

What Clients Find Helpful in Psychotherapy: Developing Principles for Facilitating Moment-to-Moment Change

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Clients who had completed psychotherapy were interviewed about the significant experiences and moments they recalled within their sessions. These interviews were analyzed using grounded theory, creating a hierarchy of categories that represent what clients find important in therapy. From the hermeneutic analysis of the content of these categories, a list of principles was constructed to guide the moment-to-moment process of psychotherapy practice. The authors respond to the call for qualitative outcome studies and demonstrate how qualitative psychotherapy research can lead to empirically derived principles that then can become the foundation of future research and psychotherapy integration efforts.

Keywords: psychotherapy, principles, integrative, grounded theory, psychotherapy process

It is difficult to determine what is significant to clients about their therapy experiences. Although some psychologists question the extent to which clients are able to provide valid information about their experiences (Howard, 1990; Kagan, 1990; Nicholson & Hogan, 1990; Nisbett & Wilson, 1977), our profession does seem to care about clients' assessments of their psychotherapy experiences and seek their feedback both clinically and in research endeavors (e.g., Kotkin, Daviet, & Gurin, 1996; Seligman, 1995). Psychotherapy outcome studies typically evaluate client change using self-report measures to assess changes in symptoms (e.g., Beck, 1972; Derogatis, 1977; Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988). Clients' reported perception of change thus guides our treatments, informs our theories, and ultimately sustains our profession by creating a continued demand for our services.

A variety of challenges to this mode of assessment, however, have been put forth. There are critiques that these measures do not assess types of change that are prized across therapy orientations and, as such, generate poor assessments of humanistic and psychodynamic approaches (Bohart, Leitner, & O'Hara, 1998; Elliott, 1998; Levitt, Stanley, Frankel, & Raina, 2005; Mander, 2000; Wallerstein, 2001). In addition, certain outcome measures have been found to privilege psychotherapy orientations most associated with their theory of origin (e.g., Oei & Free, 1995), and measures do not appear to be selected to assess the different goals of the therapy orientations being evaluated (Levitt, Stanley, et al., 2005). Finally, the research developed by using outcome measure

assessments has been criticized, as it rarely provides information on what therapists should do at the level of moment-to-moment process within the psychotherapy session and rarely assesses what symptom changes or their absence mean in clients' lives (e.g., Rennie, 1994b).

As a result, some psychotherapy researchers have been calling for qualitative approaches to inquiry as one path through which researchers can develop understandings of this in-session interpersonal process of change. They argue that these methods allow a focus on subjectivity that is appropriate for understanding therapy and allow clients to articulate and contextualize elements of change that appear to be important in their own experience (e.g., McLeod, 2000; Rennie, 1994b). Of note in this literature is the research examining significant psychotherapy moments.

The Significant Moments Literature

This significant moment paradigm, largely developed by Robert Elliott, has been used to heighten researchers' understanding of specific events or therapy processes. A broad spectrum of themes have been examined in interview studies, including clients' descriptions of moments of misunderstanding (Rhodes, Hill, Thompson, & Elliott, 1994), insight events (Elliott et al., 1994), helpful events (Paulson, Truscott, & Stuart, 1999), problematic reaction points (Watson & Rennie, 1994), and helpful therapists' interventions (Elliott, James, Reimschuessel, Cislo, & Sack, 1985). Significant events research has been conducted on both client and therapist perspectives (e.g., Elliott & Shapiro, 1992; Martin & Stelmachzonek, 1988), and a task analytic study of significant moments (Stiles et al., 1990) has generated problem resolution scales.

Within the body of research that examines descriptions of significant moments in psychotherapy, a variety of analytic methods have been used. Elliott (1989) developed "comprehensive process analysis" for the purpose of analyzing therapy sessions by coding the text using a variety of coding systems. Using a different approach, Paulson et al. (1999) had client-participants categorize statements from their interviews on what was helpful in therapy.

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Other researchers have matched clients' descriptions with categorical systems developed from the analysis to assess what works in psychotherapy (e.g., Lietaer, 1992; Martin & Stelmaczek, 1988; Wilcox-Matthew, Ottens, & Minor, 1997).

Across the significant moment and other qualitative research studies, the factors identified as significant have differed. For instance, a review of prior literature by Elliott and James (1989) organized the research on clients' psychotherapy experiences in the following nine categories: clients' intentions, feelings, style of relatedness, style of relating, central concerns, therapists' intentions, therapists' characteristics, therapeutic impacts, and helpful aspects of therapy. Other researchers have identified similar elements of therapy but often using different labels. For instance, different researchers have identified processes of reflexive self-examination as a central function of the psychotherapy process (e.g., Martin & Stelmaczek, 1988; Rennie, 1992), and others have identified clients' processes of deference or covert resistance (Heppner, Rosenberg, & Hedgespeth, 1992; Levitt, 2001; Rennie, 1994a). Although this literature has brought to light many important factors in therapy, they tend not to be contextualized within the therapist–client interaction and not to convey *when* an element might best be used or privileged over another element, which was the focus of the present article.

Study Objectives

In the present study, we advanced this literature by using interviews on significant moments to identify not only components of psychotherapy experience but also principles that can be used to guide the moment-to-moment process of therapy. In order to achieve this aim, clients were interviewed about their retrospective recall of significant moments, and these interviews were analyzed, producing a grounded theory hierarchy. Then, using a hermeneutic process of analysis, principles were identified to encompass and reconcile clients' reported and sometimes contradictory experiences in therapy.

Method

Participants

Twenty-six participants interviewed for the study varied in terms of their gender (6 men and 20 women), age (mean age = 29.23, $SD = 13.90$, range = 18–79), careers (including blue collar, white collar, and student occupations), and presenting problems (including concerns such as familial issues, assertiveness, depression, rape, anxiety, anger, attention deficit/hyperactivity disorder, and eating disorders). These differences within participants are a strength in grounded theory approaches as researchers seek to diversify sources of information to develop results that are as rich and encompassing as possible (Glaser & Strauss, 1967).

Participants were involved in individual psychotherapies that were, at a minimum, eight sessions in duration. With the exception of 1 client who reported being in therapy for 10 years, the therapies were under 1.5 year in length, ($M = 15.80$ months, $SD = 23.54$ months, range = 1 month–10 years). All clients completed their course of psychotherapy 2 months prior to the interview, allowing time to reflect on and assess their experience, but not greater than 1 year prior so that details of their experience remained accessible. The mean length of time since completion was 6.64 months ($SD = 3.13$, range = 2–12 months).

To facilitate a sense of comfort about disclosure, participants were not asked to disclose the identity of their therapist or the context in which they practiced, and most could not describe their therapists' orientation or

professional degree. The researchers surmised, however, from the descriptions of gestalt chairing exercises, assertiveness training, early childhood exploration, cognitive thought records, pillow-beating, hypnosis, and paraphrasing that therapies ranged across major therapeutic orientations.

Procedure

Recruitment. Twenty-six client-participants were recruited for this study through advertisements in newspapers and the offer of extra credit in psychology classes. The advertisements asked for adult clients who had completed psychotherapy within the last year and who could describe their "experience of psychotherapy or any significant events that [they] recall from [their] psychotherapy." Clients were screened using a brief telephone interview to ensure that they were comfortable with the purpose of the interview and fulfilled the participation criteria.

Interviews. Clients were interviewed for approximately 1.5 hr during in-person meetings with Heidi Levitt. The interviews were semistructured and exploratory in nature. The main questions asked clients to describe whatever was significant or important to them about their general psychotherapy, specific psychotherapy moments, and therapeutic relationship. Additional probes were used to further clarify the meanings in their responses. They were told that "significant" did not carry a positive or negative valence. Interview questions were designed to promote discussion in a nonleading manner.

For descriptive purposes, clients were given the short form of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and a modified version of some outcome-related questions from an outcome questionnaire (Strupp, Wallach, & Wogan, 1964). Clients in this study reported moderate to strong alliances with their therapists on the WAI (on a 7-point scale ranging from 1 [*never*] to 7 [*always*] $M = 5.60$, $SD = 0.89$, range = 3.75–6.83). When asked on the outcome questionnaire how much they changed as a result of therapy, on a 5-point scale ranging from 1 (*not at all*) to 5 (*a great deal*), the mean score was 4.15 ($SD = 0.92$, range = 2–5), suggesting considerable change.

Adaptation of grounded theory methodology. A grounded theory approach was used in the present study (Fassinger, 2005; Glaser & Strauss, 1967) within a methodological hermeneutic epistemological framework (Rennie, 2000) to analyze the transcribed interviews. This approach to qualitative analysis assesses rigor from the standpoint of more constructivist criteria as opposed to objectivist criteria. For instance, these researchers are likely to subject an object of study to interpretation in conjunction with the interpretative process itself to assess bias in their approach (e.g., through processes such as note taking, self-reflection, or memoing). In addition, this approach is likely to augur more faith in analyses that are conducted by a few researchers who are deeply immersed in a set of data (via intensive study and lived experiences) than in analyses that are conducted by less engaged observers who can objectively agree on a point.

Grounded theory methods have been advanced in psychological research as a way to explore subjective experience (e.g., Rennie, 2000). It is an inductive process in which a researcher is guided by the analysis of data to facilitate the development of theory of phenomena grounded in empirical observation. This approach allows investigators to identify patterns within reports of complex experiences, such as psychotherapy, and to develop new understandings without constraint by a priori hypotheses. Unlike research using outcome measures incorporating preset questions, this method facilitates the exploration of what clients experience as leading to or detracting from their psychotherapy outcome.

In this process, the two secondary investigators each divided 12 transcripts into units that each contained one main idea, called "meaning units" (see Giorgi, 1970). Using a two-line margin of error in unitizing the interview transcripts, these investigators obtained a percentile agreement rate of .84 from the segmentation of 111 units from two randomly selected transcripts (Cohen's $\kappa = .71$), demonstrating a high level of consensus in their method of identifying meaningful units. Following the procedure developed by Rennie (e.g., Rennie, 1992), once a unit was established, it

was studied to ascertain the meaning “contained” within the unit and given a label close to the wording in the transcript.

Using a process of constant comparison, the three researchers compared the meaning units with one another and created categories to reflect the commonalities identified. As the data can be sorted into as many categories as are relevant to its content during this analysis, the categories are not independent of one another. Once initial-level categories were formed, these categories were compared with one another, and higher order categories reflected the commonalities therein. Repeating this process with each layer of categories, a hierarchical structure of categories was developed. A core category was conceptualized, representing the connection between categories at the apex of this hierarchy. The computer program Nudist 4.0 facilitated this sorting of text.

Data collection continued until the categories were “saturated,” that is, until further categories that added to or changed the meaning of the analysis did not appear to be forthcoming. In this study, no categories were generated within the analyses of the last five interviews beyond the first, most concrete, level of the hierarchy. This saturation suggested that the hierarchical model was comprehensive.

Throughout this process of analysis, the authors met weekly for 8 months. Memoing was used throughout the analytical process to record shifts in hypotheses and conceptualizations in an attempt to record and bracket theories that developed during the analysis and to restrict the influence of a priori ideas upon the analytic process.

Credibility checks. Checks on investigators’ understanding were conducted in three forms in this study. First, clients were asked a series of questions to determine whether their experience was fully represented at the end of each interview (e.g., “Was there anything that wasn’t asked about that feels significant about your therapy experience?”). This process provided the opportunity to collect information that may have been omitted.

A second check was attempted by mailing a summary of the results to participants and requesting feedback. Because of the lengthy transcription of the data (1 year) and analytic process (8 months) required by this intensive method and the mobility associated with a university-city, however, half of the envelopes were returned unopened. Only 2 participants responded, although they declined to complete the questions that would have aided in the further development of the hierarchy.

As a third credibility check, the investigators used a method of consensus while making coding decisions. As Heidi Levitt conducted the interviews and had more extensive experience conducting psychotherapy, however, her lived experience was privileged in cases of differences in interpretations between investigators, as is in keeping with a hermeneutic approach to analysis (see Rennie, 2000). Because of power differences between the primary investigator (a faculty member) and the secondary investigators (graduate students), the primary researcher encouraged the expression of differences of opinion overtly and worked to include different perspectives within the hierarchy as opposed to representing only one interpretation of a unit (for instance, a segment of text might be coded as representing both the importance of empathy and trust if it held both implications). Irreconcilable conflict did not occur. In terms of background, the primary author, Heidi Levitt, practiced an integrative theoretical approach to psychotherapy with a constructivist emphasis and had received training and had practiced using humanistic, cognitive, and psychodynamic approaches. She has expertise in qualitative methods, has published extensively using grounded theory methods, and teaches a graduate-level course focused on qualitative research methods. Mike Butler and Travis Hill were graduate students, one who had an integrative orientation most influenced by psychodynamic, systems, and humanistic approaches and another who had yet to develop his psychotherapy orientation.

The development of principles about psychotherapeutic process. Principles to describe the main patterns of interaction were developed from the hermeneutic analysis of the hierarchy that was formed (see Levitt, Neimeyer, & Williams, 2005, for a discussion of the term *principles*). While

grounded theory methods can identify processes, the hierarchical structure tends to lend itself to the production of typologies rather than to context-sensitive or “if-then” principles. In contrast, hermeneutic methods can be more apt for forming principles for practice at the moment-to-moment level because of their attunement to contextual and covert factors in psychotherapy.

In a hermeneutic analysis, patterns are identified, and the studying of these patterns leads to the identification of implicit meanings within a text (in the present study, within the hierarchy developed in the grounded theory analysis). The process of making judgments is examined, and investigators attempt to become aware of their biases (the use of memoing helped in this process). In addition, hermeneutics prize lived experience with a subject matter as a form of understanding, as it can aid in the identification of implicit meanings (see Packer & Addison, 1989). In this case, the researchers bring both experiences with the phenomenon of psychotherapy as well as the experience of conducting and analyzing these interviews that can enrich this analysis.

In this process, the hierarchy was reviewed by Heidi Levitt to identify processes that may provide direction to therapists. When clients’ responses conflicted, the context and assumptions within the interview text were examined closely to provide differential guidance on when or under what conditions an intervention may be helpful. Principles were reviewed by Travis Hill to ensure consensus. The principles proposed in this study can become the foundation for future psychotherapy research and differ from many other initiatives to generate psychotherapy principles, as they focus on the moment-to-moment level of psychotherapy rather than on the level of overall outcome. Although these principles were formed to suggest directions that can guide therapists’ intentionality in session by increasing their awareness of clients’ experiences, they were not intended as behavioral prescriptions, and, indeed, each principle may lead to many possible interventions. These principles are presented following the category they were based on so that their derivation is clear.

Results

Overall, our analysis produced 1,673 meaning units. The hierarchy consisted of seven levels. To distinguish these levels, a specific vocabulary is used: One “core category” encompassed six “clusters,” which were above a “category” level that subsumed a level of “subcategories.” As all the data cannot be described within the confines of an article, the clusters are described in turn (see Table 1), making reference to the categories they encompass, followed by a description of the core category.

Within this description, the numbers of participants who endorsed each cluster or category are provided. When interpreting these numbers, readers should keep in mind that the interviews were semistructured. As a result, the participants were not each asked to address identical content areas, rather, they spoke of the issues that were salient for them within their own experience of therapy. Also, as the coding was not exclusive, a participants’ interview may be coded into multiple categories, so the sum of category endorsement numbers may exceed the overall endorsement number of their cluster. These numbers, then, are best understood as an assessment of how many clients referred to a specific experience as a significant or important part of their therapy. See Table 1 for an illustration of the hierarchical organization of the clusters and categories. On average, clients were able to describe only 1.6 discrete significant moments that occurred across their therapy experiences. Instead of recalling episodic memories, much of the therapy experience appeared to be stored in generalized memories. Client numbers that follow are indicated after the quotes.

Table 1
Clusters and Categories, With Number of Participants Who Contributed Units

Cluster title	Category description
Cluster 1: Commitment to Therapy: Honesty Is Negotiated for Success (23)	Generally negative (9) Generally positive (19) Importance of client expectations about therapy (14)
Cluster 2: The Therapy Environment as a Reflection of Therapists' Care (9)	Background music (1) Office environment (8)
Cluster 3: Out-of-Session Processing: Structuring Transitions Between Worlds (10)	Processing or self-therapy (9) Transitioning between session and nonsession worlds (4)
Cluster 4: The Therapeutic Relationship: Building Trust That Self-Exploration can Be Sustained, Even in the Face of Threat (21)	Therapist considered in terms of other role or person (15) Quality of connection (15) Structuring the relationship (23) Feelings to/about therapist (19) Client covert control in session (13) Agenda and goals of therapy (14) Problematic characteristics (9) Characteristics that have multiple effects (23) Helpful characteristics (25)
Cluster 5: Therapist Characteristics: Caring the Right Amount yet Providing Firm Direction When Needed (26)	Specific techniques (22) Therapist challenged (or forcefulness) (21) Therapist teaching self-understanding (17) Offers new perspective (17) Emotional experiences (15) Expression as important (13) Therapist questions client (8)

Cluster 1: Commitment to Therapy: Honesty Is Negotiated for Success

Data in this cluster was gathered from 23 participants, which described his or her global understanding of and attitude toward being in psychotherapy. Most of the participants (19 of 26) described therapy as being a positive experience. Clients' pretreatment attitudes and expectations about therapy varied, however. Although some clients entered therapy believing that it was an important commitment and a chance for help, others entered with a sense of apprehension or an embarrassment about needing psychological assistance.

Nine of the participants shared negative perceptions of therapy. Some participants specified that therapy was not worthwhile (1 of 26), ineffective (3 of 26), or too difficult (4 of 26). Others (3 of 26) reported that therapy was not effective because they themselves were uninterested, too rebellious, or unable to enter the truly challenging work of therapy. One client described therapy as follows: "I'd touch on it [my issue], I mean I wouldn't go too much into details about it, or, I mean, I would use vague general examples. . . . I felt so ashamed" (C-19).

Clients (7 of 26) who had initial concerns about therapy tended to report developing a sense of commitment to the therapeutic endeavor once an alliance was formed. This shift sometimes required the therapists' direct intervention. For instance, 1 client described how her therapist initiated a discussion on her engagement: "She [the therapist] showed me—that she was invested in my therapy, so—that let me know that I could be invested in my therapy. [So I said,] "So I need to know that you . . . are not going to hurt me, because it's happened too many times" (C-18). These sorts of frank discussions led clients to acknowledge their fears and risk being open. The principle that was developed from this

cluster was *Initially, clients may enter therapy with expectations or fears that work against their engagement. If a commitment to therapy does not develop, it may be helpful if clients are guided to frankly discuss their shame or fear of examining threatening topics, or if the relationship is mutually examined.*

Cluster 2: The Therapy Environment as a Reflection of Therapists' Care

This cluster contains clients' descriptions of the impact of the therapy environment on their experience in sessions. Nine of the participants reported that the office environment was significant in their experience of therapy. These clients described experiences of safety, comfort, and relaxation as being facilitated by physical attributes of the therapy room. Objects in the room provided a sense of their therapist's personality, professionalism, and concern for clients. One client described the impact of the office in her first session:

It wasn't just an office. . . . It was like, I could kind of like see her personality. . . . [I] identified with the lady when I first walked in there by the stuff she had out. . . . I remember that made like a big impression. . . . I went "Wow, I like this." (C-10)

Repeatedly, the therapy room was described as a projection of the therapist. Relaxing or familiar environments were said to provide clients with a sense of being cared for, with some clients describing environmental qualities such as background music or furniture with a cherished reminiscence in the interview. The principle identified in this cluster was, *The therapeutic environment is experienced as a reflection of therapist care and can facilitate clients' relating in a more relaxed way.*

Cluster 3: Out-of-Session Processing: Structuring Transitions Between Worlds

The interview segments collected in the third cluster described the participants' attempts to engage in continued self-reflection out of session, while having to reconcile this activity with the demands of their everyday lives (10 of 26). Clients (4 of 26) vividly described the process of moving between these two separate worlds of therapy and "real life." The ending and beginning of sessions were particularly difficult for clients, however, as they had to negotiate transforming from person to client and back to person again. In order to ease this process, some clients would engage in activities such as allowing time before or after sessions to prepare or consciously deciding to become less emotional toward the end of sessions so as to be able to go home and "pretend I'm happy" (C-18). Between sessions, some clients (9 of 26) reported being very actively engaged in their therapeutic process—feeling that the therapy gave them the strength to maintain a reflexive stance during the week to come. They reported reading self-help books, thinking about the therapeutic dialogue, and engaging in self-questioning. As one client described,

[I] took like all the advice and, you know, I went home that night and I just thought about what she said, and then, I started thinking about like what I can do. . . . And like so my dad like stopped, like, he wouldn't be pressuring me as much, and . . . [it] would like get better. (C-26)

The following principle was developed from this cluster: *Transitory activities that allow preparation for vulnerable exploration in therapy, for resuming daily activities when leaving therapy, or the integration of insights through the week can aid in clients' progress.*

Cluster 4: The Therapeutic Relationship: Building Trust That Self-Exploration can Be Sustained, Even in the Face of Threat

Cluster 4 was one of the more extensive ones in the study and described the clients' thoughts about their therapeutic relationship in terms of its meaning, quality, and structure. Twenty-one of the participants described their relationship with their therapist as a central part of therapy. In the first category, clients (15 of 26) described their therapist in terms of significant others in their lives. These "others" included friends, family members, role models, and past therapists. Although sometimes therapists fared worse in the comparison, as when one client talked about his therapist as a "paid friend," overall (12 of 26), this transference process was described as positive and appeared to aid alliance building. The qualities that clients emphasized as differentiating therapists from significant others were understanding, impartiality, and reliability. For instance, one client described her therapist by saying, "It was like she was kind of like, a mother. [But] a mother who was not angry with me" (C-12). For some clients, the therapist was described in comparison to themselves but at a healthier future point. The principle developed here was *Transference to therapist tended to strengthen the relationship—providing missing elements of understanding, impartiality, and reliability in relationships.*

In the second category, clients (15 of 26) described changes in their dependence on others as a result of their growth in therapy. The centrality of the therapist role often increased as trust was solidified between client and therapist initially. It then was de-

scribed as decreasing across the therapy as the client became more self-reliant. It appeared that the therapist acted as a surrogate for others' approval until the client had developed a strong enough sense of self-approval. One client described this process as follows: "He made me learn to depend on myself where . . . I was depending on everyone else to fix me. And this time, he was saying, 'No.' 'First and foremost, depend on yourself,' and that's what I did" (C-23). This process was described as becoming emotionally closer to others but as a connection in which participants retained their sense of self rather than becoming lost in dependency. The principle derived from this category was, *Initially in therapy, an increasing dependency on therapist appeared to allow the client to individuate from significant others, and then it tapered off as the client became more self-reliant.*

Trust was described by 12 clients as a core trait in the relationship, and aspects like professional credibility were described as assisting its development. Clients' trust deepened after revealing vulnerable aspects of themselves and perceiving the therapist as responding in a caring way. Therapists were thought to contribute to this development by demonstrating faith in their clients' self-assessment, sincere care for the client as a person, and respect for the pace they wished to maintain in therapy. One client described the basis of his trust in his therapist:

From the moment I ever had a first session with him, he was completely open with me about everything. . . . And I told him a lot of things about me. . . things that I had done that. . . I regretted and he never blinked an eye, I never heard him say anything under his breath. . . . He always listened to me, you know, he always encouraged me to express my feelings, he always encouraged me. (C-02)

The principle that was developed from this category was, *Clients tended to develop trust after scrutinizing therapists for displays of caring, especially when vulnerable issues arose. Therapists can convey caring by appearing genuine, showing respect for the client's process, and demonstrating faith and expertise in the therapeutic process.*

In the fourth category (including units from 23 of the 26 interviews), issues related to the structuring of the relationship were grouped, including therapeutic boundaries, confidentiality guidelines, terms of payment, control over the therapy hour, regularity in sessions, and sense of priority during sessions. Overall, having the therapy structured in a consistent and clear manner allowed for the security to develop in therapy, security that could be shaken if the structure was broken. For instance, one client described the effects of an overly flirty therapist:

In conversation [there were] innuendos . . . I mean there were topics I could not discuss with him after that, which at the time, I really wanted to get into. . . . He'd just laugh a little too hard, and kind of kept the conversation there a little too long, and would like go off on one of his stories. (C-06)

Clients typically (17 of 26) reported discomfort when therapists broke from professional roles and boundaries, diminishing their sense of the alliance and their engagement in therapy.

At the same time, however, this structure also created the possibility of displaying powerful evidence of sincerity in caring—ironically, by violating these same boundaries. The same client describes how a transgression acted to build the alliance:

He ran overtime, big time, that session, which impressed the hell out of me, because he could have just said, "Well, time's up," like he always did, but we were really into it. I don't know if he had an appointment following that or not, but it didn't matter. . . . He didn't look at the clock and point at the door. . . . He genuinely cared what was happening in the room at the moment . . . (and) treated me like a real person. (C-06)

In these cases (21 of 26), avoiding forming or actively breaking the rules was viewed as evidence that the therapist was truly invested in their treatment. Hence, the following principle was developed: *Structure in the relationship provides safety and empowerment. Transgressions of structure, however, can improve the alliance when they illustrate care but weaken the alliance when they lead to client discomfort.*

Clients (19 of 26) described their emotional connection to their therapists in the category Feelings about Therapist: Caring the Right Amount. Although most participants liked their therapists, they described feeling anger when therapists' caring did not appear sincere. Clients' responses to a felt betrayal included withdrawing, terminating treatment, maintaining an angry stance, and lying to their therapist. Caring too much by either therapist or client, however, also could disrupt the therapeutic activity:

We got to where I was like caring more about his feelings than he was caring about mine, and it was just . . . I don't think you should care about your therapist's feelings . . . it's kind of unprofessional. It was like we were relatives. . . . I worry about my own problems, I can't worry about the way you feel now. (C-23)

This client conveyed that her own sense of emotional connection and obligation impeded her from making progress.

It is interesting to note that clients were able to manipulate the therapists' care to draw attention away from vulnerable issues. For instance, one client described leading her therapist to becoming overly invested in a conversation:

It's really easy to run circles around someone if . . . you don't really want to get into what's going on. And its not even that you're deceiving them, its just that—you know, like I said, you're not connected with what you're saying. (C-18)

From this cluster, the following principle was formed: *A caring relationship is essential but becomes dangerous when it oversteps the clients' agency, confers dependence upon clients, or allows clients to manipulate therapists.*

Clients (13 of 26) described engaging in covert processes to control the session, regulate the relationship, and avoid the discussion of threatening topics (see Bohart & Tallman, 1999; Levitt, 2001; Rennie, 1994a, for more on covert client processes). Some clients reported concealing their opinions in the initial stages of therapy, as they thought that etiquette forbade disagreement or intimacy, or they required time to develop comfort with disclosure. Participants also admitted to deceiving therapists when they wished to avoid therapist disapproval, were embarrassed about the truth, or were upset with their therapist. These acts could be injurious to both themselves and their therapy:

And then when I started to lie again [in session], I went home and I thought 'God, I'm feeling lonely again. . . .' You know, if I'm lying, it's my problem. It will be forever. . . . And then I start to miss [sessions] a lot. I think that, you know, it's hard to draw the line.

(C-17) Learning to risk honesty was a process that could take time if it was to happen at all.

Others withheld disturbing stories or ideas to protect their therapists from feeling upset during their sessions. Some clients kept silent about their perceived lack of progress in therapy because of their reluctance to hurt or challenge their therapist, at times blaming themselves for being poor clients. "A month went by where I didn't go and I felt really guilty, I felt like, like I was rejecting him. . . . I didn't want him to think that he wasn't helping me because he was so nice" (C-19).

Clients also withdrew when they were confused about the tasks at hand or wished to avoid difficult emotions.

The hurt and the pain . . . I was very good at hiding it or controlling it. She was more just trying to ask me some questions to guide where we were going. . . . I don't think she realized how strongly I was feeling inside, just because I didn't let her know. (C-20)

The associated principle was as follows: *to avoid client deception, explicitly communicate the etiquette of therapy as one in which painful experience needs to be discussed, that therapists wish not to be protected, and the importance of talking about topics that might be threatening or invite disapproval.*

Fourteen participants described the process of setting goals in the next category. Clients wished for more of an agenda when stuck focusing on unimportant issues and yet were unsure how to redirect the process. "Looking back, it probably would have helped me had I [thought] . . . I am going to come in and we are going to work on this . . . cause you really do have to push yourself to not avoid things, it is really so easy to avoid" (C-8).

These clients were uncomfortable, however, when therapists set goals without consulting them, particularly when based on courtroom recommendations or clients' parents' desires. In contrast, the clients who engaged in collaborative agenda setting with their therapist reported strongly positive reactions to this process.

She gave me ideas that led me into good directions, but I never felt like she gave me advice and tell me "This is what you need to do. . . ." I think that it was helpful not to set a goal [for me]. . . . That would have given me more of a sense of failure if I couldn't accomplish that goal or if I decided, "Well maybe that isn't the goal that I want to accomplish anymore," because my goals definitely changed. (C-16)

The principle from this category was, *Allowing the client to set goals is experienced as empowering, but, when mired in unimportant topics, clients want therapists to provide direction after checking for clients consent.*

Cluster 5: Therapist Characteristics: Caring the Right Amount yet Providing Firm Direction When Needed

As distinct from those qualities described in Cluster 4, in these interview segments, clients (26 of 26) described qualities that they attributed to the therapist more than to the therapeutic interaction. Hence, the categories in this cluster contain clients' opinions on what makes a good therapist. Although clients described some characteristics as entirely problematic or helpful, others could have multiple effects in relation to the context at hand.

Problematic characteristics. Clients (9 of 26) identified two polarized problems with therapists' personalities: being too distant

and being overinvolved. Distant qualities included therapist defensiveness and insensitivity—typically manifested in the lack of attunement to clients. As one client quipped, “If you can’t find the problem, you sure as hell can’t solve it” (C-14). However, clients also objected to therapists who were overly involved in therapy. Therapists described as too invested in the client’s recovery, pitying, or jealous of the client’s other relationships were experienced as compromised in their efficacy. One client described an overcontrolling therapist:

I do feel bad because I feel like he kind of formed a relationship with me, but it was too much of a relationship . . . he cared about me too much He really started taking things personally. He started calling me, like from home to check up on me and stuff like that. . . . He thought of me as more like his child . . . he got a little too close to where he couldn’t be unbiased. He couldn’t be that person to listen to my problems. . . . I do care about him, but I just, you know, it wasn’t helping. (C-23)

It seemed that excesses in either extreme of care prevented clients from discussing and exploring their experiences in a helpful fashion.

Facilitative characteristics. The subcategories in this category emphasized qualities of the therapist that allowed them to convey to their clients care and sincerity. These factors included qualities that convey an invitation to greater intimacy (e.g., vocal quality), an acceptance of the client, genuineness, attentiveness, and empathic concern. Clients (25 of 26) repeatedly testified that these types of traits helped them to be open in sessions and make progress in therapy. The principle developed to represent the clients’ descriptions of both problematic and helpful characteristics was, *Negotiating Distance: A sense of professional caring is needed, or the therapist is experienced as too distant, defensive, or unattuned to clients’ emotions. However, caring is too intense if the therapist is experienced as jealous, controlling, or pitying.*

Complex characteristics. There were a number of therapist qualities that enhanced therapy in certain situations but were detrimental in others. Generally, therapists’ challenging was not well received by clients, with discussion to this effect from 19 of 26 of the participants. The clients thought it was important to come to their own decisions and did not want a therapist who felt more strongly about an issue than they did themselves. They described these therapists as pushy, annoying, and judgmental.

Challenging was interpreted differently, however, when it was used to confront clients who were being manipulative within the therapeutic context or were avoiding important aspects of their experience. One client with an eating disorder described being pleased to have found a therapist who was “stronger” than her eating disorder:

I couldn’t manipulate him. . . . Even when I was not lying, he said I was lying, like he would say, “I bet you’re throwing up.” He was so condescending too. He was like, “Why don’t you write in your diary . . .” and I’d just throw it at him, but finally I would just start to do it, and I guess in a way he put ideas in my head, and then it would get to where I chose it. . . . He just really gave me direction. I just really respected him. (C-23)

Clients who did not use their sessions productively wished that their therapist had been more confrontational: “I wish she would

have like kicked my ass. She would have been like, ‘Let’s do this, get it over with,’ [instead of] ‘Oh, you’re tired? Okay, you only have to do one’” (C-8). On the basis of this analysis, the following principle was shaped: *Confrontation was thought to disrupt trust and compromise the therapy in most cases, with the exception of when the client was being manipulative or avoidant of difficult material, and then it was desirable.*

Most clients did not describe therapist–client demographic characteristics such as race or gender as significant in their therapies. One female client, however, said that she requested a female therapist as she wanted to work out difficult issues with her father. One older white client, whose interview was littered with praise for the Aryan race, said he would have preferred a white therapist. The following principle was developed to represent these findings: *Gender and race were not commonly reported as important factors unless the client experienced a strong prejudice or threat by persons of a gender or race.*

The influence of therapists’ professional status appeared to depend on whether this status was thought to limit therapists’ sincerity. Four clients reported that the therapist gained credibility through expert knowledge, whereas 6 clients described that the therapist being too “doctor-y” caused distance and thus hindered openness in the relationship.

I feel we’re not really talking to each other as human beings, honest, direct. It’s like a little game. . . . I don’t wanna make a “session” out of this. I want to be heard, I want to try and get in touch with my own feelings. . . . Therapeutic-y stuff tends to get you more into spinning your wheels. (C-5)

The following principle reflected this experience: *Therapist professional status added to credibility unless it was thought to preclude the therapists’ sincerity of caring.*

Finally, clients (18 of 26 participants) appeared to think that therapist emotional or personal disclosure was helpful in moderation. Helpful disclosure was described as “humanizing” and increased the level of intimacy in the moment. One client described the advantages of therapists’ impartiality over the disclosure of strong opinions and beliefs.

He was emotionally neutral, I would say. . . . He was like a reporter. Where you don’t see the news as being something that is a function of the reporter, you see the news as being substance in itself. And that’s important because the information, if it becomes associated with the therapist, then it’s harder to internalize and say, “This is right.” “This is something that I need to know.” (C-21)

Disclosure was thought to be particularly distancing, however, if the therapist was not invested in the clients’ issues. Emotional expressions, then, were seen as connected with the therapist’s needs rather than the client’s state. Therapists who cried or joked too much, pitied clients, or “pouted” during sessions were viewed as self-centered and as disregarding clients’ processes of self-exploration. From this understanding, the following principle was formed: *Therapists’ emotional expression was humanizing so long as it conveyed concern about the client rather than about the therapist’s self-interest, bias, or need.*

Cluster 6: Therapeutic Intervention: Structuring a Focus in Which to Encourage Reflexivity and Client Self-Discovery

A variety of interventions were described within the interview (by 24 of 26 participants). In addition to discrete or specific “techniques,” clients described general therapist activities such as therapist challenging, pattern identification, teaching self-reflection, offering new perspectives, allowing emotional experiences, allowing expression, and questioning or probing clients’ meaning. Most of the clients’ attention was directed toward these general interventions that are not specific to any one orientation. In this cluster, clients described interventions as helpful when they guided them within a self-reflexive examination of their emotional, cognitive, relational, and expression patterns.

Twenty-two clients discussed specific therapist interventions that occurred within their therapies. Clients described the use of homework, tapes, artistic or written tasks, cathartic techniques, role-playing or gestalt chairing, therapist note taking, metaphor-exploration, behavioral or goal-setting interventions, developing communication skills, psychological testing, and suicide contracts. In general, structured interventions were described as productive, as they helped clients express themselves, demonstrated that the therapist was attempting to support their progress, and guided them to new insights. For instance, one client described her reaction to creating a suicide contract, “It was sort of like my word of honor. It felt good that someone is actually taking my word like that” (C-7). All the interventions that clients recalled were viewed as helpful, but there was some disagreement about two. Whereas 2 clients described not minding note taking, 1 client said her therapist’s note taking made her feel carefully listened to, and another client reported that note taking made him feel like just “a number” among many other clients whose concerns might be forgotten. Similarly, homework was not thought to be useful for those clients who described themselves as emotionally or conceptually unprepared to complete a task.

Three principles were developed from this category: (a) *Clients liked engaging in structured therapeutic tasks, as these gave them confidence that they were making gains and that the therapist was thinking about their issues*; (b) *Homework may be most useful if clients are asked if they are emotionally and conceptually ready to complete it*; and (c) *Note taking may be most useful when it is explained as a listening aid rather than a recollection aid*.

Clients (17 of 26) discussed a variety of ways that they engaged in the process of self-discovery. They repeatedly described their therapists as guiding them in a dialectical process of self-questioning to develop their own insight and understanding:

[The therapist] also understood the importance of the fact that I needed to come to things myself. . . . Even though she knew where I was going . . . she knew that it was important for her to sit there and let me come to them. (C-08)

Therapists’ questioning, paraphrasing, and reflecting were described as such interventions. Although some clients described initial frustration when the therapist did not provide direct guidance, they learned to like this intervention when the rationale for self-discovery was explained, and they became confident that the therapist was not simply being evasive. Most of the significant moments described unfolded in this manner, in the course of

facilitating the therapeutic dialogue rather than through structured therapeutic tasks.

Therapists’ main contributions to client self-discovery included challenging the client (21 of 26), suggesting new perspectives (17 of 26)—often those of significant others, questioning the client (8 of 26), and pointing out patterns in the client’s functioning (3 of 26). One client’s description of self-discovery was as follows:

I am one of those who overly compensate. And, I didn’t realize I was doing it, and one day I brought her candy. . . . She said, “See, you are doing it to me.” That was kind of like a true example. It was just like a turning point I think, because I really believed her because it was right there in front of me. (C-11)

Clients described these interventions as promoting a reflexive process of inquiry and heightening self-awareness. The therapist being outside of the clients’ daily lives allowed clients to consider these interventions more easily, to feel more comfortable exploring other perspectives, and to focus on themselves in a sustained way without feeling guilty about their self-concern. In this process, clients could come to reformulate or accept problems and connect issues. The principle that was derived from this analysis is as follows: *Clients were pleased when therapists encouraged reflexivity by questioning the client, offering new perspectives, discussing how to engage in therapy, or indicating clients’ patterns. Therapists should be challenging to the extent that clients are being avoidant or manipulative, but otherwise, therapists should allow clients to come to realizations themselves*.

Clients (13 of 26) described the expression of their personal narratives in therapy as cathartic and as providing the basis for exploration. While listening to the stories, helpful therapists were said to guide clients to explore more deeply and reference emotions. Learning to understand, accept, and cope with difficult emotion was a vital part of therapy for some clients (16 of 26). Clients described a need for therapists to help them tolerate their emotional experience at length—as it could lead to new emotions and understandings. For instance, venting anger in therapy was described as clarifying as well as cathartic, and laughter allowed clients to shift perspective, heighten the sense of alliance with the therapist, and release tension. After recognizing the emotions that occurred within their stories, clients could approach future situations with a new awareness, cope with emotions differently, and accept a broader range of emotion.

[When] your sad emotion is your enemy . . . you react to it with distance and you are like, “I don’t want to cry.” “. . . I want to get away from it. . . .” [But if] you make friends with your emotions, then you are like, “Crying is okay.” . . . It just has this really remarkable effect, in the sense that, you know, you are not running away from it. You are not angry at yourself for doing it. You are not trying to stop yourself and trying to hold back because that is *who you are* at the moment. . . . I am happy to be with the crying cause that’s what I need to do right now. (C-08)

In contrast, clients who avoided emotion in therapy described this restriction as a shortcoming in their therapy that limited their progress. Two principles were developed in this analysis: (a) *Emotional experiencing is threatening, but it helps client recognize, clarify, accept, and learn to tolerate or change emotional experience*; and (b) *Expression of experiences and emotions allows clients’ defenses to drop, and leads to relief, a sense of self-justification, and a stronger alliance*.

Core Category: Clients are Needing Just Enough Structure to Facilitate Reflexivity While Needing to Feel Special Enough to Risk Revealing and to Be Known

The core category is the central finding from the analysis. Although clients described a desire to engage in self-development, they also explained that there were dangers that kept them from being able to engage usefully in therapeutic work. At times, for instance, they confessed feeling too rebellious, too disconnected from the therapist, or too obliged to the therapist to explore pressing issues. Although they could see that it was helpful when they could sustain a reflexive exploration of threatening internal processes and relational dynamics, they often colluded in avoiding these processes to seek safety.

There were numerous ways in which clients described negotiating this tension. First, their attention could be structured, such as in a guided therapeutic task, and the resulting focus could sidestep their anxiety to the point that they could sustain reflection. This structuring could come about by the therapist's initiative (e.g., when therapists asked questions or used guided reflection) or by the client's self-direction (e.g., when clients structured time between sessions to reflect on therapy gains). Ideally, this structure was calibrated so that it was just enough to allow clients to focus on a question that was a central concern but did not push any one response on the client. When the structure was too tight and clients were pushed to consider a range of options that felt restrictive (e.g., the therapists' challenging in most cases), interventions could lead to resistance, deference, or deception on the client's part. When it was too loose, clients reported avoiding topics of importance, disengaging from useful reflexivity, and feeling stuck.

Second, clients reported feeling most comfortable engaging in exploration when they felt compassion and care from therapists. The need to be liked by their therapist was an urgent and recurrent theme. During vulnerable exploration, therapists' compassion and self-compassionate attitudes aided clients in sustaining reflexivity, as it kept clients from pulling away because of the fear or pain resulting from self-damnation that might be incited otherwise. By teaching clients to structure their own self-exploration, soothe fears or self-destructive attacks, and helping them feel special and accepted, therapists helped clients to maintain the therapeutic process. On the basis of these analyses of clients' interviews, these findings frame the two core therapist tasks as monitoring the degree of structure that is needed by clients to engage in the reflexive examination of central concerns and the provision of a degree of compassion that is needed for clients to reveal new aspects of experience to another and to themselves.

Discussion

This article contributes a deeper understanding of clients' experiences in psychotherapy and catalogues their experiences of significance at the level of moment-to-moment process. The findings presented may sensitize therapists to clients' internal and covert processes as well as inform therapist decision making. In addition, the findings highlight for researchers directions for future exploration that appear to be important within clients' experiences and may produce attuned recommendations for therapy.

In keeping with our constructivist approach, we offer this analysis with the awareness that these findings are not the only pos-

sible interpretation of these data, but instead are an interpretive understanding that is based on the rigorous analysis of clients' interviews. A limitation was introduced because of the time needed for this large and intensive analysis, which made it difficult later to obtain useful feedback from participants. The credibility checks and the finding of saturation, however, suggest that this analysis was thorough and continued to the point that new data were redundant with that collected. Also, these results meet the call for qualitative outcome studies (e.g., McLeod, 2000), as they suggest successful methods of intervention that are sensitive to contextualized practice.

In a companion study to the present one, eminent therapists from different therapeutic orientations have been interviewed on their process of facilitating change. A grounded theory study was conducted, and principles for change were formed (e.g., Levitt & Williams, 2005; Williams & Levitt, in press-a, in press-b). Together with the present study, the principles developed can form a framework for understanding common factors and processes in psychotherapy from the perspective of both client and therapist.

A Caring Relationship Promoting Reflexivity Versus Symptom-Focused Techniques

Clients in this study spoke of their therapeutic relationship in excess of any other factor and emphasized the importance of the experience of care within that relationship. This finding is supported by meta-analyses that indicate that relational and contextual factors contribute more to change than do specific interventions (e.g., Wampold, 2001). Specific interventions that therapists used were described as helpful, but clients rarely attributed important change or insight to one intervention. Indeed, they only recalled, on average, 1.6 discrete significant events across their therapies. Instead, clients attributed change to interventions that were not specific to therapeutic approaches (e.g., offering new perspectives, questioning or challenging the clients), the relationship, and the development of personal understanding across sessions.

Within the interventions described, introspection on relationships, cognition, emotion, and expression were the dominant mechanisms of change described. These processes unfolded within a context of encouraging and structuring reflexivity, supporting Rennie's (1992) supposition that reflexive engagement is the central task in therapy. Added to this understanding is the emphasis on care, or self-compassion, within this reflexive stance, as modeled by the therapist and integrated by the self. From this perspective, therapy can be considered a method of structuring clients' attention so that they can withstand the anxiety that may be generated by sustained reflexivity on a threatening or self-condemning topic.

It was noticeable that clients rarely discussed symptomatic change per se as an important outcome of their psychotherapy. To check this interpretation, after the hierarchy was formed, the researchers reread all the interviews to identify any discussion of specific symptoms (e.g., sleeping, eating, anxiety changes, sexual functioning changes). Although clients did mention symptoms in connection with the medication that they took, they did not describe symptom reduction as a reason why an experience in therapy was important to them. They tended, instead, to discuss global changes such as relating better with others and understanding or feeling better about themselves or others. Clients with an eating disorder who described changes in eating as significant were the

exceptions to this rule. These findings support the view that although symptom reduction may be a positive effect of therapy, it may not be the primary benefit for many clients. They support the literature that questions the use of symptom checklist measures as primary assessments of psychotherapeutic change (e.g., Levitt, Stanley, et al., 2005). These findings offer a basis to form an outcome measure for therapy that assesses what appears to be important to clients in the process of change; they suggest that evaluations of therapy by psychologists (and potentially by insurance companies) may benefit by the development of broader ways to define outcome.

The Utility of Moment-to-Moment Principles

Researchers (Levitt, Neimeyer, & Williams, 2005; Rennie, 1994b) argue that qualitative methods are ideal for initiating research on psychotherapy process and outcome. The development of contextualized principles at the “moment-to-moment” level of outcome can be one advantage of this approach. Greenberg and his colleagues (e.g., Greenberg, Rice, & Elliott, 1993) have drawn attention to this level of outcome in which therapists are engaged in the continual diagnosis of shifts in clients’ states, processes, and the content of their speech and attempt to adjust their interventions accordingly. This intensive analysis brings to light experiences that psychologists rarely consider in formal training and that may not be easily observable within sessions. For instance, although many training courses focus on how to demonstrate caring and empathy, texts rarely discuss the dangers of caring too much (e.g., Brems, 2001). It also explicates clients’ internal experiences that can be informative when therapists are considering interventions—for instance, in considering how to use self-disclosure with clients, how to explain note taking, or when to use confrontation. Although some of these themes exist in the literature, the study organizes, supports, and highlights those issues that are of greatest significance to clients across therapy modalities. As such, it provides some direction to guide therapists while engaged in the continual assessment of their clients’ engagement.

In addition, the findings emphasize clients’ agentic process, as participants describe not only how their therapists improve sessions but also how they guide themselves to engage productively in therapy (see Bohart & Tallman, 1999). Accordingly, the insights in this article may be used to orient clients to make better use of their therapy experience. For instance, I (Heidi Levitt) now initiate therapy by talking to clients about the importance of giving feedback to the therapist when I am off track and by encouraging them to consider ways to incorporate out-of-session reflection on the therapeutic process.

Legal theorist, John Braithwaite (2002), argued that, when situations are characterized by complexity, principles are more useful than rules, as they allow for flexibility and adaptability (see Levitt, Neimeyer, & Williams, 2005). When considering adapting these principles to their own practice, therapists should keep three processes in mind: (a) *Different methods of implementation are possible*: For instance, although therapists are encouraged in this analysis to adopt clients’ goals within sessions, switching to a more confrontational style only with clients who are not actively engaged in therapy, the principle suggests that this recommendation would be reversed for therapists who work with populations that are resistant to treatment; (b) *Principles themselves could be*

adapted to situational factors: For instance, depending on the structure (e.g., inpatient or outpatient), client factors (e.g., difficulty engaging in therapy), and duration of their client contact, therapists might draw on principles to suggest that clients structure some transition time before or after sessions, or they might incorporate such time within sessions to help clients engage productively; (c) *Principles can be adapted to different therapy orientations*: For instance, one principle indicates that protecting boundaries can communicate care and preserve a good alliance but that breaking boundaries in a way that conveys a therapist’s investment in a client can communicate care powerfully as well. These transference dynamics may be dealt with differently within a psychodynamic therapy, in which they may provide content for in-session analysis, than within therapies whose mechanism of change do not center on the therapy relationship, in which the therapist may elect to break boundaries judiciously to communicate care (e.g., going 10 min over session time on occasion). In this manner, the development of principles that span therapy orientation can be adapted to different contexts, situational factors, and orientations. Indeed, they can form the foundation of an integrative approach to guiding moment-to-moment change in psychotherapy.

The suggestion put forward in this article is that the empirical exploration of the phenomenon of psychotherapy using qualitative analyses can provide a foundation for later verification assessments of how psychotherapy functions. These studies can focus the field on independent variables that move beyond hypotheses at the level of competing therapy orientations (which, despite decades of research; tend to be found to account for little of the variance in psychotherapy outcome; Wampold, 2001). Instead, they develop an understanding of specific processes of moment-to-moment change that can generate suggestions for practice that are sensitive to the context within which therapeutic dialogue occurs. After developing a nuanced understanding of what the task of psychotherapy comprises, researchers can be more secure that future investigations are appropriate to the ontology of psychotherapy as an intentional and interactional process.

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