Therapist Responsiveness in the Blank Landscape of Depression:

A Qualitative Study among Psychotherapists

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Abstract

Evidence about the high burden of depression on society and the immediate environment of patients has accumulated over the past decades. Yet, empirical data about the impact of depression on the environment of psychotherapy are limited. ***Objective***: The present study investigates the phenomenon of therapist responsiveness in the treatment of depression. Specifically, this qualitative study examines the influence of a client's severe depressive symptomatology on psychotherapists' immediate experience and reflections about interventions. ***Method:*** The responses of 26 Flemish psychotherapists and counselors to a questionnaire with open questions and as part of a focus group were investigated by using Consensual Qualitative Research methodology. ***Results:*** First, experiences with a negative valence were most common in the responses of the psychotherapists and counselors. A particular negative experience, a sense of "constriction", affecting the therapist's relational, cognitive, emotional, and bodily level of experiencing, was a predominant response. Second, most psychotherapists and counselors considered a therapeutic attitude of being present for the client and the different aspects in the client's experience to be crucial, although most of them experienced difficulty in maintaining an attitude of presence. ***Conclusions:*** The results of this study suggest that exploration of the different aspects of the clients' experience and working with the self-split of the client might be essential in the psychotherapeutic treatment of depressive disorder.

Keywords: depression, therapist response, client characteristics, therapeutic relationship

Clinical or Methodological significance of this Article

This study presents the in-depth description of therapists' immediate subjective experiences and thoughts about interventions when in contact with a depressed client. The results of this study might improve therapists' understanding of the micro-processes associated with potential blockages in therapy with depressed clients, and present suggestions to work through these impasses in therapy.

Introduction

Therapist Responsiveness

For many decades, clients' experiences of themselves, others, and the world have been believed to contribute strongly to the therapeutic interaction (May, 1958). As a result, assumptions about treatment effect based on linear relations between the therapeutic modality and symptom severity do not represent the whole picture. The current field of research on psychotherapy has reached a consensus on the fact that differences in therapy approaches, but also fixed therapist characteristics (e.g., years of experience, level of training) do not play a substantial role when it comes to client outcome (Beutler et al., 2004; Cuijpers et al., 2008; Constantino et al., 2021; Johns et al., 2019). Consequently, the possible role of *common factors* has received increasing interest. Common factors are those aspects that are shared across psychotherapies of different orientations (Norcross & Wampold, 2011).

One important category among these common factors is the therapist's interpersonal skills, such as the therapist's empathy and the flexibility of the therapist to make adjustments in their treatment approach (Constantino et al., 2021; Norcross & Wampold, 2011; Wampold and Owen, 2021; Zilcha-Mano et al., 2016). Empathy enables therapists to make adjustments to their therapy approach, with the aim of providing the best treatment for their client (Hatcher, 2015). Effective therapists tailor their therapeutic techniques to the specific characteristics (e.g., diagnostic features) of the client, as well as to the therapy process (Kramer & Stiles, 2015; Wu & Levitt, 2020). This attunement process demands sensitivity and openness to the person and context of the client and the therapy, often referred to by the term *therapist responsiveness* (Kramer & Stiles, 2015; Stiles et al., 1998; Wu & Levitt, 2020). Empathy is a necessary condition for appropriate therapist responsiveness. By taking the perspective of the client and by being sensitive to the client's feelings, experiences, and history, a therapist gains information about which technique to introduce at what time for a particular client (Hatcher, 2015).

Therapist responsiveness represents the moment-to-moment attunement of the therapist to the relational dynamics with their clients (e.g., feelings of countertransference, attachment style) and to broader contextual aspects (e.g., the cultural or socio-economic context). It also includes the therapist's adjustment to the dimension of time, as each moment in therapy is unique and each episode in the therapeutic process calls for different interventions (Kramer & Stiles, 2015; Wu & Levitt, 2020). The ongoing bidirectional influence between therapist and client is reflected in the two-fold definition of therapist responsiveness of Stiles et al. (1998). He distinguishes (1) responsiveness of the therapist *to* the client, pointing at the sensitivity of the therapist for the client's specific features, and (2) responsiveness *with* a therapist response, referring to the specific intervention that is chosen by the therapist to match the client's characteristics and the specific context in which the therapy enfolds.

As a result of this complex interplay between relational and contextual factors, therapists differ in the way they provide techniques (Zuroff & Blatt, 2006). This variety among and within clinicians potentially explains why treatment modalities as such account for so little, and common factors account for so much in terms of therapy outcome (Wu & Levitt, 2020). Despite its influence on the therapy process, the phenomenon of responsiveness is often overlooked in therapy outcome research (Kramer & Stiles, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). There is a need for research designs that take the concept of responsiveness into account. Research designs that include evaluative process measures such as therapists' or clients' rating of the empathy of the therapist or the therapeutic alliance between them (Greenberg & Watson, 2022) adress this need, but do not specify the therapists' and clients' specific behaviors that contribute to the process variables that are measured (e.g., empathy or alliance). A qualitative design describing therapists' responses in contact with a client can contribute to this need. In this study, therapist responsiveness to a client's depression is considered.

Therapist responsiveness in the treatment of depression

Depression is one of the most common forms of psychopathology (World Health Organization, 2020; Herrman et al., 2022). Studies have amply shown that depression is associated with a high socio-economic burden (Herrman et al., 2022). The impact of a client's depression on the therapist, however, has gained less attention. The influence of the client's negative mood, loss of interest, and feelings of hopelessness and guilt—the core features that mark depression (Allen, 2022; American Psychiatric Association, 2013)—on therapists and their interventions is a relatively unexplored area of research.

The extent to which therapists' interventions match their clients' characteristics varies from session to session and from one therapist to another (Kramer & Stiles, 2015). Empathic attunement to the client's experience provides the therapist with the information that is needed to introduce techniques in a responsive way (Elliott et al., 2018; Hatcher, 2015). Yet, when face to face with the severe and compelling helplessness, worthlessness, guilt (American Psychiatric Association, 2013), and meaninglessness (Allen, 2022) of clients with depression, it is not always easy for therapists to stay empathically attuned (Gross and Elliot, 2017; Hennissen et al., 2023; Roubal & Rihacek, 2016). The loss of the therapist's empathic attunement to the client may lead to a decrease of therapeutic responsiveness in the session. A chronic erosion of the therapist's empathy can eventually lead to a loss of faith in a good therapeutic outcome and stagnation of the therapy process itself (Vanhooren, 2019). Empirical findings support this idea: decreasing empathy and negative feelings of therapists toward their clients have been found to be negatively related to the therapeutic alliance and outcome (Heinonen & Nissen-Lie, 2020; Nissen-Lie et al., 2010).

The client's experience influences the therapist's response and also the therapist's own experience (May, 1958; Stiles, 1998). As in every human interaction, the therapist aligns with the client's behavior and emotions. This means that the therapist may feel a tendency to take on the sensory, motor, physiological, and affective states of the client (Prochazkova & Kret, 2017). Recent empirical findings support the idea that this process of mirroring between therapist and client

emerges on the conscious, as well as the unconscious, neurocognitive level of experience (Pochaskova & Kret, 2017).

The experiential inner world of the therapist is an important source of empathy for the client's suffering, and can provide insight into the therapeutic process (Gendlin, 1997). Nevertheless, therapists can also be overwhelmed by despair evoked by the client's experiences (Greenberg & Watson, 2010). This reality might be particularly important when it comes to the psychotherapeutic treatment of depressive disorders. Depressed clients often have an overly negative experience of themselves, others, and the world (Greenberg & Watson, 2022). Greenberg and Watson (2010) argue that a depressed client is stuck in the "same old story". This is a repetitive, unproductive experience based on core maladaptive emotional schemes about the self, others, and the world, such as "I am a failure" or "I can't find anything to hold on to" (Angus & Greenberg, 2011; Greenberg & Watson, 2022).

As the therapist and the therapeutic environment are part of the client's world, the client's negative experiences will inevitably unfold in the therapy process (Greenberg & Watson, 2010; Hennissen et al., 2023; Roubal & Rihacek, 2016). These experiences are typically conceptualized in terms of unmentalized depressive experiences that are associated with a tendency toward either internalization (e.g., expressed in high levels of self-criticism and self-loathing) or externalization (e.g., expressed in feelings of anger or criticism toward the therapist) (Kealy & Ogrodniczuk, 2019; Luyten et al., 2015). The sense of hopelessness and meaninglessness can become an experience that is shared by the client and the therapist (Vanhooren, 2019). Moreover, the negative experiences of the client may influence the therapist's experience in such a way that the therapist feels compelled to take a role (e.g., a protecting, caring, or pedagogical role) that is congruent with the role of important others in the client's life history (Kealy & Ogrodniczuk, 2019; Luyten et al., 2017). Such countertransference responses may lead therapists to disengage from the client, albeit unintentionally, as a result of a tendency to protect themselves from unbearable feelings of meaninglessness, hopelessness, or self-criticism (Colosimo & Pos, 2015; Gelso & Hayes, 2007).

Eventually, these feelings may lead to a loss of responsiveness and attunement in the therapist and, in some cases, frustration, boredom, indifference, and rejection of the client (Roubal and Rihacek, 2016). In this way, unfortunately, the client's negative schemas about themselves and others, stemming from earlier experiences with attachment figures, are reenacted and confirmed. As mentioned earlier, such therapeutic withdrawals can have a negative effect on the basic conditions of empathy, congruence, and unconditional positive regard (Rogers, 1965) and on the outcome of the therapy process.

These assumptions are consistent with recent research findings on the response of therapists to the depressive symptomatology of their clients. For instance, a thematic analysis of transcripts of supervision sessions by Hennissen et al. (2023) demonstrated that countertransference responses of therapists (*N*=7) in therapy with depressed clients encompassed both positive and negative aspects. The therapists' responses consisted of four recurrent themes, encompassing positive and negative aspects: (1) empathy, compassion, and support; (2) anxiety, feeling overwhelmed, and protection; (3) frustration, irritation, and confrontation; and (4) inadequacy, incompetence, and fatalism. Similar findings were reported by Roubal and Rihacek (2016), who conducted focus groups with 30 therapists who treated depressed clients. They found that therapists' experiences tended to oscillate between coming closer to and moving away from the depressive experience of the client.

Existing studies on the impact of clients' depression on therapists typically involve retrospective reports of therapists' experiences with patients, but not their immediate thoughts and feelings in contact with the clients. In addition, empirical findings on the specific interventions that therapists respond with when in contact with the depressed symptomatology of their clients remain scarce. Therapists differ in the way they use techniques (Wu & Levitt, 2020), but empirical findings on the processes underlying these variations are missing.

The Present Study

The present study aims to contribute to a better understanding of the microprocesses that are involved in the phenomenon of therapist responsiveness in the treatment of depressive disorder. The study adressesses two research questions, which are in line with the two pathways of responsiveness as described by Stiles et al. (1998). First, therapist responsiveness *to* the client's features is considered, by investigating the impact of a client's severe depressive symptomatology on the *immediate experience* of therapists and counselors. Second, responsiveness *with* a therapist response is considered, by investigating the psychotherapists' and counselors' reflections about the *interventions* that they would use in order to deal with the client's severe symptomatology.

The qualitative design of the study enabled us to obtain an in-depth description of the therapists' experience at the moment that they are confronted with a patient with a severe depression. This study aimed to gain a deeper insight into the aspects that encourage therapists to provide empathically attuned responses in the treatment of depression, and the aspects that prevent therapists from being responsive to the client. This knowledge could be a stepping stone in the improvement of psychotherapeutic treatment and the reduction of the high relapse rates of this disorder (Moriarty et al., 2020).

Method

Participants

Data were collected in June 2019, after receiving approval for the study from the Ethical Board (G-2019 05 1653). Two groups of 13 Belgian primarily person-centered psychotherapists and counselors registered for two parallel sessions on the topic of existential themes and depression held at the annual conference of the Flemish Federation for Person-centered Experiential Psychotherapy and Counseling (Vlaamse Vereniging voor Cliëntgericht-Experiëntiële Psychotherapie en Counseling; VVCEPC). Earlier, the participants of the parallel sessions were invited to participate in this study by mail. They were given information about the study and asked for their consent to

make use of their personal written reflections and the audio recording of the focus groups for this study. All 26 participants in the workshops chose to participate in the study. Each of the two workshops had the same structure: (1) a short lecture on depression and existential themes in the first 30 minutes; (2) presentation of the video clip of the client with depression in the next 10 minutes; (3) an experiential reflection exercise, assessing the therapists' experiences and reflections; and 4) a focus group of 45 minutes about the reflection exercise. The focus groups were organized serially, in the same afternoon. Both of the focus groups consisted of psychotherapists and counselors. The participants signed up for the parallel sessions of this conference and therefore were able to choose which of the two focus groups (first or second) they wanted to participate in.

Data Collection Procedure and Instruments

The two groups of 13 participants were shown the same video clip of one part of a therapy session (10 minutes) with a severely depressed client and his therapist, who was one of the researchers involved in this study. The video clip was specifically chosen because of the client's expression of his negative mood, his sense of hopelessness, and feelings of guilt, which are considered core features of major depressive disorder (Allen, 2022; American Psychiatric Association, 2013). In the videoclip the client expressed his desire and grief about the difficulty in engaging in society he encounters in his everyday life. The participants received some background information about the client, as follows: "The client is a 45-year old man who consulted a private psychotherapy practice, seeking help for symptoms of depression, anxiety, and possibly autism spectrum disorder. He is highly educated and highly intelligent. He is socially withdrawn, and expressed severe difficulties in contact with others, professionally and in private contexts. He has a stable and supporting relationship with his wife, with whom he remained involuntarily childless. The client gave his consent to use this particular fragment for scientific reasons and was informed about the procedure of this study.

The video clip was transcribed verbatim (see Textbox in Appendix) and provided to all participants. After the video clip was shown to the participants, they were offered two open

questions. First, participants were asked “which physical sensation, action tendency, feeling, thought, interpersonal pull, fantasy,… was evoked in them while watching the video clip”. Secondly, they were asked “what they would do if they were the psychotherapist or counselor of this client, in this particular video clip.”

We showed a video clip of a real client because we wanted to offer the same stimulus of the depressive symptoms of hopelessness, worthlessness, and guilt (American Psychiatric Association, 2013) to all therapists and evoke the therapists’ immediate experience, an aspect that usually remains uncovered by other sampling designs (Stiles et al., 1998). The sampling method used in this study aligns with the Facilitative Interpersonal Skills method in qualitative research (Anderson et al., 2020). This research method aims to investigate therapists’ responses in difficult moments with clients, and typically uses videos of clients as a stimulus of challenging moments in therapy. In the present study specifically, the stimulus offered to the therapists encompassed a client’s expression of the symptoms of depression. The client gave permission to use this part of video clip for this study and he was informed about the method of the study.

The first data source of this study consists of the written responses of the therapists and counselors to the open questions. Through these written responses, we collected the therapists’ individual experiential reactions and their individual ideas about interventions for this client, without the influence of other participants. Subsequently, the therapists and counselors were invited to share their personal reflections in a focus group. Two focus groups with a duration of 45 minutes were organized (one per parallel conference session) and were moderated by the first researcher. The first researcher and moderator invited the participants to share (parts of) their written individual responses. The moderator invited the participants to elaborate more on their experiential reactions to the video and on their reflections about their proposed interventions. By using focus groups, we aimed to obtain rich data in a verbal context, similar to an interview. The Consensual Qualitative Research (CQR; see Data Analysis) recommends the use of interviews for data collection, but this was not possible given the large sample size (26 participants) and the time frame of data

collection in the current study. The discussions in the two focus groups (one in each workshop), which 18 of the 26 therapists joined actively, were video-recorded. The second source of data for this study consists of verbatim transcriptions of the video-recorded discussions.

Data Analysis

To capture the immediate experience and ideas of the psychotherapists and counselors, the CQR method of Hill (2012) was used. This method is indicated as ideal for the in-depth study of the experiences, attitudes, and beliefs of individuals, to obtain a rich, detailed description and understanding of a phenomenon (Hill, 2012). It is a bottom-up or inductive approach, related to Grounded Theory (Urquhart, 2013), where results arise from the data. This means that CQR enables us to grasp the experience of the therapists as a whole and remain open to unexpected and new aspects in their responses, and to build a theory out of the specific data.

First, in line with the CQR method (Hill, 2012), a preliminary domain list was created, based on the open questionnaire. A "domain" is an umbrella term for all pieces of narrative in the cases that express a similar idea. In this study, the two main aspects that we wanted to capture in the questionnaire were (1) the immediate experience of the therapists and (2) the therapists' ideas about what they would do or the interventions they would use. Consequently, the two preliminary domains "experience" and "do" were extracted from the questionnaire.

Subsequently, the two primary researchers reviewed the transcripts of the 26 questionnaire cases and the 18 focus group cases to see which topics naturally arose out of the data. This list of topics was compared to the preliminary domain list based on the questionnaire. Based on this review, the domain label of "do" was changed to "direction", after intensive deliberation between the two main researchers and the auditor. The "do" label did not seem to completely encapsulate the whole meaning that was expressed by the core ideas: a substantial number of therapists tended to make hypotheses about the therapy process, the client, or the possible effect of interventions, rather than making a clear suggestion for an intervention. For example, one of the therapists hypothesized that "*the reluctance of the client to change may serve as a protection against the*

expectations that come his way". This refers to the therapist's idea about how to interpret the feelings and behavior of the client, rather than a suggestion for a therapeutic intervention.

Second, a *within-case analysis* was conducted. In this study, each "case" corresponds to an individual therapist or counselor. Within cases, the raw data were transformed into meaning units and core ideas. A "meaning unit" is a set of words, sentences, thoughts, or paragraphs about the same topic, sharing the same meaning. A "core idea" is the essence of the corresponding meaning unit, or a brief summary of the meaning unit. An illustration of the way the raw data are clustered in into domains, meaning units, and core ideas is presented in Table 1 in the Appendix.

This coding process was first completed by the two main researchers individually. Subsequently, the final clustering of the meaning units and core ideas was discussed and agreed upon or changed by consensus, which is another key characteristic of CQR. The two sources of data were analyzed separately, resulting in 26 cases stemming from the written (questionnaire) and 18 cases from the transcribed verbatim (video-recorded focus groups) individual responses of the therapists and counselors. Ultimately, the within-case analysis resulted in 306 meaning units and corresponding core ideas.

The clustering into meaning units and core ideas was done by taking the whole case into account, in order to stay close to the data and keep interpretation bias to a minimum. Therefore, the context of the whole response of the therapist to the questionnaire, and the context of the topic of conversation in the group discussion, was taken into consideration. Attending to the specific context in which experiences occur is an important aspect of CQR.

The within-case analysis of the 26 questionnaire cases was an intensive process, because the data contained a high density of meaning. This was in contrast with the focus group cases, where a lot of background data were detected. This background created a context within which to distinguish meaning units and core ideas, but did not itself reflect meaningful ideas. After the within-case analysis, auditing was performed by the third researcher. The auditor reviewed the clustering into meaning units and core ideas by the first two researchers and helped to make definite decisions

about the final clustering of some of the core ideas where the first two researchers felt unsure about.

After the within-case analysis, a *cross-case analysis* was performed. The two main researchers went through the core ideas circularly, to discover recurrent themes or patterns. Ideas exhibiting the same meaning were clustered together into categories and subcategories. For each domain ("experience" and "direction") and each set of cases (questionnaire cases and focus group cases) a cross-case analysis was conducted, which resulted in four cross-case analyses. The researchers kept on going back and forth through the data until all the core ideas crystallized into categories and subcategories. In this way, a model was built up out of the data. The researchers kept on investigating the core ideas circularly until saturation of the model was achieved. The set of focus group cases was subjected to the same procedure, resulting in two data-driven models: one model for the individual therapists' responses and one model for the group responses.

In line with the CQR method of Hill (2012), categories were considered to be *general* if they applied to all cases of the set (26/26 questionnaire cases or 18/18 focus group cases), and *typical* if they applied to 14–24/26 or 10–16/18 cases, respectively. Categories were labeled *variant* if they referred to 4–13/26 questionnaire cases or 4–9/18 focus group cases. Finally, categories were labeled *rare* if they applied to fewer than four cases in each set. To make the results more insightful, the proportions are also presented as percentages. For the sake of readability, rare categories are not described in the following sections, but are included in the tables. The results of the questionnaire cases are presented in Tables 1 and 2, and the results of the focus group cases are presented in Tables 3 and 4 (see Appendix).

Results

Individual therapist responses

With respect to the first research question, concerning the impact of depression on the immediate experience of the therapists and counselors, cross-analysis of the questionnaire cases,

within the domain “experience”, exposed a first raw pattern in the data. The majority of participants reported experiences with a negative valence. A smaller number of participants described experiences reflecting both positive and negative aspects: this category was labeled “experiences with a mixed valence”. Others responded with experiences with a uniformly positive valence (see Table 2).

With respect to the second research question, concerning the therapists’ and counselors’ ideas about which interventions they would use, the domain “direction” showed three categories. The therapists and counselors responded with (1) therapeutic reflections, referring to thoughts and hypotheses about the client and the therapeutic process; (2) therapeutic attitudes, referring to the emotional-relational stance of the therapist; and (3) therapeutic actions and techniques, referring to specific verbal and nonverbal interventions that the participants would make when faced with the client in the video clip (see Table 3).

Therapists’ experiences with a negative valence

With regard to the 26 questionnaire cases, the psychotherapists and counselors typically (20/26 cases; 76%) exhibited a kind of experience that we labeled “constriction” after they had been exposed to the video clip. The constriction they experienced was variantly (13/26; 50%), conceptualized as “the feeling of being stuck, fixed, the feeling that things could not be changed” (13/26; 50%), “a feeling of heaviness” (5/26; 19.23%), or an experience of “helplessness, powerlessness, or meaninglessness” (13/26; 50%). For example, one of the therapists reported that “the image of a block of granite stone” came to his mind while he was watching the video clip. Another therapist shared a metaphor of “a turtle, lying on his back, waiting for someone to turn him over”. The first subcategory—the feeling of being stuck—was described as an experience of rigidity, rigor, and control (5/26; 19.23%) or a physical experience of being stuck (5/26; 19.23%), resulting in variant subcategories. For example, some therapists expressed that they felt like “their throat was being squeezed or that they couldn’t breathe any more”. Others felt a tendency to “slump or sigh”. A variant proportion (5/26; 19.23%) of the therapists felt disconnected or distanced from themselves

or the client. A variant number of other therapists (4/26; 15.38%) felt frustrated or irritated; for example, one of the therapists reported feeling "like wanting to kick the client's ass or shake him up".

> "I make contact with an experience in him (the client) that prefers to hold on to the feeling of immutability, or to an illusion of immutability. Especially when he uses it as a defense: "I am like this", in response to an expectation. I have an image of a little boy who is stable, 'stays at home' and desperately needs expansion, immutability, and not having to 'answer' to the life he is in."

Therapists' experiences with a positive valence

Some of the therapists (10/26; 38.46%), a variant proportion, had an experience that was labeled "expansion" after they watched the therapy fragment. Some of these therapists felt expansion in terms of hope (6/26; 23.08%), and another variant proportion (7/26; 26.92%) of the therapists felt activated. These therapists felt movement, energy, power, or liveliness. In parallel to the experience of expansion, a variant proportion of therapists expressed empathy (8/26; 19.23%) with the client: these therapists felt sadness or were emotionally touched (5/26; 19.23%). One of the therapists said that she felt sadness because of the client's feeling of being stuck. A final variant category of experiences with a positive valence contained therapists' experiences of being in contact with themselves or the client (7/26; 26.92%). A variant proportion (6/26; 23.08%) of the therapists felt in contact through attraction (6/26; 23.08): these therapists felt curiosity, interest, or concern for the client.

> "I still feel life energy in the person behind his immovable wall of 'immutability'. I feel a desire to work with that person, which I usually don't experience in contact with depressed clients."

Therapists' experiences with a mixed valence

The variant (8/26; 30.77%) category of therapists' experiences with mixed valence contained a variant (8/26; 19.23%) category of ambivalent experiences. This ambivalence could be experienced

in terms of energy (5/26; 19.23%): one therapist expressed that she was “bubbling with energy at one moment and sinking at the other”. Some therapists expressed an ambivalence with regard to the possibility to change (5/26; 19.23%): they experienced “a longing for change in the client, accompanied with a feeling to be stuck and that nothing ever could change”.

Therapists’ interventions

The therapists and counselors described various therapeutic interventions that they would use when they imagined to be the therapist or counselor of the client in the video clip. Some did not formulate specific therapeutic interventions; their responses presented inner reflections or “precursors” of therapeutic interventions. They expressed their inner reflections about the therapy process and the client in different ways: their responses were variantly formed into hypotheses (6/26; 23.08%), wishes, goals, or desires (6/26; 23.08%), critical remarks about the client, or a call (for help) (4/26; 15.38%). For example, one therapist thought that “the client is experiencing grief, and that this is the reason why he holds on to his belief of immutability”. Another therapist was “curious about the conflict between hope and despondency in the client and wants to understand this conflict better”.

More than half of the therapists reported the importance of the therapeutic attitude of being there, being present for the client and his experiences (14/26; 53.85%). This typical response contained the variant therapeutic attitudes of acknowledging the experiences of the client (12/26; 46.15%) and “being/staying there” (with the experience of the client) (5/26. 19.23%).

A final variant category of therapeutic approaches reflected various therapeutic interventions. All therapists highlighted the importance of being actively present as a therapist (26/26; 100%). According to these therapists, this approach could be achieved through the variant act of paraphrasing and empathic gesturing (5/26; 19.23%); for example, one of the therapists experienced a longing for significance in the client and would present her experience to the client. A second typical category of therapeutic interventions was composed of further exploration of the client’s experiences (17/26; 65.38%). Therapists said that they would like to explore the client’s

(longing for) meaning and significant aspects in the client's life (5/26; 19.23%), his needs and desires (4/26; 15.38%), his loss (4/26; 15.38%), and his emotions (14/26; 53.85%) in more depth. One of the therapists said that he would like to explore "the desire of the client to make a meaningful contribution to society in more depth". A lot of therapists reported that they would like to explore the client's fear or the client's feeling of being stuck.

A third, typically present category of interventions was composed of interventions that reflected work with the client's inner conflict (14/26; 53.85%). Some of these therapists would acknowledge both parts of the conflict in the client (4/26; 15.38%), whereas others would like to go one step further in this task, by offering space alternately to both opposing parts in the client (7/26; 26.92%). Some therapists would even try to start up the dialogue between the opposing parts in the client (4/26; 15.38%): for example, one of the therapists "would invite the client to contact alternately the anxious and the hopeful part in him by making use of the two-chair dialogue". A fourth and final category of interventions that reflected active presence on the part of the therapist included responses of therapists who would focus on contacting the bodily felt component of an experience as expressed by the client (4/26; 15.38%); for example, one of the therapists said that "he would try to let the client make more contact with his felt sense about his feeling of powerlessness".

Remarkably, despite the value that was attached by the therapists to an actively present therapeutic approach, some of the therapists also tended to distance themselves from the negative experiences expressed by the client (10/26; 38.46%,). They reported that they would focus on positive experiences in the story of the client (6/26; 23.08%), for example, by "trying to convince the client that his life has meaning, that he can change, or to invite him to focus on the hopeful and positive experiences in his life".

> "I would focus on the conflict: the idea of immutability versus the desire for changeability. I would explore both parts further, and reflect on how difficult that must be. I would express my belief in changeability and possibilities that people have in general, in a way that the

client does not feel that his sense of changeability is not taken seriously. I would focus on the fear for change."

Group responses

Therapists' experiences

With regard to the first research question about the impact of depression on the immediate experience of the therapists, the therapists and counselors in the focus groups mainly expressed responses with a negative or mixed valence. Experiences with a positive valence were reported only rarely. With regard to the category of experiences with a negative valence, a variant proportion of the therapists and counselors (10/18; 55.55%) expressed an experience of constriction. Constriction in terms of the feeling of being stuck and that nothing can ever change was variantly present (8/18; 44.44%), as was the experience of rigidity, rigor, and control (6/18; 33.33%). For example, "the image of a little boy, who clings on to the belief that things cannot change, out of fear, as a way of not having to respond to the world", came to the mind of one of the therapists. Experiences with a mixed valence were variantly present (4/18; 22.22%), and were mainly about an ambivalence with regard to the feeling of immutability (4/18; 22.22%). For example, one of the therapists symbolized the immutability in the image of a "bunker or a fortress", but also grasped "a less static part in the client, in his desire to change". Results are presented in Table 4.

"I did not really feel an interactional pull to do something. I rather felt forced to sit as a spectator and listen to his beliefs. Occasionally, I did feel stimulated and I felt energized when it came to his desire. I thought: "It is a very creative solution to not having to do something, to say: 'That's my character'"… That stimulated me in that sense that I thought: "I wouldn't have come up with that!" That is where I would actually like to set my limits, in my autonomy or self-determination. So I was like, in the way he regulates the distance, let you get closer, but then put you at a distance again by: "it is fixed and there's nothing you can do about it". Yes, I was fascinated by that."

Therapists' interventions

With regard to the second research question, concerning the interventions that therapists and counselors would use, within the domain of "direction", the same broad pattern of therapeutic reflections, attitudes, and actions and techniques as in the questionnaire cases was observed. However, differences were found in the representativity of the subcategories: several subcategories that were variantly present in the questionnaire cases were absent, or present only rarely, in the focus group cases.

Therapists made reflections by formulating hypotheses (8/18; 44.44%) and critical remarks (4/18; 22.22%). One of the therapists hypothesized that the "strong belief (that things in his life cannot change) of the client was a way to avoid the anxiety that change brings with it". The therapeutic attitude of being present was highly valued (7/18; 38.88%) by the therapists. Therapists reported that they would acknowledge the client's experience (6/18; 33.33%).

Therapists frequently highlighted the importance of interventions that express the therapist's active engagement and presence, resulting in a typical subcategory (12/18; 66.67%). A variant proportion of therapists and counselors said that they would explore the client's feeling of being immutable, his feeling of being stuck, his resistance to change, and his anxiety (6/18; 33.33%). Therapeutic interventions in terms of identifying, paraphrasing, empathic gestures, and empathic resonance were mentioned only rarely in this dataset. Another variant proportion of the therapists would work with the different parts of the conflict in the client, by addressing the different parts of this conflict (i.e., the desire versus anxiety with regard to change), and by exploring and giving space to these different parts (6/18; 33,33%). Finally, parallel to the questionnaire cases, a variant part of the therapists distanced themselves from the negative experience of the client (4/18; 22.22%). One of the therapists reported that they would confront the client with his resistance to change. Results are presented in Table 5.

> "So that made me think that, as a therapist, I would invite him at some point to work more on contact with himself, because that is of course a whole process of getting more in touch

with that part of his experience and relating to it, and entering into a relationship with you as a therapist with that part. Because I think there is a pitfall: he goes to therapy and seems to ask for change, but he ignores a part of him that does not want change and that creates tensions for changes. So as a therapist you can very much step into that trap of "yes, but he wants change", you go along with that in avoiding relating or being avoiding relating to that other piece. Because I think there's a developmental need there, but that is of course a hypothesis. As long as that is not allowed to exist or receive attention or recognition, it will hold the process, the therapeutic process. I would start exploring that and at least maybe he can feel… Because at a certain point he says "do I really want that?". So that's true… that also reminds me… I also think his step to go to therapy triggers even more in the inner relationship with himself that part that wants to hold on to immutability. You can go along with that contradiction as a therapist, so I really feel something like: "Ho, watch out!""

Discussion

This qualitative study investigated the phenomenon of therapist responsiveness in the treatment of depressive disorder. First, therapists' responsiveness to a client's depressive symptomatology was investigated. Second, therapists' responsiveness in terms of their interventions was investigated.

Regarding our first research question, concerning the therapists' responses to the client's depressive symptomatology, the results of this study revealed three recurrent categories. The therapists' experiences, both individual and in the group, clustered into (1) experiences with a positive valence (e.g., the therapist feels liveliness), (2) experiences with a negative valence (e.g., the therapist feels emotionally withdrawn), and (3) experiences with a mixed valence (e.g., the therapist feels emotionally touched). Experiences with a negative valence were dominant in both the individual and group responses of the therapists in this study. Furthermore, a specific kind of

negative immediate experience, “constriction”, was expressed by the majority of the therapists. The experience of constriction was a typical response in the individual and group responses.

The therapists’ experiences of constriction occurred on the cognitive, emotional, physical, and relational levels. For some therapists, the constriction was felt more literally, through physical sensations. They experienced a drop in their energy level, they felt a tension rising in their body, or they felt their “throat being squeezed, making it hard to breathe”. Some of the therapists used the metaphor of “a block” or “a stone” to describe their experience. Others expressed a feeling of being stuck or sensing a kind of heaviness. An image of “a stubborn little boy who stays at home and does not respond to the outside world”, and “a turtle lying on his back, waiting to be turned over”, came to some of the therapist’s minds. Therapists also described feelings of powerlessness. Some therapists expressed that they lost contact with themselves and the client. Some of them felt frustrated and irritated. In contrast with these different expressions of constriction, a very small number of the therapists in our sample reported experiences of “expansion”. A few therapists (resulting in a rare category) expressed feeling energized, excited, or hopeful while watching the video clip and could sense a certain power in the client.

The variability in experience among the therapists in this study may have led to a parallel variation in their choice of interventions. With respect to the second research question of this study, concerning the therapists’ ideas about the *interventions* that they would use with the client shown in the video clip, the therapists’ responses revealed three recurrent categories: (1) therapeutic reflections, (2) therapeutic attitudes, and (3) therapeutic interventions and techniques. In the individual responses, most therapists emphasized an attitude of “being and staying with” the client and the different aspects of his experience. This typical category of individual therapeutic response was labeled as “presence”. In the group responses, presence was a variant category.

In contrast with the latter finding is that a variant number of the therapists in our study, in both the individual responses and the group responses, showed a non-present attitude. These therapists seemed to actively “go away” from the client’s experience; they felt a tendency to direct

their attention to the positive aspects of the client's life, to convince him, or to confront the client. Some of the therapists used the metaphor of "kicking his ass or shaking him up, or trying to convince him of the therapist's own belief that he can change".

As aforementioned, the majority of the therapists in this study reported an experience of constriction while they watched the video clip showing a severely depressed client. This experience may have led to difficulties in maintaining a present attitude in contact with this client, despite the fact that the majority of the therapists emphasized the importance of presence as a therapeutic condition. Possibly, in order to provide an empathically attuned response, an immersion with the clients' experiences, including their sense of constriction, is needed in the first phase of the therapy process. Maybe it is a necessary step to take before the therapist can draw back from this feeling and can regain a reflective position in a second phase of the therapy process. Therapists who felt their mental space being constricted potentially adjusted their ideas about interventions in such a way that they could expand their mental space again, to get in more contact with themselves and the client again.

This idea might be reflected in the therapists' responses about the interventions that they would like to use with the client. The therapists in this study expressed an intention to use two main therapeutic techniques: (1) exploration of the emotions of the client and (2) facilitating a dialogue between the different parts of the emotional split the client exhibited.

First, the therapists reported "exploring the emotions of the client". For example, some therapists expressed that they would help the client to explore his fear of pursuing change in his life, his grief about not being able to change, and his desire to mean something. Second, therapists reported that they would "work with the self-split of the client", resulting in a typical individual response and a variant group response. For example, therapists reported that they would give alternating attention to both parts of the clients' inner conflict—the part in the client that wants to change, and the part that does not. Some of the therapists said that they would like to try to start a dialogue between the two parts.

By using this technique of exploring the different aspects of the emotional world of the client, therapists can help the client to make contact with his primary maladaptive (the fear…) and adaptive (the grief, the desire…) emotions that underlie the symptoms of depression. The self-image of the client in the video clip was dominated by his sense of worthlessness and hopelessness, and his conviction that he was unable to change or to make a significant contribution to society, despite a strong desire to do so. By revisiting the primary emotions and the negative experiences that are associated with their unmet needs, clients can become more aware of the impact of these negative experiences, and more able to access and regulate their emotional reactions (Salgado et al., 2019). Through the exploration of the primary emotions, the therapist can help the client to reconnect with childhood experiences of emotional neglect, abandonment, or criticism by important others (Salgado et al. 2019). The metaphor of a "stubborn little boy" provided by one of the therapists in our study was particularly interesting in this regard because of its evocative potential. Exploring the different aspects of the client's experiential world can potentially cultivate new emotional schemes and new stories for the client. By constructing new stories, the client can discover new meanings. The ability to experience meaning is believed to buffer the symptoms of depression (Schnell & Krampe, 2020).

There were some differences between the individual responses and the narrative that the therapists constructed as a group, concerning the therapists' experiences and their reflections about interventions. In general, the individual responses showed more variation, resulting in more variant subcategories than in the group responses. Within the therapists' experience of constriction, a subcategory of "physical stuckness" was a variant category in the individual responses, whereas this category was absent from the group responses. In addition, the individual therapists' responses showed a wider range of subcategories for the experience of "expansion" and "empathy" than the group responses did. For example, the therapists' individual responses included an experience of expansion in the form of "hope" and "activation", whereas these subcategories did not occur in the group responses. Furthermore, the individual responses showed that the therapists experienced

empathy in “feelings of grief” and “being touched” (in a variant subcategory), whereas the group responses did not show this subcategory. With regard to the therapists’ interventions, the individual responses of the therapists showed therapeutic reflections in the form of “wishes, goals and desires for the client or the therapy process” and a “call for help”. “Resonating” was also a unique subcategory for the individual responses. In the context of the group, therapists inevitably also influenced each other’s experience. They possibly felt less free to be open about the different facets of their inner experience, resulting in more homogeneous reflections about their experience and the interventions they would use.

Limitations and Strengths

With respect to the principles of CQR, the present study made some noteworthy adaptations that could have influenced the results. The primary research team was composed of two instead of the recommended three researchers (Hill, 2012). In addition, the two researchers and the auditor involved in the study shared a person-centered and existential orientation, which might have induced a bias in the analysis. Their theoretical background might have increased the responsiveness of the judges to aspects concerning the therapeutic relationship and existential topics in the data.

Furthermore, the sample sizes of both the questionnaire cases and the focus group cases (two groups of 13 participants) slightly exceeded the recommended number of eight to a maximum of 12 participants (Carlsen & Glenton, 2011). The large number of participants might explain why some therapists (eight of the 26 focus group cases) did not engage in the discussion. As mentioned earlier, the variation of responses was smaller in the group responses than in the individual responses, showing the influence of the therapists on each other’s response.

Finally, individual written and transcribed verbatim discussion group data were used; this was in contrast to data collection by means of an interview as suggested by Hill (2012). By using this sampling technique, a large sample size and a triangulation of sources of data was achieved, increasing the internal validity of the study. However, the density of the data made the within-case and cross-case analyses complex. Data collection by interview could have provided more context to

interpret the data, and consequently might have reduced the complexity of interpretation. Furthermore, because we made use of a qualitative design, our sample size and methodology do not permit generalization across clients or therapists.

Nevertheless, the results of the present study reflect an in-depth insight into the immediate experience and ideas about interventions of therapists in contact with a severely depressed client. Because a video clip of a fragment of a real therapy session with a real client was used, the ecological validity of the results of the study are high. In addition, by using a design with open questions and an open discussion, we collected data showing a richness that could not have been achieved through forced responses in a survey-based design; the responses of the therapists revealed many layers.

Furthermore, survey-based designs tend to capture the conscious and superficial aspects of an experience and often leave negative experiences hidden due to social desirability bias. We argue that the present study has made a valuable contribution by probing for the *immediate* experience of the participants, which is not affected by recall bias as may occur in other designs. With our use of an open questionnaire that evoked the immediate physical sensation, action tendency, feeling, thought, interpersonal pull, fantasy, and so on, of therapists, we were able to grasp the therapists' experience as a whole, including its subconscious and negative aspects.

Our study provides a unique and detailed description of the difficulties, as well as the possibilities, that psychotherapists experience in the encounter with a client with depression. We argue that the results of this study could enhance psychotherapists' understanding of the blockages they might encounter in therapy with clients with depression. Furthermore, the results of this study might improve therapists' knowledge about how to work through these impasses.

Thanks to the current design, we could capture some of the feelings, action tendencies, hypotheses, and intentions of the therapists, but we do not know how the therapeutic process would proceed if these responses were made in a naturalistic situation. Results might have been different if the participating therapists were in real-life contact with a depressed client instead of

watching a video clip. A qualitative design with data extracted from audio or video recordings of therapy sessions could further expand our understanding about the impact of the clients' features on therapists' responses in the treatment of depression.

Finally, although our study has made a valuable contribution in describing therapists' responses, different results may have been obtained with a video clip of another client. Describing therapists' responses to more than one client with major depression could have increased the validity of our results.

Conclusion

The findings of this qualitative study illustrate the phenomenon of therapist responsiveness in the treatment of depression. The results contribute to understanding how therapists construct their responses in the encounter with a severely depressed client.

The individual responses of the therapists in this study showed great variability, in terms of both their experience and their reflections about interventions. The responses that therapists made in the context of a group of therapists showed less variation, but revealed the same broad pattern of responses as the individual responses did. The therapists in our study expressed experiences with mostly a negative valence when confronted with a video clip of a depressed client. An experience of "constriction" was a typical response among the therapists in this study. Furthermore, the results indicate that a therapeutic attitude of "being there and with the client" was valued strongly by the therapists. The therapists highlighted the importance of exploring the different aspects in the client's experience and to start a dialogue between the conflicting parts of the client's self. Therefore, according to the therapists, the client's desire—as well their resistance—to change must be attended to.

As earlier research indicated that even small negative interpersonal interactions impact the client and the outcome of therapy to a great deal (Anderson et al., 2020), it is of great importance to know how appropriate responsiveness can be achieved during difficult moments in therapy with

depressed clients. The results of this study make two suggestions in this area, which can be implemented in psychotherapy training.

First, training programs can enhance therapists' *awareness* of experiences of constriction in their contact with a depressed client. Drawing on the models of Safran and Muran (2000) for the resolution of alliance ruptures, the therapists' constricted experience can be conceptualized as a *marker* that indicates the need to initiate the therapeutic task of exploration.

Second, training programs can teach therapists to encourage their clients to *explore* the conflicting parts in their experience and self-image, express the feelings and thoughts on both sides of the conflict, and talk about the life events that are associated with these experiences. For example, therapists could invite their clients to explore both the desire for change and the desire for not changing, to elaborate more on the heavy and dark feelings as well as the light feelings, or to bring conflicting parts of the self of their clients into a dialogue (e.g., "Part of me thinks that I can change, and part of me doesn't."). In this way, the therapist can disembed from the feeling of constriction, expand their mental space again, and help the client to process feelings that were being avoided until that point.

Future research should focus on the moment-to-moment investigation of the effect of exploration in therapy episodes marked by experiences of constriction. This will require a study design that enables the investigation of micro-processes in therapy, for instance, by analysis of transcribed verbatim therapy recordings focusing on these specific therapist or client markers.

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Appendix

Text box

Transcript of the video clip

T: Apparently these two parts can go together; it feels right somehow, but on the other hand, it feels very wrong somehow?

C: Hmm. Yes, I know, I also had that, more or less in the beginning, and I had to laugh about it, like: "What are you doing here (in therapy)?", but I still have that feeling of: actually, it's not going to work. I keep on having that. (T: Hmm… What...)

C: Oh...

T: What makes you have the feeling that it is not going to work?

C: I think I especially have a very deep feeling of immutability somewhere. In essence, it will always be "me".

T: Like: "It does not matter who sits here besides me..."

C: And I can then perhaps learn to see better why things are going wrong and whatever, but…

T: I will remain "stuck"?

C: I'm not going to be strong enough to stand up to that fear and stuff like that.

T: A failure to believe in yourself, your own strength, your changeability, your possibilities?

C: In changeability, I think, yes. In one way or another, I have a strong image of: people are as they are, and that is unchangeable, the essence that does not change.

T: Hmm. People are the way they are...

C: I know as a child that I once used that as a strategy for not having to do something. I didn't want to do that. At a certain moment I said something like: "Yes, but that's my nature!" That doesn't change, that can't change! You can't change the way you commit yourself. That is who I am.

T: Ah, and how did that happen?

C: Well, I don't remember, but I know that it felt like this. If it was like: "You have to learn that or..." If I felt like: It is to make me do something that I do not want to do, then I said: "Yes, but that's my character".

T: Your parents?

C: Yes, and also something that you hold on to, something that is almost protective or something like that.

C: Maybe that was also part of it, but also: Yes, but I am like that. That doesn't change anyway.

T: You also already really believe: this is how it is.

C: This is it. I think so, to a certain extent, yes. And I still experience it that way, the world around me. Maybe I could change the circumstances, but not the core of it.

T: Is it about the immutability of yourself or the world around you?

C: Myself... and the others. There is such a block, a personality, it is there and it stays like that.

T: You have the feeling that even if I want it so much, I cannot change it?

C: I do have that feeling. (T: Hmm.) C: And that is...

T: That is?

C: It can't be 100%, otherwise I wouldn't try to come here, but it's there, deep down.

T: But...

C: I can't imagine that I would be different, that's what's going on there. Imagine a situation in which I no longer have that fear.

T: You don't see that possibility?

C: No, no.

T: You cannot imagine that possibility: that possibility without fear or with less fear or that something moves in you? You do not feel that possibility?

C: Actually, no.

T: But what is it like to be in therapy, or life as such, if you don't see any possibilities or any possibility of movement?

C: Hmm. Well, in life in general is at times discouraging, actually. Like: "Yes, it is like this now, and I don't see it getting any better". And in theory, there is hope that maybe something... But not really seeing where that should come from or where there could be a way to get there. (T: Hmm.)

T: That seems very difficult, I think: Not seeing the road or not seeing any road and yet hoping. That seems difficult.

C: Hmm.

T: And what gives hope? You don't see the road, but what gives you hope?

C: It is more of a desire, I think.

T: A desire. To feel like: I really want that, that something moves.

C: Yes, I think.

T: That something changes...

C: And even than I start to question myself. Like, “Do I really want that?” Because I often see that I don’t change and don’t... And then I start doubting again: “Do I really want it then?”

T: That “I am very afraid” is going to turn into: “Maybe I don't actually want it”.

C: Hmm, yes.

T: What do you really want, X, to change? What comes first?

C: The feeling that I really... that I am making my... my contribution somewhere. That I’m really doing something... that I’m not spending most of my time at work worrying about this and that, but that I’m... That I’m really accomplishing something, I think. That feeling.

T: At work?

C: Or in a broader sense.

T: Society?

Note: T = therapist, C = client.

Table 1

Illustration of transformation of raw data into meaning units and core ideas of one case

Raw data	Domain	Meaning unit	Core idea
Powerlessness, sadness, frustration Soothing, saying everything will be all right Turtle lying on its back and waiting for someone to turn him over, so he can continue. He seems to be asking if it's okay to stay down. It must be hard to think that you have to change and that change is not possible: How do you feel about this? How do you deal with this? At what moments do you manage to deal with this or is the difficult feeling less present? What could help you with this? (Therapist 4, individual written response)	Experience	Powerlessness	The therapist feels powerlessness
	Experience	Sadness	Therapist feels sadness
	Experience	Frustration	Therapist feels frustrated
	Direction	Soothing, saying that everything will be all right	Therapist feels a demand to soothe and to say that everything will be all right.
	Experience	Turtle lying on its back and waiting for someone to turn him over, so he can continue. He seems to be asking if it's okay to stay down.	Therapist describes the helplessness of the client with a metaphor.

Direction	It must be hard to think that you have to change and that change is not possible	Therapist acknowledges the suffering brought on by the inner conflict in the client.
Direction	It must be hard to think that you have to change and that change is not possible: **How do you feel about this? How do you deal with this?** At what moments do you manage to deal with this or is this difficult feeling less present?	Therapist asks about feelings related to client's inner conflict.
Direction	It must be hard to think that you have to change and that change is not possible: How do you feel about this? How do you deal with this? **At what moments do you manage to deal with this or is this difficult less present?**	The therapist asks about the moments in which the client feels better and makes use of other coping strategies related to his inner conflict.
	It must be hard to think that you have to change and that change is not possible: How do you feel about this? How do you deal with this? At what moments do you manage to deal with this or is the difficult feeling less present? **What could help you with this?**	The therapist asks about resources that can help the client to cope better/differently with his inner conflict.

Note. One case corresponds to one therapist or counselor

Table 2

Results of the cross-case analysis of individual responses to questionnaire for domain "experience"

Categories	Frequency	Frequency (%)
Therapists' experiences with a negative valence		
Constriction	Typical	76.92%
Stuckness, feeling that things cannot be changed	Variant	50%
Stringency, rigor, control	Variant	19.23%
Impasse	Rare	3.85%
Interactional stuckness	Rare	3.85%
Physical stuckness	Variant	19.23%
Heaviness	Variant	19.23%
Powerlessness, helplessness, meaninglessness	Variant	50%
Distance, losing contact (in the narrow sense)	Variant	19.23%
Irritation, frustration	Variant	15.38%
Therapists' experiences with a positive valence		
Expansion	Variant	38.46%
Hope	Variant	23.08%
Activation	Variant	26.92%
Humor	Rare	3.85%
Empathy	Variant	19.23%
Grief, being touched	Variant	19.23%
Compassion	Rare	11.54%
Silence, standing still	Rare	3.85%
Proximity, contact	Variant	26.92%
Attraction	Variant	23.08%
Therapists' experiences with a mixed valence		
Ambivalence	Variant	30.77%
Ambivalence about energy	Variant	19.23%
Ambivalence about the potential to change	Variant	19.23%
Ambivalence about contact	Rare	7.69%
Not specified	Rare	7.69%

Note. N = 26; General = 25–26; Typical = 14–24; Variant = 4–13; Rare: 1–3.

Table 3

Results of the cross-case analysis of individual responses to questionnaire for domain "direction"

Categories	Frequency	Frequency (%)
Therapeutic reflections		
Hypothesis	Variant	23.08%
Wish, goal, desire	Variant	23.08%
(Critical) remark	Variant	15.38%
About the therapeutic process	Rare	3.85%
About the client	Variant	15.38%
Call (for help)	Variant	23.08%
Therapeutic attitude		
Presence, being there	Typical	53.85%
Acknowledging, recognizing the right to exist	Variant	46.15%
To the suffering of the client	Rare	11.54%
To the person of the client	Rare	11.54%
To the coping of the client	Rare	3.85%
To the different aspects in his emotions	Rare	7.69%
To his experiences and emotions	Rare	11.54%
Staying with	Variant	19.23%
Therapeutic actions and techniques		
Active presence	General	100%
Identifying, paraphrasing	Variant	19.23%
Of the experience, emotions of the client	Rare	7.69%
Resonating	Variant	15.38%
Empathic gesture	Rare	3.85%
Exploring	Typical	65.38%
Self-image of client	Rare	3.85%
Significance, meaning	Variant	19.23%
Needs, desires of client	Variant	15.38%
Loss, costs	Variant	15.38%
Coping	Rare	3.85%
Feelings of client	Typical	53.85%

Feeling that things cannot change, being stuck, resistance, fear	Variant	42.31%
Desires, desire to change	Rare	11.54%
Feelings not specified	Rare	7.69%
Working with self-split of client	Typical	53.85%
Indicating, differentiating	Variant	15.38%
Exploring, giving space	Variant	26.92%
Start up dialogue	Variant	15.38%
Metacommunication, relational intervention	Rare	
Focusing	Variant	15.38%
Going away	Variant	38.46%
Exploring	Variant	23.08%
Hopeful, positive, remarkable experiences of client	Variant	23.08%
Coping resources	Rare	7.69%
Convincing client	Variant	19.23%
Confronting client with resistance with regard to change	Rare	3.85%
Cognitive reaction	Rare	3.85%
Therapeutic intervention not specified	Rare	3.85%

Note. *N* = 26; General = 25–26; Typical = 14–24; Variant = 4–13; Rare: 1–3.

Table 4

Results of cross-case analysis of the responses in the focus groups for domain "experience"

Categories	Frequency	Frequency (%)
Therapists' experiences with negative valence		
Constriction	Typical	55.55%
Stuckness, feeling that things cannot be changed	Variant	44.44%
Stringency, rigor, control	Variant	33.33%
Impasse	Rare	5.55%
Interactional stuckness	Rare	5.55%
Heaviness	Rare	11.11%
Powerlessness, helplessness, meaninglessness	Rare	5.55%
Deactivation	Rare	16.67%

Irritation, frustration	Rare	11.11%
Fear	Rare	5.55%
Therapists' experiences with positive valence		
Expansion	Rare	16.67%
Empathy	Rare	11.11%
Proximity, contact	Rare	11.11%
Therapists' experiences with mixed valence		
Ambivalence	Variant	22.22%
Ambivalence about the potential to change	Variant	22.22%
Ambivalence about contact	Rare	5.55%
Not specified	Rare	5.55%

Note. *N* = 18; General = 17–18; Typical = 10–16; Variant = 4–9; Rare: 1–3.

Table 5

Results of cross-case analysis of the responses in the focus groups for domain "direction"

Categories	Frequency	Frequency (%)
Therapeutic reflections		
Hypothesis	Variant	44.44%
(Critical) remark	Variant	22.22%
About the therapeutic process	Rare	16.67%
About the client	Rare	5.55%
Therapeutic attitude		
Presence, being there	Variant	38.89%
Acknowledging, recognizing the right to exist	Variant	33.33%
To the person of the client	Rare	11.11%
To the different aspects in his emotions	Rare	16.67%
To his experiences and emotions	Rare	5.55%
Staying with	Rare	11.11%
Therapeutic actions, techniques		
Active presence	Typical	66.67%

Identifying, paraphrasing	Rare	5.55%
Exploring	Variant	38.89%
Significance, meaning	Rare	5.55%
Needs, wants and desires of the client	Rare	5.55%
Feelings of client	Variant	33.33%
Feeling that things cannot change, being stuck, resistance, fear	Variant	33.33%
Desire, desire to change	Rare	5.55%
Feelings not specified	Rare	11.11%
Working with self-split of client	Variant	33.33%
Exploring, giving space	Variant	22.22%
Identifying, differentiating	Rare	5.55%
Start up dialogue	Rare	11.11%
Focusing	Rare	5.55%
Going away	Variant	22.22%
Exploring hopeful, positive, remarkable experiences of client	Rare	16.67%
Confronting client with resistance with regard to change	Rare	11.11%
Therapeutic intervention not specified	Rare	5.55%

Note. N = 18; General = 17–18; Typical = 10–16; Variant = 4–9; Rare: 1–3.