

# Patients' thoughts on effective psychotherapy

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## Bios

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## Abstract

Earlier studies of patients' experiences in psychotherapy identify relationship factors as being significant for patients. Our aim in this study conducted in accord with grounded theory, was to explore in some depth patients' thoughts about what is effective in psychotherapy and thereby increase our knowledge about the process of psychotherapy from a patient perspective. Data were collected in open interviews that provided rich and varied information. Several informants had been in more than one therapy and thus, eight interviews provided data about sixteen psychotherapies. The core concept that emerged from the data was that of the therapist's responsive acceptance. This concept provides an answer to the question "What do patients think is effective in psychotherapy?" If the therapist is responsive and accepting, the mutual interplay between the patient and the therapist becomes productive and collaborative. On the other hand, if responsive acceptance falters, the whole therapy process is at risk.

### *Key words*

Empathy; grounded theory; interviews, unstructured; mental health and illness; psychology; relationships, patient-provider; research, qualitative

According to psychotherapy research, the outcome of a given psychotherapy has several different sources other than the choice of therapeutic method. Factors present in all therapies, for example the therapist's empathy and understanding as well as patient factors, such as motivation and the ability to change, all play a part in therapy outcome (Lambert & Barley, 2002; Sandell, 2004). Upon testing specific methods in randomized controlled trials, all the recognized methods based on psychological theory produce a positive outcome for the patient (Messer & Wampold, 2002; Shedler, 2010). Research also suggests that upon closer examination, significant variations in outcome exist among psychotherapists using the same generally effective treatment (Luborsky, McLellan, Diguier, Woody, & Seligman, 1997). Luborsky et al. in their study found that two outstanding therapists used very different psychotherapy approaches and concluded that there might be quite different paths to a successful outcome in psychotherapy as long as certain relationship qualities are present. In this case, there were strong working alliances; that is, common goals for therapy and mutually positive feelings between therapist and patient.

The significance of an active patient in psychotherapy is highlighted in Bohart's (Bohart, 2006) overview of research on patient participation. He concludes that psychotherapy is useful because it provides patients with a meaningful structure in which they use and transform the therapist's interventions as best they can. This is why, according to Bohart, there is not a direct one-to-one relationship between the therapeutic methods or techniques that are used and the outcomes achieved. A therapist might be able to present the methods for all patients in the same manner according to a manual, but patients as well as their individual abilities to use interventions constructively differ.

According to Norcross and Lambert, (Norcross & Lambert, 2006) numerous studies have concluded that a client's relationship with the therapist is the most helpful component of psychotherapy. It seems that patients, to a lesser extent, attribute progress in therapy to the various psychotherapeutic methods or techniques used.

Therapists, just like their clients, consider the relationship with the therapist most important when they themselves take part in therapy as patients (Norcross & Lambert, 2006). Other positive factors include the therapist's warmth and empathy as well as working with transference and counter-transference (the enactment of unconscious aspects in the relationship between patient and therapist). Studies of health-care professionals who have been in psychotherapy themselves show that complications in the therapeutic relationship such as an emotionally absent therapist, a seductive therapist or an inadequate matching of patient and therapist, may be

potentially harmful (Norcross & Lambert, 2006).

Elliott and James (1989) summarize what clients perceive as helpful factors. These factors can be divided into two broad categories; one that contains “Interpersonal/Affective Aspects” such as “Facilitative Therapist Characteristics” and “Client Unburdening” while the other contains “Task/Problem Solving Aspects” with the sub categories “Self-Understanding” and “Perceived Therapist Encouragement for Gradual Practice”. The authors consider clients’ views and perceptions important because the clients’ experience is what psychotherapy aims to influence and change. They also contend that an important part of therapist skill is to be able to understand client experience.

Some qualitative studies of psychotherapy from a patient perspective have been made. In one study of young adults, Lilliengren and Werbart (2005) describe curative factors such as “An atmosphere of acceptance and respectfulness”, “Expressing, reflecting and labeling thoughts and feelings” and “Having time and continuity”. Among the therapeutic impact factors were “New relational experiences” and “Learning new ways of thinking”.

Thus, earlier research suggests that patients take an active part in psychotherapy and have rather consistent views of what is helpful, based on their experience and their perspective of treatment. The relationship factors, or rather the interactions between patients and therapists are consistently valued by patients across many studies. Relationship aspects in psychotherapy research, however, often appear as “properties” of a therapist or of a therapy rather than as the outcome of specific reciprocal actions that constitute a certain relationship (Lundh, 2008). Psychotherapists, according to Lundh, perform specific acts in order to establish a positive and useful relationship with the patient by means of “relational techniques”. It might prove valuable, as a complement to other research that focuses on the theoretical and technical aspects as seen from the therapist perspective, to see these kinds of actions that lead to a positive therapy relationship from the point of view of an active patient. A further, in-depth exploration of this interaction could tell us more about how psychotherapy brings about change. In what way are relationship and interaction factors important to the patients and how do these factors manifest and interact in the therapeutic process? This interview study is aimed at contributing to understanding the patient perspective of what needs to be done and how it needs to be done in successful psychotherapy.

### *Aim of the study*

Our aim in this study is to explore patients' thoughts on what is effective in psychotherapy and thereby increase knowledge about patients' perceptions of the psychotherapy process

### *Method*

Data collection, sampling procedures and analysis in this interview study were conducted according to grounded theory (Glaser, 1998, 2007; Strauss & Corbin, 1998). Grounded theory was chosen since it is a methodology designed for exploration and conceptualization of phenomena. A qualitative approach to psychotherapy research offers the benefits of capturing complexity and nuances as well as the advantage of giving a voice to subjective experience (Thorne, 2011). Glaser provides four criteria (Glaser, 1998) for a solid grounded theory and these were used as guidelines. The grounded theory should (a) *work* to explain behavior that is studied, (b) *fit* the data it claims to conceptualize, (c) be *relevant* to the persons in the studied field and (d) be open for development and *modifiable*.

Grounded theory has some distinct methodological features that distinguish it from other qualitative and quantitative methods. The sampling procedure is iterative; data are collected and analyzed alternately. A starting point is chosen where rich data relevant to the phenomenon is expected to be found; eventually, theoretical sampling begins and data collection is guided by emerging concepts and the theoretical framework.

## Procedure

Informants, people who have experienced individual psychotherapy as an adult with a certified psychotherapist, were recruited by advertising in local newspapers. In the advertisement, potential informants were invited to contact the researcher either by telephone or by e-mail. At first contact, additional information about the study was given and some background data were collected. The background data collected were: informant age, gender, address and telephone number, therapist(s) name(s), length of therapy, frequency of sessions, time elapsed since end of therapy, planned or spontaneous ending to therapy, private practice therapist or public health care therapist and whether or not the patient was satisfied with therapy. The name of the therapist was used to verify if the therapist was certified by the Swedish National Board of Health and Welfare (SNBHW) and to ensure a sample of therapies with a diversity of therapeutic orientations. It was understood by all informants upon first contact that they were to be contacted again, eventually, either to set an interview date or to inform them that they had not been chosen to participate in the study. Furthermore,

the background information we received was reviewed in terms of the exclusion criteria at this point. Exclusion criteria were: (a) A non-certified therapist, (b) an informant who had formerly been a patient of the interviewer (first author) and (c) informants currently in psychotherapy or planning to begin therapy in the near future.

## Sample

Twenty people responded to the ad and seven were excluded on the basis of the aforementioned criteria. Of the remaining 13 informants, eight were interviewed. Several informants had been in more than one therapy and thus, eight interviews provided data for 16 psychotherapies. Informants were chosen as suitable for the study on the basis of “variation”. The sample size was decided by the saturation of the core concept of the emerging grounded theory. The specifics of the interviewed informants are presented in table 1.

Table 1.  
Sample background data.

Nr	Age	Patient gender	Therapist gender	Nr of ther	Therapy length	Frequency of sessions	Time elapsed	Ending	Therapist setting	Satisfaction
1	67	female	female	2	10 sessions	unknown	20 years	time-limited	private	unsatisfied
			female		1.5 years	once weekly	2-3 years	mutual agreement	private	unsatisfied
2	58	female	female	1	7 years	once weekly, eventually once monthly	21 years	mutual agreement	private	satisfied
3	45	female	male	3	1 year	once weekly	12 years	mutual agreement	private	undecided
			male		3.5 years	once weekly	5.5 years	mutual agreement	private	undecided
			female		2 years	once weekly	2 years	therapist ended	private	satisfied
4	43	male	female	2	4 sessions during 6 months	unknown	3 years	time-limited	occup. health	satisfied
			male		3-4 months	once every other week	1 year	mutual agreement	private	satisfied
5	50	female	female	1	2 months	once every other week	9 months	patient quit	public	unsatisfied
6	54	female	female	1	9 months	once weekly	12 years	time-limited	private	satisfied
7	62	male	female	4	1.5 years	once weekly	20 years	time-limited	private	satisfied
			female		2.5 years	once weekly	10 years	patient quit	private	unsatisfied
			female		2 years	once weekly	1 year	patient quit	private	satisfied
			female		7 sessions	unknown	<1 year	mutual agreement	private	satisfied
8	42	female	male	2	6 months	once weekly, eventually sparser	9 years	patient quit	private	undecided
			male		1.5 years	once weekly	5 years	mutual agreement	private	satisfied

Note. The informants are numbered in the order they were interviewed. Nr = Informant number; Nr of ther = number of therapies; Time elapsed = time elapsed since the end of therapy; Ending = what caused the ending to therapy; Therapist setting = private practice therapist (paid by patient, employer or contracted by public health care system), occupational health service or public health care therapist; Satisfaction = whether or not the patient was satisfied with the therapy.

## The interviews

The interviews lasted between 27 and 52 minutes and were conducted as an open dialogue (Kvale, 1997). The interviews had one initial question, “What do you think was effective in the psychotherapy or psychotherapies that you have been in? If you were not satisfied with the therapy, why was that?” When the informant had experienced more than one psychotherapy, data were collected about one therapy at a time. Thereby, specific information about each therapy was received and generalizations across therapies by the informant avoided. The interview approach was supportive and the informants were able to create a narrative without much interruption by the interviewer. Sometimes the interviewer introduced a theme in order to saturate emerging concepts; sometimes the interviewer directed attention to an area not fully explored.

Recorded interviews were transcribed as closely to verbatim as possible. Quotes from the interviews are translated from Swedish to English and have been edited into a readable format.

## Analysis

Text documents were analyzed using computer software, QSR N6, designed for qualitative studies. Statements made by informants were coded statement by statement. The codes were gradually grouped into both categories and sub-categories, and eventually, a core concept was formulated. When the core concept was saturated, a theory grounded in the data was developed. The interviews, transcription and coding were carried out by the first author. The three authors performed the continuous analysis and elaboration of concepts collaboratively.

## Ethics

The Regional Ethical Review Board in Uppsala, Sweden has approved this study (Dnr 2010/113).

### *Results*

The core concept developed from the data is *The therapist's responsive acceptance*. What needs to be done in effective psychotherapy is according to the patients mainly related to the therapist's responsive actions. How it should be done effectively is on the other hand mainly related to the therapist's presence and personal qualities;

the therapist's ability to respond to the patient without fear and hesitation, in a non-judgmental manner. The patients benefit from therapy in two ways according to the patients in this study; they learn from the therapists and they experience new dimensions in personal interaction when interacting with the therapists (table 2).

Table 2.

The therapist's responsive acceptance; categories, sub-categories and quotes as examples from the data.

Category <i>Sub-category</i>	Short quotes as examples from the data
<b>The therapist's actions</b>	
<i>Specific interventions</i>	"I often talk more on an analytical level, disconnected from the feeling (...) if I explore feelings in the body [my body sensations] I think thoughts that are connected to my feelings so I'm more able to express what I'm experiencing"
<i>Questions and comments</i>	"I don't know exactly how it happened really but the conversation [the dialogue] made me start reflecting and I dared to explore my feelings"
<i>Advice and guidance</i>	"I didn't have to feel afraid because I had gained knowledge about how they [the panic attacks] worked"
<i>Challenge to behaviour and conclusions</i>	"and it scares you and then you get even more insecure (...) if you get things thrown at you (...) if you get something negative in return then it gets more difficult"
<b>The therapist's robust being there</b>	
<i>Upholding a structure</i>	"She sat there for me once a week for about fifty weeks"
<i>The therapist as a person</i>	"I never had the slightest inkling that she was doing something with me out of a personal need"
<b>The patient's benefits from therapy</b>	
<i>The patient learns new skills</i>	"and then I got to learn to interpret my signals"
<i>The patient makes new experiences with the therapist</i>	"to heal this, not having been properly handled in my childhood"

## The therapist's actions

*Specific interventions.* The patients expect the therapist to make an intervention that the patient finds useful and well-timed. If the patient is unwilling to comply with the demands of the technique for any reason, the patient thinks that the therapist should reconsider method or technique; the patient needs something else. Thus, the timing of specific interventions is crucial in terms of whether or not patients will find them useful. Specific interventions or therapy



techniques are not “right” or “wrong” according to the informants; they are appropriate or inappropriate, depending upon the patient’s needs, the situation and the context.

The patients in this study mention several useful specific “tools” used by the therapists. Among them are both traditional psychoanalytic techniques such as lying on a couch or interpreting dreams as well as cognitive-behavioral techniques such as exposure training as homework. Creative techniques such as art therapy or music therapy are considered as effective by some patients with experience of such methods. The encouragement to take a moment to close one’s eyes and turn inward, exploring body sensations before speaking, was also mentioned as an effective intervention.

“(…) I often talk more on an analytical level, disconnected from the feeling, then these thoughts aren’t at all ... they aren’t connected to what I feel, but if I explore feelings in the body [my body sensations] I think thoughts that are connected to my feelings so I’m more able to express what I’m experiencing.”

It is commonly reported that specific techniques help the patient to “open up”, get in touch with memories, feelings and experiences that are otherwise hard to get access to and verbalize directly.

*Questions and comments.* There is a continually ongoing dialogue during or between more specific and well-defined interventions by the therapist. The need to talk or to verbalize is reportedly strong in psychotherapy patients; these patients say that putting words to their thoughts and feelings is effective treatment in itself. The therapist is perceived as helpful when asking questions and commenting on what patients say, thereby helping patients think for themselves, sort through their thoughts and connect fragments to a coherent narrative. It is also a way for patients to acknowledge and work through their feelings in what they accordingly perceive as a spontaneous dialogue.

“And I don’t know exactly how it happened really but the conversation [the dialogue] made me start reflecting and I dared to explore my feelings ... I didn’t shut down when this unpleasant feeling came but I dared to go into it more after the sessions and during the sessions and I dared to let out, I cried during therapy and things like that, so I dared to thaw, so to say.”

“It was by talking, laughing, crying and dreaming.”

Therapeutic interview techniques thought to aid the patients include offering a new context for or a new interpretation of what the patient talks about. This might reveal new or hidden meanings in the material that the patient can elaborate on further.

“What I think has been the most meaningful to me is not just the acceptance that my various interests are kind

of acceptable, but in fact that they possibly are an expression of the same thing and that in the end it makes sense (....) that they aren't that disparate these interests of mine, no they very much belong together."

*Advice and guidance.* Patients also think positively of advice and guidance pertaining to how they can handle themselves in different life situations. This also goes for information from the therapist regarding, for example, the nature and process of anxiety, grief or child development.

"Because she did it that way [explained the physiology of panic attacks] I felt that I didn't have to be afraid any longer when I felt one of those attacks, I didn't have to feel afraid because I had gained knowledge about how they worked."

*A challenge to behavior and conclusions.* Patients' thoughts on what is effective in psychotherapy include reflections on the pros and cons of frustration and discomfort. Experiences considered negative by the informants include, for example, feeling criticized by a "fault searching" therapist, having criticism "thrown at you", feeling "exposed" and vulnerable. On the other hand, when a patient feels understood, trusts the therapist's goodwill and believes that the therapist tolerates the patient's flaws and shortcomings, frustrating interventions can be thought of as helpful feedback, not as criticism.

### **The therapist's robust being there**

*Upholding a structure.* Therapists are expected to have a nice room to work in, to keep appointments and to arrange for regular sessions and generally uphold the agreement made between patient and therapist. Informants who have been in open-ended therapies are satisfied with the arrangement and the time frame as are informants who have been in time-limited psychotherapy. It is the therapist's ability to create and uphold the treatment structure as well as its consistency and predictability that patients describe as safe, trustworthy and helpful.

"She sat there for me once a week for about fifty weeks."

*The therapist as a person.* Patients also think about the personal characteristics of the therapist and their private lives insofar as they get to know something about private aspects of their therapists. These perceived personal qualities are mixed with patients' thoughts about therapists' professional competencies and are equally important for the development of trust. Patients think that an effective therapist is a non-judgmental, respectful and honest person, sensitive to the patients' needs, focused on the task and resilient as a person.

"Nothing was peculiar to her (....) yeah, there was no judgment (....) yeah, exactly, I could say anything I wanted and everything was met with respect."

Patients are also observant of whose needs are in focus and think that the therapists' needs better be left out of therapy.

"I never had the slightest inkling that she was doing something with me out of a personal need."

Patients do not find everything the therapist says or does useful. If the therapy is generally satisfying, the patients do not pay much attention to small errors or transgressions by the therapist. They "shrug their shoulders" and move on, accepting that nobody is perfect.

"I took notice of it [the therapist passing unfair judgment] and I forgave her."

On the other hand, if a therapist, for example, encroaches on the patient by disclosing something of a private character or appears selfish or unforgiving, patients find that this can stay with them as something to brood upon for a long time as the therapy moves on.

"The small things don't matter so much more than maybe, or they didn't matter that much, but I have thought a lot about this last thing [the therapist disclosing problems of her own]."

In some therapy situations, patients report feeling hurt or neglected in a way that causes them to consider giving up on the therapist and the therapy. Therapists who are continually perceived as authoritarian, selfish, weak or indifferent seem to be the most difficult for patients to tolerate. Patients can find themselves encroached upon or rejected but sometimes stay in therapy for a while despite this. In such cases, they report losing trust in the therapist, disengaging from the therapy process and withdrawing emotionally.

"I'm tired of being treated like an immigrant the whole time ... I would like to be like a regular patient; we all have different problems, different backgrounds."

## The patient's benefits from therapy

**The patient learns new skills.** Patients frequently refer to the benefits of psychotherapy as having "learned" something new. By this they mean, for example, learning to respect their own limits and limitations, to identify and differentiate different feelings, to harbor and contain strong impulses and feelings and to identify those needs which are their own and those that are the needs of others. Caring for oneself and the right to care for oneself is thought of as having been learned in psychotherapy as is receiving help and the right to accept oneself as one is, as a person. Many of

these lessons are thought of and described in terms of what the therapists could and did allow and accept. It was from the therapists that the patients learned to do for themselves, allow themselves and accept themselves. Learning, in this sense, also includes integrating new skills with old patterns and patients provide examples from life and relationships outside of therapy that illustrate how they think they have changed and are able to use what they have learned, for example, the improvement of close relations.

“Of course, and then I got to learn to interpret my signals and see what needs you have and what needs you neglect in yourself.”

**The patient makes new experiences with the therapist.** Patients make new experiences in therapy that they think enable them to explore new and maybe unknown areas of life and personal expression. Psychotherapy is an opportunity to be part of a helpful relationship that they often have not had access to in their childhood and earlier life. New areas of life can also be introduced by therapists through assigning different tasks as homework for the patient. Homework often challenges the patient to face old fears and anxieties and encourages the patient to behave in new ways or enter into situations that have been previously avoided. Therapists are reported as encouraging patients to explore new possibilities. In regular dialogue, as well as in planning and evaluation of homework, therapists convey belief in the patients’ ability to grow as well as acceptance and understanding.

“(…) to heal this, not having been properly handled in my childhood, I can heal it together with the therapist when I feel there is someone who really understands me and doesn’t make these judgments, good and bad, wrong and right (…) but can withstand the need to classify all the time.”

“(…) sometimes it felt like I was a little girl sitting there and it was ok to cry with my therapist or she said things that maybe in fact my mother should have said to me when I was a child (…) so after this I might say that it’s easier for me to show myself as vulnerable to others, that’s also an effect.”

New experiences with the therapist considered to be effective by informants are sometimes not planned, or may even come as a surprise to both the patient and the therapist, such as when technical errors occur. When therapist and patient manage to contain a mistake by the therapist and sort it out, it is thought to be of great value to the patient, especially if and when the incident has an implicit meaning in the patient’s life history that can be understood and worked with. Then there are instances when the patient thinks it is best to go against the therapist in order to benefit from the situation; these are situations in which independence issues are at stake. The patients need the therapist to tolerate this type of distancing or disagreement in order to leave the conflict strengthened. Even long after therapy has ended, patients think about these situations of conflict or disagreement with their therapists and seem proud and

satisfied that they stood their ground and maybe even disregarded advice from the therapist.

“(...) she didn’t want me to continue on, in her opinion we were done [therapist ending therapy] but at least I got to tell her that I was disappointed with her, that I could find the words to say that.”

## A process model

*The therapist’s responsive acceptance* is at the core of what patients in this study think is effective in the psychotherapy process. *Responsiveness* is a word used by one of the informants that conceptualizes the therapists’ sensitivity to patients’ needs and emotional states and their ability to respond adequately and promptly to them. *Acceptance*, which is also a word used by an informant, constitutes a non-judgmental and supportive atmosphere. It is defined by a therapist’s attitude of tolerance, benevolence and understanding. When acceptance is at hand, patients report feeling free of shame and guilt.

The therapist’s responsive acceptance informs *the therapist’s actions* and permeates *the therapist’s robust being there* as the patient experiences them during the therapy sessions. In an emotionally loaded interaction like psychotherapy, the therapist more or less inevitably also makes mistakes. The destinies of these mistakes are to a large extent decided by the accumulated experience of the patient with the therapist. There is either trust enough in the therapist’s robustness and benevolence to continue the effective interaction, or the perception of a weak or hurtful therapist dominates, eventually causing the patient to drop out of therapy.

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## Discussion

The perhaps most obvious clinical implication of this study is that psychotherapists need to show a

deeper interest in how they are perceived by their patients in therapy. The therapist should not however expect the patient to initiate the dialogue about how the therapy proceeds. Patients are reluctant to risk the continuation of therapy by making a conflict with their therapists explicit, up till a point of no return when they quit therapy by their own initiative. This tendency of patients to deference to their therapists is found also in other qualitative studies (Rennie, 1994).

Another important result of this study is the patients' focus on the therapists' reactions to them; the therapists' amount of responsivity and acceptance. For the clinician responsive interaction means that the use of the different therapeutic techniques needs to be modified and moderated according to the patient's ability and state of mind and the context of their relationship (Krause & Lutz, 2009; Stiles, Honos-Webb, & Surko, 1998). This moderation of the therapeutic process as a continuous negotiation between therapist and patient is essential to establish and re-establish the therapeutic alliance during the course of any psychotherapy (Bordin, 1979; Safran, Muran, Wallner Samstag, & Stevens, 2002). Feed-back research as well as research concerning working alliance and the repairing of alliance ruptures point to these interactive aspects of psychotherapy as well as to the need for psychotherapists to constantly develop their "context awareness" (Claiborn, Goodyear, & Horner, 2002; Safran, et al., 2002). Therapists need to be able to see themselves from the "outside" and their patients from "within".

Research have also shown that there is an optimal level of adherence to procedures, rather than a simple linear relationship between adherence and therapeutic outcome (Barber, et al., 2006). In the event of an impending alliance rupture it is seldom wise for the therapist to continue the line of intervention with "more of the same" (Coutinho, Ribeiro, Hill, & Safran, 2011; Safran, et al., 2002). The idea of optimal levels of adherence is covered also by the informants in this study. Feeling accepted and safe, patients report benefitting greatly from a variety of psychotherapy approaches as long as they are fine-tuned interventions. They learn new ways of understanding themselves and others and make corrective experiences in relationship with their therapists; they are listened to and taken seriously, sometimes for the first time in their lives.

The informants in this study also shed light on another important aspect of working alliance research; the intimate relationship between the working alliance and the therapeutic process. Taken out of its original psychoanalytic context the concept of working alliance tend to be alienated from the technical aspects of

psychotherapy as well as from the concept of transference. In psychoanalytic theory (Etchegoyen, 1991) the working alliance and the “real” relationship between therapist and patient are inseparable from the transference. Thus, all negative feelings and conflicts in psychotherapy may not simply be alliance ruptures as is presumed in some research (Coutinho, et al., 2011). Instead some of these conflicts need to be addressed therapeutically as natural parts of the process. In the working alliance the patient identifies with the accepting and empathic therapist and with the therapist at work, observing, reflecting and interpreting. When the therapist at work is perceived as competent, benevolent and robust by the patients in this study the working alliance is strong and durable. The patients can endure emotional pain and forgive almost any mistakes. When the therapist repeatedly fails to safeguard the psychotherapy process, the cooperative efforts of the patient, that is the working alliance, subsides and the patient may lose faith in both the therapist as a person and in the treatment. Therapists that the informants consider as robust are also therapists with the ability to contain (Bion, 1984) countertransference feelings. Working through issues in the transference without countertransference interference, is mentioned by the patients as one of the factors that contribute to the benefits of psychotherapy.

The fact that patients are sensitive to changes and fluctuations in their therapists also points to the need for a thorough examination of personal qualities, integrity and emotional robustness when selecting candidates for psychotherapy training. Nothing in this study, however, suggests that technical skills are of less significance than the personal qualities of the therapist. Rather, this study suggests that patients think of psychotherapy as a “seamless integration” of the therapist’s personal qualities and technical skills. The challenge of psychotherapy training is to integrate the learning of technical skills with personal development in order to produce efficient therapists. For psychotherapy research, this means that, at least from a patient point of view, studying psychotherapy techniques separately from the therapist-patient interaction may be somewhat misleading.



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