

# Clients' Perspective on Predetermined Time Limits for Therapy in the Context of the Norwegian Welfare System

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## Abstract

Limited capacity and high demand for mental health care drive efforts to improve the efficiency of treatment and increasingly result in predetermined time limits for treatment, even in government-covered treatment in welfare systems. How do clients experience having predetermined time limits for psychotherapy? We analyzed the transcripts of interviews with 18 participants who had completed a return to work (RTW) intervention based on emotion-focused therapy (EFT) that had predetermined time limits. The analysis identified four experiential trajectories through therapy with predetermined time limits, representing four narrative themes: *Trajectory A: It is ok to stop here—Not wanting more therapy*; *Trajectory B: Seeing the benefits of continued therapy, but ready to give life a go without treatment*; *Trajectory C: Being on one's own too early—Economic obstacles hindering the continuation of therapy*; and *Trajectory D: I need more than this—Securing continued therapy*. Having the therapist communicate the timeframes for therapy clearly, while leaving room for individual tailoring of therapy, was experienced as very important by clients receiving psychotherapy with predetermined time limits.

## Keywords

time-limited therapy, return to work, qualitative interview, client perspective, emotion-focused therapy

## Introduction

Mental health problems are a common and global challenge (Alonso et al., 2004; Steel et al., 2014) and create human suffering and reduce the life quality of those afflicted by them, as well as their families. Mental health problems also affect the ability to function in everyday life and the ability to work to a larger degree than chronic physical illnesses do (Kessler et al., 2001; Knudsen et al., 2012). Mental health problems are an economic burden at the societal level, and as many as one in five workers are estimated to meet the criteria for a mental disorder at any given time (OECD, 2012; World Health Organization, 2000). There is, therefore, growing interest in understanding the predictors and mechanisms related to making it possible for individuals to return to work (RTW) after suffering from common mental disorders. While research has shown that work ability, social support in the workplace, socioeconomic status, and positive expectations of returning to work facilitate RTW (Gragnano et al., 2018; Victor et al., 2017), mental health problems, themselves, have been found to pose a barrier for transitioning back to work (Gragnano et al., 2018), which indicates the potential of psychotherapy as an RTW intervention. This notion is supported by recent research that

showed a positive association ( $\beta .482$ ) between the duration of time before initiating psychotherapy and the duration of sick leave in a large sample of persons diagnosed with anxiety and mood disorders (Alonso et al., 2018).

Norway, which has a strong welfare system where what is considered necessary treatment is covered by the government without requiring insurance, has implemented a national 18-week RTW program for persons with common mental health problems that involves psychotherapy with predetermined time limits (15 sessions of 45–50 min duration). The inclusion criteria for admission to the program are mild mental health problems (e.g., anxiety or mild depression) and an assessment that the person will probably return to work within an 18-week period. Different contractors within this government program have provided treatment based on different approaches to psychotherapy,

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depending on their expertise. One of these providers, Institute for Psychological Counselling has offered emotion-focused therapy (EFT; Greenberg, 2017) as an RTW intervention, and has systematized experiences with EFT through a clinical trial that included data from video-coding of sessions, self-report measures, and qualitative post-treatment interviews (Stiegler et al., 2018a,b). EFT is a humanistic psychotherapy that emphasizes helping people access and transform maladaptive emotional schemes (e.g., overgeneralized fear or shame), and mobilize adaptive emotions (e.g., assertive anger, self-compassion, and sadness over losses) that promote growth and therapeutic change (Greenberg, 2017). The nature of this government program of psychotherapeutic interventions to enhance RTW raises important questions beyond the scope of RTW, as it is an example of psychological treatment where the time limits are set up front and fixed.

Why should we be interested in how clients experience having predetermined time limits for therapy? Both short-term (<25 sessions, e.g., Knekt et al., 2008) and long-term psychotherapy (>40 sessions, e.g., Abbass et al., 2014) have been found to be effective for reducing mental health problems, and many therapeutic approaches have developed versions that are adopted for a short-term format: for example, EFT for depression (Greenberg, 2017), cognitive behavioral therapy for anxiety disorders (Clark & Beck, 2011), Affect Phobia Therapy (McCullough et al., 2003), and intensive short-term psychodynamic therapy (Abbass et al., 2012). Therapists in the late 1990s expected efficient psychotherapy to take between 30 and 40 sessions (Lowry & Ross, 1997), with the expectations of young adults about therapy duration matching those of therapists (Constance et al., 2008). Therapy duration is influenced by factors other than the expectations of therapists or clients, such as prioritizing guidelines within a health care system, insurance coverage, and system demands regulating the activity of psychotherapy. While historical trends suggest that the duration of psychotherapy, generally, is decreasing (Olfson et al., 2002; Olfson & Marcus, 2010), some research suggests that clients with more complex disorders (like personality disorders) and high degrees of comorbidity might display rates of improvement that differs from those with less complex disorders, underlining the need for flexibility regarding duration of psychotherapy (Nordmo, 2020). Moreover, researchers have suggested that the efficacy of long-term psychotherapies might not be correctly depicted unless one applies a longer timeframe for follow-up measurements (Knekt et al., 2008). Also, there is still a large number of persons diagnosed with a mental disorder who never receive psychotherapy (Harpaz-Rotem et al., 2012). The goal, then, is to fine-tune the provision of psychotherapy as efficiently as possible to as many as people as possible who need and want it, without reducing its duration below the threshold for effective therapy.

There is, however, a dramatic difference between brief therapy, where therapy is focused and active, with the client and therapist trying to reach therapeutic goals in the shortest time possible, and therapy where the time limits are set before the client and therapist even meet (Stern, 1993). Therapists and clients increasingly have to work therapeutically within a context of predetermined time limits. The effect and experience of having predefined time limits for therapeutic work, however, has been understudied across therapeutic approaches, and we have been unable to find any research that has explored the first-person perspective of receiving therapy with predetermined time limits. It is particularly important to examine the implications of having a predetermined timeframe for treatment within more experiential and explorative approaches to psychotherapy, such as psychodynamic, humanistic, and EFT, where therapeutic goals and length of therapy has traditionally been negotiated in close cooperation with the client. Moreover, limited capacity and high demands for mental health care have led to stronger regulation of services in many countries (e.g., New Public Management as a regulation tool of health services), including countries where services traditionally have been adjusted to the individual needs of the client. While some countries, like the United States, have a tradition that the duration of mental health care depends on insurance coverage and private funds, countries with a strong welfare system have a population that is accustomed to the duration of treatment, to a large degree, being determined by treatment needs. Thus, the client perspective on predetermined time limits for psychotherapy is highly relevant, but critically understudied, particularly in the context of a strong welfare state. In this article, we explore how clients experience having predetermined time limits for psychotherapy within the context of the Norwegian welfare system.

## Method

### Setting

The data reported in this study were collected as part of a larger clinical trial of EFT in Norway. The primary scientific goal of the clinical trial was to examine the effect of an emotionally evocative intervention, called “the two-chair dialogue,” which is used to address debilitating self-criticism in depression and anxiety disorders. Previous publications from the clinical trial have reported the effect and client perspective of the two-chair dialogue (Stiegler et al., 2018a,b) and clients’ experiences of the therapeutic relationship within the context of EFT as an RTW intervention (Nødtvedt et al., 2019). Good qualitative data is rich, which often makes it necessary to publish different foci in different articles to do justice to the data material (see, e.g., Råbu & McLeod, 2018). The current article reports on the clients’ perspective of having predetermined time limits for

therapy. The focus of the article is, therefore, not specific to EFT or RTW, but these are important contexts that shaped the participants' experiences of time limitation, and thus, are included to ground the findings contextually. The focus on time limitation was not explicitly included in the original research design, but all but one participant spontaneously shared experiences about having predetermined time limits when asked more generally about the experience of treatment participation. Hence, the article explores an aspect of treatment that was clearly important from the client perspective, drawing on one of the unique possibilities of qualitative methods, namely the openness to being surprised by your data, and thus, expanding your horizon of understanding (Marecek et al., 1997; Råbu & McLeod, 2018).

### *Recruitment and Participants*

Participants were recruited from a government-funded RTW program, where persons on sick leave are offered psychotherapy with predetermined time limits (15 sessions within 18 weeks from referral) to overcome common mental health problems and transition back to work. In this study, all participants received EFT, and displayed symptoms of anxiety and/or depression in the clinical range, assessed during a clinical intake interview. As the main focus of the clinical trial was on a psychotherapeutic intervention designed to alleviate debilitating self-criticism, only participants who reported moderate to high scores on self-criticism were included. Self-criticism was measured using The Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS; Gilbert et al., 2004), and participants had to score above a cutoff of 22 on the subscale Inadequate Self (IS; Gilbert et al., 2004) to be included in the clinical trial. As part of the clinical trial, participants' symptoms were measured before each session. Analysis of these scores indicated a reduction in symptoms of anxiety, depression, and self-criticism over the course of treatment. For more details, see Stiegler et al. (2018a).

Among the 21 participants who completed the clinical trial, 18 participants (13 women and five men) volunteered to participate in individual qualitative research interviews after the completion of treatment and were included in the interview study. These 18 participants were aged 20–63 (mean age 38.3 years), and all were native Norwegian. Thirteen participants had children and 11 were in long-term relationships. Five participants had not completed higher education. The remaining 13 had, on average, completed 2 to 4 years of higher education. The participants' total scores on Beck Depression Inventory (BDI-II; Beck et al., 1996) before the first therapy session ranged from 13 to 47 ( $M = 22.89$ ,  $SD = 8.36$ ), their total scores on Beck Anxiety Inventory (BAI; Beck et al., 1988) ranged from 5 to 50 ( $M = 23.29$ ,  $SD = 12.29$ ), and their total scores on the IS subscale of FSCRS (Gilbert et al., 2004) ranged

from 8 to 33 ( $M = 24.35$ ,  $SD = 6.29$ ). The current study reports findings from interviews with these 18 participants within 3 months of their completion of the RTW program.

### *Data Collection Method*

The interviews were conducted by the first, second, fourth, fifth and last authors between August and September, 2015. The interviews were based on a semi-structured interview guide. The interview guide contained separate sections covering (a) clients' motivation for seeking help, (b) clients' experiences of the treatment, (c) their relationship with their therapist, and (d) clients' experiences of working with the two-chair dialogue. The full interview guide is provided in the supplemental section. All the interviews were audiotaped and transcribed verbatim by eight graduate students in clinical psychology, who were instructed and supervised by the last author.

As already mentioned, although participants were not explicitly asked about their experiences of time limitation, all but one participant spontaneously talked about the time limitation of the treatment and how this had influenced them when talking about the psychotherapy they had received. Given the semi-structured form of the interviews, participants were given an opportunity to elaborate on these aspects of psychotherapy when they mentioned it. Due to the consistent focus on predetermined time limits across interviews, we decided to analyze the data systematically, with a focus on the client perspective on predetermined time limits for therapeutic work.

### *Methodological Approach and Data Analysis*

To explore how participants experienced having predetermined time limits for psychotherapy, we initially chose to use a hermeneutic-phenomenological approach to reflexive thematic analysis (Binder et al., 2012; Braun & Clarke, 2006, 2019). As the analysis progressed, we saw a need to use the participants' narratives actively in interpreting the patterns of meanings across participants. In the later stages of analysis, we therefore also drew on narrative thematic analysis (Riessman, 2008).

The aim of this hermeneutic-phenomenological approach is to establish empirical knowledge about psychological phenomena by interpreting and exploring how people describe and understand their own lived experiences and life world. This methodological approach seeks to combine the phenomenological investigation of human experience with hermeneutic interpretation of transcribed texts from qualitative interviews (Binder et al., 2012). Hermeneutic-phenomenological epistemology acknowledges that the research process is a co-construction of meaning, based on participants' descriptions of their lived experiences, where the researcher needs to be as reflexive as possible of his or her role as an interpreter throughout the different stages of

the research process (Alvesson & Sköldbberg, 2009; Finlay & Gough, 2003; Gadamer, 1960/2004).

The analytical process started with all members of the research team reading the transcripts thoroughly and openly, to familiarize themselves with the data. Following this initial reading, the first author got particularly interested in the participants' experiences of predetermined time limits of the therapy they had received, that they shared spontaneously during interviews, despite no explicit questions tapped this aspect of their treatment experience. After a discussion in the team of possible analytical foci, we therefore decided to analyze the data with a focus on participants' experiences of having predetermined time limits for therapy. The first author then coded the transcribed material line by line and identified units of meaning relevant to the analytic focus, with the assistance of NVivo 11 software (QSR International, 2015). Based on these units of meaning, the first author formulated tentative themes under which the units of meaning could be organized. Following this initial analytical process and organization of data according to traditional themes in reflexive thematic analysis, the first, second, fifth, and last author met to discuss the preliminary thematic structure. During this meeting it became clear to us that to do justice to the data, the narrative and experienced therapeutic process of each participant needed to be included as a context for understanding and interpretation of the patterns of meaning across interviews. Abstracting meaning units to a more traditional thematic structure would risk losing the richness and nuances in the data material, and would potentially confound their meaning. The meaning units "not enough treatment" and "not enough time," abstracted to the tentative theme "I have not gotten there yet—Experienced need for continued therapy," had, for example, several meanings attached to them, depending on the participants' experiences of their current life situation. Fifteen out of 18 participants expressed a desire for continued treatment. Yet, their experiences of and journeys through psychotherapy with predetermined time limits had led them down different paths, resulting in their situations and views on the necessity of continued therapy differing substantially at the time of the interview. We therefore decided to organize the data material according to different experiential trajectories or pathways through therapy with predetermined time limits, defined by the participants' experienced need for continuation of psychotherapy after completion of the RTW program and ways to cope with this need. We then analyzed participants' experiences of predetermined time limits for psychotherapy within each trajectory separately.

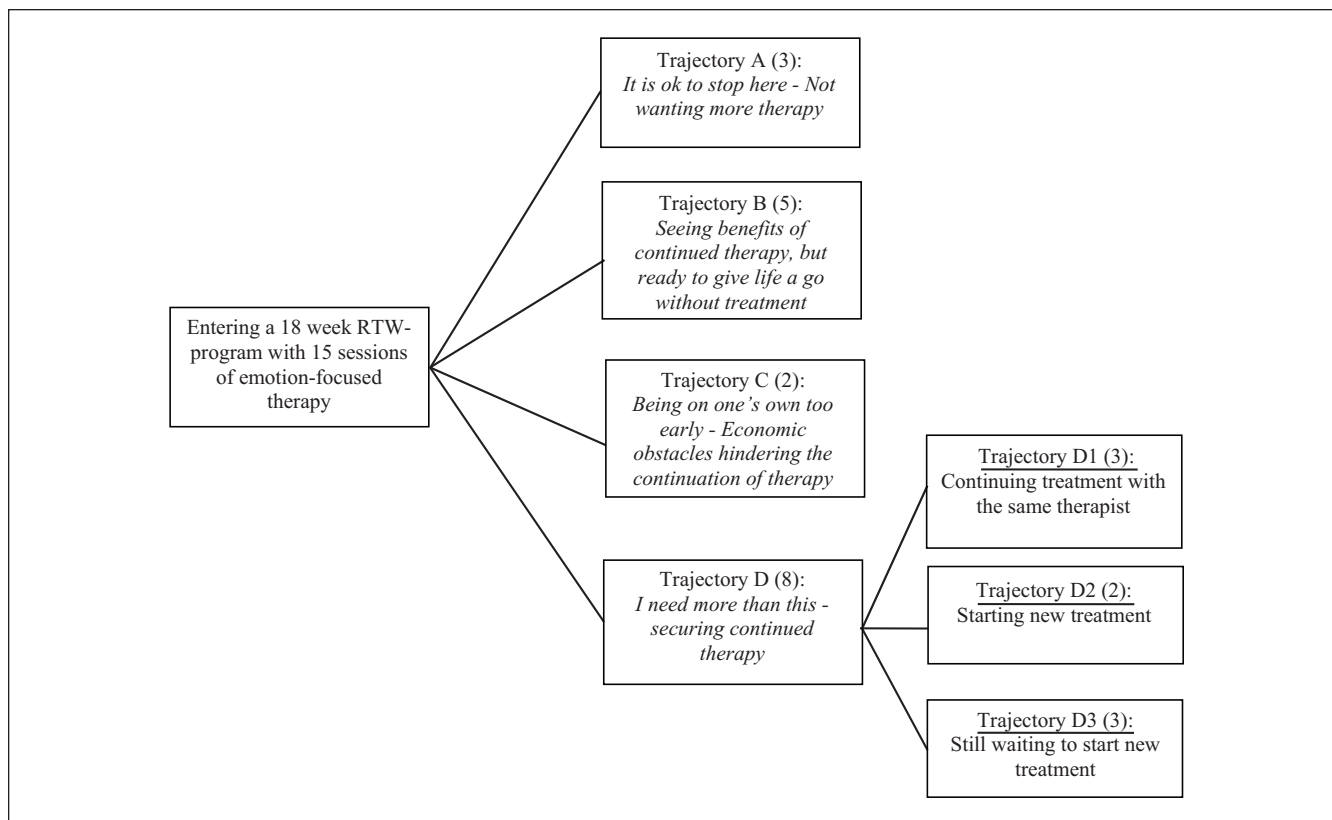
Given the inductive and explorative starting point of our analysis, we decided to stick with a hermeneutic-phenomenological approach to reflexive thematic analysis as a framework guiding our analytic process. This enabled us to highlight complexity and divergence, even within our constructed trajectories, and to shed light on how similar experiences could result in different trajectories, depending on the

experiential horizon of the participants. However, by keeping the participants' narrative and experience of the therapeutic process intact, as a context actively used in our interpretations and organization of the data material, our analysis also drew on narrative thematic analysis (Riessman, 2008) in the last part of the analytical process, and each of the four trajectories can be seen as a narrative theme. Following the decision to organize the data material according to trajectories, and analyze interview transcripts within each trajectory separately, the first author worked through the coded transcripts again, interview by interview, formulating short narratives for each participant. Based on these narratives, the first author identified four different experiential trajectories through therapy with predetermined time limits and sorted the data in four different subsets corresponding to the four trajectories. As the interviews were already coded with a focus on participants' experiences with predetermined time limits, the first author used these meaning units from the first stages of the analytical process as a starting point for a thorough analysis within each trajectory. Upon completion of the analysis within each trajectory, the first author formulated tentative narratives, to shed light on the converging and diverging experiences of therapy with predetermined time limits within each trajectory. These narratives included important contextual information, like experienced problems and expectations at the time of entering therapy, and the experienced benefit of the therapy they had received. The resulting analysis of the four trajectories and corresponding narratives to summarize participants' experiences within each trajectory was then brought back to the full research team for critical discussion. The final narratives for each trajectory, presented below in the findings section, were formulated in cooperation between all team members, including quotes to illustrate the findings. As a final part of the analysis, we referred back to the participants' symptom scores prior to their first therapy session and explored visually (not statistically) whether there were systematic differences in symptom scores in relation to the four trajectories. We used this as context for understanding and interpretation of the participants' experiences with psychotherapy with predetermined time limits.

### *Ethics*

The study was approved by the Regional Committees for Medical and Health Research Ethics in Norway. Written informed consent was obtained prior to treatment. All interviews were conducted after the participants had completed the clinical trial. Interviewers (the authors) were experienced psychologists and researchers who were attuned to clients' well-being during the interview. None of the interviewers were service providers or therapists in the clinical trial. The research assistants that transcribed the material could not identify the names of the participants





**Figure 1.** Overview over four trajectories through EFT with predetermined time limits, based on clients' experiences with completing an RTW program for common mental health problems.

and were only given the research ID of the participants, thus ensuring anonymity in the transcriptions.

## Findings

Our analysis resulted in the construction of four different trajectories, or narrative themes: A: *It is ok to stop here—Not wanting more therapy*; B: *Seeing the benefits of continued therapy, but ready to give life a go without treatment*; C: *Being on one's own too early—Economic obstacles hindering the continuation of therapy*; and D: *I need more than this—Securing continued therapy*. This last trajectory had three different branches (see Figure 1).

To highlight how the experiences shared by several participants (e.g., not having financial resources to continue treatment with the same therapist, or experiencing predetermined time limits as interfering with therapeutic processes) could be associated with different trajectories for different participants, each trajectory is presented as a detailed narrative of the participants' journeys through therapy and the way predetermined time limits influenced this, with sufficient contextual information to allow the reader to get a picture of the complexity of the experiences at the core of the four trajectories. The distribution of participants in trajectories and their scores prior to the first therapy session on

BDI-II, BAI, and the IS subscale of FSCRS can be found in Table 1. Given the qualitative frame of this study and small “n,” making it impossible to conduct statistical analysis between trajectories in a meaningful way, no statistical analyses have been run. However, a visual inspection of the scores in Table 1 reveals that there are no systematic differences in scores on BDI-II, BAI, and FSCRS between participants in Trajectories A, B, and C. Nevertheless, the participants' own experiences of their situation at the completion of the RTW program differed significantly depending on their trajectory, as detailed below. It is also interesting to notice that most of the participants reporting the highest scores on these three measures prior to therapy can be found in the three branches of the D-trajectory (5 of 5 for BDI-II, and 4 of 5 for BAI and FSCRS). Possible implications of this will be discussed in the discussion section.

### *Experiential Trajectories Through Psychotherapy With Predetermined Time Limits*

**Trajectory A:** *It is ok to stop here—Not wanting more therapy* (n = 3). Three participants followed a trajectory where continuation of treatment following the RTW program was not a theme for them, and where time limits had not interfered with their experience of the therapeutic process. Two of the

**Table 1.** Overview of Participants in Different Trajectories and Their Scores on BDI-II, BAI, and the IS Subscale of FSCRS at Intake.

Participant	Total BDI-II score pretreatment	Total BAI score pretreatment	Total FSCRS-IS score pretreatment
<i>Trajectory A: It is ok to stop here—Not wanting more therapy</i>			
A	24	12	21
B	20	8	22
C	22	5	33
<i>Trajectory B: Seeing benefits of continued therapy, but ready to give life a go without treatment</i>			
D	15	24	27
E	16	7	26
F	22	13	20
G	23	29	25
H	22	31	19
<i>Trajectory C: Being on one's own too early—Economic obstacles hindering the continuation of therapy</i>			
I	20	23	22
J	13	13	8
<i>Trajectory D1: Continuing treatment with the same therapist</i>			
K	34	24	32
L	26	35	22
M	13	28	29
<i>Trajectory D2: Starting new treatment</i>			
N	28	24	19
O	27	34	30
<i>Trajectory D3: Still waiting to start new treatment</i>			
P	17	36	27
Q	47	50	32
R	n.a. <sup>a</sup>	n.a. <sup>a</sup>	n.a. <sup>a</sup>

Note. BDI-II = Beck Depression Inventory-II; BAI = Beck Anxiety Inventory; FSCRS = Forms of Self-Criticizing/Attacking and Self-Reassuring Scale; FSCRS-IS = Inadequate Self, measuring the tendency to dwell on mistakes and feeling inadequate.

<sup>a</sup>Dichotomous response style. Too much missing to compute a reliable score.

three participants were clearly content with the amount of psychotherapy they received and did not mention any desire for continued treatment. They expressed that they had received a lot of help from the program:

I did not manage to accept my situation at home [when I entered therapy]. It was really difficult for me. So, I wanted help to get that acceptance. [. . .] So, it [the acceptance] came during the weeks I was there [in treatment]. That's what's great, that you can talk to someone in these situations that makes . . . that makes it possible to live with. (Participant A)

Both these participants had entered the program upon sick leave due to challenges in their personal lives: "The main reason for my sick leave was losing my father to cancer" (Participant B). They also entered psychotherapy with an open mind, really ready to put in the effort and give therapy a chance:

When I was referred to treatment I thought: "If this is going to be helpful, it is best if he [the therapist] knows everything." So, that he could do a good assessment, and give me the help I needed the most. (Participant B)

They experienced that psychotherapy provided them with opportunities to discover new things that helped them deal

with their life situations differently. However, one participant was also very clear that to reap the fruit of therapy with predetermined time limits you had to give it your all:

It was a lot of eureka moments. "Do I think like that?" And what was good was that when we talked about these situations, we practiced it in a different situation, and I took it with me home and worked with it during the week, and I got back to her [the therapist], and we talked about it again, and she said: "I can see you have worked on it." [. . .] But I was very conscious and set at getting that change and effect out of it [therapy]. That you don't think: "well, it's just some sessions in there," and then you don't work with yourself [outside the sessions]. (Participant A)

One participant felt however that therapy was not helpful, and explicitly expressed that he was happy the treatment had ended for this reason:

I had expected something different from what I got. I thought that I would go there [in therapy] and get very concrete things I could work on, regarding thoughts and feelings. What to do if certain feelings came up. But that wasn't what the outcome was, I feel. We talked a lot about how I felt about things. I had my thoughts and felt I didn't get the answers I had expected up front. Whether it was my expectations that were wrong, or what, but that was the negative for me. (Participant C)

*Trajectory B: Seeing benefits of continued therapy, but ready to give life a go without treatment (n = 5).* Five of the participants spontaneously mentioned in the interviews that they could see clear benefits of continued psychotherapy but were, for different reasons, ready to continue their journeys without continued treatment. The reasons for sick leave varied within this group. Three of the participants had previously been on sick leave without being able to understand fully the reasons for their inability to work:

I had a break-down earlier, four years ago. Then I just got . . . I went to the doctor and got some tablets that I did not want. So, then I wasn't offered anything else. [. . .] So, I was gone from work for a few months. I managed to get myself back together, then I started over again, in the same way. (Participant D)

For two of the participants, the reasons for sick leave were more directly attributed to their situations, either physical demands at work or difficult life situations at home: "Well, sometimes it gets very physically demanding at work. I think, because, at work it is mostly related to the physical aspects. That's why I didn't really feel I needed the focus on the psychological aspects" (Participant E).

Although their reasons for being on sick leave and their initial beliefs about the usefulness of therapy varied, all the participants stated that the decision to continue on their own was not easy. All five felt that the therapy they had received provided something of importance to them, but that the length of therapy was only enough to start a process. They had to continue to work on the issues they had focused on in therapy also after therapy had ended:

I remember when therapy came close to an end, I thought: "Okay, what will happen now?" I was quite scared and worried about that, because it had been a security line, something to hold onto. So, I remember I thought hard on it: "Shall I do something else [therapy], just to have somewhere to go?" But, then the summer and autumn has been okay. It has been weeks without talking to the doctor or the psychologist, and it has been okay. [. . .] Just from when I ended therapy until now a lot has happened, in myself, and in my process, and my recovery, really. Yes. I think a lot about the therapy, on what happened, what we talked about, and. Yes. I think about it and I write. (Participant F)

However, for most of these participants, the fact that the psychotherapy was time-limited sparked uncertainty about what would happen after therapy, which influenced the participants' experience of being in therapy: "I was just going to be there 18 weeks, and then . . . I wasn't sure whether it would be enough or not" (Participant E). Especially the link between the time limitation of psychotherapy and expectations to return to work within the same timeframe was experienced as a burden for many of the participants:

So, I got a bit scared at the thought of: "What will happen if I don't get back to my job?" Then the whole world falls apart. So,

you are sitting there with a feeling of panic. "Oh, no! I will be left on my own!" Even if you are always on your own. You see? (Participant D)

Despite their uncertainty about how they would manage without psychotherapy, and seeing the clear benefits of continued therapy, these five participants were ready to take a leap of faith and give it a go without treatment at the time they ended therapy:

There wasn't time for anything more. She [the therapist] had put her energy in a way of doing this that suited me well, and I thought she got me where I was. So, I just wanted there to be a few more sessions. But it succeeded in getting me back [to work] I was back, and it was no problem for me getting back [to work] because I felt better. I had gotten an understanding of what I could do to feel better. (Participant G)

Three months after completing therapy, three out of these five participants were still confident with their choice. Two participants were, however, second guessing their choice:

I manage better now. I mean, I feel a lot better than I did a year ago. I do. But . . . I think . . . Because we talked a bit about that I am going to start 100% work again after the holidays, and then the question: "Should I continue therapy then, or should we end it, since I will start work again?" And we agreed that I should end therapy. But I am unsure whether that was a good decision, really. (Participant H)

*Trajectory C: Being on one's own too early—Economic obstacles hindering the continuation of therapy (n = 2).* Two participants really wanted to continue psychotherapy beyond the sessions provided through the RTW program. They experienced, though, that the company providing the treatment was private and that continued psychotherapy cost more than they could afford to pay. They were, therefore, forced to end therapy—not because they felt ready to give life a go on their own, but because financial obstacles hindered the continuation of treatment.

One of these participants had initially been quite skeptical of the treatment but agreed to join because she had been sick for many years and wanted to make sure that she had not missed ways she could influence her health. Despite her initial skepticism, she found the psychotherapy very useful—but too short:

I wish I could be here [in treatment] a bit longer, because she [the therapist] has changed my way of thinking quite a bit and made me more realistic regarding things I haven't wanted to see, and what I can expect from myself. And it is a process I have just started working with, and I have a long way to go. (Participant J)

The other participant had actively used her knowledge about the time limitation of psychotherapy to make the most of the sessions available to her:

I was, in a way, actively searching for situations to talk about next week. At the same time, I was more efficient when we talked about it because we could start at that point. Instead of her having to dig for it: “How was the previous week? How was it . . .?” we got there right away. (Participant I)

Both of these participants experienced a sense of grief to end the therapeutic process before they felt ready: “If I could afford to go [to therapy], I would go until I felt that I was done. But, it didn’t quite turn out that way. So, I just try to carry it with me, somehow” (Participant I).

*Trajectory D: I need more than this—Securing continued therapy* (n = 8). Eight of the participants clearly felt they needed more treatment upon completion of the sessions provided through the RTW program and managed to secure continuation of psychotherapy. Similar to the other trajectories, the participants’ reasons for sick leave and entering the RTW program differed among participants. Some participants related their current situation to concrete life situations, like somatic illness, childhood trauma, or a sudden loss of a significant other. Other participants understood their current situation in light of long-standing patterns of how they related to themselves and others:

Well, what can I say? Your personality sticks with you, so this has maybe been with me since childhood [. . .] In addition I had pushed myself too hard for many, many, many years, but I refused to realize that until I collapsed. (Participant M)

There were three different branches within this trajectory: D1: Continuing treatment with the same therapist; D2: Starting new treatment; and D3: Still waiting to start new treatment.

*Trajectory D1: Continuing treatment with the same therapist* (n = 3). Three participants had continued treatment with the same therapist but paid for it after the 18 weeks covered by the RTW program. Their journeys toward this decision were quite different, though. Two of the participants had felt quite anxious early on about the time limitation:

So, that was a thought that came quickly, after I started therapy. “What happens after these sessions? Where shall I continue? What am I going to do from here? What will happen when I am on my own again?” That was something I felt quite early on. (Participant K)

The time limitation also influenced their experience of psychotherapy:

In relation to those 16 weeks, I mean, when he [the therapist] got very focused on how many weeks we had left . . . I felt he put pressure there. I mean, he was more focused on the overall framework for this. I understand that this was the starting point, but maybe it annoyed me that it took so much space. (Participant L)

These two participants approached the continuation of this situation quite differently, though. While participant K went through the program, and then decided to pay for continued treatment with the same therapist, participant L chose to address his uncertainty about the time limitation with his doctor and therapist. As a result, he was reassured quite early on that therapy could continue beyond the 18 weeks provided by the RTW program: “Then I experienced that he [the therapist] didn’t stress about the 16 weeks anymore. It became a bit . . . there can be a continuation beyond the 16 weeks. He gave me a guarantee about that” (Participant L).

The third participant also felt that she was not ready to end therapy when the RTW sessions came to an end. She experienced that the things they were working on were rooted in things that had been going on since her childhood, and that she needed more time to work on them. Therefore, she applied for additional sessions through the program and was granted six additional sessions with her therapist.

*Trajectory D2: Starting new treatment* (n = 2). Two of the participants who felt a need to continue therapy could not continue with the same therapist for different reasons. They had, however, quite different experiences of not quite getting there within the sessions provided and having to change therapist. For one participant, treatment had sparked a genuine curiosity about what eventually will help her resolve her problems—and was seeking continued therapy with an excitement:

I have sought more therapy, because I *am* going to figure it out [laughs]. [. . .] And I am really, really excited to see what really . . . what will cause it all to be resolved. I am really curious about that because I had no idea what it would be. (Participant N)

The other participant found the time limitation and the fact that she did not reach her treatment goals within the specified time was much more problematic:

What I found difficult was knowing that we just had a set number of sessions. I felt I had to hurry, in a way. So, it [therapy] helped me in some areas, but in other areas I got more confused, in many ways. [. . .] It felt a bit like there were a lot of balloons up in the air, without enough time to take them down again. Some of them I managed to take down, but a lot of them were left hanging and confused me, and then, next session there were even more balloons. (Participant O)

This participant also really wanted to continue with the same therapist but was forced to seek help elsewhere due to economic reasons. This was also very difficult to deal with:

It was quite a bad feeling to have completed the last sessions and to stand there on the last day [of treatment] and feel that things are really difficult in your life, and the door is closing in your face. [. . .] Because, yes, you can pay for sessions there,



privately, but in the real world very few, at least in my line of work, can afford it. So, in a way, to be invited in and told, “We will help you,” and “We will figure this out,” and to get a lot of help, but [on the last day] still stand there feeling a bit abandoned. Snip, snap, snout, the tale’s out. You are really worse off than when you started, but thanks for everything. That was tough. (Participant O)

**Trajectory D3: Still waiting to start new treatment (n = 3).** Three of the participants who wanted more treatment and could not continue with their original therapists were left in a bit of a limbo after their initial treatment, and they were still waiting to start new treatment 3 to 4 months after completion of the RTW program:

I really wanted to continue with her, the therapist, but she will not continue to work there. So, now I am in a bit of a vacuum, really, where I wait for them to get the capacity to take me in. (Participant P)

One of the participants, who was still waiting to be referred to a new therapist, was still using the experience from the sessions provided by the RTW program as a motivational drive toward new treatment:

Now I know a bit more about what I need to work on and things like that. But, at the same time, I see that after 18 weeks I am still in the starting pit. I have barely, how to say it, almost gotten to the edge of the starting pit, really. [. . .] But even though I am just in the starting pit, I have become quite confident in the usefulness of therapy. Even if it is no fun, it is useful. (Participant Q)

One of the participants had to change therapist due to economic reasons. She had not realized the cost associated with continuing treatment with the same therapist after the RTW program: “So, in a way, knowing up front that if you are going to continue here, after this treatment period, it will actually cost you substantially” (Participant R). She also had found it very demanding to establish a bond with her first therapist. Having to change therapists and still be waiting for a new therapist elicited feelings of being abandoned: “You got that time, and then . . . Then [in therapy] you were very well looked after, really, when you look back at it. But then [when therapy ended] it was, nothing, in a way” (Participant R).

## Discussion

Participants in this study had received EFT with predetermined time limits within the framework of an 18-week government-initiated RTW program and were interviewed upon completion of the program. The participants’ experiences can be described within four main trajectories: *Trajectory A: It is ok to stop here—Not wanting more therapy*; *Trajectory B: Seeing the benefits of continued therapy, but ready to give life a go without treatment*; *Trajectory C: Being on one’s own*

*too early—Economic obstacles hindering the continuation of therapy*; and *Trajectory D: I need more than this—Securing continued therapy*. These four trajectories represent our interpretation of converging and diverging experiences within each of four experiential pathways through therapy with predetermined time limits. By keeping the participants’ narratives and experience of the therapeutic process intact, expressed through the four experiential trajectories, we got an opportunity to explore and shed light on how partly converging themes, like experienced benefits of continued therapy shared by Trajectories B, C, and D, were given different meanings by participants depending on what trajectory they had followed. This analytical decision also enabled us to elucidate nuances within each of the four experiential trajectories, as well as showing how some experiences were shared across trajectories. For example, many participants across different trajectories experienced that the predetermined time limits sparked uncertainty regarding whether they would get sufficient help to complete the demanding processes initiated in therapy. How they dealt with this uncertainty and the way it interfered with their experience of therapy differed among participants and between trajectories, as we have seen above.

Moreover, the visual inspection of the participants’ symptom scores prior to their first therapy session provided useful context for the presented findings and illustrate the benefit of accessing both qualitative and quantitative data when exploring psychotherapy processes. For example, the clear experiential differences between Trajectories A, B, and C did not come across by looking at the participants’ symptom scores prior to therapy. Actually, the two participants in Trajectory C who felt that their therapy processes were amputated by the preset time limits and their inability to pay for continuation of treatment scored lower on BDI-II, BAI, and FSCRS-IS prior to therapy than many participants in Trajectories A and B, who felt ready to deal with their life situation without therapy after the RTW program. This reminds us of the limits of symptom measures to capture the full and complex picture at play in psychotherapy-related processes, and the need for accessing different sources of information to draw valid inferences regarding such complex phenomena. Also, the implication of the somewhat higher scores among participants in the three branches of Trajectory D will be discussed below.

The presented results shed light on the first-person perspective of set time limits for psychotherapy, in itself important knowledge as this is an understudied area. However, the findings also point to more general, and important, clinical and ethical implications of psychotherapy with predetermined time limits. On an organizational level, there is a clear need for efficient and time-limited treatments that can ensure economic predictability, so that the needs of people can be met within the capacity of mental health systems. On the individual level, there is a need to alleviate pain, and therapists have a responsibility to ensure that contact with clients

does not result in deterioration, but preferably, sustainable improvement. Often, these two perspectives and interests can be accommodated within the framework of the treatment provided, but sometimes the timeframe possible within the health care system is not sufficient to alleviate a client's pain. How then, can the system and individual needs be met and balanced within the framework of psychological treatment with predetermined time limits?

The ending of therapy, regardless of timeframe, is often associated with ambivalence by both clients and therapists (Råbu et al., 2013). Moreover, there is an important difference between short-term psychotherapies that are focused, but still have some flexibility regarding the timeframe at disposal, and time-limited psychotherapies that have a predefined number of sessions. Predetermined time limits for psychotherapy need not be problematic, though. For eight of the 18 participants in this study (Trajectories A: *It is ok to stop here—Not wanting more therapy*, and B: *Seeing the benefits of continued therapy, but ready to give life a go without treatment*) the given timeframe was perceived to be sufficient to meet their needs, and they were ready to give it a go without treatment. Some participants even found that awareness of the predetermined time limits was helpful for making the most of the sessions provided, and the time limitation was an incentive to open-up and get to core issues more quickly. Moreover, seven of these participants found the EFT approach highly useful for helping them with their perceived problems, regardless of their work status at the time of the interview. This shows that experiential and explorative approaches to psychotherapy can be adapted to an RTW context with predetermined time limits in a meaningful way. One participant did not receive what he expected from the intervention, however. This points to the importance of providing treatment rationales that give clients the sense that they will benefit from treatment (Nilsson et al., 2007), and thus, the benefit of having a broad range of therapeutic interventions to draw from to match clients' needs and preferences.

Yet, 10 of the 18 participants in this study did not feel that the timeframe provided was sufficient to meet their needs. The way they dealt with this, however, varied greatly. The two participants in Trajectory C (*Being on one's own too early—Economic obstacles hindering the continuation of therapy*) did not find ways to ensure that their treatment needs were met, despite a clearly felt need for continued therapy. When economy hindered continued treatment, they gave in to their circumstances. The eight participants in Trajectory D (*I need more than this—Securing continued therapy*) did, however, secure continued treatment. On visual inspection, most of the highest symptom scores were reported by participants in the three branches of Trajectory D. Importantly, they had clearly found therapy meaningful and wanted to continue treatment. The participants' symptom scores prior to therapy thus provide important contextual information when interpreting the presented findings. The

combination of data also elicit hypothesis that need to be explored in future research, like whether a higher symptom score at intake is associated with higher motivation for change and/or a stronger belief that change is possible, thus an increased likelihood of seeking continued therapy.

While all participants had been assessed by experienced clinicians that believed 15 sessions of EFT would be sufficient to return to work (prerequisite for the RTW program), these participants were not ready to stand on their own after the completion of the program. This raises important questions regarding when, and in what ways, flexibility should be integrated, also in therapies with predetermined time limits. Some research has, for example, suggested that the improvement rates in psychotherapy might differ between different groups of clients, depending on the complexity of disorders and degrees of comorbidity (Nordmo, 2020). Seeing our results in light of this research suggests implications that are important both on an organizational and personal level. While psychotherapy can lead to change, even when the client struggles with more complex problems, it might take more time before this change is visible. Notably, all participants in this study struggled with self-criticism in the form of reporting feelings of being inadequate and the tendency to dwell on own mistakes. When an individual has a habitual tendency to evaluate himself or herself as inadequate, flawed or bad, this may present some challenges in psychotherapy (Gilbert & Procter, 2006). Feelings of inadequacy may have left them particularly vulnerable in a context with predetermined time limits for therapy, as clinicians and researcher consider self-criticism as a problem area that often needs time to change (McCullough, 2003; Rector et al., 2000; Scharffee & Tsignouis, 2003; Zuroff et al., 1994). Practicing a strict time restriction might interrupt and end fruitful therapeutic processes prematurely, forcing clients to seek treatment elsewhere and start all over again with a new therapist—a strenuous and time-consuming exercise. Some level of flexibility in timeframes might, therefore, be beneficial and cost-effective—both on the individual level and at a societal level. These important questions should be explored systematically in future research.

Also, the processes of securing continued treatment differed greatly among different participants within Trajectory D (*I need more than this—Securing continued therapy*), with these differences influencing participants' experiences of therapy with predetermined time limits. Some participants found the uncertainty of whether they would get what they needed within the provided timeframe so challenging that they took measures to ensure an extended timeframe early on—thus, being spared the uncertainty of what would happen after the sessions provided by the RTW program. Other participants also felt this uncertainty strongly, and felt it hindering them from utilizing the full potential of the treatment. Yet, they did not challenge the provided timeframes. Rather, they sought help elsewhere after the RTW program had ended. Importantly, the three participants in

Branch D3 were still waiting to start their new therapies 3 months after completion of the RTW program—despite having secured a referral—thus a guarantee that they would get more psychotherapy. One of the participants still waiting to start the new therapy had the highest symptom scores of all participants at intake. This is thought provoking and warrants reflection also on therapists' role in determining the clients' journey through mental health care. Securing treatment also relates to the success of conveying your treatment needs effectively and credibly and the interplay between client and therapist.

These examples raise difficult, but important questions. Who should be offered treatment with predetermined time limits? Whose responsibility is it if the provided timeframe is not sufficient to help the people we meet as a therapist? Do we have an obligation as therapists to help the client find solutions, regardless of the timeframes we are provided? Or is it the responsibility of the person, who is an autonomous adult? Should the amount of help received depend on personal qualities, such as the ability to stand up for one own needs, or on the professional assessments of needs? How can ending time limitations on therapy be addressed in a constructive and helpful way?

One important clinical implication of the findings is the importance of preparing the client for the termination of therapy and having open and clear communication about the timeframes for therapy. This is important from both ethical and therapeutic points of view. However, as the findings show, for some clients a strong focus on timeframes and the ending of therapy can also awaken feelings of being in a hurry and elicit doubts about whether or not they will be able to reach important therapeutic goals within the given timeframe. Addressing and exploring thoughts and feelings concerning timeframes and ending might, therefore, be an important therapeutic intervention in itself as seen in short-term psychodynamic interventions (see, for instance, Levenson, 2010). Feelings of sadness when a relationship ends, and frustration and worries about one's ability to cope and master future situations might be related to important issues in the client's life, in general, and is therefore important to address when therapy draws to an end.

Specific to the context of this study, therapy that focuses on the capacity for emotional experience, and at the same time has predetermined time limits, can get the client heading in the desired direction, but not bring him or her to the final destination. Particularly because EFT is an evocative therapy format, ending therapy at a time when the client feels vulnerable and has not yet achieved sufficient capacity for self-soothing and emotion regulation might be counterproductive. The significance of having flexibility about the timeframe might, therefore, partly depend on the therapeutic format and approach. It also reminds us about the clinical significance of a strong and dynamic alliance, where client and therapist negotiate realistic goals within the available timeframe. Moreover, it seems to be important that the

therapist put the responsibility on his or her shoulders when this therapy format has been proven to be insufficient. One part of this is to communicate to the client that it was the therapy that did not fully succeed, not the client who failed. Another part of this issue, which has to do with economic and practical limitations, is the importance of clarifying the responsibility for providing suitable frameworks for the therapeutic endeavor one has begun. Although the emotionally evocative format of EFT particularly highlights the need for clarifying these issues, the same questions are valid for all types of psychotherapies with predetermined time limits. Future research should seek to clarify how, when, and for whom predetermined time limits for therapy can be used productively, and what kind of flexibility should be inherent in time-limited treatment to ensure it is helpful for the clients.

## Scope and Limitations

The study provides important knowledge about the first-person perspective of having predetermined time limits for therapeutic work, a field in which knowledge of the client perspective of interventions is scarce. Moreover, the participants had received experiential and explorative psychotherapy within an RTW context, thus providing important new insight into how clients experience the benefit of such a focus on experiencing and emotions in an RTW context. The study was, however, embedded in a larger clinical trial that utilized a multi-baseline design. In the original trial, a main focus was on the effect of "chair work" on self-criticism influenced both the treatment provided and characteristics of the sample. The baseline was, therefore, longer than is common in EFT (5–9 vs. 3–5 sessions), and the therapists were bound by the design with regard to what interventions they could use and when. This probably meant that the maximum potential for efficiency within the predetermined time limits provided was not fulfilled. In addition, all the participants scored high on self-criticism. This made it possible to study the experiences of predetermined time limits in a relatively homogeneous group, but these aspects are also relevant for the transferability of the presented findings. Future research should explore the experience of predetermined time limits as context for therapeutic work in a broader range of clinical groups, and with different approaches to psychotherapy. Working therapeutically with predetermined time limits may influence therapists as well. Future research should explore the therapist's perspective of working therapeutically within predetermined time limits and their reflections on timing the end of therapy within this context. Moreover, ambivalence when ending therapy is common regardless of therapy duration, and future research should explore the link between clients' perceived need for continued treatment and treatment outcomes across different approaches to therapy and different timeframes.

Although participants spontaneously shared experiences of how the predetermined time limits influenced



their experience of therapy, the focus of predetermined time limits was not part of the initial design. Hence, there were no direct questions about this in the interview guide. This means that, even though participants' descriptions were followed by exploration so they could elaborate on their experiences, we had no direct questions aiming at teasing out the difference between participants' feelings about psychotherapy in general, and their feelings and experience of having predetermined time limits for psychotherapy. Future research should plan for this research focus explicitly, and explore participants' experiences in different treatment contexts, to expand our knowledge on the client perspective on therapy with predetermined time limits.

Finally, as our analysis progressed, we deviated from a pure reflexive thematic analysis and drew on narrative thematic analysis to shed light on the nuances and complexity in the data material. Although resulting from an inductive and explorative approach to analysis and utilizing the potential of the flexibility inherent in qualitative analysis to present the most meaningful stories in a data material (see, e.g., Malterud, 2012; Stige et al., 2009), it makes it harder for the readers to follow the analytical steps and assess the rigor of the analytical process. Utilizing the degrees of freedom available within qualitative analysis thus put an ever greater responsibility on us as researchers to present sufficient information about the analytical process and the theoretical framework utilized to allow the reader to assess the quality of the research process, thus the trustworthiness of the presented findings. Moreover, while the analytical choice of constructing four trajectories allowed us to explore the participants' experiences within the context of their narrative of their therapeutic process, this deviation from conventional theme presentation in reflexive thematic analysis meant less focus on more phenomenological aspects in the presentation of the findings. The names of the trajectories are also less phenomenological and give less information about the experiential content of each trajectory than conventional theme names would provide—thus a possible obstacle to effectively communicate our findings.

## Conclusion

The findings shed light on different ways clients can experience and relate to predetermined time limits in the context of therapeutic work in an RTW setting. The findings point to important ethical and therapeutic questions related to therapy with predetermined time limits and the significance of having a certain degree of flexibility regarding the time limitation. The findings also show the potential for adapting experiential and explorative approaches to an RTW setting. More research is needed to expand our knowledge of how and when treatment with predetermined time limits should be provided and how different psychotherapeutic approaches can adapt to time-limited treatment in an RTW setting.


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## Supplemental Material

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