for industry and to feel useful was possibly perceived by the therapist as at odds with the goal of self-care and to strive less. This may also indicate a conflict of values between the participant and therapist. In addition, it may be that the rationale for less striving and what that implied was unclear for the participant.

In a third instance, one participant described that there was disagreement about how to understand the nature of the presenting problem – the relative contribution of physical and psychological influences:

> I remember that I was somewhat unsure of him in the beginning, because I felt that he had a different understanding than me about what the problem was. Because, I am physically ill too, and I felt that he thought that everything was psychological. But we sorted it out eventually. He said he wrote a letter to my general practitioner that said that he thought it was indeed physical, but that the psychological made it worse. But still, the way I see it, it is mostly physical.

Here, the disagreement was discussed between the participant and therapist, but seemingly without being completely resolved. Another type of challenge that some participants experienced in the therapeutic relationship revolved around the notion of there not being enough space for what they needed to talk about in the sessions. As such, the need to address pressing concerns was not sufficiently accommodated in the therapy. For instance, one participant had immediate concerns about how to regulate anxiety between sessions and regarding a tough choice in her everyday life:

> I remember I had many questions and difficulties regarding a choice I had to make, and I could not tolerate my anxiety. I needed to talk about ways to manage it. … And to talk about what I could do the rest of the week. There were multiple times I very clearly understood that we were now supposed to switch topics, as if the therapy had been arranged before I arrived. What we worked on was helpful, but it was not necessarily what I needed the most at that time.

Similarly, another participant felt pressed for time during the therapy and struggled with novel, existential questions that emerged from the work which were not adequately addressed. This left the participant confused and unsure about how she could deal with these issues that emerged during the therapy:

> I thought it was hard to constantly know that we had a limited number of sessions. I felt I had to rush. The therapy helped in many areas, but in others I got more confused – in many ways. For instance, when I was to talk to myself it affected me deeply and existential questions came up such as ‘What is my meaning in my life?’, ‘What do I believe?’ and ‘What are my goals?’ It was confusing because I felt we did not have time to deal with all these questions that came up in me. Too much in too little time.

Difficulties negotiating the sessions' content within the limitations in therapy were also evident when other participants experienced confusion due to not getting enough time to process novel and deep emotional experiences that came up in the therapy sessions. Some participants found the continuous direct work with emotions from session to session as too fast-paced and intense. One participant wished that they could spend the session after such work to process that which had emerged in the last session. However, how strongly this work had affected the her was not picked up.

> The intensity just continued every session and I did not get to process it and ask about the things I wondered about. … I felt as if there were loads of balloons up in the air with no time to pull them down again. Some of them I managed to put down, but others remained. That was confusing. The next session, more balloons were added. Also, it would have been nice if we had spent some time at the end of each session to gather myself again. I missed that.

b) It is difficult to be open about challenges in the therapeutic relationship. The second sub-theme describes participants' difficulties in addressing aspects of the therapy that did not work well with their therapist. In one case, a participant was unable to express that the manner in which the therapy unfolded was not in line with her expectations. What was most important for her to talk about were therefore not addressed.

> I was perhaps not clear enough or good enough to address it and say that it was not completely in line with my expectations. So there I could have been clearer. … If you feel it is not as helpful, it is somewhat wasted. When it requires such energy, it is a pity if in the end you don't feel that one has gone into what one thought was most important beforehand.

This statement indicates that the participant blamed herself saying that she might not have been "good enough" to address these difficulties with the therapist.

4. The Relationship as a Transformative Experience

The final main theme, "The relationship as a transformative experience", describes participants' important transformative experiences in the therapeutic relationship. This included simple acts by the therapist and sharing important moments where new ways of being with another person occured in the relationship with the therapist. Participants described that being met in a particular and novel way when feeling vulnerable was a very profound and meaningful experience that changed how they viewed themselves. Two sub-themes emerged: "Being tolerated and accepted for who I truly am", and "Sharing deep and meaningful encounters with anger, grief and compassion together".

a) Being tolerated and accepted for who I truly am. The first sub-theme presents participants' significant and positive experiences of being met in a novel and unexpected manner when feeling open and vulnerable. Often, these profound experiences occurred when sharing vulnerable experiences that they had not shared with anyone before. Being met with respect and tolerance when revealing one's vulnerability provided novel learning experiences for several participants, and could consequently result in relating to one's pain with more acceptance. Thus, the participants' experience of being in an accepting relationship helped them to foster acceptance towards themselves.

> Participant: I had never talked to anyone about those things... I felt that it was something good and helpful in just say those things, be revealing, and at the same time being treated respectfully back. I talked about that I felt my mom did not tolerate my vulnerability – something the psychologist did.
>
> *Interviewer: So just getting that experience, somebody tolerating it.*

> Participant: Yes, and I have maybe not tolerated my vulnerability myself because I have worked so – so hard to fit in, not take up space, or to be "good" - so not tolerated it in myself either, and never released it. When I did release it, I was treated with that it is OK.

This participant described that being tolerated and accepted by the therapist after fully revealing his innermost avoided feelings and vulnerable self was a new and healing experience. Another participant who had a similar experience further described how being met in this deep state of vulnerability became such an important transformative experience:

> He was with me, when you are kind of on the other side of the bridge. He gave much support as to the reality of [my difficulties] and how understandable they were. When those closest to you disappear... how you understand yourself and those things. He went into it and started to normalize my reactions. They had to go somewhere, he said. It has to come out somewhere. Now, it was a kind of bridge building.

The experience of having her inner pain being seen and validated as real and important, in addition to getting help from the therapist to reconsider her emotional reactions as normal and understandable, enabled this participant to come out of the isolation that the pain resulted in. Together, they "built a bridge" so that she could join into a more intimate relationship and share her vulnerable and painful experiences with another human being. Such experiences were often felt as new and corrective compared to how they were met with their pain by others in the past.

> The support he gave when we talked about my sexual orientation... that session affected me deeply. An incredibly good feeling, you know, a person I really experienced actually managed to understand my despair – how it was for me. That sticks out. It was such a contrast to the attitudes I remembered. And then you get this

kind of recognition on these matters. I had not even thought beforehand that this topic would come up.

Again, the experience of being accepted as the person one is underneath with all the negative emotions, challenges in life and difficult experiences comes up as significant for changing one's view of oneself. One participant emphasized the significance of the therapist being genuinely touched by the painful story she presented. That made her able to relate to her difficulties as real human struggles. Furthermore, another participant found the experience of having one's self validated and empowered as having worth and value lead to real behavioral changes in life. This included a sense of acting more authentically and assertively, and allowing herself to have positive emotions. The acceptance she felt in the therapeutic relationship and help to become more self-assertive opened up new experiences of personal dignity and self-respect in everyday life.

> He helped me to confirm for myself that I am allowed to be myself, and that I am not supposed to be self-critical and put myself down, but feel good inside. To get confirmation that I am worth an hour break, I am worth to say no and to take care of myself. Getting that confirmation in the room... Standing up for myself – that was the turning point – putting it into words together with that support from him.

b) Sharing deep and meaningful encounters with anger, grief and compassion together. The final sub-theme presents participants' specific, vivid and memorable moments in their relationship with the therapist that they experienced as meaningful and empowering during the therapy. Often, these moments were accompanied with powerful positive or negative emotions. For instance, two participants brought up particular experiences where the therapist allowed and encouraged expression of assertive anger. Both pointed out that anger was an emotion that they had not felt or expressed much in the past, and that it was relieving to approach it.

> One time when the session was over and I was on my way out, we talked about something and then I say ‘Damn!’ And then she said ‘Say it again!’ (laughter). That was one of the times I really showed some anger (laughter). Yes, get it out. Get angry, say it one more time. That was an important episode.

Another participant pointed out how such encouragement enabled her to be more comfortable with expressing anger afterwards:

> I dare to feel anger. I haven't done that much before. When we talked about it I said that I wanted to go scream in the forest. And then he said: ‘Do it immediately when you feel anger. Hit a punching bag, get it out.’ And I have done that. Maybe not screamed, but ripped apart some paper, hit the table and such, and it was like: ‘Oh, it was a relief to get some of it out’. It is good to allow yourself to be angry – it is healthy. Because before, I just shut down my anger … I have been very afraid to get angry in the past and never showed it to others. And then I shut it out from myself too. I just had it contained within and did not do anything with it.

Here, the therapist’s encouragement of anger might have communicated to the participant that she was allowed to express previously disavowed emotions. Thus, having all aspects of one's experience embraced by another human being seems to have been important for participants in embracing all aspects of those experiences themselves. Another such important in-the-moment experience in the relationship was after one participant’s particularly hard session where the therapist did a spontaneous act of compassion.

> After a very difficult session … eventually it is almost like you start to laugh when you are going to leave because it was so terribly hard. Then she asked me a question because she felt so sorry for me, and that was if she could give me a hug. I really needed that at that moment.

In this case, the therapist was particularly sensitive and responsive to the participant's need in the moment which the participant experienced as highly significant. In addition to moments involving anger, pain and compassion, one participant reminisced how the relationship also included important moments with positive emotions, such as humor and joy, between them:

> There were small episodes where I could tell her something about my week, and she would laugh, and then we had a kind of 'hahaha' - laughed together ... There were many such moments where I felt that we really were at the same wavelength, and I thought that was really nice.

Thus, participants found that being in a relationship that accepted and encouraged all expressions of who they really were and what they experienced, including vulnerability, anger, pain and joy, was healing and transformative.

Discussion

In this study, we have explored how 18 clients found aspects of the therapeutic relationship as helpful or hindering for working with emotions in the context of emotion-focused therapy for depression and severe self-criticism. We identified four main themes in our analyses of the clients' descriptions of their experiences. Figure 1 provides a visual model of the results.

In summary, clients experienced that the establishment of a trusting bond was important in the first phase of treatment for them to feel safe to open up, have an inner focus and subsequently letting go of control in order to work directly with accessing and transforming disavowed emotions. The understanding manner in which participants were met by the therapist in response to revealing their vulnerability resulted sometimes in profound corrective experiences. However, sometimes there occurred ruptures and conflicts about

values in the therapeutic relationship that were difficult to express for the client. For several participants, the therapeutic relationship itself was the most memorable aspect of the treatment, underscoring its central importance in psychotherapy.

Creating Optimal Conditions for Inner Exploration

The results from the first main theme, "Forming a trusting relationship" can be understood as describing how the therapist in the initial phase of treatment helped to establish a safe atmosphere for subsequent exploration of the client's difficulties. Many participants emphasized the experience of the therapist relating to them in a manner characterized by such as warmth, authenticity, non-judgment and interest. It was important that the therapist seemed to care about their difficulties which formed a sense of the therapist being there for them. This was also made especially apparent for some clients who specifically highlighted how the therapist remembered details and names from the clients' life between sessions. Remembering seems to have conveyed a genuine interest and presence to these participants. The therapists' clear and consistent focus on their problems in the sessions was also highlighted as important and surprising.

Some participants even considered the personal traits of the therapist as the most significant aspect of their experiences in therapy. This is consistent with prior research where clients with successful outcomes have frequently stressed the importance of therapist attributes such as attentiveness, affirmation of the client, warmth, interest and respect. It is also not uncommon for clients to attribute a good outcome to positive characteristics of the therapist (Lambert & Barley, 2001; Orlinsky, Grawe, & Parks, 1994; Sloane, Staples, Cristol, & Yorkston, 1975). Similar characteristics have been conceptualized in humanistic-experiential therapies such as client-centered therapy and EFT as necessary to facilitate conditions that enable the construction of an affect-regulating bond, including conditions of congruence, unconditional positive regard, and empathy (Greenberg, 2002, 2010b; Greenberg

& Watson, 2006). Rogers (1957) described these as the necessary and sufficient conditions for therapeutic personality change. Within the framework of EFT, such a bond is thought to create a therapeutic atmosphere where clients feel safe enough to explore their inner world with the therapist making new learning and emotional change possible (Greenberg, 2007). Multiple participants found that an honest, non-judging and accepting therapist was important for them to feel safe to open up to their inner experience with the therapist. Greenberg (2014) points out that an atmosphere of unconditional acceptance frees up attention for inner exploration. Instead of being preoccupied with the therapist and worrying that the therapist judges him/her, the client can participate fully in the task of paying attention to inner processes. When interpersonal anxiety due to projections of judgement is reduced, the client get an increased capacity to tolerate more intrapersonal anxiety that stems from their inner conflicts (Greenberg, 2014). Importantly, the manner in which some participants described the therapist seems to suggest that they experienced meeting a real and genuine person who conveyed respect and personal equality, instead of meeting an authoritative health professional only.

Participants also described how being recognized as a person and having their pain seen by a person, as opposed to only a professional, helped them to feel safe to open up and share their vulnerability. The experience of meeting a real person as equals who are present to bear witness to one's inner pain may reflect aspects of Gelso's (2002, 2010) concept of the real relationship (also called the "personal relationship"). The real relationship refers to something beyond the Rogerian conditions of congruence, unconditional positive regard and empathy as those conditions are therapist-offered (Gelso, 2010, p. 4). The real relationship, in contrast, is fundamentally dyadic, intersubjective and interactive. Here, two different people, with their idiosyncratic personalities and life horizons, come together to form a relationship that creates a "we" in addition to two separate "I"s (p. 5). As presented in the introduction, the

real relationship is composed of genuineness and realism between the actors in a relationship. In humanistic therapies such as EFT, genuineness has been given most attention as they stress the importance of creating an I-thou encounter characterized by openness and honesty in the here-and-now (Buber, 1958; Greenberg, 2007). Greenberg (2014), following Lietaer (1993)**,** break down genuineness into two components. First, awareness of own inner experience, and second, transparency in willing to convey this inner experience to the other (Greenberg, 2014, p. 354)**.** The findings presented here seem to tap into such processes where participants described interpersonal experiences with the therapist going beyond the therapeutic work itself. However, the co-creation of a real relationship of genuineness often contributed to the participant's sense of safety which facilitated the therapeutic work.

The findings also indicate that some participants did not appreciate the empathic stance of the therapist in the initial phase of therapy. Two participants seemingly expected a more solution-oriented focus on their problems from the outset, and found the therapists' empathic way of being as excessive and unhelpful for their needs at the time. Other participants also seemed to have had clear wishes from the therapy at the start that were not accommodated nor negotiated including specific and concrete assignments, homework, techniques, and advice focusing on particular symptoms that were felt as overwhelming and debilitating. This may reflect a conflict of core values where the emotionally-focused therapist stress that change has to come from within, and the most helpful way of alleviating the participant's pain is through work on the "inside". However, the participants may not have shared these assumptions or sufficiently understood this model of change. Finally, some participants described that they entered treatment with a specific pressing concern such as high anxiety, which the therapist did not address as directly as they needed to cope in their everyday lives. In such cases, the therapist may have been too embedded in his or her model

in a manner that limited the flexibility needed to address the participant's most important concerns at the outset.

Moving on, the findings subsequently describe the process of getting a mutual understanding of the meaning of the participants' problems. Several participants found the therapist to be skilled in taking their perspective and reflecting this back to them. Some even stated that they had never been understood in such a close and deep manner before in their life. Furthermore, with inner and outer chaos it was often difficult for clients to verbalize and concretize their problems and difficulties in life. Many participants highlighted how important and helpful it was that the therapist helped them to express themselves more precisely. Through such an often challenging process, it made possible a fusion of experiential horizons – a common understanding with shared terms to describe the participant's life world – which form a basis for deeper work (Stolorow, Atwood, & Orange, 2008). Also, precise empathic responses by the therapist sometimes produced spontaneous feelings of sadness and grief. Having one's story and struggles confirmed and understood in this manner seemingly enabled their difficulties to feel more real and apparent for the participants. Having the therapist maintaining focus and following them even when the participants had difficulties in staying on one topic was also helpful in getting a clear understanding of what the problem was, enabling greater precision in the following work. Participants also described that with the process of exploration with the therapist, new perspectives and meaning about their problems emerged.

In summary, the results of the first theme describe different helpful and unhelpful ways of being met, felt and understood by the therapist in the initial phase of therapy and the manner in which this helped create a safe atmosphere of inner exploration of painful experiences and feelings.

Approaching and Transforming Difficult Emotions through a Trusting Relationship

The second main theme, “Collaborating to find new ways to change distressing feelings”, describes how the safety established during the formation of the therapeutic relationship, the topic of the first main theme, enabled participants to dare approach intense and painful emotions. Also, the findings show how the manner in which the therapist responded to the expression of feelings was significant for how the participants subsequently related to their own feelings, and provided a new self-understanding. Finally, the findings explore how participants experienced the increasingly active guiding by the therapist throughout treatment in positive and negative ways.

Several participants explicitly stated that how they felt in the relationship with the therapist was paramount in their ability and willingness to continue explore and feel disavowed, scary and painful feelings – including a space within of feelings that had “never been opened before”. Many stressed the sense of safety and trust that the relationship provided. Indeed, one participant realized in retrospect the necessity of spending a sufficient amount of time establishing such trust before working directly with emotions using chair work, despite being initially impatient with the non-directive structure at the beginning of treatment.

Some participants also mentioned that they initially thought it was embarrassing to have and express their feelings, or had an implicit assumption that they would not be allowed to feel and express their them. Therefore, the ways the therapist welcomed, encouraged and took seriously the expression of feelings signaled to the clients that it was safe to do so, which made their expression easier afterwards. One important therapist behavior often mentioned was that of normalization. Normalization is a term that has been understood as referring to ways of depathologizing clients and change the manner in which they view themselves and their feelings from abnormal to normal (Corcoran, 2002). However, in the context the participants in our study used this term, it may more precisely refer to the experience of being

empathically validated and supported in gaining an accepting sense of self where one does not feel shame due to one's feelings. Normalization may thus often mean contextualization of feelings as natural and valid reactions to hardship and stressful circumstances, instead of feelings due to personal insufficiency. By understanding this, participants could become increasingly aware that they are part of a common humanity, as opposed to realigning themselves on the socially constructed dichotomy of normal-abnormal. Getting support in this way to internally rendezvous with humanity presumably helped alleviate some of the participants' feelings of isolation and shame. The therapist modeled and conveyed acceptance for the participants as human beings with understandable emotional reactions. Greenberg (2010a, p. 8) highlights the importance of such contextualization when clients feel vulnerable to strengthen their sense of self.

In addition to normalizing feelings, several participants highlighted the experience of having one's emotions explicitly validated by the therapist, including their verbal (e.g. exploratory probing and empathic affirmations) and non-verbal expression (e.g. pointing out subtle shifts in body language). Several participants found that this helped them to both verbalize and become more aware of their feelings. Being aware of one's emotions, including the ability to recognize and label one's emotions, is considered to be an important component in emotion regulation (Moyal, Henik, & Anholt, 2013). Emotion regulation can been defined as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 1998, p. 275). A similar formulation regards emotion regulation as the ability to manage one's emotions, use their energy and information to motivate for and guide adaptive action and expression (Solbakken, Rauk, Lødrup, & Monsen, 2017). This capacity is central to healthy human functioning (Gross, 1998; Solbakken et al., 2017). Furthermore, difficulty with emotion regulation has been implicated as a transdiagnostic phenomenon as it is characteristic across many different

types of mental disorders (Kring, 2008). Therefore, many psychotherapeutic approaches seek to increase the client's emotion regulation by for instance facilitating emotional awareness and adaptive expression of emotion (Fosha, Siegel, & Solomon, 2009).

Although many participants felt safe enough in the relationship to increasingly express themselves in an authentic manner, some participants still held back their thoughts from their therapist due to shame. This exemplifies the isolating nature of shame (Nathanson, 1994). For instance, certain particularly harsh self-critical thoughts were deemed as too embarrassing to say aloud by one participant during inner critic chair work. This may have become an obstacle to the task's effectiveness, as it is thought important that the self-critical thoughts from the inner critic part of the self should become explicit to create a sufficient distance between the inner critic and the observing self so that the client can more clearly perceive their own agency in such behavior (Greenberg, 2010a, p. 7). These findings thus suggest that clients can withhold important negative experiences from the therapist during chair work in EFT. In general, holding back relevant experiences from the therapist is not an uncommon phenomenon in psychotherapy (Rennie, 1994).

The findings from the second main theme seem to conform to the conceptualization of the therapeutic relationship in emotion-focused therapy as an affect-regulating bond. According to Greenberg (2014), the therapeutic relationship ideally serves as a dyadic regulation of emotions, where through a sense of safety, security and connection the client's separation and isolation from others is remedied. The explicitly (i.e. verbal) and implicitly (i.e. affective non-verbal micro-expression) communicated compassionate presence of the therapist is sensed by the client and promotes safety. The empathic and supportive presence of the therapist is thought to subsequently be internalized by the client such that it serves as a form of implicit emotion regulation and self-soothing. In addition, the therapists' stance of unconditional positive regard and empathy may foster self-empathy and confirm self-

experience. These conditions enable the active engagement in exploration and new learning (Greenberg, 2014). Thus, instead of teaching specific emotion regulation skills such as reappraisal, the relationship itself becomes a way of implicitly building the ability for emotion regulation. Many participants described variations on these themes where the manner in which the therapist related to them and their feelings helped them to feel safer to more fully engage in the therapeutic task of exploring inner states and narratives, and to approach difficult emotions in collaboration with the therapist.

The second main theme also present findings concerning participants' experiences of letting go of control during the second phase of treatment where the therapist take on a more leading role when actively seeking to process emotions using different types of evocative techniques, such as chair work. Many participants appreciated that the therapist led on and held the process on track. During intense emotional work, it was sometimes difficult for participants to stay focused and answer questions. In those cases, it was helpful when the therapist was able to be sensitive to this and adjust the process by giving participants sufficient time and space before returning to the task. Also, when the therapist took explicit responsibility for maintaining focus, participants did not have to be occupied about it. Instead of worrying about not being present in the process, participants could actually become more present. Other participants felt that the therapist was not sufficiently sensitive in terms of the timing of their instruction. Sometimes, the therapist's guiding disrupted the participants when they were trying to stay with their inner experience. This highlights the importance of therapists being aware and sensitive to the clients' state at every moment, particularly during intense and demanding phases of therapy.

Similarly, participants experienced the process of surrendering control to the therapist during this phase differently. For instance, participants experienced it as helpful as it enabled a new way of relating to and staying with her feelings without needing to control them, which

was previously the normal manner of handling them. However, it seemed that it was important that the participants let go of control due to voluntary willingness and trust, and not due to pressure or expectations from the therapist. Although these different motivations for releasing control is probably difficult for a therapist to ascertain, it illustrate how important it is that therapists clearly establish and monitor the clients' own will and motivation to immerse themselves in the process of approaching avoided feelings so that clients do not feel obligated to do something they do not feel safe enough to do.

Alliance Ruptures as Unmet Client Needs

The findings of the third main theme, "Alliance ruptures and needs for repair when working with distressing emotions" describe participants' experiences of challenges in the therapeutic relationship related to misalignment between the therapist's and participant's understanding of the problem, and how to use the time in the sessions. Such instances may reflect challenges in the relationship that concerns experiential horizons that do not fully meet and fuse, and possibly conflicts about core values (Binder et al., 2012; Stolorow et al., 2008). What seems to be an overall theme is that what was most important and pressing for participants in a given session were not always picked up by the therapist. In addition, explicit disagreements about the nature of participants' problems occurred.

Safran and Muran (2006) have defined alliance ruptures as a "tension or breakdown in the collaborative relationship between patient and therapist" (Safran, Muran, & Eubanks-Carter, 2011, p. 80). Alliance ruptures can range from minor and vague to dramatic and pervasive (Safran et al., 2011). Following Bordin's (1979) definition of the working alliance, ruptures can involve tensions and disagreements about the task and goal of treatment, as well as strains in the bond. They are not mutually exclusive and a rupture can involve tension in all three simultaneously. Disagreements about the goals and tasks of therapy can for instance induce tension in the relational bond. Safran and Muran (2006) developed the concept further

by distinguishing between confrontation ruptures and withdrawal ruptures. The first involve the client directly states concerns about the therapy and/or relationship, while the second occurs when the client indirectly signals, consciously or unconsciously, concerns by complying, withdrawing or deferring (Safran & Muran, 2006, p. 287). Ruptures can occur in all phases of therapy. In EFT where a main task is to encourage exploration of inner experience (Elliott, 2004), clients can be reluctant to do this, or not understand the rationale properly. Some statements by the participants in this study indicate that there occurred both minor and major ruptures that were either not addressed by the therapist or disclosed by the client. For instance, some participants wanted sometimes to focus on other topics than focusing on inner emotions. This may illustrate that some clients wished for more flexibility in the therapist so that their needs in therapy were met. This is consistent with a recent study by Silberschatz (2017) finding that the degree to which the therapists were responsive to the clients' own formulation of their problems and conflicts related strongly to outcome. However, the study design of the trial the present participants underwent predefined that chair interventions were going to be implemented after a number of sessions such that it may have limited the therapists' flexibility (Stiegler, 2017).

Corrective Experiences in the Therapeutic Relationship

The final main theme, "The relationship as a transformative experience" describes experiences in the therapeutic relationship that participants described as particularly significant and healing during their therapy. A common theme in the findings was that participants experienced being met and related to in a novel and unexpected manner when showing their deepest vulnerability to the therapist. The experience of being respected and indeed tolerated for the person one is when one has dared to let go and revealed vulnerable aspects of themselves more fully provided participants with a new way of relating to themselves. Such instances may be considered as examples of experiential learning where

participants had corrective experiences of being met with acceptance and confirmation standing in contrast to negative experiences with other people in the past. A newfound sense of self-respect and self-worth was some of the implications that followed such experiences. Alexander and French (1946) described "corrective emotional experience" as a process where the therapy:

> re-expose[s] the patient, under more favorable circumstances, to emotional situations which he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experiences. (Alexander & French, 1946, p. 66)

In later years, the concept has been broadened to describe a common curative factor not only from a psychodynamic perspective, but across theoretical orientations. The simpler term "corrective experiences" (CEs) allows for relational, cognitive and behavioral events in addition to emotional and is defined as an experience "in which a person comes to understand affectively an event or relationship in a different and unexpected way (Castonguay & Hill, 2012, p. 5). Although a general concept, the manner in which this principle is clinically implemented differs between theoretical orientations.

From the perspective of EFT, a CE is an experience "in which a person has a new emotional response to an old situation" (Greenberg & Elliott, 2012, p. 90). EFT conceptualizes both intrapersonal and interpersonal CEs. In terms of intrapersonal CEs, one fundamental goal in EFT is to transform primary and secondary maladaptive emotions to primary adaptive emotions (Pascual-Leone & Greenberg, 2007). The therapist offers a safe environment and encourages the client to attend to novel aspects of past distressing experiences. In this way, new emotional responses to old situations are possible enabling the expansion of the client's emotional response repertoire. For instance, in response to past violations the client can learn to respond with assertive anger and self-compassion instead of

fear, hopelessness and shame. Through repetition of such lived corrective experiences in therapy, these new emotional reactions are automatized and integrated into one's self-organization (Greenberg & Elliott, 2012). The findings in the final main theme seem to describe examples of such CEs where participants got access to new-found adaptive anger after encouragement from the therapist which had meaningful positive real-life consequences. Also, the way the therapist accepted the anger instead of rejected it taps into the second type of CEs in EFT, interpersonal CEs.

Interpersonal CEs in EFT are understood as events where new lived experiences with the therapist meeting the client in a new way compensate for and repair damage from earlier relational deprivation (Greenberg & Elliott, 2012). This concept is quite broad as it refers to all instances in which the client experiences the therapist as genuine, attuned and validating throughout the therapy (Greenberg & Elliott, 2012). CEs are also thought to be facilitated by a safe environment where the therapist modulates the intensity of buried feelings as they emerge (Greenberg & Elliott, 2012, p. 98). These notions seem to conform to the current findings in several respects. For instance, many participants emphasized the importance of the trust and safety in the relationship that developed due to validation and empathic attunement. Also, participants described instances when the therapist safely contained the emotional intensity by suggesting a time out or to change topics when participants were overwhelmed and lost focus. Furthermore, the aforementioned act of conceptualizing clients' emotional reactions as natural might have constituted CEs by disconfirming pathogenic beliefs. It has been argued that any instances in which the therapist interacts in a way that is contrary to the client's pathogenic expectations can be regarded as a CE (Silberschatz, 2013). The findings also describe specific experiences that particularly stood out for some participants where they were met with genuine acceptance for one's whole being when showing themselves at the most vulnerable. CEs often involve risk taking by clients as they show new behaviors in

therapy that they do not show otherwise (Castonguay & Hill, 2012, p. 16). Some participants in this study described taking such a risk by revealing who they were at the core for the first time in years. The trusting relationship enabled participants to open up in a radical way, including revealing core shame. In this vulnerable state, these participants seemed to have had CEs where the therapist did not show the presumably expected denigration or contempt, but rather concern and recognition. The participants experienced that nothing bad happened when showing their inner feelings and this was described as very powerful.

The Dual Power of the Therapeutic Relationship

This study, seeking to understand client's experiences of the therapeutic relationship in EFT, may inform a recurring debate in the psychotherapy research literature as to whether common factors, such as the Rogerian conditions, is both necessary *and* sufficient, or if specific factors are also needed for optimal outcomes for clients (Wampold & Imel, 2015). Silberschatz (2007) proposed that although Rogers thought the relationship with its Rogerian qualities itself as sufficient for successful treatment (Rogers, 1957), there are also clients "who require more technical approaches (e.g. interpretations, homework, relaxation techniques, mindfulness training, etc.)" (Silberschatz, 2007, p. 266). A few prior studies have addressed this question in the context of EFT as the model emphasize a client-centered approach, but also include specific markers and interventions from other traditions such as Gestalt therapies (Elliott & Greenberg, 2007). For instance, Greenberg and Watson (1998) compared the effectiveness of client-centered therapy where 34 clients with major depression. Clients were randomized to a treatment emphasizing Rogerian relationship conditions only or Rogerian relationship conditions plus the use of specific gestalt interventions such as chair dialogues. The results showed that although there was no difference in depressive symptom reduction, it seemed to hasten treatment response and also yield greater beneficial effects on total number of symptoms, self-esteem and interpersonal problems (Greenberg & Watson,

1998). However, another study treating 38 depressed clients using a similar design did find that adding process-guiding, emotion-focused interventions to client-centered conditions enhanced improvement on both depressive symptoms and interpersonal problems (Goldman, Greenberg, & Angus, 2006). Corroborating these findings, the results of the trial from which the participants of the present study where recruited showed that the second phase of treatment in which two-chair dialogue interventions were added had a larger effect on symptoms of depression and anxiety compared to the first phase consisting of client-centered empathic responding (Stiegler et al., 2018).

Participants' experiences of the quality and nature of the therapeutic relationship in the present investigation may shed some light on these matters as the relationship is the context in which specific interventions are implemented. As reviewed above, participants in this study highlighted the significance of establishing a genuine and affectionate relationship with their therapist. It seems that for many participants, the real relationship itself was important in changing their sense of self and emotional pain. The emphasis given to the experiences of genuinely being met with empathy, understanding and acceptance from a real person seems to reflect change due to Rogerian conditions. Some participants also seemed to have corrective experiences when they were met with unconditional positive regard and recognition in response to showing their vulnerability. However, the findings also seems to suggest that the therapeutic relationship served as a means to an end in that the safety that the relationship provided enabled participants to dare open up to disavowed painful feelings, letting go of control and voluntarily participate fully in the specific chair interventions. Thus, one way of understanding the findings of this study is that the therapeutic relationship manifested dual powers: both providing new relational experiences and regulating affect, but also facilitating successful implementation of interventions designed to transform emotions. One way to put it theoretically is that participants experienced common factors as important for them in order to

make use of and involve themselves in what constituted specific factors. This also goes together well with Greenberg's (2014) conceptualization of the dual purpose of the therapeutic relationship in EFT: both as an end in itself and as a means to an end.

Reflexivity

In qualitative investigations, the researchers' subjectivity and preconceptions will inevitably influence the manner in which the material is selected and interpreted (Finlay & Gough, 2003). As the participants of the study underwent treatment with EFT and as the aim of the study is to investigate relational experiences in EFT, the results were analyzed through a lens based on existing theoretical concepts from EFT. Also, 3 out of 5 interviewers were trained in EFT. Researcher allegiance is therefore a possible concern. However, the candidate analyzing the data has no formal training in EFT. The interview guide focused on experiential and emotional aspects of the participant's experiences in therapy. Although enabling a more precise investigation of the research question, it may have come at the expense of a more open query (Stiegler et al., in press). Hopefully, these notions have been more or less transparent in this research article and the candidate has been vigilant to notice participants' experiences that do not conform to preconceived theoretical constructs from EFT. Indeed, it is likely that many of the findings can be related to therapies from diverse theoretical orientations. An important objective as a researcher in the study has been to describe "both sides of the story" (Hjeltnes, Moltu, Schanche, Jansen, & Binder, 2018) by investigating both helpful (positive) and unhelpful (negative) aspects of the relationship in EFT. This approach promotes an as open and balanced investigation as possible.

Limitations

The present study has important limitations. First, as with most qualitative investigations, the findings are of a nature that does not allow inferences about causality.

However, as the interviews were in-depth, the study yielded information about important relational experiences that corroborate with previous findings and theoretical constructs. Also, holistic, phenomenological descriptions in a natural context can generate new avenues for research. Second, the study investigated experiences from 18 Norwegian participants, the majority of them women, limiting the generalizability of the current findings. Third, the participants were interviewed approximately 3 months after treatment termination. This length of time would arguably influence how precisely participants remembered events from therapy. Clients may have found it hard to access and verbalize important yet subtle processes of change, limiting the usefulness of their accounts. There is also a general worry in qualitative research about whether clients make attributional errors where they mistakenly attribute positive changes to the therapy when they actually are the result of events outside the therapy, including life events, own efforts, or biological changes (Elliott, 2002, 2010). Fourth, it is possible that participants found it hard to be fully open about negative experiences during therapy in the interview context, just like in psychotherapy itself (Rennie, 1994). Finally, although the trial included a naturalistic sample, its study design prescribing a certain predefined structure may have limited its ecological validity.

Implications for Clinical Practice

Despite limited generalizability, some significant common themes emerged in the findings that might inform clinical practice. First, the findings suggest that it is important to spend sufficient effort and time to develop a trusting relationship before implementing more emotionally demanding interventions. It may also be important that the clients do not feel pressured to undergo such interventions if they do not feel safe, but rather voluntarily engage in tasks based on trust. Contextualizing emotions as normal seemed to be an important therapist behavior to strengthen the clients' sense of self and trust in the relationship. Second, the findings suggest that sensitivity to clients' needs at any time in therapy is important.

Sometimes it might be helpful to allocate time to novel issues that emerge throughout therapy. Also, different clients responded differently to therapists' empathic stance indicating the importance of timing and flexibility. The therapeutic model of the therapists with its accompanying values was at odds with some of the clients' current needs or expectations of the therapy. Discussing expectations openly in the beginning of treatment may help to tailor the treatment to each individual client. Third, sensitivity to clients' changing states seems to be helpful such that the therapist does not disrupt inner processes and the client does not become overwhelmed. Some clients also need time after demanding emotional work to process what occurred. This emphasis on sensitivity and flexibility conforms with a study by Swift, Tompkins, and Parkin (2017) finding that both the most helpful and hindering therapist behaviors as judged by clients were very similar, but that the timing and clients' perception of the therapists' intention influenced its success. Fourth, some participants' difficulty with being transparent about negative aspects of therapy highlights the importance of the therapist being open to feedback, particularly negative, and that this attitude is expressed clearly and unequivocally to the client.

Implications for Research

The present study is the first to empirically investigate clients' actual subjective experiences of the therapeutic relationship in EFT. With only 18 participants, there is a need for more in-depth studies of participants' experiences. The diverse findings that are consistent prior findings illustrate that qualitative approaches may add another dimension to understand what occurs in therapy. Future research should investigate how therapists can recognize and negotiate possible conflicts about values and preferences, and be more flexible within a therapeutic model. More research is also needed to investigate how ruptures and its effect on the therapeutic relationship are experienced by clients when working with emotions in EFT, and what would be perceived as helpful in such cases.

Conclusion

This study investigated how clients with depression and self-criticism experienced the therapeutic relationship in EFT including specific helpful and unhelpful aspects. Four main themes were identified: 1) Forming a trusting relationship, 2) Collaborating to find new ways to change painful feelings, 3) Alliance ruptures and needs for repair when working with distressing emotions, and 4) The relationship as a transformative experience. The findings suggest that clients found the development of trust to be vital for them to engage fully in demanding emotional work in later phases in treatment. The Rogerian conditions and the act of contextualizing emotions as normal were highlighted as helpful. Sometimes, value conflicts occurred between the client and therapist such that the therapist was not able to fully relate to the clients' experiential horizons. Therapists' sensitivity and flexibility in response to clients' changing needs are implicated as important to maintain a beneficial and constructive therapeutic relationship.

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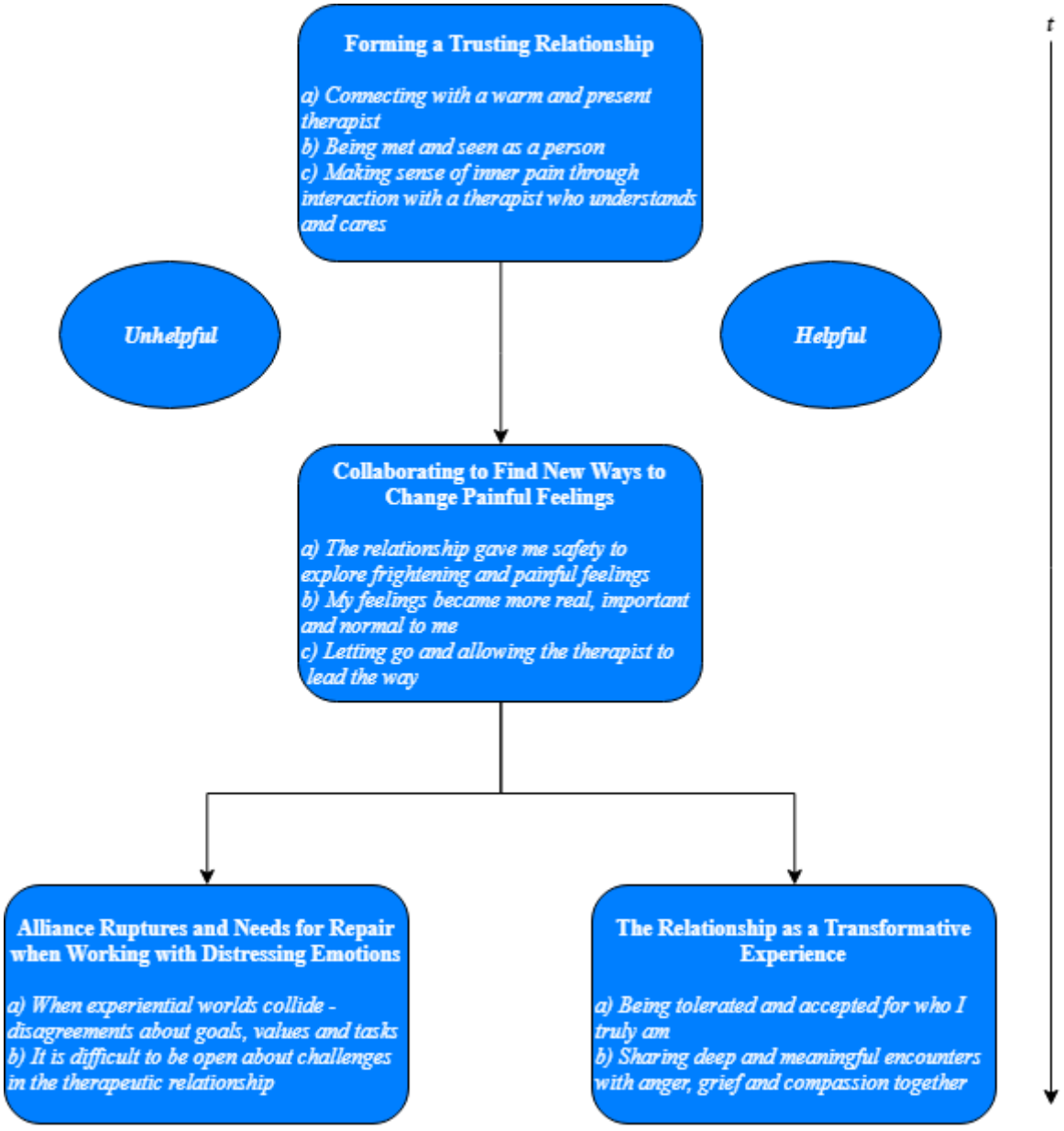
Figure

Figure 1. Visual model of the findings.



Appendix

INTERVIEW GUIDE

EFT - Qualitative follow-up study

Introduction:

Thank you for taking part in this interview.

Inform about intention/rationale for interview: did not advance knowledge about you, what you tell will be anonymous, the interviews will be anonymous so that nothing that could identify you, the results of all the interviews will be presented scientific papers.

Instruction before interview: I'd like to talk to you about your experiences related to having carried emosjonsfokusert therapy, and I have some questions I am going to ask about how you have experienced it to go in this treatment - what you have experienced, which positive or negative experiences you have had in the course of treatment and how you feel that it has helped or not helped you in as to what made you seeking treatment. In addition to the forms you've filled it is also helpful for us to get to know each participant's quite specific experiences during and afterwards.

Background for seeking treatment

If I may begin with a general question, nor come up with some more specific questions later. First of all, can you tell us about how you experienced the therapy you went in?

At first I could be happy to hear a little bit about how you came to seek treatment. Is it okay?

a. Before you started: What was it you wanted to change your life?

b. What did you think when the reason for the difficulties your? Has it changed during the therapy? Thinking differently about it now?

c. How did you envisage that the treatment should be before you started?

d. What were you would be most help to you before you started?

e. To what extent was the treatment you received in line with the expectations you had?

How it was for you to take part in the treatment

Can you tell us about how you experienced the first meeting with your therapist?

How did you experience the contact with the therapist? (possibly following up with "how did you feel that the therapist understand what was difficult for you?"
Changed this up for you during treatment?

What was the main objective you had in therapy? (goals)
a. Did you feel that the goal of therapy changed during treatment?

How did you work together to achieve this goal? (Method)?
a. Did you feel that you were working on ways changed in any way during treatment?
b. Follow up: What was it that changed? how was it for you?
c. What known, felt, thought when you did this?

Can you remember a situation of therapy that was difficult or challenging for you?
a. Which situation was this? What happened?
b. What known / felt / thought?
c. Perceived therapist that this was difficult or challenging for you?

How did this situation handled?
a. What did the therapist?
b. What did you do?
c. What mattered what happened to you?
d. How did you experience that therapy was for you after this?

IF NOT MENTIONED ALREADY: At some point you began doing exercises where you used the chairs to work with individual topics. Did you notice that?
How was it for you to begin with chair exercises?
How did you experience this transition?

What worked with you when you spent chair exercises? / Can you tell us about what you worked / talked about when you did this?

What did you aim was chair exercises?

Did you feel that the therapist brought out the purpose in a way that made sense to you?

How was it for you to work with these chair exercises?

In this way of working takes therapist part management. How did you do it?

Helped these exercises you work with things that were important to you? Follow up more concrete: How, in what way?

This treatment you've gone through has a focus on emotions. How did you do it?

How was it for you to know for their own feelings?

Was it different in chair exercises?

How was it for you that the focus was often on what you knew in your body?

Was it different in chair exercises?

How was it for you to talk about feelings?

Was it different in chair exercises?

Do you feel that the treatment has changed the way you relate to your feelings in everyday life? In what way?

How do you feel that this treatment has helped you the ways you relate to other people? In what way?

This treatment you have gone through also has a strong focus on self-criticism.

How did you work with the way you talk to yourself?

Too many can also selvkrtikken be a challenge in itself therapy. How was that for you? (If yes: follow-up - could you elaborate / when / how)

What was most important to you in the work of self-criticism?

Was it different to work with the way you talk to yourself in the chair exercises? What was different? In what way?

You filled the also the form of self-criticism for every hour. How was it for you?

Did you feel that it affected the work of self-criticism in the treatment? How, in what way?

Does this way of working changed how you treat yourself? How, in what way?

After treatment

When you look back on the time that has been since you started in treatment, what is the most important change that you experienced / changed for you / helped you?
What was most helpful to you? / What was it that helped you the most?

Have you noticed any other changes?
a. Are there things that have not changed or gotten worse since the therapy started?

Often there is a fact that when we think back on something we get up specific memories or images that stand for something important. If you were to draw a picture, episode, or memory from therapy which were or were important to you, what would it be?
If the episode was positive: Were there any important negative episodes as well?

Now towards the end I just want to ask you some questions about the job and the workplace. How do you feel that this treatment has helped you in your everyday work?
What made it difficult for you to be at work when you started treatment? (obs. private or job-related reasons for sick leave)
Did you feel afterwards that the treatment has helped you with this? / relate to this? In what way?
Coping: What they describe as the main problem
Mastery of work
Relate to colleagues
Respond to management

Concluding the interview

Was there some things you missed on therapy, or that you felt would better treatment for you?
What / how?
Was there anything you would have had more of?
Was there anything you would have had less of?

If a best friend of yours should have been this kind of treatment, what it would have been important that they had known?

Is there anything that was important to you, that we have forgotten or are not asked about? Something you have not mentioned?

Debriefing: How have you experienced it to participate in this interview?

THANKS FOR PARTICIPATION