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RESEARCH ARTICLE

Psychodynamic psychotherapists' perceptions of change: A phenomenological analysis

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ABSTRACT

Objective: This qualitative study aimed to investigate how experienced psychodynamic psychotherapists conceptualize change in psychotherapy by engaging in guided reflection on their professional experiences. **Method:** Eight psychodynamic therapists participated in the study, with four females and four males. Semi-structured interviews were conducted within a phenomenological-hermeneutic research framework, focusing on several key themes related to the change in psychotherapy. Then, phenomenological categories were identified through a consensual content analysis, applying an inductive approach. **Results:** Through an iterative analysis, nine overarching themes and their respective subcategories emerged: (a) Orientation; (b) Motivations For Choosing to Train in the Psychodynamic Approach; (c) Areas of Intervention; (d) The Relational Space as the Foundation of Therapy and the Process of Change; (e) Focusing, Exploring, and Processing the Patient's Internal States; (f) The Tools of Change in the Psychodynamic Approach; (g) The Subjectivity and Experiences of the Therapist; (h) New Conceptions of Change in the Psychodynamic Approach; (i) Change as an Unpredictable Process Difficult to Model. **Discussion:** The findings underscore the importance of employing qualitative methods to study psychotherapy change, as its complexity cannot be easily reduced to simplified models.

Keywords: psychotherapy change; psychodynamic psychotherapy; phenomenological-hermeneutic approach; psychotherapists' perceptions; psychotherapists' experience

Clinical or methodological significance of this article: The findings underscore the central role of the therapeutic relationship, the importance of tailoring treatment to individual needs, and the recognition of each patient's uniqueness as a key variable in therapeutic work. The qualitative approach may yield more adherent and realistic change models that are beneficial for clinical practice, aiming to bridge the gap between practice and research.

Although there is consolidated evidence that psychotherapy is effective (e.g., Dragioti et al., 2017), the underlying mechanisms of change—why and how it occurs—remain less understood. Over the past few decades, process research has sought to identify key factors contributing to therapeutic outcomes and develop research process models that illustrate the phases and dynamics of change in psychotherapy, such as the theory of common factors or the sequential phases of the process. These models have undoubtedly facilitated progress in process research, operationalizing variables, and enabling a more systematic investigation of change mechanisms. Their notoriety is also highlighted by the fact that many scientific articles use these models as a framework in psychotherapy research, thereby constituting a solid scaffolding.

However, despite their advantages, these models are based on a series of simplifying assumptions that may not adequately capture the complexity of clinical practice and may contribute to the gap between research and practice by overlooking the

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dynamic, individualized, and context-sensitive nature of therapeutic processes.

For instance, the separation between common and unique factors may reflect a false dichotomy (Castonguay, 2000; Cuijpers et al., 2019). Unique mechanisms frequently operate across multiple therapeutic approaches, and common factors may be deeply embedded within specific modalities. For instance, cognitive restructuring can also be found in other models, although it is central to cognitive therapy (Lemmens et al., 2017). Similarly, Goldfried (1980) proposed a transtheoretical perspective on change principles, emphasizing that specific mechanisms can be both general and uniquely expressed depending on the therapeutic context. Twomey et al. (2023) found widespread agreement among nearly 2,000 therapists on the relevance of these transtheoretical principles, regardless of age, gender, setting, or level of experience.

Furthermore, stage-based models, such as the transtheoretical model (Prochaska & Diclemente, 1986) and the phase model (Howard et al., 1993), propose distinct phases for psychotherapy; however, the distinction between stages may be arbitrary. Specifically, patients frequently exhibit diverse trajectories that do not conform to sequential stages (Callahan et al., 2006; Mander et al., 2013), and such frameworks may not align with real-world clinical experience. As Molenaar and Campbell (2009) argued, conceptualizing change as uniform and sequential risks lacks a fit related to the real clinical process. Indeed, over the past two decades, psychotherapy research has increasingly recognized the heterogeneity of change, leading to efforts to model different change trajectories across patient groups (e.g., Koffmann, 2018).

Moreover, the notion that change occurs linearly and gradually has been increasingly contested. Research suggests that change often happens nonlinearly, through sudden shifts or early rapid gains (Hayes et al., 2005; Hayes & Andrews, 2020; Tang & DeRubeis, 1999), which challenges models that assume steady progression.

Ultimately, it is possible to conclude that although assumptions enable modeling and understanding a phenomenon, they can oversimplify complex processes such as psychotherapy change. Therefore, dynamic and flexible conceptualizations of change that better capture the variability observed in clinical practice are needed. Qualitative methods might represent a valuable means of capturing this variability.

Understanding How Psychotherapy Works through Qualitative Research

Qualitative methodologies provide a way to explore the complexity of psychotherapy change by focusing on personal experiences and individual heterogeneity. Precisely, qualitative methods can capture the meaning behind the experiences of clinicians and patients. Moreover, qualitative analysis enables an in-depth examination of physical and social contexts, as well as the process through which experiences evolve (e.g., Levitt et al., 2024; Maxwell & Levitt, 2023). As a result, there has been a growing call to integrate qualitative research into the study of psychotherapy processes research (e.g., Cuijpers et al., 2019; Maxwell & Levitt, 2023).

Qualitative studies have highlighted key patient experiences that contribute to change. For instance, patients perceive the therapist's emotional and technical competence as a crucial change factor. Qualities such as warmth, empathy, active listening, and professional competence help establish a trusting therapeutic relationship, making patients feel understood, reassured, and supported (Dourdouma et al., 2020; Levitt et al., 2006; Timulak, 2007). Additionally, patients view themselves as active agents in the change process, emphasizing the importance of engagement, readiness, and willingness to change. Self-exploration, self-understanding, and self-discovery are fundamental elements that enable individuals to deconstruct and reconstruct their self-perception, ultimately leading to increased self-awareness (e.g., Dourdouma et al., 2020; Ladmanová et al., 2022; Timulak, 2007).

Tzur Bitan et al. (2022) identified several key processes that therapists thought contributed to meaningful change in psychotherapy. These included the therapeutic bond (e.g., openness, trust, secure environment), therapist characteristics (e.g., empathy, flexibility, curiosity), professionalism (e.g., theoretical knowledge, setting, treatment planning), theory-driven mechanisms (e.g., transference interpretations, object relations, containment, defense mechanisms), client motivation, client characteristics, cognitive processes (e.g., psychoeducation, cognitive restructuring), and a final cluster for general or undefined mechanisms. Overall, the therapeutic alliance remains a fundamental factor, aligning with previous research that highlights its role as a primary mechanism of change and reinforcing the idea that effective therapy is rooted in relational depth, collaborative engagement, and the integration of both general and theory-specific techniques (Gyani et al., 2015; Stamoulos et al., 2016). This evidence shows how qualitative studies can identify factors of change that explain how the therapy works.

The Phenomenological Approach to Psychotherapy Research. While qualitative research has significantly contributed to understanding psychotherapy change, many approaches, such as thematic analysis, grounded theory, and discourse

analysis, often focus on identifying patterns, constructing theoretical models, or analyzing linguistic structures. However, these methods may overlook how the dimension of change is felt, internalized, explained, and experienced by patients and therapists. The phenomenological approach fills this gap, focusing on the subjective experience and meaning associated with a phenomenon. Specifically, change is a phenomenon that both patients and therapists actively perceive and experience. Hence, phenomenological analysis offers a valuable method for exploring the factors and processes underlying therapeutic change and how they are experienced.

The phenomenological approach has been widely applied to various aspects of psychotherapy, including perceptions of treatment adherence (Dean et al., 2005), therapeutic alliance (Bachelor, 1995), significant moments of connection in therapy (Duarte et al., 2020), and general experiences of the therapeutic process (Iwakabe et al., 2022). In psychotherapy change research, it has primarily focused on the patient's perspective. For example, Binder et al. (2009) conducted a phenomenological analysis of patients' explanations for why they changed in therapy, identifying four core themes: forming a trusting relationship with an insightful, empathetic, and competent professional; maintaining a stable therapeutic connection to counteract internal fragmentation; revising self-perceptions and personal assumptions; and developing new insights while recognizing recurring life patterns. Similarly, Sousa and Vaz (2020) emphasized the significance of self-awareness, insight, behavioral changes, empowerment, emotional relief, and the therapeutic relationship as essential for fostering understanding, connection, support, reassurance, and active participation in therapy. Murray (2002) further explored the transformative aspects of therapy, revealing that increasing self-awareness for self-reflection, engaging in corrective emotional experiences, experiencing catharsis, and uncovering one's authentic self can lead to a sense of transcendence, marked by greater self-acceptance, autonomy in decision-making, and inner peace.

Furthermore, Spinelli (2015) identified different ways patients relate to change: minor changes that do not challenge one's self-concept tend to be accepted automatically without conscious reflection, while more substantial changes may be embraced when recognized as meaningful and beneficial. However, modifications perceived as undesirable, threatening, or intolerable can provoke discomfort and resistance, leading patients to reject or struggle with them.

Understanding how patients experience change and what they perceive as helpful enables therapists to refine their clinical approach, prioritizing the factors that research identifies as most beneficial. By aligning therapeutic interventions with the aspects of change patients find meaningful, clinicians can enhance the effectiveness of psychotherapy and better support the transformative process. In contrast, no research has specifically employed a phenomenological analysis to explore psychotherapists' experiences regarding the factors and processual nature of change in psychotherapy. However, therapists' perceptions are essential for understanding the nature of change, allowing for the development of explanatory models of change grounded in their experiences and bridging the gap between clinical practice and research.

Aim

Therefore, the study aimed to qualitatively examine therapists' perceptions of the factors and processual dynamics of change through in-depth interviews and a hermeneutic-phenomenological approach to their lived experiences.

Method

Participants

The study involved eight individuals, comprising four males and four females, with gender equivalence achieved randomly and not planned by the authors. All participants were associated with Florence's CRCPF (Psychoanalytic Research Center for Couples and Families). They were experienced psychotherapists specializing in psychoanalytic or psychodynamic approaches, and they practiced in public services, institutional contexts, or private settings. The age range was from 40 to 60 years, and each participant had at least 10 years of professional experience.

Instruments

An ad-hoc interview was designed to explore therapists' perspectives on changes within psychotherapy. The interviews followed biographical and phenomenological methods (Bichi, 2002; Montesperelli, 2001; Smith et al., 2009; Tong et al., 2007). The biographical—or in-depth hermeneutic—interview provides a comprehensive account of a person's meaningful experiences. Its open-ended and non-standardized format allows participants to share their interpretations, evaluations, and experiences freely, enabling the researcher to understand how they perceive the world. The research team collaboratively determined the initial questions, forming a flexible framework or guideline that was open to adjustment based on critical issues, participant feedback, or unexpected themes that emerged during the

study. However, no adjustments were required in this research since no unexpected feedback, critiques, or unanticipated topics arose during the process, leaving the interview framework unchanged.

The interview covered several thematic areas, including participants' descriptions of their therapeutic orientation, the motivations behind choosing a psychodynamic approach, and their career evolution. Additional questions explored their understanding of change within their therapeutic framework, their ability to differentiate between general factors and those specific to particular clinical contexts or patient profiles, and how their perception of change had evolved throughout their careers. Participants were also asked to discuss any discrepancies between theoretical models and their practical experiences, reflect on the processual nature of psychotherapy-related change, and identify any significant aspects they believed had been overlooked during the interview (see Appendix 1 for the detailed interview framework).

Procedure

The study received approval from the University of Florence's Ethical Commission.

First, a group meeting was organized to introduce and explain the research objectives prior to the data collection phase, serving exclusively as an informational session. Therapists from the center who were interested in the research were invited to participate in this meeting. In total, 12 people were present who declared their willingness to participate and shared their email contacts. Subsequently, the first author contacted the therapists by email, and only eight agreed. The other four did not respond to the invitation. Participation was voluntary, and no incentives were offered.

Data collection took place between October 2022 and December 2022. To accommodate participants' professional schedules, interviews were conducted online. Only the participant and the first author were present during each session. Each interview lasted approximately 30 minutes and was audio-recorded, transcribed, and anonymized.

The interviews followed biographical and phenomenological methods (Bichi, 2002; Montesperelli, 2001; Smith et al., 2009). Each session began with an open-ended statement to elicit participant input on a specific topic (e.g., "To start, we would like you to describe your orientation as a psychotherapist"). The researcher aimed to establish a symmetrical relationship with the participant, fostering a "biographical pact" based on mutual trust and clarity regarding the study's objectives. The interviewer adopted a listening-focused, empathetic, and nonjudgmental approach, following a phenomenological orientation that involved suspending personal biases and assumptions (epoché) to gain a deeper understanding of the participants' perspectives. The non-directive nature of the interview allowed participants to navigate through the topics in their preferred sequence freely. The researcher intervened only to clarify the participants' statements, trying to capture the essence of participants' experiences without imposing external points of view or biases. Although the interviewer guided the discussion to explore specific themes, the process remained flexible, allowing the interviewee to shape the interaction. As such, each interview was unique, characterized by its unrepeatable and singular nature, influenced by the dynamic interaction between the researcher and the participant.

Data collection ceased after the eighth interview, as researchers had evaluated saturation in a group meeting. Specifically, after reading the interviews in full, it was agreed by consensus that the interviews adequately covered the themes that the article aimed to investigate and that further testimonies would have produced redundancy. The number of participants and saturation evaluation were in line with the minimum standards for phenomenological research (e.g., Creswell, 2013; Moustakas, 1994).

Data Analysis

The Research Team Dynamics. The team consisted of three members: the first author, a psychologist with a Ph.D.; a university professor trained in psychoanalytic psychotherapy; and a student pursuing a master's degree who held a bachelor's degree. The team was familiar with the field of psychotherapy research, the most well-known change processes in the literature, the nature of change, and various theoretical models. Consequently, members attempted to bracket their knowledge during the analysis process to adopt the participants' perspectives, setting aside personal preconceptions, knowledge, and biases. Specifically, all team members were asked to suspend their judgment and "pretend" to no longer be experts on a specific topic, to capture the meaning and create categories as closely as possible to those used by the participants in their interviews. Additionally, each member was tasked with warning one another if they perceived that they were using prior knowledge in their data analysis. Finally, to address power dynamics resulting from differences in seniority and academic grades, we fostered an open and collaborative environment during analysis meetings, where all team members were encouraged to question interpretations critically and suggest alternative

readings. For example, each team member could propose changes to the categories proposed by the other members. Decisions were reached only through consensus.

Phenomenological-hermeneutic analysis. In the initial familiarization stage, each team member read the interview transcripts independently. First, potential interviewing conduct biases were assessed, but none were reported. Second, the team member had to evaluate saturation independently and discuss its achievement in a meeting. Subsequently, each member segmented the interviews into meaning units that represented the key elements of the experiences described by the therapists. These meaning units were identified and refined during multiple in-person meetings, while redundant or irrelevant content was excluded. The meaning units were then grouped into broader thematic areas representing core aspects of the phenomenon under investigation (i.e., psychotherapy change). These thematic areas were further categorized into phenomenological categories using an inductive approach guided by the principle of phenomenological evidence, which implies that each category must be grounded in meaningful and recurring excerpts from participants' lived experiences, rather than being based on theoretical assumptions or speculative interpretations. All identified themes were systematically searched for across the entire dataset to ensure their presence was not limited to individual cases. Category names were determined through a process of consensual validation within the research team. Each category was initially proposed by one team member and subsequently discussed, revised, and finalized collectively until complete agreement was reached. The category formation process was iterative, continuously updated, and refined as new insights emerged from the analysis. After the results were obtained and finalized, the findings were presented to the participating therapists during an in-person meeting to ensure clarity, validate interpretations, and foster collaborative understanding. No substantial objections were raised by participants, confirming the overall validity of the categories.

Results

Based on the analysis, nine phenomenological categories was coded: (a) Orientation; (b) Motivations For Choosing to Train in the Psychodynamic Approach; (c) Areas of Intervention; (d) The Relational Space as the Foundation of Therapy and the Process of Change; (e) Focusing, Exploring, and Processing the Patient's Internal States; (f) The Tools of Change in the Psychodynamic Approach; (g) The Subjectivity and Experiences of the Therapist; (h) New Conceptions of Change in the Psychodynamic Approach; (i) Change as an Unpredictable Process Difficult to Model. This article will focus on categories "d," "e," "f," and "i" (see Table I for

Table I. Summary of phenomenologic anlaysis.

Category	Summary
The Psychoanalytic-Psychodynamic Orientation of Therapists	Therapists identify with psychoanalytic or psychodynamic orientations.
Motivations for Choosing to Train in the Psychodynamic Approach	The choice is influenced by personal affinity with psychodynamic thinking, passion for understanding the unconscious, clinical usefulness, and work experience in the field.
Areas of Intervention	Work in public mental health services, hospitals, private practice, therapeutic communities, and supervision activities, addressing individual, family, and group therapy.
The Relational Space as the Foundation of Therapy and the Process of Change	The therapeutic relationship fosters transformation through subjectivity, relational models, trust, and shared experiences between therapist and patient.
Focusing, Exploring, and Processing the Patient's Internal States	Change occurs through emotional processing, internalization, symptom interpretation, and an expansion of awareness of mental states, behaviors, and events.
The Tools of Change in the Psychodynamic Approach	Key change mechanisms include emotional listening, theoretical training, setting adaptation, patient-centered interventions, transference interpretation, and structured/unstructured therapeutic approaches.
The Subjectivity and Experiences of the Therapist	The therapist's subjectivity, experience, personal growth, and adaptation influence therapeutic processes, with a shift from idealization to eclectic perspectives.
New Conceptions of Change in the Psychodynamic Approach	Different theoretical models and perspectives on change exist, requiring integration, reinterpretation of classic theories, and a shared language in psychotherapy.
Change as an Unpredictable Process Difficult to Model	Change is unpredictable, individualized, and non-linear, depending on patient variability, back-and-forth progress, and the unexpected nature of human transformation.

the summary of categories and Appendix 2 for the complete list). The latter choice is based on considerations of manuscript length and on researchers' consensus that these categories are the most representative of how therapists perceive change in psychotherapy.

The Relational Space as the Foundation of Therapy and the Process of Change

The category encompasses the therapeutic factors identified as central to fostering change through the relationship between therapist and patient. For example, therapists emphasized the development of subjectivity in both parties and the mutual transformation occurring within the therapeutic dynamic.

> Interview 1: I think that every human being has the right to fully develop their characteristics, whether they are personal or familial. This [idea] also applies to the therapist because every time a therapist meets a patient, they encounter a situation where they must question themselves, and their subjectivity resonates. With the suffering of others, we are forced to retouch our [personal] issues [i.e., conflicts]; I would define subjectivity as the potentialities and the limits that exist in every human being.

Therapists described how the patients' internalization process of the therapist figure influenced their everyday life interactions and generalized to relationships outside the therapy.

> Interview 3: You see changes that occur not only in the therapeutic relationship but also in other relationships during the life outside the treatment [setting].

> Interview 6: The internalization of the therapist means that the patient carries inside the experiences that emerge in the session, which can then be reapplied in other relationships in daily life.

Therapy offers a new relational experience, enabling patients to feel and think differently and engage in novel ways with themselves and others. Listening to patients fosters a sense of being understood and accepted, which is essential for establishing mutual trust and promoting change.

> Interview 6: The new possibility of experience that is created in the relationship with its crises and its resolutions and satisfactions; a chance for a different type of relational learning that breaks somewhat from the patterns carried since childhood; the patient has the chance to engage in a new way or to observe themselves.

> Interview 7: Among the general factors, I would include the relationship with the patient and the fact that they feel welcomed, not judged, and understood. This [aspect] can be present in every type of orientation because it is based on the relationship; the patient perceives that we are there to listen and to be together.

Psychodynamic therapy was described as uniquely focused on continuously analyzing the therapeutic relationship in the here and now, differentiating it from other orientations. This focus enables transformative work at an emotional and unconscious level. Psychodynamic psychotherapy is perceived as less structured and without a protocol to follow.

> Interview 4: A change in the internalized relational models through the therapeutic relationship, which is impactful, a relationship that can represent a new and emotionally corrective relationship. This, I believe, is what differentiates the psychodynamic model from other models of psychotherapy, which certainly have transformative objectives but are less focused on the here-and-now therapeutic relationship, what happens moment by moment. The specificity lies in the fact that this relationship is continuously analyzed.

> Interview 7: Psychodynamics is not directive work but is more listening-oriented and focused on the emotional side. This, in my opinion, is the main aspect because other psychotherapies focus on tasks to do and protocols, tasks to be performed. The analysis of transference and countertransference is specific to patients.

The notion of a collaborative "we" in psychotherapy was also identified as a key aspect of processuality to build the therapeutic alliance. Creating this shared dynamic between therapist and patient was essential to explore, address, and resolve problematic areas collaboratively.

> Interview 1: At a certain point, there must be a "we" in psychotherapy. If this occurs, there will surely be a transformation; otherwise, it will be very difficult for it to happen.

> Interview 3: When you meet the patient with a more or less established and defined setting, whatever it may be, you feel you start to work because that therapeutic alliance has been established in which, somehow, the components of the relationship get more comfortable working on certain problematic areas or deepening understanding.

The notion of recognizing otherness was emphasized as a transformative element in therapy. Therapists described this as a significant shift that occurs when the patient acknowledges the therapist not only as a professional but also as a person.

> Interview 1: The real transformation is when there's a couple's relationship in which the other is

> recognized. So, when the therapist is recognized as an object, […] and recognized as a person, not just as a specialist, there has been an important change. Still, much depends on what the therapist can invent and the degree of transformation foreseen inside his/her mind.

Trust was identified as a cornerstone of the therapeutic process, with therapists highlighting its role in fostering deeper engagement and exploration. They described trust as evolving into reliance, which allows patients to confront more intimate or vulnerable aspects of their experiences.

> Interview 2: Usually, the patient or the person needs to reach a point of reliance, not just trust. This is the first step. The last phase is one of reliance, to see the therapeutic process as the development of reliance, thus the development of transference in practice; the last phase is the possibility that the person talks about their sexuality, not the obvious one, but their sexual fantasy.

Finally, therapists described how participants often share a collective fantasy of unity in group settings. This initial phase fosters cohesion and sets the stage for further group therapeutic work.

> Interview 2: If you want to translate this aspect from an individual level to the level of groups, for example, Claudio Neri talks about the group's fantasy of being all one in the initial phase of a psychotherapeutic group. When the participants of a group manage to fantasize about being all one, the first phase has been achieved.

Focusing, Exploring, and Processing the Patient's Internal States

The category captures the change of patients' internal world, fostering self-awareness, emotional tolerance, and new understandings. For instance, the symptom was described as a key entry point into the patient's subjectivity, acting as a proxy for personal, familial, or societal dynamics.

> Interview 1: Understanding the value we give to a patient's symptoms is important. The symptom is an element, […], that helps us enter into the mind and functioning of the individual and their personal history. The symptom is an important access point for defining subjectivity; the symptom is a proxy for the patient, a community situation, or a family group.

Therapists highlighted the concept of psychic digestion, referring to the patient's ability to tolerate, process, and integrate emotional experiences. This involves developing a capacity to engage with emotions rather than being overwhelmed.

> Interview 2: In a Bionian sense, the model is that of the alpha function, my capacity to digest the psychic and emotional elements that I happen to live through, […], that is, of its psychic apparatus to digest emotions and experiences; it's a development of the person's capacity to live experiences, to hold them within themselves, to use them, chew them over, and not be overwhelmed by them.

Therapists also emphasized the need to widen the focus of therapy to access the patient's most intimate experiences. This involves moving beyond surface-level issues and exploring deeper emotional and psychological themes.

> Interview 2: Then there's a second phase that will involve […] the person's narrative regarding the focus of discomfort […], the reason they come, what often will be the theme [and] the content during the sessions. So, the subsequent phase is widening the focus so that a person brings their discomfort and then goes beyond to reach the most intimate experiences.

Therapists discussed the importance of fostering a new understanding and a new way of perspectives about mental states and events. This includes being able to interpret internal phenomena autonomously, increasing awareness of internal objects, unconscious meanings, and mental functioning. This new understanding affords greater degrees of freedom, enabling individuals to adapt more effectively and respond to their environment.

> Interview 7: Increasing awareness with respect to our internal objects and how we relate to them; becoming aware of how we function, observing ourselves, and managing to understand our mental functioning.

> Interview 8: The other aspect is the patient's progressive ability to perceive aspects of themselves without my intervention.

Finally, therapists emphasized that change is deeply connected to shifts in the patient's way of feeling and processing their internal experiences.

> Interview 2: From the perspective of approaches and conceptions that heavily rely on the inner world—since there are various psychoanalyses—I believe that change is tied to changes in the person's way of feeling.

The Tools of Change in the Psychodynamic Approach

The category highlights the various mechanisms and strategies employed in psychodynamic therapy to facilitate change, with a particular emphasis on emotional, relational, and contextual factors.

The change process begins with anamnesis, assessing the patient's clinical and developmental history to plan interventions, objectives, and set expectations for change.

> Interview 5: It depends a lot on what the patient or patients ask, […], their clinical history, but also their developmental life history, which then leads them to seek consultation or intervention in mental health; what issues you go on to identify at the level of psychopathological diagnoses. Based on this, you plan an intervention; thus, the changes you can expect are consequential to this approach.

Therapists identified consultation to analyze requests and problems as the first phase of therapy, where initial interviews can already lead to change. Problems may arise if this phase is rushed or skipped, since it may compromise the development of a shared therapeutic frame.

> Interview 3: Clearly, there is a first phase that has to do with the consultation. It usually involves initial interviews with the patient, and there is already a change. [There is a problem if there is] a consultation phase where the person coming already knows what they want to do perhaps very quickly, brings clinical material, and induces you to go too fast. It happens that when there's "too much fullness" in the interviews, and you don't ask why, then there's a poor reflective attitude with respect to what happens within the interview. The risk is that then, for some reason, [the patient] does not continue with the care.

Several factors external to the therapeutic process were also seen as influential. These include the context of the intervention and the psychic and physical elements of the setting, such as light, physical contact, language, encompassing verbal, paraverbal, and bodily communication.

> Interview 3: In my opinion, the place where the intervention occurs or where psychotherapy begins is very important because it greatly conditions the work and the type of work; in the case of couple or family work within a public institution, it's completely different compared to a path within a professional studio.

> Interview 5: The physical environment where you carry out the explanation of what happens; the smell of the environment, physical contact, the light, the gaze, the very environments where it is located, the hours of the day. The language you use to speak, the verbal, paraverbal, bodily aspects, the clarifications.

The therapist must be free from personal desire to change patients, accepting that sometimes change is not possible at a particular moment.

> Interview 1: Often, changes are not possible […], but this does not mean that we have failed. We must take into account what is possible for the patient; We must […] aesthetically enjoy the fact that the patient returns, and we must have an assumption as much as possible, as Bion said, with little memory and desire, we must not have the desire for change, the patient must have it, not us.

Therapists identified emotional listening as a central tool, describing it as a process of attuned, non-directive listening that fosters connection and understanding.

> Interview 7: Psychodynamics is not directive work but more listening-oriented and focused on the emotional side. The patient perceives that we are there to listen and to be together.

Therapists described adapting the model as essential to addressing the patient's individual needs, even if it meant modifying traditional practices or theoretical frameworks. Indeed, the model is diluted based on a person's request.

> Interview 5: The theoretical model of reference of therapists […] must be diluted; Based on […] the analysis of the request that you make to the person, you can also go on to choose different intervention modalities not based on your exclusive model but on what are the needs and evaluate on that the changes that occur.

> Interview 8: I believe that the model must always adapt to the patient and not vice versa; that is, the patient must adapt to the model.

Integration—bringing together fragmented aspects of the psyche—was highlighted as a key therapeutic goal, although reaching this phase requires significant trust.

> Interview 2: Integration is the focus of psychotherapeutic work, to integrate and put together in the face of defenses that are instead to deny, split, rationalize, etc. When you get to this phase, there is a very high level of trust; sometimes, you never get to this phase.

Therapists emphasized the importance of the therapist's unconscious in overcoming impasses and facilitating more profound transformation.

> Interview 7: The therapist must also get involved, asking why we are stopped and not only why the patient is stopped. Therefore, also working on oneself, if there's something at the unconscious level that is transmitted to the patient, something that the patient involuntarily recalls to us. There are often periods when it seems there is no change and that everything is blocked, sometimes even for a year. [We need to] stay [on countertransference] and perhaps face it even with the patient.

Similarly, resolving patients' transference is a key to therapy progression.

> Interview 8: Change is obtained at the end of the entire journey, which, as I said at the beginning, occurs in the resolution of transference. The transference can be interpreted, and the analytic couple shares this heritage. [Change is obtained] working with transference and on the unconscious.

Therapists can use different means to consolidate change, such as the families of patients.

> Interview 6: The aspect is more than anything else: […] how to help the patient to take it [i.e., the change] away with them in the greatest measure. In some cases, they can carry it within themselves. In other cases, they cannot do it either because they are too ill, too young, or because it takes too much time, and then it's important to use different devices or question oneself about the device. [For example,] to accelerate the phases of change and to help a greater consolidation, sometimes it's very important to involve the family.

The conclusion phase often involves processing separation and can be remarkably delicate.

> Interview 4: There is indeed a phase of processing the conclusion, of separation from the therapist. That, too, is a very useful conclusive phase of therapy.

Finally, the training in the clinical theoretical model is perceived as fundamental, as change is more likely if therapists understand theories, techniques, and interventions.

> Interview 1: There are specific factors that have to do with training, theories, and specific interventions; We must ask ourselves if we have a theory of the patient's mind; for example, this refers back to our training.

Change as an Unpredictable Process Difficult to Model

The category explores the inherent variability and non-linearity of the therapeutic change process. Therapists highlighted that change is difficult to predict and cannot be fully generalized or modeled.

> Interview 7: In my opinion, there can be phases, but it's difficult to generalize them. Apart from the classic standard initial and final phases that are easily distinguishable, the journey in the middle depends on the patient. What's in the middle is very variable, and it's difficult to find phases.

Therapists often described change as a process of "anda e rivieni" (back-and-forth), where progress is not linear but rather oscillates between moments of transformation and moments of stagnation or regression.

> Interview 8: It's a motion that seems to me to observe slow and transformational. Surely, it can be observed, as a motion of back and forth, on aspects of change and aspects that instead take back, and surely progressive changes can be observed over time.

Finally, the patient's individuality was also identified as a critical variable shaping the change process. Therapists recognized that the process depends significantly on the patient's specific characteristics and experiences. Indeed, the individual's uniqueness was seen as an unpredictable element that makes change inherently dynamic.

> Interview 8: [There are phases] for some patients [but] not for others, [and] there can be difficulties with that specific patient. Making it universal remains difficult for me.

> Interview 6: For me, the unexpected is what has to do with the freedom of the subject […], aspects can be predicted, interventions can be made hoping to go in a direction. Then, at a certain point, the plot twist occurs, and […] it has to do with real life, […] with the intimacy of the subject, […] with that less exposed part that perhaps had not emerged;

Discussion

The category "The Relational Space as the Foundation of Therapy and the Process of Change" encompasses several key themes, including the development of subjectivity, where both the patient and therapist are transformed through interaction. The concept of subjectivity development aligns with the fundamental principles of humanistic psychology, which emphasize fostering personal growth and self-actualization (Ford, 1991). However, in this context, it takes on a broader meaning, allowing patients to be more than their current selves and to discover who they are or have been concealing for some time. Nonetheless, through the therapeutic encounter, both the therapist's and the patient's subjectivities evolve as their interaction mutually transforms them (Hatcher et al., 2012; Kottler, 2005).

Other significant themes include the focus on the therapeutic relationship, which therapists thought is uniquely emphasized in psychodynamic therapy. These findings partially diverge from previous literature. For example, the therapeutic relationship is associated with treatment outcomes and is considered a common change mechanism across various approaches (Baier et al., 2020; Goldfried,

1980). Additionally, therapists prioritize the therapeutic relationship and reflect on their emotional responses when engaging with patients, irrespective of their theoretical orientation (Gale & Schröder, 2014; La Torre, 2005). Additionally, listening, trust, and the "we" formation were highlighted as foundational elements that enable patients to feel understood and to build a therapeutic alliance. These findings align with existing literature, which highlights therapists' genuineness and authenticity (e.g., Schnellbacher & Liejssen, 2009; Wampold & Imel, 2015) as well as the importance of feeling heard and understood in therapy (Dourdouma et al., 2020; Timulak, 2007). The "we" dynamic aligns with the concept of the working alliance (e.g., Vaz et al., 2024), which facilitates emotional processing —a core mechanism of change across multiple therapeutic approaches (e.g., Helland et al., 2023; Sakiris & Berle, 2019). Specifically, the relationship offers a new relational experience for the patient that can be internalized, allowing them to integrate therapeutic experiences into their lives and generalize the change into everyday relationships. A good outcome is predicted if patients recall the conversational and visual aspects of the relationship and can use them to cope with everyday life, indicating that the internalization process of the representation has been completed (Gablonski et al., 2023).

The category "Focusing, Exploring, and Processing the Patient's Internal States" describes the therapeutic work with the patient's inner world. Therapists represent change as a shift in how patients perceive and process their emotional and psychological experiences, enabling patients to tolerate, integrate, and make sense of their emotions. Therapy begins by addressing surface-level issues and then further explores the patient's unconscious contents. Then, therapy aims to let patients autonomously interpret and understand their experiences. Therefore, psychotherapy enhances self-awareness, helping patients understand how their cognitive and emotional patterns influence their lives, consistent with the assimilation model (Stiles, 2001). Gaining self-knowledge is a key objective of psychotherapy (e.g., Dourdouma et al., 2020; Roseborough et al., 2018). Patients often identify self-understanding and self-acceptance as essential factors in achieving change (e.g., Murray, 2002; Sousa & Vaz, 2020). Similarly, symptoms are viewed as a key access to the patient's personal and relational history, offering a pathway to deeper understanding and knowledge. Exploring unconscious meanings in symptoms without adhering to structured protocols appears to be a distinguishing feature of psychodynamic therapy. In contrast, other approaches, such as cognitive behavioral therapy (CBT), often conceptualize symptoms as elements to be directly modified or eliminated through specific techniques (Pilecki et al., 2015).

The category "The Tools of Change in the Psychodynamic Approach" highlights the various mechanisms that facilitate therapeutic transformation. Emotional listening is a crucial aspect, fostering a strong connection between the therapist and patient, which enables a more meaningful exploration of internal states. Indeed, patients need to establish a trusting relationship where they feel listened to before exploring the parts of themselves they know less about. This result aligns with the literature since common factors such as trust and empathy foster the working alliance and predict better outcomes (e.g., Benedetti, 2011; Nienhuis et al., 2018). Additionally, therapists thought that their attitude influenced the outcome and process of psychotherapy. For instance, the concepts of "being without memory" and "desire for change" emphasize the importance of being present alongside the patient without imposing personal expectations. This theme appears to be supported by the literature, as therapists' expectations regarding change can also influence therapy outcomes through their impact on the therapeutic alliance (e.g., Constantino et al., 2020). Therapists must be aware of unconscious dynamics that can be transmitted to the patient to avoid therapeutic impasses, which aligns with classic psychoanalytic literature (e.g., Stack, 1998). However, Tzur Bitan et al. (2022) showed how psychotherapists of different approaches monitor their introspection.

Moreover, therapists considered the initial and the conclusion phases to be crucial. Specifically, the initial one involves consultation and problem analysis, where one of the main risks is progressing too quickly due to highly idealized expectations of change. This finding aligns with prior research indicating that the first session is critical for assessing and managing patients' expectations about therapy outcomes since unmet unrealistic expectations may undermine the therapeutic process by affecting the therapeutic alliance (e.g., Davis & Addis, 2002). If therapy is successful, the final phase involves consolidating progress, a process of reinforcement during which therapists help patients solidify their achievements (Maples & Walker, 2014). Similarly, patients emphasize that long-term success depends on acquiring skills beyond therapy, including emotional regulation strategies, coping mechanisms, and revisiting therapeutic insights (Perren et al., 2009; Stiles, 2001).

Therapists noted the importance of model training for practicing psychoanalysis. Nevertheless, psychodynamic therapy is not the only approach that does

not rely on structured procedures. Similarly, the necessity of training appears to be a fundamental aspect across different therapeutic approaches (e.g., Rocco et al., 2019). Additionally, therapists acknowledged the physical environment, verbal and nonverbal communication, and the definition of the therapeutic setting as tools for change in the psychodynamic approach. Similarly, most approaches establish a structured setting at the beginning of treatment, outlining the therapeutic contract, including session frequency, duration, and payment agreements (e.g., Loriedo & Acri, 2009). Additionally, research suggests that the arrangement of furnishings and the overall physical space play a role in the therapeutic experience (e.g., Gabbard, 2004).

A distinctive element emerging from therapists' perspectives is the integration of split self-representations, a fundamental aspect of psychotherapeutic change. Specifically, therapy helps patients shift toward more mature defense mechanisms, thereby reducing their reliance on immature defenses, such as splitting (Babl et al., 2019). Additionally, change is facilitated by the resolution of transference, a critical phase that allows the patient to work through emotional blockages. Although there are no studies investigating how the evolution of transference is directly linked to therapeutic outcomes, some review studies have demonstrated that transference-based work through interpretation is associated with therapy outcomes, warning that their impact depends on various moderating and mediating factors, such as the therapeutic alliance, the quality of object relations, the patient's level of functioning, and the type of countertransference (e.g., Antichi et al., 2022; Yılmaz et al., 2024). Although transference and countertransference analysis originated within psychoanalytic theory, self-reflection and attentiveness to the connection between present interactions and early relational patterns may also be employed in therapeutic models beyond the psychodynamic framework (e.g., Tzur Bitan et al., 2022). Therefore, transference and countertransference can be understood as examples of what Castonguay (2011) refers to as *faux unique variables*—mechanisms that are often considered specific to a particular approach, such as psychodynamic therapy, but may also operate across other models, even if not explicitly acknowledged in their theoretical frameworks.

Finally, the analysis of "Change as an Unpredictable Process Difficult to Model" highlights the inherent variability of therapeutic change, which cannot be fully predicted or schematized. This theme aligns with theories emphasizing the dynamic and unpredictable nature of therapeutic change, where progress is often marked by sudden improvements, impasses, or regressions (e.g., Hayes & Andrews, 2020; Tang & DeRubeis, 1999). The reason for this uncertainty depends on the uniqueness of each patient, which introduces an unpredictable element to the therapeutic process, making universal models challenging to apply to psychotherapy change. This finding aligns with research highlighting the heterogeneity of individual change trajectories and the need to develop models that account for person-specific variance (e.g., Molenaar & Campbell, 2009). Stages are challenging to delineate for therapists, especially in the middle of therapy, a sort of "central abyss." Similarly, patients report experiencing therapy as a process divided into three distinct phases (e.g., Perren et al., 2009), which challenges models that divide therapy into clearly defined stages.

Limitations

Although this study has the merit of investigating the complexity of the change experience, it is limited by several shortcomings. First, the interview questions had specific themes, such as the stages of change and the factors responsible, that could influence the participants by shifting the focus away from their experience of change. However, the purpose of the study was to investigate those aspects of the topic for which no better alternative questions were possible, based on the authors' judgment. Furthermore, the participants themselves, as evident from the results, denied the existence of certain aspects of change present in the questions (such as the stages), indicating that they were probably not significantly influenced.

Second, the research group may be affected by power dynamics, as a professor holds more authority than a student. However, the climate was collaborative, and the categories, which anyone could question, could only be formed through unanimous consensus.

Third, although the selected group of participants is homogeneous, the transferability of the results may be limited to other clinical settings (e.g., different institutional, geographical, cultural, economic, and social contexts) or psychotherapy orientations. However, participants were experts, engaged in both private and public settings (e.g., communities, hospitals, private practices), and the article aimed to investigate changes in psychodynamic psychotherapy, without focusing on other orientations. Additionally, the participants themselves acknowledged that the coded categories accurately

represented their experiences in the final group meeting. Finally, many of the themes — such as the complexity of change, the role of the therapeutic relationship, and the non-linearity of the process — are concepts that are relevant beyond the psychodynamic approach and may resonate with other clinical orientations as well.

Conclusion

This study examined the perceptions of psychodynamic psychotherapists regarding change, highlighting key factors and the processual nature of change through a hermeneutic-phenomenological approach. The findings underscore the significance of the therapeutic relational space, the change process, or "tools," and the nonlinearity of change, which is unpredictable and non-generalizable due to the patient's individuality, the therapist's approach, and their unique interaction. The findings challenge the applicability of stage models in psychotherapy, confirming the need for a more flexible and idiographic representation of change that accounts for the personal trajectories of patients and unique characteristics of the therapist-patient relationship. Furthermore, the study highlights the limitations of traditional research models, which rely on unrealistic assumptions. Instead, it advocates for integrating qualitative and phenomenological methodologies to capture the complexity and uniqueness of therapeutic change. Future phenomenological research should compare common change factors across different therapeutic orientations to identify universal principles of change. Moreover, investigating how the specificity of the patient-therapist relationship influences the change process is crucial, given the variability and singularity of each therapeutic interaction.

In conclusion, understanding change from therapists' perspectives contributes to bridging the gap between clinical practice and academic research. By acknowledging the unpredictability and relational nature of change, future psychotherapy models may better align with real-world clinical experiences. Exploring change factors across therapeutic orientations may provide further insights into universal principles of change, fostering a more integrative and comprehensive approach to psychotherapy research.

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Appendices

Appendix 1

The framework of the Interview

N°	Question
1	To begin, could you describe your orientation as a psychotherapist and share the motivations that influenced your decision to adopt this approach?
2	Can you explain how your professional practice has developed and evolved over time, including the fields, contexts, types of interventions, and roles you have undertaken?
3	Considering the specific perspective of your therapeutic orientation, is there a generally accepted conceptualization of change within psychotherapy? If so, could you describe it?
4	Is it possible to differentiate between general factors that facilitate change and those specific to certain clinical situations or patient profiles within your orientation? If so, could you provide concrete examples?
5	Reflecting on your career, how has your perception of change in psychotherapy evolved? Are there particular observations or distinctive elements you would like to highlight? Has your understanding of change shifted over time? If so, in what ways?
6	In your clinical practice, have you encountered any new or unexpected elements that differ from those outlined in your theoretical working model?
7	Based on your experience, do you believe there is a typical change process in psychotherapy (e.g., phases of engagement or a temporal progression of the therapeutic process)?
8	Reflecting on your clinical experience, are there specific examples or situations—whether with positive or negative outcomes—that stand out to you? Could you elaborate on some of these cases?
9	Before we conclude, do you believe there are any significant aspects related to the topic of change that we have not addressed? If so, would you like to bring them to our attention for further exploration?

Appendix 2

Results of Phenomenological Analysis

Categories	Themes
The Psychoanalytic-Psychodynamic Orientation of Therapists	
Motivations for Choosing to Train in the Psychodynamic Approach	A choice based on one's way of being
	Equipping oneself with useful tools for the clinic
	A choice based on work experience
Areas of Intervention	Working in the public mental health service
	Hospital activity
	Private practice
	Activities at community and therapeutic centers
	Supervision activities
The Relational Space as the Foundation of Therapy and the Process of Change	The development of the subjectivity of the patient and the therapist
	The Therapist's Internalization and the Generalization to Everyday Life
	A New Relational Experience to Feel and Think Differently
	A Deeper Analysis of the Therapeutic Relationship Compared to Other Orientations
	Listening Within the Relationship
	A "we" in Psychotherapy to Build the Therapeutic Alliance
	Recognizing Otherness
	The Development of Trust
	Being a whole in the Group

(*Continued*)

Continued.

Categories	Themes
Focusing, Exploring, and Processing the Patient's Internal States	The Symptom as a Proxy for Subjective Meanings
	Psychic Digestion as a Tool to Tolerate Emotional Experiences
	From the Surface of Behaviors to the Depth of Feeling and Intimacy
	Toward an Autonomous Perceiving and Thinking of Internal and External Events
	Change in the Inner World
The Tools of Change in the Psychodynamic Approach	Anamnesis as the Compass of Change
	Consultation as the First Phase to Analyze Requests and Problems
	The Psycho-Physical Setting of the Intervention
	A Free Therapist Without Memory and Desire for Change
	Emotional Listening as a Process of Change
	Adapting and Diluting the Model to Reach the Patient
	Integrating and Putting Together
	The Unconscious of the Therapist as a Tool for Resolving the Impasse
	The Resolution of Transference as a Key to Therapy Progression
	Taking Change Away from Therapy to Consolidate It
	Conclusion as a Critical Phase
	Training in the Clinical Theoretical Model
The Subjectivity and Experiences of the Therapist	The Therapist's Interest in People
	The Therapist's Subjectivity
	The Therapist's Choices
	Idealization as a Risk Factor
	A Different Therapeutic Focus
	A More Eclectic and Broad Perspective
	Considering New Types of Change
	Transformation of the Therapist's Mind
	Experience as a Personal Validation
New Conceptions of Change in the Psychodynamic Approach	A "Sea of Troubles" of Different Theoretical Conceptualizations
	The Limits of the Psychodynamic Approach in Highlighting Patient Change
	Integration of Different Theoretical Models to Explain Phenomena
	Reinterpreting the Model in the Contemporary Context
	A Shared Common Language in Psychotherapy
Change as an Unpredictable Process Difficult to Model	The change process is unpredictable and indivisible
	A Process of "Anda e Rivieni" [back and forth]
	The Uniqueness of the Patient as a Crucial Variable