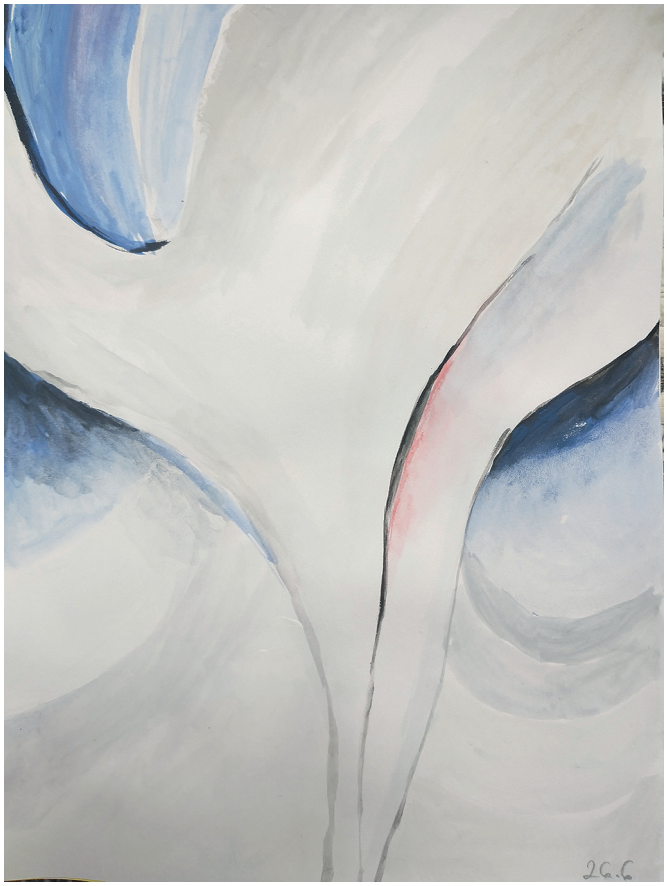
JYU DISSERTATIONS 813

Édua Holmström

Conceptualizing the Therapist's Relational Positioning

Basic Need Support to Facilitate Patient Engagement and Emotional Change



UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF EDUCATION AND PSYCHOLOGY

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Conceptualizing the Therapist's Relational Positioning

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ABSTRACT

Holmström, Édua
Conceptualizing the therapist's relational positioning: Basic need support to facilitate patient engagement and emotional change
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This dissertation examines how psychotherapists can engage better clients in the therapeutic process, thereby addressing an important gap in research on therapeutic action. The dissertation develops a new concept, termed the therapist's relational positioning, to analyze how therapists can support clients' basic psychological needs and facilitate their autonomous engagement in important psychotherapy situations, ultimately fostering emotional change. The concept of the therapist's relational positioning is motivated by the observation that therapeutic action supportive of basic needs comprises various dimensions: it is both intrapsychic and interpersonal, both verbal and nonverbal, and hence a truly multifaceted phenomenon that benefits from an integrative concept. Client engagement and the relational positioning of the therapist that facilitate this are examined in a first encounter suicide intervention, client engagement in the therapeutic task of chair work, client re-engagement in an alliance rupture, and therapeutic action for client engagement with important others. The results show that the therapist's relational positioning supporting clients' basic needs manifests differently and relies on different theoretical propositions when the client's problem concerns important others outside therapy than in situations where the client's problem explicitly concerns the therapist. In relation to theory, this dissertation proposes a thorough examination of the compatibility of therapeutic actions in the different psychotherapeutic traditions with the basic tenets of the self-determination theory (STD). In relation to empirical psychotherapy research, the dissertation proposes extending the use of SDT methods to psychotherapy process research. To facilitate therapeutic engagement in clinical practice, the dissertation highlights the importance of clients' autonomous motivation and the corresponding therapeutic action supporting clients' basic needs. This concept of relational positioning shifts our perspective of understanding support for basic needs from merely what the therapist *does*, to inherently including the therapist's *way of being* with her client. Through her relational positioning towards her client, the therapist can both support the client's basic needs and enhance engagement in the therapeutic process or, inadvertently, she can thwart these needs, leading to compliance and limiting long-standing change. The dissertation also shows that the manifestations of relational positioning supporting basic needs depends on the therapeutic situation at hand: it manifests differently and requires from the therapist different skills when the client's problem is with an important other outside therapy than when the client's problem is with the therapist.

Keywords: client engagement, self-determination theory, therapist's relational positioning, alliance rupture, emotion-focused therapy, relational psychoanalytic theory, suicide intervention

TIIVISTELMÄ (ABSTRACT IN FINNISH)

Holmström, Édua
Psykoterapeutin suhteessa asemoituminen: miten sitouttaa asiakkaan terapiaprosessiin ja emotionaaliseen muutokseen perustarpeiden tukemisen kautta
Jyväskylä: Jyväskylän yliopisto, 2024, 76 p.
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Väitöskirja tarkastelee, miten psykoterapeutti voi edistää asiakkaan autonomista sitoutumista terapiaprosessiin terapian eri vaiheissa, täyttäen näin aukon psykoterapeuttista toimintaa koskevassa prosessitutkimuksessa. Väitöskirja käsitteellistää asiakkaan sitoutumista terapiaan autonomisena motivaationa, jota psykoterapeutti voi edesauttaa tavoillaan asemoitua suhteessa asiakkaaseensa. Tutkimus kehittää ja jäsentää terapeutin suhteessa asemoitumisen käsitteen ja havainnollistaa sen soveltuvuutta erilaisiin terapeuttisiin tilanteisiin. Terapeutin suhteessa asemoitumisen käsite viittaa sekä terapeutin mielensisäiseen, asiakkaan perustarpeita tukevaan suhteessa olemisen tapaan, että terapeutin kielelliseen ja keholliseen terapeuttiseen toimintaan. Terapeutin suhteessa asemoitumisen käsitteen avulla voimme tutkia miten terapeutit voivat parhaiten tukea asiakkaiden autonomian, yhteenkuuluvuuden ja kompetenssin perustarpeita ja tätä kautta edistää asiakkaan autonomista sitoutumista psykoterapiaprosessiin, jossa psyykkinen muutos tapahtuu. Väitöskirja tarkastelee asiakkaan sitouttamista (mitä terapeutti tekee, jotta asiakas sitoutuisi), sekä asiakkaan autonomista sitoutumista (miten asiakas sitoutuu ja mistä sen voi havaita) neljässä eri terapeuttisessa tilanteessa: ensitapaamisen yhteydessä toteutuneessa itsemurhainterventiossa, tunnekeskeisen psykoterapian tuolitekniikassa, terapiaprosessin katkostilanteessa, ja asiakkaan sitoutumisessa terapiahuoneen ulkopuoliseen tehtävään. Suhteessa asemoituminen käsite haastaa näkemystämme perustarpeiden tukemisesta pelkkänä toimintana, laajentaen tukemisen käsitteen sisältämään myös terapeutin asiakkaan kanssa toteuttaman olemisen tavan. Terapeutti voi suhteessa asemoitumisen kautta tukea asiakkaan perustarpeita, ja sitä kautta edistää hänen autonomista sitoutumistaan terapeuttiseen prosessiin, tai tahtomattaan ja huomaamattaan ohittaa näitä perustarpeita, jarruttaen tai jopa estäen asiakkaan psyykkistä muutosta.

Avainsanat: asiakkaan sitoutuminen psykoterapiaterapiaprosessiin, itsemääräytymisteoria, allianssikatkos, tunnekeskeinen terapia, relationaalinen psykoanalyyttinen teoria, terapeuttinen itsemurhainterventio

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FOREWORD

The route of my clinical writing that led to this doctoral dissertation took shape five years ago. I wrote a paper on the importance of supporting self-determination when working with suicidal youth, as a final assignment for my specialization training for child and adolescent psychology. It is difficult to imagine a more controversial therapeutic context for autonomy support. That assignment was the first step on my journey of discovering and disentangling the importance of self-determination for psychological change, which finally led to this dissertation.

We humans are essentially social creatures, and every aspect of our well-being is determined by our relationships to others. This basic characteristic of a person comes to the fore in the process of psychotherapy. Scholars and clinicians, associated with a process-oriented view of psychological change has long advocated a paradigm shift in psychotherapy: from the primacy of cognition to the primacy of affect; from the primacy of content to the primacy of process; away from technique and towards the intricacies of the therapeutic relationship. In contrast to outcome-oriented therapists, these clinicians believe that when we talk with people about themselves in a way that allows them to experience and give voice to what they feel as wholly as possible, we as therapists can facilitate radical changes in their lives.

Some associate this paradigm shift with the so-called relational turn in the field, but it is still an open question how psychotherapy research will respond to this shift in paradigm. The academic community conducting research on self-determination theory does not seem to be aware of the opportunities these shifts of emphasis offer to research and theory building. My motivation for this dissertation is the understanding that self-determination theory at its core is a relational theory. Its basic tenets pose considerable challenge to outcome-oriented therapies that rely on an individualistic view of the self, on a primacy of content as opposed to process, and on a one-person approach to psychological change. I believe that the field of psychotherapy needs a reconceptualization of selfhood as a relational entity, inseparable from other selves. The field also needs a reconceptualization of psychological change that can be firmly rooted and longstanding if, and only if, it takes form within a meaningful therapeutic relationship that supports basic needs.

Now, *how* to do this exactly as a therapist is indeed a difficult question. The extent of this difficulty, I believe, has not been acknowledged by self-determination theory, that has so far restricted its recommendations for therapists to general principles. As every therapist knows, general principles are not enough for guiding therapeutic action. We are waiting for research to answer the question of how to support clients' self-determination during the bumpy road of the therapeutic process. This dissertation is a small step in that direction.

My enormous gratitude goes to my clients, who have contributed centrally, and sometimes very concretely to my current thinking, and who were partners in intimate conversations giving inspiration for my wish to write. I am grateful

to my main supervisor, Associate Professor Virpi-Liisa Kykyri, who, after my long search for a supervisor in vain, became interested in my research proposal, and has helped me through the ups and down of the project, both academically and emotionally. I also thank Assistant Professor Frank Martela, my second supervisor, for his always warm, friendly and professional input. I extend my appreciation to the third member of the supervisor committee, Professor Raimo Lappalainen, for his time and helpful suggestions. I express my special gratitude to Éva Rambala and Sari Vuohtoniemi, whose help was essential for the process of data collection of my thesis.

I am grateful to Associate Professor Carla Cunha and Professor Cathrine Eubanks for their time and effort in reviewing my dissertation. Their feedback, critical insights, and detailed comments were valuable in refining the presentation of my research and essential in pushing me to think through many important aspects of my theoretical position. I am sincerely grateful to Associate Professor Carla Cunha for accepting to be my opponent in the doctoral disputation.

From my personal life, I want to thank Agnieszka, Hanna and Paula, whose friendships over the years have positively affected and inspired me in my work as a psychologist and psychotherapist, as well as in the emotional processing of the doctoral project. Many thanks to my sister, Krisztina, with whom I share the professional interest in psychotherapy. I also want to thank my parents, Katalin and Ferenc, whose love for my children, and an interest in spending time with them made it possible for me to every now and then concentrate on this work without parental responsibilities. I wish my father could have seen me finishing this journey. I want to thank my husband, Jan, who has been a part of my life longer than he hasn't, for all his love and support through our relationship, and my children, Indár, Altay and Ainda, who challenge me day after day by showing me that supporting autonomy can be a tricky thing indeed, when you are a parent. Finally, I want to thank Outi for accompanying me in this formative phase of my life and for helping me to learn to feel loved.

Helsinki 14.06.2024
Édua Holmström

LIST OF ORIGINAL PUBLICATIONS

Paper 1: Holmström, É. (2020). Self-determination theory and the collaborative assessment and management of suicidality. *Mental Health Review Journal, 25(1),* 75-83.

The Collaborative Assessment and Management of Suicidality (CAMS), a suicide-prevention intervention based on structured elements designed to explore both the reason to die and the reason to live, has the potential to engage the patient in both treatment and life. How the intervention works, however, has not been theoretically explained. The purpose of this paper was to explain the mechanism of change underlying effectiveness of CAMS in engaging suicidal patients in treatment. The paper focuses on a theoretical examination of clinical procedures of CAMS, applying the psychological basic need theory as a theoretical framework. The paper proposes that the clinician's support for the patient's basic human needs of autonomy, competence, and relatedness, manifested in the clinician's relational positioning, result in the suicidal patient's engagement in treatment and choosing life. The research was confined to an examination of the clinical procedures and philosophy of care. The results point to the clinical importance of engaging clients through therapeutic action that supports their basic needs and reducing the use of autonomy thwarting approaches.

Contribution of the author: Single-author paper

Paper 2: Holmström, É., Kykyri, V. L., & Martela, F. (2024). Chair work with the empathic other: Providing basic need support for resolving unfinished business. *Journal of Contemporary Psychotherapy,* 1-10.

This paper presents a case example of a modification of the chair-work technique, termed chair work with the empathic other and examines the participant's process of emotional change. We found that talking directly to the empathic other supports the participant's emotional engagement with the task and guides her emotional processing through the four necessary components of successful empty chair-work, as specified in research (Greenberg and Malcolm, 2002): experiential access and intense expression of primary adaptive emotion, expression of thwarted need, and a shift in the representation of self and other. We conceptualize the therapist's relational positioning as a need supporting therapeutic action, relying on self-determination theory. Throughout the chair-work process, the need supportive positioning of the important other consistently engages the participant in the task: it deepens and widens her emotional exploration, leads her to express thwarted need and to change her representation of self and other. We discuss the findings from a self-determination theory perspective in relation to a theoretical understanding of emotional change and therapeutic practice.

Contribution of the authors: The study conception, design, analysis, and writing of the manuscript was conducted by Édua Holmström. Virpi-Liisa Kykyri has supervised the data collection, participated in the analysis of the transcript, and commented on the manuscript. Frank Martela commented on the theoretical framing and commented on the manuscript.

Paper 3: Holmström, É., Kykyri, V. L., & Martela, F. (2024). Pitfalls and opportunities of the therapist's metacommunication: A self-determination perspective. *Journal of Contemporary Psychotherapy, 54,* 9-18.

Psychotherapy research identifies alliance ruptures and their resolutions as significant events in psychotherapy that influence its outcome. However, we know little about the process itself, i.e., how such events influence outcomes; instead, we simply assume that if clients stay in therapy, then the rupture has been resolved, and hence the outcome will be positive. The purpose of this paper is to problematize this assumption against the backdrop of self-determination theory, introducing motivation and relational positioning as relevant theoretical concepts for understanding rupture resolution and its effect on outcome. A therapeutic transcript demonstrating best practice for alliance rupture resolution in a brief integrative therapy is critically examined, calling the attention of both clinicians and researchers to the risk of prescribing and blindly following techniques during therapeutic impasses. Our analysis of metacommunication demonstrates how the therapist's use of a specific technique for resolving threats to the therapeutic alliance can lead to the client's external motivation and compliance, negatively influencing the therapeutic outcome. Focusing on the therapist's relational positioning we present two alternative courses of therapeutic action, 'mindfulness in action' and 'embracing the patient's ambivalence', for supporting the client's autonomous motivation for the therapy process.

Contribution of the authors: The study conception, design, analysis, and writing of the manuscript was conducted by Édua Holmström. Virpi-Liisa Kykyri participated in the analysis of the transcript and commented on the manuscript. Frank Martela commented on the theoretical framing and on the manuscript.

Paper 4: Holmström, É. (2023). Enhancing the effects of emotion-focused individual and couples therapy by nonviolent communication. *Person-Centered & Experiential Psychotherapies, 22*(1), 23-40.

Nonviolent communication (NVC), a person-centered communication process, is a potential tool for enhancing the interpersonal effects of emotion-focused therapy and helping clients to engage with important others outside the therapy setting. After establishing an NVC model for fostering compassionate communication and connection between people, the paper presents the model's interpersonal processes and the theoretical premises for its use in emotion-

focused therapy. The paper elaborates on how an emotion-focused therapist could introduce the NVC model for helping clients express their feelings and needs to important others, thereby facilitating interpersonal engagement. The timing for beneficial use of the NVC model is described for both the individual and couples therapy process.

Contribution of the author: Single-author paper

TABLES

CONTENTS

1 INTRODUCTION

1.1 Motivation and overview

Engaging clients in the therapy process is a major goal for every psychotherapist. For psychotherapy to work, clients must become involved with the process in the first place and stay engaged, even at times of setbacks and difficulties, be it in their lives outside therapy, or in the therapeutic frame itself. As every psychotherapist knows, problems during the therapeutic process abound, challenging therapists over and over again to maintain their clients' engagement in the collaborative journey of psychological change.

There is surprisingly little systematic knowledge to help therapists meet the challenge of engaging clients and keeping them engaged. This lack of knowledge has partly to do with the absence of a scientific consensus about what we really mean by clients becoming engaged in psychotherapy. The psychotherapy literature contains no agreed-upon definition of engagement. More importantly, we lack a theory of client engagement in the therapy process (Holdsworth et al., 2014). Engagement has been variously defined as attendance at sessions, participation and involvement in therapeutic tasks or homework, or as an aspect of the therapeutic relationship. If we do not know precisely what our aim is, we cannot properly pursue it.

Drawing on the self-determination theory (SDT), one of the topics of this dissertation research is to conceptualize client engagement as an autonomous motivation for doing therapeutic work. SDT classifies motivation based on the level of people's autonomous endorsement for pursuing a certain action. As such, the extent to which people feel that their selves align with pursuing an action has far-reaching consequences on their subsequent behavior. From this perspective, understanding psychotherapy engagement in terms of behavioral indices, like session attendance or adhering to therapeutic tasks or homework is problematic, as such indices tell us but little about clients' intrapsychic engagement with the therapeutic process, that in turn is a result of internalization. SDT also specifies the necessary environmental components for internalization to take place and

explicates this internalization process in its mini theories on organismic integration and basic psychological needs (Ryan et al., 2021). In short, for people to autonomously engage in any endeavor, their basic psychological needs of autonomy, relatedness, and competence must be supported. While we know that psychotherapy by nature requires clients' intrapsychic engagement with the therapy process itself, we know little about how therapists can support this process in their therapeutic action.

There is one research area, where clients' lack of engagement or risk of disengagement has been extensively explored and empirically studied from the perspective of therapeutic action. Safran and Muran (2000), building on relational psychoanalytic theory, conducted groundbreaking work on the nature of alliance rupture and resolution by focusing on the therapist's metacommunication. Their model led to a bourgeoning of empirical research into the causes, indices, and potential consequences of those dire therapeutic situations in which the client's engagement breaks down or threatens to break down. They point out the importance for the therapeutic outcome of the therapist's metacommunication in cases of alliance rupture. However, neither their model nor subsequent research informed by their work have examined why and how their model results in client re-engagement, and ultimately therapeutic change.

The research questions that this dissertation sets out to answer are the following: How support for the client's basic needs is manifested in the therapist's therapeutic actions in different psychotherapy situations and how can these manifestations be examined?

In investigating these questions, I aimed to widen the theoretical interest from the narrow field of therapeutic impasses to include the entire therapeutic process, and specify therapeutic actions that facilitate client engagement both theoretically and empirically in four different phases of therapeutic work: in a first-encounter therapeutic intervention for engaging suicidal patients in treatment; in client engagement in the therapeutic task of chair-work; in the process of client re-engagement following an alliance rupture in a brief integrative therapy; and finally, in a therapeutic intervention to help both individual and couples therapy clients to engage and re-engage with each other outside the safety net of the therapy session.

The aspect of therapeutic action of interest here is what I term the therapist's relational positioning vis-à-vis the client. Drawing on SDT, this dissertation research aimed at formulating a hypothesis on the mechanism through which the therapist's relational positioning affects emotional change in the client's initial engagement in treatment, emotional engagement with a therapeutic task, re-engagement following rupture, and engagement with others outside the therapy session. The hypothesis was that a certain type of relational positioning on the part of the therapist supports the client's need for autonomy, relatedness, and competence, facilitates client engagement in all four psychotherapy situations, and leads to emotional change. I further hypothesized that the therapist's basic need supportive relational positioning would take different forms in these different therapeutic situations.

On the level of theory, this dissertation contributes to existing research (Bijkerk et al., 2023; Holdsworth et al., 2014) by introducing clients' autonomous motivation as the needed definition for client's engagement in psychotherapy, and SDT as the needed theory for conceptualizing client's therapeutic engagement. Furthermore, conceptualizing engagement as an outcome of a specific type of relational positioning of the therapist, that aims at supporting client's self-determination, contributes more generally to the theory of therapeutic action.

On the level of clinical practice, the findings of this dissertation enhance therapist's knowledge and understanding of the concept of relational positioning, important for their therapeutic practice. SDT can be included in clinical and therapeutic practice as a heuristic. To engage clients through relational positioning, therapist must include the concept of autonomous vs. controlled motivation in their working models of therapeutic action. The engagement of suicidal patients to treatment, emotional engagement of clients in experiential interventions, therapeutic action aiming for clients' re-engagement after rupture resolution, as well as clients' engagement with important others outside the therapy session all benefit from SDT's theoretical implications, pointing to its general relevance in therapeutic practice.

1.2 Theoretical background

1.2.1 Client engagement in psychotherapy

The study of patients' psychotherapy engagement has to a surprising extent focused on the measurement of the concept, as compared to theoretical efforts to reach a consensus about its actual meaning, which would be essential in progressing research (Bijkerk et al., 2023; Holdsworth et al., 2014).

Review articles (Bijkerk et al., 2024; Kelders et al. 2020) have defined three main dimensions of engagement used in empirical studies: behavioral, cognitive, and affective. As Bijkerk et al. (2024) noted in a recent extensive review, existing studies on client engagement have inconsistently used various easily measurable indices, or combination of indices, from these three dimensions, as proxies for the concept. The same study also identifies four theoretical models of engagement in mental health interventions, from which only two is related to in-person context, the rest two theorizing clients' engagement in internet-based therapeutic interventions.

In these two models, used in empirical studies on clients' engagement in in-person therapeutic context, behavioral proxies of engagement, such as session attendance, intervention adherence and task or homework compliance are most frequently used (e.g. Borghouts et al., 2021; Flynn et al., 2022; Glenn et al., 2013; Hall et al., 2001; Harris et al., 2021; Mallonee et al., 2021; McGonagle et al., 2021; Patel et al., 2019; Richards & Simpson, 2015; Tetley et al., 2011; Walton et al., Zelencich et al., 2019). Studies aiming for a more thorough behavioral

measurement of engagement combine different behavioral indices. McGonagle et al. (2021) understand engagement with mental health intervention as consisting of multiple behavioral dimensions, such as adherence to regular meetings, availability for appointments, collaborative responsibility in problem management, and help-seeking behavior. Regarding behavioral indices outside session, Mallonee et al. (2021) and Yardley et al. (2016) use measurements that target the efforts clients put in practicing behavior change between sessions. Reliance of behavioral data can be understood by its availability when it comes to internet-based interventions, as well as by its objective nature, increasing reliability.

As opposed to the objective behavioral measures, measures exploring the subjective aspect of clients' engagement rely on self-report data (Bijkerk et al., 2024). The cognitive dimension of engagement pertains to the extent to which clients understand and accept the rationale behind the intervention (Walton et al., 2017), as well as their perception of its suitability for achieving their goals, allying it to the concept of intervention expectancy (Yardley et al., 2016). Other measures of engagement, cognitive in nature, operationalize the concept as the experience of progressing, or self-efficacy (Tzavela et al., 2018). Several studies using cognitive proxies for engagement understand it as a multidimensional construct, including attention and interest toward an intervention (Elkin et al., 2014; Saleem et al., 2021; Perski et al., 2017).

The affective dimension of engagement involves clients' emotional experiences with the therapist, the therapy process, and the intervention. According to a recent review (Bijkerk et al., 2024), studies that operationalize client engagement in terms of affective experience are few, and usually combine the affective aspects with behavioral or cognitive dimensions, providing a composite index of engagement (e.g. Perski et al., 2017). One of the few studies exploring the affective aspect of engagement is Elkin et al. (2014). In their definition of engagement, they include clients' perception of and contribution to the relationship with their care provider. It is important to note, however, that the extent to which affective and cognitive aspects are components or predictors of engagement remains debated, with some scholars viewing them as the latter (e.g., Holdsworth et al., 2014; Kelders et al., 2020). Furthermore, studies on face-to-face therapeutic interventions typically regard affect as an outcome of engagement, often referring to it as intervention satisfaction (e.g., Holdsworth et al., 2014).

In the light of current knowledge, I consider the use of cognitive, affective and behavioral indices as a proxy for engagement highly problematic. Research has repeatedly showed, that just because people value something, show interest for something, agree to do something, and even when they do something, they are not necessarily mentally and wholeheartedly, autonomously engaged (Ryan et al., 2011; Zuroff et al., 2007, 2012). While relying on cognitive, affective and behavioral dimensions, engagement above all requires a continuous, intrapsychic dedication to and identification with the change process itself. Existing research has not fully addressed the necessary components of the

therapeutic actions that support clients in developing an intrapsychic dedication to the therapeutic process. This requires moving beyond quantitative measures of clients' characteristics, towards psychotherapy process research. This dissertation addresses the gap in research by conceptualizing basic need support in a way that allows the examination of both its intrapsychic and interpersonal components, as well as its verbal and nonverbal aspects.

1.2.1.1 Engagement as process and index of the quality of the therapeutic relationship

In a recent multidisciplinary review of the concept of engagement across different domains, Kelders et al. (2020) noticed two different ways of approaching engagement: one regarding it as a state, the other regarding it as a process. Calling attention to the process nature of engagement is important because engagement refers to continuity in a dedicated action, a conscious ongoing allocation of attention and energy to something that is considered worth pursuing.

In a more recent review, while recognizing its complex and multi-dimensional nature, engagement is more loosely defined as a process of interaction between a client and an intervention (Bijkerk et al., 2023). This definition recognizes engagement as a process. However, defining engagement as something that exists between a client and an intervention is theoretically far from straightforward. While this definition may suit professionals allying themselves with the cognitive behavioral tradition, it has a poor fit with psycho-dynamically oriented frameworks. In the psychoanalytic tradition, engagement could never refer solely to a patient's relationship to an intervention without it simultaneously referring to the therapeutic relationship. Indeed, the inseparability of the process of the client's engagement from the therapeutic relationship, which provides its context, finds substantial empirical support in the strong and repeatedly found correlation between the two (Bijkerk et al., 2023; Holdsworth et al., 2014), pointing to the need to clarify the relationship between these concepts. It is to this that we now turn.

As compared to engagement, the concept of the therapeutic alliance and its relationship to outcome has been extensively studied (Cirasola & Midgley, 2023; Del Re et al., 2021; Horvath, 2018). In fact, the therapeutic alliance is currently considered to be the most robust correlate of the therapy outcome (Tschuschke et al., 2022). However, empirical research on this alliance has been hampered by its measurement as a static concept, i.e., as a trait of the relationship between client and therapist.

Bordin (1979), in his pan-theoretical framework, defined the therapeutic alliance as consisting of agreement on the therapeutic goals and tasks and the therapeutic bond itself. This conception of the alliance as a trait characteristic of the therapeutic dyad that is measured by the participants' self-report is rather static (Zilcha-Mano, 2017). In a similar vein, studying therapists' and patients' personal contribution to the alliance has concentrated heavily on examining the effects of their respective personal attributes on variation in the alliance, and

ultimately on outcome. The accumulated research findings on the significance of therapists' personal characteristics affecting their ability to form and maintain the alliance has amounted to viewing the different characteristics of therapists as robust, albeit indirect, predictors of psychotherapy outcome (Del Re et al., 2021). What these therapist characteristics are, however, is still in a nascent stage.

Overall, as Horvath (2018) has more recently noted, alliance research focusing on the alliance as a construct that can be conceptualized and measured as a static attribute has run into difficulty. Reviewing 40 years of alliance research, Horvath identifies the need for restarting the academic conversation and for developing a new theory of the therapeutic alliance. In my view, this would require a move away from static conceptualizations of the therapeutic relationship and alliance towards a process-like understanding of these concepts. One strategy, used in more recent studies to move away from static conceptualization of the alliance is to measure it before and after each session by patient and therapist report (Weiss et al., 2014; Zlotnick et al. 2020). While this intensive data collection has yielded understanding of the intricate relationship between reported fluctuations in alliance and outcome, it has left the mechanisms of change unexplored.

Recent findings separating trait and state conceptions of the alliance point in this direction, suggesting that when measured as a trait, the alliance predicts outcome. On the other hand, the alliance only has therapeutic potential when it is conceptualized as a state or as a process in a continuous flow of negotiation between patient and therapist (Zilcha-Mano, 2017; Zilcha-Mano et al., 2019). Recent research has also examined the alliance as an inherently co-created process of client and therapist, involving both verbal and nonverbal elements (Kykyri et al., 2019).

Research that has reconceptualized the alliance in more process-like, dynamic terms, has gained increasing academic interest in recent years. Building on the seminal work of Safran and Muran (2000), this research tradition has clearly moved away from a static conceptualization of the therapeutic alliance towards an understanding of it as a process of negotiation (Muran et al., 2018; Safran & Kraus, 2014). Building on relational psychoanalytic theory (Hoffman, 2014; Mitchell, 2022), this research approach understands the negotiation process as consisting of an ongoing cycle of enactments of the patients' characteristic relational dynamics that resonate with the characteristic relational dynamics of the therapist. Relationally oriented therapists view these mutually constructed enactments and their collaborative exploration as an essential part of the therapeutic process.

In specifying the meta-communicational principles necessary to help the therapeutic dyad out of cumbersome therapeutic impasses, Safran and Kraus (2014) emphasize the therapist's implicit relational positioning vis-à-vis the patient as an essential element in maintaining and strengthening the therapeutic alliance. In so doing, they strongly advocate a process-like understanding of the alliance, closely resembling the concept of engagement when understood as a process (Zilcha-Mano et al., 2019). In contrast to research that focuses on static

characteristics of therapists and patients that affect alliance and outcome, this dissertation takes a different approach. The approach taken, is to focus on what can happen and happens in the process, not what are the characteristics of the people involved. This approach, that focuses on process, has the potential to directly advance clinical practice. Distinct from the alliance as a trait, recent studies have found this alliance as a process to be specifically therapeutic (Zilcha-Mano, 2017).

1.2.1.2 Engagement of the patient's self means autonomous motivation to engage in the therapy process

Once defined both as a process, and as a process inseparable from the relationship of the people involved, the concept of engagement emerges as similar, if not identical to the concept of autonomous motivation within the framework of SDT (Ryan & Deci, 2017).
SDT understands human motivation not as a quantitatively measurable attribute of individuals, but as internalized forms of self-regulation. Internalization is a relational process, inseparable from the concept of the 'relational self' (Safran and Kraus, 2014). Drawing on the psychodynamic theories of Loevinger (1976, p. 5) and Loevinger and Blasi (1991), who view the ego as a synthetic, integrating function of internalized relationships, SDT conceptualizes the self as an organismic process aiming at the internalization of relational dynamics between the phenomenological self and 'the other' (Schafer, 1968; Ryan and Deci, 2017, p. 44). In sum, SDT understands motivation as inseparable from self-regulation, which in turn emerges from internalized interpersonal dynamics. Furthermore, and again in line with psychoanalytic theorizing (Schafer, 1968), SDT recognizes that internalization can often stay partial, leading to introjects that remain somewhat alien to the self, giving rise to more external and less autonomous forms of motivation (Ryan and Deci, 2008).

Notwithstanding acknowledgement of the links between SDT on the one hand, and psychoanalytic understanding of self and internalization on the other hand, SDT has not participated in the more recent theoretical discourse within psychoanalysis and psychotherapy research and practice more generally, known as the 'relational turn' (Lingiardi et al., 2016; Safran, 2003; Stern, 2019). This is unfortunate, since, as will be argued in this dissertation, SDT, as a solid theory of motivation, has much to offer to the relational view of psychotherapy. This dissertation takes the position that SDT is a relational theory in that it conceptualizes the self as a relational entity consisting of internalized relationships.

The over 40 years of empirical research on SDT and its theoretical elaboration into 6 interrelated mini theories can in retrospect be seen as amounting to a Copernican turn in the study of human motivation (Ryan et al., 2021), the impact of which can hardly be overestimated. I would argue that at the heart of this revolutionary turn in the scientific discourse on motivation and self-regulation is SDT's cardinal emphasis on the concept of the self as a relational entity. Notably, SDT posits that both the subjective self as a basic unit of focus of

human psychology, and changes in this self can be conceptualized as processes of internalization, as ever-changing networks of internalized relationships, ranging from controlling introjects to autonomous endorsements (Ryan, 2018).

At the time of the seminal phase of SDT research, behaviorism and the cognitive revolution had all but rooted out phenomenological conceptions of selfhood, resulting in a rather mechanical conception of human beings who can be controlled and changed by external contingencies and cognitive manipulations (Ryan & Deci, 2017). In contrast, SDT set out to study how human motivation can be understood as experienced from within, in contrast to from without, with special research interest in the environmental components that do not control observable behavior but facilitate intrapsychic motivational processes. SDT's conceptualization and emphasis on the self as a relational entity can be considered revolutionary in the field of mainstream psychology.

Even today, most social-cognitive theories of personality emphasize automatic thoughts and maladaptive core beliefs (Bargh & Chartland, 1999; Greenwald & Banaji, 1995) and downplay the concept of a phenomenological self that owns agency (Wegner, 2003). The resistance of mainstream psychology towards the notion of a self with agency might stem from the philosophical view that equates selfhood and free will with freedom from the laws of causality (Koole et al., 2019). In contemporary scientific accounts however, selfhood and free will are not understood as free from the laws of causality, but rather as complex forms of self-regulatory systems, guided by internalization processes, and leading to subjectively held values and endorsements with varying degrees of internalization (Baumeister, 2008; Kuhl & Koole, 2004).

SDT's conceptualization of the self also aligns with organismic theories of the self as self-regulation, with inherent biologically determined basic needs (Ryan et al., 2021). We humans are self-regulating organisms. We continuously work to maintain and elaborate ourselves, and our lower-level functional units give rise to higher level complex self-organizing processes, amounting to what we can experience as the phenomenological self (Koole et al., 2019). According to SDT, the self as an essence is an illusion (Dennett, 1993), a construction of the human mind, yet it is an illusion with the important function of providing the organism with a sense of agency, capable of generating, selecting, and pursuing goals (Sheldon & Prentice, 2019). This dissertation will explicitly draw on this relational conceptualization of the self as a process. This is a theoretical stance that is opposed to the social-cognitive conceptions of the self-as-object of one's own perception and evaluations (McAdams, 1990; Mead, 1934; Morf et al., 2012; Ryan & Deci, 2017).

1.2.1.3 Facilitating engagement of the self through therapist's support of clients' basic needs

According to SDT's basic psychological need theory (Vansteenkiste et al., 2020), individuals tend to realize their full potential when their environmental conditions support their three fundamental psychological needs: autonomy, which pertains to the desire for volition, inner consistency and locus of control as

opposed to external control; competence, reflecting the need for engaging with challenges and a sense of effectiveness; and relatedness, encompassing the need for feeling valued and connected to others (Ryan et al., 2021; Vansteenkiste & Ryan, 2013).

To the degree that these three basic psychological needs are supported by the environment, individuals tend to internalize external goals and social norms while at the same time perceiving this internalization as driven by their own will (Sheldon, 2013). Subsequently, to the extent that people's basic psychological needs are fulfilled, their innate inclination for growth emerges, resulting in their intrapsychic engagement, accompanied by a sense of vitality, and overall well-being. In contrast, when these basic needs are thwarted, i.e., when people are confronted with external pressures to conform, to fit, and to adjust at the expense of their needs, their self-regulation may either remain external or be only partially internalized, causing intrapsychic conflicts (Roth et al., 2019; Sedikides et al., 2019).

There are additional propositions, backed by empirical findings, related to SDT's basic psychological needs theory. First, according to Ryan et al. (2017), all three basic needs are essential to psychological wellbeing, and in different settings any one of these three needs can emerge as the most important. However, in most contexts, environmental support for autonomy plays a critical role in the satisfaction of the other basic needs, and contexts that are controlling necessarily thwart also the needs for relatedness and competence. Autonomy support is found to be a critical aspect of need-supportive environments and relationships (Ryan et al., 2021; Vansteenkiste et al., 2020). Second, basic needs theory takes a strong position on the issue of universality, supported by two recent and extensive meta- analysis regarding its relevance across cultures (Slemp et al., 2018, 2020; Yu et al., 2018), and extensive research on its distinction from detachment and independence (Koestner & Losier, 1996; Ryan & Lynch, 1989; Ryan et al., 2017; 2019). Basic needs are functional requirements for psychological well-being, and the extent to which they are supported or thwarted by the environment will have corresponding effects on the individual, regardless of the sociocultural context, the individual's personality profile or his or her explicit valuing of these needs (Vansteenkiste et al., 2020).

SDT's organismic integration theory (Ryan et al., 2021) distinguishes four levels of psychic internalization, entailing increasing levels of autonomous regulation: *external regulation* occurs when individuals are directly controlled by external rewards and punishments. *Introjection* is a process in which people adopt external regulations for reasons of avoiding conflict or need for acceptance, without wholeheartedly accepting these goals as their own (Koole et al., 2019). In the process of *identification*, individuals experience a conscious valuing of the behavior or attitude to be internalized and connect it to their subjective selfhood. Finally, in the process of the most autonomous form of internalization, termed *integration*, people integrate identified regulations into congruence with their other personal values and needs (Ryan & Deci, 2021).

When deeper levels of internalization are hindered by environmental contingent control, in the form of contingent reward or punishments in any forms, individuals may experience conflict or pressure, leading to a decline of interest and an increase in negative emotions (Ryan et al., 2021). Prolonged periods of external regulation can result in lasting declines in well-being, eventually leading to a controlled self-regulation mode, where pursuits become detached from their genuine psychological needs. In such cases, individuals may become increasingly diverted by alternative self-protective tendencies, including the inclination to dissociate from psychological experiences, engage in psychological withdrawal, and develop narcissistic strivings as compensatory motives for unmet needs (Ryan et al., 2019; Vansteenkiste & Ryan, 2013). SDT has explored and clarified the etiology of psychopathology and the development of various character disorders through the above-described processes (Sedikides et al., 2019).

Both the psychoanalytic and the person-centered therapeutic traditions have conceptualized selfhood as a relational entity, born out of internalization processes during development. In the field of mainstream psychology, however, the SDT is unique in that it has succeeded in combining this explicit relational conception of selfhood with solid empirical methods that support its theoretical positions (Ryan et al., 2019). Over the last 40 years, SDT has built upon multiple forms of cumulative and convergent evidence, deploying a wide variety of empirical methods, to shed light on the relational nature of human motivation, its antecedents, functions, consequences, and inner dynamics (Ryan & Deci, 2017). SDT's basic tenets have been tested across all the sub-disciplines of psychology: social, developmental, positive, clinical, cognitive, emotional, individual, and organizational. SDT has generated a wide range of both basic and applied research, indicating broader interest and higher relevance than perhaps any other contemporary psychological theory (Ryan et al., 2019; Sheldon & Prentice, 2019).

While studying the self, understood as a process and as a relational entity, poses considerable scientific challenges, it has profound implications for studying psychological interventions, and psychotherapy in particular, because it means that interventions that try to 'solve' people's problems, no matter how well intentioned, are most likely to backfire by fostering external dependencies and constraining people's agency (Koole et al., 2019). According to SDT, environmental factors supporting or thwarting basic psychological needs play a critical role in internalization. Relationships that support people's need for autonomy, relatedness and competence foster greater internalization. This general dynamic applies across age and spans various life domains, from early attachment to caregivers to the various domains of formal and informal interpersonal relationships experienced across the lifespan (Ryan et al., 2021). Client engagement with psychotherapy thus requires that therapists strive to engage the client's self throughout the entire therapeutic process, via the provision of support for autonomy, relatedness, and competence, so that internalization can occur through autonomous motivation. Engaging the client's self means that the client comes to endorse the value of the therapy process, not

only the desired outcome, experiencing it as aligning with their own personal values, manifested through integrative self-regulation.

1.2.2 Self-determination theory and psychotherapy

Compared to the amount of research attention and the steady increase in empirical support for the tenets of SDT in other domains of psychology, its application to psychotherapy research is relatively new (Zuroff & Koestner, 2023; Zuroff et al., 2012; van der Kaap-Deeder et al., 2014). While plenty of research evidence exists on the application of the SDT in seeking to induce health behavior change (e.g., Gillison et al., 2019; Ntoumanis et al., 2021; Silva et al., 2014; Teixera et al., 2020) research on the integration of SDT with theories of psychotherapy proper has remained rather limited. In their thorough review of the role of autonomous motivation in health interventions, Ryan et al. (2011) use the concepts of counseling and psychotherapy interchangeably. They justify this position by reference to the contemporary landscape, where pressures from health care, organizational, and educational systems for greater efficiency have resulted in increasingly briefer interventions and convergence between these two endeavors. While this pragmatic argument is perhaps understandable, I also see it as counterproductive. This dissertation takes the position that to enhance the applicability of SDT in psychotherapy research and practice necessitates delving more thoroughly into the theory of therapeutic action in the different therapeutic traditions and their compatibility with SDT. This has previously only been done with motivational interviewing (Britton et al., 2011; Markland et al., 2005; Vansteenkiste & Sheldon, 2006; Vansteenkiste et al., 2012), a brief person-centered intervention, thus making it an exception.

In a recent handbook, Ryan and Deci (2017) briefly discuss the theoretical alignments of the basic assumptions of SDT with the underlying theories of both outcome-focused and process-focused psychotherapies. They classify as process-focused approaches two main therapeutic frameworks: the person-centered and the psychoanalytic traditions. Albeit short, their theoretical discussion touches on some basic and important conceptual similarities between SDT and these process-focused approaches. They point to the similarities of SDT's emphasis on the developmental importance of the self's organismic integration processes with the actualizing tendency as a developmental concept in Roger's person-centered theory (1957), and the synthetic function of the ego in psychoanalytic meta-theory (Hartmann, 1940). They also note the compatibilities with SDT of the theory of therapeutic action and the corresponding conceptualization of personality change in the person-centered and the analytic approaches. Both these process-oriented frameworks understand personality change as a long-term process of integration and internalization, supported by a particular type of therapeutic relationship. In contrast, entrenched introjections, manifesting entrenched external motivation (Ryan & Deci, 2017), are seen as the bedrock for psychopathology (Fairbairn, 1952; Rogers, 1957).

At the other extreme of therapeutic approaches, outcome-focused therapies, in particular the cognitive-behavioral tradition, do not have a conceptualization

of the self as a relational entity. Nor do they distinguish between levels of internalization in psychological change that influence motivation. In fact, motivation is not a theory-consistent concept in outcome-focused approaches and is commonly understood merely as a requirement for entering treatment (Ryan & Deci, 2017). With respect to therapeutic action, outcome-focused therapies allocate attention to cognitive persuasion though reasoning and employ contracts and rewards to reinforce and assure treatment compliance. According to SDT, these are interventions induce external regulation. The cognitive-behavioral tradition is constantly evolving, and recent ramifications have led to the incorporation of new concepts, rooted in humanistic and developmental psychology, and recognized as relevant for psychological change. The importance of values in acceptance and commitment therapy (Hayes et al., 2011), and relational schemas in schema therapy (Young et al., 2006) are two examples of this development. There is need for research to examine whether and how the therapeutic action in these newer cognitive approaches is actualized in accordance with this underlying change in theory.

Interestingly, although noting the theoretical mismatch between outcome-focused therapies and the basic tenets of STD, Ryan and Deci (2017) do not initiate a theoretical discussion aimed at clarifying these inconsistencies. Instead, they diplomatically express the belief that effective practitioners of outcome-focused therapies can and often do support their clients' internalization process, leading to a positive outcome, even though this therapeutic action is not rooted in the meta-theory of their approach. In contrast to this optimism, I believe that scrutinizing theoretical inconsistencies between SDT and different therapeutic frameworks would advance both theoretical and clinical knowledge of therapeutic action and would facilitate the extension of research on SDT to include the field of psychotherapy.

Empirical studies of SDT in the field of psychotherapy have so far concentrated on two interconnected phenomena: the reported level of patients' autonomous motivation for treatment and their self-reported perception of the therapist's basic need support. Research has consistently supported the two hypotheses presented by Ryan and Deci (2017) regarding psychotherapy: outcome correlates positively with both patients' reported level of autonomous motivation for treatment (Leibert et al., 2022; Mitchalak et al., 2006; Moore et al., 2021; Sansfacon et al., 2020; Zuroff & Koester, 2023) and their perceived levels of need support from therapists (Dwyer et al., 2011; Steiger et al., 2017; Zuroff & Koestner, 2023). More recent research has extended these findings by observing a gradual increase in psychotherapy clients perceived fulfillment of their basic needs (Quitasol et al., 2018). Overall, whereas in other domains research on autonomy support in interpersonal relationships using SDT have been based on convergent sources of evidence that include experimental (Wuyts et al., 2017), longitudinal (Mageau et al., 2017), and observational (Ahmad et al., 2013) studies (see also Ryan et al., 2019), SDT research in the context of psychotherapy, has hitherto relied on clients' self-report data.

Studies relying on patients' self-reports of motivation and perceived need support certainly enhance clinical practice by underlining the importance for a successful psychotherapy outcome of basic need support by the therapist. However, they do not provide useful knowledge on the therapeutic actions to be taken. Recent research on the therapeutic alliance is instructive in this respect. When the alliance is measured as a trait, patient's positive view of the therapeutic relationship predicts a good outcome. However, when alliance is measured as a state, it is found to be therapeutic when it fluctuates and is constantly negotiated and renegotiated as the therapeutic relationship deepens and evolves (Zilcha-Mano, 2017). Another study examined the effect of alliance ruptures on sudden therapeutic gains and found that it was the therapists' and not patients' awareness of ruptures that predicted these sudden gains (Zilcha-Mano et al., 2019). When therapists are attuned to the immense significance of the quality of the therapeutic relationship, they take important steps to correct it when needed. Most importantly and in support of the hypothesis that not every therapeutic orientation fits easily with autonomy-supportive practice, Zilcha-Mano et al. found that the therapist's awareness of rupture only led to significant therapeutic gains in cases where the therapist was working within a framework that considered the therapeutic relationship an important vehicle of psychological change. Therapists working within a cognitive-behavioral framework were unable to transform alliance ruptures into new relational possibilities.

In the light of these research findings, and in contrast to the optimistic position taken by Ryan and Deci on the clear applicability of autonomy support to any approach, I see a need for deeper theoretical discussion and empirical research on the pitfalls and opportunities of incorporating autonomy support in different therapeutic approaches. Furthermore, when studying the field of psychotherapy, there is a need for SDT research to widen the scope of methods beyond clients' reported level of autonomous motivation and experience of autonomy support (Zuroff & Koester, 2023), and integrate methods that tap into, and enhance knowledge of the autonomy enhancing vs. autonomy thwarting therapeutic actions of therapists. Let us examine these two issues separately, starting with the need for deeper examination of the theories of the self and the corresponding theories of therapeutic action that characterize different psychotherapies.

Prominent clinicians and scholars on psychotherapy integration have pointed out the difficulties that arise when therapists eclectically use different, mutually incompatible approaches (Saffran & Messer, 1997). SDT's emphasis on the cardinal importance of the concept of autonomy in psychological change is inseparable from its conceptualization of the self as inherently relational in nature. SDT's findings on the importance of autonomy provision will neither enhance theoretical knowledge nor meaningfully and substantially improve therapeutic practice in a therapeutic approach whose theory characteristically lacks a conceptualization of the self as a relational entity, along with the related concept of levels of internalization that affect the patient's quality of self-regulation in a specific domain. This view is supported by the findings of Zilcha-

Mano et al. (2019), that the therapist's awareness of a rupture in the alliance led to therapeutic gains in clients of only those therapists who worked within a framework that considers the therapeutic relationship as a vehicle of psychological change. Thus, the theory underlying an approach does indeed matter when we aim for increasing therapists' basic need support in their therapeutic action.

Regarding methodology needed for conducting SDT research in the field of psychotherapy, I suggest two necessary additions. First, SDT research could turn its attention to examination of the theory of therapeutic practice in the different psychotherapeutic theories and protocols of therapeutic interventions, as happened with motivational interviewing (Britton et al., 2011; Markland et al., 2005; Vansteenkiste & Sheldon, 2006; Vansteenkiste et al., 2012). Second, SDT research could also examine therapeutic interaction based on established methods in psychotherapy process research, such as analyzing transcripts or voice and video recordings in order to find out what happens in the session between patient and therapist (Greenberg, 1991; Krause, 2023). SDT research in domains other than psychotherapy has already used methodologies that examine basic need support in both verbal and non-verbal communication, such as listening and tone of voice (Itzchakov et al., 2022; Weinstein et al., 2018; Weinstein et al., 2022). This type of methodology in SDT research could also be used in the domain of psychotherapy. Does the patient fall silent after something the therapist says, possibly indicating withdrawal and thwarting by the therapist of the patient's need for autonomy and relatedness? Do the therapist words invite and expand the patient's exploration, thereby indicating support of the patient's need for competence and autonomy? Psychotherapy process research regularly relies on both transcript analysis and embodied aspects of the therapeutic interaction to enhance scientific knowledge of these types of psychological processes that can lead to psychic change (Kykyri et al., 2017; Levitt, 2001).

1.2.3 The therapist's relational positioning

Relational positioning as a vehicle of psychological change and as an organizing concept relevant to the support of clients' basic needs by the therapist is a new concept that has been developed in this dissertation research. However, it is rooted in two main existing process-focused traditions: the psychoanalytic tradition, and the person-centered therapeutic tradition (Mitchell & Black, 2016; Rogers, 1957; Stark, 2000). These approaches share both a conception of the self as a relational entity, and the related concept of internalization as an intrapsychic process, characterizing both the development of the self and the process of change in psychotherapy. The psychoanalytic tradition, however, has numerous variations, not all of which can be used as a foundation for developing the concept of the therapist's relational positioning. In fact, classical psychoanalytic theory accepts and promotes only one theory-consistent therapeutic positioning, that of positional neutrality (Stark, 2000). Conceptualizations of the therapist's normative relational stance towards the patient have evolved simultaneously with the development and ramification of classical psychoanalytic theory. In

contrast to the Kleinian and the American ego psychology tradition, which continues to consider the analyst's neutral position as a cornerstone of therapeutic action, both the British object relation theorists, called 'independents', and therapists belonging to the more recent 'paradigm' of relational psychoanalysis have developed a theory of therapeutic action that exhibits an experience-facilitative type of relational positioning, which contributes to the patient's corrective emotional experience (Aron, 2013; Davies, 2023; Hoffman, 2014; Mitchell, 2022).

It is, of course, no coincidence that both the object relation theorists and the person-centered tradition have given the self, as a relational entity, a central place in their respective theorizing (Fairbairn, 1994; Guntrip, 1971; Rogers, 1957). Once the self is theorized as constituted through the experiential internalization of important relationships, as is the case in these traditions, personality change cannot but be conceptualized as the outcome of the experience of a corrective type of relationship (Winnicott, 2016). Let us now turn to how (1) the British independent object relation theorists, (2) the person-centered and emotion-focused therapists, and (3) the more recent school of relational psychoanalysis conceptualize the therapist's relational positioning as an important mechanism of change.

1.2.3.1 Object relation theory

The British object relation theorists, called 'independents' (Mitchell & Black, 2016) have modified classical psychoanalytic theory of psychic development and psychic change. This modification led to changes in their therapeutic action, including the advocacy of the curative role of a specific kind of relational positioning of the therapist. Object-relation theorists understand the development of the self as a relational process in which successive layers of self- and object representations, infused with affects, become consolidated into overarching, either more or less integrated, views of the self and others (Davies, 2023). Accounting for the immense clinical importance of object relations has been the primary conceptual challenge for psychoanalytic thought ever since. Each prominent psychoanalytic theorist has grappled with this subject, and the manner in which they resolved it has shaped their fundamental approach and established the groundwork for subsequent theorizing (Greenberg & Mitchell, 1983).

Fairbairn (1952) stressed the importance of therapists' taking on the role of the patient's 'bad object' to which she is attached. Bion (1962), presented his concept of the therapeutic action of containment of the patient's unbearable affects. Guntrip (1971) emphasized the importance of the therapeutic provision of the patient's dependence. Winnicott (1971) focused on the holding and facilitating environment. All these psychoanalysts, from somewhat different viewpoints, emphasized the importance of the therapist taking an empathic, validating kind of relational positioning towards the patient, providing the patient with new experience, and facilitating psychic change. With a similar focus on the concept of the self as a relational entity, albeit from a different framework,

the founder of self-psychology, Heinz Kohut (1984) also emphasized the provision of the empathic self-object as a fundamental aspect of therapeutic action.

While classical psychoanalysts, focusing on 'nature', understand the patient's psychopathology as deriving from the patient, object relation and self-psychology theorists emphasize the cardinal importance of 'nurture' in the person's development, locating the etiology of mental disorders in the failure of early environmental provision (Greenberg & Mitchell, 1983). Relational trauma in the formative years results in pathogen introjects, internal bad objects, forming intrapsychic templates through which the person experiences her world and herself (Mitchell & Black, 2016). In shifting the etiology from 'nature' to 'nurture', the object relation theorists changed the central component of therapeutic action from the enhancement of knowledge to the restitutive provision of a new type of experience in the therapeutic relationship (Stark, 2000). Compared to the therapist's neutral stance in the classical psychoanalytic model, this entails an active kind of relational positioning, implying that the therapist's active commitment and concern for her patient (Davies, 2018, 2023) lies at the heart of therapeutic action.

1.2.3.2 Person-centered theory

Similarly, although relying on a very different metatheory, Rogers' person-centered theory places a very specific type of relational positioning of the therapist at the center of his therapeutic action. In person-centered theory the personality is comprised of two components: organismic experience and self-structure, the latter referring to people's representations of themselves. Rogers theorized that people are always trying to integrate these two components of the personality. When integration fails, people feel discomfort and pain, which in the long term leads to entrenched psychological suffering (Rogers, 1995). Rogers theorized that human suffering is caused by people's unnecessarily rigid self-structures, internalized conditions of worth, that are rooted in the introjected values of early caretakers and other important people during development. Correspondingly, the central mechanism of change in the person-centered theory is the therapist's provision of an accepting environment, characterized by what Rogers called the necessary and sufficient conditions for psychic change: unconditional positive regard, empathy, and congruence on the part of the therapist (1957).

EFT grew out of person-centered therapy, but extended Roger's basic principles by specifying experiential interventions for clients self-defying emotion processing, indicated by various process markers (Greenberg et al., 1993). Emotion focused therapists are trained to recognize these markers in their clients' emotion processing, upon which they suggest corresponding therapeutic interventions. Nevertheless, in EFT, the relationship principles proposed by Rogers (1957, 1995) are considered crucial and are given priority over the therapeutic tasks. While emotion processing is conceptualized as the main mechanism of change in this approach, it is explicitly facilitated by the provision

of the therapist's adoption of a relational position of empathy, unconditional regard, and intrapsychic congruence (Goldman & Greenberg, 2019). Although the nature of the person-centered principles as supportive of basic needs has been acknowledged in SDT research in the context of motivational interviewing (Markland et al., 2005), Rogers' theory of personality and personality change has not yet received due acknowledgment within SDT research. In seeking to extend SDT theory to psychotherapy, this would, I believe, be necessary.

From a historical and meta-theoretical perspective, psychodynamic therapists, building on the work of object relationship theorists presented above, represent a fundamentally different tradition from person-centered and emotion-focused therapists. The therapist's provision of new experience is correspondingly conceptualized in profoundly different ways. In session, in the safety of the therapeutic relationship, clients of person-centered and emotion-focused therapy tend to talk about important others in their lives. The therapist's provision of empathy, unconditional regard and her intrapsychic congruence is thought to provide a facilitative environment for the client to fully experience her emotions vis-à-vis these important others (Goldman & Greenberg, 2019). In contrast, object-relation theorists, grounded in the psychoanalytic tradition, place the working through of the patient's transference at the center of the therapeutic action. For therapists working within the framework of object-relation theory, the patient's intrapsychic 'self-other' configurations saturate the therapeutic relationship in both complementary and concordant forms (Davies, 2023; Racker, 2018). Thus, in psychoanalytically oriented treatments, the analyst indeed becomes 'the important other', perceived by the patient similarly to an internalized object, or a particular version of that object, good or bad or both, to whom the patient relates, based on her developmental relational history. Accordingly, in psychanalytically oriented therapies, the provision of a new experience, as a vehicle of change, is not the facilitation of the full range of experiences relating to an important other outside the therapeutic dyad, as is regularly the case in the person-centered and emotion-focused traditions, but the experience of a new kind of relationship directly with the therapist (Aron, 2013; Benjamin, 2018; Davies, 2023; Mitchell, 2022). Notwithstanding these cardinal differences in both theory and practice, therapeutic action emphasizing the client's emotional experience as the basic mechanism of change, as well as the therapist's relational positioning facilitating this change, unifies these traditions.

It is important to note that in these traditions, with their emphasis on the provision of a new relational experience in the therapeutic relationship, therapeutic action entails a relational positioning where the therapist positions herself at the 'giving end', and the client at the 'receiving end' of the interaction. In the object relation tradition, it is the patient who must experience being 'contained' (Bion, 1962), being held (Winnicott, 1971), being dependent (Guntrip, 1971) in her transferential experience, before she can attain psychological change. Similarly, in the person-centered tradition, therapeutic action focuses on a radical de-centering of the positioning of the therapist (Rogers, 1957, 1995), who enters the client's framework to facilitate loosening in the client's rigid self-concept and

ultimately achieve psychological change. In both traditions, the therapist's own subjectivity (although of informative value) is not part of the interactive process between therapist and client since the therapist is expected to decenter from her own subjectivity to enter the internal world of the client (Stark, 2000). As we will see in the following section, in the contemporary landscape of relational psychoanalytic theory the therapist's subjectivity has gained importance comparable to that of the patient in facilitating therapeutic action.

1.2.3.3 Relational psychoanalytic theory and relational theory

Let us now turn to therapeutic action in relational psychoanalytic theory. Here, we find that conceptualizations of therapeutic action bear relevance to the concept of relational positioning, particularly in therapeutic situations where the patient's problem is not with an important other in her life, but specifically with the therapist. Relational psychoanalysis started to develop in the mid-1980s within the sein of the North American psychoanalytic tradition. More recently, it has influenced integrative psychotherapy theory and practice more generally, to the extent that the international therapeutic landscape is said to have undergone a 'relational turn' (Lingiardi et al., 2016; Safran & Kraus, 2014; Stern, 2019). Building on an integration of British object relation theory (Greenberg & Mitchell, 1983), American interpersonal theory (Levenson, 1983; Sullivan, 1953; Wolstein, 1994), Kohut's self-psychology (1984) and post-modern philosophy, relational psychoanalysis does not form a unified school of thought but can rather be considered as a loose grouping of clinicians and theorists who consider themselves working with a certain type of relational sensibility (Aron, 2013; Davies, 2023). Relational psychoanalytic practice is based on a two-person psychology (Ghent, 1989), placing emphasis on both the intrapsychic experience and the interpersonal behavior of the therapist (Stern, 2019). Here, therapeutic action is grounded in the assumption that the therapeutic situation is constituted by a human encounter that is characterized by both mutuality of influence and asymmetry in roles and responsibilities. What ultimately heals the patient is an interactive engagement with the therapist that accepts the inevitability of mutual participation and takes responsibility both for her contribution to cumbersome interactions and the initiation of collaborative disentanglement from these (Davies, 2018).

In contrast to previous generations of object relation theorists, who understand enactments between therapist and patient as the interpersonal manifestation of the patient's problematic object relations (Jacobs, 1986), relational psychoanalysts and relational therapists consider enactments as mutually constructed unformulated interpersonal events, emerging from the psychic vulnerabilities of both participants' (Stern, 2019). Relationally oriented theorists understand enactments and alliance ruptures as events co-constructed by patient and therapist. Accordingly, in the relational model, it is the vicissitudes of the therapeutic relationship that constitutes the locus of therapeutic action. Following relational psychoanalysis, the various contemporary integrative frameworks building on these relationally focused

frameworks have taken this theoretical position (Finlay, 2015; Lingiardi et al., 2016; Wachtel, 2014).

In what way can the relational positioning of the therapist, working within the framework of relational psychoanalysis or other relationally oriented approaches, be considered basic need-supportive? In my view, acknowledgment of the mutually constructed nature of enactments in general, and alliance ruptures in particular, leads to a radical reconceptualization of the therapist's relational positioning, manifested in a therapeutic action that is explicitly basic need supportive.

To start with, a basic need supportive relational positioning during alliance rupture is grounded in a constructivist, as opposed to objectivist epistemology. The therapist is aware of her own limitations in her knowledge of her participation in the enactment (Hoffman, 2014; Safran & Muran, 2000), indicating that knowledge about this is to be found together. Intra-psychically, the relationally oriented therapist does not assume that she can know with certainty her own participation in the enactment: her work consists of mentalizing her countertransference (Barreto & Matos, 2018), and mindfully reflecting on her participation of the enactment (Stern, 2019).

Interpersonally, when the therapist is trying to disentangle herself from cumbersome enactments, need-supportive therapeutic action requires a constructive use of the therapist's self. This may include and entail 'mindfulness in action' (Safran & Muran, 2000), verbalizing of the therapist's contribution to the enactment, and therapeutic exploration of the patient's thoughts about the therapist's contribution (Aron, 2013; Hoffman, 2014; Saffran & Muran, 2000). Most importantly, drawing on Winnicott's concept of a transitional space (Caldwell, 2022), basic need-supportive relational positioning consists of a relentless building of an intersubjective 'third', to assist in helping the dyad out of complementarity (Aron, 2006; Benjamin, 2018). In contrast, what Benjamin (2018) calls the complementarity of enactments can be understood as a controlling, need-thwarting positioning of the therapist, that thwarts the patient's basic need for competence, autonomy, and relatedness. The essence of Benjamin's 'third' position is to step out of this complementary power relation by tolerating and nourishing the creative potential of the ambivalence of the patient as a central component of the therapeutic action. Relational positioning becomes need-supportive in its nature when the therapist in her therapeutic action succeeds in transcending the complementarity characteristic of enactments.

1.2.4 The effect of the therapist's relational positioning on engagement

Drawing on self-determination theory, I conceptualize clients' engagement in psychotherapy as autonomous motivation for the therapeutic process, relying on integrative self-regulation (Roth et al., 2019). This autonomous engagement can be enhanced by the therapist's relational positioning, manifested in therapeutic action, that supports the client's basic needs for autonomy, relatedness, and competence. *I define the therapist's relational positioning as both intrapsychic and*

interpersonal. It is a kind of mindset, as well as a corresponding interpersonal behavior, a key aspect of each therapeutic action. Thus, in line with the theoretical understanding of human communication consisting of a content and a relational aspect (Watzlawick et al., 1967), each therapeutic intervention by the therapist is simultaneously a relational act, manifesting an implicit relational statement vis-à-vis the client (e.g. Saffran & Muran, 2000, p. 41).

We observe two important gaps in psychotherapy research relying on the SDT framework. *First*, in their theoretical discussion on therapists' basic need support Ryan and Deci (2017) have listed certain principles of therapeutic actions, focusing explicitly on the interpersonal dimension of basic need support. However, in their theorizing, the intrapsychic aspect of a basic need supportive therapeutic stance is left unexplored. Psychotherapy is a professional endeavor, that must be guided by theory of therapeutic action. Although the therapist psyche is an amalgam of both personal and professional (theory of therapeutic action) elements, a theory of therapeutic action worth of its name should explicitly address the question of how to deal with and make professional use of her personal experience.

Second, when it comes to empirical psychotherapy research utilizing SDT, therapists' support of basic human needs has only been examined through client self-reports. Direct examination of basic need support by therapists in their therapeutic action has so far not been employed as a method.

These two gaps are addressed in this dissertation by conceptualizing the therapist's basic need support as her relational positioning vis-à-vis the client, manifested in her therapeutic action and heavily influenced by her particular theoretical framework. To examine the therapist's relational positioning manifested in therapeutic action, it is essential to examine both its intrapsychic and its interpersonal aspects. We must examine both the theory of therapeutic action of the approach in question and the concrete interaction between patient and therapist, the latter consisting of both verbal and nonverbal behavior.

The overarching research question of my thesis is: *How is basic need support manifested in both the theory and practice of therapeutic action in different situations of psychotherapy, and how can these be examined?* I am interested both in basic need support in therapeutic action focused on clients' problems outside the therapy relationship, and in therapeutic action focused on problems between the client and the therapist, as in alliance ruptures.

The overarching question of the effect of the therapist's relational positioning is reflected in the objectives of the original papers. Paper 1 seeks to understand how the clinicians basic need support in her therapeutic action contributes to the suicidal client's engagement. How the clinician provides basic need support, both verbal and nonverbal, is highlighted in the clinical procedures. In paper 2, basic need support in a therapeutic task for unfinished business is provided by modifying the task according to person-centered principles. The paper analyzes the participant's emotional processing, seeking to understand how conversing with the 'empathic other' supports her basic needs. Paper 3 aims to make explicit what happens in a rupture situation, when the therapist is communicating in an autonomy thwarting way, instead of supporting the

patient's basic needs for autonomy, competence, and relatedness. The objective of paper 4 is to investigate the possibilities for therapeutic actions in emotion-focused therapy that help clients to engage with important others outside the therapy session in a basic need supportive manner.

2 METHODS

The research problem set for this dissertation was to understand how psychotherapists, in different psychotherapy situations provide clients with basic need support and engage them in the psychotherapy process. In order to achieve this objective, four studies, each on a different therapeutic situation, were conducted and reported in four corresponding original papers: engagement of suicidal clients in a first-encounter therapeutic intervention (Paper 1); emotional engagement of clients with a therapeutic task (Paper 2), re-engagement of the client after alliance rupture (Paper 3), and emotion-focused individual and couples therapy clients' engagement and re-engagement with attachment figures outside the therapeutic session (Paper 4).

This dissertation develops the concept of relational positioning for study of therapist support for clients' basic needs. The relational positioning of a therapist in her therapeutic action is naturally determined both by the theory governing the therapeutic action and the underlying theory of the self, and by her actual intrapsychic and interpersonal behavior. Accordingly, the data collected were chosen to represent these two determining factors: the theory and clinical protocol adopted in a suicide-prevention intervention; a description of the theory of emotional change and therapeutic action adopted in emotion-focused therapy; a therapeutic transcript of an alliance rupture event in cognitive-analytic therapy, and a videorecording and transcription of a therapeutic chair work task.

In their methodology, the studies utilized two kinds of methods: two studies (Paper 1 and 4) examined the theory of psychological change underlying the therapeutic action and intervention protocol. In these studies, the focus was on the basic need support manifested in the therapist's theory-driven relational positioning and conceptualized in the approach as an important vehicle for change. The other two studies (Paper 2 and 3) utilized qualitative process research methods to examine how therapists provide their clients with basic need support through relational positioning. In these analysis, transcript and video recorded data were used.

The method employed in investigating the clinician's basic need support during the Collaborative Assessment and Management of Suicidality (CAMS)

intervention was directive content analysis (Hsieh & Shannon, 2005). Using the deductive category application procedure (Mayring, 2000), the objective of a directed content analysis approach is to conceptually validate or expand upon the existing SDT framework, thereby illustrating its relevance in a clinical context. The overarching methodology employed in Paper 4 was theory-driven analysis (Perkins et al., 2007; Walshe et al., 2007), a method commonly used to improve clinicians' behavior in health care (MacFarlane & O'Reilly-de Brún, 2012). For the purposes of this study, a theory-driven analysis enables a structured and systematic examination of the therapist's opportunities for need-supporting therapeutic action to enhance the client's engagement with important others outside the session.

The study reported in Paper 2 was based on videorecorded data, subsequently transcribed, depicting a novel variation of chair work. The study reported in Paper 3 was based on therapeutic transcript data displaying an alliance rupture. These studies used qualitative process research methodology (Greenberg et al., 1993; Krause, 2023) to examine the therapeutic dialogue and identify the relational positioning of the therapist and trainer, as manifested in their communicative and metacommunicative actions that supported or thwarted the client's basic needs.

2.1 First encounter suicide intervention: directive content analysis of clinical protocol and procedure

Paper 1 examines engagement in the very first encounter with a suicidal patient. The data for this study is the published handbook of the Collaborative Assessment and Management of Suicidality (Jobes, 2016). The handbook describes both the theories associated with development of suicidality, and the theory behind the therapeutic assessment and management of suicidality on which the approach is built. CAMS is a very different approach to suicide assessment from the other current approaches, in that it is designed to be a therapeutic intervention as opposed to a suicide-specific intervention that focuses exclusively on a clinical assessment of the patient's suicidal status and general psychological state. The CAMS handbook, which serves as data in the study, describes in depth the philosophy of care and the guiding principles of therapeutic action. The intervention protocol and therapeutic actions are described in detail, enabling the investigation of basic need support.

The method employed for investigating CAMS's basic need support is directive content analysis (Hsieh & Shannon, 2005). Content analysis is a versatile approach for the study of textual data (Cavanagh, 1997), encompassing a spectrum of analytical methods, from impressionistic and intuitive interpretations to systematic and rigorously structured textual analyses (Rosengren, 1981). In conventional content analysis, coding categories are derived directly from the data. That approach would not have served the

purposes of this study, the explicit aim of which was to expand on SDT's basic need theory by examining its manifestation in the context of a suicide intervention protocol (Kyngas & Vanhanen, 1999). The objective of employing a directed approach in content analysis is to conceptually validate or expand upon an existing theoretical framework or theory. This approach, known as the deductive category application (Mayring, 2015), involves a more structured process than the conventional content analysis method (Hickey & Kipping, 1996).

Guided by basic need theory, the directive content analysis focused on the manifestations in therapeutic action of three key concepts of basic need theory as coding categories (Potter & Levine-Donnerstein, 1999): the clinician's support of the patient's autonomy, relatedness, and competence. Through the lens of the SDT's basic need theory, the study examined both the handbook's detailed account of the aims of the intervention and the exact clinical protocol and procedures. The latter describe not only content - the questions discussed with the suicidal patient - but also *how* the interaction is conducted, including the way the assessment is presented to the patient, the explanation of the aim and focus of the assessment given to the patient, the embodied behavior of the clinician, and the priority order of the questions.

This type of directive content analysis allows the reliable investigation of the clinician's relational positioning vis-à-vis the patient, as manifested in the provision of basic need support.

2.2 Chair work with the empathic other: video and transcript analysis of a psychotherapy process

Paper 2 examines a process of emotional engagement with an experiential chair work task for unfinished business. The data were supplied by a video recording of a variant of chair work, showing a dialogue between a participant and a facilitator. The data were selected from four video recordings that had been collected for the specific purpose of studying basic-need support in different tasks used in a person-centered communication training program, nonviolent-communication (NVC). People usually enroll in NVC trainings because of the interpersonal difficulties they experience in their everyday lives. This aspect renders the NVC training somewhat like a therapy context. The collection of video-recordings was included in the study design submitted to and approved by the Human Sciences Ethics Committee at the University of Jyväskylä. This committee works in accordance with the guidelines issued by the Finnish National Board on Research Integrity in 2019 for research involving human participants.

Data collection and recruiting of participants. The four video recordings show interaction situations during an NVC advanced training course, where participants, familiar with NVC engage in discussions, conducted according to NVC principles. Participants were recruited for the study as follows: individuals

who had enrolled in the NVC training received a letter, inviting them to participate in the research. This included a description of the research aims and role of participants. Those interested in participating were sent a comprehensive information package about the research, including its objectives, participation, participant rights, data management plan, and publication plan. Upon attending the course, participants were instructed to bring the signed consent form with them. Participants had the right to withdraw from participation in the research at any time during the NVC course. Due to the explicit focus of the research being on the observable emotional process (manifested in verbal and nonverbal behavior) of the participants following need-supporting responses from the trainer, no background data, other than gender and age was collected from the participants. By protocol, NVC training tasks always end by the facilitator asking the participant how she or he is feeling in the moment, providing an index of her emotional state at the end of the intervention.

Participation procedures. During the NVC training, the participants and trainer decided together when to record their NVC interaction. All interactions involved the NVC trainer and a participant. The NVC trainer made the video recording. The interaction situations typically lasted for approximately 15-45 minutes. A total of 4 recordings were collected. The video recordings were securely transferred directly to the researcher using a protected Funet File Sender connection. Following the consent process and before participation in the research, a link and instructions for uploading the recording was sent to the participants. The researcher transferred the files to the university server (Next Cloud) using only the researcher's username and password to ensure secure access. To ensure participants anonymity, pseudonyms were assigned in place of their real names throughout the study. All other information that could enable identification was changed.

Four videos, each 10-15 minutes long, were collected. They involved four participants: the NVC trainer and three training participants, one of whom participated twice. All four videos show a conversation between a participant and the NVC trainer during the training, using NVC communication.

Selection of data. In the initial screening, I examined all the recordings. Of the four recorded videos, the detailed and rich interactions of one video rendered it the best example for a detailed analysis of the impact of basic need supportive relational positioning on the participant's emotional processing.

The chair-work video chosen for analysis prominently demonstrated several situations in which the trainer employed basic need-supportive techniques to navigate the conversation, demonstrating a nuanced understanding of the participant's underlying needs as well as her supportive and validating response to these needs. The selected video also clearly showed the participant's emotional responses to the trainer's relational positioning. The participant's emotional cues, both verbal and nonverbal, were clearly discernible. The interactions provided material for a detailed examination of the interplay between the trainer and the participant.

Transcription of the video recordings. As a native speaker of Hungarian, I translated the video recording of the modified chair work, conducted in Hungarian, into English. This translation process ensured that linguistic fidelity and cultural nuances were preserved in the transcribed data. Silences, recognized as crucial elements in psychotherapeutic interactions, were measured and included in the transcript, providing a situational understanding of pauses in the therapeutic dialogue. The transcription also includes nonverbal communication manifested through facial expressions, body language, sighs, and crying. The inclusion of nonverbal elements is important when analyzing a therapeutic process using transcriptions (Kykyri et al., 2017). In the chosen video of chair-work, the description of these nonverbal elements was essential for examining the effect of basic need support on the participant's emotional processing.

Analysis. The transcription was process-analyzed following psychotherapy process research procedures (Greenberg, 1991; Krause, 2023). Visual and nonverbal phenomena, including the participant's movements and facial expressions, were also analyzed, providing additional information about the activation, presence, length and change of important emotions during the experiential exercise (Kykyri et al., 2019).

The analysis was structured according to the three core stages of the empty chair technique specified by Rice et al. (1996): the arousal stage, the expression stage, and the completion stage. The expression stage was divided into four parts, each describing a specific topic and the corresponding emotional processing of the participant. The aim of the analysis was to shed light on the emotional engagement of the participant during the three stages of the chair-work in relation to the basic need support given by the facilitator in her communication and relational positioning.

The chair-work variation used in this study differs from the conventional technique in one important way. The facilitator, instead of assuming an outsider neutral 'third' position vis-à-vis the chair-work dyad, takes on the role of the significant other, but in a special way, communicating with the participant according to person-centered principles, and thus focusing on feelings and needs. To examine the effects on the participant's emotional processing of talking directly to an 'empathic other', the study analyzed the participant's reactions, both verbal and nonverbal, to the empathic other's person-centered, explicitly basic need-supportive utterances (Pascual-Leone, 2018; Roth et al., 2019). Additionally, the analysis paid particular attention to the presence or absence in the participant's speech of the key components of a chair-work process leading to a successful resolution (Greenberg & Malcolm, 2002): expressions of intense, primary emotion; expressions of previously unmet interpersonal needs; and a shift in the view of self and the other.

2.3 Pitfalls of the therapist's metacommunication: psychotherapy process research on an alliance rupture situation

Paper 3 investigates an event of alliance rupture in a brief integrative therapy, in which the therapist tries to re-engage a patient who intends to leave therapy abruptly, risking premature termination. The data of the study is the published therapy transcript in the article of Bennett et al. (2006) titled Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: A task analysis, published in the journal Psychology and Psychotherapy: Theory, Research and Practice, 79(3), pp. 395-418.

In order to conduct a secondary analysis on the published transcript in the study, subsequently published in the Journal of Contemporary Psychotherapy, a copyright license was requested and obtained on 23 July 2023 from the publisher John Wiley and Sons.

There were two reasons for the decision to use a published transcript as data for the analysis. First, data depicting an alliance rupture and the therapeutic efforts to resolve it during a clinical session are very difficult to obtain. Second, the published transcript is embedded in the context of theorizing therapeutic practice for alliance rupture resolution in cognitive-analytic therapy and is intended to demonstrate recommended practice. The published transcript demonstrates such practice for the purpose of re-engaging the patient, while at the same time shows the relational positioning of the therapist and its possible unintended effects on this objective.

The method employed follows established praxis in psychotherapy process research (Krause, 2023): the microanalytic level analysis of the transcript enables comparison of a single idiosyncratic interaction sequence to a context-specific model (Greenberg et al., 1991). In our study, this context-specific model of rupture resolution specifies what is expected to happen in the therapeutic process once the rupture markers have been identified (Safran & Kraus, 2014). In the analysis, two different theoretical lenses were used. First, the analysis focused on the presence or absence of the meta-communicational principles for successful rupture resolution in the therapist's meta-communication (Safran & Kraus, 2014). Pitfalls in this meta-communication were operationalized as the therapist's divergence from these communicative and metacommunicative principles. The patient's utterances were also examined to analyze the therapeutic effects of the therapist's communication on the patient and the extent to which the therapist was responsive to these effects. Second, the analysis examined the interpersonal dynamics of the rupture situation through the relational positioning of the therapist vis-à-vis the patient to see if the therapist supported or failed to support the patient's basic psychological needs. The presence of complementary relational dynamics between therapist and patient was also examined (Benjamin, 2018). When left unexplored by the therapist complementary relational dynamics carry the risk of increasing the patient's external motivation (Roth et al., 2019).

2.4 Enhancing clients' engagement outside therapy session: a theory-driven integration of emotion-focused therapy and need-supportive communication

Paper 4 examined the opportunities for basic need-supportive therapeutic action towards the end of therapy to help clients to engage with important others outside the therapy session. This was done by introducing a person-centered communication tool to integrate with the therapeutic practice of emotion-focused individual and couples (EFT-C) therapy. The need for this type of research design is supported by findings that structured exercises can be successfully incorporated into an emotion-focused framework to enhance the therapeutic effects of the approach (e.g., Greenberg & Warwar, 2006).

The use of a person-centered communication tool, nonviolent communication (NVC), a potential heuristic for need-supporting communication, was examined for these purposes. Our data comprised both the theory and practice of the NVC process (Rosenberg, 2005, 2015), and the theory of therapeutic actions of both EFT and EFT-C (Greenberg & Goldman, 2008; Johnson, 2019).

To demonstrate the applicability of NVC to individual EFT, the study drew on secondary data consisting of a clinical vignette and a transcript of a systematic evocative unfolding task used in an individual EFT session, as presented by Greenberg et al. (1993, p.161).

During the therapeutic task, the client discovers important meanings she had previously been unaware of and becomes aware of a poignant feeling of guilt. At the end of the task, the client also gains experiential access to her need for honesty and her valuing of it in her couple relationship. Greenberg at al. (1993) argue that achieving resolution, as defined by her awareness of feelings and needs, the client will have a sense of what she wants to change and may feel energized to initiate change. However, one part of the transcript (C4) indicates that the client experiences fear, anxiety, and uncertainty about how to proceed with the problem at hand outside the therapy session. Thus, despite the significant changes obtained in therapy, the client in this vignette expresses both her fear and lack of skill in communicating her feelings to an important other outside the therapy setting. The study used this clinical vignette to demonstrate the opportunity for therapeutic practice to include NVC at this stage of therapy and offered two possible examples of communication the client could aim to attain.

To demonstrate the applicability of NVC to EFT-C, the study examined the theory of therapeutic change and therapeutic action specified by Greenberg and Goldman (2008) and Johnson (2019). Based on existing research on clients' difficulties at different stages of therapy, the study investigated the clinical opportunities to integrate nonviolent communication in EFT -C therapeutic practice, as a basic need-supportive communication tool to enhance client's engagement with important others outside the therapy session. In particular, the

study examined the stage model of therapeutic action in EFT-C to identify the stage where NVC could be therapeutically used to enhance the therapeutic effects of EFT-C (James, 1991; Johnson, 2019).

The overarching methodology employed in this study was theory-driven analysis (Perkins et al., 2007; Walshe et al., 2007), a method commonly used to improve clinicians' behavior in health care (MacFarlane & O'Reilly-de Brún, 2012). For the purposes of this study, a theory-driven analysis enabled a structured and systematic examination of the stages of emotion-focused couple therapy and a more nuanced understanding of when clients might benefit from additional interpersonal skills. Theory-driven analysis brings consistency and coherence to the examination of the usefulness and effectiveness of need-supportive communication to enhance clients' engagement with important others outside the therapy session.

Furthermore, the combination of theory-driven analysis with the recommended additional need-supportive therapeutic action has immediate implications for clinical practice. By identifying specific stages where clients may need the acquisition of interpersonal skills, the study provides valuable insights on the application and refinement of emotion-focused individual and couple's therapy in real-world clinical settings.

3 SUMMARY OF RESULTS

Client engagement was investigated in four different contexts. Paper 1 examines client engagement in a first-encounter therapeutic intervention, in a particularly dire situation of suicidal risk, where the patient's successful engagement can mean saving her life. Paper 2 analyzes the effect of basic need support on emotional engagement in a therapeutic chair-work task. Paper 3 reports on the risk of disengagement and increase in external motivation of the patient through possible compliance, following a therapeutic rupture situation that illustrates an adverse, complementary relational positioning of the therapist. This third paper also proposes need-supportive alternatives for therapeutic action to re-engage the patient, exemplifying a relational positioning of the therapist that could facilitate positive emotional change. Paper 4 identifies the opportunities for the EFT therapist to facilitate individual clients' and couples' interpersonal emotion regulation and emotional engagement outside the safety net of the therapeutic session by teaching them to engage in need-supportive communication, specifying when and how in the therapeutic process this therapeutic action can be used.

3.1 Paper 1: First encounter suicide intervention

The first paper focuses on a suicidal patient's engagement with treatment in the very first encounter with a clinician. Engagement in this context means motivating the patient to actively participate in the collaborative assessment of her suicidal state as well as to choose life and actively participate in treatment.

As a suicide-prevention first encounter intervention, CAMS is specifically designed to engage suicidal patients in treatment. Given that the stakes are high, clinicians working with suicidal patients tend to resort to controlling practices, increasing external motivation for treatment.

The key finding of this study was:

> "The underlying philosophy of care and the clinical procedures of CAMS enhance the autonomy, relatedness, and competence of the client in the first encounter. The paper proposes that fulfilling these basic human needs results in the intervention outcomes of treatment engagement and choosing life for the time being."

Thus, the usefulness of CAMS to engage suicidal patients can be attributed to its unique combination of a person-centered therapeutic philosophy of care with a structured, thorough assessment. Compared to the alternatives, CAMS is unique in its priority of focus on the therapeutic relationship and on the creation of a therapeutic alliance already in the first encounter, when both client and therapist are under significant pressure. CAMS succeeds in this by maintaining a therapeutic focus on two interrelated subjective experiences of suicidal patients: the suicidal wish and the patient's extreme ambivalence between wanting to live and wanting to die. CAMS places an emphasis on the clinician providing empathy and understanding regarding the patient's suicidal wish as well as a verbalized acceptance of the patient's ambivalence about living and the undeniable reality that the patent has the possibility to take her life.

The study found that in contrast to the commonly used controlling practice in first-encounter suicide-specific care (Linehan et al., 2015; McMyler & Pryjmachuk, 2008), a clinician using CAMS is committed to take a relational positioning that is specifically non-controlling (Jobes, 2016). The clinician makes it clear from the beginning that it is the patient who knows most about her situation and ultimately decides what she will do, and that the clinician is present for the patient to understand her current difficult experience and explore it together with her. The clinician's focus is not on ensuring that the patient is not going to kill herself, but on being present and providing a safe climate for an empathic exploration of her current psychological suffering and psychic pain, the underlying reasons for these, and her reasons for dying and not dying.

The physical, and kinesthetic arrangement of CAMS, as described in its protocol, embodies the clinician's need supportive relational positioning. The results of the study emphasize the importance of conducting CAMS with patient and clinician sitting next to each other. Before starting with CAMS, the clinician explains its purpose and use, and asks the patient's permission to sit next to her. The clinician then gives the patient a pen and asks her to write down her answers to questions designed to explore her psychological pain and suicidal wish. The relational positioning of the clinician in this clinical arrangement is unique in suicide interventions: it expresses the clinician's explicit rejection of a position of authority, knowledge, and power; instead, this position is handed over to the patient.

SDT's basic psychological need theory was used as a theoretical lens to explain the working mechanism of CAMS with the aim of facilitating client engagement and motivation for treatment and life. Although several empirical studies have supported the efficacy of CAMS in motivating clients to choose life and engage in treatment, no previous research has explained its underlying mechanism which leads to change or its potential for client engagement. This study contributed to filling this research gap by showing that the effectiveness of CAMS in engaging clients can be explained by the SDT's basic psychological

need theory. The philosophy of care and clinical procedures of CAMS provide a unique combination of autonomy, relatedness, and competence support for the suicidal patient, helping her to re-engage with life.

3.2 Paper 2: Chair work with the empathic other

Empty chair-work is an experiential therapeutic task, commonly used in Gestalt therapy and EFT. In recent years it has also been applied in other therapeutic frameworks, such as cognitive and compassion-focused therapies (Bell et al., 2020; Pugh, 2017). While the effectiveness of empty-chair work for resolving unresolved feelings towards important others has been a repeated finding in psychotherapy research (Butollo et al., 2016; Paivio et al., 2010;), it is a therapeutic task that clients find difficult to engage with (Muntigl et al., 2020). When they do engage, they often do not engage with the necessary emotional intensity (Greenberg & Malcolm, 2002).

In this paper, we present a new variant of chair work, which we name chair work with the empathic other. We present a case-example of chair-work with the empathic other and examine the process of emotional change of the participant. The rationale for this variant of chair-work is derived from person-centered theory, positing that a particular kind of relational positioning of the therapist as a direct interlocutor, characterized by Rogers' necessary and sufficient conditions (1957), induces therapeutic change in the client. In conventional empty chair-work the client engages in a dialogue with an imagined important other and is supported by the therapist to express her unresolved feelings to this imagined other. In chair-work with the empathic other, the therapist takes on the role of the important other. However, this role-taking is very specific. It is the role of the empathic other, communicating with the participant in a need-supportive, person-centered way, concentrating on feelings and underlying needs, thereby exhibiting Roger's necessary therapeutic conditions for emotional change.

The paper examines the emotional engagement process of the participant when the trainer positions herself as the participant's empathic other. We found that talking directly to the empathic other supports the participant's emotional engagement and guides her emotional processing through the four necessary components of successful resolution specified in the research literature (Greenberg & Malcolm, 2002): experiential access and intense expression of primary adaptive emotions, expression of thwarted need, and a shift in the representation of self and the other. Throughout the chair-work process, the need-supporting positioning of the important other is consistently followed by the emotional engagement of the participant in the task: it deepens and widens her emotional exploration, guiding her through anger, rage, sadness, and hopelessness, finally leading her to express thwarted need and to change her representation of self and other.

Because the research was interested in the emotional process of the participant during the task, she was not explicitly asked about her subjective

perception of the degree of unfinished business resolution (Singh, 1994), or the degree of distress related to unfinished business (Klingspon et al., 2015). However, NVC task always ends by the facilitator asking the participant about his or her feeling at the moment. At the end of the task, the participant of the study reported a decrease of tension, expressed her interest in examining the relationship from her father's perspective, and even contemplated the possibility to write a letter to him. We suggest that these expressions of the participant strongly indicate resolution of unfinished business. These findings are discussed using SDT's theory of basic psychological needs, according to which emotion and need-based communication leads to autonomous engagement.

We also found that when the facilitator of the chair work, playing the empathic other, inquired about the participant's interest and readiness in hearing the important other's feelings and needs, this suggestion intensified the participant's emotions, leading her to express her thwarted needs, as well as to a shift in her representation of the other.

The implications of the findings for theory of therapeutic action and therapeutic practice are discussed, particularly in relation to the topic of client engagement in the chair-work task.

3.3 Paper 3: Pitfalls and opportunities of the therapist's meta-communication in alliance rupture

Paper 3 examines the therapist's pitfalls and opportunities for re-engaging the patient during alliance ruptures. First, the pitfalls of therapist metacommunication, such as adverse complementary relational positioning vis-à-vis the patient during a therapeutic impasse, were examined. We analyzed a published therapeutic transcript depicting a purportedly successful resolution of an alliance rupture in cognitive-analytic therapy. The transcript was analyzed through the combined theoretical lens of the relational psychoanalytic theory and the SDT's basic psychological need theory and focused on the clinical implications of these theories.

Drawing on the SDT, we problematized the assumption that if patient remained in therapy after the rupture, the rupture was resolved, and the outcome will be positive. We introduced motivation and relational positioning as relevant theoretical concepts for understanding rupture resolution and its effect on outcome. We critically analyzed a therapeutic transcript exemplifying best practice for addressing alliance ruptures in a brief integrative therapy. Our goal was to draw the attention of both practitioners and researchers to the potential risks of rigidly prescribing and blindly following techniques when facing therapeutic challenges.

Through our examination of metacommunication, we illustrate how a therapist's strict adherence to a specific technique to address threats to the therapeutic alliance can exemplify adverse relational positioning, thwarting the

patient's needs for autonomy, relatedness, and competence. A relational positioning of the therapist that sidesteps these basic needs can easily lead to external motivation and compliance by the client and may also have a negative influence on the therapeutic outcome. To counter this, we focused on the importance of the therapist's basic need-supportive relational positioning, offering alternative therapeutic actions to re-engage patients after threats to the alliance. Intra-psychically, the therapeutic action of building an intersubjective third to transcend relational complementarity (Aron, 2006; Benjamin, 2018), includes embracing the patient's ambivalence and playing with the patient's fantasy to enhance the latter's agency and creativity (Winnicott, 2016). Interpersonally, therapeutic actions to support the client's basic needs and bolster her autonomous motivation for the therapy process include what Safran and Muran (2000) have called 'mindfulness in action'.

3.4 Paper 4: Enhancing clients' engagement outside the therapy session

Paper 4 examines the possibilities of a therapist in EFT to facilitate individual clients' and couples' interpersonal emotion regulation and emotional engagement with important others outside the safety net of the therapy session. A person-centered communicational process was introduced that can be taught to EFT clients to help them engage with each other emotionally in their everyday life, and overcome adverse, complementary dynamics. The study showed how nonviolent communication, a person-centered communication tool that helps clients to learn to take an empathic relational positioning towards the other, can facilitate a connection through shared feelings and underlying needs. Thus, nonviolent communication can be understood as autonomy-supportive communication, manifesting the basic components of SDT's basic need support.

To justify the therapeutic use of NVC, as a person-centered heuristic tool for clients to learn, a case example and therapeutic transcript presented in Greenberg at al. (1993) was utilized. The case features an EFT client who, despite a successful therapy process in which she had got in contact with previously unacknowledged feelings and needs, expresses fear and lack of confidence over expressing important feelings and needs to her partner. Regarding therapeutic use of NVC in couples therapy, the study builds on previous research findings on couples therapy clients who lack the confidence in their skills to engage and re-engage with each other outside the safety framework of the therapy session (Johnson, 2019).

Drawing on the research finding of Greenberg and Warwar (2006) that experientially based exercises enhance therapeutic gains for EFT clients, the paper proposes the teaching of a person-centered, psychological need-supporting tool applicable to both individual clients and couples at the end phase of EFT experiential tasks as well as the end phase of EFT-C therapy. Examining

the consecutive stages of both EFT and EFT-C, therapists' opportunities to integrate the teaching of this tool to clients with their therapeutic action are discussed. The paper also discusses the necessary relational positioning that therapists must take in order to enhance clients' interest and motivation, and to ensure that clients do not feel controlled when learning to use the tool. The paper concludes by arguing that teaching EFT clients a heuristic person-centered tool to help them to engage with important others outside session will enhance their basic psychological need of competence, thereby facilitating engagement with the therapy process.

4 DISCUSSION

This dissertation conceptualizes clients' engagement as autonomous motivation for the process of psychotherapy. Drawing on the SDT's basic need theory, the dissertation examines how basic need support is manifested in the therapist's therapeutic actions in different situations of psychotherapy, and how these can be examined in four different stages of therapeutic work: in a first-encounter therapeutic intervention for engaging suicidal patients in treatment; in the engagement of clients for a therapeutic chair-work task; in the process of re-engaging patients during a rupture resolution in a brief integrative therapy; and finally, as a therapeutic intervention to help both individual clients and couples therapy clients to engage and re-engage with important others or with each other outside the safety net of the therapy session.

The dissertation focuses on a key aspect of therapeutic action: the therapist's relational positioning vis-à-vis the client. The concept of relational positioning is novel and is developed in this summary drawing on the SDT. The four studies comprising the dissertation propose that relational positioning is the mechanism through which the therapist's action affects emotional change. The hypothesis developed in this dissertation is that relational positioning of the therapist that supports the client's basic needs facilitates client engagement in the four psychotherapy situations, leading to emotional change. The dissertation illustrates how research using the SDT framework can be conducted in different therapeutic contexts. I also find that relational positioning supportive of the patient's basic needs takes different forms in these different therapeutic situations.

4.1 Theoretical contribution

Table 1 below provides a summary of findings and contributions. The key findings of each study are presented, along with the contribution of the dissertation to psychotherapy research on engagement, SDT research in

psychotherapy, and the role of the therapist's need-supportive relational positioning in facilitating client engagement. The main contribution of this dissertation with respect to engagement in psychotherapy is the definition of engagement as autonomous motivation, applicable in different therapeutic situations. With respect to the SDT, the contribution is identifying new methods for examining basic need support provided to psychotherapy clients by the therapist. Two such methods are identified: examination of the theory underlying the therapists' therapeutic action and the application of psychotherapy process research methodologies commonly used in psychotherapy research (Krause, 2023). An important contribution of this dissertation summary, beyond what has been presented in the four papers, is the conceptualization of the therapist's support of basic needs as a relational attitude, both implicit and explicit, towards the client. This novel conceptualization manifests what in this dissertation is called the therapist's relational positioning. This relational positioning is of paramount importance because it shifts our perspective of understanding basic need support away from referring solely to what the therapist does, to its inherent inclusion in the therapist's way of being with her client.

This has important implications for how we study therapy processes. The concept of the therapist's relational positioning allows examination of the therapist's basic need support not only interpersonally, but also intra-psychically, in guiding her therapeutic actions. On the interpersonal level, it is important to examine both the verbal and nonverbal behavior of the therapist in order to find out if these behaviors support or thwart the client's basic needs. Finally, this dissertation contributes to psychotherapy theory by positing that the therapist's provision of basic need support during the therapy process is not the same in situations where the patient's problem is related to an important other outside the therapeutic dyad as it is in situations where the patient's problem is with the therapist, as it is the case in alliance ruptures. In the first case, the therapist's basic need support is facilitated by a therapeutic action relying on person-centered theory (Rogers, 1957), whereas in the second case the therapist's basic need support is facilitated by a therapeutic action relying on the relational psychoanalytic theory and associated relational integrative theories (Aron, 2006; Benjamin, 2018; Hoffman, 2014; Safran & Kraus, 2014).

TABLE 1 Contribution of summary and papers

Note: SDT: self-determination theory; NVC: nonviolent communication; EFT: emotion-focused therapy; CAMS: Collaborative Assessment and Management of Suicidality

	Engagement	**Self-determination theory**	**Relational positioning**
Summary	Definition of psychotherapy engagement as autonomous motivation relying on integrative self-regulation. Examination of engagement, thus defined, at the start of therapy, during a therapeutic task; in re-engagement after alliance rupture; and in engagement with other attachment figures outside the therapy session.	In psychotherapy contexts, the thesis indicates a need for widening the scope of research methods. Two novel methods for studying therapists' basic need support were used: first, examination of the theory of therapeutic action and intervention protocols; second, the use of process research methods in the examination of in-session interactions between client and therapist.	The development of a new concept, the therapist's relational positioning, for examining the extent of the therapist's basic need support manifested in the theory of therapeutic action in each approach and both intra-psychically and interpersonally in the verbal and nonverbal therapeutic action of the therapist.
Paper 1	The paper contributes to the suicide prevention literature on the importance of the clinician's basic need support, facilitating client engagement.	SDT is applicable in extreme clinical situations where autonomy support is controversial. The paper explains of the effectiveness of CAMS by identifying the mechanism of change as basic need-supportive relational positioning by the therapist.	CAMS exhibits both intrapsychic and interpersonal aspects of a need-supportive relational positioning that can be identified by examining the theory underlying the CAMS protocol. The importance of clinicians' need-supportive relational positioning is emphasized in the intrapsychic and nonverbal aspects of their relational positioning.
Paper 2	Variation of chair work technique supports the participant's emotional engagement in the task, facilitating progress through the components necessary for a successful resolution to unfinished business.	Person-centered communication is a basic need-supportive communication.	A modified version of chair work, where clients receive direct support for their basic needs, enhancing their emotional engagement in the task and facilitating a successful resolution.
Paper 3	Re-engagement of patient after alliance rupture through the therapist's relational positioning that supports the patient's basic needs. Relevant theory for therapeutic action is to be found in the relational psychoanalytic literature.	SDT is an important concept when examining the resolution of ruptures. A resolution that happens through compliance can thwart long-standing change. Basic need support during ruptures is provided by therapeutic actions rooted in relational psychoanalytic theory.	When the patient problem is with the therapist, as it is the case during alliance ruptures, the therapist's need-supportive relational positioning is specified by relational psychoanalytic theory.
Paper 4	Teaching clients to engage and re-engage with each other outside the safety net of the therapy session by basic need-supporting communication.	NVC as basic need-supportive communication can be taught to clients, enhancing their engagement with important others outside the session.	The therapist's relational positioning is also important, when teaching clients experiential tasks.

The developments in psychotherapy research and practice have led to a change both in theory and practice that has been termed the 'relational turn' (Lingiardi et al., 2016; Safran, 2003; Stern, 2019). This relational turn can be understood as the result of a combination of factors. The most important is an increasing interest, by both researchers and practitioners, in building on and using integrative frameworks of psychotherapy (Finlay, 2015; Wachtel, 2014). Furthermore, increasing sophistication in the methodologies used tap directly into the process of change in psychotherapy, originally initiated by Greenberg et al. (1991) within the emotion-focused framework. Moreover, recognizing the relevance of the concept of attachment in psychotherapy and the therapeutic relationship has led to an increasing use of object-relationship theories in all forms of integrative psychotherapies (Normandin et al., 2023; Shahar, 2021). Last, but not least, the burgeoning research area of the therapeutic alliance, and in particular of alliance ruptures, has further called both researchers' and clinicians' attention to the importance of acknowledging cumbersome transference-countertransference configurations in the therapeutic process, manifested in the enactments of patients' problematic relational dynamics, and their therapeutic potential, when skillfully dealt with by the therapist.

This dissertation argues that this relational turn in psychotherapy (Lingiardi et al., 2016) is a favorable opportunity SDT researchers can capitalize on. Although not explicitly recognized, SDT is inherently a relational theory. It emphasizes the phenomenological self as a relational entity and conceptualizes the internalized quality of self-regulation in terms of the relational dynamics between the phenomenological self and 'the other', be it a caregiver, a romantic partner, or any other attachment figure, including the therapist (Ryan & Deci, 2017). The supreme importance of the concept of internalization in SDT, formulated explicitly in its organismic integration theory, has been a paramount preoccupation of psychoanalytic thinking ever since Freud (1923; Loewald, 1973; Jacobson, 1964; Schafer, 1968).

However, vast differences exist between the different schools of psychoanalytic thinking in how they conceptualize internalization and psychological change, and the therapeutic action needed (Schafer, 1968). Relational psychoanalysts have questioned ego-psychology's claims that classical techniques such as neutrality and abstinence are manifestations of a respect for the patient's autonomy (Aron, 2013; Hoffman, 2014). The relational school has equally made a very compelling case for considering therapeutic enactments as events mutually constructed by the patient and the therapist, as opposed to the claim by ego-psychologists' that it is the result of the patient's intrapsychic projection. Considering enactment as the patient's projection easily leads to a controlling therapeutic positioning as well as patient compliance (Benjamin, 2018; Safran & Muran, 2000). The controversies related to this topic in psychoanalytic discourse have not been commented on by advocates of SDT, although the theory has the potential to contribute considerably to this discourse.

For SDT research to capitalize on this opportunity, this dissertation points to the need to widen the scope of research methods, away from patient's self-reports on their type of motivation and perceived support of their basic needs (Zuroff et al., 2007, 2012). In this dissertation two methodologies are proposed: First, a conceptual examination of the theory of the self as well as theory of psychological change and the related therapeutic action and intervention protocols in different therapeutic approaches; and second, the use of established methods in psychotherapy process research for studying the in-session interaction between patient and therapist. To study basic need support in the psychotherapy contexts, a new concept, that of the therapist's relational positioning, is proposed. Basic need support can be conceptualized as the therapist's relational positioning towards the patient, detectable both in the implicit or explicit theory of the self and the theory of therapeutic action or in the intervention protocol, and in the concrete interaction between patient and therapist in the therapy session.

To give an example, the provision of insight and enhancement of knowledge as a therapeutic action by the therapist during an alliance rupture can be basic need thwarting for the client. Such action is widely used in both classical psychoanalysis and in the cognitive tradition, where it is considered an important vehicle for change in many therapeutic situations, including ruptures. However, the therapeutic action of knowledge enhancement can easily result in a need-thwarting relational positioning of the therapist, as was found to be the case in the analysis of the therapy transcript in Paper 3.

While therapeutic interaction is commonly examined by studying transcription data and employing discourse and conversation analysis techniques to detect themes and patterns, the use of the proposed relational positioning concept directs attention to both the intra-psychic and the interpersonal aspects of the therapist's need-supportive therapeutic action, with the intra-psychic often guiding the interpersonal. With respect to the interpersonal aspects of the therapist's relational positioning, both the verbal and nonverbal behavior of the therapist must be examined, to investigate whether the therapist's actions support the client's basic needs. Study of the intra-psychic aspect of the therapist's basic need support requires a method that can explore the theory of therapeutic action, whereas the study of the interpersonal aspect of the therapist's basic need support, particularly its non-verbal manifestations, requires methods commonly used in psychotherapy process research (Greenberg, 1991; Krause, 2023).

As pointed out in Paper 1, not all aspects of the therapist's need-supportive relational positioning can be studied by focusing exclusively on verbal expression. In CAMS, theory-supported relational positioning is also manifested by the clinician's nonverbal behavior, as in asking permission to sit next to the suicidal patient or handing the patient a pen for filling out the Suicide Status Form. Also, the priority of asking first about the subjective experience of suicidality, and only after this moving to a more objective assessment of the

patient's suicidal risk is a therapeutic technique designed indicate to the patient that the therapist is adopting a basic need supportive relational positioning.

On the topic of the therapist's basic need support, this dissertation points to the importance not only of what the therapist says, but also of what she does not say. To study the need-thwarting implications of both what is said and what is not said is made possible using the concept of relational positioning. The therapist's lack of responses to or reflection on the patient's limited talk or her silencing or expression of disapproval of the patient also indicate a need-thwarting relational positioning. Thus, to study a therapist's basic need support in the therapeutic process, it is important to examine both the intra-psychic and interpersonal aspects of this need support. Furthermore, to study the interpersonal aspects of the therapist's need-supporting relational positioning, we must examine both the verbal and the nonverbal aspects of her therapeutic action. The concept of relational positioning makes these two types of above-mentioned analyses possible.

With respect to the verbalized aspects of basic need supportive relational positioning, we propose that two elements should be present: an interest to enquire about the feelings and underlying needs of the patient and encouraging the patient to express these. These are the elements classified as the basic mechanisms of change in EFT, and more generally in person-centered theory. Together, they amount to communication supportive of basic needs, thereby facilitating autonomous regulation and emotional change. Empty chair-work is a therapeutic task, employed to help clients to express unresolved feelings to important others. Despite the considerable support found for its effectiveness, it is not always easy to engage clients emotionally in this therapeutic task. The findings of the study on what we term 'chair work with the empathic other', contribute to research in two important ways. First, the findings show how feeling- and need-supportive communication, manifested in need-supportive relational positioning, can facilitate emotional change and the resolution of unfinished business, supporting SDT's assumptions on the importance of need support for integrative emotion regulation (Roth et al., 2019). Second, the findings show that need-supportive relational positioning can be even more effective when it comes directly from the important other, a role played by the therapist. This result must be interpreted as tentative, as it relied on a single case study. Nevertheless, the result it is very inspiring and interesting, since the participant progressed through the four elements of emotional processing necessary for the resolution of unfinished business (Greenberg and Malcolm, 2002) in a theory-predicted fashion. This finding is encouraging and will, it is hoped, serve as a springboard for replication with wider data and elaboration in further research.

As demonstrated, autonomy-supportive communication can not only be employed in session, as is commonly done in EFT, but it can also be taught to clients to enhance the interpersonal effects of psychotherapy. EFT has developed important techniques to support patients' need for autonomy and relatedness.

Teaching clients basic need-supportive communication supports their need for competence to benefit even more from their experiences in therapy.

This dissertation contributes to the SDT literature in the psychotherapy context, by affirming a clear distinction between a need-supporting relational positioning of the therapist vis-à-vis the client when the therapeutic work is focused on a problem in the client's life outside of therapy vs. when the therapeutic work is directed to the relationship between client and therapist. To be sure, different therapeutic traditions give different emphases to these two kinds of therapeutic focus: therapies building on the psychoanalytical tradition conceptualize the therapeutic relationship, and the working through of the patient's transference, the very vehicle of psychological change, while other traditions focus more on the client's problematic relationships with other people and situations in their lives. Nevertheless, albeit with different emphases, all traditions of therapeutic work employ both kinds of focus.

The results of this dissertation show that it takes a different kind of therapeutic action to be need-supportive when the client explores her intense feelings and needs towards important others outside the therapeutic dyad than in a therapeutic situation where she explores and expresses intense feelings and needs directed at the therapist. In the first case scenario, the therapist's need-supporting relational positioning amounts to what Rogers (1957) specified as the necessary components of therapeutic action leading to personality change. This has been noticed by a growing number of theorists familiar with both SDT research and the person-centered tradition (DeRobertis et al., 2018; Lynch et al., 2020; Sheldon, 2013). In the second scenario, the therapist's need-supportive relational positioning is manifested by therapeutic actions that are rooted in relational psychoanalytic theory and the associated relationally oriented approaches (Aron, 2006; Benjamin, 2018; Safran & Kraus, 2014; Safran & Muran, 2000). Example of these basic need-supportive therapeutic actions, as manifested in the therapist's relational positioning in the intrapsychic realm, are the building of an intersubjective 'third' in order to transcend complementarity (Aron, 2006), as well as the therapist's embracing of the patient's ambivalence (Benjamin, 2018). Examples of basic need-supportive therapeutic action as manifested in the therapist's relational positioning in the interpersonal realm are what Safran and Muran (2000) called 'mindfulness in action' and what the relational psychoanalyst Jessica Benjamin (2018) called – drawing on Winnicott (2016) – playing with the patient's fantasy.

This dissertation also reveals a benefit of introducing SDT theory into the research on alliance rupture, a therapeutic instance where the therapist commonly finds herself to be the very problem of the patient. Therapists and researchers often assume that the alliance has been repaired when a patient continues in therapy after a rupture. Analyzing a published transcript, purportedly showing a successful resolution of alliance rupture, questions this assumption and raises the possibility that the alliance rupture was resolved through client compliance, thus manifesting external regulation and thwarting long-standing change. Resting on the concept of relational positioning, the study

argues that the patient's compliance may be a result of a lack of basic need-support, and a controlling stance in the therapist's metacommunication.

Paper 3 proposes two alternative therapeutic actions that have been supported by research, 'mindfulness in action' (Safran & Muran, 2000), and 'embracing the patient's ambivalence' by playing with her fantasy (Benjamin, 2018). Both therapeutic actions are difficult to conceptualize as examples of observable acts of communication. They express instead a relational positioning towards the patient that is inherently autonomy-, relatedness-, and competence-supportive. Mindfulness in action can be considered a very powerful need-supporting practice when the therapeutic impasse is related to the relationship between patient and therapist.

This dissertation contributes to the study of engagement in psychotherapy and has practical relevance to psychotherapists of all orientations, but particularly to those who work within a relational integrative framework, encompassing techniques from the psychodynamic and the experiential traditions. Studying the process of engagement and how it can be facilitated is an important topic for all psychotherapists. Behavioral indices do not do justice to the intricate complex nature of engagement (Roth et al., 2019), which is inherently relational in nature.

This dissertation examined engagement at the first encounter, engagement in a therapeutic task, relational re-engagement after alliance rupture, and engagement with other attachment figures outside the therapy session. To account for patient engagement in these very different clinical situations requires a coherent theoretical framework such as that provided by SDT and its pivotal concepts of autonomous motivation and regulation.

4.2 Contribution to clinical practice

SDT has gained widespread recognition and been applied in different social contexts aiming at inducing psychological change, and to a lesser extent in counseling and health interventions. However, in psychotherapy proper its importance and clinical applicability has remained limited. An important contribution of this dissertation to the clinical practice of psychotherapy is it calling the attention of practitioners to the relevance of the SDT's basic need theory in understanding therapeutic change. More specifically, the present research proposes that psychotherapists recognize that the purported theoretical void regarding client engagement is only apparent. A theory, resting on solid empirical evidence, on people's engagement in psychological change does in fact exist - it is SDT. The dissertation applied SDT in the psychotherapy context and demonstrated what its basic propositions mean in relation to specific therapeutical tasks. This research highlights how engagement in psychotherapy is a continuous process, sustained by the client's autonomous motivation, as defined by SDT. The four studies showed how the therapist can facilitate client engagement by basic need-supportive therapeutic action, providing specific

examples for first encounter, chair-work, alliance-rupture, and outside-therapy tasks.

SDT posits that it is support for people's three basic psychological needs–autonomy, relatedness, and competence–that engenders autonomous motivation, engagement, and long-standing change. But what does that mean in the psychotherapy context and at the level of therapeutic interaction? This research conceptualizes therapists' basic need support as their relational positioning towards their clients, considering different aspects of this relational positioning: intrapsychic, interpersonal, verbal, and nonverbal. Paper 1 highlights the importance of the nonverbal aspects of a therapist's autonomy-supportive therapeutic action when seeking to engage a suicidal patient. Paper 2 describes how basic need-supportive communication facilitates the participant's emotional processing throughout the entire therapeutic task of chair-work, and Paper 3 shows how easily during alliance ruptures the therapist's relational positioning, despite her good will and clinical experience, can become controlling, and thwarts the client's basic needs.

On the level of clinical practice, the most important contribution of this dissertation is that it enhances therapists' knowledge and understanding of the importance of their relational positioning and the effect this has on client engagement. This research directly supports therapeutic practice by describing relational positioning by the therapist that is need-supporting, or need-thwarting, in specific therapeutic situations. This research directly supports therapeutic practice by describing need supporting or need thwarting relational positionings in specific therapeutic situations. The findings reported in Paper 1 suggest that the mechanism underlying the effectiveness of an intervention in engaging suicidal patients in treatment, which hitherto has not been fully understood, can be explained by an autonomy-supportive stance of the clinician towards the patient's suicidal wish. Papers 2 and 4 show how an explicit basic need-supportive communicative stance engages clients and keeps them engaged in important change-oriented emotional processing, both in and outside session. Paper 3, in turn, presents an example of basic need thwarting, showing how the therapist's metacommunication engendered detrimental complementarity, leading to compliance and external motivation of the client. These results show how therapists working within different integrative frameworks, in specific therapeutic situations, can combine need-supportive relational positioning with their specific theoretical framework. We also show how person-centered theory and related frameworks are basic need-supportive when the client's problem is related to important others outside therapy. In cases where the client's problem is with the therapist, as in therapeutic impasses, the therapist should provide basic need-supportive therapeutic action by drawing on relational psychoanalytic theory and practice.

The present specification of the therapist's relational positioning as a means of supporting clients' basic needs provides a useful template for therapists aiming at client engagement in different phases of therapy and in different therapeutic situations. The research has specified concrete therapeutic actions to

support client's basic needs as manifested in the therapist's relational positioning, some of which are interpersonal and verbal (enquiring and verbalizing feelings and needs), some nonverbal (the therapist's embodied behavior), and some intrapsychic (mindfulness in action, transcending complementarity by embracing the client's ambivalence and playing with the client's fantasy).

To engage clients through relational positioning, the therapist must recognize the difference between autonomous vs. controlled motivation in their working models of therapeutic action, whether intrapsychic or interpersonal. The present research can help therapists with this task. Once recognized, SDT's basic needs theory can be used as a heuristic to determine therapists' appropriate relational positioning and therapeutic action. The engagement of suicidal patients in treatment, client emotional engagement in therapeutic tasks in and outside session, and therapeutic action aiming at rupture resolution can all benefit from the SDT's understanding of engagement as autonomous motivation, pointing to its general relevance in therapeutic practice.

4.3 The reliability and limitations of the research

In Paper 1, the reliability of the directive content analysis was secured through maintaining the consistency and transparency of the theoretical concepts used. Subjectivity was mitigated, reliability ensured, and replicability improved by relying on the CAMS clinical protocol and procedures. Similarly, reliability was addressed in Paper 4 by relying on clearly defined theoretical concepts and constructs.

Reliability in Papers 2 and 3, both of which employed process research methods, was ensured through the application of established methodology (Greenberg, 1991; Krause, 2023). In Paper 3, the categorization of therapeutic actions as basic need-supportive was conducted transparently for the reader and with high agreement among the co-authors during the analysis. Discrepancies, if any, were resolved through consensus, ensuring the reliability of the results. In Paper 2, using two independent evaluators to assess the degree or steps achieved in the process of unfinished business resolution would have made the conclusions regarding the outcome of the task more persuasive. However, we believe that the presentation of the entire transcript of the recorded video, which is rather unique in this type of research, has substantially increased transparency, and added an extra layer of reliability, compensating for the lack of use of two independent evaluators.

As all research, this dissertation has its own share of limitations. Like the human mind, psychological change is a complex, multifaceted and context-dependent phenomenon. Notwithstanding the solid empirical support of SDT, its application in psychotherapy context is in its infancy. While this dissertation research highlights new research avenues and points to possible ways in which SDT can impact psychotherapy research, theory, and practice, applications to new contexts always reveal new gaps in knowledge. Although this dissertation

examined and interpreted suicidal clients' engagement to treatment as a general example for engaging clients for psychotherapy, this might not necessarily be a typical case. Most clients contemplating therapy are far from suicidal, and their engagement might be enhanced, and contingent, on other forms of therapeutic action. Moreover, this dissertation only examined engagement in two types of therapeutic tasks: in chair work, rooted in EFT and in rupture resolution. Many other therapeutic tasks, besides those examined here, also merit study. Further research is needed to explicate how therapists can take engagement-supportive actions during different therapeutic tasks and situations. A further limitation of this research is its reliance on a single source of data for each of the examined tasks: a therapy transcript of an alliance rupture, and a videorecording of a chair-work dialogue. It is nevertheless important to note that through qualitative research it is possible to foreground phenomena that are not exclusively situation- or case-dependent and hence transferable to other situations and cases (Levitt, 2021).

As this dissertation argues, the theoretical compatibilities of the different psychotherapeutic traditions with the basic assumptions of SDT would benefit from a thorough examination. For this purpose, the present research is only a starting point. Because the field of psychotherapy is wide and constantly developing, much remains to be done. On the issue of extending SDT research to integrate the different methodologies of psychotherapy process research, this dissertation is also only a first step. Further research needs methodological innovations that both preserve the SDT's commitment to rigorous research methods and enable its application in the psychotherapy context, where quantification is notoriously challenging. For SDT research in the field of psychotherapy to develop, it cannot remain dependent on clients' self-reported data. Research has shown that clients tend to both overvalue and undervalue therapy experiences in self-report measures (e.g. Schwartz et al., 2023). In order to examine therapists' basic need support, we need to study actual interaction between therapists and their clients, preferably in video recordings, observing how clients react both verbally and nonverbally to specific types of communication and metacommunication by therapists. The results of this dissertation indicate promising avenues for such research.

4.4 Ethical considerations

Overall, this dissertation research was conducted in accordance with relevant ethical guidelines for conducting research with human participants. These included obtaining participants' informed consent to participate in the research, the safeguarding of their privacy and confidentiality throughout the research process, and the principle of minimizing harm. Apart from this general adherence to ethical guidelines, three additional research ethical considerations pertaining to specific studies were taken into account: methodological transparency in Papers 1 and 4; the ensuring of participants' informed consent,

confidentiality, and anonymity in Paper 2; and the ethics regarding the utilization of secondary data in Paper 3.

Transparency of the qualitative methods used in Papers 1 and 4 ensured the ethical principles of replicability, intellectual honesty, and accountability, all important aspects of academic research.

To ensure participants' informed consent, confidentiality, and anonymity in Paper 2, established ethical guidelines were followed during the recruitment of the participants, during their participation in the study, and in the handling of the data collected. Paper 2 is based on a research design that had been submitted to and approved by the Human Sciences Ethics Committee of the University of Jyväskylä. This committee works in accordance with the guidelines for research involving human participants issued by the Finnish National Board on Research Integrity in 2019. Participant anonymity was safeguarded using pseudonyms throughout the study. Importantly, participants were not exposed to anything that they would not otherwise have experienced during their participation in the communication training.

The utilization of secondary data in Paper 3 involved the analysis of a previously published therapy transcript. Permission was sought and obtained from the publisher for usage of the data, ensuring compliance with ethical standards and copyright regulations. The publisher's authorization allowed for the extraction and analysis of the therapy transcript, demonstrating our commitment to transparency and adherence to ethical guidelines. Relying on previously published transcripts for secondary analysis can be considered a sustainable way of using data, since the research does not require the recruitment of new participants, which in the therapy context often involves feelings of discomfort. However, when relying on previously published data, one cannot know how the participants would have evaluated the correctness of the analysis.

5 CONCLUSION

This dissertation introduced, examined, and demonstrated the applicability and relevance of SDT for psychotherapy theory and practice. Answering the call for a lacking and urgently needed unifying theory of client engagement in psychotherapy (Holdsworth et al., 2014), this dissertation proposes that SDT can serve this purpose. However, SDT cannot be introduced in the context of psychotherapy without careful explication and application. Based on a review of research on client engagement and empirical research supporting the tenets of SDT, this dissertation demonstrates how client engagement in psychotherapy can be understood as autonomous motivation throughout the therapeutic process. This can be enhanced and promoted by therapeutic actions of the therapist that support clients' basic needs of autonomy, relatedness, and competence (Ryan and Deci, 2017).

Despite the solid empirical evidence accumulated in SDT literature on the importance of basic need support for autonomous motivation, what this really means in the psychotherapy context has so far received little attention and the methodology used by the few studies that exist has been limited (Dwyer et al., 2011; Quitasol et al., 2018; Steiger et al., 2017; Zuroff & Koestner, 2023;). This dissertation finds that conceptualizing basic need-supportive therapeutic action requires considerable elaboration in the psychotherapy context. First, the therapist's support for clients' basic needs has both intrapsychic and interpersonal dimensions, the former often giving rise to and influencing the latter. More specifically, the theory of the self and therapeutic action that the therapist draws on has relevance for the therapist's basic need support. Hence, it is argued in this dissertation that a need exists to examine the compatibility between, on the one hand, the different psychotherapeutic theories of the self and therapeutic action and, on the other, the tenets of the SDT. While this dissertation does not question that all types of therapies can be done in a more or less autonomy-supportive way (Ryan et al. 2017), it argues that theory *does* matter. Certain psychotherapeutic theoretical frameworks are more compatible with SDT than others.

Second, the dissertation calls for an extension of the methodologies so far used to study basic need support in therapeutic contexts. This call for methodological extension is related to the realization that the interpersonal aspect of basic need support by the therapist is both verbal and nonverbal and hence requires examination of both. To incorporate all the different dimensions of basic need support, that is, intrapsychic and interpersonal, verbal, and nonverbal, this dissertation proposes the use of a new concept, the therapist's relational positioning vis-á-vis the client. This new concept will help both theory development and clinical practice by enhancing understanding of basic need-supportive therapeutic action and its explication and elaboration.

The four articles comprising this dissertation examine different therapeutic actions in different therapeutic contexts manifesting basic need-supportive relational positioning, and in one case, basic need-thwarting relational positioning. The studies show with concrete therapeutic examples what is needed to engage clients in the therapeutic process manifested in the therapist's relation positioning. The studies also elucidate how the therapist, through basic need support, can enhance clients' autonomous motivation for embarking on the therapy journey, engaging in a therapeutic task, re-engaging after rupture, and engaging with important others outside session. The dissertation further argues that need-supportive relational positioning is different when the client experiences problems with important others from when the client's problem is directly with the therapist. Whereas in the first case the therapist can rely on person-centered and emotion-focused theory of therapeutic action (Rogers, 1957, 1995; Goldman & Greenberg, 2019) to safeguard need-supportive relational positioning, in the second case, autonomy-supportive relational positioning can be supported by the tenets and sensibilities of the relational psychoanalytic theory and associated relationally oriented integrative approaches (Aron, 2006; Benjamin, 2018; Finlay, 2015; Lingiardi et al., 2016; Safran & Kraus, 2014). Implementing basic need support in psychotherapy may sound simple. However, a more thorough examination shows it to be very challenging, requiring from the therapist a constant awareness of her implicit or explicit relational positioning.

YHTEENVETO (SUMMARY)

Psykoterapeutin suhteessa asemoituminen: miten sitouttaa asiakkaan terapiaprosessiin ja emotionaaliseen muutokseen perustarpeiden tukemisen kautta

Väitöskirjan suomenkielinen nimi on ”Psykoterapeutin suhteessa asemoituminen: miten sitouttaa asiakkaan terapiaprosessiin ja emotionaaliseen muutokseen perustarpeiden tukemisen kautta”. Väitöskirja tarkastelee, miten psykoterapeutti voi edistää asiakkaan autonomista sitoutumista terapiaprosessiin terapian eri vaiheissa, täyttäen aukon psykoterapeuttista toimintaa koskevassa prosessitutkimuksessa. Psykoterapiatutkimuksessa puuttuu yksimielisyys siitä, mitä asiakkaan syvällinen ja pitkäjänteinen sitoutuminen psykoterapiaan täsmälleen tarkoittaa ja miten psykoterapeutti voi terapeuttisella toiminnallaan tätä sitoutumisprosessia parhaiten tukea ja edistää. Väitöskirjatutkimus esittää itsemääräämisteorian psykoterapian prosessitutkimukseen soveltuvana teoreettisena viitekehyksenä ja asiakkaan autonomista sitoutumista selittävänä mallina.

Vaikka itsemääräytymisteoria on alettu viime vuosikymmenen aikana jonkin verran soveltaa psykoterapiatutkimuksen alueella, psykoterapian prosessitutkimuksessa se on uusi viitekehys ja tämän väitöstutkimuksen tärkeä teoreettinen kontribuutio. Itsemääräytymisteoriaan mukaan terapeutin eräs olennainen rooli sitouttamisprosessissa on asiakkaiden perustarpeiden tukeminen. Väitöskirjatutkimus laajentaa itsemääräytymisteorian soveltuvuutta psykoterapian prosessitutkimukseen käsitteellistämällä asiakkaan sitouttamista ja sitoutumista terapiaan autonomisena motivaationa, jota psykoterapeutti voi edesauttaa tietynlaisella suhteessa asemoitumisella.

Tutkimus kehittää ja jäsentää terapeutin suhteessa asemoitumisen käsitettä ja havainnollistaa sen soveltuvuutta erilaisiin terapeuttisiin tilanteisiin. Terapeutin suhteessa asemoitumisen käsite viittaa sekä terapeutin mielensisäiseen, asiakkaan perustarpeita tukevaan suhteessa olemisen tapaan, että hänen terapeuttiseen, sekä kielelliseen että keholliseen toimintaansa. Terapeutin suhteessa asemoitumisen käsitteen avulla voimme tutkia miten terapeutit voivat parhaiten tukea asiakkaiden autonomian, yhteenkuuluvuuden ja kompetenssin perustarpeita ja tätä kautta edistää asiakkaan autonomista sitoutumista psykoterapiaprosessiin, jossa psyykkinen muutos tapahtuu.

Tutkimus tarkastelee asiakkaan sitouttamista (mitä terapeutti tekee, jotta asiakas sitoutuisi), sekä asiakkaan autonomista sitoutumista (miten asiakas sitoutuu ja mistä sen voi havaita) neljässä eri terapeuttisessa tilanteessa: Terapiatilanteet, jotka ovat tarkastelun kohteena edustavat myös terapian eri vaiheita. Ensimmäinen artikkeli tutkii, miten terapeutti, ensitapaamisen yhteydessä toteutuneessa itsemurhainterventiossa, voi tukea asiakkaan autonomista sitoutumista hoitoprosessiin ja samalla elämän valitsemiseen. Toinen artikkeli kuvaa, miten tunekeskeisen psykoterapian perinteisen tuolitekniikan muokkauksella terapeutti voi tukea asiakkaan syvempää tunnetason osallistumista terapeuttiseen tehtävään. Kolmas artikkeli tarkastelee asiakkaan uudelleen sitoutumisen haasteita ja mahdollisuuksia terapiaprosessin katkostilanteissa. Neljäs artikkeli ha-

vainnollistaa rakentavan vuorovaikutuksen menetelmän integraation mahdollisuutta tunnekeskeiseen yksilö-, ja pariterapiaan, edistämään asiakkaan sitoutumista terapiahuoneen ulkopuoliseen, tunteisin ja tarpeisin pohjautuvaan vuorovaikutukseen. Väitöstutkimus myös tarkastelee, kuinka terapeutin asiakkaan perustarpeita tukeva suhteessa asemoituminen ilmenee eri tavalla ja nojautuu eri teoriapohjaan riippuen siitä, koskeeko asiakkaan kokema ongelma terapian ulkopuolista kohdetta, vai nimenomaisesti terapiasuhdetta.

Väitöskirja tuo uuden näkökulman psykoterapian prosessitutkimukseen yhdistämällä asiakkaan sitoutumisen käsitteen itsemääräämisteorian viitekehykseen, ja korostamalla asiakkaiden perustarpeiden tukemisen tärkeyttä terapeuttisessa vuorovaikutuksessa. Suhteessa asemoitumisen käsite haastaa näkemystämme perustarpeiden tukemisesta pelkkänä toimintana, ja laajentaa käsitettä sisältämään myös terapeutin asiakkaan kanssa toteuttaman olemisen tavan. Terapeutti voi suhteessa asemoitumisen kautta tukea asiakkaan perustarpeita, ja sitä kautta edistää hänen sitoutumistaan terapeuttiseen prosessiin. Terapeutti voi myös tahtomattaan ja huomaamattaan ohittaa näitä perustarpeita, jarruttaen tai jopa estäen asiakkaan psyykkistä muutosta. Väitöskirja myös kuvaa, miten perustarpeita tukeva suhteessa asemoituminen nojautuu eri teoreettisiin viitekehyksiin riippuen käsillä olevasta terapeuttisesta tilanteesta.

Terapeutin suhteessa asemoituminen on moniulotteinen, sekä mielensisäinen että vuorovaikutuksellinen ilmiö. Se sisältää sekä terapeutin kussakin hetkessä mielensisäisesti tapahtuvan tilannekohtaisen jäsennyksen, että hänen tämän jäsennyksen pohjalta toteuttamia suhteessa olemisen tapoja, niin sanallisia kuin sanattomiakin. Perustarpeita tukeva asemoituminen vaatii terapeutilta erilaisia taitoja, kun asiakkaan ongelma kohdistuu johonkin terapian ulkopuolella olevaan, verrattuna tilanteeseen, jossa asiakkaan ongelma kohdistuu terapeuttiin tai terapiasuhteeseen. Suhteessa asemoitumisen käsite tarjoaa tärkeän heuristiikan terapeuteille siihen, miten tukea asiakkaan autonomian, yhteenkuuluvuuden ja kompetenssin perustarpeita, ja sitä kautta sitouttaa hänet hänelle itselleen merkitykselliseen terapiaprosessiin ja psyykkiseen muutokseen.

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ORIGINAL PAPERS

ORIGINAL PAPER 1

SELF-DETERMINATION THEORY AND THE COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY

by

Édua Holmström, 2020

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Self-determination theory and the collaborative assessment and management of suicidality

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Abstract

Purpose: The collaborative Assessment and Management of Suicidality (CAMS) is a first-encounter suicide-specific brief intervention that clearly motivates suicidal individuals for voluntary treatment engagement and choosing life. How the intervention works, however, has not been theoretically explained. The purpose of this paper is to explain the effectiveness using self-determination theory (SDT).

Design/methodology/approach: The paper focuses on the theoretical examination on the philosophy of care and the clinical procedures of the CAMS suicide intervention. Self-determination theory is used as the theoretical lens of the examination.

Findings: The underlying philosophy of care and clinical procedures of CAMS enhance autonomy, relatedness and competence of the client in the first encounter. We propose that fulfilling these basic human needs result in the intervention outcomes of treatment engagement and choosing life, for the time being.

Research limitations/implications: The research is limited to the examination of the documented clinical procedures, and philosophy of care. Further research applying self-determination theory to the design of therapeutic interventions for suicide prevention is warranted.

Practical implications: Clinicians working with suicidal clients need to empathically address suicidal individuals' motivation to engage in voluntary treatment and reduce controlling and autonomy-thwarting approaches.

Social implications: Suicidal behavior is conventionally considered as a manifestation of a mental disorder characterized by limited informed decision-making. The success of CAMS points to the contrary. Despite their suffering, many suicidal individuals make informed decisions on treatment with the support of an empathetic clinician.

Originality/value: CAMS has previously not been theoretically explained. We explain the effectiveness of the intervention to engage suicidal clients to further treatment through self-determination theory.

Key words: Self-determination theory, Suicidality, Collaborative assessment and management of suicidality, Treatment engagement

Introduction

Suicide prevention lacks a preventive, strategic framework due to limited theoretical understanding of working mechanisms (Calear et al, 2016, De Silva et al., 2013). There is evidence for the efficacy of therapeutic interventions for self-harm behavior (Ougrin et al., 2015). While suicide specific interventions show a reduction in suicidal ideation (Calear et al., 2016) these have not been examined to discover the mechanisms that deliver the desired therapeutic changes. While motivation is clearly one of the most essential of these mechanisms, the engagement of suicidal clients on the first clinical encounter is still a neglected aspect of the research (Lizardi & Stanley, 2010).

Collaborative Assessment and Management of Suicidality (CAMS) is a suicide focused intervention for assessing, treating and tracking suicidality, developed on theoretical work on suicidal cognition. It uniquely combines a thorough assessment with a client-centered therapeutic framework, which over the years has gathered considerable evidence of effectiveness (Jobes, 2016). CAMS is associated with

reduction of distress, increase in treatment satisfactions and hope, as well as higher retention (Comptois et al., 2011), reduction in suicidal ideation (Jobes et al., 2012, 2016, 2017), decrease in emergency department visits (Jobes et al., 2005), and decreased suicide attempt and self-harm behavior (Andreasson et al., 2016). A recent study comparing CAMS and dialectical behavior therapy (DBT) found that DBT is not superior to CAMS for reduction of suicide attempts (Andreasson et al., 2016).

The mechanisms of *how* the CAMS works to engage and ally suicidal patients in the field extends beyond the theoretical premises based on which it was developed. The effectiveness of the intervention has never been explained in light of a coherent theoretical framework. This paper examines the effectiveness of CAMS through working mechanisms derived from self-determination theory (Ryan and Deci, 2008).

Self-determination theory and CAMS

Self-determination theory is a meta-theory of human motivation, self-regulation and personality that cumulatively developed from the seminal work of Richard Ryan and Edward Deci over the years (Ryan and Deci, 2000, 2017; Vansteenkiste et al., 2010). The theory is applied in fields as different as health-promotion (Ryan et al., 2008), work (Gagn§é and Deci, 2005), sport and physical exercise (Ryan and Deci, 2017), attachment and close relationships (La Guardia et al., 2000), and psychotherapy (Ryan and Deci, 2017). SDT has more recently been used to explain the mechanisms of the development of suicidal ideation through thwarted satisfaction of our basic psychological needs of belongingness and autonomy (Tucker et al., 2014).

An important part of SDT is the basic need theory that specifies the innate psychological nutriments necessary for motivation and psychological health (Vansteenkiste et al., 2010). It proposes three basic human needs: autonomy, relatedness and competence and specifies three dimensions of the social environment that support these needs: *autonomy- supportive* context support autonomy, *well-structured context* support competence, and an *accepting, empathic context* support relatedness.

Regarding psychological interventions, SDT maintains that the extent to which the first clinical encounter supports the three basic needs of autonomy, relatedness and

competence will determine the level of engagement of the client (Ryan and Deci, 2008). More specifically, SDT maintains that when patients' autonomy is supported in the therapeutic process, they will be more likely to engage in behavioral change, leading to more positive outcomes. When the patient, on the other hand, experiences conflict with the therapist or pressure for certain outcomes he/she will feel externally controlled and his/her motivation for changes in the direction of health will be curbed (Ryan and Deci, 2008).

Jobes developed CAMS to address unmet needs of the suicidal patient: the need for empathy with the suicidal wish, and the need of being understood and accepted in a state of high ambivalence. The approach conceptualizes suicide differently from conventional medical approaches in its emphasis on enhancing therapeutic alliance, empathy with the suicidal wish and active engagement of the client in the creation of an outpatient treatment plan. It diverges from the traditional client-centered approach in that it has a structure and protocol. (Jobes, 2016)

CAMS views ambivalence as a defining characteristic and essential underlying psychological experience of suicidal individuals who seek help in clinical settings (Bergmans et al., 2017; Linehan, 1993). On the one hand, patients have reasons that keep them alive, but at the same time experience that suicide is the solution to end their immense pain and suffering. A resolution acknowledges both sides of the inner conflict and the patient's right to die by suicide (Jobes, 2006). This position may provoke and make many clinicians uncomfortable, especially when working with underage patients. Yet experts claim that it creates the best possible conditions to engaging the suicidal patient to clinical care (Michel and Jobes, 2010; Orbach, 2001). Jobes (2016, 1998) identifies the negotiation of putting off suicide to a later point in time is the most powerful clinical intervention with a suicidal person who sees the option of coping *indefinitely* with their perceived pain and suffering as highly unreasonable. Instead, the clinician using CAMS suggests to the autonomous patient that, before he/she takes his/her life and ends his/her suffering, gives treatment a reasonable chance with the aim of finding other ways of coping.

Although the focus of attention of SDT anchored research has been mainly on autonomy support, efficient therapeutic encounters should satisfy all of the basic

needs of humans. The therapist's warmth and unconditional positive regard, as well as genuine interest in the patient, conveys relatedness that, according to the SDT theory, works as essential nutriments to engagement. The need for competence is connected to the feeling of self-efficacy with respect to an autonomously selected goal. Structure and relevant feedback in the therapeutic environment facilitates fulfillment of the need for competence in the client (Ryan and Deci, 2017).

CAMS: Clinical procedures

In the following, I present only a short overview of the clinical procedures. A detailed discussion of CAMS is found in Jobes (2016).

The use of a multipurpose tool, called Suicide Status Form (SSF), is central to the approach. The SSF consists of four parts: Section A, B, C and D. Sections A and B are assessments conducted in close interaction with the patient.

Section A explores deeply subjective experiences such as psychological pain, suffering, and hopelessness. The emphasis in Section A is delving into the subjective experiences of the patients through the use of a structured assessment process, and does not focus on suicide per se. It was built on Baumeister's work on suicide as an escape from the self (1990), Shneidman's concept of psychache referring to psychological pain (1993), as well as Beck's cognitive therapy for depression (1979).

Section B concentrates on the objective assessment of specific suicidal risk factors and warning signs, thereby providing some objective perspective on various suicide-related variables, such as suicide ideation, plan, rehearsal, and history of suicidal behaviors. The clinician takes over the task of writing and asks the patients in a matter-of-fact manner about the different suicide related risk factors as specified by previous research (Linehan, 1993; Rudd et al., 2004, Maltsberger, 1986).

Section C consists of writing the Stabilization and Treatment Plan, whereas **Section D** is filled out by the clinician after the session providing information required by the HIPAA.

An important feature of CAMS with respect to SDT is the *order of the CAMS sections* A-D. The theoretical premise is that enhancing autonomy, relatedness and feeling of competence *at the beginning of the encounter* is paramount. The emphasis of Section A is expressly meant to communicate to patients that they are the experts of their own experience. Here, the clinician's job is to see the suicidal risk through the eyes of the patient, focusing on the patient's phenomenology and intra-subjective suicidal struggle. At its best, the initial SSF assessment makes a lasting and important impression: "I am genuinely interested in understanding your pain and suffering by seeing your world as you experience it." (Jobes 2016, p. 56)

Autonomy, relatedness and competence support in CAMS

Next, we detail how the CAMS enhances the feeling of autonomy, relatedness and feeling of competence of the client, resulting in alliance and a deeper engagement of the patient within his or her own care. To help the reader, italics is used to emphasize SDT relevant features of the intervention.

Autonomy support is inherent both in the underlying philosophy of the CAMS intervention and throughout the clinical procedures. Within the CAMS approach to care, there is an inherent intention to avoid hospitalization and rely on inpatient care only as the last resort. Outpatient care stands in line with the importance of endowing autonomy to the client, supporting self-determination.

As for the clinical procedure, autonomy is emphasized before and during the completion of Section A of the SSF. The autonomy supportive atmosphere is explicitly stated to the patients at the beginning of the procedure by *asking directly about and validating suicidal thoughts as possible and understandable thoughts in the face of unbearable pain and suffering*. Clients' autonomy is further enhanced by *offering the collaborative SSF assessment* with *the explicit rational of understanding suicidality from the framework of the patient's unbearable suffering* (as opposed to interrogating the client about a presumed mental disorder). While recommending the collaborative assessment, *the clinician acknowledges the option of the patient for suicide by asking them to give a chance to treatment only for a limited period of time*:

"Because I know you suffer deeply, I am only asking that you travel with me for a specific period of time, a minimum of 3 months. After that, we can decide together whether we should continue our travels together or perhaps part ways so that you can drive on your own or perhaps travel with a different navigator. Despite your suffering, I still believe this is a reasonable request to ask of you, given both the promise of our desired destination and the seriousness of the alternative you are considering" (Jobes, 2016, p. 78).

Validating the client's right to decide upon his life is regarded by Jobes as one of the most essential components of CAMS (2006, 2012). Once the client agrees to do the SSF, the clinician continues with autonomy support by not taking anything for granted, i.e. *by asking for permission to take a sit next to the client in order to complete the Suicide Status Form together*. Autonomy is further enhanced by *making sure that the patient is informed about the name and usefulness of the procedure and by asking the client to take the pen him/herself to fill out the first part of the assessment while emphasizing the role of the clinician as a coach or a consultant who helps and support if the client needs it.* Autonomy is also marked by *asking patients to determine themselves what they find most painful, most stressful and most hopeless in their life and to give reasons to their wish to die which are subsequently met with empathy as opposed to judgement and confrontation*.

After finishing Section A and while moving to Section B, the clinician continues supporting the client's autonomy by *repeating once more the rationale for completion: to gain a better understanding about the pain and suffering that led the patient to feeling suicidal, with the aim of alternative ways of coping with the pain and suffering of the patient*.

Finally, patients are themselves co-authors of their stabilization and treatment plan, endowing them with a further sense of autonomy. At the end of the assessment part, *clients are informed about the clinician's appreciation of their choice of sharing their painful experiences* and the *clinician thanks the client for collaboration*, indicating respect for the client as a subject with agency, whose collaboration is not taken for granted.

Support for the need for competence is accommodated above all by the *inherently collaborative nature of the CAMS protocol* that creates an essential synergy that is the backbone of the approach. The *patient is considered an expert on his or her situation who can give an account on the reasons that led to a suicidal state*. This subjective account is validated as a reasonable psychological response to unbearable pain. Competence is further enhanced by *telling the client, that the clinician's role is to follow and support, to work as a coach, a collaborator to clarify and assist if needed*.

The competence of the patient is also marked by him/her *sitting next to the clinical worker and by filling out himself/herself the paper, marking his/her expertise on the subject* (instead of sitting opposite to and being interrogated by a worker of institutionally vested authority, as is often the case in emergency setting). *Writing the answers themselves, the clients rate their level of psychological pain, stress, agitation, hopelessness and self-hate and give an evaluation of an overall risk for suicide*. Their feeling of competence is further enhanced by *rank-order these factors in terms of importance*. Clients' competence in their suicidality is further enhanced by asking them to *give their reasons to live and reasons to die, and by asking them to rank order these reasons in terms of importance*. Furthermore, clients are asked to *report the extent to which they wish to live and wish to die, and give information on the one-thing that would make them non-suicidal*.

In addition to the informational content that the client provides about his/her own suicidality, the very structured nature of CAMS with both self-rating and open-ended questions further facilitates the feeling of competence of the client. The importance of providing structure in order to enhance competence has been widely recognized in clinical and health-related interventions (Linehan, 1993; Rudd et al., 2004; Jobes, 2006) and can been explained in the light of SDT (Ryan and Deci, 2017).

Managing the client's suicidality in CAMS fundamentally relies on what the patient says that puts his or her life in peril. Rather than relying on a mental disorder diagnostic bias or using an a priori theoretically driven treatment model, it *directly turns to the client who is assumed to most intimately know about the suicidal struggle. It is the client who knows what problems, issues, or concerns most make him/her want to take his/her life.*

Subsequently, when patients come to realize that their view of things are actually central to CAMS treatment planning, they often become engaged because of the truly pivotal role they play in the development of their own treatment plan. *As a "coauthor" of their treatment plan*, it is interesting to see how quickly many suicidal patients latch on to the idea of targeting and treating their suicidal drivers (Jobes, 2016, p. 76).

As a client-centered approach, the ***support of relatedness*** is inherent in the CAMS procedure in its *emphasis of genuine interest in the client's subjective experience, unconditional positive regard, and empathy with the suicidal wish.* Relatedness is enhanced from the beginning of the first session, when the *clinician addresses suicidality without a hint of judgement, by making it clear that he/she hears and sees that the patient is extremely overwhelmed by pain and suffering*.

As the session unfolds, relatedness is expressed when the *clinician justifies the assessment as a way of helping him/her to understand better the situation of the patient*. Relatedness is further enhanced by the *clinician sitting next to the patient and by offering to be like a coach who follows supports and helps in case the patient needs it*. The sense of relatedness is maintained during the time the client fills out the SSF core assessment.

Upon finishing Section A, the clinician expresses again the importance of the client's sharing of his/her experience leading to a better understanding on the part of the clinician. *The clinicians express to the client that his/her enhanced understanding of the client's perspective allows them to come up with a workable treatment plan* for effectively dealing with the client's pain and suffering.

The language of the clinician, as Jobes describes it (2016), is outstandingly relatedness-supportive during the entire CAMS process. Relatedness is manifested by the *invitation for true collaboration and by an open, accepting and non-judgmental attitude on the part of the clinical worker*. The clinician *talks in first person plural (we) and emphasizes the treatment as a common journey* to which they both commit themselves and where the clinician will accompany and support the patient all along.

Upon moving to Section B, *the clinician remains seated next to the client marking the continuity of relatedness under the rest of the assessment*. In Section C the clinician uses the metaphor of "the therapeutic road trip" (p. 78), where he/she *compares their collaboration to a common journey they take together, marking relatedness as a central element during the entire collaboration*:

"I want you to consider taking a therapeutic road trip with me. On this trip you will be the driver and I will be the navigator. I have taken this trip many times before, I know the roads well, and I have excellent maps and a GPS. But the journey is never the same route for any two drivers. It is unique to the driver and the way we decide to travel together— which roads to take, when to stop, and how fast or slow we decide to go." (Jobes 2016, p.78).

Discussion

Recent years have renewed the academic interest in person-centred care within mental health settings, exemplified by an interest in shared decision-making (Ramon et al., 2017) and recovery-oriented care (Davidson et al., 2017). Assessment is moving away from a diagnostic reductionism towards an experience-based framework that emphasizes self-determination (Binnie, 2018; Binnie and Spada, 2018). However, endowing suicidal individuals with autonomy and relying on their competence to decide for themselves is provocative in many clinical settings (Jobes, 2016).

Suicidal behaviour has traditionally been seen as a manifestation of a mental disorder characterized by a lack of capacity for informed decision-making, which compromises patients' autonomy rights. At the same time, controlling practices are widely used, including psychotropic medications, non-suicidal contracts and psychiatric hospitalizations for suicidal ideation. However, given the lack of empirical support for these controlling and autonomy-thwarting approaches, the reliance on them is puzzling (Brodsky et al., 2018). Evidence of the effectiveness of psychotropics is mixed, and inpatient care that is not suicide-specific may even increase post-discharge risk (Linehan et al., 2015). Furthermore, Czyz et al. (2016) noted that the rehospitalization of suicidal youth increased vulnerability to suicidal crisis. Linehan et al. (2015) contended that contemporary inpatient psychiatric hospitalization has no empirical support for preventing suicide.

Britton et al. (2008) suggested that suicide prevention techniques would benefit from the theoretical premises of SDT. Recently, Hill and Pettit (2013) pinpointed autonomy support as an important element in suicide prevention. The heavy emphasis on relatedness has always been a benchmark of therapeutic work but its lessons are new in the mainstream assessment of suicidality (Dunster-Page et al., 2017). Converging evidence shows that psychological assessments that are therapeutic in nature have positive, clinically meaningful effects on treatment, especially regarding the treatment processes. Highlighting the support of SDT's basic needs as the key potential factors of intervention effectiveness also gets support from findings of the role of the thwarted needs of autonomy and relatedness in suicidal ideation (Tucker and Wingate, 2014).

The weight of evidence for engaging suicidal patients appears to be consistent with SDT, and thus, far, little has been found to contradict or refute it. Based on a 10-year systematic review of evidence-based findings in suicide prevention, Brodsky et al. (2018) summarized the areas necessary for translating suicide prevention research into clinical practice. This present study suggests that these guidelines be extended to explicitly address treatment engagement. This should be done by emphasizing the social-interactional factors of the first clinical encounter that support the client's needs of autonomy, relatedness and competence.

Conclusion

This study examined an evidence-based suicide prevention intervention, the CAMS, and showed that its constituent elements and a unique philosophy of care provide the social-environmental factors postulated by SDT to support autonomy, relatedness and competence. It is hypothesized that the support of these three basic needs in the first clinical encounter is responsible for CAMS's effectiveness as a suicide prevention intervention. While not compromising the importance of a thorough assessment and the writing of a safety plan, CAMS gives temporal priority to providing time and space for the clients' subjective feelings and for empathy of the suicidal wish, as well as to understand their reasons for suicide ideation and to detain them from controlling practices.

Both theoretical work on SDT and clinical work with suicidal patients benefit from bridging theory and practice. Connecting theory to practice usually occurs through operationalizing theoretical constructs to apply them in clinical work, thereby leading to cumbersome issues of validity. This study took the opposite road and aimed to highlight the motivational processes that may produce the observed effects of CAMS on detention from suicide. This approach provides clinicians with a concrete example of the application of SDT in their clinical work that can be used in the development and refining of interventions and treatments of suicidality. Similarly, SDT researchers in the academic field may benefit from seeing an interesting set of techniques providing insights on how the support of the three basic needs can be implemented in suicide prevention practice.

The theoretical perspective is taken in this study also has its limitations. Taking an explorative perspective has led to a hypothesis explaining the effectiveness of a suicide-specific intervention. Future studies should empirically test this hypothesis by measuring clients' perceived need satisfaction during the CAMS sessions and empirically examine the effects of these factors on quantified measures of treatment motivation, treatment engagement and other therapeutic outcomes, such as reduced dropout and relapse.

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ORIGINAL PAPER 2

CHAIR WORK WITH THE EMPATHIC OTHER: PROVIDING BASIC NEED SUPPORT FOR RESOLVING UNFINISHED BUSINESS

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ORIGINAL PAPER

Chair Work with the Empathic Other: Providing Basic Need Support for Resolving Unfinished Business

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Abstract
In this case study we present an example of a modification of the chair work technique, called 'chair work with the empathic other', and examine the process of emotional change of the participant. We find that talking directly to the empathic other supports the participant's emotional engagement with the task and guides her emotional processing through the four necessary components of successful empty chair work, specified in previous research: experiential access and intense expression of primary adaptive emotion, expression of thwarted need, and a shift in the representation of self and the other. Drawing on self-determination theory, we conceptualize the trainer's person-centered communication as a basic need-supporting therapeutic action. Throughout the chair work process, the need-supporting positioning of the 'empathic other', provided by the trainer, consistently engages the participant in the emotional processing of unfinished business: it deepens and widens her emotional exploration, leads her to express thwarted need, and finally, to change representation of self and other. We discuss the findings within the framework of self-determination theory and in relation to research on emotional change and therapeutic practice. Previous research has pointed out the difficulties many clients face with engaging in chair work. Introducing need-supportive communication, drawing on self-determination theory, we suggest that the modified technique is a possible intervention to facilitate engagement in chair work and emotional change.

Keywords Basic Need Support · Client Engagement · Self-determination Theory · Unfinished Business · Psychotherapy Process Research

Introduction

As a therapeutic intervention, the purpose of empty chair work is to help clients to work through a specific type of painful emotion scheme called in the literature *unfinished business* (Pascual-Leone & Baher, 2023). Unfinished business is a complex affective experience of resentment and pain, resulting from a longstanding intrapsychic process of closing out of awareness painful emotions and needs towards a significant other (Greenberg & Foerster, 1996). The empty chair technique has in emotion-focused therapy been found therapeutically effective for various interpersonal problems and childhood maltreatment resulting in unfinished business (Carpenter et al., 2016). Research even suggests that chair work can be an effective standalone intervention (Pugh et al., 2023).

Notwithstanding the therapeutic effectiveness of empty-chair work, research reveals that it is not always an easy task for clients to engage in (Muntigl et al., 2020). Besides those clients who engage wholeheartedly, there are also clients who are reluctant to engage in chair work for various reasons. There are also those who do engage but do it without the necessary emotional involvement (Greenberg & Malcolm, 2002), compromising deep-seated emotional change. The appropriate therapeutic action to tackle this inner obstacle to engage with chair work is so far not fully understood. In this article we argue that self-determination theory

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provides theoretical insight for helping clients engage emotionally to resolve unfinished business.

To explore the facilitation of engagement, we examine a variation of chair work, developed as part of a need-supportive communication training, nonviolent communication. Nonviolent communication is a communication process developed on person-centered and experiential principles (Rosenberg & Chopra, 2015), extending on Roger's later work on the applicability of person-centered principles outside the therapy room (Rogers, 1995). Grounded in experiential principles, nonviolent communication includes chair work into its training. This chair work, however, differs from conventional empty chair work in an important way: the participant talks to the imagined, significant other, played by a facilitator (nonviolent communication trainer, or another participant), who exemplifies the 'empathic other'. In this present study we will call this version of chair work '*chair work with the empathic other'*. Building on insights from self-determination theory, and its concept of basic need support for integrative emotion regulation (Roth et al., 2019), we expect that a direct dialogue with the empathic other, will facilitate the emotional engagement and the resolution of unfinished business of the participant. This we can also observe in our process analysis of a case example, with a participant going successfully through the emotional processing that is necessary for the successful resolution of unfinished business (Greenberg & Foerster, 1996), facilitated by the basic need support of the empathic other.

Theoretical Background

Empty chair work originated in psychodrama and was further developed in Gestalt therapy (Perls et al., 1951). Today, its most thorough elaboration as a therapeutic task is found in emotion-focused therapy (Greenberg & Foerster, 1996). The therapeutic target of empty chair work is unfinished business. Unfinished business is the intrapsychic result of a relationship with an attachment figure in which the client reacted to overwhelming and painful experiences by holding back not only the expression, but even the awareness of primary adaptive emotions and thwarted underlying needs (Narkiss-Guez et al., 2015). In emotion-focused therapy, empty-chair work is designed to activate in clients with unfinished business the relevant maladaptive emotion scheme, and to help them to express to the imagined other the previously unexpressed primary adaptive emotions and needs, leading to a change in the representation of both the self and the other, followed by a significant decrease of psychic tension (Greenberg & Malcolm, 2002). The therapist's role is to engage the client in the task of imagining the other sitting in an empty chair and support her emotional expression towards this other from an outside position.

Research has revealed the outstanding effect of chair work to support clients in accessing painful primary emotions and thwarted needs, necessary to working through distress, and ultimately leading to better therapy outcome. Chair work was found to have the potential for activating unresolved inner conflicts (Pascual-Leone & Baher, 2023), self-referential negative feelings (Nardone et al., 2022), and attachment related sadness (Narkiss-Guez et al., 2015), followed by positive emotional change outside session, and better outcome.

Greenberg and Foerster (1996) have identified four characteristic components of empty-chair work, that discriminate successful from unsuccessful change processes: experiential access and intense expression of primary adaptive emotions, expression of thwarted need, self-validation, and a shift in the representation of the other, either by holding the other accountable or by reaching a more nuanced understanding of the other. Greenberg and Malcolm (2002) have extended these findings by relating the attainment of these necessary elements to therapeutic outcomes. Their findings reveal a significant variation between clients regarding emotional engagement and the presence of the active ingredients of the experiential process of empty chair work: some of them engage fully, others partially and yet others only minimally, with corresponding positive correlation between level of engagement and treatment outcome. Greenberg and Malcolm (2002) do not discuss the factors determining client's limited task engagement but given the significant difference between resolvers and non-resolvers in terms of experiencing primary emotions during chair work, they point to the possibility, that client's limited activation of emotional arousal during the empty-chair dialogue might explain these findings.

What then, if anything, is there that a therapist can do to facilitate clients' deeper emotional engagement in chair work? One possibility could be, depending on the unfinished business and wishes of the clients, to modify the chair work protocol in a way that makes it easier for clients to engage. To do this, we need theoretical understanding of the process of emotional engagement and its facilitation. Self-determination theory is a theory of human motivation and regulation, that has gained solid empirical evidence over the last forty years across various domains of mainstream psychology, but less in psychotherapy research (Ryan et al., 2021). Self-determination theory is a relational theory that conceptualizes human motivation and engagement as the result of relational processes, resulting in qualitatively different types of motivation (Roth et al., 2019). One tenet of self-determination theory is that engagement in a task is facilitated by support of three basic psychological

needs: autonomy, relatedness, and competence (Vansteenkiste et al., 2020). To the extent that these basic needs are supported by others, people's autonomous engagement increases, leading to healthy emotional processing and integrative regulation. A growing number of self-determination theory research has supported the paramount importance of the clinician's basic need support in the context of health interventions, facilitating clients' engagement (e.g., Zuroff & Koestner, 2023). In particular, and relevant for the data of this study, self-determination theory research has revealed that high-quality listening, especially when the other expresses affect-laden or potentially threatening messages to self, is autonomy and relatedness supportive and enhances disclosure and integrative emotion regulation (Weinstein et al., 2022). Furthermore, validating responses, in the form of empathic conjectures and a tentative way of confirming the interlocutor's emotional expression, support the latter's basic needs, leading to healthy emotional processing and integrative emotion regulation (Roth et al., 2019). These findings clearly indicate the possibility that talking directly to a significant empathic other in chair work may bear additional benefits for engagement as compared to support from the outside.

Variations of technique in chair work, motivated by theory, has its precedents. In two chair self-soothing dialogue, clients can enact themselves an idealized parental figure that responds empathically to the part of the self, also played by the client, that needs soothing (Goldman & Greenberg, 2013). In this study, we suggest a further variation of chair work, to be used with clients struggling to emotionally engage in the task and experience the necessary elements for successful resolution (Nardone et al., 2022). We motivate this modification by self-determination theory, arguing, that clients' emotional engagement and integrative emotion regulation are facilitated by the interlocutor's basic need support of autonomy, relatedness, and competence (Roth et al., 2019). Our research is seeking answer to the following question: Does talking directly to the empathic other, who communicates through basic need support, facilitate the emotional processing and successful resolution of unfinished business?

Data and Method

Data Collection and Recruiting of Participants

The collection of the videorecording was part of the study design that has been submitted to and approved by the Human Sciences Ethics Committee of the university. The videorecording was recorded during a nonviolent communication advanced training course. The trainer participant of the study was a certified nonviolent communication trainer, with over twenty years of experience. Nonviolent communication trainer certification requires 3–5 years of training as well as 2 years of nonviolent communication teaching experience. Exact criteria for nonviolent communication trainer certification can be found at the webpage of the Center for Nonviolent Communication (www.cnvc.org).

Participants were recruited for the study as follows: Individuals who have enrolled in the nonviolent communication training received a letter, enquiring interest of participation in the research. This included a description of the aims and participation in the research. The study was designed to specifically focus on the observed emotional processing of healthy participants in a communication training, both verbal and nonverbal. Accordingly, the study did not include self-report information, other than participants' age and gender. For those interested in participating, a comprehensive information package about participation, the research, as well as the consent form was sent. Participants were instructed to bring with them the signed consent form when arriving to the training. The trainer was also a participant of the research, and not otherwise involved in the research process. Participants had the option to withdraw from participation in the research at any time during the nonviolent communication training without any consequences.

Participation Procedures and Case Selection

During the communication training, the videorecorded interactions involved the nonviolent communication trainer and the training participant. Participants and the trainer decided together when to videorecord their interactions. The trainer made the videorecording that she subsequently securely transferred directly to the researcher. The case example was chosen because it demonstrated immediate and clear consequences of the basic need support of the trainer on the emotional processing of the participant. The observed effects raised the interest of the researcher to explore what is going on in the case example, leading to the process analysis of emotional engagement and resolution of unfinished business. The conceptualization of the case example as a modification of chair work followed the selection of the case and the exploration of what was going on.

Nonviolent Communication Chair Work with the Empathic other

In nonviolent communication, in accordance with person-centered theory, all human behavior and experience can be conceptualized in terms of emotions and underlying needs. Conflict resolution and emotional change is conceptualized as the result of emotional connection created when people

can communicate their experiences to the important other in the language of emotions and needs, and they experience that the significant other *expresses* that he or she has heard these emotions and needs (Rosenberg & Chopra, 2015). Accordingly, training aims at practicing the awareness and verbal expression of, as well as the empathic listening to emotions and underlying needs, employing different experiential techniques. The facilitator playing the other starts out with listening empathically to the participant's feelings and needs, following person-centered principles. Once the participant has expressed primary emotions and underlying needs, the facilitator inquires the participant whether she or he is interested in hearing the significant other's feelings and needs. It is important to emphasize that if the participant is not ready or open to this, the facilitator respects this decision, thus providing support for the participant's need for autonomy (Vansteenkiste et al., 2020). Subsequently, the facilitator moves sensitively and attentively between listening empathically and expressing empathically, providing support for the participant's basic needs of autonomy to decide whether she is ready to hear the important other's side (Weinstein et al., 2022). The participant's ambivalence for and against connection is respected, which is a fundamental autonomy-supportive therapeutic action, enhancing engagement. While listening empathically is considered the most important part of the exercise, the empathic expression is also considered an important element in the process of change. It potentially intensifies the participant's feelings, guiding her processing through the experience of primary emotions, moving towards, and facilitating the restructuring of painful emotional schemes (Nardone et al., 2022). Apart of helping the participant to imagine the other and gain access to the pertinent emotion scheme, chair work with an empathic other also intensifies the emotional experience and engagement, an element for successful resolution (Greenberg & Malcolm, 2002).

Method of Analysis

The selected video recording was transcribed and process-analyzed, relying on psychotherapy process research (Krause, 2023). Along with verbal exchange, nonverbal elements were also analyzed, including the participant's movements and facial expressions, providing additional information about the activation, presence, length and change of important emotions during the experiential exercise. As common practice in this type of process research, we analyze the transcript at a micro-level to compare it to a research based, expected sequence of emotional processing. Successful chair work for unfinished business contains four necessary elements: (1) the presence of experiential access of primary emotions, (2) expression of thwarted need, (3) change in the representation of self, and (4) change in the representation of the other (Greenberg & Foerster, 1996). Primary emotions, like sadness, anger and fear are universal human states, with adaptive value for action. They arise when attachment needs for safety, integrity, acceptance, and belonging are thwarted. Awareness of and experiencing of these states and needs are required for adaptive shifts in the representation of self and other (Greenberg & Paivio, 1997).

The relationship between the participant's emotional processing and the trainer's basic need supportive communication is made explicit by presenting the transcript of the chair work in its entirety. Although the authors' subjectivity cannot be eliminated, the specification of the necessary elements makes the analysis of the relationship between necessary elements and provision of basic need support transparent and replicable. The analysis is structured according the three core stages of the empty chair technique: the arousal stage, the expression stage, and the completion stage. The expression stage is divided in four parts, each describing a certain topic and the corresponding emotional processing of *June*, a pseudo name given to the 46-year-old female participant of the chosen example.

The focus of our analysis was on shedding light on the emotional processing of *June* during the three stages of a chair work process that differs from the conventional technique in one important way. The facilitator, instead of taking on an outsider neutral 'third' position vis-à-vis the chair work dyad, takes on the role of the other but does this in a special way: communicates with *June* according to person-centered principles, explicitly focusing on her feelings and underlying needs. Our first interest relates to the effects that talking directly to this 'empathic other' has on the participant's emotional processing. This is examined by analyzing the participant's reactions, both verbal and nonverbal, to the empathic other's explicitly basic need-supportive utterances. Additionally, the analysis pays particular attention to the presence or absence in the participant's speech of the key above mentioned components of a successful chair work process, leading to resolution. Drawing on psychotherapy process research and examining the manifestation of both basic need support, as specified by self-determination theory, and the presence of above-mentioned elements of successful emotional processing, we refer to relevant literature while presenting our results.

Results of Process Analysis

Below we present the 'chair work with the empathic other'. T stands for nonviolent communication trainer, while P stands for participant. During the analysis, on the other hand, we call the participant *June*, the pseudo name of the participant of our study. Those times the trainer is in the trainer's role;

we call her the trainer. Those times when the trainer is in *June*'s father's role, we refer to him as the *facilitator/father* and correspondingly use for him the male pronoun *he*, corresponding his gender identity in the chair work.

Arousal Stage

The transcript starts out with the trainer, introducing the task. *June* seems quite tense from the beginning, as visible from her uneasy laughing, her avoiding eye contact, and her fixing of her leggings with her fingers. Observing *June*'s nervous body language and helping her to engage with the task, the trainer, taking on the role of the *facilitator/father*, expresses four empathic conjectures regarding *June*'s feelings (T4, T6, T8, T9), trying to build emotional contact with her in the here and now.

T1: *June*, thank you very much for this opportunity. So, we agreed that we would send this recording to (name of author), and I'm your daddy with 'giraffe ears'. I can even be when you are 2 years old or… you (2) or as you feel now. (2) How are you doing, my little girl?

P2: Oh… [June laughs uneasily, avoids looking at T., starts fixing nervously her leggings with fingers, sighs deep and looks in another direction. At the end she looks at T.]

T3: And we have about 10 min.

T4: (7) Is it difficult? (6) Are you scared?… is it painful?

P5: Well, yes [laughs nervously while looking at T.]. You never ask me how I am. You've never been and never are curious about what I answer [voice trembling]. I don't even think you notice how I am. So, this is a very strange question [looks straight at T.], yes, it's -.

T6: I see, so very, very often… (2) so, you don't remember that I have ever asked how you are?

P7: Hm. [looking straight at T., trembling voice]

T8: Actually, it seems to be a confusing question?

P9: Yes, because you always told me how things should be or what is the program, or what we should do… [making vivid gestures].

T10: (6) So, I have told you what to do, how to be, but asking with an open heart how you are…this a completely new question for you?

P11: Yep. [looking straight at T.'s eyes, corner of mouth starts trembling]

Empathic conjectures are highly relatedness-supportive actions, while tentative probing are prominent examples of competence-supportive therapeutic actions (Ryan et al., 2021). The effect of empathizing is immediate for *June*: she quickly gets into touch with her resentment towards her father and is able to express her genuine surprise at *the facilitator/father*'s empathic reflections. The *facilitator/father*'s empathic conjecture opens *June*'s exploration of own experience and evokes childhood memories. The transcript shows how speaking directly to an empathic *facilitator/father* helps *June* in the process of experiential access to primary emotions, manifesting the first important necessary element of successful resolution as specified by Greenberg and Foerster (1996).

Expression Stage

The first part of the expression stage starts out with the trainer/father's explicit inquiring of June's experience, supporting her need for competence, and relatedness (Weinstein et al., 2022). This section revolves around June's hurt of not being seen as a little girl with wishes on her own, as well as her feelings and thoughts that her father did nor respect her need for privacy.

T12: (8) And is there anything you would like to tell me?

P13: I want a pink dress. (3) A really big one. (2) And I don't want you to look into my closet. (2) Because that's my closet. It's nice that you made it, (3) but I would have been happy if you had asked me what color I wanted. I don't want that damn white. (2) It looks like a hospital closet. [laughs nervously]

T14: (5) So we could also say that you're grateful that I made the closet because it turned out nice. (2) The color… (2) you would have preferred pink instead?

P15: Well, some girly color, right? [looking straight at T. eyes]

T16: Well, a more girly color, because white is more hospital-like. (2) And it's true that I made the closet, but I shouldn't look into your closet because that's your life. [*June* nods as a sign of agreement]

P17: Hm. Just because you made it doesn't mean it's yours! You made me too, but I am still not yours! [looks straight into T. eyes, her voice getting irritated]

T18: I see. You want me to acknowledge that you're an independent being. And not (1) my possession.

P19: Yes. [nods, looks straight into T. eyes]

P20: Long silence (25) [*June*'s tears are slowly welling up].

T21: Does this hurt a lot? [June cannot keep back tears anymore, starts crying] You really wanted me to notice you more often, as a soul, as a person, didn't you? [*June* looks straight at T., eyes filled with tears, corner of mouth trembling]

The empathic validation of by the *facilitator/father* of the emotional pain has an immediate effect on *June* helping her to get deeper in the exploration of her experience, visible from her statement 'You made me too, but I'm still not yours!' made with the nonverbal emphasis of irritation and affirmation. In the transcript we witness the effect on emotional engagement of the *facilitator/father's* verbalization of *June*'s unfulfilled need for being seen as a unique person

on her own, supporting June's basic need of autonomy and relatedness (Roth et al., 2019). The validation breaks *June*'s defensive emotions of anger, providing access to primary emotions of loss and sadness.

The second part of the expression stage revolves around June's feelings of hopelessness about being seen by her father as she is, with her own unique subjective preferences and wishes. The consistent focus on trying to understand *June*'s experience, not only supported *June*'s need for competence, but indirectly also her needs for autonomy and relatedness, facilitating emotional engagement and integrative emotion processing (Roth et al., 2019). The *facilitator/father*'s empathic conjecture (T26) helps *June* to maintain focus on her feelings, and to search further and find the right expression of her problems. The *facilitator/father*'s empathic reflections from T28 to T32 are explicitly autonomy-supportive (Roth et al., 2019), and help *June* in her journey of emotional exploration to the point that she puts into words (P36) her angry fantasy of sending her father to an imaginary place, where he would be forced to learn to see the world from a different perspective.

P22: Silence (15).

T23: Is there anything else you'd like to tell me, my little girl? [June drops eye contact, looks up, out of the window, starts looking for handkerchief in her pocket, sighs a deep one, blows and wipes her nose. She turns back looking out of the window, apparently focusing inside, reflecting on the question]

P24: Silence (12).

P25: That I am also someone and not everything needs to be criticized. [looks straight to T. again, voice irritated and hurt]

T26: Hm. (4) Are you tired of the fact that the only way I can relate to you is by telling you what's wrong with you, what you did wrong?

P27: No, but you do it in a way that makes it seem like you care, but you actually don't pay attention to how I am or who I am. You give me food, I have a room, and all that. But who I am doesn't interest you at all. You always give me shit-brown clothes, and you even sew the swimwear too. (2) You control everything completely. (2) I'm not like you! [Raised, self-affirming voice] I don't like it when even my socks are ironed and neatly stacked. [looking straight at T., voice explaining, irritated, imitates father's actions with gestures]

T28: (4) On the surface it seems like I really take care of you….

P29: That's right, everything was described in the textbook like that. Yes, I believe it. [agreeing serious voice, at the same time expressing irony]

T30: So, what can be done in the material, like sorting socks by color, even sewing your swimwear, making the closet, so it seems like my life is all about… you.

P31: That's correct. [wipes nose]

T32: The only thing missing is to see you, 'to be seen', [June look straight at T. and keeps nodding] to ask you what you want, how you want it, to help you connect with yourself and make sure that even that what you want happens. And not always… as if you were only a prop for me to take care of someone?

P33: Yes! [looks upwards, nods agreeingly, then looks back again to T. eyes]

P34: Silence (18).

T35: Is there anything else you would like to say?

P36: I would like to send you to a place where everyone is obligated to love each other, where everyone wears stupid clothes and paints themselves with weird colors, where they do whatever they want, and you would have to stay there for a long time. [explains this punishment fantasy vividly, irritated] And you would realize that there are more important things than 'how much this is on my mind, who I greet, who I don't, or how polite I am. [very exaggerated ironic mimicking of father's voice and body language] Or (.) I really don't give a fucking damn! [angrily] And you should go to a place like that, seriously, to see that things can be done differently. [voice less angry, calmer and more cooperative]

T37: (4) You would like me to hear that parenting is not just about how you hold your body, how you greet, how you keep your mind organized, [June looks straight at T., eyes filling up with tears, wipes nose] but also about the fact that you have a soul, and you would like me to try to connect with your soul as well, and even ask you what you would like, what is it that you think?

P38: Yes. [looking straight in T. eyes]

In the attempts of being the perfect parent, the *facilitator/father* recognizes he was blind to her actual feelings and needs. *June*'s explicit acknowledgment of the thwarted need to be seen manifests the second necessary element of successful resolution (Greenberg & Foerster, 1996).

The third part of the expression stage starts again with an explicit inquiry of emotional experience, supporting June's need for competence and relatedness (Weinstein et al., 2022), and further deepens *June*'s feelings of primary anger, sadness, and loss. Maybe because of the previous exploration of her feelings and her growing trust in being heard empathically, she feels safe to express here very difficult feelings, starting with the expression of her heavy thought about her father not loving her. Her difficulties of verbalizing these feelings are clearly visible in her body language: during P40, she looks down at her hands every time she shares a part of her experience, as if being unsure whether it is allowed or even possible to say out loud the

unbearable thoughts and associated feelings of never having been wanted and loved by him. The primary unbearable emotions of sadness and loss seem very difficult for *June* to stay with, so she moves back to a blaming, angry position.

T39: (5) Is there anything else you would like to tell me?

P40: Actually, [June looks down to her fingers, then looks up again to T. eyes] I don't even think you really love me. (5) [looks down again to her hands then looks back to T. eyes]. Because Mom was more important to you (.), than me. (3) And you were angry [looks down at her hands again and looks back at T. eyes] when you found out that I was going to be born because you were more worried about Mom getting hurt no matter what, rather than me being born. (3) You didn't even want me and whatever [voice raised looks down at her hands, then looks back at T. eyes again], and now you come with that textbook crap, that 'you're parenting your children perfectly' [exaggerated very ironic mimicking]. Bullshit! I think [looks down at her hands again then back to T. eyes] it would have been just as good for you if we hadn't been there. [looks straight at T. first. When T. looks down, June also looks down]

T41: Silence (9).

T42: Are you interested about how I am in this situation?

P43: (6) [looks up on the side, grimaces with mouth, the looks out of the window, then back at T.] No! [very defying voice starts looking at T. straight in the eye again, with tears in her eyes]

T44: So, you're fed up with me loving you in a textbook way, [June wipes nose] and maybe (3) I might not really know how to love at all?

P45: Hm [in an agreeing intonation]. Sorry, but this question is coming a bit too late, so after forty-six years you ask: 'Oh, and how are you? [Exaggerated, very sarcastic mimicking] Well, how the hell should I be doing? You didn't give a damn about how I am. How would I be doing? [leans toward T., looks straight in T. eyes, tears in her eyes, voice hurt].

T46: Hm.

P47: And then I should be empathetic and understanding, and then, [escalating anger] now should I throw myself and say, 'Oh, how nice that you're asking!'? [Exaggerated very ironic mimicking]. Oh, and weather I can connect… I don't want to connect with you! [Leans forward, looks straight into T. eyes] Go somewhere, get a treatment to yourself, then come back, redo these forty-six years, and then we'll meet! [looks defying straight in T. eyes, then wipes nose]

T48: (4) If at that time when you needed this connection, when it would have really supported you as a child if I had paid attention to how you were, what was happening to you… not just constantly pushing what needs to be done….

P49: …what way it is right [June helping T. expressing herself with a calm voice].

T50: …that the right solution is not just raising you, but trying to get to know you, to see your humanity. Well, if I didn't do that when it was supposed to happen, then… as for now, well… you say, 'thank you very much, but I don't want it anymore'.

P51: Well, it's a bit strange, yes. [with a calm voice, looking straight at T]

T52: (6) Is there anything else you would like to say?

P53: That I missed you. (4) That it was shitty being alone. [starts crying]

T54: It would have been so important if I could have been there for you not only physically but emotionally as well.

P55: Yes. [crying, corner of mouth trembling]

*June'*s anger gives energy to her expression and supports her to mimic and enact sarcastically her father's voice as remembered, allowing her to fully experience her anger. The extremely emotionally laden combination of her primary feelings of sadness about never having been wanted and loved with her anew escalating secondary anger is reaching here a point, where for the *facilitator/father* it seems impossible to move further by empathic listening alone. Instead, after a very long pause of 9 s, the *facilitator/father* in T42 asks *June* weather she is interested in knowing how he is feeling in this situation. *June* hears and seem to reflect on this question seriously, as can be deduced from her looking up, out of the window, with tears in her eyes for 6 s, after which she looks back to him and answers with a very clear "No!". The *facilitator/father* acknowledges immediately *June*'s reluctance to consider his perspective, and in T44 goes back taking the emphatic listening position, supporting the basic needs of competence and relatedness (Weinstein et al., 2022), saying "You're fed up with me loving you in a textbook way, and maybe I might not really know how to love at all?". In P45 and P47 *June*'s anger is escalating further, and as she explores and verbalizes this experience it becomes clear to both her and the *facilitator/father*, that the very idea of taking his perspective in this situation infuriates her.

When the *facilitator/father* empathically reflects to June his understanding of her experience in T49, *June* suddenly takes over the *facilitator/father*'s speech and with a calm, collaborative voice continues his sentence. In T50 the *facilitator/father*'s empathic, validating expression of understanding of June's experience, that it is too late to forgive and to connect, with the associated feelings of loss not only in the past, but also in the present and the future, is a remarkable turning point in the chair work, and manifests the integrative effect of an autonomy-supportive response of a highly intensive emotional experience (Roth et al., 2019; Weinstein et al., 2022) as well as the presence of the necessary elements of successful resolution: experiential awareness of and expression of both primary emotions

and thwarted need (Greenberg & Foerster, 1996). In P53, after being asked whether she has anything else to say, June verbalizes her feelings of loss to her father, her unbearable loneliness during all these years, and she starts crying.

The fourth and last part of the expression stage focuses on limit setting and the process of arriving to the position of keeping her father accountable of past happenings. *June* is still angry and expresses more clearly that she is not interested in considering his explanations for what has happened in the past. Yet, the *facilitator/father*'s consistent calming responses from T57-T73 helps her attain a position where she feels calmer and more relaxed and accepting with her reluctance for connection.

T56: Silence (20).

T57: I missed you too.

P58: I don't believe [looks at T. eyes straight, crying more].

T59: I didn't know how to connect.

P60: That's nonsense. [looks away a second, then looks back at T., crying, wiping her nose]

T61: If I had been able to, I would have experienced the joy of getting closer to your soul.

P62: Well, judging by your mother, you couldn't do that, [looks away, leans down to search more handkerchief], so don't feel sorry for that. [wipes nose]

T63: Maybe it wasn't just my mother who influenced my life?

P64: I don't know who influenced your life, but you could have had a better impact on mine, that's for sure. [wipes nose then looks T. in eyes]

T65: I deeply regret not being able to give what I truly wanted. Back then, that's all I could give. Is it possible that I was filled with fear and anxiety, trying to raise a perfect child and be a perfect parent?

P66: Maybe, but that's your own business! [looking straight at T.'s eyes]

T67: I agree with that. There's one thing I would like from you, though. Please don't think that I intentionally hurt you to make you suffer.

P68: But it did hurt! I don't care if it was intentional or not! [angry voice]

T69: I hear that it hurt. I sincerely apologize for not being able to give what I wanted.

P70: Do you even know what you wanted in the first place? [looking straight in T.'s eyes]

T71: (4) No, because I wasn't in touch with my own feelings.

P72: So now should I feel sorry for you? In the end, it seems like I should feel sorry for you as a parent whose duty was to lovingly care for their child. It might even turn out that I'll say, 'Oh, sorry, Dad, that it was so terrible for you.' [angry, ironic mimicking voice. leans forward and looks straight into T's eyes] Go see a psychologist or something!

T73: I'm sorry for not being able to provide the emotional support that would have benefited you. As a result, I was also emotionally alone. (9) [June is looking straight at T.'s eyes] Is there anything else you would like to say?

P74: No. [calm voice]

T75: Is it possible that I'm now happy and deeply grateful that you showed yourself to me in this way?

P76: You can indeed be, yes. [with a calm and affirming voice]

June keeps her father accountable for what has (not) happened between them during those formative years, and clearly sets her limits regarding any external expectations for opening up to connection and closeness in their future relationship. When in T75 the *facilitator/father* tentatively asks, again supporting June's need for competence and autonomy, whether it is possible that he is feeling grateful that *June* has showed herself to him to this extent, *June*'s voice is calm and affirming, when she answers "Yes". This part of the transcript manifests two further necessary experiential processes for successful resolution: self-validation and change in the representation of the other (Greenberg & Foerster, 1996).

Completion Stage

In the completion stage the *facilitator/father* once more expresses tentatively that it feels painful for him to understand that he and his daughter has missed important opportunities to connect to each other when he, as a parent had the possibility to do it. *June* calms down, and nods at his father's acknowledgement of their - now commonly shared - pain and loss. The *facilitator/father* inquiring June how she is feeling now, and *June*'s question whether it is asked by the *facilitator/father* or by the trainer makes it clear, that the chair work is approaching its end.

T77: I genuinely thank you! On the one hand, I'm grateful, but on the other hand, can it be, that it feels very painful that we didn't experience these moments when they should have happened?

P78: Hm. [calm, but crying voice, looks straight into T.'s eyes]

T79: (5) How are you doing now, *June*?

P80: [Sighing deep and laughing] Who's asking?

T81: Who should ask?

P82: Rather (name of the trainer) [laughs more relaxed, while wiping tears from her eyes].

T83: Then I, as (name of the trainer), ask, how are you doing now?

P84: (5) [June crying, laughing, looks out of the window] Well, at least a rainbow appeared in the sky. [looks down, closes her eyes, and touches her eyelids with tum and index

finger] Well, it reduced my tension. [sighs deeply]. It's good to see, how I perceive it in this way, but at the same time, there may be something else [laughing] on the other side, which I am consciously aware of… I've been dealing with this topic a lot, but somehow it hasn't arrived… to me on an emotional level. [wipes nose and looks at T.]

T85: Hm. So, we can say it's a drop in the ocean. Has it helped you in some way?

P86: Well, I was just thinking that maybe I should also write to him, [laughing] (.) concerning these.

T87: Write something to him something concerning these?

P88: Yes.

T89: We can leave it at that, then I'll stop the recording, thank you.

During the completion phase *June* is considerably less tense, which finds expression both metaphorically, by her noticing and commenting on a rainbow in the sky, and literally, by her stating in a calm voice accompanied by a deep sigh, that her tension has decreased. At the end, she is indicating, that even tough during the chair work she was not willing to consider her father's perspective, now, after the process is done, she is. Here we witness once more a clear change in the representation of the other, the fourth significant necessary element of successful resolution (Greenberg & Foerster, 1996). The transcript ends by *June* contemplating the possibility of writing a letter to her father.

Discussion

This study presented and described a modified version of chair work, called 'chair work with the empathic other', taking place within the framework of an advanced nonviolent communication training. The justification for closely exploring the participant's emotional processing in this variation of chair work for unfinished business is the recurrent research finding that many clients find engagement with chair work difficult, even unsurmountable, compromising the depth of emotional change (Muntigl et al., 2020). Previous research has pointed to the compatibility and applicability of nonviolent communication in emotion-focused therapeutic settings (Holmström, 2023). In this current study, drawing on insights on basic need support for motivation and psychological change (Roth et al., 2019), we show through a case example that talking directly to a need-supporting, empathic other helps to emotionally engage the participant, and guides her through the four necessary components of a successful chair work, leading to resolution. While the conventional chair-work technique, where the therapist takes an empathic stance and supports the process from an outsider position is need supportive, talking *directly* to the empathic other provides the participant with additional communicational and relational experiences that cannot be provided from an outsider position: being actively listened to and experiencing one's own perspective empathically conjectured and validated by the significant other. Previous research has found these elements essential to integrative emotion regulation and autonomous motivation (Weinstein et al. 2020; Roth et al., 2019). Psychodynamic theory, that conceptualizes the human mind as the result of internalization of significant attachment relationships, also supports the therapeutic significance of a new experience directly form the significant other (Slade & Holmes, 2019).

The analysis of the transcript shows how chair work where the facilitator takes on the role of the 'empathic other', who communicates according to basic need-supporting principles, guides the participant through the experiential components to successful resolution of unfinished business. The necessary factors for successful resolution of unfinished business specified by Greenberg and Foerster (1996) were all present in the transcript: experiential access and intense expression of primary adaptive emotions, expression of thwarted need, and a shift in the representation of the other. Receiving empathic listening and understanding *directly* from the significant other facilitated the participant's exploration of emotional experience, supported the evocation of relevant childhood memories, and intensified the expression of emotions during chair work. The transcript shows how direct conversation with the empathic other facilitated emotional engagement in the task as well as the associated activation and expression of the participant's needs behind these emotions (Nardone et al., 2022).

Limitations and Further Research

The presented study examines one participant's experiential process during a modified version of empty- chair work in a person-centered communication training. We acknowledge the exploratory nature of the study, not claiming generalization. A communication training setting is different from counselling and psychotherapy settings. Also, characteristics of both the client and the therapeutic relationship can influence the feasibility of the technique, as well as its effectiveness and outcome. Future research could repeat this study in counselling and therapeutic settings with participants of varying backgrounds, both as a single intervention, and as part of experientially oriented integrative therapies.

The therapeutic effect of the empathic other introducing his or her feelings and needs, while keeping the communication strictly within a person-centered framework also deserves further studies. In our study, this had beneficial effects on the participant's emotional engagement in chair work. Our findings point to the possibility that also in therapeutic settings, when used judiciously and carefully, it can have beneficial effects. However, there is a need to

be cautious about the situations this approach is applicable. Certainly, there are also situations, where it can be counter therapeutic, like when the significant other was so traumatizing, that even imagining an encounter with him or her requires specific therapeutic preparations (Leal et al., 2021).

Given the substantial number of clients facing unsurmountable difficulties with engaging in chair work or engaging with the necessary emotional intensity, future research is needed to shed light on the requirements and potentials of possible modifications in technique to support these clients experientially.

Author Contributions The study conception, design, analysis, and writing of the manuscript was conducted by Édua Holmström. Virpi-Liisa Kykyri supervised the data collection and research design, participated in the analysis of the transcript, and commented on the manuscript. Frank Martela commented on the theoretical framing and commented on the manuscript. All authors read and approved the final manuscript.

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Declarations

Ethical Approval The collection of video-recordings was part of the study design that has been submitted to and approved by the Human Sciences Ethics Committee at the University of Jyväskylä, approval number 1487/13.00.04.00/2022. This committee works in accordance with the guidelines for research involving human participants, issued by the Finnish National Board on Research Integrity in 2019.

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ORIGINAL PAPER 3

PITFALLS AND OPPORTUNITIES OF THE THERAPIST'S METACOMMUNICATION: A SELF-DETERMINATION PERSPECTIVE

by

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Pitfalls and Opportunities of the Therapist's Metacommunication: A Self-determination Perspective

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Abstract
Psychotherapy research identifies alliance ruptures and their resolutions as significant events in psychotherapy, influencing outcome. However, we know little about the process how such events influence outcomes, only assuming if clients stay in therapy that the rupture was resolved, and the outcome will be positive. The purpose of this paper is to problematize this assumption against the backdrop of self-determination theory, introducing motivation and relational positioning as relevant theoretical concepts for understanding rupture resolution and the effect on outcome. A therapeutic transcript demonstrating best practice for alliance rupture resolution in a brief integrative therapy is critically examined, calling the attention of both clinicians and researchers to the risk of prescribing and blindly following techniques during therapeutic impasses. Our analysis of metacommunication demonstrates how the therapist's use of a certain technique for resolving threats to the therapeutic alliance can lead to the client's external motivation and compliance, negatively influencing therapeutic outcome. Focusing on the therapist's relational positioning we present two alternative courses of therapeutic action, 'mindfulness in action' and 'embracing the patient's ambivalence', for supporting the client's autonomous motivation for the therapy process.

Keywords Relational psychoanalytic theory · Therapist's metacommunication · Alliance rupture resolution · Self-determination theory · Compliance

Introduction

Over the last twenty years, there has been a growing interest in psychotherapy research on the formation and maintenance of the therapeutic alliance (Cirasola & Midgley, 2023; Horvath, 2018), as well as factors associated with alliance ruptures and its relationship to outcome (Krupnik, 2022; Monticelli & Liotti, 2021; Tschuschke et al., 2022). The work of Safran and Muran (2000) on the negotiation of the therapeutic alliance is a foundation of this recent development. Their work on alliance rupture resolution synthesizes different therapeutic traditions but is most influenced by relational psychoanalytic theory. Their model has been extended by considerable empirical research, aiming to examining therapeutic communication during alliance rupture and repair processes, and has served as impetus for refining and developing the operationalization of relevant rupture markers (Eubanks et al., 2019; Gersh et al., 2018) as well as for developing an alliance focused training for therapists (Perlman et al., 2020).

Despite the recognition of the therapist as one side in the therapeutic communication, the empirical investigation of therapeutic ruptures has heavily concentrated on the communication of the patient, besides a few exceptions (Colli et al., 2019). Understanding ruptures only in terms of client behavior leaves half the story unexplored, and is contrary to a dyadic, relationally imbued understanding of therapeutic impasses (Eubanks et al., 2019). Examining impasses in terms of the therapist communicative behavior is notoriously difficult. One reason for this is the observation that successful resolution of a therapeutic rupture might be more a matter of following metacommunicational principles, reflecting therapists' relational positioning, than a matter of following

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behavioral techniques (Safran & Kraus, 2014; Muran et al., 2018).

Our paper's important contribution to current theorizing of alliance ruptures is the introduction of self-determination theory as a relevant theoretical framework for examining therapist's relational positioning and metacommunication. Self-determination theory is a theory of human motivation and regulation with solid empirical evidence across various domains (Ryan et al., 2021). It conceptualizes motivation in terms of quality, not quantity, ranging from external to intrinsic, with far-reaching consequences on behavior (Vansteenskiste et al., 2020). Most importantly, self-determination theory understands motivation, both external and intrinsic, as an essentially interpersonal phenomenon, being determined by the relationship between people involved. This aspect renders it relevant to examine therapeutic metacommunication, aiming for patient's psychic change.

Viewing through the lens of self-determination theory, the therapist communication and metacommunication can result in external motivation, leading to compliance and curtailing therapeutic change (Roth et al., 2019). Compliance without proper motivational internalization is also a pitfall of the therapist's metacommunication. The observation of Eubanks et al. (2019), that getting to an immediate resolution is *not* a guarantee for successful alliance repair can be explained by self-determination theory. Successful resolution of a threat to the therapeutic alliance is not just about avoiding rupture, but also about avoiding compliance (Ryan et al., 2021).

Taking the perspective of relational theory, this article is a critical examination of the therapists' metacommunication and relational positioning vis-à-vis a patient, presented in a published paper that represents recommended practice in a brief integrative therapy (Bennett et al., 2006; Parry et al., 2021). We analyze the transcript from the perspective of the metacommunication principles of Safran and Kraus (2014), the basic theoretical assumptions and clinical implications of relational theory (Aron, 2013; Benjamin, 2018; Stern, 2019) and through the lens of self-determination theory. Our critical examination of the therapist's metacommunication questions the attainment of rupture resolution of the presented transcript and raises the possibility that it depicts resolution by compliance, curbing the patient's long-standing change (Ryan et al., 2021).

The paper is structured the following way: First we present the theoretical and clinical tenets of relational psychoanalysis, with particular emphasis on the relational conceptualization of enactments and the corresponding therapeutic action. Second, we introduce the relationally imbued ideas of Safran and Kraus (2014) on the importance of the therapist's metacommunication during ruptures, and link these to the propositions of self-determination-theory (Ryan et al., 2021), a prominent motivational theory of solid empirical evidence, with implications for therapeutic communication. The core of the paper is the presentation and critical examination of a therapist's metacommunication during rupture in a brief integrative therapy, followed by a proposal of alternative therapeutic action that rely on relational techniques and support the client's self-determination. The discussion will summarize the findings and consider the theoretical and clinical implications for alliance rupture resolutions more generally.

Relational Psychoanalytic Theory of Enactments and Clinical Practice

Relational psychoanalysis is a contemporary and evolving school of psychoanalytic thought, considered by its founders to represent a paradigm shift in psychoanalysis (Hoffman, 2014). Relational theory was born from a synthesis of American interpersonal theory (Stern, 2019), the various insights of self-psychology (Magid et al., 2021), British object relations theory, and neo-Kleinian thought (Aron, 2013). A basic credo of relational theory, the one we also take in this study, is the understanding of the clinical situation in terms of a 'two-person psychology', as compared to mainstream psychoanalytic theory, criticized as being rooted in a 'one-person psychology' (Davies, 2018). Based on this new paradigm of the clinical situation, relational theorists have problematized and challenged two related clinical phenomena: 'enactment' and the underlying mechanism of 'projective identification' (Aron, 2013; Mitchell, 2022).

The theoretical critique directed toward the concepts of enactments and projective identification is twofold: First, mainstream psychoanalytic theorists understand *enactments* as 'put on stage' by the client, playing out his or her internalized object relations. They further assume that therapists can and should be able to differentiate the feelings that result from projective identification from what is part of their psychic content. Drawing on relational theory, we consider enactments as mutually constructed unformulated interpersonal events, emerging from the interaction of the participants' vulnerabilities (Stern, 2019). Enactment is conceptualized as mutual dissociation, an intersubjective process, when either the client or the therapist, or most often both fail to become conscious of the verbal or nonverbal meaning of the interaction in which they are together participating (Safran & Kraus, 2014). Therapists cannot naively assume that their seemingly neutral mentalization, their reflective observational stance is not the result of their own vulnerabilities and defenses. The therapist's insights are not only what he or she thinks they are: they are also participations in what most needs to be understood, communicated indirectly through metacommunication and relational positioning (Stern, 2019).

The other relational critique concerning 'enactment' contends that by isolating a certain 'event' of the therapeutic process as 'enactment' we inadvertently view the rest of the process as not being enactments, and these therefore remain unexplored in interactional terms (Aron, 2013). To speak of 'enactments' gives the impression that these happen every now and again (when the therapist cannot 'contain' the feelings aroused in him by the patient), but it denies that the client and the therapists are always 'enacting', mutually participating in a continuous flow of mutual relational configurations, from the beginning to the end of the therapeutic process. If the therapist focuses attention on an event he or she considers 'enactment', this will probably affect the extent to which he or she can hold awareness on the unfolding relational dynamic.

Relational clinicians emphasize the contrast between the twoness of complementarity that characterizes enactments, and the intersubjective space of thirdness that transcends this complementarity (Benjamin, 2018). Allying with this, our study also conceptualizes the therapeutic third radically differently from the concept of the therapist's neutral stance or observing function (e.g., Lacan, 1975; Ogden, 1994). The therapeutic third in relational theory bears similarities to Winnicott's concept of transitional space (Caldwell, 2022), but extend this concept by synthetizing it with the social constructivism of relational thinking, with direct implications on therapeutic practice.

Therapists operating within the third do not assume to have privileged access to their own motives that inevitably influence their interventions, nor do they claim to know what is best for their clients. For relational theorists, the objectivity of the therapist is not about demonstrating to the client how his or her transference ideas and expectations distort reality. Instead, it is for the therapist to notice and to realize other potentials in the therapeutic experience. The third, as an intersubjective space, requires an attitude of doubt and openness regarding the therapist's countertransference (Barreto & Matos, 2018; Tishby & Wiseman, 2022), a mindfulness in action (Eubanks-Carter et al., 2015; Safran & Muran, 2000).

Thus, the essence of the third position is to use it to step out of complementary power relations that characterize enactments (Benjamin, 2018, p. 21), by tolerating and nourishing the creative potential of the ambivalence of the client as a central component of therapeutic action. From this perspective, the 'bad object' that is lurking in every therapeutic situation is the one that pulls the participants into an absolute commitment to one side of the patient's conflict, with the result that the other side is repressed (Hoffman, 2014, p. 217). We propose that this view finds substantial empirical support from self-determination research, emphasizing the importance of the therapeutic support of autonomy and refraining from a controlling position vis-à-vis the patient's ambivalence (Roth et al., 2019).

From Relational Theory to Self-determination Through Metacommunication

That all therapeutic interventions are relational acts is an idea that most, if not all, therapists would agree with. When we communicate, we position ourselves to the recipient in a particular fashion. Communication theorists has long distinguished between the report and the command aspects of communication (e.g., Calvert et al., 2020; Watzlawick et al., 2011). The report aspect refers to the content of the communication, whereas the command aspect is an implicit interpersonal statement that is being conveyed. Correspondingly, therapists must monitor the relational implications of their interventions on an ongoing basis. This includes the mentalizing of their own motivations, not seldom defensive in nature, underlying their decision to use a therapeutic technique. Is the therapist making a definitive interpretation to affirm his or her own sense of potency, or, alternatively, to cover up anxiety?

Building on a solid base of relational psychoanalytic theory Safran and Kraus (2014) emphasize the importance of metacommunication during therapeutic impasses. Drawing on the idea that successful resolution might be less a matter of applying behavioral techniques and more a matter of following certain relational principles, they advocate both general and specific principles of therapeutic metacommunication. These principles promote relatedness between the therapeutic dyad, strengthen mentalization of the patient and ultimately lead to the patient's emotional healing.

We consider that the therapeutic principles of metacommunication and relatedness, as advocated by Safran and Kraus (2014) summarize and concretize both the conceptualization of enactments as mutual dissociation (Stern, 2019) and the conceptualization of the third as an intersubjective space transcending complementarity in the here-and-now of the therapeutic relationship (Aron, 2019; Benjamin, 2018). We further propose that these metacommunicational principles also stand in line with the tenets and sound empirical support of self-determination theory. Self-determination theory focuses on the importance of therapist's autonomy support for internal motivation. By taking an autonomy supporting position, the therapist promotes engagement and long-standing change, as opposed to external motivation and compliance (Roth et al., 2019; Ryan et al., 2021). Both relational theory and self-determination theory understand resistance as a product of the interpersonal matrix between the patient and therapist. Correspondingly, motivation is something emerging from the relational dynamics of the partners implied, forming a continuum: controlled and external on the one end to autonomous and intrinsic on the other

end (Ryan et al., 2021). Research on self-determination has consistently shown that conceiving motivation as simply an intrapsychic attribute of people, varying in quantity, misses something essential about its nature: the degree to which it is controlled versus autonomously endorsed.

The degree of autonomy support of the therapists affects the degree of autonomous regulation and motivation of the client. Correspondingly, while a controlling stance on the part of the therapist leads to external motivation and compliance, an autonomy supportive stance enables autonomous motivation, supporting solid and long-term psychological change, maintained across time and circumstances (Roth et al., 2019). A relational conceptualization of 'the therapeutic third' can also be read to describe the therapist's support of the client's autonomous motivation: it implies abstaining from any form of control of the other, the ability to take in the other's reality while accepting its separateness and difference (Aron, 2019; Benjamin, 2018).

Case Example of Rupture Resolution

As a brief integrative approach to psychotherapy, cognitive analytic therapy has been developed through synthetizing cognitive theory with analytic concepts, particularly the various contributions of object relation theorists (Ryle & Kerr, 2020). The collaborative reformulation of the client's problems early in therapy in terms of characteristic and problematic 'reciprocal role procedures', is a central feature of the approach. Reciprocal role procedures are defined as goal-directed sequences of roles which were acquired during development and are maintained and strengthened in subsequent relationships. Maladaptive deep-rooted reciprocal role procedures or the inflexible use of them are considered to constitute the underlying reason for problematic and often entrenched behaviors, which are understood as functionally protective, yet self-defying processes of avoiding the emotional experience associated with certain roles. The reformulation is meant to make the implicit relational patterns of the client explicit and functions as a tool for the development and strengthening of the patient's reflective self-observation (Simmonds-Buckley et al., 2022).

The therapeutic phenomena of transference, countertransference and the underlying process of projective identification are understood and conceptualized in cognitive analytic therapy as reciprocal role procedures between the therapist and the patient (Parry et al., 2021). During the therapeutic process the therapist expects the client to enact one pole of his or her characteristic role procedure, while putting simultaneously pressure on the therapist to assume the reciprocal role. Countertransference, on the other hand is conceptualized as the therapist own tendency to respond to this pressure (Ryle & Kerr, 2020), pointing to the importance of awareness and recognition of this dynamic.

Therapeutic alliance in the approach is explicitly thought to become facilitated and strengthened through a collaborative reformulation process, explicitly thought to support the therapist in avoiding collusion with the patient's problematic reciprocal roles (Simmonds-Buckley et al., 2022). This emphasis on problematic relational dynamics shares similarities with other brief integrative and dynamic therapies, focusing on an early conceptualization of the client's characteristic relational dynamics (Farber & Motley, 2023; Julien & O'Connor, 2017; Markin et al., 2018). Cognitive analytic therapy considers the collaboratively created reformulation the main tool and the most important therapeutic technique to guide the dyad out of impasses when the client's problematic relational dynamic threatens to lead to rupture in the therapeutic alliance (Parry et al., 2021).

Bennett et al. (2006) developed a cognitive analytic model for resolving threats to the therapeutic alliance, serving as guidelines for therapeutic practice. The aim of Bennett's article was to "test and refine the model of how cognitive analytic therapists successfully resolve threats to the therapeutic alliance, involving enactments of problematic relationship patterns". After presenting the collaboratively developed reformulation of the characteristic relational dynamics of the patient, Bennett et al. (2006) presents a transcript depicting what the authors consider a successful resolution to a threat to the therapeutic alliance, intended to demonstrate recommended practice in cognitive analytic therapy. Their model was recapitulated by Parry et al. (2021), who specify the therapist's skill to apply it during alliance ruptures as one of the key therapeutical competencies of the approach.

The Therapist Metacommunication: A Relational Critique

Our analysis examines the last part of the transcript presented by Bennett et al. (2006). As the established praxis in this type of process-research (Krause, 2023), we adopt a microanalytic level of analysis to compare a single idiosyncratic interaction sequence to a context-specific model, in this case a model for rupture resolution, that specifies what is expected to happen in the therapeutic process when rupture markers are identified (Safran & Kraus, 2014).

We analyze the transcript through two different theoretical lenses: through the perspective of the metacommunicational principles of successful rupture resolution (Safran & Kraus, 2014; Safran & Muran, 2000), and trough the examination of the interpersonal dynamics of the enactment: the relational positioning of the therapist vis-à-vis the patient during the interaction, affecting the level of the patient's autonomous motivation (Benjamin, 2018; Roth et al., 2019; Simmonds-Buckley et al., 2022). Although the examination of the transcript cannot escape the subjectivity of the authors of this article, we believe the criteria used makes

replicability of the analysis possible: the metacommunicational principles presented by Safran and Kraus (2014) are sufficiently concrete and precise to allow for a replication of the analysis.

Safran and Kraus (2014) present both general and specific principles of therapeutic metacommunication that promote relatedness between the therapeutic dyad, mentalization of the patient and leads to emotional healing. Examples of these principles are: 'explore with tentativeness', 'establish a sense of 'we-ness', 'do not assume parallel with other relationship', 'emphasize one's own subjectivity', 'emphasize awareness rather than change', 'accept responsibility for own contribution to the interaction', 'evaluate the client's responsiveness to all interventions', 'provide feedback regarding subjective experience'.

Our exploration and critique concentrate specifically on the metacommunication of the therapist: We operationalize pitfalls in metacommunication as the therapist's divergence from the communicative and metacommunicative principles specified by Safran and Kraus (2014), as well as the presence of complementary relational dynamics between therapist and patient (Benjamin, 2018), which -when left therapeutically unexplored- bear the risk of decreasing the patients' autonomous motivation (Roth et al., 2019). To analyze the therapeutic effect of the therapist's words on the patient, the patient's utterances are also examined. Does the therapist's communication help the patient to further explore his subjective experience? Or alternatively, does it contribute to closing the patient's exploration and withdrawal from the dialogue? The patient's utterances are also explored for examining the extent to which the therapist is responsive to them. Does the therapist react to the patient's expression or does the therapist ignore them? The examination of the extent to which the therapist takes into consideration the patient's perspective allows us to evaluate the therapist's support or lack of support of the patient's self-determination and autonomous motivation (Roth et al., 2019). Let us now turn to the first part of the transcript.

TRANSCRIPT 1/3

T160 I think what's happening here, what happened then, what's happening in you, is that part of you, that is desperately in need of some care, like you said last week, you wish to be able to be held and rocked and allowed to cry, which is understandable. That part of you, when you get any kind of sense of someone being there for you, you are so overwhelmed by the intensity of the feeling that you have to back off. There is such a well of neediness that you can't risk letting anyone near enough to help you. So you back off to the sand-dunes as if it is the only place to go.

P161 I disagree. Silence

P162 Are we talking about the past or on the ward?

T163 The ward, friends, me. In all those contexts, people are allowed so near and then you break contact.

P164 I still disagree. Silence

What first catches the attention of the reader familiar with the book of Safran and Muran (2000), which Bennett et al. (2006) use as a reference point for their model development, is the striking difference of metacommunication between what Safran and Muran (2000) explicitly advocate and the metacommunication of the therapist in the transcript. The therapist does not explore with tentativeness but tells the patient a strong interpretation, explicitly assuming a parallel with other relationships (T163). The patient repeatedly expresses disagreement with the therapist's interpretation, and gets silent in the end, possibly indicting relational withdrawal. These stay unexplored by the therapist. In their article, the authors of Bennett et al. (2006), emphasize the therapist's combined focus on the therapeutic interaction and on the patient's problematic relationship patterns, a key factor in achieving resolution. However, one of the consequences of assuming and expressing parallel with other relationships is that focus is shifted from the concrete and specific of the here-and-now of the therapeutic relationship and lead to generalized interpretation of the patient, silencing and closing intrapsychic exploration (Safran & Kraus, 2014). In fact, based on the patient's responses, the therapist's interpretation did not deepen the patient's exploration of his inner experience. The patient's utterances as compared to the therapist are few and limited to expression of disagreement with the therapist's interpretation in T160 and T163, except for one clarifying question. Maybe more importantly, as we can see from the next section, the therapist has not explored the patient's repeated disagreement, nor his possible gradual withdrawal that might lie behind his silence.

TRANSCRIPT 2/3

T165 Are you saying that that was one of the lessons not to get close to people because they are going to betray you?

P166 Yes, I still stood by her.

T167 With Anna, that was true, with Tina it wasn't true, you wouldn't go back, and you still feel angry with her. What about the therapy, you haven't felt betrayed yet, I hope you won't be but you may feel it.

T168 Can you risk it?

P169 No.

T170 Why is that more difficult?

P171 Because the things I want aren't going to happen (crying)

T172 One of the problems about the degree of want that you have and degree of need that you have is that it is very hard to know what you could take that is less than you need. In a sense, that is what you have to do always, get what you can from people, but nobody ever gets all they want, nobody ever gets everything made up for. In your case it is hard to take because there is so much deprivation there. But you have, for example, with Anna, not got all that you want but you got something, that's what you have to do and not be so angry and disappointed that you just cut off from it.

In T165 the therapist continues focusing attention on the patient's general tendency 'not to get close to people', rooted

in his characteristic problematic relational patterns. The therapist proceeds to point out in T167 that the patient's expectations of being betrayed are not substantiated by evidence.

In T167 the therapist changes to focus from the patient's problematic interpersonal pattern to the exploration of therapeutic relationship, presenting three questions from T167 to T170 with the aim of understanding his difficulties to take the relational risk specifically in therapy. It seems that this refocusing of attention on the therapeutic relationship has a positive effect on the patient, who in P171 is on the verge of connecting to deeper aspects of his experience. Here, our analysis agrees with Bennett et al. who also classify the therapist's utterances at P168 as emphatic exploration, followed by a deepening of affect.

One of the most touching utterances of the entire transcript is at P171, where after a long phase of a withdrawing position with short and limited utterances, the patient's feelings of hopelessness, desperation, disappointment, and fear regarding therapy come to the surface as he starts crying. Bennett et al. contend, that the therapist "facilitates the patient to be in touch with painful previously avoided affect" (p. 406), and state that this, combined with the "explicit self-disclosure, also reflects a therapeutic relationship in which there is authentic human contact" (p. 406).

Examining the metacommunication of the therapist points to another perspective. In P171 the patient presented an opportunity for the therapist to stay with him in the here-and-now: hearing, witnessing, and bearing with him his difficult feelings. The therapist does not stop to explore these inner meanings, but instead tells the patient about the problem of his 'unrealistic expectations' and what he should do, followed by two normative statements regarding objective reality. In T172, instead of exploration of feelings and open inquiry of meanings the therapist tells the patient how he should change. There is no explorative tentativeness, nor any hints of marking that what he or she says is a subjective opinion.

TRANSCRIPT 3/3

P173 I disagree, I've been so shat on…I deserve a good deal.

T174 Yes, you do, but a good deal can only be what people can manage and not something that is magical, that makes everything better or gives all that you need. you may deserve that but can only get what people can give. It's imperfect but human. Silence

T175 So you don't disagree too much about that?

P176 (different tone of voice) I wonder how my judgement formed?

T177 Your judgment is informed by many things but of the many things, I still see traces of your history, although you have rejected what people did to you, you have also incorporated some of it into yourself. I you hadn't lived your life in the way you were treated, you would get better, if you could give consideration to yourself like you do to others but part of you still treats yourself in the way you were treated, which I can understand, but I am not on that side. I am on the side of repair rather than continuing damage. Do you understand that?

P178 Yes.

In this last part of the transcript the patient expresses disagreement once more, a third time, indicating his emotional distancing, further away from the change that the therapist expects him to take. Here, from a self-determination perspective, the therapist self-positioning as an arbiter of objective reality, while ignoring the patient's repeated disagreement, clearly thwarts the latter's needs for competence and autonomy, undermining autonomous motivation for change (Vansteenkiste et al., 2020).

The therapist makes a last point, explaining the patient what he should do to get better: he should notice what went wrong in his developmental history and object relations and choose to do better. The therapist then points to the dynamics of the patient's ambivalence regarding change: there is the 'side of continuing damage', where he is treating himself the way he was treated in the past, and there is the other side, the 'side of repair', as represented by the therapist. The therapist then asks the patient whether he has understood what was said, -a rather patronizing expression- to which the patient responds with a short 'Yes'. Bennett et al. (2006) claim, that at this point the 'enactment' was over, and the therapist and the patient have together reached a resolution to a threat to the therapeutic alliance.

To sum up the critique: the transcript reveals pitfalls of the metacommunication of the therapist, when facing a potential rupture situation: the therapist (1) explicitly pointed out to the patient how his current behavior has been present in his life previously, moving the attention explicitly away from the therapeutic interaction of the here-and-now, (2) left unnoticed and unexplored the patient's repeated disagreement and the subsequent narrow participation in the interaction, possibly indicating relational withdrawal and compliance, (3) expressed normative judgements of the patients characteristic traits as perceived by the therapist, (4) presented subjective opinions as objective reality, and (5) took explicit side in the patient's ambivalence. Furthermore, the authors didn't examine or discuss what happened in the therapeutic relationships before and after the situation they describe as 'enactment'. Doing so would have provided a wider perspective on the relational dynamic of the therapeutic dyad, that remained unexplored in interactional terms (Aron, 2013).

Our exploration of the therapist metacommunication points out the stark differences between the approach of Safran and Kraus (2014) that is imbued with the sensitivities derived from relational psychoanalytic theory, and the actual approach of Bennett et al. (2006). The complementarity of 'doer and done to', transpiring from the transcript bears the characteristic of problematic enactments. When the therapist feels compelled to protect her internal, observing third from the patient's reality, this is a sign of possible breakdown into complementarity (Benjamin, 2018). The therapist also took

explicit side in the patient's ambivalence, underscored with normative judgments, that research had found to negatively influence outcome (Colli et al., 2019). From a self-determination theory perspective, a complementary positioning is a controlling positioning, where the patient's basic needs for autonomy, competence and relatedness are sidestepped, easily leading to compliance and external motivation (Roth et al., 2019).

Relational and Autonomy Supportive Metacommunication

Based on the communicational recommendations of Safran and Kraus (2014) and the work of relational theorists, here we present two examples of a more relational, autonomy supportive way of dealing with the threat to the therapeutic alliance in Bennett's et al.'s (2006) presented transcript. We concentrate on two basic therapeutic techniques: mindfulness in action, that strengthens the patient's mentalization while establishing we-ness (Safran & Muran, 2000; Stern, 2019), and the embracement of the patient's ambivalence that nourishes the patient's creativity and agency (Aron, 2013; Benjamin, 2018).

Mindfulness in Action

'Mindfulness in action' (Eubanks-Carter et al., 2015) is an example of the very same relational positioning that Stern (2019) takes in his theory of enactment as mutual dissociation, where both the therapists and the client are embedded in the relational configuration, mutually contributing to it. Had he or she been working with the sensibilities of relational theory, the therapist in the article of Bennett et al. (2006) could have mindfully mentalized the interaction between the therapeutic dyad in the here-and-now.

As an example of mindfulness in action, the therapist, in the silence following P164, could have mindfully commented on what is happening between them by saying e.g.: "*I notice that I have moved into a position, where I try hard to convince you of something, while you keep on disagreeing. Do you notice the same?*" Or, alternatively, the therapist could have said: "*When I hear myself talking to you, I notice in my voice a hint of blaming tone, is it something that you can also recognize?* ".

These kind of utterances of mindfulness in action exemplify many of the principles of metacommunication necessary to the resolution of therapeutic impasses, while simultaneously supporting the patient's needs for autonomy, relatedness and competence (Vansteenkiste et al., 2020): they exemplify exploration with tentativeness, establish a sense of 'we-ness' by commenting on what may be a shared experience, emphasize own subjectivity by accepting responsibility for one's own contribution, promote the practice of reflecting on one's mind trough modelling it, focus on the here-and-now of the relationship, as well invite the patient to explore the therapist's contribution. All these foster the capacity of mentalization (Barreto & Matos, 2018; Fonagy et al., 2019), the willingness to reflect on one's own experience and that of others, allowing us to detach from any interpretation of our own and remain open to whatever we encounter (Aron, 2019; Stern, 2019).

Embracing the Patient's Ambivalence, that Nourishes Creativity and Agency

As noted above, the therapist in the article of Bennett et al. (2006) may very well be embedded in a complementary relational configuration, where the therapist pulls the patient into a rigid commitment to one side of his ambivalent conflict, with the result that the other side is abandoned (Hoffman, 2014, p. 217). A central component of relational therapeutic action, the essence of the third position, is to use it to step out of this complementary power relation by tolerating and nourishing the creative potential of the ambivalence of the client. The third requires an attitude of curiosity and openness for alternatives to a linear complementarity (Benjamin, 2018). How to do this in practice?

One potential timepoint for the therapist in Bennett et al. (2006) to disengage from complementarity and building the third would have been after P171, the most touching and arguably the most crucial timepoint of the entire presented transcript. Here, the patient is in contact with his feelings on a new and deeper level than before. Instead of the therapist 'educating' the patient about 'reality', 'realistic expectations', and normative recommendations for behavior, he or she could have taken the opportunity to embrace ambivalence by entering the transitional space together with him, and playing with his fantasy (Aron, 2019; Winnicott, 2016). The therapist might have said something like the following, with a soft, empathic, and maybe somewhat playful voice:

> *I see. I hear what you say, you feel you must give up all those things you are so sorely longing for to happen and it tears your heart. Would you like to tell me what are these? I would very much like to hear them. Let's take some time together to play with that fantasy, the fantasy that you could get these things or some of them, how would that be?*

Playing with fantasy in the transitional realm is what Winnicott described is needed for the development of psychological growth, agency, and creativity (Caldwell, 2022; Ogden, 2021). Furthermore, playing with fantasy also has the powerful potential to take out the therapeutic dyad from linear complementarity (Aron, 2019). In the intersubjective

realm of the third that transcends complementarity, there is no need to establish whether the patient's expectations are realistic or not. They are not judged unrealistic, but neither are they validated as realistic, which would equal collusion. The therapist's worlds 'fantasy' and 'play' might be clear enough to function in the therapeutic interaction like the pivotal concept of 'marking' in parental communication based on mentalization theory (Fonagy et al., 2019), establishing both the therapeutic containment of the patient's unbearable affect and interpersonal relatedness, while supporting the patient's need for competence and autonomy (Vansteenkiste et al., 2020).

Playing with patients' fantasies opens the possibility to deepen exploration of their own subjectivity, to strengthen mindful awareness, to model them acceptance and cherishment of their inner world. Above all, it promotes patients' ownership of inner experience. Readiness to enter such a play from the part of the therapist is also an interpersonal statement of acceptance that establishes a sense of 'we-ness'. These are among the principles of metacommunication that Safran and Kraus (2014) advocated.

Discussion

To deepen our theoretical and clinical understanding of factors affecting the outcome of alliance ruptures, we have in this study bridged two contemporary theories of psychological change: relational theory and self-determination theory. In doing this, we have answered the call for research of Krause (2023), who in her thorough review of psychotherapy process research concluded, that in order to generate useful future knowledge in the field, change mechanisms need to be linked to ongoing process, requiring models of change that are transtheoretical by nature.

Taking a relational theory perspective, our study examined the therapist's metacommunication in the application of a cognitive analytic model for resolving threats to the therapeutic alliance. The analysis shows what pitfalls may arise in the therapist's metacommunication and relational positioning when under pressure of a therapeutic rupture. The presented transcript reveals the difficulties therapists face in dire impasses and the challenge of maintaining contact with the patient so that rupture does not occur. The therapist of the examined transcript managed to avoid a direct rupture. However, evading an immediate rupture does not necessarily inform about the long-term effect of the impasse on the therapeutic alliance (Eubanks et al., 2019). The therapist might have managed well with respect to avoiding immediate rupture, but perhaps less so regarding the avoidance of the patient's compliance, potentially curtailing internal motivation, and long-standing change (Vansteenkiste et al., 2020).

One of the best ways to evaluate the effectivity of a therapist's intervention is to examine whether it furthers the therapeutic inquiry or shuts it down (Mitchell, 2022). Based on the patient's verbal silencing, the therapist's utterances in the transcript cannot be considered effective: the therapist did not pay attention to this unfolding communicational and relational configuration, left unexplored the therapists normative and educative positioning, and did not notice or comment on the patient's gradual silencing.

The results stand in line with Muran et al.'s (2018) findings, that when confronted with problems in the therapeutic relationship, those therapists who tend to increase adherence to technique escalate the adverse dynamic that in turn correlates with negative outcome. More specifically, when initial reformulation of the patient's characteristic and problematic relational dynamics is used as a tool for the therapist to reach for when things get difficult in the therapeutic relationship, the reformulation becomes the third as an observing function that relational theorist so passionately argued against (Aron, 2006; Benjamin, 2018). By taking the side of the adult part in the patient's ambivalence, the patient's more traumatized, abandoned, or hated parts get easily silenced, possibly leading to pseudo maturity, compliance, or the strengthening of the 'false self', as it is called by Winnicott (Ogden, 2021). Relational theory encourages therapists to mentalize and be aware of their relational positioning, their implicit interpersonal statement when offering insight to the patient. When the therapist focuses attention on insight - the third, understood as an observing function - she will likely expect this insight to be accepted, meaning that the client's illness has caused the impasse. In therapeutic situations that are characterized by the 'doer and done to' complementarity (Benjamin, 2018, p. 59), there are only two possible outcomes: in the best-case scenario, the client feels partly content, because he or she has at least expressed protest, eliciting enough attention from the therapist that they can go on together- until the next time, when the same situation arises. In the worst case, the patient is left defiant or compliant, bearing the burden for 'being destructive', feeling the therapist has withdrawn or retaliated, in either case 'not survived' (Abram, 2021; Winnicott, 2016).

From a self-determination perspective, complementarity boils easily down to compliance of the client, a form of external motivation that empirical studies on self-determination have found to curb long-standing change (Roth et al., 2019; Vansteenkiste et al., 2020). Taking a controlling relational positioning in interactions strengthens external motivation and decreases autonomously endorsed psychological change and regulation. The key to psychological change and autonomous regulation is the therapist's support of the client's needs of relatedness, competence, and autonomy, best

achieved through refraining from a controlling interpersonal positioning, and sustaining the inner tension characterizing the patient's ambivalence (Ryan et al., 2021; Weinstein et al., 2022).

In the relational paradigm, the therapist's primary task is not to avoid collusion. Instead, the therapist's task is participation and mindful reflection and mentalization of his or her involvement (Safran & Kraus, 2014). The therapist is not considered to be in the position to objectively grasp this involvement and offer interpretation of it as it happens. Instead of assuming repetition of the patient's characteristic relational patterns, therapeutic action is grounded on the therapist's readiness to participate in an unfolding, emergent process and relentlessly reflect on their mutual participation.

Originally, in psychoanalysis the prevailing view was that psychoanalytic therapy was essentially informational: insight and awareness would bring about changes in the ways one would experience events and respond to them. Over time, there has been a shift from the informational to the transformational perspective, with an increasing emphasis on the experiential aspect of psychological change (Davies, 2023), where insight is retrospective. With the relational turn, the goal of psychoanalysis has further moved from insight to the freedom to experience and the expansion of relatedness (Davies, 2018; Schwartz Cooney, 2018).

Winnicott emphasized the 'transitional realm', between the realm of fantasy and reality, subjective and objective, as a facilitating environment creating the conditions for psychic growth and authentic agency (Ogden, 2021; Winnicott, 2016). Instead of a 'thing' to hold on in the therapist's mind, instead of an observing function, the third in relational theory is a process in a continuous flux, a shared intersubjective phenomenon, created by the therapist and the client together during their idiographic therapeutic process (Benjamin, 2018). To promote the third is to promote a quality of experience of intersubjective relatedness in a flow of change, a relationship that nonetheless also has a correlate of an internal mental space of the patient. It is the therapist's task to facilitate and consciously work towards building a shared intersubjective space between herself and her client.

The most important therapeutic task of the therapist is not about demonstrating to the client how his or her transference expectations twist reality. The task of the therapist is to become aware of complementarity and to realize more collaborative potentials in the therapeutic experience. For this to happen, however, there needs to be a model for therapeutic action, relying on theory, that guides therapists to allocate relentless attention to the present moment. As we have shown in this paper, 'mindfulness in action' of Safran and Muran (2000) and Benjamin's (2018) emphasis on 'embracing ambivalence' are prominent candidates for such therapeutic action.

While examining a specific interaction sequence allowed us to focus attention to potential pitfalls in rupture resolution processes, further research based on more systematic data collection is needed. Collecting video recordings of alliance rupture events, and analysis of the therapist's nonverbal communication in seeking resolution, could deepen our understanding of how therapist's relational positioning influences the patient. Our findings point to the promise that such study of relational positioning holds for informing both theoretical discussion and clinical work.

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Declarations

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ORIGINAL PAPER 4

ENHANCING THE EFFECTS OF EMOTION-FOCUSED INDIVIDUAL AND COUPLES THERAPY BY NONVIOLENT COMMUNICATION

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Enhancing the Effects of Emotion-Focused Individual and Couples Therapy by Nonviolent Communication

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Abstract

Nonviolent communication (NVC), a person-centered communication process, is a potential tool for enhancing the interpersonal effects of emotion-focused therapy. After establishing NVC's model for fostering compassionate communication and connection between people, we present NVC's interpersonal processes and the theoretical premises for its use in emotion-focused therapy. We elaborate how an emotion-focused therapist could introduce NVC as a facilitating tool for helping clients express their needs in a manner that likely engenders compassion. NVC also assists clients in hearing others with empathy outside the therapy session, without the emotion regulation support from the therapist. The timing for the beneficial use is described for both the individual and couples therapy process.

Introduction

Emotion-focused therapy (EFT) blends of person-centered theory and gestalt approaches to therapy, and reformulates them in terms of emotion theory and affective neuroscience (Goldman and Greenberg, 2019). EFT places emphasis on the therapeutic goal of helping clients become aware of and transform their implicit emotion schemes that guide their problematic experiences (Goldman and Greenberg, 2015). Greenberg and Warwar (2006) show the benefits to clients of structured exercises that rely on the experiential principles for identifying and regulating their emotions and making use of the insights gained in therapy sessions. EFT tasks conceptualize emotion regulation as an intrapsychic challenge with an emphasis on awareness of feelings and needs as well as self-soothing to consolidate and reinforce in-session changes through extra-session practice.

EFT is not alone in focusing on the intrapsychic processes of emotion regulation. Until recently, emotion regulation research has emphasized intrapsychic processes (Zaki and Williams, 2013). Behind this emphasis on the individual lies the assumption, that individuals can change intrapersonal processes and that this change will lead more flexible and adaptive interpersonal functioning (Greenberg and Watson, 1998; Watson et al., 2003).

In addition to intrapsychic emotion regulation, individuals also draw on interpersonal emotion regulation defined as "the formation and pursuit of goals designed to change one's own or others'

emotions through social interaction" (Zaki, 2020). As recent research on emotion regulation shows, the extent to which individuals rely on interpersonal emotion regulation strongly affects both their emotional and social well-being (Williams et al., 2018). Interpersonal processes beneficially scaffold emotion regulation throughout life, starting from the development of attachment (Bowlby, 1990; Zaki and Williams, 2013; Beebe and Lachmann, 1998). With this in mind, the question arises of whether there is an opportunity to integrate explicitly interpersonal emotion regulation into EFT. This process would entail not only helping clients constructively express their feelings and needs in social interactions in a manner that likely results in these feelings and needs being heard, but also to better perceive and respond to the feelings and needs of the significant others.

Interpersonal processes appear explicitly in emotion focused couples therapy (Greenberg and Goldman, 2008; Woldarsky Meneses, 2017) wherein the couple's mutual regulation of affect is considered the core motivating force in a couple's relationship. Here, the transfer of interpersonal processes acquired in therapy to situations without the 'safety net' provided by the therapist, is conceptualized as implicit learning through the internalization of the therapeutic attitude. If it is through the experience of emotion that emotional distress can be cured, then why not explicitly teach clients to attend to their own emotions and others', when they are experienced in the first place? When a client ignores or hides emotions instead of attending to them, it is not only the client who suffers. The client's relationships suffer too, reverberating pain for everyone involved, justifying more attention to the interpersonal processes.

The purpose of this article is to show that a relevant body of knowledge and potential tool for interpersonal emotion regulation, compatible with EFT, already exists in the form of a person-centered method of communication developed by Marshall Rosenberg, a student of Carl Rogers. Rosenberg named his method nonviolent communication (NVC). Referred to as compassionate communication in many countries, NVC capitalizes on Rogers' idea that the necessary conditions for personality change and growth need not be limited to the therapy room but instead could be widely taught and used for all types of human interactions (Mayes, 2010). NVC's skills are unequivocally interpersonal, and are designed to help people connect to each other by mutual recognition of universal feelings and needs. As a therapeutic process, EFT relies on and makes use of implicit learning and symbolization of emotion, identifying needs and trying out ways to express these. NVC can augment and consolidate these implicit skills by providing the explicit communicative skills of mutual emotional regulation. These skills can support clients to express their lived experience in constructive ways as well as help them accurately perceive and respond to the feelings and needs of significant others.

Next, we present the historical background and core elements of NVC, highlighting the elements of NVC that complements EFT. The main section of this paper has two parts. The first section presents a clinical example of an individual EFT process reported by Greenberg et al. (1993) with suggestions for how to use NVC to help the client to express her needs and hear the needs of the significant other in a challenging interaction. The second part of the main section presents suggestions for integrating NVC into emotion-focused couples therapy. In our discussion, we consider the client perspective on the integration and explore how further research can support a fruitful integration of NVC and EFT.

Nonviolent communication

After receiving his Ph.D. in clinical psychology, Rosenberg developed NVC based on person-centered, experiential and cognitive principles, building on the conceptualization of the nonviolence of Mahatma Gandhi. NVC is a heuristic guide for teaching people to think and communicate in accordance with their and others' organismic experience, i.e., their feelings and underlying needs, with particular attention to the mutually beneficial ways this can be achieved [1]. NVC contends that everything that people do or say is the expression of underlying needs. Using the NVC process, we can reframe and express ourselves as well as hear others in a constructive manner, moving away from habitual, automatic reactions towards an awareness and expression of what we feel and need (Rosenberg, 2015). The basic elements of NVC are observation, feeling, need, and request.

Observation: With respect to the process, the first component of NVC entails the expression of what we observe that affects our well-being. This step entails the separation of our observation from our evaluation (Beitman and Soth, 2006; Kabat-Zinn, 2012). When we do not judge the other but instead talk about what we observe, feel and need, the proposition is that the other will more likely hear our message.

Feelings: The second component of NVC is the awareness and expression of feelings. NVC conceptualizes emotional experience as the organism's self-regulatory mechanism to satisfy needs. When our needs are satisfied, we experience positive feelings. When our needs are not met, we experience negative feelings. Similar to EFT (Greenberg and Paivio, 2003, p.16), "positive" and "negative" refer to the phenomenological aspect of emotion, referring to our experience of the

[1] Teaching NVC requires training, with trainer certification obtained after many years of documented practice. The Center for Nonviolent Communication, a global nonprofit organization that offers trainings and certifies NVC trainers, is active in over 65 countries around the globe (Center for Nonviolent Communication, 2020).

emotion as pleasant or unpleasant. NVC shares with EFT the premise that emotions provide us with a rich source of complex meanings and important experiential information regardless of whether the emotions are pleasurable or not. NVC heuristically pools together emotional experiences under the umbrella term of feelings. This simplification is justified by parsimony in teaching NVC, offering a heuristic tool to verbalize inner experience. Although social interactions evoke different feelings in people depending on culturally ascribed meanings, the evoked feelings themselves are considered universal and recognizable to people in every culture.

Needs: The third component in the NVC process is the awareness and expression of the underlying needs that give rise to our feelings. Connecting feelings to underlying needs is a tenet shared across a spectrum of experiential approaches. Rosenberg defines needs in accordance with the theory of human scale development of Manfred Max-Neef (2005; Max-Neef et al.1992). Max-Neef placed human needs at the center of his social-economic theory and presented them as belonging to the higher-order categories of subsistence, protection, affection, understanding, participation, creation, leisure, identity, and freedom. Max-Neef is credited for the conceptual separation of needs from its satisfiers, i.e., the strategies we can use to satisfy a need. For example, food and shelter are not seen as needs but as satisfiers of the fundamental need for subsistence. The curative and health systems in general are satisfiers of the need for protection. There is no one-to-one correspondence between needs and the strategies we use to satisfy them. A satisfier may contribute simultaneously to the satisfaction of different needs, or conversely, a need may require various satisfiers to be met. While satisfiers for the needs are culturally determined, the needs themselves are considered universal and present in all cultures and historical periods. This separation of needs from strategies to satisfy them is important in NVC with implications that we return to later in this manuscript.

Request: In the fourth and final component of the NVC process, we address a concrete request to the other. We ask for concrete actions that might contribute to fulfilling our needs. We express what we are asking in a clear and concrete format instead of expressing what we do not want. Asking the other to “talk kindly” is not enough. Vague language leads to confusion and decreases our chances of fulfilling our needs (Rosenberg, 2015).

While NVC’s core elements of feelings and needs are grounded in person-centered and experiential theory, the elements of *observation* and *request* are both cognitive in origin (Beitman and Soth, 2006; Speed et al., 2018). Their role in the NVC process is justified by the interactive nature of communication, which is often prone to misunderstandings. NVC’s four steps of observation, feeling, need, and request are visible in the following expressions of a mother of a teenage boy:

"Felix, when I see two balls of soiled socks under the coffee table and another three next to the TV (Observation), I feel irritated (Feeling) because I want order in the rooms that we share in common (Need). Would you be willing to put your socks in your room or in the washing machine?" (Request) (Rosenberg, 2015, p.6). Table 1 presents a model of the interpersonal NVC process.

Table 1. The interpersonal NVC process

I express myself	**The NVC process**	**I hear you empathically**
I hear… I see…	**Observation**	You heard… You saw…
I feel…	**Feeling**	You feel…
I need…	**Need**	You need…
Would you be willing to…?	**Request**	You would like me to…

As the table shows, NVC is both a form of expressing ourselves and a process to guide us when hearing others. This gives NVC a true interactive character. The process provides us with a heuristic tool to communicate empathically, to express ourselves sincerely, and to "translate" people's messages to an experiential language, guiding their perception towards their feelings and underlying needs.

What can NVC add to EFT?

EFT emphasizes the importance of symbolizing and verbalizing feelings and needs in the therapy session. The focus of chair work rests on the client's intrapsychic dynamics of emotional experience and less so on how to change the outcome of current interpersonal processes. Although empty chair work does not explicitly exclude on-going relationships, the term 'unfinished business' indicates an approach that aims at restructuring schemes of old relationships and ultimately to say good-bye to the other (Greenberg et al., 1993, p. 260). Similarly, two-chair works target the different parts of the self (Greenberg et al., 1993, p. 187 and p. 216) and to a lesser extent the cumbersome interpersonal processes that clients are currently facing, including how the other receives the client's expression of needs.

Emotional awareness, regulation and transformation was later extended to the situations outside the therapy session (Greenberg and Warwar, 2006) yet with an explicit intrapsychic focus and no reference to current interpersonal processes. Limited attention is given to *the way* people should express these needs *in order for the other to hear it.* Surely if we express our needs, we should be interested in doing it in a way that our message will be heard. NVC's potential to complement EFT lies in the recognition that if we want to experience real change in our lives, we also must be able to communicate our needs to others in a way that it will be heard with compassion. This is not an easy task, as anyone who has struggled in cumbersome interactional patterns can testify. An EFT client who has become aware of his/her maladaptive emotion scheme in the safety of a therapeutic relationship and achieved change in this scheme, can still struggle to apply these new insights in emotion-laden social interactions.

Why is it difficult? Rosenberg thinks it has to do with the violent language people use. By violent language, he meant judgmental, evaluative language with detrimental consequences on human interactions. Two important points are relevant here. First, instead of gaining awareness of what is what we need, we are accustomed to think about what is wrong with other people when our needs are not fulfilled. When we negatively evaluate our counterpart's action, he/she will probably hear it as a criticism, leading to the activation of defense instead of listening to what we feel and need. Second, occasionally in difficult interactions, the other partner is not ready to hear our needs, even when expressed constructively before they are heard themselves with empathy (Rosenberg, 2015). To address these two issues, NVC proposes certain person-centered skills to express our needs and hear the needs of others with compassion.

Interpersonal NVC skills for EFT clients

Skills for compassionate communication can be explicitly taught and explicitly learned and could be helpful for EFT clients embarking upon the challenge of improving interpersonal relationships. The most important of these NVC skills include the *differentiation of observation from evaluation,* the *differentiation of feelings from thoughts*, the *separation of needs from strategies to satisfy needs*, the *importance of requesting without demand,* and *empathic listening*. Although these skills may seem at least partly intrapsychic in nature, the elaboration and specification of their interpersonal function make these skills explicitly interpersonal in the context of NVC, e.g., how is the expression of need received by the listener? Avoiding the caveats of evaluating the other and addressing his/her needs when appropriate expresses NVC's explicit focus on interpersonal processes. Nevertheless,

the ultimate goal in NVC is not to learn tools. C*onnection* with others is the goal, and the skills are merely a means to achieve this goal. In the following section, we will briefly review each of these key skills.

Observation versus evaluation: NVC reminds us that communicating observation without judgment is difficult (Eiser, 1975). Static generalizations are a typical example of evaluative speech. When we use words, such as *always* or *never*, or generalize adjectives, such as *lazy* or *careless*, we grossly generalize the current behavior of the other, typically leading to defensive reactions from his/her part. Instead, NVC encourages us to talk about what we observe in any concrete situation and describe our observation without a hint of evaluation followed by an expression of our feelings and needs (Rosenberg, 2015). This method will increase our chances of being heard because the other does not hear criticism and can concentrate on what we need.

To help participants train observation and refrain from judgments, NVC specifies several typical types of words that are highly evaluative in nature (Rosenberg, 2015). The main types include the following: (1) adverbs expressing temporal stasis (*always, never,* etc.); (2) adjectives expressing a character or an ability (*clever, inattentive*, etc.); (3) the verb "to be" expressing static adjectives (he *is* poor in mathematics) and verbs with evaluative connotations (*to exaggerate, to insult*). Several types of sentences are also specified as evaluative: presenting predictions we cannot know to be certain (e.g., she won't get her work done in time); generalizations about groups (immigrants don't take care of this); and inferences about another person's thoughts, feelings, intentions or desires (he is not motivated). Note that NVC does not require that we completely withstand evaluation. Instead, it requires that we maintain a separation between our observations and our evaluations. By avoiding static generalizations, we avoid defensive reactions and enhance our chances of a mutually fruitful interaction.

Differentiation of feelings from thoughts: The importance of the differentiation of thoughts and feelings in NVC is based on the observation that people tend to use words, such as "betrayed" or "manipulated", to express how they feel, attributing the cause of their feelings to others, preventing them from gaining ownership of their emotional experience (Rosenberg, 2015). NVC training makes a point of teaching people to use feeling words that truly express how they feel, helping them take responsibility for and subsequently owning these feelings. Responsibility for feelings is explicitly cultivated in NVC. What others do or say can be the stimulus of our feelings but never the

direct cause. Our feelings arise from needs as well as from how we chose to receive what others do and say.

Differentiation of needs from strategies: There is no one-to-one correspondence between needs and the strategies we use to satisfy them (Max-Neef et al., 1992). Needs do not require a specific action of a specific person and can be fulfilled in many different ways. Separating needs from the strategies to satisfy them will widen the perspective of clients and provide them with more flexibility when communicating their needs to important others, enhancing the chances of a mutually enriching interaction.

Request vs Demand: We must acknowledge that an interpersonal request is not equivalent to a demand. If we get a "no" as an answer and then get angry, we were not requesting but rather demanding from the other. Demands by others are experienced as controlling, thwarting our basic need for autonomy, and decreasing motivation, as research in self-determination theory has amply shown (Ryan and Deci, 2017, pp. 298). In EFT couples therapy, Johnson makes a point of distinguishing requests from demands (2004, p. 174), yet she does not elaborate how to proceed when the answer to a request is "no". Using the NVC process of communication, we are aware of the other and his/her autonomy to say *no* to our request. This does not mean that we need to put up with our unsatisfied need. Instead, NVC encourages us to "hear the yes in the no", meaning the underlying need of the other when he/she says "no" to our request. When we become clear about his/her needs, we can start thinking about new ways to satisfy our needs, leading to another request that might be more conceivable for the other to fulfil.

Empathic listening: When we are faced with a negative message and want to communicate compassionately based on feelings and needs, NVC presents a useful heuristic tool to orient ourselves in this process. According to NVC, we have four options for receiving a negative message: (1) blame ourselves, (2) blame the other, (3) focus on and express our feelings and needs, and (4) focus on and ask about the feelings and needs of the other. EFT clearly helps clients to change entrenched habits of blaming themselves, thereby reducing maladaptive splits or self-interruptive dynamics between different aspects of the self. EFT also teaches clients to focus on, become aware of, and express their needs. NVC can help clients to avoid blaming the other, learn to express feelings and needs in a way that is likely to result in being heard by compassion, and learn to listen to the other empathically when he/she is still unable to listen to our needs. In sessions, the EFT therapist facilitates the acquisition of these NVC skills by providing information on the model *and* through experiential methods, which is similar to chair work, thereby encouraging clients to

enact need expression using the structured NVC process. We will examine this methodology in the following section.

Integration of NVC to therapeutic work

An exhaustive presentation of the methods that NVC trainers use to teach skills is not possible here. The teaching methods vary depending on the length and intensity of the training. Methods are both cognitive and experiential in nature, with lengthier trainings emphasizing experiential exercises. This is very similar to 'hot learning' techniques endorsed by EFT (Greenberg and Paivio, 2003, p. 91). Regarding paper-pen exercises, the interested reader can gain ideas from consulting the original sources of NVC (e.g., Rosenberg, 2015, 2005).

NVC in a group format, the conventional form of NVC training, can be learned before, parallel to, or after an EFT process, benefitting participants in different ways. Group learning has many beneficial effects, e.g., inducing hope, reducing feelings of uniqueness, and increased agency by being in the role of the 'helper' (Ivanova, 2013; Yalom, 1995). Intensive NVC group trainings build heavily on experiential learning, enacting past, current or future interactional situations in small groups with the help of a certified trainer. Intensive NVC trainings can have powerful experiential effects on participants that are comparable to the encounter groups developed on person-centered principles (Proctor et al., 2019).

Vulnerable clients with substantial emotion regulation difficulties are unlikely to benefit from NVC given that mentalizing the needs of the other is likely not in their zone of proximal development (Vygotsky, 1986). Emotional vulnerability requires therapeutic validation, trust and safety. These clients will likely benefit from the NVC process if taught on an individual basis during the therapy session in the later stages of therapy.

Because EFT therapists are experts in person-centered principles of communication, they are well equipped to integrate NVC into the therapeutic process once acquainted with the basic elements of NVC. In many ways, teaching NVC skills to clients bares resemblance to teaching clients the very communication skills that therapists are using when communicating in session (Tolan and Cameron, 2017). Concentrating on interpersonal processes is particularly useful when chair dialogues represent conflict not only between different parts of the self but also clients' cumbersome recurring interactions with significant others. Introducing NVC is recommended in the later stages of therapy, in connection to the post dialogue phase of the EFT therapeutic tasks. Once the client has acquired

the basic principles of NVC, he or she can try them out in subsequent chair-work. In practicing NVC within EFT session, it is important to direct the attention of the client to the verbalization of feeling and needs, and never evaluate clients' utterances as right or wrong according to NVC. If the client expresses evaluative language, the therapist can gently ask "What do you observe?" or "What would you like to ask from this person?" It is good to emphasize that in empathic communication there is no right and wrong, there are only different needs.

Because teaching NVC skills comes from the therapist's frame of reference, imposing an external view of reality, it should be introduced with caution and consideration in a therapeutic process. This method should never be used when the client presents a marker of intense vulnerability requiring intense empathic listening and validation from the therapist. Although the teaching of NVC skills is not intended to be a homework task, the recommendations presented by Greenberg and Warwar (2006) for introducing homework in EFT sessions could provide useful guidelines for NVC. Specifically, interpersonal skills training should occur in the client's zone of proximal development and initiated when the client expresses a desire for learning about compassionate interactions.

When presented after the resolution stage in connection to the 'carrying forward' phase, the therapist helps clients to connect new NVC concepts to previous experiential learning. A self-determination theory perspective of psychotherapy (Ryan and Deci, 2017, p. 438) posits that the autonomy support gained through emotional validation enhances motivation for change. Relational depth experiences (Kim et al., 2020) in the completion of EFT tasks thus provide motivation for acquiring tools for compassionate communication.

Clinical example of an individual EFT and suggested complementary use of NVC

Greenberg et al. (1993, p. 161) present a therapy transcript of a systematic evocative unfolding task of an individual EFT session. The client describes in therapy her intense reaction to a friend's question "How are things with David?", a reaction that seemed to her unreasonable afterwards. During the process, she realizes that her friend's question reminded her of her discovery of that David is engaging in a relationship with another woman and her feelings of guilt about not telling this to him. At the end of the task, she accesses her need for and value of honesty in a relationship. The authors argue that achieving resolution, the client will have a sense of what she wants to change and may feel energized to initiate a change.

However, does this client know how to change in a way that will satisfy her needs? Can she communicate these feelings and needs to David in a way that he will hear it compassionately? In this transcript, at C4, the client states: "I know that if I tell him I know these things, he will get very defensive. He'll go nuts!" indicating not only fear and worry but also uncertainty about how to tell David about this and how to react if David gets defensively angry.

At this stage of therapy, the client might express a desire to talk to David about her feelings despite doubts about her ability to do so. In this situation, the therapist and the client might want to explore how to raise the subject and begin discussing the principles of NVC.

If interested in trying out NVC in practice, the client can go through, with the help of the therapist, the four consecutive steps of the NVC process (observation, feeling, need, request), helping her to orient herself in a feared, emotionally laden interaction. She can delineate, with the therapist, the difference between observation and evaluation, feelings and thoughts, as well as needs and strategies and understand the importance of request. Equipped with these heuristic tools and some in-session practice, she might be able to formulate to David something like the following: *"David, there is something I would like to discuss with you. I found a short note falling from your shirt pocket. A note from Betty referring to a kiss between you and her. (Observation). I feel guilty (Feeling) for finding and reading this note; after all, it is yours and I value privacy (Need). Still, I read this note, and upon reading it, I felt shocked, worried and angry (Feelings) because I value trust and honesty above everything in our relationship (Need). I have postponed talking about this with you because I was scared (Feeling) that you would be furious. I need to feel safe, and I need connection (Need). Can you please tell me what you hear me saying, and what this awakens in you? (Request)"*

If the client can communicate her experience without blaming, David will more likely hear and respond to her needs and request. In the therapy session, the client can also learn and practice NVC's empathic listening skills. If David gets defensive and angry, she could respond to him empathically based on training in NVC skills:

"I see that you are angry and disappointed (Feelings) that I've read a note that was written to you. You, too, value privacy and would like to trust that your privacy is respected (Need). At the same time, I cannot ignore what I know now (Observation) and need clarity and an understanding of what is going on (Need). Maybe there are things you were not ready to tell me before you

understood their significance. Would you be willing to discuss this issue with me now (Request)? Or if you need some time to think, could you suggest another time we could discuss this? (Need, Request)"

In addition to working with the client using other tasks, the therapist can offer to teach NVC to further support her in addressing the conflict in the relationship. NVC's explicit interpersonal elements provide the client with heuristic tools to communicate needs compassionately and hear David with empathy.

Can a therapist facilitate resolution when the conflict is not only between two sides of the self but also with significant people in the client's life? Some empirical evidence suggests that clients after EFT therapy report improved interpersonal relationships (Watson et al., 2003; Greenberg and Watson, 1998). However, this does not exclude the possibility that many clients would benefit from skills facilitating self-expression and the ability to hear the other in a more compassionate way, as indicated in the above-described clinical example. Some clients struggle with communicating in emotionally charged interpersonal situations and might desire and benefit from structured and instructional support based on person-centered and experiential principles to enhance their interpersonal emotion regulation and communication skills in challenging situations. NVC can be used to enhance therapeutic gains and assist clients in implementing intrapsychic insights in interpersonal practice.

Use of NVC in emotion-focused couples therapy

The goal of emotion-focused couples therapy is to restructure the relational bond of the couple such that they are able to express and hear each other's needs (Johnson, 2004; Greenberg & Goldman, 2008), leading to mutual affect regulation. In the model of Greenberg and Goldman (2008) this goal is achieved in 5 stages, consisting of 14 steps, through the guidance of the therapist, who after creating safety and developing a collaborative alliance with the couple (stage 1) reduces emotional reactivity by reframing their problems (stage 2). Stage 3 is characterized by deep processing of the emotional experiences of the partners. During this process, the therapist tracks, heightens awareness of, and validates the experiencing partner's emotional experience, helping him/her to gain ownership of these feelings and access to the underlying attachment needs. The therapist then facilitates partners to express needs to each other. During stage 4, the therapist guides partners to be able to hear and receive expressed feelings as well as attachment and identity needs, initiating mutual affect regulation (Greenberg and Goldman, 2008).

During stage 4, in the safety of the therapy session, partners are able to communicate to each other their needs and hear the other with compassion. Up to stage 4 and particularly though stage 3, the couple often present markers of intense vulnerability, requiring attentive empathic listening and validation from the therapist.

What happens in therapy in stage 4 can be conceptualized as an interpersonal emotion regulation process *with the therapist in charge*. Without the safety of the therapy session, the accepting attitude and validation of the therapist, the partners would not be able to express and compassionately receive the needs of the other. As the couple enters stage 4 they begin to take more initiative, and the therapist becomes less active and starts to hand over the interpersonal emotion regulation process to the couple, much like the facilitator of an encounter group gradually becomes redundant (Proctor et al., 2019). Here, the heuristic tools of NVC can be of help to the couple, i.e., from stage 4 to 5 at the end of the therapy, *when the couple increasingly takes charge of their interpersonal emotion regulation.*

At this stage of therapy, couples often express fears about not having the 'safety net' of the therapy sessions (Johnson, 2004, p. 193) and probably with good reason. As Rosenberg noted, most of us are not used to thinking in terms of needs. Instead, when needs are not fulfilled, we start thinking about what is wrong with the other (2015, p. 53), not with the process. The couple's fear is most likely grounded in an awareness of their lack of skills in regulating each other's emotions, justifying a need for a heuristic tool to assist them in this process. NVC tools can help them to feel more confident in their ability to maintain new interactional positions.

The steps of stage 5 can be enhanced with NVC's person-centered skills that rests on the same principles that facilitated the development of the couple's secure base during the previous therapy sessions. Research indicates that couples appreciate the use of such tools to enhance benefits gained during emotion-focused couples therapy (James, 1991).

We suggest three ways NVC can help couples consolidate new positions they achieved with the help of the therapist:

1. *NVC assists partners with a heuristic tool to take charge of their interpersonal emotional regulation.* EFT theory assumes that clients learn new behaviors through the therapist's

modeling of new ways to speak to and reach the partners by observing it. NVC provides additional structure and explicitly teaches the person-centered tools to communicate compassionately, leading to increased hope and confidence that the clients will manage on their own.

2. *NVC tools to communicate compassionately are not limited to attachment issues, but provide a general model of compassionate communication.* Johnson (2004) noted that many couples face life dilemmas that cannot be easily resolved. Living with these problems often requires mutual affect regulation that can be augmented by skills of compassionate communication, in line with the EFT-C model of Greenberg and Goldman (2008) that assumes that the mutual regulation of affect is a core motivating force in a couple's relationship.

3. *NVC training in a group format* can be an important experience for couples in EFT. Clinics offering EFT for couples can also organize special NVC training sessions. Learning NVC skills in a group has many benefits, and the most important is social learning (Yalom, 1995). The efficacy of such NVC group training for couples in enriching marriage quality has been reported by Vazhappily and Reyes (2017).

As with individual therapy, the EFT couple therapist can facilitate the acquisition of these skills by providing information on the model *and* through experiential methods, which are similar to chair work, encouraging clients to enact need expression with the help of the NVC process.

Discussion

What are clients, in both individual and couples therapy of emotion-focused orientation, longing for when they embark upon the therapeutic process? Arguably congruence and authentic connection with important others in their everyday lives. Introjected 'shoulds', disowned feelings, self-controlling actions are all examples of lack of emotional congruence (Greenberg et al., 1993), with implications for interactional difficulties. Clients long for being in touch with their lived experience, and their feelings and underlying needs not only when being on their own, but in particular when being together with significant others. They long for mutually enriching, satisfying relationships. In the therapy session, they work hard and courageously face their most vulnerable parts and difficult experiences in order to learn experientially about their needs, concerns and values. Still many, when leaving the safety of the therapeutic setting, struggle in emotionally laden social interactions and

feel a lack of competence in negotiating the tension between relatedness and autonomy (James, 1991; Johnson, 2004).

This article argues for supporting EFT clients' interactional emotional competence with a heuristic model for compassionate communication. Nonviolent communication is a person-centered tool for helping people to achieve connection with others while staying in touch with their lived experience. NVC grew out of the observation that people tend to use language in a way that alienates us both from our lived experience and from others (Rosenberg, 2015). Instead of connecting us, our use of language often distances us. NVC is a process that teaches us to think and communicate in terms of feelings and needs. Seeing and hearing these needs in others and ourselves connects us by helping us to recognize our common humanity.

Greenberg and Warwar (2006) showed that structured exercises can be successfully incorporated into an emotion-focused framework, enhancing therapeutic gains, as long as they stay aligned with person-centered, experiential principles. They emphasize the need to fashion uniquely the tasks to fit the client and to respond to the therapeutic context, while keeping tasks within the clients' zone of proximal development. NVC fits comfortably within the range of structured exercises developed by Greenberg and Warwar (2006). As Greenberg and Watson (1998) and Watson et al. (2003) have found, active interventions at appropriate points in the therapeutic treatment appear to hasten and enhance improvement in psychotherapy. Their findings indicate that chair dialogues implicitly improve interpersonal communication. Teaching NVC can explicitly teach these skills, and consolidate changes in clients' interpersonal functioning.

Rosenberg developed NVC as a communication tool for social interaction prone to result in conflict. Thus, he added the components of observation and request to the core components of feelings and needs, making it especially suitable for conflict situations. Training *observation* and abstaining from interpretation has been widely used within different therapeutic traditions (Beitman and Soth, 2006), and has gained further attention in the last decade from mindfulness-based interventions (Kabat-Zinn, 2012). Furthermore, observations help us focus on feelings and needs by freeing attention from self-defense and fruitless argumentation that results from opposing interpretations of a given situation. Making *requests* to important others in which we clearly express what we need is also an element that has received support within the field of cognitive and developmental psychology pertaining to educational and parenting practices. Telling people clearly

and concretely what we need is an important element of self-assertiveness (Speed et al., 2018), enhancing the well-being of both parties.

From the perspective of research, the theoretical similarities of NVC and EFT provides a good opportunity for exploring a fruitful integration of the two. Conventionally, research in emotion regulation has had an intrapsychic focus (Zaki and Williams, 2013). However, the emerging new field of interpersonal emotion regulation that emphasizes the social embeddedness of emotional experience (Hofman, 2014) might lead research in person-centered and experiential therapies back to its roots. Carl Rogers repeatedly expressed that it is the relationship itself, which is characterized by congruence, together with the lived experience as well as the acceptance of and prizing of the other person that accounts for personality change and growth in psychotherapy (Rogers, 1957). He also explicitly hypothesized that this relationship does not need to be unique to psychotherapy. Humans thrive and flourish when they experience everyday relationships characterized by the same specified conditions (Rogers, 1967). His student Marshall Rosenberg took Rogers' idea seriously and developed NVC to help people acquire such relationships.

Further research could elaborate and scrutinize the exact method of integrating NVC to EFT's different therapeutic tasks. In particular, the integration of the NVC process to into different types of chair work might be an important contribution. The author's experience is that if clients become interested in the NVC process, they will experiment with NVC communication in connection with the subsequent chair-work, e.g., how an NVC expression of need 'tastes' as opposed to an expression without NVC, and how the listener may react to these two types of expressions. We hope that this paper provides an initial inspiration for research-oriented therapists to contribute to such integration.

The most evident opportunity for further research is on interpersonal emotion regulation through the introduction of the NVC process in EFT couple therapy in the end stage of therapy (Greenberg and Goldman, 2008). As a person-centered approach, EFT has developed excellent tools to support clients' needs for autonomy and relatedness, two out of the three basic needs, which four decades of solid empirical research on self-determination theory has postulated to be necessary for self-regulation and psychological well-being (Sheldon, 2013; Ryan and Deci, 2017). In facilitating individual responsibility for interpersonal emotion regulation, NVC's person-centered, heuristic model could complement EFT to support couples' third basic need, namely, the need for competence.

There is an opportunity for the NVC community to contribute to the discourse on the psychological benefits of compassionate communication. Collecting empirical evidence of NVC's psychological benefits is difficult, because the nature of these effects do not easily rend themselves to measurement (Jundacella, 2013). Still, recent years have brought empirical research supporting the benefits of NVC (Marlow et al., 2012; Cox and Dannahy, 2005; Suarez et al. 2014; Lee et al., 1998; Museux et al., 2016). Wacker and Dziobek (2018) found that NVC training of health workers prevented empathic distress and social stressors, whereas Nosek and Durán (2017) presented improved skills in conflict resolution skills. NVC has also been used to enrich peace education among university students (Baesler and Lauricella, 2014), and to foster dialogue and authenticity among nurses (Nosek, 2012). Embedding NVC within the solid theoretical framework of EFT would further facilitate the opportunities for empirical investigation.

Conclusion

NVC tools explicitly address interpersonal dynamics while still maintaining a person-centered framework. The interpersonal NVC process is a potential tool for EFT clients to facilitate the communication of needs in a manner that will likely result in compassion and increased listening to the other with empathy. When clients gain access to the emotion schemes underlying their emotional experiences and, within the safety of a therapeutic relationship, reach a point in which constructive emotional expression is possible, they may benefit from the NVC skills of communicating feelings and needs constructively. NVC can help clients apply the insights gained in EFT to different situations and everyday interpersonal interactions, thus potentially improving important relationships.

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