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A Phenomenological Inquiry Into the Client Experience of the Psychotherapy Relationship

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A PHENOMENOLOGICAL INQUIRY INTO THE CLIENT EXPERIENCE OF THE PSYCHOTHERAPY RELATIONSHIP

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ABSTRACT

A PHENOMENOLOGICAL INQUIRY INTO THE CLIENT EXPERIENCE OF THE PSYCHOTHERAPY RELATIONSHIP

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Meta-analyses have indicated that there are likely common factors across varied treatment modalities that account for the effectiveness of psychotherapy. Research has attempted to identify therapist and treatment relationship components that correlate with effective mental health treatment. Yet, there is a paucity of research directly addressing the qualitative experience of the relationship between psychotherapists and their clients.

Eight adult psychotherapy clients were interviewed regarding their experience of the psychotherapy relationship with their mental health therapist. The interviews were analyzed through the use of Interpretative Phenomenological Analysis (IPA). Seven themes emerged. Three themes related to the formation, and overall foundation of a therapeutic relationship, were identified as: *Knowing the Therapist*, *Trusting the Therapist (or Treatment Process)*, and *Ruptures (and Resilience)*. Four themes related to therapeutic components of the psychotherapy relationship were identified as: *Re-parenting/Hierarchy-Status*, *Seen/Witnessed By Therapist (Attunement)*, *Therapeutic Qualities of the Therapy Relationship*, and *Specialness of the Relationship*. Each participant report underscored the significance of the relationship to the therapeutic effect of the mental health treatment. This dissertation is available in open access at AURA, http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.edu/.

Keywords: psychotherapy relationship, common factors, phenomenological study

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CHAPTER I: INTRODUCTION

I began my career as a mental health therapist working with mandated clients in an alcohol and drug abuse treatment program at a community mental health center in Portland, Oregon. Working with mandated clients is a challenging experience. In this case, the majority of clients were adolescents, with some adults. These clients had been mandated to treatment by parents, school administrators, social workers (e.g., after placement in foster care and group homes), and the juvenile justice system/probation officers/judges (e.g., due to arrests, DUII conviction). Mandated clients are often not particularly reticent about letting their therapist know that they do not believe they need mental health/substance use treatment and are doing therapy/treatment against their will. In other words, they do not want to be meeting with a therapist.

While working with these clients, I became fascinated and curious about the clients who appeared to become engaged in the treatment process. This was treatment the clients did not want or believe was necessary. Yet, some clients found ways to continue the treatment beyond initial requirements. This continuation of treatment might be due to failing an expected urine analysis (i.e., testing positive for illegal substances) or telling a parent or caseworker about a desire to continue therapy. This response was of interest to me. These clients did not bring specific material to therapy. As clients, they did not have specific goals/objectives for their treatment. Yet, they appeared, even stated, to have an interest in continuing the process. I began to suspect the therapy relationship was the key to this process and effect. My suspicion caused me to ponder: What specifically is occurring within the psychotherapy relationship to ultimately engage and affect the client? I became curious to examine this question.

What makes the psychotherapy relationship potentially therapeutic? Presumably, there are qualities, or conditions, to a therapeutic relationship. Historically, there has been an emphasis on specific treatment interventions, their effectiveness, and the foundation of empirically supported treatments (ESTs). Meanwhile, I have observed that the client experience of the therapy process has been a relatively absent partner in the research. I have also observed that ESTs are generally evaluated as interventions that decrease symptoms, mimicking the medical model (e.g., Butler & Strupp, 1986). The emphasis is generally on a reduction strategy rather than a developmental model. Presumably, high psychological functioning is disturbed rather than developmentally-impeded.

Thus, most ESTs have resulted in an emphasis on external processes applied to diagnoses. This approach is more in line with external curing rather than internal healing. The implication, or assumption, is that a standardized application of a particular method brings particular results. This approach is neither abstract nor illogical. However, it may not be the best, or even particularly appropriate approach concerning mental health treatment and conceptualization.

A holistic approach based on *common factors* of psychotherapy has been proposed as an alternative to the medical model and empirically supported treatments. Common factors theorists propose that, regardless of theoretical orientation or interventions used, there are common factors among therapist-client encounters (e.g., the relationship) that best explain treatment efficacy (Simon, 2006). In other words, common factors within the therapist-client encounter, across various modalities, function as the therapeutic component. Common factors proponents believe the therapeutic relationship is the foundation of effective therapy. Studies of the therapeutic relationship consistently demonstrate that the strength of the relationship (in the view of the

client) is a significant contributor to treatment effectiveness (Blow et al., 2007). Common factors will be examined in greater detail in the literature review below.

Objective

A form of art is generally deemed significant by an observer based on subjective experience, not based on the construction of the piece (although the construction is a worthy area of study). Similarly, what makes psychotherapy therapeutic is what is experienced, not simply its application. Thus, the presented research is an attempt to increase our understanding of the nuanced complexity, and unique individuality, of the client's experience.

The proposition of this study is that psychotherapy is deemed therapeutic based upon the essence of the client's experience. This exploration into the essence of the therapy experience is an attempt to mine the underlying processes of the components of the therapeutic experience. Understanding the basic elements of the psychotherapy experience is to develop an understanding of the underlying elements of an effective best practice. This study is intended to highlight—not the applied treatment/method—but the perspective of the mental health client phenomenologically.

Theoretical Framework

A relationship experience can have common, shared elements, yet is also a uniquely individual experience. In fact, any shared elements of interpersonal experience are dependent upon the unique individuality of the experience for the people involved. Common experiences are dependent upon an individual, subjective experience and can be known only through the individual, subjective experience. Søren Kierkegaard referred to the phenomenon as follows:

> Whatever the one generation may learn from the other, that which is genuinely human no generation learns from the foregoing . . . Thus, no generation has learned from another to love, no generation begins at any other point than at the beginning, no generation has a shorter task assigned to it than had the

previous generation. (as cited in Martin, 2014, p. 37)

Some elements of life are inherently experiential. Such phenomena are understood through the experience. Explanatory concepts can be conceived and widely acknowledged; but the process of attachment, for instance, must be experienced to be truly known. Attachment is a process, not a static entity. Yet, although some experiences are by nature experientially-known, this process does not preclude these experiences from being reflected upon and conceptually explored. This issue is an epistemological concern. In summary, relationships are experiential and inherently phenomenological.

The emphasis of this study is on the significance of the interpersonal relationship and individual phenomenological experience. The relationship has become an acknowledged aspect within some methods of psychotherapy, particularly relational psychoanalysis (e.g., Aron, 1991). While the phenomenological experience is the methodological foundation for this study, relational psychoanalysis and common factors are the theoretical foundation for the study.

Research Question

An emphasis on the inter-subjective (addressed in the Literature Review/Relational Psychoanalysis) presupposes individual subjectivity as a co-creating force with the subjectivity of another being. Individual subjectivity necessitates a uniquely individual phenomenological foundation/experience. The significance of this phenomenological subjectivity to the psychotherapy process is the inspiration for the research question: What do psychotherapy clients experience in the therapy relationship with their therapist?

CHAPTER II: BACKGROUND/LITERATURE REVIEW

This literature review focuses on finding a general array of knowledge regarding the interpersonal and psychotherapy relationship. The current existing literature addresses specific therapist traits and techniques that seem to benefit the therapeutic relationship (Yalom, 1998). There appears to be minimal information available regarding the phenomenological experience (qualitative data) of the psychotherapy client in the therapy relationship. This perspective is a significant starting point to understanding whether specific phases and experiences are inherent in the development of a therapeutic relationship. In addition, other relevant information might be gathered from understanding the client experience in the therapy relationship from a subjective (phenomenological) research design. That is, beginning with reflection upon some substantially personal experiences, patterns can eventually appear and become identified, as well as insight about factors that inhibit treatment effectiveness.

This literature review will examine constructs deemed applicable to the therapy relationship. A brief overview of attachment theory sets a foundation for understanding interpersonal relationships. Next, the construct *the real relationship* in psychotherapy (Gelso, 1994, 2011) incorporates a specific conceptualization of the psychotherapy relationship. A review of Relational Psychoanalysis underscores the basic theoretical foundation of this study, specifically the importance of the therapy relationship to psychotherapy. Last, the aforementioned construct common factors is examined in more depth. Common factors have also been called nonspecific or universal factors (Cuijpers et al., 2019). Common factors had been a non-specific (i.e., speculative) conceptualization of the therapeutic components of psychotherapy. Nonspecific factors are the elements of psychotherapy that are unspecified, or unspecifiable. Several common factors have been specified and the term “nonspecific” is

potentially misleading (McAleavey & Casonguay, 2015). The therapeutic alliance, empathy, and expectations have been considered the most important common factors (Cuijpers et al., 2019).

Attachment Theory

Bowlby (1988) conceptualized a relational-developmental model founded on the *secure base*. According to Bowlby, parents provide the child with a secure base to which to return after making sorties into the outside world. The parents welcome the child, as well as nourish, comfort, and reassure, as necessary. The parental role entails being available and ready to respond to the child. The base role is primarily a waiting position. Comparing the concept to a military situation, Bowlby stated that commanders press forward (taking risks) only when confident that the home base is secure. As children mature, their expeditions become more substantive.

Attachment theory views the creation of intimate emotional bonds an inherent part of human nature. Humans turn to other people for protection, comfort, and support. Throughout the lifespan, such relationships are viewed as crucial to survival. Intimate emotional bonds involving care-seeking and care-giving are principal aspects of functional personality and of mental health. Care-seeking is generally exhibited by weaker/less experienced individuals toward others in more powerful/stable positions. Care-seeking is complemented by care-giving (Bowlby, 1988).

Attachment theory proposes that a homeostasis develops with the attachment figure. The attachment control system maintains the individual's relation/proximity to the attachment figure for beneficial accessibility. Attachment style is a response, or interplay, with the child's environment/attachment figure. A pattern develops, which is amenable. As the individual ages and develops, the pattern (style) becomes increasingly the property of the individual. This attachment style is then imposed on relationships with other people, for example, therapists

(Bowlby, 1988).

The child's self-model (i.e., the child's view of itself, self-esteem, self-confidence) is profoundly influenced by characteristics the caregiver notices/recognizes in the child. Whatever the caregiver fails to recognize, the child might also fail to recognize in the self. This failure of recognition could result in some material and/or aspects of personality being split off from that which is recognized/communicated (Bowlby, 1988). Bowlby (1988) contended that the course of subsequent development is not fixed. Rather, changes in the way the individual is treated can alter development in more favorable or less favorable directions. The capacity for developmental change diminishes with age, but change continues to occur throughout the life cycle. A person's attachment formation remains amenable to new influences.

Attachment is a concept with significant inherent potential for psychotherapy. Yet, according to Eagle (2006), Bowlby became disappointed with the lack of significant impact of attachment theory upon clinical practice. This situation seems to be changing in recent years. Yet, many attachment therapies have minimal empirical support and/or are not particularly connected to/derived from attachment theory (Eagle, 2006). Rather, an understanding of attachment presently informs rather than defines clinical intervention.

One such way clinical thinking is informed by attachment theory is the concept of the therapist as an attachment figure. Ongoing speculation is that psychotherapy can function to change the client's *internal working model* (internal representations of the self and attachment figures; Shilkret, 2005). This alteration process is accomplished through the *circle of security* concept. According to attachment theory, the attachment figure offers a secure base and a safe haven. The secure base is a safe place to return to after exploration of the outside world. A safe haven offers a secure base and comfort during distress. Thus, the individual has a *home* to which

to return and also possible comfort when returning home distressed. Being soothed when distressed provides the individual reassurance to continue exploration of the outside world. Competence results from the exploration and soothing (i.e., support, encouragement, etc.) process. The attuned caregiver (secure base and safe haven) fosters the individual's exploration process, resulting in development of competence and independence (Bowlby, 1988; Eagle, 2006).

Therapists conceivably provide clients with secure bases and safe havens in which to examine/explore various psychological aspects of life. Considering the significance of this situation, Shilkret (2005) postulates a reasonable assumption that clients will enact their attachment styles in the therapeutic relationship; therapists should be able to use attachment style to further the therapy. Whether attachment style changes over time (and whether psychotherapy can assist in the process) is not yet clear. Does psychotherapy simply help individuals develop more stable versions of their pre-existing attachment style? Yet, some empirical evidence supports the probability that attachment style can be transformed from insecure to secure through therapy (Eagle, 2006; Shilkret, 2005). This evidence appears to underscore a significant aspect of the therapeutic relationship.

The Real Relationship in Psychotherapy

In the past two decades Gelso (e.g., 1994, 2011) has used the ideas of psychoanalyst Ralph Greenson (1967) as a foundation for exploring the psychotherapy relationship. This conceptualization consists of three components: the working alliance, the transference configuration, and *the real relationship* (Gelso, 2011; Gelso & Carter, 1994). The working alliance, transference configuration, and real relationship interact and influence each other.

Gelso and Carter (1994) defined working alliance as "the alignment or joining of the reasonable self or ego of the client and the therapist's analyzing or 'therapizing' self or ego for the purpose of the work" (p. 297). The strength of the working alliance assists in addressing transferential material and in expressing feelings within the real relationship. The transference configuration involves a distortion of the therapy relationship. Transference is a repetition of a previous relationship experience/structure that is projected onto the therapy relationship (Freud, 1905/1953). In contrast, the real relationship is relatively independent of transference. The real relationship is founded on two features: genuineness and realistic (i.e., accurate) perceptions. Transference distortion is incompatible with genuineness and realistic perceptions. If the transference configuration or the real relationship becomes more pronounced, the other recedes. In addition, as transference distortions become understood/resolved, accurate perceptions increase (Gelso, 2011).

Gelso and others (e.g., Gelso, 2011; Gelso & Carter, 1994; Marmarosh et al., 2009) propose that all psychotherapy includes a real relationship; this real relationship affects the process and outcome of treatment. More specifically, the stronger the real relationship, the more effective the therapy. When therapy inherently includes a real relationship, the client is able to realistically perceive the therapist to some degree. The client's feelings toward the therapist that are based upon these realistic perceptions are an important aspect of the therapy process. As the client comes to know more about the therapist, and vice-versa, the real relationship develops. This process is most salient during the later stages of therapy; as transference distortions become clearer, in turn, the real relationship moves forward. Clients commonly become more curious about the therapist as a human being during this later process; the curiosity is not transference-based. The authors conclude by describing the usefulness of studying the interactions between

and among the three components of the psychotherapy relationship, that is the working alliance, transference configuration, and real relationship. The current study addresses this invitation to study the client's experience of the therapeutic relationship by directly interviewing psychotherapy clients regarding their therapy relationship.

Relational Psychoanalysis

During the past few decades, psychoanalysis has been evolving. The emphasis of psychoanalysis is changing from focusing on intra-psychic dynamics to interpretation of the interaction between client and therapist at an intra-psychic level (O'Shaughnessy, 1983). Possibly a development is underway in which the therapist and client are no longer conceptualized as separate subjects who perceive one another as objects (Ogden, 1994). This change of focus within psychoanalysis seems to be based upon an acknowledgement that intra-psychic development and processes do not occur in isolation. Dinnerstein (1976) recognized this interdependent process many decades ago: "Every 'I' first emerges in relation to an 'It' which is not at all clearly an 'I.' The separate 'I'ness of the other person is a discovery, an insight achieved over time" (as cited in Aron, 1991, p. 246). This process can be viewed as a developmental process that begins with the other as object and moves toward recognition of the other's separate subjectivity.

The means toward further development lies within the *inter-subjective*. Buirski and Haglund (2001) defined inter-subjectivity as "the complex field that is created when two or more individuals with their unique subjectivities come together" (p. 4). Inter-subjectivity is a developmentally-achieved capacity of recognizing another person as possessing a separate subjective experience (Aron, 1991). This shared process begins to develop, recognizing separateness/individuality, while gradually creating a shared, understood perspective. The

relational psychoanalysis approach conceptualizes the client-therapist relationship as continually established and re-established through ongoing mutual influence in which both client and therapist systematically affect and are affected by each other. A process is established in which influence flows in both directions (Aron, 1991).

Inter-subjectivity is beneficial for the individual. The connection within inter-subjectivity decreases isolation/aloneness. The process also benefits the individual's own psychological development. Clients probe their therapists in an attempt, and need, to connect and to do so in an authentic, emotional realm. Thus, clients search for information regarding the therapist's inner world. Attending to others in one's life is the way by which clients begin to think more psychologically about themselves (Aron, 1991). Recognition of the mutuality of the psychotherapy relationship is a key aspect of relational psychoanalysis, and of this study.

The Common Factors Perspective in Psychotherapy Outcome

In 1936, Rosenzweig first proposed the idea that treatments are effective more likely due to common elements (factors) than the specific theories on which they are based. These are elements/factors that all therapies share. The unrecognized elements within the therapeutic environment might be more important than those being purposely applied (Cuijpers et al., 2019; Sprenkle & Blow, 2004). These shared components have been referred to as unspecified, nonspecific, universal, and general factors—as opposed to the specified and unique components of particular treatment modalities (Cuijpers et al., 2019; McAleavey & Castonguay, 2015; Sprenkle & Blow, 2004). In 1961, Frank emphasized the importance of the therapeutic relationship, eventually identifying four shared (i.e., common) components of all psychotherapies; Frank also stated that the relationship elements are client driven (Frank & Frank, 1961/1991). Frank’s four shared psychotherapy components are: (a) a confiding

relationship; (b) a therapeutic setting with a trusted professional; (c) a credible schematic understanding of presented symptoms; and (d) a credible procedure for addressing symptoms (Frank & Frank, 1991). This study does not directly address the four identified components, but does indirectly examine the relationship and setting through participant reflection upon the psychotherapy relationship experience. More recently, the movement toward psychotherapy integration and empirical validation has increased the interest in common factors. In a 2001 meta-analysis, Wampold found support for the shared components as a basis for a contextual model of psychotherapy, which is contrasted with the medical model. Contextual model theorists argue that these shared therapy components explain most of the outcome variance in psychotherapy (Wampold, 2001, 2015).

A significant component of the common factors model is a belief that something inherent within the therapy relationship is therapeutic. Some proponents of common factors take this belief further to consider the deeper implications of the therapeutic element within this relationship. For common factors proponents, the question is: What if the relationship itself is the primary intervention?

The orientation towards ESTs had resulted in a dichotomous situation that presumed that intervention and treatment relationship are relatively unrelated. Yet, evidence supports the contention that intervention and relationship factors are intertwined. Resolution of the debate will require developing a unified, or balanced, perspective regarding psychotherapy outcome (Fraser & Solovey, 2007; Norcross & Lambert, 2011). Distinguishing between unique factors (e.g., a specific intervention technique) and common factors might be a mistaken dichotomy because neither can exist without the other, they cohabitate within a treatment. Unique and common factors likely work mutually inter-dependent as psychotherapy is a complex, nuanced

process. Conceiving unique and common factors as separate entities is misleading. There is a systematic link between the unique and common aspects of psychotherapy (McAleavey & Castonguay, 2015). In addition, the dichotomous approach has resulted in a "polarizing effect on the discipline" (Norcross & Lambert, 2011, p. 3)—which can divide providers, researchers, and payers.

Historically, interventionist strategies have been favored over relationship factors, despite evidence that relationship factors are the most potent aspect within change (Wampold, 2001). This emphasis on specific interventions might be based on the relative ease of defining and assessing specific techniques compared to doing so within the relational process. Yet, when meta-analysis is applied, the effects of specific interventions disappear, because many treatment modalities seem to work similarly well (Wampold, 2001). By definition, interventions inherently incorporate the therapist influencing change. To separate the intervention from the relationship implies that no significant influence exists within the relationship. The therapeutic relationship does not exist for its own sake. Rather, in psychotherapy, change occurs within the context of the treatment relationship between therapist and client. The relationship itself is an intervention (Fraser & Solovey, 2007). An examination of the common factors perspective will be divided into specific components that I have deemed relevant to this study. The specific components regarding the common factors construct to be examined (not the common factors themselves, but the structure for this literature review) are: elements of treatment, research on the therapeutic alliance, treatment models, meta-analysis of treatment models, client factors, and future directions for research.

Common Factors: Elements of Treatment (Empathy and The Therapeutic Alliance)

Proponents of common factors have identified some common elements of treatment,

which includes factors in why clients seek treatment, and what are viewed as common aspects of treatment and the therapy relationship (i.e., common factors). Reviewers (e.g., Bohart & Tallman, 2010; Fraser & Solovey, 2007; Tallman & Bohart, 1999; Wampold, 2001, 2015) have explored the impact of the therapeutic relationship, including some treatment dynamics that underlie therapeutic progress. The process of analyzing the therapeutic relationship/treatment dynamics begins with an exploration of reasons that individuals enter treatment. Frank and Frank (1991) proposed that a common cause in the initiation of psychotherapy is an underlying sense of *demoralization*. When clients enter treatment in a demoralized state, they are experiencing a sense of desperation, discouragement, and states of disorder and/or confusion. The ongoing distress creates a sense of uniqueness in one's situation (e.g., uniquely incompetent or powerless, uniquely misunderstood). The feeling of demoralization frequently brings clients to treatment, rather than described problems/symptoms and failed solutions (Frank & Frank, 1991). The critical first step of therapy is moving from demoralization to empowerment. The therapeutic relationship reverses demoralization, engendering hope. Progress can begin before intervention strategies are even addressed (Fraser & Solovey, 2007).

Once in treatment, psychotherapy must offer an explanation for the client's distress and a plan for addressing the distress (i.e., treatment conceptualization). Therapy without an explanation and plan, just an empathic therapist, is not a sufficient treatment (Laska & Wampold, 2014). Yet, common factors proponents strive to identify and verify the qualities of effective, empathic treatment that complements the explanation and plan. This process has resulted in dozens of common factors having been named (Cuijpers et al., 2019; McAleavey & Castonguay, 2015). The specified common factors have grown in quantity to become an expansive construct, perhaps difficult to manage. Yet, the therapeutic relationship is considered a distinct category of

common factors (McAleavey & Castonguay, 2015). Regarding the identification of common factors, not all proposed factors will be validated, but the objective is identifying factors involved in effective psychotherapy (Laska & Wampold, 2014). This literature review will address two of the most supported common factors: empathy and the therapeutic alliance (Cuijpers et al., 2019; McAleavey & Castonguay, 2015). I have deemed empathy and the therapeutic alliance as two identified common factors most closely aligned with the psychotherapy relationship, heavily supported (e.g., Norcross, 2010), and probable components of participants' experiential reports.

Looking more deeply into the dynamics (elements) of the therapeutic relationship, the role of therapist empathy has been identified and assessed. Many decades ago, Rogers (1957) emphasized the role of empathy, in addition to unconditional positive regard and genuineness, as sufficient factors in therapeutic change. The discipline's interest in empathy has fluctuated over the decades, but has returned as an area of emphasis and research (Elliott et al., 2011). A meta-analysis by Bohart et al. (2002) identified the effect size between empathy and outcome as 25 to 32%. The experience of empathy is a subjective phenomenon—that research has localized to three different neuroanatomically-based processes (Elliott et al., 2011). Bachelor (1988) studied empathy in therapy and concluded that empathy is not a singular construct and can be understood in multiple forms. Understanding the client experience is the foundation to understanding empathy and its role in treatment outcome. Fraser and Solovey (2007), upon reviewing outcome measures, found the client experience of empathy best predicted treatment outcome (25%); followed by observer measures (23%); and, lastly, by therapist ratings of their own empathy (18%). Clients appear to be the best judge of their therapy experience.

The ways in which empathy is conceived and understood as a construct is also subject to individual interpretation. Empathy as a primarily emotional experience or empathy as a primarily

cognitive experience is an individualized phenomenological construct. Defining and understanding empathy varies with individual experience. This same variability of definition also exists within the theoretical realm of psychotherapy. Some perspectives emphasize emotional elements of empathy, while other perspectives are more cognitive in nature (Fraser & Solovey, 2007). Subsequently, empathy is a nuanced construct with a variety of components and form (Elliott et al., 2011).

The therapeutic alliance has been recognized as an important aspect of the psychotherapy relationship (Asay & Lambert, 1999). Common factors proponents have also considered the therapeutic alliance, a seemingly natural area of interest. Of the proposed common factors, the alliance or therapeutic relationship is considered the most important (Cuijpers et al., 2019). The therapeutic alliance is the joint product of clients and therapists working together. This alliance is heavily dependent upon the client's perceptions of the work/relationship. Clients' ratings of the therapeutic alliance are more significant in predicting outcome than the therapists' ratings of the alliance (Bachelor & Horvath, 1999; Orlinsky et al., 1994). In addition, the alliance has been consistently supported as a significant factor in treatment outcome across a variety of methodologies (Horvath & Bedi, 2002).

The therapeutic alliance can be conceptualized in a variety of ways. In the mid 1970s both Bordin and Luborsky separately proposed that the alliance could be viewed as a common component of helping relationships. They did so by separating the alliance from its psychodynamic origins and affording it a trans-theoretical position with broader implications (Horvath, 2011). The result was that the alliance was described as an ambiguous process rather than defined as a concept. The expansion of the alliance from psychodynamic theory to general therapy made it more dispersed, and more popular. There are now dozens of methods for

assessing the alliance, which are not necessarily unified in their definition and measurement of the alliance (Horvath, 2011).

At this point, the common factors viewpoint does not have a particular explanatory (i.e., all-encompassing) theory. Rather, the common factors perspective is focused on attempting to understand the nuanced similarities among different treatment modalities. Thus, common factors proponents naturally seem to emphasize experiential components of the therapeutic alliance. For instance, an experiential perspective about the therapeutic alliance is a belief that the clinician's demonstration of tolerating the client's emotional arousal fosters client development in the capability for self-management of unpleasant emotions (Fraser & Solovey, 2007). This particular perspective is, to a degree, speculative, rather than research-derived information.

For common factors proponents, the therapeutic alliance is a logical construct to expound and examine. The alliance most likely exists across a variety of modalities, is relational and experiential, and is receiving validation through research. Besides validity as a construct, the therapeutic alliance also appears to be a fluid and powerful construct. As a construct in psychotherapy research, the therapeutic alliance has been found to produce a reliable correlation with treatment outcome across a variety of psychotherapeutic modalities. Yet, we do not understand the actual meaning of the therapeutic alliance for clients (Nuetzel et al., 2007). The implication could signal a need for information from therapy recipients regarding their therapy relationship experience. Researchers have gathered and meta-analyzed quantitative research-based information about the therapeutic alliance (e.g., Horvath et al., 2011).

Common Factors: Research on the Therapeutic Alliance. The therapeutic alliance has been the focus of studies by researchers examining common factors, which is possibly the most prominent common factor studied in psychotherapy research. This research on the alliance has

resulted in a debate as to whether the alliance causes therapeutic change, is a result of productive therapy, or a combination of both (McAleavey & Castonguay, 2015). Bachelor (1995) found support for three types of therapeutic alliance. Clients fell into one of three categories: nurturant (46%), insight-oriented (39%), or a collaborative (15%) alliance. The nurturant-type defines the therapeutic alliance by trust and friendliness. The therapist embodies attitudes of respect, being nonjudgmental, attentive listening, and empathy. The insight-type defines the alliance through the acquisition of insight through self-revelation and therapist clarification. The collaborative-type defines the alliance through active involvement in the conduct of therapy. Thus, clients view the therapeutic alliance differently, emphasizing more importance to other aspects. In general, the therapy environment, developing self-understanding, and collaborating together are three contrasting realms for experiencing the therapeutic alliance and evaluating the working relationship (Bachelor, 1995).

Nuetzel et al. (2007) examined the client's perspective about the therapeutic relationship. The authors' results found that the therapeutic alliance accounts for 35% of the variance in therapy, far ahead of the next closest factor at 9%. Within the therapeutic alliance, many defining items are associated with positive feelings toward/from the therapist and with the therapy experience itself. The authors found that the client's perception of pleasantness in life and perceived level of adjustment had a positive relationship with the perceived strength of the therapeutic relationship. The authors concluded that increased strength of the client's perception of the therapeutic alliance is correlated with the client's perception of their lives as more positive on a variety of dimensions. The researchers also found that the therapeutic alliance continues to grow over time, with a progressive facilitating effect, which can empower clients to tolerate challenges in the therapy relationship.

Nuetzel et al. (2007) found less support for treatment variance due to the constructs of resistance, transference love, and negative transference. Each of these constructs, significant to the therapeutic relationship and process, are aspects of clients' phenomenological experience within psychotherapy. The authors concluded that their findings indicate a mixture of transference and reality-based elements in the alliance between clients and therapists, experiencing both positive and negative affect toward therapists might have therapeutic value.

Interestingly, Nuetzel et al. (2007) found that most productive psychotherapeutic work occurs beyond the second year of treatment. The authors' findings appear to underscore the significance and complexity of the therapeutic alliance/relationship, as well as implicate a need for phenomenological research. An emphasis on longer periods of treatment is a factor that I have incorporated into this study through the participant exclusionary criteria. In summary, research results on the alliance undermine a medical model approach and contextualize what is therapeutic more broadly (Wampold, 2001, 2015).

Common Factors: Treatment Models

The emphasis on best practices and empirically supported treatments assumes there are significant discrepancies among various treatment approaches (e.g., cognitive-behavioral therapy, dialectical behavior therapy, emotion-focused therapy, psychoanalysis). So far, the current emphasis for ESTs has been upon isolating a treatment and then empirically testing the treatment. I believe that this process is one of a separation and discrimination, with a resulting prejudice. For instance, separating a phenomenon into constituent parts can provide greater simplicity for understanding; yet, one can lose sight of the overall phenomenon being studied (Butler & Strupp, 1986). Conversly, the common factors approach emphasizes the broader elements of effective treatment. Empirically supported treatments isolate the treatment, but not

the significant factors. Common factors attempts to understand the significant factors within psychotherapy as a construct. The importance of an inclusive orientation to examining psychotherapy is founded in the importance of the therapy relationship. An encompassing viewpoint of the psychotherapy relationship is recognized and promoted by other researchers within the field. This is recognition that the therapeutic relationship and the alliance is the common ground shared by most forms of psychotherapy (Horvath & Bedi, 2002).

The psychotherapy relationship is not a structured intervention, but rather a continuously evolving entity. This relationship varies based upon the individuals involved. The relationship is developmental in nature, as is much of psychotherapy treatment. As relationship development goes, so goes the therapy, with no fixed point at which relationship building stops (Fraser & Solovey, 2007).

The common factors perspective does not imply that all therapeutic treatment is equally effective. Rather, the focus is on a different level of the treatment than the specified intervention. Common factors consider the relational element underlying most psychotherapy treatment. The interest is whether these relationally based factors are the main therapeutic factor. The crossover, or intersection, of the effect of applied interventions with the effect of the therapy relationship is a compelling interaction to consider, and difficult to dissect. For instance, Fraser and Solovey (2007) propose that commonly termed techniques are actually specialized therapeutic relationship skills.

An additional consideration regarding the effectiveness of psychotherapy treatment is the therapist. Interventions are applied and relationships are developed; yet, both factors are dependent upon a therapist. Psychotherapy exists through the skill-set of the therapist. Therapists' skill-sets include many uniquely individual qualities, some of which include:

attitudes, aptitudes, self-confidence, inter- and intra-personal perceptiveness, cognitive complexity, abstract reasoning, and empathic capability. These individual qualities are enacted through a therapist. Many common factors work through models, which in turn, work through therapists. Similarly, many key changes in therapy are initiated and/or influenced by the therapist and the therapist's ability to identify and maximize change opportunities. Therapists' interventions in the therapy context facilitating change, combined with the tact of the intervention process, are as significant as the treatment modality employed (Blow et al., 2007).

To conclude, common factors proponents recognize the significance of treatment models. Yet, these proponents also emphasize that all treatment modalities are enacted through a human therapist. As noted by Blow et al. (2007), treatment modalities are concepts, not effective in isolation. Rather, models facilitate therapist effectiveness. Similarly, therapists make models appear effective.

Common Factors: Meta-analysis of Treatment Models. Common factors recognize that many models are quite integrative and that many models have much in common (Blow et al., 2007). This perspective is somewhat contrary to the basic attitude of the empirically supported treatments approach. This discrepancy in approach is reflected in research that draws attention to treatments while de-emphasizing therapist effects, reflecting the emphasis of the medical model among many investigators. An implication of the medical model is that the specific particulars of the treatment are the important factors in therapy, not the means of delivery (Blow et al., 2007).

In response to the discussion regarding empirically supported treatments, Wampold (2001) undertook a substantial meta-analysis of a variety of treatment modalities. Wampold's interest was to examine multiple modalities rather than a single technique. As reported within published empirical studies, Wampold compared the measured effectiveness of many treatment

modalities. The general finding of the meta-analysis is that 8% of outcome variance is due to unique aspects of a therapy model, general/common factors account for 70% of outcome variance, and 22% is unexplained (Sprenkle & Blow, 2004). Wampold's (2001) meta-analysis provides evidence that therapists affect the outcome much more than the specific methodology employed. In fact, Wampold's meta-analysis underscores significantly the higher percentage of therapists believing in the procedure rather than performing interventions in perfect conformity with the manual (Fraser & Solovey, 2007).

A holistic, broad perspective underscores the common factors approach. This holistic approach includes the treatment model, therapist, client, and known and unknown factors within therapeutic relationships/environments. One challenge is to separate the therapeutic factors: specifics of the treatment from the therapist's faith in the treatment, the client's belief in the treatment's credibility, and the client's attitude toward the therapist delivering the treatment (Sprenkle & Blow, 2004).

Common Factors: Client Factors

In recognition of the therapeutic relationship, common factors proponents acknowledge the role the client plays beyond being a passive recipient of services. Psychotherapists form therapeutic relationships with treatment-engaged clients, not despite client involvement. The client ultimately determines (often unconsciously) the services needed/desired, the pace, and the extent of the relationship. Psychotherapists attune to that information.

A significant aspect of the common factors movement has been an emphasis on the client (as opposed to the methodology) as a primary force in the therapy. Tallman and Bohart (1999) speculate that effective therapy depends on the client's ability to work with the specific treatment/therapist that is presented. In this sense, clients individualize the treatment for their

own purposes.

Historically, consideration of psychotherapy has generally put the treatment model, and to a lesser extent the clinician's skills and traits, at the center of the focus/debate. As already noted, recent research has been expanding the realm of exploration into the psychotherapy process. This broader exploration process highlights the assumptions inherent in theory development: findings emphasize less-considered aspects of psychotherapy. Interestingly, the strength of the therapeutic relationship is more dependent upon client factors/contributions than factors/contributions of the therapist. Therapeutic outcome is more a reflection/consequence of the client's contribution to constructing an alliance (Blatt, 2001; Krupnick et al., 1996).

Studies offer some recognition that the perception of therapy and its constructs, as defined by researchers, might or might not be the same as the perceptions of therapy that clients would produce (Elliott, 1989; Patton & Jackson, 1991). The understanding of psychotherapy and its effects can be as unique and subjective as each individual entering treatment. In addition, the constructs assumed to be therapeutic might rather be arbitrary. To that extent, therapists and clients can use a different reference point when evaluating the therapeutic process (Fraser & Solovey, 2007). When clients and therapists have a different understanding of effective therapy, the means of assessing treatment might also be misguided and/or arbitrary. Apparently, each evaluator has a unique perspective about the therapeutic relationship and its qualities (Bachelor, 1995).

To summarize, a shared viewpoint is emerging (Beutler et al., 1998; Miller et al., 1997; Tallman & Bohart, 1999). Based upon research, the client is the most important contributor to psychotherapy outcome. Should not the client also be an important contributor to psychotherapy research, particularly because clients and researchers have differing conceptions of effective

therapy?

Common Factors: Future Directions for Research

The concept of common factors de-emphasizes specific modalities/interventions in favor of the therapeutic relationship and client factors. For that reason, common factors researchers and theorists propose that research should have a different focus than has been the case in the drive to empirically support specific treatments.

Bachelor (1995) argues that because interventions are mediated through the client, the client experiences changes; and, client perceptions are most predictive of improvement. The aforementioned research findings support the usefulness of investigation into clients' perspective about the therapeutic alliance. The alliance has been widely studied, having obtained the attention of many researchers of psychotherapy. Yet, there is no consensual definition for the therapeutic alliance, and no definitive understanding of how the alliance relates to other relationship constructs (Horvath, 2011). Bachelor (1995) supports "discovery-oriented approaches" (p. 324) that emphasize clients' perceptual experience, including ways in which clients create, understand, and cope with the counseling experience. This type of information offers a richer understanding and more clinical relevance than interpretations offered from outside observers (Elliott, 1989; Rice & Greenberg, 1984).

Likewise, Blow et al. (2007) state that most research studies do not devote sufficient attention to the mediating and moderating factors that can affect the relationship between therapist characteristics and outcome. The authors recognize that many aspects of the therapist's characteristics are a result of the therapist's adapting to client preferences, expectations, and traits. Sprenkle and Blow (2004) have proposed the probability of the importance for all clinical research to look at therapist effects and that a common factors perspective forces a focus upon

therapeutic effects more than therapeutic strategies or techniques. Therapeutic effects lead to positive treatment outcome.

Common factors proponents are also turning their attention to the research methodologies that might be best suited to acquiring the desired information. In part, this focus is based on a desire to gather more introductory information that can serve to foster a more complete and deeper expose on psychotherapy. The current level of knowledge about therapist variables could benefit from hypothesis-generating methods such as qualitative methods (Blow et al., 2007).

Therapist variability is but one aspect of the psychotherapy relationship and its participants. Dissecting the psychotherapy relationship into significant constituent components is the task that informs the common factors perspective. Process research to discover therapists' interactions in therapy is expanding in volume (Blow et al., 2007). Blow et al. (2007) emphasize the importance of therapists being attuned to the phenomenological and idiosyncratic elements of client experience, especially concerning the therapeutic relationship. Phenomenological research is a logical extension of this attitude toward the study of the therapeutic relationship. The proposition: clinical research would benefit from including interview methods that emphasize clarification and elaboration of participants' experience in order to create a deeper understanding of relevant clinical elements. This objective would require some form of idiosyncratic methodology and an in-depth research approach (Bachelor, 1995).

Lastly, Nuetzel et al. (2007, p. 1350) consider the possibility of identifying "uncommon factors" in psychotherapy through the use of experiential research methods. To discover any unique, idiosyncratic factors would require a research technique with flexibility and lacking a predetermined set of assumptions. Although common factors have received extensive research through quantitative methods, McAleavey and Castonguay (2015) propose that qualitative

methods would broaden the possibilities of the research. Qualitative methods offer a unique research approach (e.g., research questions) that provides an opportunity to uncover unknown phenomena (McAleavey & Castonguay, 2015). The presented study coincides with suggestions for research regarding the psychotherapy relationship incorporating qualitative methods.

Conclusion

The aforementioned concepts, theories, and perspectives are direct in stating the significance and necessity of a relationship to the developmental process of each respective concept. None of the examined constructs could exist outside the framework of a subjectively experienced relationship.

Although the reviewed constructs are relationally-based, there appears a paucity of examination from the experiential perspective of psychotherapy clients. As was stated earlier, relationships are understood as formulation of subjective experience. The relational experience has both interpersonal and intrapersonal aspects. Cuijpers et al. (2019) have observed that although there have been many studies examining how psychotherapies work; the research has not focused on understanding the mechanisms of change. Therapeutic procedures and processes are frequently joined together as mechanisms of change, yet it is important to differentiate between them and consider their interaction. How psychotherapies work is not well understood (Cuijpers et al., 2019). A formalized examination of psychotherapy clients' subjective relational experience seems potentially beneficial within the broader context of psychotherapy. The lived experience of the psychotherapy relationship is worthy of further exploration that could support existing theories and/or raise new areas of interest. Thus, the purpose of the current study is to uncover the variety of experiences mental health clients experience in the treatment relationship with the psychotherapist.

CHAPTER III: METHODOLOGY

Participants

Participants were a convenience sample recruited through the snowball, or word-of-mouth format. I began by recruiting three known mental health therapists as participants. One of these participants recruited three other participants (including two therapists). One of those recruited participants recruited another participant. Lastly, I recruited a known university professor as a participant. In total there were eight participants in the study, including five mental health therapists, one former professor of cultural anthropology, and two professionals in other fields. All eight participants have bachelor's degrees, five participants have master's degrees, and one participant has a doctorate.

The interviews were conducted from May 2019 into October 2019. There were four male and four female participants ranging in age from 35 to 54 years old. Six participants are Caucasian/European American, one is Asian American, and one is Hispanic/Latinx. One participant is Jewish, with another participant exploring Buddhism.

The approximate duration of the therapy relationships discussed were: 21 months, three years, three-and-a-half years, four years, five-and-a-half years, six years, 10 years, and 14 years. The discussed therapy relationships involved five female clinicians and three male clinicians. The client-clinician treatment dyads included: two of male client-female clinician, three of female client-female clinician, two of male client-male clinician, and one female client-male clinician combination.

Participant Exclusionary Criteria

Participants had to have participated in treatment for a minimum of 20 sessions, or six months, of individual therapy. For the purpose of this study, 20 treatment sessions/six months

was considered a rough baseline/minimum for the development of a treatment relationship with different phases and multiple therapeutic encounters/experiences. A baseline of 20 treatment sessions/six months was expected to provide minimally sufficient time for clients to both enact relational material, and also be able to reflect upon the therapeutic relationship. As noted in the previous section, participants in this study had significantly longer treatment relationships.

Participants with a professional background in the social services/sciences (e.g., therapists) were deemed preferable for their presumed capability to reflect upon personal and interpersonal psychological material. This participant background objective was based upon my varied professional experience. My experience and bias as a mental health provider is acknowledged at the outset of the research.

Procedure

Interviews ranged in duration from 35 to 70 minutes with the mode being approximately 60 minutes. Interviews were audio recorded and transcribed by myself. The interviews occurred in settings chosen by the interviewees for their comfort and convenience. Half of the participants chose public settings and reported being comfortable discussing the subject matter in these settings. Participants were given the research questions ahead of time to have an opportunity to consider their comfort with the subject matter. Participants could opt out of the interview if uncomfortable with the subject matter; none did so. In addition, the additional time allowed participants the opportunity to reflect upon the questions before the interview. This process proved beneficial for some participants who commented on their pre-interview consideration of the questions.

Materials

Research Questions/Interview Guide

Phenomenological research is intended to unearth the basic nature of a phenomenon through examining its experiential qualities. The research questions are designed to be rather general/vague and thought-provoking for the subject. There is no specific type of answer that is desired. Rather, the participant/subject matter determines the nature of the response, which the researcher considers while determining a direction for follow-up inquiry.

The research questions for this study were designed to uncover disparate aspects of the psychotherapy relationship experience in a complementary format. In other words, questions were designed to unearth diverse aspects of the relational experience for participants. The questions were designed to offer a subtle lead into a potentially general area of experience. The questions were not as broad as traditional phenomenological studies. Rather, the questions were designed with a general focus on different elements of the psychotherapy relationship. I designed the questions to have a particular focus (i.e., subtle direction) due to prior experience in intake interviewing; very broad questions frequently result in vague responses.

The questions were designed to examine aspects of the psychotherapy relationship based upon the literature review and my professional experience and bias. The literature review provided some relational constructs pertaining to significant relationships (e.g., attachment theory) and to psychotherapy (e.g., the therapeutic alliance, the real relationship). Questions were designed to reflect these constructs without addressing them more directly, or specifically. The literature review had an influential role on question development to broaden my personal/professional bias.

My research bias reflects observations I have made over years of providing therapy. These observations initiated and reinforced thoughts regarding the importance of the therapy relationship to the overall treatment process. The intent of the research was to broadly examine relationally-based experiences that clients might have and the feelings attached to them. The original goal was to unearth the commonality, breadth, and nuance of these relational experiences, not necessarily to search for the therapeutic quality. In addition, the research questions were designed to examine whether there are common factors in the client experience of the psychotherapy relationship, and its therapeutic components. See Appendix A for the semi-structured interview schedule, including the introductory data collection and rapport building questions.

Conceptual Framework: Phenomenological Inquiry

The field of psychology often has areas of interest that are unformulated, vague, and thus, rather impractical for study. Careful honing can turn an interest into a feasible research topic (Giorgi & Giorgi, 2008). Phenomenological studies examine situations in which individuals have first-hand experience. The objective is to capture the experience of the phenomenon and to discern its psychological essence. Often, human capacity to live through an experience exceeds our capacity to know the exact reasons for our responses. For this reason, analysis of the experience and its psychological meaning could be enlightening (Giorgi & Giorgi, 2008).

As a research methodology, phenomenology is debated and evolving. Phenomenological research has unique/idiosyncratic methodological concerns, although a phenomenological perspective is more an orientation than a methodology. The term “method” is misleading because the approach focuses as much on the way the researcher's mind deals with the data as in the way the data are collected (Hallet, 1995). The aim is to understand a phenomenon by having the data

speak for itself. The researcher interprets the description of an experience through a particular theoretical perspective. The theoretical perspective is an acknowledged influence upon the interpretation process. The researcher employs *bracketing* as a process of self-reflection incorporated to understand one's own predispositions and biases. The resulting knowledge is not considered objective but is perspectival. Interpretation in science is pervasive, with results employing researcher persuasion, thus objectivity is a misnomer (Osborne, 1990).

Phenomenological research is oriented toward describing the meaning of individuals' lived experience. The goal is to reduce the description of experience to its basic essence. A composite description of the essence of an experience is created from the reports of participants. The description includes objective details of the experience, as well as subjective qualities of the participants' experience (Creswell, 2007).

Participants in phenomenological studies are considered co-researchers. The objective is to gather participants' pre-reflective experience. The description of experience comprises the data in the study. Discussion and/or interpretation of data can create new data for further discussion/interpretation. Successive data gathering can create a more in-depth illumination of the phenomenon, similar to ongoing therapy sessions (Osborne, 1990).

Data analysis involves reading participants' reports and reducing material to basic paraphrases or extended illuminating quotations. The paraphrases/quotations are organized into sections based upon content. Themes of each section are created/interpreted. Themes are then clustered into tiers, creating a hierarchy of themes. The focus is on the deep structure of meaning that characterizes the phenomenon. The structure should present itself, rather than be based upon a preconceived theory. The researcher's sensitivity and perceptiveness influences the interpretation process, as does the researcher's theoretical orientation. In essence, data analysis is

an interaction between the participant and researcher, which is the reason ongoing dialogue can be beneficial. The shared structure is the most important factor in phenomenological research (Osborne, 1990).

In phenomenology, reliability is considered context bound. Measurement is of something being conceptualized in order to be measured (i.e., validity). The focus of phenomenological research is about creating meaning rather than discovering facts (Osborne, 1990). Unreliability and invalidity reside in the interpretive process, although no absolute interpretation of the data is possible. A researcher's best effort is to argue an interpretation persuasively, supported by the data, leaving final judgment to the reader. The methodology identifies four ways to address and assess validity: (a) bracketing the researcher's orientation; (b) checking interpretations for accuracy with participants; (c) presenting coherent and convincing arguments; and (d) describing the extent to which the interpretive structure resonates with the experiences of others (Osborne, 1990).

Phenomenological research requires a relationship between researcher and participant similar to that between therapist and client. As a methodology, phenomenological research is closer to counseling practice and stays closer to the meaning of human experience. The researcher is part of the participant's experience similar to how the therapist is part of the client's experience. Lastly, another perspective about the similarity between psychotherapy and phenomenological research is that clinical diagnosis and the interpretation of phenomenological research data require perceptive intelligence and empathic knowing which enables the therapist or researcher to intuit the data/information. Both practices rely upon building an argument for a specific interpretation of the data. Several interpretations are potentially available for most data/information (Osborne, 1990).

Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a qualitative method gaining momentum and popularity since the 1990s (Smith et al., 2009). This method's psychological roots recognize the role of the researcher in making sense of participants' experience (Smith, 2004). The objective of IPA is to explore ways in which individuals make sense of their world. This examination is completed via studying the meaning that specific experience holds for participants through their perceptions of the experience. IPA does not attempt to make an objective statement regarding the experience (Smith & Osborn, 2008).

Smith and Osborn (2008) state that IPA recognizes an active role for the researcher in the research process. The researcher's own conceptions are required to make sense of the participants' world through a process of interpretation. IPA recognizes the ways in which this factor complicates the research process. This awareness involves a two-stage process of interpretation (*a double hermeneutic*). In other words, participants make sense of their own experience, and a researcher makes sense of the participants' process of making sense of their experience. IPA is concerned with the participants' perspective. Yet, IPA analysis can also include asking critical (analytical) questions of the participants' sense-making process. In this sense, *to understand* means to both identify/empathize with, as well as make sense of, the participants' experience. IPA proposes that doing both leads to a fuller analysis of the experience. This useful in-depth qualitative analysis yields complex, process-oriented, or unique material.

The case-by-case analysis is detailed and lengthy. The goal is a detailed description of the understanding of the participants' experience. More general claims are not the primary objective. In-depth studies with specific populations are meant to complement other in-depth studies with other populations. This complementary process eventually results in more generalized

observations. The significance of an IPA study is determined by whether its findings shed light on the reader's personal experience.

Although IPA is inherently phenomenological, some researchers and theorists have proposed that IPA studies can contribute to theory development (e.g., Caldwell, 2008, as cited in Pringle et al., 2011; Rose et al., 1995). A *theoretical dialogue* can contextualize the research contribution within the broader literature. This dialogue can result in a valid contribution to theory. Knowledge gained regarding the individual might transfer to knowledge of the whole. The emphasis is on the development of transferable theory rather than generalizable empiricism (Smith et al., 2009).

Data Analysis Method

Data analysis was based upon the aforementioned phenomenological methodology (IPA), involving the collection of participant quotations and the creation of themes (incorporating paraphrasing of data) and superordinate themes. The theoretical orientation of the research, acknowledged during the bracketing/analysis process, is relational psychotherapy.

I spent three months transcribing the interviews. Each transcript was subsequently read multiple times. The research process evolved from reading each transcript as an idiosyncratic, unique story to broadly conceptualizing each participant’s reported experience. The re-reading of each interview allowed themes to emerge from each interview, and across interviews. This process required progressively less focus upon the specific details of each participant’s reports; rather, to broadly conceptualize the client experience that was being shared. Significant participant disclosures, insights, and quotations were noted in the margins of the interviews. This material was then grouped into larger themes and constructs observed across the interview samples. Thematic analyses were used to identify commonalities across the interviews.

Observations that were originally construed as subthemes or too idiosyncratic were eventually incorporated into the seven general themes. This incorporation was because the overall material was deemed extremely inter-related and many apparent subthemes were recognized rather as supporting aspects of many of the larger themes. In many cases the varied support (subthemes) was actually redundant and repetitive across different themes and could not be isolated as a sufficiently supported subtheme of a particular theme. Rather, all of the identified material was highly inter-related and multi-factorial dependent.

I chose to supply many lengthy quotations to illustrate the depth and complexity of the participants' responses, and to illustrate the nuance of each theme. I did not provide extensive details regarding the participants out of respect for participant privacy—and a belief that the participants' direct words speak for themselves. The participants' reports, frequently displayed in their complexity, illustrate the research's double hermeneutic process of making sense of the participants making sense of their experience.

CHAPTER IV: RESULTS

Overall, participants experienced their psychotherapy relationships with a coherent and consistent perspective with some outlying experiences. For example, all of the participants stated that they had relatively strong positive feelings regarding their therapists. Thus, there are significant overlaps/redundancies in the selected quotations. The identified themes offer more nuanced explanations and conceptualizations of the data. These themes (described in detail below) are: *Knowing the Therapist, Trusting the Therapist (or Treatment Process), Ruptures (and Resilience), Re-parenting/Hierarchy-Status, Seen/Witnessed By Therapist, Therapeutic Qualities of the Therapy Relationship,* and *Specialness of the Relationship*. The seven themes were organized into two groups, or classifications, based upon how the included themes relate to each other within the psychotherapy relationship. The two organizational categories are: *Foundational Components*, which consists of *Knowing the Therapist, Trusting the Therapist (or Treatment Process), Ruptures (and Resilience);* and, *Therapeutic Components,* which consists of *Re-parenting/Hierarchy-Status, Seen/Witnessed By Therapist (Attunement), Therapeutic Qualities of the Therapy Relationship, and Specialness of the Relationship*.

Each of the themes was endorsed, to varying extent, by all of the eight participants. In some cases, an endorsement was relatively idiosyncratic, unique to the individual, but still applied to the broader theme. The identified themes were developed, and given nuance, based upon their broad support and the complexity of perspective (i.e., experience) supplied by each of the participant reports.

Foundational Components

Two themes, *Knowing the Therapist* and *Trusting the Therapist (or Treatment Process),* were deemed inter-related and significant to the participants' development of a therapeutic

relationship with their therapist. Thus, these themes are considered foundational components (a generalized category) within the psychotherapy relationship for clients. *Ruptures (and Resilience)* is a theme also related to the psychotherapy relationship foundation. In this case, ruptures are challenges to the strength and durability of the relationship's foundation.

Knowing the Therapist

Six of the participants reported having a sense of knowing their therapist as a person (i.e., specific personal details or general beliefs, et cetera). Two participants reported that their therapist was not disclosing or transparent, yet they believed they had a sense of the therapist's values, and that was important to them. The sense of knowing the therapist takes place in a variety of ways, as examined below. All of the participants reported having some sense of knowing their therapist, despite three participants acknowledging that they knew few personal details about their therapist. It was reported by six participants that it was important to the formation of their therapeutic relationship that they know their therapist to some varied extent (particularly the essence of the person). Conversely, participants also stated that their therapist's self-disclosure is boundaried and professional. Despite knowing little specific information/details regarding their therapist (i.e., minimal therapist self-disclosure), participants reported that a sense of knowing their therapist was important to their feelings of care concerning the therapist.

> P1: Feeling like I know her really well…when I'm talking, I really sense I'm understood…Even if we have a session where she doesn't even share that much, something about feeling that I know her, it brings out a different part of myself that's helpful for me to hear myself talking, and to process through stuff in her presence.

> P2: I knew him pretty well, to some degree. But, you know, one of the things that was really interesting…is he never talked about his family [e.g., personal history/family-of-origin].

Clients will use different ways to read/know their therapist:

> P7: I don't know her very well…I actually don't know her a ton, which doesn't bother me too much. In fact, I think one of the strengths of hers is she's good at boundaries…That doesn't bother me because I can still feel like I know a little bit about her just because of her mannerisms, because she is warm, because she's got a personality. I still feel like there's a little bit of her that leaks out because she is this kind of person.

When little is known about the therapist, the client can find ways to fill the gaps. In particular, it is possible that clients project positive traits/qualities and feelings onto therapists in productive therapeutic relationships. Thus, unknown material regarding the therapist is filled through inference.

> P3: So, do I think I know him? I think I know him just enough…I can infer a lot, but it's just me…projecting.

For P6, therapist willingness to self-disclose was important to the development of trust as it interacts with knowing the therapist:

> P6: Oh yeah, [knowing the therapist is] hands-down why I trust her, right. I mean, because I know about her life, I guess…So, recently she's been having a hard time in her marriage…I know that she's going through a stressful time. So, that's a little bit harder for me to kind of be, maybe as needy as sometimes I would like to be…or emotionally vulnerable, I guess.

Yet, participant report also indicates that therapist self-disclosure can inhibit client disclosure if the client becomes concerned about hurting the therapist or feels guilt in burdening the therapist with needs that might interact with known material regarding the therapist.

> P8: I did not know much about her. She disclosed a few things…she did not disclose very much, though. And I think she really held a belief that the more she disclosed about herself, the more I would have a story about her, and then put expectations based on who I thought she was…And so I will cater what I say.

Knowing the therapist was connected to having feelings of care for the therapist. Care for the therapist seems interrelated with a feeling that the therapist cares for the client. The mutual

care that a client might feel can have an awkward juxtaposition with the professional nature of the therapy relationship.

> P6: Yeah, it's important to me [knowing the therapist] because I care about her. And I think there's a frustration in that I don't feel like I can—it's odd to feel like I can't reciprocate in a relationship where she's really been the most important person in my life at some times. And, so, sometimes that does feel conflicted to me because...If I don't pay you, I don't have a relationship with you. And that can feel really, um, rocky when you're counting on someone to be your life-line...The basis of your relationship is finan—it's transactional. It's financial, you know.

Participants reported a sense of knowing the "heart" (what I refer to as the *essence*) of their therapist. Participants said that their therapist's way-of-being in the world (e.g., general comments, behaviors, judgments/viewpoints) provided the feeling of essence (i.e., intrinsic nature, character), despite knowing few details. The therapist's provision of space (i.e., complete attention upon the other being as opposed to oneself) for other people (e.g., the client) might be a key component to the client's way-of-being/essence experience regarding the therapist.

> P3: I mean, I'm very perceptive. So, I don't know how much of it was my…little fishing, and how much of it was—there's very little self-disclosure…I infer that a lot of his therapeutic presence is based upon his life, and his training. So, that's just me inferring that I know things about him that he's never told me, but I've inferred…So, he's paying as much attention to me, and I'm paying attention to him, too.

> P4: I feel like I know who she is in her heart but not a bunch of details about her life. I know who she is by how she interacts with me, and how she approaches things, and how she views the world...I don't know anything that's not necessary for me to know, or isn't more than rapport-building, or things like that…She doesn't talk about her personal life a lot. It seems like, it's appropriate amounts of disclosure, and I feel like I know her really well. But, it's an interesting feeling to know her heart, and who she is, without a bunch of details about her life.

Clients will "sense" things about their therapist when information is unknown (i.e., knowledge based upon a feeling):

> P5: I know him better than the average client knows their therapist simply because I go to his house. He doesn't disclose very much…I have a sense of his values…I think I have a sense also of when his personal values maybe are different than mine and he is separating from them to join with me. I could not explain to you how I know that (laughter). That's

> the feeling that I have. So, then that gives me some feeling about what his personal values are.

The process of normalizing the client experience and joining it (e.g., through therapist self-disclosure) plays a part in the development of trust and empowerment. This experience underscores the reported client experience of feeling special to the therapist/within the therapy relationship. There can be an interest in developing another type of relationship with the therapist.

> P6: She speaks from a place of having been through a lot of trauma herself. She's done the work that she now does for other people…She had been there before…She's told me before that I remind her a lot of herself…I know about her son, and her husband now…I do know a lot…She'll tell me things because she knows I'm curious. There's also a part of me that's a little relieved that she holds that boundary…I like clear boundaries…So, I can kind of appreciate wanting to have more and not having it come because I like more that she's holding the boundary, than I would like, I think, having the information behind it, if that makes sense…I know her pretty well. I think I know her pretty well. She'll often tell me stories…I've heard a lot of personal stories, which I feel like it gives me a good idea of who she is, and what her life is like…She definitely fills me in on what's going on with her. So, I know a lot about her life. But, she won't really let me in and just talk about it…I think she's pretty conscious of what she tells me…I think she gives me enough to kind of keep that relationship satisfied…It is odd that you can be so close to someone, and it still is hard for me to feel like I can't reciprocate some of that relationship. And I can't be a little bit more included in her life, or…yeah.

Care for the therapist can be connected to a desire for a broader relationship:

> P4: Also, though, loving and respecting her, well you know, and being excited to be colleagues in this field together.

In some cases, trust in the therapist is interrelated with knowing the therapist. Trust increases as the client develops a stronger sense of knowing their therapist. Thus, for some clients, knowing their therapist can play a crucial role in the formation of the psychotherapy relationship.

> P1: I think I trust more when I feel like I really know somebody. It's harder for me, I think, to trust someone when I'm not quite sure I can read them; I'm not sure what they think about me, or what they're like…There does seem to be a lot of trust in that feeling like I know who this person is.

The sense of knowing the essence/character of the therapist played a significant role in the development of the therapeutic relationship, particularly the development of trust. A belief in knowing one's therapist exists even without much concrete knowledge of the therapist. Despite variability in the amount of disclosure the therapists displayed, the participants still believe they know their therapist, sometimes as a result of inference or projection. Clients relate feelings of care with knowing their therapist. The care is experienced as a mutual, reciprocal process. Knowing the therapist and reciprocal care can also lead to a desire for another type of relationship with the therapist. In summary, a sense of knowing the therapist plays a role in the client's development of trust in the therapist and/or the treatment process.

Trusting the Therapist (or Treatment Process)

The issue of trust was reported as a significant component to developing a therapeutic relationship. All eight of the participants reported experiencing trusting their therapist, while one participant also disclosed having significant trust in the treatment process/format. The development of trust can have variable timelines and is related to a number of different factors. Participants identified the development of trust as related to the therapist's personality/personal traits, non-judgmental acceptance, and the therapist's general dependability and care.

Participants reported both an initial/immediate trust, and that trust built over time. In some cases, the therapist is immediately liked. Clients link this trust development experience to the non-judgmental and professional nature of the therapy relationship, and feeling liked by the therapist.

> P6: She was just someone that I immediately trusted and she's been someone I've trusted implicitly ever since…It was sort of, like, intuitively I trusted her right off-the-bat. And then…that trust really built over time…She's a very powerful person. She's a big personality, and a very powerful person. That helps me trust her…I would say, "I'm trusting you. My fate is in the palm of your hands like a small bird" (laughter)…It's really only because we keep coming back, and back, and back. She's constantly shown

> up for me, every time. She's never left. So, I trust her at this point, ten years later, to not judge me as a person, and think we can't work together, or I'm beyond help, or whatever, which used to be my fears.

For P8 patience fostered the development of trust:

> P8: To really trust that she wasn't judging me…I wasn't ever being judged…It was such a safe place…I think that the trust with her did build over time. And so at first…there was a little bit of a rub of, like, "I'm not sure if I trust you to be able to really help me"…She knew that that [the relationship] just needed to build over time in order for me to trust that.

Participants reported an immediate sense of fit (e.g., ease of communication/being understood) creating comfort. Feelings of comfort are important to a reported sense of safety when vulnerable and exposed in the treatment setting. There can even be excitement and reassurance by the amount of trust clients place in their therapist.

> P2: It's like permissive trust. It's like aspects of trust, and I'll do this with clients, sometimes. I feel like they're hanging out there all by themselves with their vulnerability. So, I'll add my relationship to that, so that we both have skin in the game.

> P3: We trust each other, and care about each other, and know each other well enough to be able to make those meta-statements about an interaction we just had, and then move on.

> P4: I trusted her so much, yeah, yeah, yeah.

From a longitudinal perspective, trust is developed through consistency, dependability, and care. The ongoing process of sharing experience and identity fosters the development of trust. As the treatment experience decreases personal confusion, trust appears to develop. The trust development process is positively impacted by the therapist's strength, power, resilience, stability, and non-judgmental acceptance. The therapist becomes viewed as wise, protective, safe, and caring. Thus, the client trusts the therapist, even when the therapist is wrong.

> P3: I certainly trust him to demonstrate that this pattern is connected to this thing that we've been talking about for several years…Sometimes he gets it wrong. And sometimes I'm, like, "No, that's not what that's about. I hear what you're saying. That's not what it's about. It's actually about…" this other thing that we know—that we'd been talking

> about. And then he's like, "Oh, okay." And then we'll go down that train of questioning…I feel better after that, 'cause I trust him, and he knows me.

The therapist's care can be demonstrated through interest in the client and their shared relationship:

> P5: [The therapist's care] deepened the trust I had in…I guess, like, his interest in our relationship or in me and my overall livelihood and well-being, you know. I don't like feeling like people are worried about me, but also, I know that a part of me really needs people to be worried about me.

Participants reported that trust is an important foundational component of the psychotherapy relationship. The trust can occur quickly, or develop over time. Participants connected the trust to the professional nature of the relationship, and to the non-judgmental and/or accepting stance of the therapist (e.g., feeling liked). Trust can develop over time based upon the therapist's dependability and care. Knowing the therapist and trusting the therapist (or treatment process) interact in mutually beneficial and dependent ways to foster the foundation/development of the psychotherapy relationship. Thus, the two themes are inter-dependent and co-creating forces.

Trust can be negatively impacted (i.e., diminish) by negative feelings toward the therapist (i.e., rupture), challenges within the treatment, a client desire for concrete solutions, and a lack of progress/results within the treatment. These occurrences are experienced and examined through therapeutic ruptures.

Ruptures (and Resilience)

As there are aspects of psychotherapy that foster the development, or formation, of the treatment relationship, there are also experiences that can damage that relational foundation. These are experiences that test the strength of the relationship and the treatment. These experiences, referred to as *ruptures* (e.g., Safran, 1993; Safran et al., 1990), challenge the

resilience of the psychotherapy relationship. This research found that such challenges can result in termination of treatment, a temporary setback, a redefinition of the experience, or a renewed commitment to the treatment process. Thus, rupture experiences test and/or foster resilience within the psychotherapy relationship.

According to participant report, ruptures in therapy are common and not necessarily insurmountable. Successful treatment repairs the rupture quickly (frequently during the same session or very soon afterward). The rupture might entail shame in resuming treatment versus a rebuilding of trust. Ruptures can test the resilience of the therapy relationship, also providing potential opportunities for reset and deeper work. Seven of the participants reported some type of rupture experience in therapy and the other participant reported some experience of mild shame/resentment toward the therapist during treatment.

P1 discovered that the therapist knew of P1's spouse having an affair before P1 became aware of the spouse's transgression. A complex combination of pain, disappointment, betrayal, and anger left P1 feeling confused. This confusion included P1's feelings regarding the therapist. The prior foundation of the relationship (i.e., trust) fostered P1's perseverance through the rupture.

> P1: For me it was a real—I had a real crisis of trust, and I really felt—I was feeling so hurt, and so confused…and that way I felt hurt and confused by her. I didn't trust her for a while and we sort of had to work through that. It was really hard…I think there was still a lot of trust from before. And then, looking back, I think she handled it pretty well. Although…she didn't take any responsibility…I felt really angry and sort of really devastated…I felt mistrustful…and confused…I thought I was betrayed by her…Yeah, it felt pretty resolved…dealing with it pretty directly…regained my trust, to feel a more full repair.

P6 experienced arguments with the therapist that resulted in some brief breaks in treatment. P6 has then approached the therapist to resume the treatment. P6 found the return/rapprochement to be awkward.

> P6: (Laughing) We've gotten in some big yelling matches, for sure. I think there's been a couple breaks of a few different natures. One, there have been times where I've not been willing to really take her suggestion and grow in ways that she's kind of leading me to grow. I think I've ended things because of a lot of—taken breaks because of a lot of feeling that's come up for me, in that way…I felt a lot of shame reaching back out to her 'cause I kinda knew that I was upset and left, kinda storming away like a kid. It feels awkward because this person, you feel like this person always has sort of, like, a one-up on you. That's also a strange dynamic, right, of working with a therapist, too. It's like, sometimes I feel like I'm always under a microscope and that they can see more about me than I know. It brought up a lot of shame.

In some cases, therapist use of insight (or challenging the client) can create brief resentment/anger in the client. Treatment homework assignments can also result in client discomfort. Yet, participants reported that such breaks/ruptures in treatment are sometimes useful. It is unclear whether clients view the therapist as a guide or manipulator during such experiences.

> P7: She's called out a thing or two…I feel like, at first, I was a little—I might have felt a little stung, or just, like, awkward, or like, "Oh, no, someone noticed that about me," and felt uncomfortable. But, once I kind of absorbed the feedback, then I wouldn't have held it against her…One of the things that I've valued is finding ways to change my self-perception. It's one of the growth aspects of therapy that I've really enjoyed…I mean, I would feel maybe shame, maybe guilt, maybe just awkwardness over some self-perceptions that are maybe negative, or need work…but, aside from maybe an initial, like, you know, ping of that that's then turned into resentment for a hot second, it's not anything that lasts very long.

Client feelings of shame can be linked to therapist insight/challenge or the challenge of unwanted homework assignments, which can feel patronizing:

> P8: I think it's easy for therapists to feel like they need to give people tools, and a checklist, and, you know, "Did you do your homework?" For me that only…maybe shamed me. Like, it kinda made me feel like I should be able to change. But, it's my fault because I'm not following their advice, maybe…I was worried that maybe she judged me, or something to that effect…or where I might have felt anger with her. I never, I never brought that up in the relationship. I never talked to her about it. But, I think that that had happened a couple times.

Unrepaired ruptures lead to the termination of treatment. In addition, treatment is terminated when it seems ineffective, with a lack of goals/objectives, when clients suspect

dependence upon the therapist, and during general states of confusion regarding the treatment and the relationship. During these periods, clients will ask themselves, "Is this helping?"

> P2: I was being a son, for the most part…So, I terminated…I think it felt like a transition to, like, a different relationship. And so, I just didn't think I needed the therapy anymore, at that point.

Unmet client expectations can have a disruptive/rupturing quality. Yet, a positive affective experience in treatment can foster patience and perseverance through the frustration (i.e., resilience):

> P8: I think at the beginning there was confusion, annoyance, and frustration, a little bit. Just because I wanted—I feel like I was looking for specific results, and just had more of the black-and-white type of thinking about it…I think it made me frustrated…I was confused about, "Is this really helping me?" Um, but I think the fact that I enjoyed going, and talking, and being validated, and listened to was enough to get me through that…I was enjoying the process, and I liked the process; but I was also looking for outcomes and I didn't know if the process was going to get me to those outcomes.

As trust and positive image of the therapist are important to the development of a therapeutic relationship, breaks in these constructs can lead to ruptures. A "crisis of trust" can leave clients feeling hurt and confused. Similarly, a disruption in the positive image of the therapist is also a factor in minor treatment ruptures. Clients appear to work through these minor disappointments. P5 had shown up for a treatment session, which takes place at the therapist's private residence. The therapist had obviously overslept and was significantly delayed in answering the door. The therapist was apologetic and quickly prepared to have the therapy session:

> P5: There was definitely a little bit of—a little too much humanity than what we generally like to perceive in our therapeutic relationship…this is an illusion that we want to maintain.

Therapists can be distracted and display a lack of presence during sessions, which can cause client frustration:

> P6: Sometimes I get frustrated that things with [the therapist] are…different from other therapist-patient relationships…she does, like, eat during our sessions a lot. Sometimes she'll be kind of distracted, or sometimes she'll be, like, "Okay, sorry, one second, I just have to take this call or text." That is frustrating. There are times I wish that she was different in that way and had more presence, or had more, sort of like, a professional demeanor…

Participants reported considering termination (i.e., an extreme rupture) when the therapist appears distracted, is too challenging/pushing for change too hard, and when the therapist is too rigid regarding treatment/case conceptualization. Similarly, clients can become insecure in the therapy relationship when therapists are not sufficiently protective/respectful of the client's experience. Clients either become disinterested in other perspectives, or did not desire to know other perspectives and experience the process as too challenging and unsupportive.

> P3: There was a couple times over the past five-and-a-half years where I thought, "Is it time to say goodbye to [the therapist]? Have I reached my end with him?" There was a period where he was less…tracking me…And I just felt like he was pushing too hard…But, I stuck with it…and I'm glad I did…He's kinda stuck on this one-track thing…I can handle his projection. I'm not put off by it, because it's loving, and he cares about me…And so, when he would just keep circling back to that I would just, "Eh…" And so, finally he stopped.

> P8: Sort of being frustrated if she would try to bring in someone else's perspective too much. Or sometimes I think I would be looking to her for concrete answers, and she wouldn't be able to give them to me. I think that was frustrating for me.

Resolution of ruptures can occur through directly addressing the issue/rupture—initiating a rebuilding of trust in the clinician. In addition, when addressing rupture and discussing termination, one participant reported that the clinician's apparent sadness, presumably due to loss of the therapy relationship, was experienced as rewarding and reassuring. The participant continued treatment with that provider.

> P2: And the thing I'll never be able to pull apart, to this day, is whether I got attracted to that practice, and went and did all the things I did in it, out of pure seeking, or if it was just to please my surrogate father…And there's no way I'll ever be able to pull that apart. When I finally came to that realization, I was angry about that…I confronted (the

> therapist) and I met with him and talked to him about it afterwards…It was great—I mean, he handled it as well as he could have.

P1's break from treatment was temporary, in part due to the therapist's response:

> P1: When I was leaving to go traveling—she was, like, "So, is this it? Is our relationship over?" I sensed a lot of sadness that she would feel if we weren't going to work together anymore. I was, like, that felt good.

In some cases, clients will terminate treatment for a chance at something new. Feelings of stagnation and disconnection were reported as underlying termination. One participant reported second-guessing the decision and wondering whether had aborted treatment with that provider too soon. The individual eventually returned to that therapist and reported having a newly productive therapy relationship, as well as taking more personal responsibility for the treatment progress.

> P4: So, I think for a long time…I really struggled that we weren't working on deeper issues…for awhile we weren't really doing much. I was, like, I want someone who can hold me to this. I want something else, this isn't quite working for me…I think I felt frustrated…I think I felt that it was her not holding me to doing the work…So, I think the frustration, or whatever, is have we done all we can do in a therapeutic relationship? Our one-on-one individual therapy relationship, is that ready to stop? My questions about, "Do I continue, do I stop?" You know, if I'm not working on these issues, should I stop going to therapy? Wondering, "Am I becoming dependent on therapy?" The actual change that I think that's occurred is a really recent one. So, I think it was leaving therapy and then coming back. So, now more than ever before, I'm taking ownership over the work that I want to do…So, I think the biggest change in the therapy relationship is actually stepping out of it…and then making the decision to go back into it with a renewed ownership over what I work on or don't work on…I didn't realize what a good fit it was until I tried to see someone else…to know what a good fit it was by being able to contrast it to someone else…I think taking a short break was helpful in going back to feel that renewed sense of, like, okay and I'm, like, ready to work…the break felt, like, I didn't believe in my ability to ever talk about some of these things…

It is possible that clients, when feeling stuck-in-life (i.e., developmentally stagnant), might project that as being stuck-in-treatment. The objective might then become to work through the stuck-spot relationally in the therapy with the therapist.

> P8: There was a little bit of a disconnect there at the end…she did, I think, expose a little bit of her own agenda…that was something that caused me to actually end the therapeutic relationship…I might have just been projecting…But, I think it was a place in my life where I felt super, super stuck…I felt ready to kind of move away from her support and guidance as much…There was this one area where she was less able to help me the whole time…I needed something different…Now looking back on it…I wonder if we had just gotten in a stuck place and if it would have benefitted me to kinda work that through with her more relationally…I think I needed to have a deeper, more relational experience…I don't know that she would have been able to do that work with me, if that makes sense.

Sometimes the professional nature of the therapy relationship has its own inherent distancing (rupturing) quality. Apparently, some therapists will even use this aspect of the relationship within the treatment. The longevity/consistency of the relationship can counter some of the discomfort related to the transactional nature of the treatment relationship.

> P6: How do you establish a relationship with someone where you really trust them to be there for you as a person in the most deepest of all ways? When really the basis of your relationship is finan—it's transactional. It's financial, you know…It's really only because we keep coming back, and back, and back. She's constantly shown up for me every time. She's never left…the consistency…I can call her anytime, text her anytime, and that she just knows how to get me through anything.

P3 was confused and hurt by the therapist's rupturing comment. But the treatment relationship evolved into one where both parties are able to be direct and disagreeable with the other one. The longevity of the relationship is one crucial factor to withstanding potential ruptures.

> P3: He also has said—I mean, it did hurt—one time he did say, "I don't care about this relationship. This is a transaction. You pay me money; that's why we talk." He said that. And I'm, like, "Okay, that kinda hurt my feelings." It did; it hurt my feelings. I didn't tell him it hurt my feelings 'cause I think he knew it…I don't remember what the point was he was trying to say…"I wouldn't be relating to you if you didn't pay me money"…It wasn't a corrective thing. It was something else…it felt a little too strong…I don't really remember. But, we moved on…Obviously, it didn't stick, and it wasn't damaging (laughter). And it was a fuckin' mean thing for a therapist to say to somebody (laughter)…Me being able to say, "No, you're wrong." So those are changes. I didn't immediately have that ability to have that kind of back-and-forth with him. Um, this is what long-term relationships are able to do.

Ruptures in therapy might be a rather common experience. Participants reported feelings of anger, mistrust, confusion, betrayal, and "devastated" when experiencing a rupture. These

ruptures can be experienced as minor areas of frustration or embarrassment, more significant experiences of distrust and shame, or as disappointment and/or disillusionment that leads to termination of treatment.

Participants reported that ruptures do not necessarily become larger obstacles if there has been a foundation of trust already formed. The longevity of the relationship apparently affects the sense of trust and resilience during moments/periods of rupture. Addressing issues of rupture quickly was reported as significant in the repair and eventual perseverance (i.e., continued treatment). In addition, special feelings regarding the therapy relationship also gird the therapist-client relationship during rupture challenges.

Therapeutic Components

Participants discussed different aspects of the psychotherapy relationship that were deemed to be therapeutic components of the treatment process. Three aspects of the therapy experience were identified and labeled: *Re-parenting/Hierarchy-Status, Seen/Witnessed By Therapist, Specialness of the Relationship*, and a fourth broad, general category *Therapeutic Qualities of the Relationship*. As is true of the previously identified themes, these themes also inter-relate significantly.

Re-parenting/Hierarchy-Status

Six participants discussed how their therapy relationship included parental/familial aspects, in some cases also directly addressing hierarchy and status components. The other two participants discussed therapy relationships that were influential and therapeutic, in part, because of the therapist's deemed status. Participants indicated that what might be termed re-parenting, or a synonymous process involving familial-like influences and support, commonly occurs in therapeutic treatment. This process incorporates reworking personal narratives and cognitive

patterns, as well as having personal identities affirmed. The therapist is viewed as wise and encouraging of self-exploration. The therapist's care, encouragement, and support concerning self-exploration and personal growth/development (e.g., as related to identity) can be experienced as a parental love, or substitute experience. In some cases, this care is a substitute for an absent parent. In treatment situations that do not directly mimic a parental relationship, the client can still rework childhood roles/patterns and/or respond to the treatment relationship as though there is a hierarchy involved, reinforcing and supporting the change process. Ultimately, participants reported the parental, or hierarchical, nature of the relationship to have corrective features.

A majority (six) of the participants reported working with a therapist one-half to a full generation older (frequently mid-50s). In these cases, participants reported viewing the therapist in a parental or mentor framework. These clients were accepting of guidance, insight, and even desirous of direction. The two exceptions, where the therapist was not significantly older, still addressed issues concerning parental influence, although the therapist was not viewed as a parent substitute, but rather a wise colleague and/or superior professional. In these two cases, the client was either reliving childhood roles or hoping to please/impress the therapist. Thus, the relationship still incorporated, at a minimum, a slightly unequal (hierarchical) stature. In such cases, participants reported an appreciation for being witnessed, but not for being directed/guided. More often, there was a hierarchical component to the relationship (i.e., therapist as "one-up"/superior). In other words, the therapist (and therapy itself) provides a stable support for a client feeling some aspect of instability.

> P2: It was such a mentoring kind of experience for me…It ended up being very…student-teacher, mentor-mentee, father-son kind of experience. So, you know, I grew up without a dad. So, it was really like a—in some ways a very healing experience to have, like, a male mentor of interest…He was probably my age now, then…he was probably in his

> early fifties then, or maybe mid-fifties. He had all-gray hair, and a big, white beard. He was very wizardly…The thing I'll never be able to pull apart, to this day, is whether…it was just to please my surrogate father…There will always be a wound of the absent father…That was a powerful experience…a mentoring-father, um, wizardly experience. For somebody to see things in you…

Participants described their psychotherapy relationship in ways that addressed/met unfulfilled needs involving parents. This process often includes rewriting/reworking one's personal narrative. Participants reported the significance of having personal identities acknowledged and affirmed. In addition, participants reported that treatment frequently negated/challenged negative personal narratives (e.g., harsh self-judgment). Addressing personal narratives and cognitive patterns were reported as important to successful treatment, and significantly/more often, the development of a rewarding therapeutic relationship.

P1 was clear about desiring parental features in the treatment relationship:

> P1: [Being directed] Felt good that someone would care. Some part of me wants to really be told what to do, honestly…Oh, this person has something that my parents don't have, that the other adults in my life don't have. That feeling that you meet somebody, there's something—this person is seeing things I'm not seeing, and I want to be able to gain their wisdom for myself, for my life.

P3 has addressed familial roles in treatment—and attempts to change the role-based behavior:

> P3: It's also positive to be reminded when I'm playing "good boy" again, and hiding, and not coming forward. And then when he finally pushes me to full-throated defend myself in a particular scenario…I appreciated that.

P8 recognized a parental aspect to the treatment relationship, particularly a protective and nurturing component:

> P8: I definitely felt like I saw her as a mother figure…I think I assumed she was close to the age of my parents…She may have felt a little protective of me…I felt ready to kind of move away from her support and guidance as much…She did help me see myself in a different—in a different way. And she did help me notice things about myself that I hadn't really been tuned into. And, um, particularly, you know, strengths, resiliency, um…you know, holding a space of compassion for my struggles…I have a lot of feelings of shame and worthlessness…And I think she did a lot of corrective experiencing through that relationship…the way that she was warm; she was nurturing.

Acceptance and affirmation can foster the reworking of a personal narrative, particularly if one has felt pressure to suppress aspects of one's identity (i.e., therapy as a form of re-parenting). For P4, having the personal identity acknowledged and affirmed is particularly significant:

> P4: She's also queer identified. So, that was actually really important to me. So, there are things that I think I get as we share some identity pieces that I wouldn't get with another therapist. Not that another therapist couldn't be good; but, I think there are things about having a lived experience in a community that I don't have to explain to her…I think the identity piece is important.

Participants referred to the wisdom of the therapist as an important component of the relationship/treatment. Therapist encouragement of self-exploration through exploratory questions was reported as a helpful, parental quality of treatment. Participants also found the therapy relationship to have a familial aspect; feeling cared for, and a parental love being experienced. Three participants referred to the therapist as "avuncular" or a "surrogate" parent. There was also reference to the wound of the absent parent that the therapy relationship addressed. Ultimately, participants viewed the relationship as corrective, in nature.

> P1: Sometimes it feels a little bit like she's a surrogate mother to me. Sometimes it's like we're friends. Sometimes it's like she's a trusted, wise sort of helpful sounding board, sort of wisdom giver. She's definitely somebody I enjoy being around…I found it really helpful when I'm in challenging situations in my life, I find her—talking with her about it is really helpful. She's given me so much advice, and talked me through so many situations that are challenging; and her, and like, consistency, it's been, like, really helpful for me to have her direction and her thoughts and insights…like motherly stuff. Like, I tell her I love her. She tells me she loves me. We say we love each other…So, I do feel like she's sorta like family to me.

P5's treatment relationship is primarily therapist-as-an-advanced-colleague, yet still has a familial aspect:

> P5: He's kind of like…It's kind of avuncular. It's interesting because we're peers; but, I also look to him for something more than just, like, consultation, right…There have been moments when I have been very surprised at how much warmth I felt from him…

P6's treatment relationship has both sibling and re-parenting components:

> P6: She's told me before that I remind her a lot of herself…Our lives and some of the things we've been through have been really similar. So, she kind of feels like one step ahead, two steps ahead, maybe. Kind of like, maybe, a big sister in a way, sometimes. It feels awkward because this person, you feel like this person always has sort of like a one-up on you…I just showed up as such a broken human. And so having her—she's been someone who's, like, re-parented me, and then helped me re-parent myself, and then helped me with a larger life-view, and helped me with tools to be with life when I don't understand the life-view that's happening. And that's been invaluable.

Participants reported feeling vulnerable regarding such aspects as the therapist knowing things about the individual that no one else knows, and also expressed curiosity regarding their therapist's perception of them. This perceptual experience included a sense of therapist amusement, curiosity, and concern regarding the client. Ultimately, there is a power dynamic, or hierarchy, that can result in thoughts of: "You're better than me."

> P5: I wonder what he thinks of me. There was a moment a few months ago when I told him that I felt like he—I felt like he was worried about me, and my decision-making. That worried me, that he was worried about me…My perception is that he's amused by me…My other therapists have been women. There has been this maternal aspect where, like, I've really leaned on that and felt like I really, really need this relationship…And with him…I don't need him, which I think is okay…I would say he's also very warm and nurturing…"You're definitely better than me…you have something to teach me…I'm here for you to mold and guide and grow" …I think there is an unspoken hierarchy in the therapeutic relationship that, as therapists, we're always like, we don't really want to use that, right. As a client, I know it's there.

The hierarchy includes the therapist's professional training and status. The professional construct of psychotherapy can have a reassuring quality:

> P7: With a therapist, you know you're being treated by professional hands…Even if it's like an imagined thing…the therapist-client relationship—if it's just a construct…yet you're still on that couch, and you think, "Yes, this is a space where this is supposed to happen. I'm supposed to say these things."…The therapist is still doing more with that. It was professional, and it was real, and there's something very grounded about that that makes me feel really good about having said everything in a professional setting like that…the professional relationship of a therapy client is very therapeutic. I mean, the actual construct is therapeutic.

The therapy hierarchy can also include the provider's assignment of homework (sometimes viewed as shaming). Yet, homework also functions to maintain the treatment relationship when treatment sessions are many weeks apart. There can be a desire to impress the therapist, as well as a pride in presenting accomplishment to the therapist.

> P8: I think it's easy for therapist's to feel like they need to give people tools, and a checklist; and, you know, "Did you do your homework?" For me that only—maybe for some people that's helpful, but for me that just—maybe shamed me. Like, it kinda made me feel like I should be able to change. But, it's my fault because I'm not following their advice, maybe.

P7 receives mental health services through an employer's health maintenance organization. Mental health treatment is provided every six weeks. Therapy assignments function to tie the sessions together and maintain the focus of the work process. A desire to fulfill therapist expectations (e.g., instilling pride) implies a parental type of hierarchical relationship.

> P7: I guess I should mention, too, one of the things that [the therapist] is really good at—we call it homework…She has always done a good job of saying, "Here's your homework for this time period until we see each other again."…It kind of tied a string between sessions…So, I didn't feel like I was too far from professional—from therapy, from the next session, or something like that…I was also proud, because I had—and I was also anxious to show that off because I'd like to think I made her proud by doing work, and feeling good after having done that work…

Participants in this study reported some aspect of hierarchy, or status, within their psychotherapy relationship. The relationship entailed the client holding respect for the therapist as a trusted guide offering input, or as mentor, or even providing re-parenting and/or corrective experience, in nature. Clients can even want to impress their therapist or experience pride in how they are viewed by their therapist.

It might be rather common for therapeutic psychotherapy relationships to involve some aspect of re-parenting and/or hierarchical/mentor component. This particular phenomenon was

reported frequently by participants during this study. Although there are nuanced components to the experience, it appears to be significant to the therapy relationship for many clients.

Seen/Witnessed By Therapist (Attunement)

All eight of the participants reported experiencing being witnessed by an attuned therapist. The experience of having one's thoughts, feelings, behaviors, and general experience known by another person is what I am identifying as being seen or witnessed. This is a process of having one's phenomenological experience shared and understood by another person's mind. Empathy is another aspect/conceptualization of this construct. I consider being seen/witnessed as an aspect of the inter-subjective process referred to earlier in the presentation of this study's theoretical foundation. This process incorporates therapist reflection of client experience through non-judgmental acceptance. Participants discussed the subsequent effects upon self-esteem, self-confidence, and feelings of shame. Therapist perceptiveness and insight are considered aspects of witnessing.

Participants reported that being seen, or witnessed, was sought after and that another set of eyes serves that function. What clients want seen is their feelings/emotions, cognitions, interpersonal interactions, relationships, et cetera. The process provides the client with another set of eyes/mind on their experience—sometimes creating a more shared experience (i.e., decreasing client isolation/aloneness). Additionally, therapists provide another perspective of one's self for clients.

> P1: She's helped me see myself more clearly in a lot of ways, which feels good…I definitely feel the reflection. I feel like she's there with me…I feel recognized, and seen, and known. It's oftentimes in tune with my experience, and connecting…It was more about—right—felt more seen…I remember having the feeling, "This is what I was looking for…"

The therapist's witnessing/affirmation can be a unique experience, unlike other relationships:

> P4: This was actually a really good fit, and a really good place to feel seen…My own experience of how powerful it was to have someone witness, and sit with me, and feel seen, and validated, and affirmed who I am different than friends or family affirm and love me…It's like a nice reminder for me as well as a clinician, that offering clients just a place to be witnessed in their story, and in their struggle, and in whatever it is, and supporting them, and loving them through whatever that is, is enough.

Being seen can be a grounding experience for the client:

> P5: I think I'm more amused at his observations, like the way he observes me…I think I see him as a really helpful sounding board, and also a really helpful, kind of, resource for grounding…He's also very warm and nurturing.

The therapist's unconditional positive regard plays a role in the witnessing process:

> P8: From the beginning I really liked her…I just appreciated that she listened. She seemed to get what I was saying, and I never felt shamed, or judged…It caused me to question the way I was seeing myself…just holding this unconditional positive regard for me…To really trust that she wasn't judging me…I felt really heard. It was this safe place…She would delight with me when something good happened. It felt like those positive feelings would resonate…My heart was really hurting, and grieving. I just think it felt so helpful for her to maybe share in a little bit of the confusion, and anger, and hurt…She really joined with me…

Participants reported that the therapists' stance of non-judgmental acceptance is an important foundation in the relationship. To begin, clients do not feel a need to justify their experience. Rather, the client experience is being reflected and recognized—fostering connection.

> P3: That's what I want, is somebody to be real with. And he's the guy…He also has given me incredible, affirming statements…"Yeah, you know me…Yes, thank you; I appreciate that."…I like the fact that I can be the fullness of my being with him. Don't have to hide…He's given me high praise in all these areas of my life…

Clients can appreciate the therapist's attempts to witness the client:

> P5: I think I have a sense, also, of when his personal values maybe are different than mine, and he is separating from them to join with me.

Therapist nonjudgmental acceptance and dedication to the client reinforces being seen:

> P6: I'm really able to trust that she can see me in all these different ways and still not think of me as, like, a terrible person…but it's really only because we keep coming back, and back, and back. She's constantly shown up for me every time…And she just knows how to get me through anything…She's gotten me through these massive, um, places in my life where I was really stuck, or I was really depressed…Her constant dedication to helping me see what's happening…

Participants stated that therapist reflection of client experience can be perceived as agreement and validation. Participants related the process of validation and feeling valued with increases in self-esteem and self-confidence. Similarly, as client shame is recognized and challenged, it becomes normalized and diminished.

> P2: I think just seeing my intelligence, valuing me…just really validating who I was as an underlying person…It was just really good…It made me, you know, really believe in myself…The self-doubt piece is so crippling and paralyzing. But, the therapeutic perspective of having such confidence…you're caught up in your own…inadequacy, or your own inability, or your own limitations. And the therapist's perspective is, like, comparing—because they have such a broad experience of other people…I just didn't grow up with that level of validation…or being seen like that…

Trust inter-relates with disclosure, affirmation, and being seen. This process is therapeutic:

> P3: My true self can come out at regular intervals with a trusted person who knows me, and cares about me, and I can check in, and drop in to what's really going on…I think being accepted and seen is validating. It's affirming…It's like, "I'm okay."…That mirror of the affirming positive in me is super therapeutic, just wonderful.

Therapist reflection of the client (i.e., being seen) fosters the client's rewriting of personal narrative:

> P4: I think it's been an interesting thing for [the therapist]…really advocate that, like, owning my own story and being able to rewrite my story…not just sticking with my own self-narrative that's been given to me by others…how I make meaning and view myself in this world, the ability to start taking ownership over that…To be able to go to therapy and look at my own patterns of behavior and have her reflect back…She's provided me a space to really reflect…She also helps me not feel shamed or guilt for being who I am in the world.

Validation/empathy is a form of being seen:

> P5: My therapist would really validate my frustration…he would continue to, like, validate frustration that I had and it really helped me…the validation that he was giving me…

The client can experience therapist reflection as approval. The reflection is actually a form of support into client self-discovery:

> P8: I thought she was approving of me…the beliefs that I was expressing…that she actually agreed with them. But, what I sort of ended up realizing was that she was just reflecting—she was just reflecting me. It actually wasn't her, which, I didn't feel upset about that…[A] good therapist might…support a person then in finding their own wisdom, and then they reflect that back to the person. And it can feel like they actually agree with you…but it actually has nothing to do with them…She did help me see myself in a different—in a different way. And she did help me notice things about myself that I hadn't really been tuned into.

Participants referred to the significance of therapist perceptiveness and subsequent guiding questions. Therapist use of guiding questions is perceived as a form/evidence of being witnessed—related to the therapist's perceptiveness. Insight and interpretation was also reported to have a similar value (i.e., being witnessed) for some clients. For P2 the witnessing and insight was a precursor to a personal awakening to unconscious material:

> P2: The idea that there was…some other piece of my being that I didn't have access to…that was brand new…to me…That was my first awakening…his process was awakening—helping me access those underlying, unknown parts of myself…He was really intuitive…I was a sponge for knowledge…have your mind see new things for the first time…It was a pretty magical experience—magical time of awakening…It was more insight-oriented…which is still my preferred way…It's just, somebody seeing deeper aspects of you, that…you don't see that they see.

Therapist perceptiveness identifies client thought and behavioral patterns, sometimes through the therapist's inquisitiveness:

> P3: The connection between my—whatever I'm struggling with, and these underlying themes, emotional growth edges that I have—that's when he's able to, sorta, point them out…Basically, he's pointing out thought patterns, and stories that I tell myself …I mean, I know that, seeing it in the moment is harder without [the therapist]. With [the therapist], it's easier to see…It's like: "See how this is connected; see how this is connected?" He

> has never tried to name my reality…He has shown me how this particular thing is related to this particular thing, is related to this particular thing…He just asks me questions and I name them…he runs with that…So, it's about creating a different story.

The identification of client patterns can also involve reflecting upon the societal forces involved,

witnessing the client's broader experience:

> P4: I think she's continually helping me see things differently than I view them…to see patterns of behavior, patterns of being…helps me to not personalize it…to not internalize those…negative societal images…reminding me…this is not actually a problem with me; it's a problem with society. I'm internalizing it…I think all those things collide to feel really affirmed and seen in the world where I think a lot of my identities are invisible, so I don't really feel seen all the time in who I am. And so, it's somewhere that I can go who understands my struggles and sees me, and then also is there with me as I, like, push through, or overcome.

Witnessing the client's experience is validating and reassuring for the client:

> P5: He was able to see all of my efforts in this jumbled—…He was just able to name it in a way that both validated and gave it some form…

Therapist perceptiveness and perspective can help clarify and diminish client confusion—

although therapist perceptiveness can also be too revealing and/or awkward:

> P6: She tells it to me like it is…She just was honest about things with me, and sort of like a shark, she has an incredible ability to really hone in on something that I didn't understand was happening, or something that I didn't know I was thinking, or understanding…Just a very strong personality, whose perspective really helped cut through a lot of confusion that I was in…This person always has sort of, like, a one-up on you. That's also a strange dynamic, right, of working with a therapist, too. It's like, sometimes I feel like I'm always under a microscope and that they can see more about me than I know…So, her strength is that she can be fast, and very cutting, and very decisive, and very to-the-point. But, sometimes that frustrates me…[The therapist] points out things about me all the time that I don't know, or that I don't see that I'm doing…and brings me back to a lot of things that are really helpful, that I didn't see about myself before…She's, of course, pointed out things that I don't want to hear…We've gotten through it.

Perceptive questions demonstrate a therapist "tracking"/witnessing a client well:

> P7: She has done a good job of reading me…She was able to let me go where I needed to go, ask the right questions, and I felt heard…This woman can really read the room, and take me where I need to go…She asks the questions that need to be asked…this warm, guiding hand kind of thing…She strikes me as someone who is emotionally open a lot of

> time, and is an excellent listener all the time…She's so good at just being able to sit there and listen and track everything I'm saying…She's called out some things that I was very appreciative of. I appreciate reflection…

Participants reported that their therapist acknowledged and affirmed their personal identity. This experience of support functions to foster client resilience. In addition, the therapist's validation countered feelings of aloneness.

> P1: I think she really recognized that I was an introvert. I think she helped me recognize that I was sort of like a(n)…external processor…she helped me appreciate sort of being reflective, and not thinking of that as sort of, like, maybe being, like, slow, a slow thinker, or something…She helped me appreciate sort of having a different perspective…than a lot of other people. And she helped me believe that that perspective…was still valuable…I think she helped me feel just kind of, like, more…like a peer, a human in the world, that mattered.

Clients are seen as individuals and as members of communities (i.e., having multiple identities and related experience):

> P4: We share some identity pieces that I wouldn't get with another therapist…I think there are things about having a lived experience in a community that I don't have to explain to her…I actually want someone who's in community…She's not going and making it about herself, she's just planting the little seed: "I see you; I've been in this, too. I understand the struggle."

Being seen is a remedy for aloneness:

> P5: I was just feeling very, very alone…It was just, like, "Is anyone ever going to support me in this so that I can just exist without having to explain myself?" In that moment, I was like, "Thank God, I don't have to explain myself to you;" (laughter)…I haven't, until now, had a lot of relationships with people who just accept what I'm saying, you know.

> P8: The feeling of, "I think I'm not alone in this."

Participants were quite clear, coherent, and at times, rather eloquent about the significance of being seen/witnessed by their therapist. The witnessing process is desired by clients and incorporates the wide range of personal experience and identity/self-perception. Therapist non-judgmental acceptance and validation was reported as significant to the overall experience of being adequately and therapeutically witnessed. In addition, being sufficiently

witnessed inter-relates with aspects of the re-parenting/corrective experience participants reported. Ultimately, deeper existential concerns can be acknowledged through therapeutic witnessing.

Therapeutic Qualities of the Therapy Relationship

All of the participants discussed a number of different aspects of the psychotherapy relationship that were deemed to have therapeutic qualities. These therapeutic qualities are considered subthemes (components) of psychotherapy's many unique qualities. None of these particular therapeutic qualities were supported by a majority of participants. Rather, each participant discussed aspects of the therapy that was particularly beneficial for that person. The reportedly unique therapeutic aspects of psychotherapy include: psychotherapy's professional nature, the therapist's expression of care, the therapist's role as teacher/mentor/surrogate parent, the orientation of the treatment (i.e., the types of interventions incorporated—particularly oriented toward personal narratives and identities), reflection upon patterns of cognition and behavior, a positive affective experience in treatment (i.e., enjoyment of the process), therapist as ally, therapist disclosure, and the therapist's genuine unconditional positive regard/care.

P7 reported trusting the history of the professional construct of psychotherapy. The professionalism of the therapist, and the professional nature of the relationship, makes personal disclosure seem appropriate. In addition, apparently the professional nature of the relationship can create a sense of mutual investment in the therapy process. The therapeutic relationship is deemed unique and different from any other relationship. Particularly important is when the care is experienced as transcending the professional transaction of the relationship.

> P7: I think with the right hand she asks the questions that need to be asked. So, 80% of the time, she's leading me from something I've said and leading me on; and then 20% of the time, "I'm going to ask this specific thing that I want to now guide you this way because I think it's the right way to go." But, she has—it's not overbearing. I don't need

> to be coached or coaxed…I feel better (laughter)...I like a connection with my therapist…steady hand, like, guiding, and stuff like that…She strikes me as someone who is emotionally open a lot of time, and is an excellent listener, all the time…She's so good at just being able to sit there and listen and track everything I'm saying. She strikes me as someone who can't really turn that off…who's able to give space to a lot of people…Did it change my self-perception? Absolutely, and, in fact, it's one of the things that I've valued is finding ways to change my self-perception. It's one of the growth aspects of therapy that I've really enjoyed…With a therapist, you know you're being treated by professional hands. This is someone who's gonna give you space and care for what you're saying, and not take anything you're saying not seriously, like, be very professional about what they're hearing…The therapist-client relationship—if it's just a construct…yet, you're still on that couch, and you think, "Yes, this is a space where this is supposed to happen. I'm supposed to say these things."…The therapist is still doing more with that. It was professional, and it was real, and there's something very grounded about that that makes me feel really good about having said everything in a professional setting like that…The professional relationship of a therapy client is very therapeutic. I mean, the actual construct is therapeutic.

According to participants, the therapist's expression of care can be experienced as a vulnerable act, an offering to the client. The process can make clients consciously aware of being uncomfortable with other people's expression of care toward them. Yet, being affected by the therapist's care, as well as accepting the care, can open clients to deeper levels of personal exploration.

> P1: Maybe it felt good that someone else would care…It felt caring. I felt cared about, I guess…I really sense that she cares about me and I care about her a lot…I feel like she actually cares about me. I actually care about her. It feels like it's transcended this sort of transactional business relationship.

For P5 the therapist's care and concern is both a pleasant surprise, and something that can be challenging to accept, but is to be appreciated:

> P5: Over the past year-and-a-half there have been moments when I have been very surprised at how much warmth I felt from him, which certainly has much more to do with me than him…He'll kinda reflect back things to me…it never feels like a challenge. It feels more like an observation, an observation with a degree of care and concern (laughter).

> P5: It's going to be okay with my therapist if I complain…even if it's not okay with me. I think over time that really helped me…to be more okay with, like, feeling this way…I think there is an unspoken hierarchy in the therapeutic relationship that as therapists…we

> don't really want to use that, right. As a client, I know it's there…When I'm a client, I'm very intentional about just, like, letting go and just being…it's really nice when I can have all the intention that I want to walk-in and just be the client and allow my therapist to take care of all aspects of the relationship in the room.

Care is connected to being witnessed with unconditional acceptance—feelings of safety:

> P8: I felt really heard. It was this safe place…I wasn't ever being judged…It was such a safe place…She really joined with me…she may have felt a little protective of me…

Four participants reported that the therapist's role/impact as teacher/mentor/surrogate parent is particularly impactful. The therapist's confidence and support plays a significant role in the client's ability to address personal issues. Participants reported that addressing self-doubt, feelings of inadequacy, and personal limitations is particularly therapeutic. The therapist's confidence and support encompassed in pushing/prodding, encouragement, and thought-provoking questions fosters the client's development of self-esteem and confidence. In addition, the client's perspective is broadened and enhanced. This developmental process is predicated upon the therapist's role/stance in a productive therapeutic relationship, as experienced by clients.

> P1: I feel very accepted by her, and appreciated by her…she's really helped me appreciate who I am…I think she's been the most impactful person in my life, I mean, positively…She's helped me see myself more clearly in a lot of ways, which feels good…I really sense I'm understood…

P2 experienced a particularly impactful session related to being witnessed, insight, and validation:

> P2: Whatever happened that day [in session] was so vulnerable and exposing. And then I went back for more. It was, like, that broke the ice of something…he normalized that, and welcomed it…Insight was huge at that point…'cause I had just been so narrowly focused, and wounded in my life…Extreme awakening, that was a big one…more insight oriented…Seeing my intelligence, valuing me…just really validating who I was as an underlying person…it was just really good…It made me, you know, really believe in myself…The self-doubt piece is so crippling and paralyzing. But, the therapeutic perspective of having such confidence…you're caught up in…the story of your own…inadequacy, or your own limitations. And the therapist's perspective is, like,

> comparing—because they have such a broad experience of other people…a confident sense of knowing…Somebody seeing deeper aspects of you…you don't see that they see.

Participants reported that having personal identities acknowledged and affirmed is important. In addition, it is significant when therapists negate clients' negative personal narrative/self-image. This process includes recognizing and highlighting cognitive patterns. Reflecting upon patterns of behavior—a process of seeing/identifying underlying patterns of behavior and making connections, normalizes the client's current situation/experience, and creates a sense of control—resulting in an empowered sense of the possibility of change, rather than the victim of random experience. This process is contextual (i.e., a "big picture" perspective). The therapist may push/challenge/prod the client without the client experiencing guilt and/or shame. The client experiences a decrease in personalization of problems—does not internalize negative social messages. The therapist's observation and challenge is a component of being witnessed, which ultimately functions to foster a change in self-perception—thus growth. The therapist functions as a guide/support to unconscious material through being observant of patterns, attentive, inquisitive, and mildly challenging.

> P3: He'll tell me…the connection between…underlying themes, emotional growth edges…He's able to, sorta point them out…He's pointing out thought patterns and stories that I tell myself…all of these patterns…connecting them to my present circumstance…

Context is beneficial:

> P4: She's provided me a space to really reflect…It's an unbiased space…So, she helps me to see the bigger context of it when I feel very stuck in the moment…She helps me to see patterns of behavior, patterns of being…to not personalize it…to not internalize those, I think, negative societal images about…myself that I get from the rest of the world.

…And perspective is an aspect of context:

> P8: I think her goal was to bring to my attention the ways that I was…"shoulding" myself…I would assume, at first, "Isn't it obvious, you must think that, too?" But, she made so much room for, like, "No, I don't know that I think that at all." So it caused me

> to question the way that I was seeing myself. But, then I think she was just holding this unconditional positive regard for me…There were some things that through my relationship with her, and her unconditional positive regard, her modeling of: "We don't have to assume that. Let's zoom out…" [to consider] another paradigm for being in relationship with myself…I think she was modeling it, and I think she was actively engaging me…She was just good at trying to hold space; or, "Let's look at this from multiple perspectives," which, over time, really, really sunk in…Holding the open space of non-judgment, and positive regard…warmth and acceptance…I think she did a lot of corrective experiencing through that relationship…the way that she was warm, she was nurturing…she just wasn't judging me. Took me a long time to believe that that was the truth…I think that was the most therapeutic element.

Three participants reported that when the therapy relationship "feels good" it is a significant factor to the therapeutic aspect of the treatment relationship/process. This affective experience is deemed corrective and important.

> P1: I guess it is the relationship…I would say this relationship has been so powerful for me…our relationship, yeah…I felt a connection.

> P7: Therapy is like letting air out of a balloon. Like, as life goes on, and stress, and experience, and things change, kind of pump air into that and the stress builds. And going to therapy is one way to relieve that stress…Whenever I go to therapy, I feel lighter afterwards. I feel like I've let some of that air out of that…

Affirmation exceeds unconditional positive regard and encourages disclosure:

> P3: That's what I want, is somebody to be real with…Where I can be me and feel like you're gonna receive it…He's just there with me, nonjudgmentally…He also has given me incredible, affirming statements…It's, like, "Yeah, you know me."…I like the fact that I can be the fullness of my being with him; don't have to hide…

The therapist as an ally, joining/validating the client experience, creates for the client the sensation of having a shared experience. Feeling liked is considered critical, "a game changer." Even if positive outcomes are lacking, participants reported the significance of enjoying the psychotherapy process with the therapist.

> P4: I think the history piece is important; I think the identity piece is important…[A] relationship that just feels really affirming…where I think a lot of my identities are invisible…It's somewhere that I can go who understands my struggles and sees me, and then also is there with me as I, like, push through, or overcome.

For P8 “enjoying the process” was important for persisting through doubting the process:

> P8: I think the fact that I enjoyed going, and talking, and being validated, and listened to was enough to get me through…I was enjoying the process, and I liked the process; but, I was also looking for outcomes, and I didn’t know if the process was going to get me to those outcomes…I thought she was approving of me…that she actually agreed…But, what I sort of ended up realizing was that she was just reflecting…It actually wasn’t her, which, I didn’t feel upset about…She held this big, open space that was her being non-judgmental and accepting. And that in that space was where I was really clarifying some beliefs, and some identity. And I think, if anything, it might have been a little bit empowering. It was like, “That really was me. It wasn’t her.”

Participants reported that therapist self-disclosure can have a therapeutic component. The client can experience a validation of their own similar personal experience when the therapist self-discloses personal information. In addition, participants stated feeling a closeness, decreasing feelings of aloneness/isolation/unique defectiveness, when their therapist self-disclosed. Addressing existential concerns: the direct and indirect ways that therapists address clients’ sense of place in the world. Clients find this process counters feelings of aloneness, shame, and worthlessness.

> P8: The feeling of, “I think I’m not alone in this,” you know…I feel like that was the whole point, kinda, ‘cause she did help me see myself in a different—in a different way. And she did help me notice things about myself that I hadn’t really been tuned into. And, um, particularly, you know, strengths, resiliency, um…you know, holding a space of compassion for my struggles. I had been very hard on myself, previous to my relationship with her, and did not really have a framework to value myself where I was struggling…feelings of shame and worthlessness…And I think she helped me see that…from a much more holistic perspective…

One participant referred to the therapeutic relationship as supportive of the client’s “relationship with reality.” The client discloses a personal reality and the therapist witnesses and accepts that experience, as well as provide additional perspective. The therapy relationship reinforces the client’s attempt to have a genuine relationship with the experienced reality. Another participant identified the therapeutic component of therapy as care. The experience of an external/other’s care is the foundation of a therapeutic relationship/experience. Both constructs

are related/interrelated, and interpersonal-relationally dependent. A synopsis might be that what is therapeutic incorporates a caring approach to the client's personal reality, a reaffirming experience.

> P3: It feels good!…I'm a crazy person and here's a sane person who's having a sane conversation with me, and…therefore I don't feel as crazy because he's saying I feel the rest of my world is crazy…It's corrective because you're not tripping… "Oh, okay; I guess I'm not crazy. I don't really have that problem…" …My true self can come out at regular intervals with a trusted person who knows me, and cares about me…That's super therapeutic to have somebody that I can share my victories, these small emotional victories…He just points out, "You are good. You are powerful. You are loveable and loving."…Being that mirror of the affirming positive in me is super therapeutic, just wonderful…I'm a really decent person…I don't allow myself to, like, acknowledge that enough…It's about creating a different story…I'll say the same thing in a different way.

The treatment relationship can be very private, unique, and special:

> P4: I've told my therapist things I've never told anyone…sharing my history, sharing my experiences of trauma…for a long time she was the only person in my life I could share those things with. I think, still, my relationship with her is different than it is with anyone else in my life…My own experience of how powerful it was to have someone witness, and sit with me, and feel seen, and validated, and affirmed who I am…"Do I believe that I'm worthy of love and belonging?"…Trying to make sense of that, or trying to figure out where I fit in this world…This relationship has consistently been one that I think allowed me to do that work.

The therapist's stability and dedication supports the client's relationship with reality:

> P6: Yeah, she's really stable. Yeah, she's…yeah, had to prove that over, and over, and over, and over (laughter)…Trusting the work that she's done, and just sticking with it even when it's been incredibly painful has been the most positive experience of my life, really, really, hands down…She's dedicated to being there in any way that I need her…She just is constantly able to say, like, "This isn't about what's happening right now." And brings me back to a lot of things that are really helpful, that I didn't see about myself before. And helps me bring patterns that are happening back in my life to other situations where I can be, like, "Okay, this isn't about this actual moment." So, that's really cool, that I can't see for myself…I'm really able to trust that she can see me in all these different ways, and still not think of me as like a terrible person…She's gotten me through these massive, um, places in my life where I was really stuck, or I was really depressed, and shown me—taught me ways to be with myself, and given me a whole tool set of learning how to live life, build those…that skill-set of living through pain, I guess. And that's been the most therapeutic…deep tissue massage versus light, fluffy massage…Her constant dedication to helping me see what's happening, and helping me

> see where my blocks are, and helping me address those, even if I don't want to, and even if it's uncomfortable…

P5 realized that feeling cared for is part of a process; allowing oneself to accept the care is the needed complement in the therapeutic experience:

> P5: I was just talking…and he got really sad…I could tell there were tears and he was, like, "That makes me so sad."…I think that was maybe one of the first moments that I realized that he actually cared about me…I can shut that off a lot, right, where I'm just not really registering somebody caring about me. So, that was a really defining moment in our relationship where I was, like, "Oh, this is a relationship where somebody really cares about me and I finally felt it."…His interest in our relationship and my overall livelihood and well-being…I know that a part of me really needs people to be worried about me…Definitely a moment where I realized that he might worry about me…"Okay, I need to let him." I need to let that worry be a part of our work…Maybe you can only really get there if you let somebody worry about you…Maybe the way that he expressed his concern for me was, um, so vulnerable and open that I could see it…that definitely was a moment where I was, like, "Oh, this is a space where we take care of my sadness, or you take care of my sadness for me sometimes, right." There is a benefit in my own life to allow for that with people who are safe…he was offering himself as a safe person…Avoidance of that care…I'm not accustomed to this; it feels uncomfortable…I think it was insightful for me…It's still subconscious and that was a moment that it was made conscious for me…The therapeutic aspect of the relationship with him is just that he's available to me; and that he can hear anything that I want to talk about…He's just really calm…there's a quietness to his presence…The help that he gives is not active; it's more like presence-oriented…Maybe this is the common thread, and why I love therapy so much—is that he offers a type of relationship, or a type of support and energy that I don't get to have with anyone else in my life…There are ways that I can be, and there are ways that I look for my therapist to be, that I wouldn't—they just don't exist in my other relationships, no matter how close they are.

Participants identified the professional construct of the psychotherapy relationship, the importance of reworking personal narratives and self-image/self-esteem (e.g., feelings of inadequacy), reflecting upon patterns of behavior/thinking, normalization of experience, and a general care/support/validation in the nonjudgmental acceptance of the client's reality as some of the potentially therapeutic qualities of psychotherapy and the treatment relationship. Each subtheme might be a particularly significant component of therapeutic treatment. Yet, each identified subtheme was not as broadly supported as the other identified themes. Thus, they were

grouped into their own more diverse category of broadly defined therapeutic qualities of the psychotherapy relationship.

Specialness of the Relationship

There was an unexpected outcome from the research: an overwhelming majority of participants reported feeling a sense of being special and unique (e.g., a favorite client) to their therapist, or experiencing special feelings and desires regarding their therapist. Four participants expressed feeling uniquely special and liked by their therapist, including one individual eventually caretaking the therapist. Five participants stated experiencing a unique feeling of love and care from and/or for the therapist—beyond the professional norm/expectation. Three participants experienced a love/respect that created a desire to have a different type of relationship (i.e., less professional/more personal)—and two other participants actually had relationships with their therapist beyond the professional norm. One participant expressed a desire to impress the therapist. All reports were of therapy relationships considered therapeutic/beneficial.

Participants were emotionally touched by their therapist's care. The care was reciprocated, with many participants expressing a similar personal care for the therapist. Client's can desire their therapist's approval, as well as a social relationship with their therapist. The therapist might be viewed as an ally or mentor. Participants discussed feeling appreciated and liked by their therapist.

> P1: I tell her I love her. She tells me she loves me…I feel very accepted by her, and appreciated by her…I think she's the most impactful person in my life, I mean, positively…I've always felt like she's there for me…I sensed a lot of sadness that she would feel if we weren't going to work together anymore…Maybe I could meet a therapist and they're great, and it's really helpful, but they don't—aren't committed to me as a person. I feel like [the therapist]'s really shown that she actually cares about me as a person…she cares about me and I care about her…The very first time we met I had that feeling, like, "Oh, this person has something I want; like, this person is different than

> the people I've met before."…I feel like she actually cares about me. I actually care about her. It feels like it's transcended this sort of transactional business relationship…but, I guess it is the relationship. I mean, I guess I would say this relationship has been so powerful for me…

For P2 the specialness of the relationship eventually resulted in feeling like an offspring with care-taking involved (and eventual rupture):

> P2: I ended up doing a lot of care-taking…I was being a son, for the most part…It was such a mentoring-father, um, wizardly experience…

There can be a desire to impress the therapist. Similarly, clients can experience pride in presenting accomplishment to their therapist. The therapist's approval is deemed important, and in some cases, is possibly assumed or inferred.

> P7: Seeing her again—I actually remember wanting to brag because I was, like, "I feel great. I'm here to work on one thing."…I was also proud…and I was also anxious to show that off because I'd like to think I made her proud by doing work, and feeling good after having done that work…

Some clients desire a social relationship with their therapist, despite commonly knowing little personal information about the therapist. The boundaries of the relationship and lack of reciprocity can be frustrating:

> P6: It still is hard for me to feel like I can't reciprocate some of that relationship, and I can't also be a little more included in her life…I care about her…There's a frustration in that I don't feel like I can—it's odd to feel like I can't reciprocate in a relationship where she's really been the most important person in my life at some times…My [therapist] has been like a lifeline. If I was in a hole, she was the rope, and I'm clinging onto it.

P8 was acutely aware of a desire to be liked and have another type of relationship with the therapist. P8 was also aware that projection might have occurred—and feeling liked, accurately or not, had its own beneficial effects:

> P8: What is she thinking about me? That was definitely on my mind…I remember thinking, "Does she like me? Oh, I think she really likes me." (Laughing) I guess I got more into the relationship part of it, was that, I really felt like she really liked me personally…The overall way that she held the relationship, over time…She actually really enjoys our conversations. She feels delighted to see me…I could not wait to go to

> therapy…I felt like she would delight with me when something good happened. It felt like those positive feelings would resonate…She was really validating…really kinda sided with me.
>
> P8: I really wished I could have a social relationship with her. You know, I really wished that I could just see her, and I didn't ever express that to her…I thought she was approving of me, and some of the choices I was making…or the beliefs that I was expressing…and that she actually agreed with them. But, what I sort of ended up realizing was that she was just reflecting—she was just reflecting me. It actually wasn't her, which, I didn't feel upset about that.

P4 viewed the therapist as an ally and reported an experience of safety.

> P4: She's also queer identified. So, that was actually really important to me…We share some identity pieces that I wouldn't get with another therapist…I think the identity piece is important…I've wondered…at what point do I complete the therapy work with her? Wait a few years and then have some other different relationship with her…At what point would I stop this relationship with her and still continue a relationship, but into a different relationship?…Loving and respecting her, well, you know, and being excited to be colleagues in this field together…I think identity history and her therapeutic orientation…collided to make a relationship that just feels really affirming…to feel really affirmed and seen in a world where I think my identities are invisible…

Participants expressed feeling appreciated/enjoyed by their therapist and feeling liked; they also reported a positive/likeable repartee with their therapist and a shared sense of joy in the client's positive experiences, and in the relationship. Participants reported the following feelings within their therapy relationship: love, kindness, respect, affirmation, and a general experience that "feels good"/rewarding. The therapy relationship also can include a sensation of familiarity. Participants discussed the importance of feeling loveable and loving in having a therapeutic experience. Mutual care appeared to be a significant aspect of the therapeutic relationships discussed. One participant summarized the therapeutic component as experiencing care, which was identified as "the magic mojo." The same participant also iterated the importance of the care being genuine. Reciprocal care might be even more therapeutic.

> P3: There's a mutual respect between us…he's able to, like, take it when I call him "a bitch."…Because I know he loves me; but, also because he's trying to push me to an edge…I can handle his projection. I'm not put off by it, because it's loving, and he cares

about me…I know he cares about me. I believe…and this could be therapist crush; I believe I'm special to him. Ah…you know, I don't think he's probably had a client as long as me. I started when he was an intern. We've been through a lot…If [the therapist] and I were to ever stop working together, I would be, really, sad. Deep grief, when I think about it. I really care about him, and I know he cares about me, too. And I don't really know how I know he cares about me, but I do know that he does. So…um…that's the magic mojo in the relationship. 'Cause I've been with therapists that, um, they were just doing their jobs…they kinda cared…But, they didn't really care. (The therapist) really cares, and that matters to me…as we know, therapeutic relationships are corrective when they're done right.

P4: My relationship with her is different than it is with anyone else in my life…I fuckin' hug my therapist every time…that is so important to me.

P6: I can tell we really like each other, and she's told me before that I remind her a lot of herself.

P8: [Feeling liked] was a game changer. I think it was critical.

P5: I have been very surprised at how much warmth I felt from him…I wonder what he thinks of me…There was a moment a few months ago…I felt like he was worried about me…That worried me, that he was worried about me…My perception is that he's amused by me…I would say my relationship with him feels different than relationships I've had with different therapists…I was just talking…and he got really sad. I could tell there were tears and he was, like, "That makes me so sad."…I think that was maybe one of the first moments that I realized that he actually cared about me…So, that was a really defining moment in our relationship where I was, like, "Oh, this is a relationship where somebody really cares about me and I finally felt it."…I know that a part of me really needs people to be worried about me…I realized…I need to let him. I need to let worry be a part of our work…Maybe you can only really get there openly if you let somebody worry about you…Maybe the way that he expressed his concern for me was, um, so vulnerable and open that I could see it…That definitely was a moment where I was, like, "Oh, this is a place where we take care of my sadness, or you take care of my sadness for me sometimes."…He was offering himself as a safe person…Why I love therapy so much—is that he offers a type of relationship, or a type of support and energy, that I don't get to have with anyone else in my life…There are ways that I can be, and there are ways that I look for my therapist to be, that I wouldn't—they just don't exist in my other relationships, no matter how close they are.

Participants reported feelings of being special, or unique, to their therapist, and the feelings had a reciprocal component. The therapist's approval is important, as is a belief that the therapist is an ally for the client. Feeling appreciated and liked/loveable were reported as significant aspects of these psychotherapy relationships.

Participant expression of the experience of personalized care within the psychotherapy relationship was an unexpected result. There is variability in how the care is experienced, but it might be relatively common for clients in particularly therapeutic psychotherapy to feel a sense of being uniquely special to the therapist. The participants in this study also appear to have developed some amount/type of feelings of care for the therapist in therapeutic treatment. Participants presented a circular process of feeling loveable and loving—a reciprocal cycle of care.

CHAPTER V: DISCUSSION

This study was designed to explore the mental health client's experience of the relationship between client and therapist. The intention was to uncover general or specific experiences commonly experienced by therapy clients. Participant reports emphasized the importance of the psychotherapy relationship within the treatment experience. The identified themes delineated some qualities within the participants' psychotherapy relationships.

Hopefully, the gathered information might contribute to the ongoing development of a better understanding of what fosters therapeutic mental health treatment. The research approach was meant to gather an array of information through its use of a qualitative method—in other words, using a discovery-oriented approach. The identified themes reflect the experiential component of being a psychotherapy client as related to the psychotherapy relationship. Although it was not the direct intention of this study, the participants themselves frequently linked these experiences to the phenomenon of having a helpful psychotherapy experience.

Ultimately, the participants supplied rich data. The results of this study provided the type of information that I was hoping to gather. This was experiential data that had sufficient similarity and common themes. The data provides a more scientific background to conceptualize treatment and the psychotherapy relationship. Thus, I have a more informed foundation for conceptualizing the relationship within the treatment, and the relationship's potentially therapeutic elements.

The seven research questions were designed to elicit unique, disparate information to complement and enhance a broader understanding of the subject matter; however, each participant generally responded similarly across each of their own questions. Thus, each participant displayed remarkably less unique distinction amongst the questions than expected.

Instead, the primary themes resurfaced across the questions with each participant (readers might notice redundancy within and across each participant's remarks). Participants reiterated the identified themes frequently throughout the interviews, despite the disparate research questions, displaying a saturation of the data. Possibly, the therapy relationship has a broad, generalized experiential quality for clients rather than compartmentalized/disparate components of the experience. To parallel the similarity in responses with an occasional outlier, therapy clients might view the therapy relationship as a generally unified experience with occasional outlying experiences/incidents. A unified conceptualization might enable the sense-making process of an individual's experience, decreasing contradictions and confusion, thus continuing the relationship. The richness and repetitiveness of the participants' responses did provide a robust phenomenological experience. Thus, although data might seem repetitive, the familiarity also provides well-supported (i.e., saturated) and nuanced perspectives.

The seven themes have much in common, as the reader will notice. Similarly, the participant reports had much in common. The themes overlapped, and even combined, as participants presented them. I concluded that the seven themes combined and represented two generalized components of the psychotherapy relationship. Participants discussed aspects of the treatment experience that comprised the formation, or foundation of the relationship, including breaks and repair within the relationship, and aspects of the relationship that were beneficial to the therapy as mental health treatment.

Knowing the therapist was described as a rather significant aspect of developing trust and feeling care for the treatment relationship/therapist. Yet, participants acknowledged knowing little factual information about their therapist. Rather, clients appear to know their therapist through a feeling, impression, or inference that is particularly oriented around the therapist's

personal qualities, character, and values. A belief in, or sense of, knowing the therapist's values appears to play an important role in the development of trust and other feelings regarding the therapist. In some cases, the sense of knowing the therapist's values and character can be inferred; in other cases, it is the client being perceptive to information the therapist has disclosed in some way. Yet, it appears to be relatively important for the client to have some belief in knowing their therapist, as opposed to the therapist experienced as a completely unknown entity.

Although the concept of the therapist as a blank entity for transferential projection is an original aspect of psychoanalysis (Freud, 1905/1953; Gelso, 2011), apparently clients will find ways to work around the unknowns regarding their therapist (including projection). It might be too uncomfortable to disclose personal information to someone whose values are an unknown and could thus be judgmental toward the client. It is possibly due to this discomfort of disclosure that knowing the therapist and trust are inter-related (according to participant report). The significance of knowing the therapist also aligns with the prospect of a real relationship in psychotherapy (e.g., Gelso, 2011). Although participants were aware of not necessarily knowing their therapist well, they believe they know their therapist, according to one participant, "well enough." Through this belief, as clients, participants were searching for a "realism" (Gelso, 2011, p. 12) within their perception of the therapy relationship. Although therapist genuineness has been a significantly addressed construct within psychotherapy (e.g., Rogers, 1957), the different ways in which clients prosper from the genuineness might not be well understood. A real relationship in psychotherapy might be predicated upon therapist genuineness fostering a sense of knowing the therapist. In addition, knowing the therapist likely fosters positive feelings about the therapist and therapy, a component of the therapeutic alliance (Nuetzel et al., 2007).

Trust is another crucial element to the foundation of the psychotherapy relationship. Levitt et al., in a 2006 qualitative study concerning psychotherapy, also found trust to be a core element of the therapy relationship. In that study, trust was related to therapist displays of care, including genuineness, while disingenuous care can anger clients (Levitt et al., 2006). In this study, trust was also identified as important to having resilience during rupture experiences. While trust can be experienced immediately, or develop over time, it was reported as necessary in the relationship. For this reason, it would be important for therapist's to focus on the means of building trust, particularly early in treatment. Unconditional positive regard and genuineness are such techniques for fostering trust. The Rogerian construct of genuineness (e.g., 1957) would also align with the experience of having a real relationship within psychotherapy (e.g., Gelso, 2011; Gelso & Carter, 1994). Trust would also seem to play a crucial foundational role in the attachment constructs secure base and safe haven (Bowlby, 1988), also discussed below. The individual's confidence in having a safe place to return for comforting is related to the trust in the relationship. Clients seeking care are vulnerable and the development of trust alleviates the vulnerability. Treatment that focuses on challenging client behaviors and cognitions before trust has adequately developed might be met with resistance, and also might not be experienced as therapeutic initially.

The themes *knowing the therapist* and *trust* seem particularly related to each other as they interact and affect the other. Both themes, based upon participant report, appear to function as foundational components of a psychotherapy relationship. As clients come to know their therapist, trust develops, and trust seems to foster a sense of knowing the essence and/or character of the therapist. As these two factors interact, they inherently affect each other's development. This proposal, based upon the study's results, might parallel Nuetzel et al.'s (2007)

finding that the therapeutic alliance grows with time and fosters the client's ability to tolerate change (e.g., growth and rupture/resilience). According to this study, a client's sense of knowing their therapist can be independent of how much self-disclosure the therapist incorporates. Based upon the findings, it is possible that clients use intuitive, perceptive, and inferential processes, as well as some projection, to facilitate the knowing process. Trusting the therapist (and/or process) is one of the four treatment factors proposed by Frank (1961). This study supports Frank's proposition, although the identified themes relate to client experience rather than components of effective psychotherapy.

Participants' reports indicating the significance of knowing the therapist and trust would seem to theoretically align with Bowlby's (1988) attachment theory emphasis on a secure base/safe haven experience as a foundation for further exploration done by mental health clients. The secure base and safe haven are foundational components of attachment, similar to knowing the therapist and trust as foundational components of the therapy relationship. The secure base as a safe place would appear similar to what knowing the therapist and trusting the therapist (or process) is providing the client. The safe haven is a secure base providing comfort. The foundational components of the psychotherapy relationship appear to provide some comfort to clients, as do some of the therapeutic components of the relationship (e.g., re-parenting, being seen/witnessed, specialness).

Psychotherapy relationships also have rupturing and resilience components. Participants described multiple situations that were some form of *rupture* within the therapy relationship. Participants indicated that ruptures might be relatively common, which aligns with the findings of other studies and researchers' views that most therapy entails at least one or more ruptures within the course of treatment (e.g., Safran et al., 1990). Participants stated that many ruptures

can be repaired quickly and successfully. Thus, ruptures appear to be inter-related with *resilience*. It is important for the rupture to be addressed soon—and directly (Safran et al., 1990). To do so, the therapist should be willing to ask for potential negative feedback in treatment, as found in other studies (Miller et al., 2010; Miller et al., 2007). In addition, the longevity of the relationship and the level of developed trust also impact the severity of the rupture's impact. This finding aligns with Nuetzel et al.'s (2007) finding that the therapeutic alliance grows over time and allows for greater challenges within the therapy relationship. In some cases, ruptures were not directly related to the relationship, but rather the therapist's choice of treatment. Such instances include: therapist overly challenging the client, treatment rigidity, and a therapist treatment agenda that is disconnected from the client's desires. Yet, sometimes a treatment rupture could be a projection/result of the client feeling stuck in life (as one participant implied).

The commonality of ruptures implicates the importance of resilience and strategies that foster resilience in the psychotherapy relationship. This study would suggest that trust and a deeper sense of knowing the therapist foster the foundation and rebuilding of that relationship. In addition, the longevity/consistency of the relationship might correlate with the sense of knowing the therapist and trust that has developed. When a rupture occurs, therapist transparency regarding thoughts, feelings, and intentions (including meta-communication) regarding the rupture might foster a repair/redevelopment of knowing the therapist and trust—foundational needs. This observation supports the ongoing research and viewpoint of Safran and colleagues (e.g., Eubanks-Carter, Muran, & Safran, 2010; Safran et al., 1990; Safran & Kraus, 2014). In fact, resilience through ruptures has the potential to foster therapeutic change—by addressing interpersonal experiences and patterns (Safran & Kraus, 2014).

The theme *re-parenting/hierarchy-status* implies that not all potential types of therapy relationships are inherently equal. Besides a need to trust the therapist, there might be a significant need to respect the therapist as someone who can provide wisdom, support/reassurance, guidance, et cetera from a position of superior development. In other words, the client might prefer, or experience more benefit, when the therapist is viewed as a higher status individual of maturity/experience. Levitt et al. (2006) found that the professional status of the therapist does aid credibility of the treatment process. This finding is synonymous with Bowlby's (1988) attachment viewpoint that weaker/less experienced individuals seek care from stronger/more stable individuals. A therapist who has coped with similar issues as the client is experiencing might foster greater trust and reassurance within the client.

A discrepancy in status that the client deems as too extreme might be a hindrance to trusting the therapist and the treatment process. In such cases, the client might question whether the therapist can be trusted to adequately witness (comprehend) the client's different experience nonjudgmentally. Examples are when clients perceive extreme differences between themselves and therapists in age, race, gender, sexuality, et cetera. Thus, a process of re-parenting must begin with someone (therapist) who can be viewed as synonymous with a parent-type figure. The therapist's status, stability, and care might be viewed as idealized parental qualities, and thus re-parenting is conceptualized as the process occurring. Levitt et al. (2006) also found that clients consider and compare their therapist as significant others in their lives, including the therapist as a surrogate for another significant person (e.g., parent).

The experience of being *seen/witnessed (attunement)* interacts directly with other themes. This theme is generally synonymous with the validated importance of feeling understood, heard, safe, and supported (Bohart & Tallman, 2010; Levitt et al., 2006; Rodgers, 2003). In large part,

being seen is a foundational component to the development of trust. Conversely, it would be very difficult to develop a disclosing relationship with a therapist without trusting the therapist. The process of developing trust in the therapist, or treatment process, is dependent upon the therapist's ability to witness the client adequately. When a therapist is inadequately witnessing a client, it can result in a treatment rupture. Resilience through the rupture is heavily dependent upon the therapist witnessing the rupture and working on repair. Being witnessed through unconditional positive regard provides a therapeutic quality to the treatment relationship (Rogers, 1957). In addition, witnessing functions as a form of reflection upon the client's patterns of cognition, behavior, and general affect (e.g., Norcross, 2010). Being seen is also a very significant component to experiencing a relationship as special. It is very unlikely that clients would experience a therapeutic specialness in treatment without the therapist's deep witnessing of the client. In summary, being seen/witnessed is significantly inter-related with other identified aspects of a productive psychotherapy relationship.

I am most fascinated, and surprised, by the prevalence of participants reporting a sense of having a *special relationship* with the therapist. A sensation of specialness could be synonymous with feeling prized by the therapist, which has been deemed a significant psychotherapy relationship factor (Bachelor, 1988). Similarly, Levitt et al. (2006) found support for clients needing to feel liked by their therapist. The experience of specialness can entail multiple possible components. For some clients, a shared/witnessed experience, particularly within a minority community/identity, might foster a uniquely special bond with the therapist. An enhanced sense of being seen and understood, due to a similar/shared experience, might foster feelings of specialness within the relationship. Other clients appear to experience unconditional positive regard and empathic support of their personal experience as a unique

(possibly special) form of connection that the individual has not previously experienced. Unconditional positive regard would seem a potent factor in experiencing any relationship as special. It is possible that clients are reciprocating some of the positive regard when they view their therapist and the relationship as special. In other words, clients expressing love and affection toward their therapist might be mirroring the unconditional positive regard that they have received.

Some mental health clientele might experience the unique professional nature of the psychotherapy relationship as something special with its own reasons for reverence. This clinical format and relationship has its own history/tradition that garners respect and trust/faith in some clientele. Although a professional relationship with boundaries, it is arguable that the psychotherapy relationship is a special type of relationship with its own uniquely special conditions. Clients are not necessarily misguided in experiencing the relationship as special, particularly when it is being experienced as therapeutic. A physician who fosters trust and successful medical treatment will often entice feelings of a powerful, useful, possibly special relationship amongst the physician's patients. A correlation between therapeutic effectiveness and specialness could be likely and expected. Eubanks-Carter et al. (2010) have noted that clients commonly rate the therapeutic alliance more highly than do their therapists. This outcome might relate to client beliefs in the specialness of the treatment relationship.

A sense of having a unique, special relationship with one's therapist might play a significant role in the overall therapeutic quality of the relationship. It is possible that the intensity of the experience of significance correlates positively with the therapeutic outcome. The greater the client's feeling of having a special, or unique relationship with the therapist, the more therapeutic the process. Bohart et al. (2002) found that client ratings of therapist empathy

and collaboration correlated the highest with outcomes. More extreme ratings might correlate with experienced specialness. This proposal is highly speculative, but interesting to consider. Similarly, clients apparently take from therapy what they need to improve/heal (Bohart & Tallman, 2010). Might clients feel a need to experience a special relationship, or feel significant feelings within their treatment, for it to be a particularly therapeutic experience?

The *therapeutic components* of the psychotherapy relationship were identified as: *re-parenting/hierarchy-status*, *seen/witnessed by therapist*, *therapeutic qualities of the therapy relationship,* and *specialness of the relationship*. These themes parallel the aforementioned constructs of empathy and the therapeutic alliance as possible common factors in psychotherapy. Participants in this study expressed many positive feelings toward and reciprocated by their therapist. This is similar to the Nuetzel et al. (2007) research, which found a similar result with many positive feelings toward/from the therapist and therapy associated with a strong therapeutic alliance. This study reinforces the findings of Nuetzel et al. (2007), implicating the therapeutic alliance in the participants' productive therapy experience.

The participants of this study provided strong support for the importance of the relationship with their therapist. The literature review addressed the construct *the real relationship* (Gelso, 2011; Gelso & Carter, 1994), which proposes that there is an actual, genuine relationship between client and therapist outside any transference configuration. The results of this study suggest the significance of many psychotherapy relationship-related factors (e.g., knowing the therapist and trusting the therapist) that might overlay with a real relationship within the treatment (i.e., support the real relationship construct as therapeutic).

The real relationship proposes that genuineness and accurate perceptions of the therapy relationship increase as the real relationship develops between client and therapist. In addition,

transference distortions recede during this relationship development process (Gelso, 2011). Participants' report of experiencing specialness within the relationship seems predicated upon a sense of genuineness within the relationship. This hypothesis would potentially align with Rogers' (e.g., 1957) emphasis upon therapist genuineness as a primary condition of therapeutic treatment. In addition, participants expressed an importance to trusting and knowing their therapist. The results of this study indicated that clients believed they were having some type of real and significant relationship with the therapist. The longevity of the participants' treatment relationships might impact the belief that the relationship is real and not transferential. Yet, many participants also discussed experiencing some awkwardness with the transactional nature of the professional relationship. Acknowledgement of the professional nature of the therapy relationship creates a contrary experience to the more personal sensation of specialness. Also, there was some participant acknowledgment that knowledge of the therapist can be based upon projection or inference. Participants reported that much of their feelings regarding their therapist were based upon knowing the essence of the therapist as a person. Such knowledge could be accurate perceptions of the therapist, or a projection/transference response. The special psychotherapy relationship experience would imply that the relationship is also experienced as genuine and real. The importance of the relationship to participants' experience of treatment as therapeutic underscores how much clients want to believe the relationship is at least somewhat real.

The results of this study could be interpreted as supporting Bachelor's (1995) research identifying three types of therapeutic alliance: nurturant, insight-oriented, and collaborative. Participants in this study offered support for each of these forms of alliance within their treatment. Yet, the nurturant form received the greatest support and seemed to be evident, to

some extent, in each of the eight participants' treatment relationships. The nurturant alliance is predicated upon trust in the therapist/treatment (Bachelor, 1995). Each participant in this study reported trusting the therapist and/or treatment process in some form. This study found evidence that the three forms of therapeutic alliance are not separate and contrasting, but rather may co-exist within the same treatment relationship.

To summarize, the significance of the client-therapist treatment relationship has become an acknowledged factor (e.g., common factor) in psychotherapy (e.g., Norcross, 2010; Wampold, 2001, 2015). Although it was not the intent of the research to link the experience of the client's relationship to treatment outcomes, the results of this study supported the significance of the therapy relationship in reported outcomes. This finding aligns with Wampold's (2001) finding that therapists (e.g., personal traits/personality, interpersonal skills) affect the treatment outcome more than does the therapist's treatment methodology.

Limitations of the Study

An initial potential bias concerns the bias of the participants. Given the phenomenological nature of the study, I desired participants who have the capability to reflect upon the therapy experience, and the comfort to discuss it relatively openly. The participants in this study demonstrated a very pro-therapy bias. The bias of the participants does not discount the experiential component reported. Yet, the participant bias concerning the psychotherapy relationship underlying each report contextualizes how the results might be interpreted and applied by therapists in clinical settings. Participants in this study placed a significant value upon the psychotherapy relationship within their clinical work and progress. (Five of the participants are mental health clinicians.) Yet, it was not the objective to recruit participants who place a particularly favorable importance upon the therapy relationship. Although the research questions

were designed to probe the psychotherapy relationship, the participants' reports underlying the significance of relational components to the success of the treatment has its own implications, specifically, emphasizing the therapeutic aspect of the relationship. This bias/emphasis on the relationship might not be as strongly applicable to other mental health clients, who might benefit more from unique treatments. I was surprised by the strength of the pro-therapy responses and believe they represent a skewed and biased sample. Participants might have felt a need to match what could have been understood as the researcher's bias. In other words, a study regarding the psychotherapy relationship implies a researcher interest/bias regarding the topic. Participants might have felt compelled to follow the implied lead of the research questions.

A second limitation is that the results of this study might not be applicable in some treatment scenarios and conditions. For example, treatment of addictions, including treatment with mandated clients, might require a stronger focus upon client behaviors and structured interventions, rather than the treatment relationship. In addition, cognitive approaches to the treatment of anxiety, or an insight-oriented and transference emphasis within treatment offered by some psychoanalysts, might not find the aforementioned results particularly persuasive. Yet, the relationship does provide much of the foundation of most any form of mental health treatment provided by a clinician, and has been supported by meta-analyses (e.g., Wampold, 2001).

Additional limitations to the applicability of the study involve the uniformity of participant demographics, including: the age range of the participants (generally middle aged), participants' socio-economic status (middle class), level of education (bachelors, masters, doctoral degrees), a lack of significant racial and cultural diversity, the longevity of the treatment relationships, and the prevalence of hierarchical psychotherapy relationships (e.g., age gap).

Each of these issues could be significant factors in the findings, and alter the results in different treatment scenarios. For instance, younger clients might develop different types of relationships with therapists (e.g., possibly less collegial/special), as might clinical situations where the client is older than the therapist (e.g., less re-parenting/hierarchy-status). The client's socio-economic, racial, or other culturally-based status might impact the feelings regarding trust, hierarchy/status, and being witnessed. It would seem likely that this is a situation where a significant gap in status would work against the development of a closer treatment relationship. The client might have difficulty trusting that the therapist can sufficiently witness and empathize with the client's experience. One of the participants (P4) was adamant about the importance of having a shared sense of community with the therapist (i.e., a shared minority experience).

A third (possible) limitation is the longevity of the treatment relationships discussed. The longevity of the therapy relationships made the issue of rupture more likely. Ruptures (and possible repairs) increased in likelihood, and possibly significance, the longer the treatment relationship exists as there are simply a greater number of treatment encounters. In addition, a longer treatment relationship would likely increase a client's sense of knowing and trusting the therapist and treatment process. Also, the longer the treatment relationship exists, it would likely increase the possibility of the relationship taking on an aspect of specialness. Whether a relationship is deemed special due to its longevity, or the relationship's longevity is due to it seeming special, is an irreconcilable issue. These are issues that are potential limitations to the study's findings.

Fourth, there are potential limitations to the study directly tied to my bias as a researcher, which is a recognized aspect of phenomenological/qualitative research (e.g., Rodgers, 2003). This is a limitation regarding the inherent bias in phenomenological research design, particularly

regarding the *double hermeneutic* (Shinebourne, 2011). Researcher bias is an often unconscious process. I acknowledge a (conscious) favorable bias toward the role of the psychotherapy relationship within treatment. The nature and design of the research questions, focusing upon aspects of the treatment relationship, inherently biases the nature of the participants' responses and the interpretation of the results. For example, a researcher bias toward therapists' theoretical orientation, rather than the relationship, might have dramatically diminished participants' reflection and acknowledgment regarding the impact of the treatment relationship. In other words, research questions regarding the psychotherapy relationship will not elicit many participant responses emphasizing the importance of the therapist's theoretical orientation or specific treatment interventions. Thus, researcher and participant bias can align and provide skewed results and interpretations. My allegiance to the role/significance of the psychotherapy relationship in the treatment process poses a legitimate risk of bias in the research. Such a bias is inherent within research, and I am aware of its implications for this study. I intentionally included extensive participant quotes to allow the reader the opportunity to assess the validity of the interpretations based upon the data.

Implications & Future Directions

The goal of this study was to create a foundation for future examination of the experiential aspect of psychotherapy deemed therapeutic. The results support the significance of the client's experience of the psychotherapy relationship to the therapeutic quality of the treatment. Participants disclosed many similar experiences within their psychotherapy relationships; some that I determined were sufficiently supported themes (i.e., commonly experienced aspects of the psychotherapy relationship). The identified themes might correlate with the construct common factors.

The findings of this study could be viewed as having tangible uses for clinical work. In other words, the themes have a moderate amount of specificity and clinical applicability. The seven identified themes would benefit from a deeper understanding. The themes might also have some usefulness in turning the therapy relationship into a more cognizant and structured intervention. In other words, a deeper understanding of therapeutic qualities of the psychotherapy relationship could enhance the focus on how to use the therapy relationship within treatment. The psychotherapy relationship could be viewed as its own empirically supported treatment if it incorporates empirically supported therapeutic components. Yet, the nature of this study is not to force the psychotherapy relationship into a narrow constriction, but to broaden understanding and respect for the relationship's therapeutic significance.

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APPENDIX

Interview Questions

Interview Questions

Introductory/Rapport Building Discussion:

(If applicable) How long have you been a therapist?

(If applicable) What brought you to this field/profession?

How long have you been attending therapy with the therapist you will be discussing today?

How did you find/come across this therapist?

Research Questions:

1. Please describe your relationship with your therapist.
2. What positive experiences occurred in the therapy relationship?
3. What challenges (i.e., negative experiences) took place within the relationship (e.g., confusion, annoyance, frustration)?
    a. Why do you think the challenges occurred?
4. Please describe how well you think you know your therapist and why (e.g., therapist use of self-disclosure).
5. Tell me about a change you noticed occur in the therapy relationship—or a change in your impression of your therapist.
    a. Why, what caused it?
6. Discuss whether your therapist recognized aspects of you that you had not previously noticed/were unaware of.
    a. Did the experience change your self-perception?
    b. Did the experience change your perception of the therapy relationship?
7. What would you consider the most therapeutic element of your therapy relationship?