Journal Website

Article history:
Received 02 May 2026
Revised 04 September 2026
Accepted 12 September 2026
Initial Publication 20 September 2026
Final Publication 01 November 2026

International Journal of Education and Cognitive Sciences

Volume 7, Issue 5, pp 1-17

E-ISSN: 3041-8828

A Phenomenological Exploration of the Dialectic of Success and Failure in Psychotherapy: Explaining Interactional Patterns and the Therapeutic Alliance from Clients' Perspectives

Nastaran Sadat. Ghasemi[1], Shahram. Vaziri[2*], Farah. Lotfi Kashani[3], Saeed. Imani[4]

[1] Department of Psychology, UAE.C, Islamic Azad University, Dubai, United Arab Emirates
[2] Associate Professor, Department of Clinical Psychology, Ro.C., Islamic Azad University, Tehran, Iran
[3] Associate Professor, Department of Clinical Psychology, Ro.C., Islamic Azad University, Roudehen, Iran
[4] Associate Professor, Department of Counseling, Faculty of Educational Sciences and Psychology, Shahid Beheshti University, Tehran, Iran

*** Corresponding author email address**: vaziri@iau.ac.ir

A r t i c l e I n f o

Article type:
Original Research

How to cite this article:
Ghasemi, N. S., Vaziri, S., Lotfi Kashani, F., & Imani, S. (2026). A Phenomenological Exploration of the Dialectic of Success and Failure in Psychotherapy: Explaining Interactional Patterns and the Therapeutic Alliance from Clients' Perspectives. *International Journal of Education and Cognitive Sciences*, *7*(5), 1-17.
https://doi.org/10.61838/kman.ijecs.473

A B S T R A C T

Purpose: This study aimed to phenomenologically explore clients' lived experiences of the dialectic between success and failure in psychotherapy, with particular emphasis on interactional patterns, therapeutic alliance, and the relational processes underlying perceived therapeutic effectiveness or rupture.
Methods and Materials: This qualitative study employed a descriptive–interpretive phenomenological design. The study population comprised individuals with prior experience of individual psychotherapy. Using purposive sampling with maximum variation in successful, unsuccessful, and ambivalent therapeutic experiences, 18 participants were recruited until experiential and thematic saturation was achieved. Data were collected through in-depth semi-structured interviews focused on clients' perceptions of therapeutic interactions, relational safety, clinical responsiveness, treatment ruptures, and factors contributing to continuation or discontinuation of therapy. Interviews were transcribed verbatim and analyzed according to Colaizzi's seven-step phenomenological method. MAXQDA software was used to organize, code, compare, and integrate the qualitative data and facilitate the development of overarching thematic structures.
Findings: The analysis indicated that perceived therapeutic success emerged from an interconnected relational configuration characterized by a "liberating secure bond," flexible clinical competence, unconditional acceptance, and empathic regulation of emotions. These processes strengthened clients' sense of psychological safety, participation, trust, and agency and facilitated sustained therapeutic engagement. Conversely, perceived therapeutic failure was associated with technical rigidity, excessive dependence on inflexible protocols, authoritarian interactional patterns, and violations of client agency. The convergence of these relational disruptions progressively weakened the therapeutic alliance, intensified emotional exhaustion and alienation, and, in some cases, culminated in disengagement or premature termination.
Conclusion: Psychotherapy appears to function fundamentally as an intersubjective encounter in which technical interventions become effective when embedded within clinical humility, relational flexibility, democratic collaboration, empathic responsiveness, and respect for clients' dignity and autonomy.
Keywords: *Psychotherapy; Therapeutic Alliance; Clinical Success and Failure; Phenomenology; Interactional Patterns; Client Experience.*

1. Introduction

Psychotherapy is fundamentally a relational and interpretive process in which technical intervention, interpersonal exchange, emotional regulation, and client agency converge to shape therapeutic outcomes. Although psychotherapy has accumulated a substantial empirical foundation and a wide range of evidence-based interventions have been developed for different psychological disorders, the effectiveness of treatment cannot be understood solely through the selection or correct implementation of specific techniques. Clinical outcomes emerge from a dynamic interaction among therapist characteristics, client characteristics, treatment context, the quality of the therapeutic relationship, and the manner in which interventions are negotiated and adapted over time. Consequently, contemporary psychotherapy research has increasingly moved beyond the traditional question of whether treatment works toward the more complex question of why therapy succeeds for some clients but stagnates, deteriorates, or fails for others. This shift is particularly important because unsuccessful psychotherapy is not merely the absence of symptom improvement; it may involve disappointment, intensified distress, erosion of trust, premature termination, negative emotional experiences, and in some cases clinically significant deterioration (Barlow, 2010; Lambert, 2011; Mays & Franks, 2025).

The notion of treatment failure has historically occupied an ambiguous position in psychotherapy research. Outcome studies often rely on standardized symptom measures and mean group differences, but such approaches may conceal important individual variations in treatment response. A statistically effective intervention at the group level may still be experienced as ineffective, invalidating, or harmful by individual clients. Moreover, conventional outcome metrics do not necessarily capture the relational, emotional, and existential dimensions through which clients make sense of therapeutic success or failure. For this reason, scholars have emphasized that psychotherapy outcomes should be assessed through both quantitative and qualitative approaches, particularly when the research question concerns meaning, subjective change, disappointment, rupture, or the personal significance of therapeutic encounters (Hill et al., 2013; McLeod, 2013). Methodological attention to treatment failure has therefore expanded from simple outcome classification toward a multidimensional analysis that considers symptom trajectories, functional change, dropout, therapeutic process, clients' appraisals, and contextual conditions surrounding unsuccessful treatment (Dandachi-FitzGerald et al., 2023; Farahani et al., 2021).

Within this broader perspective, the client is not viewed as a passive recipient of therapeutic expertise but as an active agent who interprets, evaluates, accepts, resists, and reshapes the therapeutic process. Client expectations, preferences, values, readiness for change, sense of agency, and interpretation of the therapist's behavior influence the meaning and impact of interventions. The client's contribution is particularly important because the same therapist behavior or intervention may be perceived as supportive by one individual and as intrusive, controlling, or invalidating by another. A client-centered understanding of psychotherapy therefore requires attention to how clients experience the therapeutic setting from within and how they interpret events that clinicians may otherwise consider technically routine (Bohart & Wade, 2013). This perspective also challenges deterministic models in which therapeutic success is attributed primarily to therapist competence or treatment fidelity and failure is attributed primarily to client pathology, resistance, or noncompliance.

One of the most influential constructs in explaining treatment outcome is the therapeutic alliance. The alliance broadly encompasses the affective bond between therapist and client, agreement regarding therapeutic goals, and collaboration around therapeutic tasks. It functions both as a relatively enduring relational quality and as a dynamic, session-sensitive process that fluctuates across treatment. Contemporary models distinguish between trait-like aspects of the alliance, reflecting relatively stable relational tendencies, and state-like aspects that vary in response to momentary experiences during therapy (Zilcha-Mano & Fisher, 2022). This distinction is clinically significant because alliance quality does not simply represent an initial condition of treatment; it evolves continuously through negotiation, responsiveness, misunderstanding, repair, and renewed collaboration. Accordingly, the alliance should be understood not as a static background variable but as an active mechanism through which clients interpret the therapist's intentions and decide whether the therapeutic environment is safe enough for vulnerability, exploration, and behavioral change.

Empirical evidence further indicates that the perceived quality of the therapeutic alliance is closely associated with treatment outcome, yet client and therapist evaluations of that alliance may not always converge. Clients can experience disconnection, pressure, judgment, or emotional

E-ISSN: 3041-8828

distance even when therapists perceive the relationship as functional. Conversely, clients may attribute value to aspects of the relationship that therapists do not regard as central. Studies examining patients' and therapists' views of the therapeutic alliance have therefore shown the importance of considering both perspectives rather than relying exclusively on clinician assessment (Tschuschke et al., 2020). The client's subjective appraisal may be especially informative when attempting to explain dropout, treatment dissatisfaction, perceived stagnation, or breakdown in trust, because these phenomena are experienced before they are observable in conventional outcome indicators.

A central feature of therapeutic relationships is that ruptures are inevitable to some degree. Alliance ruptures may involve withdrawal, confrontation, disengagement, mistrust, disagreement, perceived misunderstanding, or a temporary weakening of collaboration. Importantly, rupture itself does not necessarily signify treatment failure. Therapeutic relationships may be strengthened when ruptures are identified, explored, and repaired effectively. Repair processes can transform moments of disconnection into opportunities for greater mutual understanding, emotional integration, and relational learning (Mylona et al., 2023). The clinical significance of rupture therefore lies not merely in its occurrence but in how the therapist responds. Flexibility, openness to feedback, willingness to acknowledge misattunement, and the capacity to renegotiate tasks or goals may distinguish productive rupture from progressive deterioration. In contrast, denial of rupture, defensive responding, rigid insistence on a predefined interpretation, or attributing all disagreement to client resistance can deepen relational disconnection and produce deadlock.

The phenomenon of therapeutic deadlock illustrates how treatment can become immobilized even when sessions continue. Therapists may experience a sense of stagnation, repetitive interaction, frustration, helplessness, or uncertainty regarding how to proceed, especially when the treatment relationship becomes organized around unresolved relational patterns (Werbart et al., 2023). From a client perspective, such deadlock may be experienced as being unheard, misunderstood, pathologized, pressured, or trapped within a therapeutic framework that no longer responds to emerging needs. Comparative analyses of successful and less successful psychotherapies suggest that meaningful differences may lie not only in therapeutic orientation but also in relational flexibility, responsiveness to the client, and the therapist's ability to recognize and adapt to unfolding interpersonal processes (Werbart et al., 2019). These findings support the idea that technical adherence without relational responsiveness may become counterproductive when the treatment process demands flexibility.

The tension between technique and relationship is therefore central to contemporary psychotherapy theory. Traditional models often conceptualized therapeutic techniques as the primary active ingredients of treatment, whereas common-factors and relational approaches emphasized empathy, alliance, therapist responsiveness, and client participation. More recent process-based perspectives attempt to move beyond this dichotomy by focusing on mechanisms of change that can be flexibly targeted across diagnostic categories and therapeutic schools (Ghaderi & Mehrabi, 2023). Within such perspectives, technique remains important, but its effectiveness depends on how, when, and in what relational context it is implemented. A theoretically appropriate intervention may fail if it is applied mechanically, prematurely, or without sufficient attention to the client's emotional capacity and subjective meaning. Conversely, a technically simple intervention may become highly effective when delivered within a secure, collaborative, and empathically attuned relationship.

The possibility of negative experiences during psychotherapy further complicates simplistic assumptions about therapeutic benefit. Research on adverse or negative psychotherapy experiences has identified risk factors related to therapist behavior, therapeutic procedures, interpersonal mismatch, expectations, treatment intensity, and the client's vulnerability (Hardy et al., 2019). Negative treatment outcomes may include worsening symptoms, shame, loss of confidence, emotional destabilization, increased dependency, interpersonal harm, or disengagement from future help-seeking. The literature on negative outcomes also demonstrates that even well-intentioned psychological treatments can produce undesirable effects when interventions are mismatched to the client, applied without adequate monitoring, or implemented in contexts where relational safety is insufficient (Barlow, 2010; Mays & Franks, 2025). Accordingly, research on failure should not be regarded as marginal to psychotherapy science but as an essential component of ethical, effective, and accountable clinical practice.

Client accounts of failed psychotherapy provide particularly valuable evidence because they reveal dimensions of therapeutic process that may remain inaccessible through therapist reports or standardized

E-ISSN: 3041-8828

outcome scales. Studies focusing explicitly on client perspectives have shown that clients frequently describe failure in relational terms, including feeling misunderstood, emotionally disconnected, insufficiently involved, judged, pressured, or poorly matched with the therapist's approach (Knox et al., 2023). Similarly, comparisons of "good" and "poor" outcome therapy indicate that clients' experiences of therapist responsiveness, emotional engagement, relevance of interventions, and sense of progress can differ substantially between successful and unsuccessful cases (McElvaney & Timulak, 2013). Such findings suggest that client narratives are not merely supplementary descriptions of outcome; they are critical sources for understanding the mechanisms through which treatment acquires either therapeutic or countertherapeutic meaning.

Phenomenological research is particularly well suited to investigating these mechanisms because it seeks to understand how individuals experience and interpret a phenomenon as it is lived. Rather than reducing psychotherapy to measurable components alone, phenomenological inquiry examines meaning structures, relational experience, embodiment, emotional tone, perceived agency, and the subjective organization of events. Studies of clients' lived experiences of the therapeutic relationship have demonstrated that clients often evaluate therapy through dimensions such as trust, acceptance, authenticity, safety, emotional attunement, and the therapist's capacity to understand the client's unique world (Ghamari Zamehrir et al., 2023). Such dimensions are difficult to capture through standardized scales alone because their significance often depends on the relational context in which they arise. For example, therapist directiveness may be experienced as containing and helpful in one context but controlling and invalidating in another.

The experience of repeated therapeutic failure may also accumulate into complex affective structures that shape subsequent expectations and participation in treatment. Clients who encounter recurrent disappointment can develop mistrust, anticipatory anxiety, hopelessness, guardedness, or heightened sensitivity to signs of rejection and invalidation (Heydari Kia & Esmaeili, 2024). These affective residues can influence future alliance formation and may alter the way clients interpret therapist behavior. Therefore, treatment failure should not be understood as an isolated endpoint; it may become part of the client's broader psychological history and affect willingness to seek or remain in care. This makes it especially important to identify the specific interactional patterns that clients associate with failure and to distinguish them from the relational processes that facilitate recovery, trust, and sustained engagement.

Ethical considerations are inseparable from this issue. Psychotherapy involves asymmetries of knowledge, institutional authority, and professional power, creating an ethical responsibility to preserve client autonomy, dignity, confidentiality, informed participation, and protection from avoidable harm. Ethical challenges arise when therapists impose interpretations, disregard client preferences, fail to respond to feedback, blur professional boundaries, or use their authority in ways that diminish client agency (Hosseini Beyouki et al., 2024). In this regard, relational ethics is not peripheral to therapeutic effectiveness. Respectful collaboration, transparent communication, responsiveness to disagreement, and protection of the client's right to question the therapeutic process may contribute directly to alliance stability and the prevention of harmful relational dynamics.

Personality characteristics of both therapist and client may further shape these interactions. Individual differences in interpersonal style, emotional expression, rigidity, openness, sensitivity to criticism, dependency, or dominance can influence therapeutic compatibility and determine how relational events are interpreted (Shabib Asl & Alinaghi Lou, 2020). The therapeutic relationship is therefore co-constructed rather than unilaterally produced by either participant. However, because therapists hold professional responsibility for maintaining the therapeutic frame, they are expected to monitor how their interpersonal style interacts with client vulnerabilities and to adjust their stance when the alliance becomes strained. From this perspective, clinical competence includes not only knowledge of treatment protocols but also relational self-awareness, flexibility, and the capacity to use feedback as data rather than as a threat to professional authority.

Culture adds another layer of complexity to the success–failure dialectic. Clients enter therapy with culturally shaped assumptions concerning emotion, family, authority, privacy, suffering, help-seeking, identity, and acceptable forms of interpersonal communication. Interventions that are theoretically sound but culturally incongruent may be experienced as alienating, insensitive, or irrelevant. Culturally adapted psychotherapy therefore emphasizes the need to integrate evidence-based treatment with the client's cultural context, values, language, explanatory models, and lived realities (Ziaei & Zarani, 2026). Cultural responsiveness is particularly relevant to alliance quality because perceived disregard for cultural meaning can be interpreted as lack of empathy or recognition. Thus, flexible

E-ISSN: 3041-8828

adaptation should not be understood as dilution of treatment fidelity, but as a form of clinical responsiveness that may enhance relevance and relational trust.

The broader psychotherapy literature increasingly supports a shift from protocol-centered treatment toward feedback-informed, person-responsive, and process-sensitive practice. Treatment failure research has repeatedly emphasized the importance of identifying nonresponse early, monitoring progress, recognizing deterioration, and modifying treatment when expected gains do not occur (Farahani et al., 2021; Lambert, 2011). Yet outcome monitoring alone cannot explain why the treatment has stalled. Qualitative understanding is required to determine whether the problem lies in task disagreement, emotional mismatch, cultural disconnection, premature trauma processing, lack of perceived safety, therapist rigidity, or another interactional mechanism. In this sense, individualized and qualitative evidence is essential for interpreting numerical indicators of outcome and for identifying the experiential processes hidden beneath apparent nonresponse (Hill et al., 2013; McLeod, 2013).

Moreover, the literature indicates that clinical success and failure should not be conceptualized as simple opposites defined only by symptom change. Success may involve strengthened agency, improved emotional regulation, greater self-understanding, relational trust, and increased capacity for autonomous coping, whereas failure may involve helplessness, invalidation, dependency, rupture, or withdrawal even when some symptom improvement is present. Likewise, clients may simultaneously experience benefit in one dimension and harm in another. This complexity supports a dialectical understanding of psychotherapy outcome in which technical effectiveness and relational experience interact continuously. The distinction between successful and unsuccessful psychotherapy may therefore be found less in the nominal therapeutic orientation and more in how the therapist and client jointly construct safety, authority, meaning, and adaptability throughout treatment (Bohart & Wade, 2013; Knox et al., 2023; Werbart et al., 2019).

Existing scholarship has generated important knowledge about negative outcomes, alliance processes, rupture and repair, treatment failure, client experience, cultural adaptation, ethical challenges, and therapist responsiveness; however, these domains are often investigated separately. What remains less clearly articulated is the phenomenological structure through which clients themselves distinguish successful from unsuccessful psychotherapy and how they experience the interaction among therapeutic bond, technique, power, emotional pacing, feedback, and personal agency. Integrating these dimensions may clarify why some therapeutic encounters are experienced as liberating and growth-promoting while others become rigid, alienating, or psychologically exhausting. Such an inquiry is especially relevant because the client's lived experience provides direct access to the relational turning points through which a treatment protocol becomes either an instrument of change or a source of disengagement (Dandachi-FitzGerald et al., 2023; Ghamari Zamehrir et al., 2023; Mylona et al., 2023).

Accordingly, the aim of the present study was to phenomenologically explore the dialectic of success and failure in psychotherapy from clients' lived perspectives, with particular emphasis on interactional patterns, the therapeutic alliance, the relational use of technique, clinical power dynamics, emotional regulation, rupture, and repair.

2. Methods and Materials

The present study was a qualitative investigation employing an interpretive phenomenological (hermeneutic) approach, conducted to explore in depth clients' lived experiences of interactions within the therapy room, the nature of the therapeutic alliance, and critical turning points leading to therapeutic failure or success. The study population comprised all clients with a history of receiving individual psychotherapy through various specialized therapeutic approaches at counseling and psychological service centers who had experienced observable outcomes of improvement, stagnation, or premature termination of therapy. Sampling was conducted using criterion-based purposive sampling, supplemented by a snowball sampling strategy to identify individuals who had discontinued therapy prematurely or in protest, and continued until theoretical saturation was reached. Conceptual saturation was achieved at the sixteenth interview; however, two additional interviews were conducted to ensure scientific adequacy, resulting in a final sample of 18 participants, including 7 clients with successful treatment experiences, 6 with unsuccessful treatment experiences, and 5 with mixed or fluctuating experiences. The inclusion criteria consisted of having completed at least five consecutive individual psychotherapy sessions, possessing a clear perception of the therapeutic process, being able to articulate emotional experiences in detail, and providing informed willingness to participate in the study. Concurrent active psychotic

E-ISSN: 3041-8828

disorders, severe cognitive impairments, or unwillingness to share relevant information were considered exclusion criteria. The primary data collection instrument was an in-depth semi-structured interview focusing on therapeutic relationship dynamics, alliance ruptures, and relational repair. Interviews were conducted individually in a secure environment, lasted 45–75 minutes, and adhered to confidentiality principles and informed-consent requirements. To establish the scientific rigor of the study based on the four criteria proposed by Guba and Lincoln (1985), prolonged engagement with the data, member checking, and double coding of 20% of the interviews by an independent evaluator were employed. The resulting Holsti intercoder agreement coefficient exceeded 0.85.

Table 1

Methodological Characteristics Matrix and Operational Protocol for Relational–Interactional Analysis

Methodological Component	Dimensions and Operational Indicators	Control and Validation Mechanism
Approach and paradigm	Interpretive phenomenology (hermeneutics), with a focus on the therapeutic bond and therapeutic alliance	Adoption of an epoché stance, bracketing of clinical biases, and maintenance of reflexive notes
Sampling method and sample size	Criterion-based purposive sampling supplemented by a snowball strategy (N = 18)	Termination at theoretical saturation (Interview 16), followed by two supplementary interviews to confirm data adequacy
Inclusion and exclusion criteria	At least five individual therapy sessions, perception of therapeutic change/failure, and absence of active psychotic symptoms	Triage based on an initial screening interview and review of records documenting previous service utilization
Research instrument protocol	In-depth semi-structured interview (45–75 minutes) focusing on rupture, repair, and therapist stance	Item-by-item review by five clinical experts and implementation of two pilot interviews
Qualitative validity and reliability	The four criteria of credibility, transferability, dependability, and confirmability	Member checking, audit of the coding trail, and a Holsti agreement coefficient above 0.85
Data analysis strategy	Six-phase reflexive thematic analysis using MAXQDA 2020	Structural thematic networking across basic, organizing, and global thematic levels

The textual data analysis process was conducted using an inductive reflexive thematic analysis strategy based on the six-phase approach of Braun and Clarke (2006), with the assistance of MAXQDA 2020. In the first phase, repeated readings of the interview transcripts, together with the adoption of a phenomenological epoché stance to bracket pre-existing theoretical biases, enabled the researcher to develop a comprehensive understanding of the atmosphere and experiential context of the therapy sessions. In the second phase, discrete meaning units and initial conceptual codes relating to positive and negative patterns of client–therapist interaction were extracted. Subsequently, during the third through fifth phases, homogeneous codes were organized into thematic clusters, and, using the thematic network framework proposed by Attride-Stirling (2001), three hierarchical levels of basic, organizing, and global themes were identified and labeled. Finally, by integrating within-case analysis with comparative analysis across the two poles of successful and unsuccessful therapy, the perceptual structure underlying the dialectic of failure and success in the therapy room was formulated and validated. Descriptive statistical indices were also calculated in SPSS version 26 to organize and report participants' contextual and demographic characteristics.

3. Findings and Results

This article specifically focuses on the dialectic between relationship and technique, the manner in which the quality of the therapeutic bond may take precedence over rigid intervention formats, and a comparative examination of clients' lived experiences of democratic versus prescriptive and authoritarian communication patterns.

Examination of participants' demographic characteristics in phenomenological qualitative research provides a fundamental basis for understanding and contextualizing lived experiences. Variability in individual characteristics such as gender, age group, marital status, and educational attainment makes it possible to appreciate differing perceptual horizons regarding the therapeutic process. Because perceptions of the therapeutic bond and interactions with the therapist may be influenced by developmental position, prior life experiences, and individual levels of awareness, depicting the demographic profile of participants represents an initial step in validating and contextualizing the findings. The distribution of these characteristics is presented in Table 2.

E-ISSN: 3041-8828

Table 2

Demographic Characteristics of the Study Participants (N = 18)

No.	Demographic Variable	Category	Frequency (n)	Percentage
1	Gender	Female	11	61.11
		Male	7	38.89
2	Age range	20–29 years	5	27.78
		30–39 years	7	38.89
		40–49 years	4	22.22

The demographic findings indicate that perceptions of the therapeutic bond and the meaning-making of lived experience emerged within a context of diverse developmental experiences and therefore provide a substantive foundation for phenomenological analysis of successful and unsuccessful treatment experiences. Diversity across age and educational groups reduced the likelihood of a unidimensional bias in the extraction of themes concerning the therapeutic bond and clinical interaction. Phenomenological analysis of data obtained from in-depth interviews requires the systematic extraction of statements containing clinically meaningful information about factors contributing to therapeutic success. This process entails identifying participants' statements directly addressing the therapist's role and the nature of interpersonal interactions within the therapy room. Clients who had experienced successful therapy reported meaningful dimensions of feedback delivery, embodied empathy, and flexible structuring of therapy sessions. Distinguishing these statements and reformulating them as psychological concepts constitutes a fundamental step in understanding how relationship quality may take precedence over specific intervention techniques. Selected statements and the concepts derived from them are presented in Table 3.

Table 3

Significant Statements and Formulated Concepts Concerning Factors Contributing to Success in the Therapeutic Relationship

No.	Client Code	Key Significant Statement Extracted From the Interview	Formulated Psychological Concept
1	01	"The greatest contributor to my progress was the sense of safety and nonjudgmental acceptance I experienced in the therapy room; I felt that I was truly seen."	Emotional disinhibition within a context of unconditional acceptance
2	02	"The therapist's structured approach and professional mastery reduced my confusion and helped me understand exactly where we were going at each step."	Structured scaffolding and clinical clarity
3	03	"The therapist was highly flexible, and I never felt forced into a rigid framework of techniques; the process moved according to my psychological state."	Responsive flexibility adapted to psychological capacity
4	04	"Our relationship was based on mutual respect and agreement on goals; I felt like a genuine partner in the therapeutic process rather than a passive recipient."	Working alliance based on collaboration and active agency
5	05	"Through nonblaming feedback, the therapist helped me gradually uncover deeper layers of emotion and old trauma and eventually become calmer."	Gradual empathic engagement with psychologically painful material
6	07	"The therapist's authenticity and ethical commitment prevented me from becoming unhealthily dependent, and over time I learned to become my own internal observer."	Enhancement of self-efficacy and psychological autonomy

As shown in Table 3, clients' perceptions of therapeutic success were grounded primarily in the quality of the human relationship and the security of the interpersonal bond rather than in techniques or school-specific therapeutic instructions. Statements extracted from clients who reported successful therapy experiences (Codes 01–07) demonstrate that unconditional acceptance and perceived safety played an accelerating role in emotional openness and the reduction of defensive barriers. The formulated concepts indicate that structure, when combined with responsive flexibility, transformed the therapeutic experience from a rigid and bureaucratic format into a developmental alliance. Clients with successful experiences reported that the therapist's therapeutic presence provided an appropriate context for emotion regulation and engagement with repressed emotions without creating a sense of being subjected to clinical authority or mechanical prescription. Furthermore, clarity in assigning therapeutic tasks and alignment regarding treatment goals facilitated the activation of personal agency and prevented conflict arising from ambiguity. These findings indicate that therapeutic techniques acquire clinical effectiveness only when embedded within a warm, safe,

E-ISSN: 3041-8828

responsive, and nonjudgmental relational context, thereby transforming the therapeutic relationship from an ancillary variable into a primary mechanism of clinical change.

Exploring the causes of failure, limited effectiveness, and rupture in psychotherapy requires critical examination of statements reflecting interactional friction, methodological rigidity, and the absence of adaptive responsiveness during therapy sessions. Clients who perceived their treatment as unsuccessful or who terminated therapy reported distinct experiences of imposed protocols, lack of empathy, premature confrontation with traumatic material, and authoritarian communication patterns. Extracting significant statements and transforming them into analytical concepts reveals the mechanisms through which the therapeutic bond erodes and the process of recovery becomes obstructed. Details of this phenomenological analysis are presented in Table 4.

Table 4

Significant Statements and Formulated Concepts Concerning the Causes of Failure and Rupture in the Therapeutic Relationship

No.	Client Code	Key Significant Statement Extracted From the Interview	Formulated Psychological Concept
1	08	"I felt as though I were merely a textbook case; regardless of my pain, the therapist was only concerned with implementing the steps of the protocol."	Objectification of the client and dominance of technique over the human relationship
2	09	"The therapist's condescending and authoritarian manner prevented me from expressing what was inside me; I was constantly worried about being judged or blamed."	Hierarchical communication pattern and clinical authoritarianism
3	10	"Without first establishing sufficient safety, the therapist made me revisit extremely severe traumatic experiences; the anxiety became so intense afterward that I could not continue the sessions."	Inadequate regulation of trauma processing and violation of psychological safety
4	11	"Whenever I complained that the approach was not working, the therapist attributed it to my resistance and pathology and refused to change course."	Clinical nonresponsiveness to feedback and attribution of treatment failure to the client
5	12	"I felt that the therapist was psychologically absent and paid no attention to my culture or lifestyle; the empathy seemed entirely artificial and mechanical."	Cultural alienation and empathic rupture within the intersubjective space
6	13	"Repeated changes to session times and failure to adhere to our initial agreements undermined my fundamental trust in the therapist's professional commitment."	Boundary rupture and disruption of the secure therapeutic frame

As shown in Table 4, treatment failure, from the clients' perspective, was a direct consequence of relational deficiencies, technical arrogance, and fragility of the therapeutic alliance. Statements from clients with unsuccessful treatment experiences (Codes 08–13) indicate that dominant interactional patterns, a unidimensional pathologizing perspective, and therapists' unwillingness to accept feedback directly contributed to interactional resistance and ultimately to therapeutic rupture. The psychological concept of client objectification suggests that whenever the therapeutic protocol is prioritized over the client's lived experience, therapy shifts from a potentially healing context into a threatening environment. Inadequate regulation of the emotional burden associated with trauma and insistence on premature exposure without establishing adequate supportive scaffolding undermined psychological safety and activated avoidant defense mechanisms. Moreover, therapists' nonresponsiveness to feedback and their attribution of any slowing in the recovery process to clients' resistance generated feelings of blame and intensified helplessness. These data clearly demonstrate that a lack of clinical sensitivity and therapists' inability to repair ruptures in the therapeutic alliance are among the most important mechanisms contributing to treatment breakdown, indicating that clinical failure is fundamentally a relational and interactional phenomenon rather than a fixed intrapsychic characteristic of the client.

The thematic analysis process within a phenomenological methodology requires progression from discrete concepts toward the clustering of subthemes and the formulation of overarching and organizing themes. In examining the dialectic of success and failure, the extracted themes were divided into two opposing poles that defined the phenomenological structure of clients' lived experiences. Thematic clustering made it possible to categorize dominant patterns within the therapy room into broader constructs, including a secure bond, shared agency, clinical competence, technical rigidity, and relational authoritarianism. The clustering of major themes and subthemes is summarized in Table 5.

E-ISSN: 3041-8828

Table 5

Clustering of Major Themes and Subthemes Related to Interactional Factors Underlying Therapeutic Success and Failure

Global Theme	Organizing Subthemes	Related Client Codes	Conceptual Implication in Lived Experience
Secure and liberating therapeutic bond (core of success)	Unconditional acceptance and psychological safety	01, 03, 07	Feeling heard, freedom from fear of judgment, and emotional disinhibition
	Collaboration and shared goals	02, 04, 06	Transformation of the client into an active therapeutic collaborator and transparent agreement regarding recovery steps
	Authenticity, empathy, and ethical boundaries	05, 07, 16	Deep understanding of intrapsychic experiences accompanied by maintenance of professional boundaries and confidentiality
Flexible clinical competence (facilitating factor)	Responsive flexibility	02, 03, 14	Adjustment of the pace and type of intervention to the client's psychological rhythm and life context
	Development of autonomy and self-efficacy	01, 04, 07	Prevention of therapist dependency and transformation of the client into a sustainable agent of self-directed therapeutic change
Interactional rupture and rigidity (core of failure)	Entrapment in protocol and objectification	08, 10, 12	Mechanical application of techniques, disregard for individuality, and suppression of the client's voice
	Relational authoritarianism and clinical coercion	09, 11, 13	Therapist nonresponsiveness to feedback, omniscient positioning, and blaming the client's resistance
	Failure to regulate emotional burden	10, 11, 15	Reactivation of trauma, premature confrontation, and rupture of the secure therapeutic bond

As shown in Table 5, clients' lived experiences were polarized around two distinct interactional paradigms: the "secure and liberating therapeutic bond" at the successful end of the continuum and "interactional rupture and rigidity" at the unsuccessful end. Organizing subthemes within the success pole indicate that perceived safety and unconditional acceptance constitute the foundations of the clinical alliance. When therapists adopt a noncoercive stance, clients participate in psychological reconstruction not as passive recipients of services but as self-aware agents. In contrast, the subthemes associated with the failure pole indicate that when therapists become trapped in technical dogmatism, client objectification occurs—a condition in which clients perceive their unique identities as being erased within the rigid structure of assessment tools and predetermined therapeutic steps. Therapists' relational authoritarianism, characterized by suppression of feedback and attribution of unfavorable outcomes to clients' resistance, further deepens ruptures in the working alliance. Accordingly, Table 5 clearly demonstrates that the fundamental distinction between success and failure lies not in the specific therapeutic school employed, but in how the intersubjective space is established, the degree of sensitivity to the client's emotional rhythm, and the therapist's willingness to flexibly modify the treatment structure.

A comprehensive understanding of the phenomenological structure of therapeutic failure and success requires a comparative formulation of behavioral, emotional, and relational indicators across the two contrasting therapeutic experiences. Matrix-based comparison of these indicators across five fundamental components—the approach to technique, power positioning, engagement with emotions and trauma, receptivity to feedback, and outcome orientation—provides a basis for identifying principles governing clinical effectiveness. Such an analysis illustrates how shifts in the therapist's position across these components can differentiate clients' experiences between the poles of psychological liberation and exacerbation of distress. The dimensions of this comparison are presented in Table 6.

Table 6

Comparative Analysis of Interactional and Clinical Components in Successful and Unsuccessful Therapeutic Experiences

Clinical Evaluation Component	Successful Therapeutic Experience (Democratic and Flexible Pattern)	Unsuccessful Therapeutic Experience (Authoritarian and Rigid Pattern)
Approach to therapeutic techniques	Technique serves the person; it is a flexible instrument adapted to the individual's capacities	Technique becomes an end in itself; rigid insistence on imposing protocols regardless of the client's circumstances
Power and communication structure	Interactive, collaborative, horizontal, transparent, and based on an equitable alliance	Hierarchical, vertical, directive, controlling, and authoritarian

E-ISSN: 3041-8828

Regulation of emotional burden and trauma	Gradual scaffolding, emotion regulation, and progression in accordance with the client's resilience	Aggressive flooding, premature exposure, and disregard for vulnerability thresholds
Approach to barriers and resistance	Viewed as a natural interpersonal phenomenon requiring empathy and methodological reconsideration	Viewed as client pathology, destructive resistance, personal inadequacy, and grounds for blame
Management of session feedback	Full openness, acceptance of client criticism, and continuous modification of the treatment plan	Rejection of criticism, rationalization of shortcomings, defensiveness, and negative responses to feedback
Developmental goal and outcome	Promotion of autonomy, sustainable self-efficacy, and internalization of therapeutic tools	Dependency characterized by learned helplessness, feelings of incompetence, failure, or premature termination

As shown in Table 6, clinical performance patterns across the success and failure continua involve substantive and structural contrasts. In successful therapeutic experiences, technique functions instrumentally and is reformulated in accordance with clients' circumstances, whereas in unsuccessful experiences, technique becomes fetishized as an end to which clients are forced to adapt, often painfully. Power distribution in successful therapy is collaborative and horizontal, with the client's voice accorded legitimacy; in unsuccessful therapy, however, the dominance of a vertical model centered on the authoritative therapist constrains client agency. With respect to trauma processing, successful treatment proceeds through safe scaffolding designed to prevent emotional paralysis, whereas unsuccessful treatment employs abrupt exposure without adequate regulation of emotional burden, thereby contributing to retraumatizing emotional flooding. The approach to resistance shown in Table 6 also reflects differences in the level of clinical maturity: successful therapists view challenges as relational phenomena and modify the treatment plan accordingly, whereas unsuccessful therapists attribute failure to the client's psychological structure, thereby obstructing the possibility of clinical correction. The ultimate consequence of this structural distinction is the development of client self-efficacy in the former pattern and learned helplessness and treatment discontinuation in the latter.

Ultimately, phenomenological exploration of clients' experiences leads to the identification of the essential structure of the phenomenon. This foundational layer summarizes the logic linking therapist behavior, dominant interactional patterns within the therapy room, and the ultimate outcome of clinical effectiveness. The essential structure emerges from the synthesis of subthemes and dialectical analysis of factors contributing to success and failure, demonstrating how the central quality of therapy is formed through the interaction of relational, emotional, and technical elements. Table 7 presents the essential structure of clients' experiences of the clinical process.

Table 7

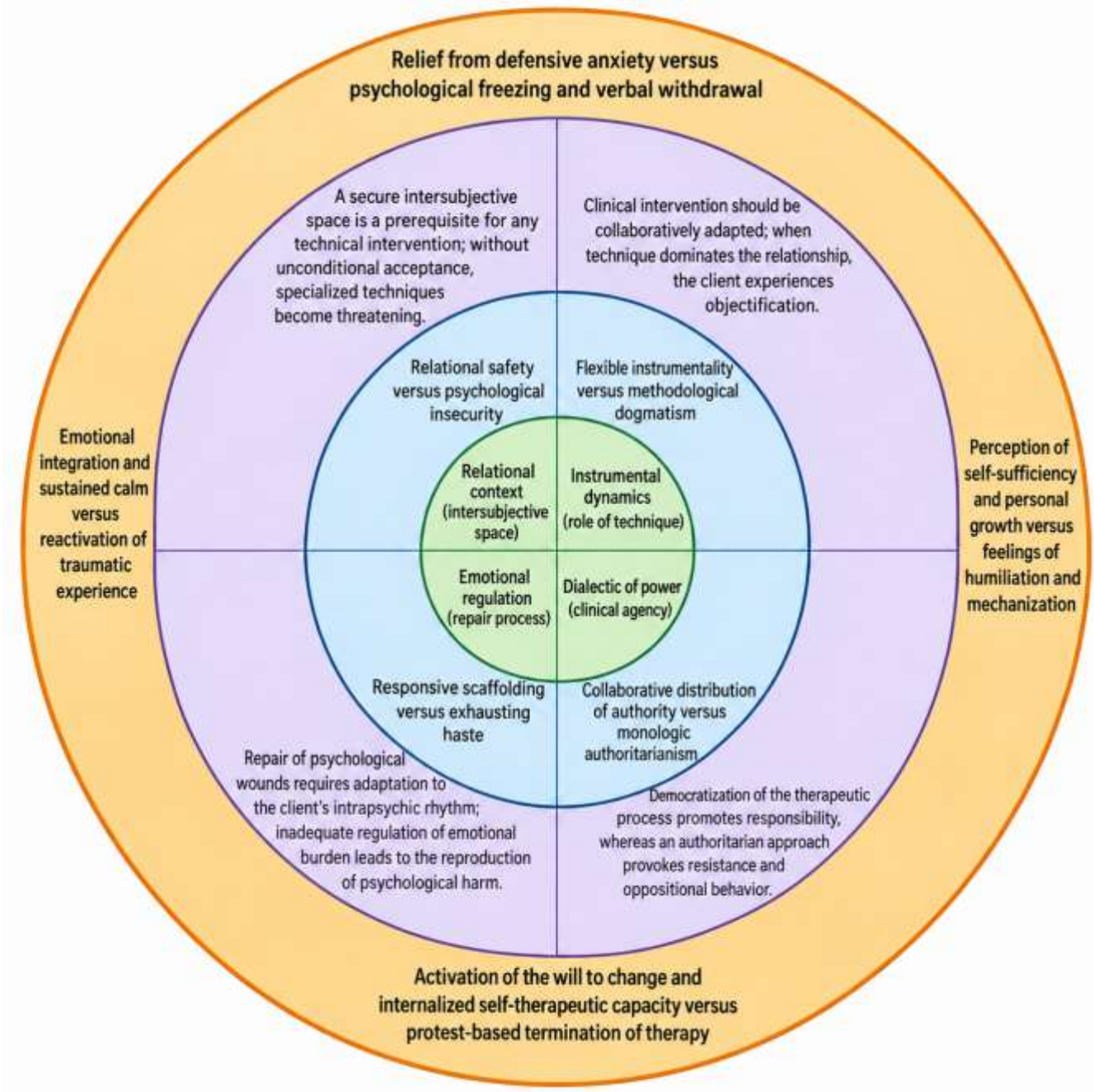
Essential Structure of Clients' Lived Experiences of the Dialectic at the Core of Therapy: Relationship and Technique

Structural Level of the Phenomenon	Fundamental Component of Lived Experience	Phenomenological Explanation and Clinical Mechanism	Ultimate Outcome for the Client
Relational context (intersubjective space)	Relational safety versus psychological insecurity	A secure intersubjective space is a prerequisite for any technical intervention; without unconditional acceptance, specialized techniques may be experienced as threatening.	Relief from defensive anxiety versus psychological freezing and verbal withdrawal
Instrumental dynamics (role of technique)	Flexible instrumentality versus methodological dogmatism	Clinical interventions should be collaboratively translated into the client's experience; dominance of technique over relationship leads to client objectification.	Perception of self-sufficiency and personal growth versus feelings of humiliation and mechanization
Dialectic of power (clinical agency)	Collaborative distribution of authority versus monologic authoritarianism	Democratization of the therapeutic process promotes responsibility, whereas an authoritarian approach provokes resistance and oppositional behavior.	Activation of the will to change and internalized self-therapeutic capacity versus protest-based treatment termination
Emotional regulation (repair process)	Responsive scaffolding versus exhausting haste	Repair of psychological wounds requires adaptation to the client's intrapsychic rhythm; inadequate regulation of emotional burden may reproduce psychological harm.	Emotional integration and sustained calm versus reactivation of traumatic experience

E-ISSN: 3041-8828

Figure 1

Essential Structure of Clients' Lived Experiences of the Dialectic at the Core of Therapy: Relationship and Technique



As shown in Table 7, the essential structure of clients' experiences rests on a central phenomenological principle: "The therapeutic relationship constitutes the psychological and experiential context within which technique operates; without a secure relationship, technique may become not only ineffective but potentially traumatizing." The analysis demonstrates that the intersubjective space precedes any specific intervention. In the absence of perceived safety, even highly effective behavioral and cognitive techniques may be experienced as intrusive or threatening, pushing clients toward freezing or defensive responses. The instrumental-dynamics component demonstrates that clients clearly distinguish between responsive flexibility and rigid protocol implementation. Clients who perceived therapy as successful viewed techniques as a ladder placed in their hands by the therapist, whereas in unsuccessful cases techniques were represented as a cage constraining dimensions of the individual's existence. The structure of

E-ISSN: 3041-8828

authority distribution further demonstrates that the delegation of agency and cultivation of a sense of collaboration constitute the foundation for sustained therapeutic engagement and prevent clinical conflicts from developing into perceived treatment failure. This essential structure indicates that achieving sustained therapeutic effectiveness requires the development of relational competencies, internalization of principles of clinical ethics, and receptivity to feedback to receive priority equal to, or potentially greater than, the acquisition of purely technical skills associated with particular schools of psychotherapy.

4. Discussion and Conclusion

The present study explored clients' lived experiences of the dialectic of success and failure in psychotherapy, with particular attention to interactional patterns, the therapeutic alliance, the relational use of technique, power dynamics, emotional regulation, rupture, and repair. The findings revealed a coherent phenomenological structure organized around two contrasting poles. At the successful pole, clients described a secure and liberating therapeutic bond characterized by unconditional acceptance, psychological safety, flexible clinical competence, collaborative goal setting, therapist authenticity, empathic attunement, ethical boundaries, and the progressive development of client autonomy. At the unsuccessful pole, clients described interactional rupture and rigidity, including domination by therapeutic protocols, objectification, authoritarian communication, limited responsiveness to feedback, cultural disconnection, premature engagement with traumatic material, and instability in professional boundaries. Taken together, the results indicate that psychotherapy was experienced not primarily as the mechanical delivery of techniques but as an intersubjective process in which technical interventions acquired therapeutic value only when embedded within a safe, responsive, and collaborative relationship.

One of the most important findings was the central role of relational safety and unconditional acceptance in successful psychotherapy. Participants who regarded their therapy as successful repeatedly described feeling seen, heard, respected, and protected from judgment. This sense of safety appeared to facilitate emotional disclosure, weaken defensive inhibition, and increase willingness to engage with difficult psychological material. This finding is consistent with phenomenological evidence showing that clients often define a helpful therapeutic relationship in terms of trust, acceptance, empathy, authenticity, and the experience of being understood rather than merely in terms of symptom-focused intervention (Ghamari Zamehrir et al., 2023). It also supports the broader client-centered position that clients are active contributors to change and that therapeutic progress depends in part on whether the interpersonal environment permits them to explore experience without excessive threat or coercion (Bohart & Wade, 2013). Thus, the therapeutic relationship appears to function not as an adjunct to technique but as the experiential context that determines whether technique is received as supportive, meaningful, and usable.

The finding that a secure therapeutic bond formed the "core of success" also aligns with contemporary conceptualizations of the therapeutic alliance as a dynamic process rather than a static treatment variable. Zilcha-Mano and Fisher distinguished between relatively stable and session-specific components of the alliance, emphasizing that the client–therapist bond changes across treatment and may itself participate in therapeutic change (Zilcha-Mano & Fisher, 2022). The participants in the present study similarly described safety and collaboration as processes continuously constructed through therapist behavior, feedback, flexibility, and interpersonal responsiveness. The findings are also compatible with evidence that clients' and therapists' perceptions of the alliance may differ and that the client's evaluation of alliance quality is particularly important for understanding outcome (Tschuschke et al., 2020). The present results therefore reinforce the importance of attending to the client's subjective perception of the relationship rather than assuming that procedural adherence or the therapist's own assessment necessarily indicates alliance strength.

A second major finding concerned the importance of flexible clinical competence. Clients with successful treatment experiences valued structure, professional mastery, and clarity, but they also emphasized that effective therapists adapted the pace, content, and form of intervention to the client's emotional capacity and life circumstances. In other words, structure was helpful when combined with responsiveness, whereas rigidity was experienced as constraining. This pattern strongly supports process-based approaches that conceptualize psychotherapy as the flexible targeting of clinically relevant processes rather than the uniform application of predefined protocols (Ghaderi & Mehrabi, 2023). The finding also helps reconcile the apparent tension between treatment fidelity and therapeutic flexibility. The participants did not reject technique or

E-ISSN: 3041-8828

structure; rather, they rejected technique when it became detached from their individual experience. This distinction is important because it suggests that successful psychotherapy requires technical competence together with sufficient relational sensitivity to determine when, how, and at what pace a technique should be used.

This interpretation is consistent with comparative research on successful and less successful psychotherapies. Werbart et al. showed that differences between better and poorer outcomes may emerge through the ways therapists respond to clients and manage evolving relational processes, rather than simply through the formal therapeutic orientation employed (Werbart et al., 2019). Likewise, client accounts of failed psychotherapy have emphasized poor fit, lack of responsiveness, and insufficient adaptation as central elements of unsuccessful treatment (Knox et al., 2023). In the current study, clients who experienced rigid protocol implementation described feeling reduced to a "case" rather than understood as a person. This form of objectification suggests that when protocol fidelity becomes the dominant organizing principle of treatment, the client's individuality may be subordinated to a standardized therapeutic script. The result is not merely dissatisfaction but a deterioration in agency and relational trust.

The contrast between "technique serving the person" and "technique becoming an end in itself" is also compatible with concerns regarding negative outcomes in psychotherapy. Psychological interventions, even when empirically supported, are not uniformly beneficial and can lead to deterioration or adverse experiences under certain conditions (Barlow, 2010; Mays & Franks, 2025). The current findings extend this literature by showing how such negative effects may be phenomenologically experienced. Participants did not generally describe harm as arising from the existence of a technique itself; instead, harm was associated with decontextualized, premature, inflexible, or relationally insensitive application. This observation is consistent with methodological discussions emphasizing that treatment failure cannot be reduced to nonresponse and should be examined in relation to process, client experience, and possible adverse consequences (Dandachi-FitzGerald et al., 2023; Farahani et al., 2021).

A third central finding involved the distribution of power within the therapeutic relationship. Successful psychotherapy was experienced as collaborative, horizontal, and based on shared goals, whereas unsuccessful psychotherapy was associated with hierarchy, command, excessive certainty, and the silencing of client feedback. Clients valued therapists who preserved professional expertise while allowing them meaningful participation in decisions. This finding is consistent with the conceptualization of clients as active agents rather than passive recipients of treatment (Bohart & Wade, 2013). The present findings further suggest that client agency is not simply a desirable philosophical principle but a clinically consequential process. When participants experienced shared authority, they reported greater responsibility, engagement, and self-efficacy; when they experienced unilateral authority, they reported defensiveness, resistance, helplessness, and eventual disengagement.

The relevance of these power dynamics is also evident in the literature on ethical challenges in counseling and psychotherapy. Ethical practice requires attention to autonomy, dignity, professional boundaries, informed participation, and the responsible use of therapist authority (Hosseini Beyouki et al., 2024). In the present study, boundary violations were not limited to overt misconduct; repeated schedule changes, lack of reliability, dismissive responses to client concerns, and failure to respect the client's perspective also eroded trust. These findings indicate that the therapeutic frame itself functions as an ethical and relational structure. Professional reliability communicates respect and predictability, whereas inconsistency may weaken the client's sense that the therapeutic environment is safe and trustworthy.

The findings related to alliance rupture provide another important contribution. Clients described unsuccessful therapy in terms of cumulative relational fractures: feeling judged, unheard, culturally misunderstood, pressured, or blamed for lack of progress. These experiences resemble alliance ruptures involving withdrawal, confrontation, reduced engagement, and breakdown in collaborative work. However, the present results indicate that rupture alone was not necessarily decisive; what mattered was whether the therapist recognized and repaired it. This observation is closely aligned with research showing that temporary failures in the alliance can shift toward repair when relational difficulties are acknowledged and processed constructively (Mylona et al., 2023). Conversely, when therapists responded defensively or attributed the problem exclusively to client resistance, rupture deepened. Thus, the findings support the view that successful therapy is not rupture-free therapy, but therapy in which rupture can be identified, negotiated, and transformed.

The experiences of participants who described prolonged stalemate also correspond to phenomenological work on

E-ISSN: 3041-8828

therapeutic deadlock. Werbart et al. showed that therapists can experience treatment as stuck when recurring interactional patterns remain unresolved and no meaningful movement occurs (Werbart et al., 2023). The current findings provide the complementary client perspective: deadlock was experienced as the therapist's unwillingness to adapt, failure to receive feedback, and repetition of ineffective interventions. This suggests that clinical deadlock is jointly constituted in the interaction, even though the therapist carries professional responsibility for monitoring and responding to it. The present findings therefore support routine attention to signs of stagnation and the use of client feedback as clinically meaningful information rather than as evidence of resistance alone.

Another salient result concerned trauma processing and emotional pacing. Participants described successful therapy as involving gradual scaffolding and careful regulation of emotional burden, whereas unsuccessful therapy sometimes involved premature confrontation with traumatic memories before sufficient safety had been established. These clients reported intense anxiety, emotional destabilization, and treatment discontinuation. This pattern is consistent with broader concerns about negative experiences during psychotherapy, where treatment intensity, client vulnerability, therapist behavior, and poorly timed interventions have been identified as potential risk factors (Hardy et al., 2019). It also reinforces the principle that technically appropriate exposure or trauma-focused work can become counterproductive if emotional readiness and relational safety are insufficient. The findings therefore suggest that pacing is not a minor implementation detail but a core component of clinical competence.

Cultural responsiveness emerged as another important dimension of successful and unsuccessful therapy. Some participants experienced relational rupture when therapists appeared inattentive to their cultural background or lifestyle, resulting in perceptions of mechanical empathy or interpersonal distance. This finding corresponds closely with culturally adapted psychotherapy approaches emphasizing that treatment should be responsive to clients' values, language, social context, and culturally shaped understandings of distress (Ziaei & Zarani, 2026). Cultural responsiveness in the present study was experienced not only as modification of intervention content but also as a relational act of recognition. When cultural context was neglected, clients interpreted the therapist's response as evidence of not being fully understood. This suggests that cultural competence and therapeutic alliance are deeply interconnected rather than separate clinical domains.

The present findings also indicate that therapist personality and interpersonal style may influence whether treatment is experienced as democratic or authoritarian. Characteristics such as rigidity, defensiveness, dominance, emotional distance, and limited receptivity to criticism can shape the therapeutic climate, while openness, authenticity, patience, and flexibility may facilitate collaboration. This interpretation is consistent with literature emphasizing the role of both therapist and client personality in the psychotherapy process (Shabib Asl & Alinaghi Lou, 2020). Importantly, however, the present findings should not be interpreted as locating responsibility solely within therapist traits. Rather, they suggest that competent therapists need sufficient self-awareness to recognize how their interpersonal tendencies interact with the client's sensitivities, expectations, and relational history.

The contrast between successful and unsuccessful experiences also mirrors previous comparisons of clients with good and poor outcomes. McElvaney and Timulak found that clients' accounts of successful therapy were distinguished by meaningful engagement, helpful therapist responsiveness, and perceived progress, whereas poorer outcomes involved less productive therapeutic experiences (McElvaney & Timulak, 2013). Similarly, Knox et al. documented that clients' perspectives on psychotherapy failure frequently center on relational mismatch, lack of understanding, and interventions that do not fit their needs (Knox et al., 2023). The current study extends these findings by organizing such experiences into a dialectical phenomenological model in which success and failure are differentiated across relational safety, technique, power, emotional regulation, feedback, and developmental outcome.

The findings further support calls to expand psychotherapy outcome research beyond standardized symptom reduction. Participants evaluated successful treatment through increased autonomy, self-efficacy, emotional integration, and internalization of therapeutic capacities, whereas failure involved shame, dependency, helplessness, or premature termination. These experiences illustrate why individualized and qualitative approaches are necessary for understanding therapeutic outcome (Hill et al., 2013). Quantitative symptom improvement may fail to capture whether the client felt empowered or diminished by therapy. Qualitative inquiry can therefore reveal clinically meaningful changes that may remain invisible in

E-ISSN: 3041-8828

standardized measures (McLeod, 2013). In this sense, the present study demonstrates that the meaning of "outcome" should encompass both what changed and how the client experienced the process through which change occurred.

The study also resonates with research on repeated psychotherapy failure. Recurrent unsuccessful experiences may create enduring emotional structures involving mistrust, hopelessness, anticipatory anxiety, and sensitivity to future therapeutic interactions (Heydari Kia & Esmaeili, 2024). Several themes identified in the present study—particularly blame, objectification, emotional flooding, and authoritarian communication—could plausibly contribute to such cumulative effects. This underscores the importance of understanding failed psychotherapy not simply as one unsuccessful episode but as an experience that may alter the client's future relationship with mental health care. Awareness of these consequences is particularly important given longstanding evidence that empirically supported treatments still produce nonresponse in a meaningful proportion of clients (Lambert, 2011).

Overall, the findings support an integrative interpretation of psychotherapy success and failure. Effective therapy appears to require more than technical accuracy: it requires an alliance sufficiently safe to permit vulnerability, a therapist sufficiently flexible to adapt technique, an ethical distribution of power that preserves client agency, careful regulation of emotional burden, and ongoing openness to feedback and rupture repair. Conversely, failure appears more likely when protocol overrides personhood, authority becomes unilateral, emotional pacing exceeds the client's capacity, or feedback is treated defensively. This integrated view is consistent with the broader literature on negative outcomes, alliance processes, qualitative outcome assessment, cultural responsiveness, and treatment failure (Dandachi-FitzGerald et al., 2023; Ghamari Zamehrir et al., 2023; Mays & Franks, 2025; Mylona et al., 2023). The central implication is that relationship and technique should not be conceptualized as competing explanations of therapeutic change; rather, technique achieves its clinical meaning through the relational context in which it is delivered.

The present study has several limitations. First, the sample consisted of 18 participants recruited purposively from individuals with prior experience of individual psychotherapy, and therefore the findings are intended to provide phenomenological depth rather than statistical generalizability. Second, the sample included successful, unsuccessful, and mixed experiences across different therapeutic approaches, which enriched the range of perspectives but limited the possibility of attributing specific patterns to particular treatment modalities. Third, the findings were based on retrospective self-reports and may have been influenced by memory reconstruction, current psychological state, or later reinterpretation of therapeutic events. Fourth, therapist perspectives were not collected, making it impossible to examine dyadic discrepancies between client and therapist interpretations of the same rupture or clinical decision. Fifth, the study did not systematically differentiate experiences according to diagnosis, treatment duration, therapist experience, or psychotherapy orientation, and these factors may shape perceptions of both alliance and outcome.

Future research should examine the proposed phenomenological structure using larger and more diverse samples and should compare clients across specific therapeutic orientations, diagnostic groups, age categories, and treatment settings. Dyadic studies including both clients and therapists would be particularly valuable for identifying discrepancies in perceptions of rupture, safety, power, and progress. Longitudinal qualitative designs could follow participants prospectively across treatment to capture turning points as they occur rather than relying exclusively on retrospective reconstruction. Mixed-method studies could combine alliance measures, symptom change, dropout indicators, and session-by-session feedback with qualitative interviews to test whether the identified relational patterns predict improvement, deterioration, or premature termination. Future studies could also investigate cultural variation in preferred forms of therapist authority, emotional pacing, and collaboration and examine how repeated treatment failure influences subsequent help-seeking, alliance formation, and expectations of psychotherapy.

In clinical practice, therapists should treat relational responsiveness as a core professional competency rather than a secondary interpersonal skill. Therapy should begin and proceed with explicit attention to psychological safety, collaborative goal setting, client preferences, and ongoing evaluation of whether the treatment approach remains meaningful and tolerable. Therapists should routinely invite critical feedback, normalize disagreement, and respond to signs of withdrawal or confrontation as potential alliance ruptures requiring exploration rather than automatically labeling them as resistance. Techniques—particularly emotionally intense or trauma-focused interventions—should be paced according to the client's readiness and embedded within adequate relational and regulatory

E-ISSN: 3041-8828

scaffolding. Training programs should place greater emphasis on rupture repair, cultural responsiveness, ethical use of authority, therapist self-reflection, and management of negative outcomes. Clinical supervision should likewise examine not only whether interventions were technically correct but also how clients experienced the therapist's stance, flexibility, boundaries, and use of power.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We hereby thank all individuals for participating and cooperating us in this study.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

References

Barlow, D. H. (2010). Negative Effects from Psychological Treatments: A Perspective. *American psychologist*, *65*(1), 13-20. https://doi.org/10.1037/a0015643

Bohart, A. C., & Wade, A. G. (2013). The Client in Psychotherapy. In (6th ed., pp. 219-257). John Wiley & Sons.

Dandachi-FitzGerald, B., Otgaar, H., & Merckelbach, H. (2023). When Psychotherapy Fails. In (pp. 301-319). Springer International Publishing. https://doi.org/10.1007/978-3-031-14332-8_16

Farahani, H., Azadfallah, P., Roshan Chesli, R., Pourmohammadreza-Tajrishi, M., Esrafilian, F., Fathali Lavasani, F., & Chiniforushan, F. (2021). Methodology for Analyzing 'Treatment Failure' in Psychotherapy Research: A Guide for Clinicians and Researchers. *Clinical Psychology and Personality*, *19*(2), 173-182.

Ghaderi, F., & Mehrabi, A. (2023). A Review of Process-Based Therapy: A New Paradigm in Psychotherapeutic Interventions. *Journal of Clinical Excellence*, *13*(1), 45-56.

Ghamari Zamehrir, V., Pournaghash Tehrani, S. S., & Ghorbani, N. (2023). Clients' Lived Experiences of the Therapeutic Relationship: A Phenomenological Study. *Journal of Psychological Science*, *22*(124), 667-684.

Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., & Parry, G. D. (2019). Risk Factors for Negative Experiences during Psychotherapy. *Psychotherapy Research*, *29*(3), 403-414. https://doi.org/10.1080/10503307.2017.1393575

Heydari Kia, J., & Esmaeili, F. (2024). Identifying Affective Structures in the Experience of Repeated Failures in Psychotherapy Treatments. *Health Psychology and Behavioral Disorders*, *2*(2).

Hill, C. E., Chui, H., & Baumann, E. (2013). Revisiting and Envisioning the Outcome Problem in Psychotherapy: An Argument to Include Individualized and Qualitative Measurement. *Psychotherapy*, *50*(1), 68-76. https://doi.org/10.1037/a0030571

Hosseini Beyouki, N., Salimi Bajestani, H., Esmaeili, M., & Farahbakhsh, K. (2024). Strategies for Coping with Ethical Challenges in Counseling and Psychotherapy. *Ethics Research*(24), 109-141.

Knox, S., Miller, C., Twidwell, R. E., & Knowlton, G. (2023). Client Perspectives on Psychotherapy Failure. *Psychotherapy Research*, *33*(3), 298-315. https://doi.org/10.1080/10503307.2022.2110020

Lambert, M. J. (2011). What Have We Learned about Treatment Failure in Empirically Supported Treatments? Some Suggestions for Practice. *Cognitive and Behavioral Practice*, *18*(3), 413-420. https://doi.org/10.1016/j.cbpra.2011.02.002

Mays, D. T., & Franks, C. M. (2025). *Negative Outcome in Psychotherapy and What to Do About It*. Springer.

McElvaney, J., & Timulak, L. (2013). Clients' Experience of Therapy and Its Outcomes in 'Good' and 'Poor' Outcome Psychological Therapy in a Primary Care Setting: An Exploratory Study. *Counselling and Psychotherapy Research*, *13*(4), 246-253. https://doi.org/10.1080/14733145.2012.761258

McLeod, J. (2013). Qualitative Research: Methods and Contributions. In (6th ed., pp. 49-84). John Wiley & Sons.

Mylona, A., Avdi, E., & Paraskevopoulos, E. (2023). Alliance Rupture and Repair Processes in Shifts from Momentary Failure to Repair. In (pp. 98-125). Routledge. https://doi.org/10.4324/9781003439219-6

Shabib Asl, N., & Alinaghi Lou, S. (2020). Client and Therapist Personality in Psychotherapy. Tehran.

Tschuschke, V., Koemeda-Lutz, M., von Wyl, A., Crameri, A., & Schulthess, P. (2020). The Impact of Patients' and Therapists' Views of the Therapeutic Alliance on Treatment Outcome in Psychotherapy. *The Journal of Nervous and Mental Disease*, *208*(1), 56-64. https://doi.org/10.1097/NMD.0000000000001111

Werbart, A., Annevall, A., & Hillblom, J. (2019). Successful and Less Successful Psychotherapies Compared: Three Therapists and Their Six Contrasting Cases. *Frontiers in psychology*, *10*, 816. https://doi.org/10.3389/fpsyg.2019.00816

E-ISSN: 3041-8828

Werbart, A., Gråke, E., & Klingborg, F. (2023). Deadlock in Psychotherapy: A Phenomenological Study of Eight Psychodynamic Therapists' Experiences. In (pp. 28-46). Routledge. https://doi.org/10.4324/9781003439219-3

Ziaei, L., & Zarani, F. (2026). Culturally Adapted Psychotherapy: A Systematic Review and Introduction of the Integrated Model of Cultural Adaptation of Psychotherapy (IMCAP). *Applied Psychology*(77), 10-33.

Zilcha-Mano, S., & Fisher, H. (2022). Distinct Roles of State-Like and Trait-Like Patient-Therapist Alliance in Psychotherapy. *Nature Reviews Psychology*, *1*(4), 194-210. https://doi.org/10.1038/s44159-022-00029-z

E-ISSN: 3041-8828