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In-session emotional experiencing in brief psychotherapy conducted by trainee psychologists: process, alliance, and the role of therapist persuasiveness

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Abstract

Despite the recognition of emotional experiencing as a key change factor in psychotherapy, gaps remain regarding how clinical training influences this dimension, particularly in brief interventions conducted by trainees, and preliminary process data on this phenomenon in Portuguese clinical training contexts are scarce. This study examined emotional experiencing in brief psychotherapy conducted by trainee psychologists undergoing structured experiential training with deliberate practice, analyzing whether patients show a progressive increase in experiential depth across sessions, whether higher levels of emotional experiencing are associated with stronger therapeutic alliance and greater symptom reduction, and whether therapists' persuasiveness predicts patients' emotional experiencing at different session moments. A quantitative repeated measures design was adopted with 5 trainee psychologists and 15 adult patients in a university clinic. Four sessions per patient were analyzed by three independent researchers using standardized measures: the Outcome Questionnaire-45 (OQ-45), the Working Alliance Inventory – Short Revised (WAI-SR), the Experiencing Scale (EXP), and the Therapist Persuasiveness Rating Scale (TPRS). Mixed linear models were then applied to assess longitudinal changes and relationships among variables. A significant reduction in psychological distress and an increase in therapeutic alliance indices, particularly in the tasks and bond dimensions, were observed. No significant changes were found in the depth of emotional experiencing, nor robust associations of this variable with symptom improvement or alliance, except for a marginal negative relationship between goal consensus and modal emotional experiencing. These findings suggest a stability of emotional experiencing in brief intervention contexts, highlighting the central role of collaborative processes in clinical change.

Key words: emotional experiencing, therapeutic alliance, trainee psychologists, therapist persuasiveness, brief psychotherapy.

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Introduction

The effectiveness of psychotherapy has been widely demonstrated in international literature, both in the treatment of psychopathology and in the promotion of psychological well-being at different stages of life. Meta-analyses and systematic reviews confirm the robust benefits of therapeutic interventions across multiple clinical contexts, ranging from the acute phase of symptoms to relapse prevention and the long-term reinforcement of psychological well-being (Abu Sabra *et al.*, 2023; Barkham & Lambert, 2021; Barkowski *et al.*, 2020; Cuijpers, 2017; Eielsen *et al.*, 2022; Hilbert *et al.*, 2019; Munder *et al.*, 2019; Rahmani *et al.*, 2020; Sousa, 2017). However, as the demand for brief treatments increases and pressure mounts to optimize resources in mental health services, a central question continues to challenge the scientific community: what are the mechanisms and intervening processes that truly enable deep clinical change in psychotherapy (Llewelyn *et al.*, 2016; Orlinsky *et al.*, 2004), and how can they be cultivated and mobilized by therapists in training (Crits-Christoph *et al.*, 2013; Gelo & Salvatore, 2016; Llewelyn *et al.*, 2016)?

In psychotherapy research, a significant portion of the focus falls on the so-called common factors, particularly the therapeutic alliance, with multiple studies demonstrating its predictive value for clinical outcomes across theoretical models and populations (Flückiger *et al.*, 2018; Horvath *et al.*, 2011; Zilcha-Mano *et al.*, 2018). The therapeutic alliance, comprising affective bond, collaboration, and shared goals and tasks, is consistently recognized as a key element transcending specific intervention models. Recent meta-analyses reveal moderate-to-strong correlations between alliance quality and therapeutic gains, even in brief interventions, underscoring the relationship's role as a vehicle for change.

The quality of the therapeutic alliance is shaped by a complex interplay of factors, including specific therapist characteristics such as warmth, flexibility, and interpersonal sensitivity (Ackerman & Hilsenroth, 2003), individual interpersonal predictors related to the therapist's attachment style and self-awareness (Nissen-Lie *et al.*, 2010), and the therapist's developmental trajectory toward greater clinical responsiveness (Wu & Levitt, 2020). These findings under-

score that alliance formation is not a static relational given but an active, co-constructed process that evolves with therapist experience and training.

At the same time, growing attention has been paid to patients' intrapersonal processes, particularly emotional experience. Emotional experiencing – defined as the degree of active engagement of clients with their emotions, including the ability to contact, explore, and meaning-making of internal experiences during sessions – has emerged as one of the main mechanisms of change in psychotherapy, repeatedly associated with better clinical outcomes regardless of the therapeutic model employed (Elliott *et al*., 2021; Goldman, 2019; Pascual-Leone & Yeryomenko, 2017).

The concept, deeply rooted in humanistic and experiential traditions, has been systematically operationalized through instruments such as the Experiencing Scale (EXP), which quantifies emotional depth throughout clinical sessions (Klein, 1969; Pascual-Leone & Yeryomenko, 2017). Emotion-Focused Therapy (EFT) models, developed by Greenberg and collaborators, posit that deep emotional processing – not only the expression but also the integration and transformation of emotion – constitutes a fundamental ingredient of psychotherapy change (Greenberg, 2016).

A meta-analysis by Peluso and Freund (2019), based on 42 studies, found a medium-to-large effect (r=0.40) between clients' emotional expression and therapeutic success, and recent meta-analyses show that the ability to work deeply with emotions is linked to significant symptomatic improvement, particularly in depressive cases (Sønderland *et al.*, 2024).

Experiential engagement is influenced by the therapist's work and the conditions of the therapeutic relationship (Anderson & Perlman, 2022; Greenberg, 2015), highlighting the importance of training in emotional competencies.

In the context of clinical practice – especially within university or community-based settings – there is a growing shift toward brief psychotherapeutic interventions (Gelo & Salvatore, 2016). This new paradigm not only demands the optimization of therapeutic processes but also poses specific challenges to emotional deepening and the gradual construction of alliance. The limited number of sessions and the diversity of patients' presenting issues often hinder the creation of space for in-depth emotional exploration and the progressive development of trust between patient and therapist (Goldman *et al.*, 2005). This challenge is intensified in the case of trainee psychologists, who are in a critical phase of consolidating relational and technical skills, and whose practices are strongly shaped by the teaching, supervision, and training models implemented during internship.

International literature – supported by clinical skill development models and recent empirical studies – emphasizes the importance of training approaches based on deliberate practice and intensive supervision for acquiring experiential skills (Greenberg, 2016; Hill *et al.*, 2015; Vaz *et al.*, 2023). Deliberate practice involves focused training, continuous feedback, systematic exposure to different clinical cases, and intentional reflection on session processes, representing a qualitative leap beyond traditional training models based solely on theoretical transmission or passive observation. Evidence shows that therapists who engage in deliberate practice develop greater adaptability, process responsiveness, and flexibility in facilitating emotional work, leading to more sophisticated, deep, and transformative sessions – even in brief interventions (Hill *et al*., 2015). Recent studies indicate that these experiential processes – especially emotional facilitation and strong alliance building – are closely linked to symptom reduction and greater maintenance of therapeutic gains (Goldman, 2019; Watson *et al.*, 2011; Yamin *et al.*, 2023).

Despite conceptual and empirical advancements, substantial gaps remain in translating these findings to initial training contexts, particularly in brief interventions and Portuguese clinical populations. Few studies systematically address the impact of deliberate practice-based clinical training on emotional processes, therapeutic alliance, and symptom adjustment in clients treated by trainee psychologists. There is also a lack of robust preliminary process data on EXP score evolution in brief interventions conducted within Portuguese clinical training contexts. This gap is particularly relevant given the specific organizational characteristics of Portuguese university clinics, including the curricular internship structure, the supervision model, and the predominantly brief intervention format, which differ meaningfully from the clinical training systems most represented in international literature (predominantly North American and Northern European). Understanding how emotional experiencing unfolds in this specific training context is therefore both scientifically and practically relevant for informing national clinical training and supervision guidelines (Sønderland *et al.*, 2024; Watson *et al.*, 2011). Additionally, time constraints and patient variability pose challenges to rigorously evaluating processes of therapeutic change.

Evaluating intersession processes thus requires rigorous, multimethodological strategies integrating reliable observational measures such as the EXP with self-reports of therapeutic alliance and psychological distress. Observational instruments hold high value for studying emotional experiencing because they allow for detailed analysis of clients' discourse and emotional involvement during sessions (Watson *et al.*, 2011). However, literature emphasizes that no single measure can fully capture the richness of clients' lived experiences, underscoring the need for methods combining external observation and subjective reporting to ensure rigor and validity in understanding change mechanisms (Elliott *et al.*, 2021). Process studies show that alignment between external coding and clients' internal experience tends to be moderate, failing to fully capture subtle, implicit, or nonverbal emotional phenomena (Greenberg & Pascual-Leone, 2006).

Therapists' skills development, especially the capacity to stimulate and deepen clients' emotional engagement, depends on multiple interpersonal and relational factors. Regarding therapist characteristics, the literature highlights empathy, emotional expressiveness, verbal fluency, persuasiveness, rupture-repair ability, and sensitivity to clients' experiences as critical indicators of clinical effectiveness (Anderson *et al.*, 2009; Hill *et al.*, 2015; Vaz *et al.*, 2023).

Persuasion is considered one of the facilitating interpersonal skills, which refers to a set of therapist characteristics that make a significant contribution to psychotherapeutic success (Anderson *et al.*, 2009; Anderson *et al.*, 2016). A persuasive therapist is characterized by a responsive voice, by verbal and non-verbal behaviors that are attuned to what is being communicated to the client, by maintaining eye contact during emotionally charged moments, and by a fluent communicative style (Afonseca *et al.*, 2023; Vaz & Sousa, 2024). This dimension has been associated with a lack of professional credibility on the part of the therapist, which seems to justify the scarcity of direct research on this construct (Sequeira *et al.*, 2024; Vaz & Sousa, 2024), making it the least studied of the common factors (Frank & Frank, 1993; Vaz & Sousa, 2024).

Frank's (1961) conceptualization of persuasion and the persuasion skills described by Vaz and Sousa (2024) supported the development of a scientifically validated instrument that specifically measures therapist persuasion, the Therapist Persuasiveness Rating Scale (TPRS), which is currently the only instrument designed for

this purpose (Afonseca *et al.*, 2023). Studies have reported associations between persuasion and emotions, such as Angie *et al.* (2011), who found that persuasion related to decision-making processes was influenced by emotional activation, and Bless *et al.* (1990), who showed that susceptibility to the persuasion of an argument depended on mood and affective states. In psychotherapy, the stimulation of emotions has been highlighted as a potential facilitator of the therapist's transmission of the "therapeutic rationale" (Frank, 1961; Frank & Frank, 1993; Greenberg, 2004) and as a process through which therapist persuasion may be influenced by the therapist's emotional expressiveness (Heide, 2013; Otterson, 2015). Additionally, Frank (1961) proposed that a persuasive therapist combines credibility (*ethos*), the quality of the argument, and the capacity to elicit emotional activation in the client.

The conceptual link between therapist persuasiveness and patients' emotional experiencing thus rests on the therapist's active role in creating conditions for emotional engagement: a persuasive therapist, through attuned nonverbal communication, responsive voice, and the capacity to elicit and deepen affective states, may function as a facilitator of the experiential depth described by the EXP. While interpersonal attunement (*cf.* Stern, 2004) offers an adjacent theoretical frame, persuasiveness as operationalized by the TPRS captures a specific, measurable dimension of this facilitative function, making it a tractable construct for process research in training contexts.

Experiential training and deliberate practice enhance these attributes, though the process is progressive and variable. Trainee psychologists frequently present more rigid technical patterns and lower responsiveness, which can partially compromise the quality of emotional experiencing facilitated in therapy (Greenberg, 2016; Watson *et al.*, 2011). This reality underscores structural limitations in initial training and clinical instruction, calling for systematic research and refinement of pedagogical strategies implemented in training contexts. Even with the abundance of international studies linking emotional experiencing and clinical outcomes, the underlying mechanisms driving emotional depth in brief interventions and early training contexts remain insufficiently clarified. Questions persist regarding the impact of deliberate practice and experiential structuring of training on trainees' competencies, as well as the evolution of clients' emotional, relational, and symptom indicators. Process-based research in Portugal remains scarce, particularly studies that integrate observational measures, self-reports, and statistical analysis suited to the nested nature of data.

Hence, it is crucial to investigate how deliberate practice-based clinical training influences change factors such as emotional experiencing, therapeutic alliance, and psychological distress in brief psychotherapy conducted by clinical psychology trainees. Understanding whether training promotes progress in clients' emotional depth, alliance building, and sustained symptom reduction can not only contribute to scientific advancement but also decisively inform the improvement of supervised clinical practices within training contexts.

The relevance of this study is twofold: it addresses methodological and conceptual gaps in national research on brief psychotherapy within clinical training and offers practical implications for supervision programs by outlining strategies to enhance emotional involvement and process flexibility within time-limited interventions. Integrating observational instruments with subjective measures ensures rigor in evaluating processes of change, validating practices and methodologies attuned to the realities of psychological services.

Accordingly, the present study focuses on analyzing the depth of emotional experiencing in clients attending brief psychotherapy sessions conducted by trainees undergoing structured experiential training using deliberate practice. It systematically examines the relationships among emotional experience, therapeutic alliance, and clients' psychological distress throughout the brief intervention process, emphasizing the influence of training, intensive supervision, and trainees' interpersonal variability in facilitating change. Recognizing the multiple individual and relational factors that enhance or constrain emotional involvement and clinical efficacy – and mindful of contextual constraints in university clinics – this research centers on process dynamics and clients' change trajectories across phases of therapy. The findings are expected to inform teaching and supervision practices, contribute to the development of clinical guidelines, and support the design of training pathways better suited to the specifics of team-based and brief psychological interventions.

Within this framework, the fundamental research question emerges: how does deliberate practice-based clinical training relate to emotional experiencing depth, therapeutic alliance, therapist persuasion, and clinical outcomes in brief psychotherapy conducted by clinical psychology trainees?

Based on a critical review of national and international literature and reflecting the methodological and process-oriented concerns outlined above, the following specific hypotheses were formulated:

1. Clients will show a progressive increase in the depth of emotional experiencing across the analyzed therapy sessions.
2. Higher levels of emotional experiencing will be associated with a stronger therapeutic alliance.
3. Higher levels of emotional experiencing will be associated with a greater reduction of clients' reported psychological symptoms.
4. The average persuasiveness levels of the psychologists will predict the patients' average levels of emotional experiencing at each corresponding moment of the session (beginning, middle, and end).

This study, by integrating a multimethod approach and rigorous statistical design suited to nested data, aims to clarify key mechanisms of change in brief psychological interventions conducted by trainees, providing empirical evidence and practical recommendations to enhance training, clinical supervision, and psychological practice in Portugal. The findings are expected to support the development of more effective training programs, respond to emerging mental health service needs, and strengthen professional practices and client well-being.

Materials and Methods

Study design

The present study adopted a quantitative, longitudinal design with repeated measures, examining the effects of a structured EFT deliberate practice training program on psychotherapy process and outcome variables. The study was conducted in the context of a three-month EFT skills training program applied to psychology trainees. Given the absence of a control group and direct measures of competency acquisition, this program is treated as a contextual feature of the training setting rather than a formally manipulated independent variable. The primary dependent variable was patients' depth of emotional experiencing. Secondary outcomes included psychopathological symptoms and therapeutic alliance. Given the naturalistic clinical context, no control group was included, and changes over time were analyzed using repeated measures (Kazdin, 2022; Shadish *et al.*, 2002).

Participants

Participants included five psychologists (four integrated master's trainees and one clinician without professional experience), aged between 24 and 60 years, recruited from a university clinic's curricular internship program. Inclusion criteria were regular participation in supervised clinical practice and the availability to complete the EFT deliberate practice training.

Each psychologist followed three patients, resulting in a total of 15 adult patients (aged 22-55 years; M=37.47, SD=10.45), recruited through the university's extension service. Patients presented emotional difficulties such as anxiety, depression, interpersonal problems, or life transitions. Exclusion criteria included acute medical emergencies, need for long-term psychotherapy, highly complex clinical conditions, lack of informed consent for session recording, or failure to complete self-report measures. The sample was non-probabilistic and based on convenience, as commonly employed in naturalistic psychotherapy research.

Training program: EFT deliberate practice training

Psychologists participated in a 16-week EFT skills training program based on deliberate practice principles. Training focused on three core EFT competencies facilitating emotional processing: empathic understanding, felt sense, and rationale for emotional work. Sessions were conducted weekly, with the first four weeks consisting of 1-hour training sessions and subsequent sessions lasting 1.5 hours. Training involved structured role-plays, video-based feedback, and supervised practice. All psychologists received weekly supervision from the same supervisor throughout the intervention period.

Measures

Outcome Questionnaire-45

The Outcome Questionnaire-45 (OQ-45; Lambert *et al.*, 2004; Machado & Fassnacht, 2015, Portuguese version) is a 45-item self-report instrument designed to measure overall psychological distress and monitor treatment progress in mental health services. Items are rated on a 5-point Likert scale (0 = *never*; 5 = *always*), yielding a total score ranging from 0 to 180, with higher scores indicating greater distress. A clinical cut-off score of 64 points distinguishes clinical from non-clinical levels of distress, and a change of 14 or more points is considered reliable and clinically meaningful beyond random fluctuation. The instrument comprises three subscales: Symptom Distress (25 items), Interpersonal Relations (11 items), and Social Role Performance (9 items). The OQ-45 demonstrates strong psychometric properties across multiple language versions, and the Portuguese adaptation shows adequate overall reliability, though the Social Role subscale presents somewhat lower internal consistency (α=.56-.61), consistent with findings in other language versions. In this study, the OQ-45 was used to assess psychological distress at each session and to test Hypothesis 3, examining whether patients' symptom levels decreased over the course of therapy.

Working Alliance Inventory – Short Revised (Client Version)

The Working Alliance Inventory – Short Revised Client Version (WAI-SR; Hatcher & Gillaspy, 2006; Machado & Ramos, 2008, Portuguese version) is a 12-item self-report scale assessing the quality of the therapeutic alliance from the client's perspective across three dimensions: Bond, Goals, and Tasks. Items are rated on a 5-point Likert scale (1 = *rarely*; 5 = *always*), with each subscale scoring up to 20 points and a total score up to 60 points; higher scores reflect more positive alliance perceptions. The Portuguese adaptation demonstrates good psychometric properties, with excellent overall internal consistency (α=.91) and subscale alphas ranging from .85 to .90. In this study, the WAI-SR was used to test Hypothesis 2, examining whether patients' perceived therapeutic alliance strengthened across sessions.

Working Alliance Inventory – Short Revised (Therapist Version)

The WAI-SR Therapist Version (WAI-PSI; Horvath & Greenberg, 1989; Machado & Ramos, 2008, Portuguese version) is a 10-item instrument assessing therapists' perceptions of the therapeutic alliance across the same three dimensions as the client version: Bond, Goals, and Tasks. Items are rated on an identical 5-point Likert scale, with a maximum total score of 50 points and higher scores indicating more positive alliance perceptions. Unlike the client version, no items are reverse-scored. The instrument demonstrates good internal consistency (α=.87), with subscale coefficients of .96 for Bond, .91 for Tasks, and .95 for Goals. In this study, the WAI-SPI was used to complement client-reported alliance data and examine convergence between patient and therapist alliance perceptions.

Experiencing Scale

The EXP (Klein, 1969) is an observer-rated instrument designed to assess the depth of patients' emotional experiencing during psychotherapy sessions. Raters evaluate session segments and assign scores on a 7-point scale, where lower levels (1-4) reflect peripheral and superficial experiential involvement, and higher levels (5-7) indicate intentional exploration of feelings and personal meaning. A qualitative shift occurs at level 4, where focus on subjective experience becomes evident, progressing toward deeper emotional elaboration and self-awareness at levels 6 and 7. Two scores are derived for each segment: *mode* (EXP-M), representing the typical level of experiencing, and *peak* (EXP-P), indicating the highest level reached. The EXP demonstrates strong inter-rater reliability (intraclass correlation coefficient [ICC]=.76-.91), good test-retest stability (r>.80), and predictive validity for symptom change across depression, trauma, and interpersonal difficulties. Although no validated Portuguese version exists, its use in this study is justified by the absence of validated alternatives in the national context and by its recognized status as a gold standard measure of psychotherapeutic process quality. Given the exploratory nature of this study, findings should be interpreted with appropriate caution pending future validation studies. In this study, the EXP was used to test Hypothesis 1, evaluating whether patients' emotional experiencing depth increased across sessions.

Therapist Persuasiveness Rating Scale

The TPRS (Afonseca *et al.*, 2023) is an observer-rated instrument assessing therapist persuasiveness during psychotherapy sessions across four dimensions: Preconditions, Rationale, Nonverbal Behaviors, and Influence. Each item is rated on a 5-point Likert scale, and sessions are divided into three temporal segments – beginning, middle, and end – to capture dynamic variations in persuasiveness throughout the session. The TPRS demonstrates acceptable internal consistency (α=.65-.88) and construct sensitivity, and is currently the only validated instrument designed specifically to measure

therapist persuasiveness. In this study, a single item from the TPRS assessing the therapist's intentional capacity to elicit, amplify, and deepen patients' emotional experience – including behaviors such as encouraging the reliving of emotionally significant memories, exploring emotions and bodily sensations, and facilitating active affective expression – was used to test Hypothesis 4, examining whether therapist persuasiveness predicts patients' emotional experiencing at each session moment.

Procedure

The study was approved by the University Ethics Committee, and all participants provided written informed consent. Patients completed self-report measures at predefined moments during therapy. Therapy sessions were audio- and video-recorded for observational coding.

A total of 60 sessions (four sessions per patient) were coded using the EXP. Sessions were divided into three equal segments (beginning, middle, and end). For each segment, EXP-M and EXP-P scores were assigned. Three trained evaluators independently coded the sessions following standardized training procedures.

Inter-rater reliability was assessed on 10% of sessions using the ICC, yielding excellent agreement (ICC=.93, 95% CI [.88, .96]). The remaining sessions were coded in pairs using a balanced rotation system.

Data analysis

Statistical analyses were conducted using IBM SPSS Statistics (version 30.0). Descriptive statistics were computed for all variables. Linear mixed models were used to examine longitudinal changes in emotional experiencing, psychopathological symptoms, and therapeutic alliance, accounting for repeated measures and nested data structures. Additionally, multilevel linear regression analyses were conducted to examine associations between therapist persuasiveness and emotional experiencing at different session moments (beginning, middle, and end). Statistical significance was set at $p<.05$.

Results

Descriptive analysis of study variables

Table 1 presents descriptive statistics for the main process and outcome variables at the session level (n=60) and patient level (n=15). For each variable, mean, SD, observed minimum and maximum values, median, skewness, and kurtosis are provided. These metrics offer a comprehensive view of the behavior of scores for emotional experiencing (EXP-M and EXP-P), therapeutic alliance as perceived by the patient (WAI-SR and its subscales), psychological distress (OQ-45) throughout the analyzed sessions, and emotional stimulation.

Regarding emotional stimulation, it is important to highlight that this indicator corresponds to a specific item from the TPRS on a 5-point scale. While the full persuasiveness scale addresses multiple dimensions of the therapist's capacity to positively influence patient engagement in psychotherapy, this study focused exclusively on the emotional stimulation item. This item assesses the therapist's intentional ability to elicit, amplify, and deepen the patient's emotional experience during the session, based on detailed scoring criteria such

Table 1. Descriptive statistics of clinical and process variables at the session and patient level.

	M	SD	Min	Max	Median	Skewness	Kurtosis
Variables at session level (n=60)							
OQ-45	59.90	22.43	16	136	59	.45	1.15
EXP-M	2.39	.48	1.33	3.50	2.33	.21	−.63
EXP-P	2.99	.46	2	4	3	.15	.09
EST-EXP	2.88	.65	1	4.33	3	−.16	.25
WAI-SR	50.63	6.16	36	60	51.50	−.36	−.45
WAI-SR-T	15.95	2.74	9	20	16	−.49	−.12
WAI-SR-O	17.23	2.67	10	20	18	−.94	.22
WAI-SR-V	17.45	2.39	11	20	17	−.44	−.75
Variables at patient level (n=15)							
Age	37.47	10.458	22	55	38	.01	−1.02
OQ-45-S1	75.80	17.21	50	106	77	.05	−1.05
OQ-45-SF	49.47	17.66	16	75	46	.05	−.85
OQ45-IM	59.90	16.69	28.5	92.75	58	.29	.15
EXP-M	2.39	.29	1.75	2.79	2.42	−.58	.05
EXP-P	2.99	.28	2.33	3.42	3	−.67	.44
WAI-SR	50.63	4.40	43.75	58.75	51	.07	−.85
WAI-SR-T	15.95	2.09	11.25	20	16.50	−.45	1.06
WAI-SR-O	17.23	1.92	12.50	19.75	17.23	−.95	1.12
WAI-SR-V	17.45	1.94	14	20	17.50	−.14	−1.10

M, mean; SD, standard deviation; OQ-45, Outcome Questionnaire-45 (intermediate mean across the 4 evaluated sessions); OQ-45-S1, Outcome Questionnaire-45 measured at the first session; OQ-45-SF, Outcome Questionnaire-45 measured at the last session; EXP-M, Experiencing Scale - *mode*; EXP-P, Experiencing Scale - *peak*; EST-EXP, emotional experiencing stimulation item from the Therapist Persuasiveness Rating Scale; WAI-SR, Working Alliance Inventory – Short Revised; WAI-SR-T, Tasks subscale; WAI-SR-O, Goals subscale; WAI-SR-V, Bond subscale.

as reliving emotionally significant memories, exploring the client's emotions and bodily sensations, or encouraging active affective expression. The choice to use only this item is justified by the specific focus of the research on the emotional component of the therapeutic process, differentiating it from other projects employing the full persuasion scale to evaluate different aspects of therapists' intervention style. Thus, the presented data reflect the psychologists' performance in promoting emotional activation in a focused manner aligned with the central study aims.

The joint presentation of these statistics provides an objective contextualization of the collected data, facilitating understanding of central tendency, dispersion, and potential spread or biases within each variable. The values concisely summarize the quantitative profile of the central measures of the therapeutic process monitored in the sample.

For the process measures assessed in the 60 sessions, a marked dispersion was observed in psychological distress scores (OQ-45; M=59.90, SD=22.43), suggesting considerable clinical heterogeneity among participants. The value range (min=16, max=136) demonstrates inclusion of cases from low to very high distress levels, which may influence the analysis of longitudinal patterns in these variables. In contrast, means of therapeutic alliance subscales as rated by patients (Tasks, Goals, Bond) and emotional experiencing (EXP-M and EXP-P) showed lower dispersion, with relatively low SDs and skewness and kurtosis values close to zero. These results indicate a balanced distribution without significant bias in these variables.

Thus, notable variability in psychological distress stands out, in contrast to greater process homogeneity in therapeutic alliance and emotional experiencing indices, a characteristic that warrants further exploration in inferential analysis and the integration of process and outcome variables throughout the sessions.

At the patient level (n=15), a pronounced reduction in patients' psychological distress is evident, with OQ-45 scores decreasing from an initial mean of 75.80 (SD=17.21) to a final mean of 49.47 (SD=17.66), accompanied by a similar reduction at the intermediate score (M=59.90, SD=16.69). This decrease is consistent with a trend of clinical improvement throughout the sessions.

These indicators suggest significant gains in psychological distress and emotion regulation difficulties, although some individual variability is observed (ranging between 50 and 106 for initial OQ-45).

Regarding emotional experiencing, the means for EXP-M (M=2.39, SD=0.29) and EXP-P (M=2.99, SD=0.28), both with low dispersion and skewness and kurtosis values near zero, suggest moderate levels of emotional involvement throughout the therapeutic process, typical for brief psychological intervention samples. Conversely, scores for the global therapeutic alliance (M=50.63, SD=4.40) and the subscales Tasks (M=15.95, SD=2.09), Goals (M=17.23, SD=1.92), and Bond (M=17.45, SD=1.94) remain high, with skewness and kurtosis close to normality, indicating generally very positive perceptions of the therapeutic relationship between clients and therapists.

It is also important to note that despite the overall improvement in OQ-45 means, the dispersion (SD) remains relatively stable from start to finish, indicating that the magnitude of change varied among patients, with relevant individual differences persisting in distress levels.

Together, the table depicts a positive evolution profile for the participant group, accompanied by process stability at experiential and relational levels, aspects that may be further explored in inferential analyses and result discussions.

Mean levels of emotional experiencing (both EXP-M and EXP-P values) and therapist-promoted emotional stimulation (EST-EXP) remained relatively stable across the four analyzed sessions, with only minor non-substantial variations, underscoring the process homogeneity of the sample regarding emotional experiencing and stimulation (*Supplementary Figure 1*).

Figure 1 depicts the mean progression of psychological distress (OQ-45) and client-perceived therapeutic alliance (WAI-SR) across the four analyzed sessions. A progressive decrease in mean OQ-45 scores is observed, indicating gradual clinical improvement in patients' psychological symptoms throughout follow-up. Conversely, therapeutic alliance levels (WAI-SR) increased consistently from session to session, suggesting a convergence between therapeutic relationship strengthening and symptom reduction over the course of therapy.

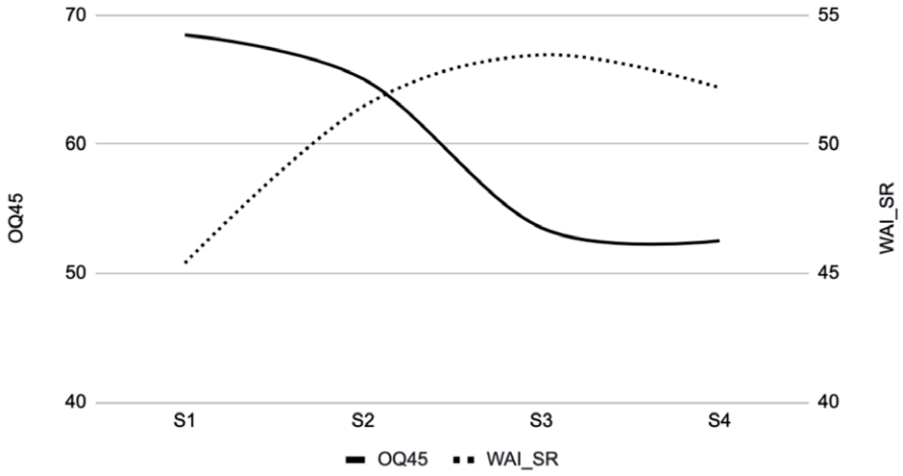

Figure 1. Average level of psychological distress (OQ-45) and therapeutic alliance (WAI-SR) by session.
OQ-45, Outcome Questionnaire-45; WAI-SR, Working Alliance Inventory – Short Revised; S1, first session; S2, second session; S3, third session; S4, fourth session.

Although patients presented similar levels of emotional involvement, their clinical profiles and individual trajectories of psychological distress differed substantially, with OQ-45 variability markedly greater than that of EXP-P across patients (*Supplementary Figure 2*).

Despite a general trend of decreasing psychological distress across sessions, individual trajectories varied considerably. Notably, some patients remained above the clinical cut-off score of 64 points on the OQ-45 at the end of follow-up, indicating persistent clinically significant distress in a subset of participants (*Supplementary Figure 3*).

Relationships among variables: multilevel analysis results

Despite notable differences in patients' mean psychological distress across therapist groups (OQ-45 means ranging from 46.75 to 78.50), relational, emotional, and stimulation processes remained highly homogeneous among trainees. Therapeutic alliance (M=50.63, SD=2.74) and its subscales – Tasks (M=15.95; SD=1.24), Goals (M=17.23; SD=1.02), and Bond (M=17.45; SD=1.59) – remained consistently high across therapist groups. Similarly, emotional experiencing levels were stable and close across trainees, both in EXP-M (M=2.39; SD=0.17) and EXP-P (M=2.98; SD=0.13), with minor variability in EST-EXP (M=2.89, SD=0.49). These patterns suggest that clinical-symptomatic variation was more strongly associated with patient profiles than with differences in relational or emotional processes across trainees (*Supplementary Table 1*).

Across the five trainee psychologists, emotional experiencing levels were remarkably similar, both in EXP-M and EXP-P measures, and EST-EXP showed only minor differences without substantial discrepancies, reflecting consistent clinical practices in patient follow-up (*Supplementary Figure 4*). Marked differences in mean psychological distress were observed across trainees' patient groups, whereas therapeutic alliance levels remained consistently high and homogeneous across all trainees, suggesting that clinical-symptomatic variation was more strongly associated with patient profiles than with differences in relational processes promoted by the trainees (*Supplementary Figure 5*). Both patients and psychologists reported high and closely aligned therapeutic alliance values across all subscales – Tasks, Goals, and Bond – without marked systematic discrepancies, indicating a generally positive and shared perception of the therapeutic relationship (*Supplementary Figures 6-9*).

Table 2 presents the fixed-effect estimates from the linear mixed model for psychological distress (OQ-45), patient-perceived therapeutic alliance (WAI-SR and subscales), and emotional experiencing (EXP), as a function of the temporal sequence of sessions (time variable). Time was conceptualized as continuous, assuming values from 1 to 4 for each patient, corresponding to the sequential order of the four sessions included in the analysis. It is important to emphasize that this coding does not necessarily reflect the actual first four sessions of each psychological follow-up process, but rather four sessions selected by methodological criteria. Thus, time represents the relative position of the selected session in the sample, allowing modeling of intraindividual variable evolution across sessions regardless of the actual chronological therapy timing for each participant.

A statistically significant decrease in psychological distress (OQ-45) was observed over the sessions (β=−5.933, t=−2.38, p=.021, 95% CI [−10.92, −0.94]), reflecting clear clinical improvement during follow-up. A significant increase was also observed in therapeutic alliance (WAI-SR and subscales), with all estimated coefficients positive and p-values below .05. For instance, the Tasks subscale registered an average increase of 0.793 points per session (p=.011), with confidence intervals excluding zero, revealing a continuous strengthening of the therapeutic alliance, particularly in the collaboration and bond dimensions, as the process advanced.

Conversely, emotional experiencing indicators – EXP-M and EXP-P – showed no statistically significant variations across sessions, with β-values approximating zero and p-values exceeding .30, suggesting stability of these indicators throughout the analyzed period. Regarding EST-EXP, the estimated coefficient (β=−0.129, p=.087) approached the threshold of statistical significance, indicating marginal significance (Olsson-Collentine *et al.*, 2019), pointing to a possible slight decrease.

Together, these results indicate a relevant decrease in psychological distress and a strengthening of the therapeutic alliance over the sessions, while emotional experiencing levels remained stable, highlighting the central role of relational processes in the observed therapeutic progress (*Supplementary Figure 9*).

Table 3 presents the estimated fixed effects of the linear mixed model for psychological distress (OQ-45) as a function of patient-perceived therapeutic alliance dimensions (WAI-SR and subscales), emotional experiencing (EXP-M and EXP-P), and EST-EXP, comparing an initial model with main predictors only (Model 1) and an adjusted model additionally controlling for time (Model 2).

Table 2. Estimated fixed effects of the mixed linear model: prediction of OQ-45, WAI-SR, and EXP based on the temporal sequence of four sessions.

Dependent Variable	β	SE	df	t	Sig.	95% CI
OQ-45	−5.933	2.49	58	−2.38	.021	−10.92, −.94
WAI-SR	2.240	.65	58	3.42	.001	.93, 3.55
WAI-SR-T	.793	.30	58	2.63	.011	.19, 1.39
WAI-SR-O	.707	.29	58	2.38	.021	.11, 1.3
WAI-SR-V	.740	1.26	58	2.83	.006	.22, 1.26
EXP-M	−.054	.06	58	−.97	.336	−.17, .06
EXP-P	.001	.05	58	.02	.984	−.11, .11
EST-EXP	−.129	.07	58	−1.73	.087	−.27, .02

β, estimated unstandardized coefficient of the fixed effect; SE, standard error; df, degrees of freedom; t, Student's t-test value; Sig., statistical significance level (p-value); CI, confidence interval; OQ-45, Outcome Questionnaire-45; WAI-SR, Working Alliance Inventory – Short Revised; WAI-SR-T, Task subscale; WAI-SR-O, Goal subscale; WAI-SR-V, Bond subscale; EXP-M, Experiencing Scale - *mode*; EXP-P, Experiencing Scale - *peak*; EST-EXP, emotional experiencing stimulation item from the Therapist Persuasiveness Rating Scale.

In Model 1, patient-perceived therapeutic alliance (WAI-SR) – particularly the Tasks (β=–2.69, p<.05) and Bond (β=−2.92, p<.05) subscales – was significantly associated with lower psychological distress. After controlling for time (Model 2), the global WAI-SR effect lost significance, while the Tasks and Bond dimensions maintained significant negative associations, albeit with some attenuation of coefficients. The Goals dimension showed no significant effect in either model.

Regarding therapist-perceived alliance (WAI-PSI), the Tasks subscale showed a significant negative effect in Model 1 (β=−2.84, t=−2.02, p<.05), indicating that better therapist perception of task collaboration was associated with reduced patient distress. In Model 2, the Goals subscale became significant (β=−6.07, t=−2.31, p<.05), suggesting that when controlling for temporal progression, greater therapist-perceived goal consensus was associated with lower patient distress.

Emotional experiencing – EXP-M and EXP-P – showed no significant association with psychological distress in either model. Conversely, EST-EXP exhibited a positive and significant effect on psychological distress in both models, suggesting that higher emotional stimulation was associated with elevated symptom levels, a pattern further explored in the *Discussion*.

Patient-reported therapeutic alliance was significantly and negatively associated with psychological distress (β=−1.07, p<.05), indicating that stronger alliance levels were linked to lower symptomatology. Therapist-rated alliance also showed a negative coefficient (β=−0.74), but this effect was not statistically significant, precluding conclusions about a robust relationship between therapist perception and patient symptom variation. These perspectives, while related to the same therapeutic relationship, tended to vary relatively independently (β=−0.001, p<.10; *Supplementary Figure 10*).

Table 4 presents the estimated fixed effects from the linear mixed model analyzing the relationship between therapeutic alliance dimensions (WAI-SR and subscales) and the depth of patients' emotional experiencing, measured by both EXP-M and EXP-P scores. Within the EXP-M domain, the Goals subscale exhibited a marginally significant negative effect (β=−0.04, t=−1.84), consistent with the criterion that p-values between .05 and .10 indicate marginal significance (Olsson-Collentine *et al.*, 2019), suggesting a trend whereby greater agreement on therapeutic goals was associated with slightly lower average experiential depth. No statistically significant effects were found for the remaining alliance dimensions or for any predictors in relation to EXP-P, indicating that no robust statistical relationship emerged between emotional experiencing and the collaborative, relational, or global alliance dimensions in this brief intervention context.

Table 5 presents the fixed effects of therapist persuasiveness (TPRS) as a predictor of patients' emotional experiencing at each session moment. Therapist persuasiveness was a statistically significant predictor of EXP-M at the beginning (F=6.152, df=43.831, p=.017) and middle (F=9.229, df=30.798, p=.005) of sessions, but not at the end (F=.512, df=54, p=.477), suggesting that the associa-

Table 3. Estimated fixed effects of the mixed linear model for psychological distress (OQ-45) as a function of therapeutic alliance (WAI-SR), emotional experiencing (EXP), and stimulation of emotional experiencing (EST-EXP).

	Model 1	Model 2
Patient		
WAI-SR	−1.07 (−2.36)*	−.76 (−1.54)
WAI-SR-T	−2.69 (−2.65)*	−2.12 (−2.00)*
WAI-SR-O	−.56 (−.51)	−.20 (.18)
WAI-SR-V	−2.92 (−2.49)*	−2.21 (−1.79)**
EXP-M	5.38 (.89)	3.69 (.63)
EXP-P	5.90 (.93)	5.93 (.98)
Psychologist		
WAI-PSI	−.74 (−1.19)	−5.52 (−2.07)
WAI-T-PSI	−2.84 (−2.02)*	−1.91 (−1.29)
WAI-O-PSI	−.56 (−.51)	−6.07 (−2.31)*
WAI-V-PSI	.01 (.01)	.69 (.44)
EXP-M	5.38 (.89)	3.69 (.63)
EXP-P	5.90 (.93)	5.93 (.98)
EST-EXP	13.90 (3.36)*	12.22 (2.94)*

Model 1 estimates the effects of the main independent variables on the OQ-45; Model 2 estimates the effects of the same variables and additionally adjusts for the effect of time, allowing evaluation if the predictor effects remain after controlling for session progress. *p<.05 (significant); **.05≤p<.10 (marginally significant) (Olsson-Collentine *et al.*, 2019); WAI-SR, Working Alliance Inventory – Short Revised Patient Version; WAI-SR-T, Task subscale; WAI-SR-O, Goal subscale; WAI-SR-V, Bond subscale; WAI-PSI, Working Alliance Inventory – Short Revised Therapist Version; WAI-T-PSI, Task subscale - Therapist Version; WAI-O-PSI, Goal subscale - Therapist Version; WAI-V-PSI, Bond subscale - Therapist Version; EXP-M, Experiencing Scale - *mode*; EXP-P, Experiencing Scale - *peak*; EST-EXP, emotional experiencing stimulation item from the Therapist Persuasiveness Rating Scale.

Table 4. Estimated fixed effects of the mixed linear model for emotional experiencing (EXP) as a function of the therapeutic alliance (WAI-SR).

	EXP-M	EXP-P
WAI-SR	−1.02 (.09)*	−.01 (−1.25)
WAI-SR-T	−.21 (−.91)	−.01 (−.64)
WAI-SR-O	−.04 (−1.84)*	−.20 (.18)
WAI-SR-V	−.03 (−1.28)	−.03 (−1.00)

EXP-M, Experiencing Scale - *mode*; EXP-P, Experiencing Scale - *peak*; WAI-SR, Working Alliance Inventory – Short Revised; WAI-SR-T, Task subscale; WAI-SR-O, Goal subscale; WAI-SR-V, Bond subscale; *.05≤p<.10 (marginally significant) (Olsson-Collentine *et al.*, 2019).

Table 5. Fixed effects of the predictor variable TPRS on the dependent variable EXP-M at each moment of the psychological intervention sessions (beginning, middle, and end).

Variables	EXP-M (beginning)			EXP-M (midle)			EXP-M (end)		
N=56	F	df	p-value	F	df	p-value	F	df	p-value
TPRS (beginning)	6.152	43.831	.017*						
TPRS (middle)				9.229	30.798	.005**			
TPRS (end)							.512	54	.477

TPRS, Therapist Persuasiveness Rating Scale; EXP-M, Experiencing Scale – *mode*; F, F-statistic; df, degrees of freedom; beginning, middle, and end = session moments (first 15 minutes, between 15 and 30 minutes, and final segment of the session, respectively); N, number of sessions analyzed; *p<.05; **p<.01.

tion between persuasiveness and emotional experiencing was stronger during the initial and intermediate phases of sessions. Variance components at both the psychologist and patient levels were relatively small, indicating that the largest share of variability occurred within psychologist-patient dyads rather than between them (*Supplementary Table 2*).

Discussion

This study's results discussion aims to provide a detailed, critical, and integrated analysis of the empirical data relative to the established hypotheses, articulating these findings with recent scientific literature on change processes in psychotherapy.

According to Hypothesis 1, it was expected that the depth of patients' emotional experiencing would increase over therapy sessions and throughout the trainees' EFT skills training. However, data from Tables 1 and 2 show clear stability in mean values of EXP-M and EXP-P across the four analyzed sessions, without statistically significant variations between sessions, clients, or therapists. Descriptive data (Table 1) reinforce this absence of a progressive trend, showing minimal fluctuations between sessions, while therapist-level data (*Supplementary Table 1*) reveal that small differences among therapists are inconsistent and minor. These findings align with studies identifying maintenance patterns of moderate emotional experiencing levels in naturalistic and brief intervention contexts, especially when session selection follows methodological rather than chronological criteria (Sønderland *et al.*, 2024; Watson *et al.*, 2011).

The low emotional experiencing levels maintained throughout follow-up can be explained by various methodological and contextual factors. Firstly, the sessions selected were not chronologically fixed across participants, as each client began therapy at different times. Session selection considered the trainees' 16-week clinical training period, distributing evaluations longitudinally without ensuring correspondence to identical therapy process stages – for example, some clients had sessions 3, 5, 7, and 9 analyzed; others 3, 7, 9, and 11, for illustration only. This lack of exact alignment may have hindered the identification of consistent emotional experiencing trajectories. Secondly, literature indicates low variability among therapists in promoting emotional experiencing in studies involving trainees or early-career clinicians, likely reflecting similar competence development and supervision levels (Sønderland *et al.*, 2024). Thus, observed homogeneity among trainees here is expected and empirically supported, emphasizing that individual professional process expression seldom robustly differentiates experiential depth indicators in such formative contexts. This supports the interpretation that significant differences in this domain probably require wider clinical experience diversity or longer, more differentiated training formats.

Moreover, among the three main competencies trained over 16 weeks (Empathic Understanding, Focusing, Rationale for Emotional Work), Focusing – directly responsible for deepening emotional experiencing – received the least training hours. This asymmetric training distribution may have limited trainees' consolidation of skills needed to promote higher experiential depth in patients, adding a constraint to experiential indicator evolution during the process (Elliott *et al.*, 2021; Greenberg, 2016).

Nonetheless, it is crucial to interpret observed EXP levels in light of international brief therapy literature. Although normative data are scarce nationally, international empirical studies suggest typical EXP-M mean values between 2.5 and 3.5 in brief or supervised practice contexts. Consistent with this, studies using the EXP in experiential therapies for depression have found that significant increases in experiential depth tend to emerge mainly in longer interventions conducted by trained therapists (Goldman *et al.*, 2005; Watson *et al.*, 2011), and meta-analytic evidence suggests that EXP effects on outcomes are more robust in extended, explicitly experiential treatments (Pascual-Leone & Yeryomenko, 2017). These findings support the interpretation that moderate and stable EXP levels are an expected pattern in brief interventions conducted by early-career clinicians. These authors note this pattern recurs in other brief intervention process studies or trainee therapists. Convergently, a meta-analysis (Pos *et al.*, 2017) shows moderate associations between experiencing levels and positive outcomes, yet average experiencing increases in brief therapy tend to be modest. High EXP values typically emerge only in prolonged and/or explicitly experiential therapies.

Thus, the observed moderate stable EXP levels, though apparently contradicting the hypothesis, align with process patterns described in comparable contexts. Overall, results support the view that significant or generalized experiential depth increases are not expected in brief interventions with novice clinicians. This should be interpreted consistently with the current understanding of emotional dynamics in brief supervised psychotherapy (Pos *et al.*, 2017; Sønderland *et al.*, 2024; Watson *et al.*, 2011).

It should be noted that the following findings must be interpreted with caution, given the small sample size (n=15 patients, n=5 therapists), which limits statistical power to detect small or moderate effects. The absence of statistical significance in this context does not constitute evidence of the absence of association, and findings should be understood as exploratory rather than confirmatory.

Hypothesis 2 – that higher levels of emotional experiencing would associate with stronger therapeutic alliance – was tested using Tables 3 and especially 4. Contrary to expectations, no statistically significant relationships emerged between EXP-M or EXP-P and global or specific therapeutic alliance dimensions (WAI-SR total, Tasks, Goals, Bond) in most models. Table 4 marginally highlights a negative association ($\beta=-0.043$, $t=-1.84$, $p=0.072$) between the therapeutic alliance Goals subscale and EXP-M, suggesting sessions with greater consensus on goals show slightly lower experiential depth. This may reflect the predominance of a directive, goal- and task-focused approach in brief interventions, which literature indicates might reduce opportunities for unstructured emotional exploration (Olsson-Collentine *et al.*, 2019; Zilcha-Mano *et al.*, 2018). No similar trends were observed for Tasks or Bond dimensions, which remained dissociated from experiencing levels, underscoring the complex interrelations among collaborative processes, emotional experiencing, and therapeutic context.

These findings invite a reconceptualization of the assumed relationship between emotional experiencing and symptom change. Rather than supporting a linear model in which deeper emotional experiencing directly drives symptom reduction, the present data suggest that in brief intervention contexts, symptomatic improvement may occur through relational and collaborative mechanisms – particularly therapeutic alliance – without requiring intensified emotional processing. This is theoretically consistent with perspectives emphasizing that early relational stability and goal consensus may be sufficient to produce symptom relief in time-limited treatments, even in the absence of deep experiential work (Zilcha-Mano *et al.*, 2018). The independence of these two change pathways in brief psychotherapy warrants further systematic investigation.

Regarding Hypothesis 3 – that higher emotional experiencing levels would relate to greater symptom reduction (OQ-45) – results from Tables 1-3 clearly refute this for the present context. Although descriptive data (Table 1) show consistent OQ-45 score decreases across sessions, linear mixed models (Tables 2 and 3) indicate neither EXP-M nor EXP-P predict symptom improvement in simple or time-adjusted models. This pattern holds in therapist-level analyses (*Supplementary Table 1*), with no substantial symptom outcome differences by mean experiential levels. These findings concur with reviews highlighting that emotional experiencing's positive clinical change effect tends to be robust in sufficiently prolonged interventions, allowing patients full emotional processing (Elliott *et al.*, 2021; Sønderland *et al.*, 2024), not in brief heterogeneous-session contexts with less explicit process focus.

Although patients' experiential depth remained moderate throughout, EST-EXP results indicate moderate trainee use of experiential promotion strategies. This suggests the low experiential depth does not stem from therapists' absence of facilitative initiatives but rather challenges inherent in developing experiential skills in initial clinical training and brief therapy contexts.

Notably, the positive association between EST-EXP and elevated psychological distress (OQ-45) indicates a complex clinical dynamic, especially relevant in brief interventions. While seemingly paradoxical, experiential psychotherapy literature clarifies that therapists often intensify emotional activation strategies when patients face blockages, resistance, or symptom exacerbations (Greenberg, 2016; Pos *et al.*, 2017).

In brief interventions, limited time to deeply explore emotional issues tends to prioritize rapid regulation and distress containment. Here, increased therapist emotional stimulation may represent a strategic clinical response to unlock emotional processes and facilitate patient experiential engagement, even if temporarily increasing distress (Greenberg, 2016; Pos *et al.*, 2017).

Furthermore, symptom increases during heightened emotional activation episodes may be a necessary therapeutic transition stage. Literature indicates activation peaks frequently precede emotional processing and transformation phases, manifesting as subsequent improvements (Greenberg, 2016). However, brief psychological follow-up formats like this study may not fully capture the complete activation-processing-resolution cycle (Greenberg, 2016), explaining the absence of immediate symptom reduction and observed positive EST-EXP-distress association.

Therefore, this pattern should not be interpreted as a direct causality of emotional stimulation on distress but rather as evidence of clinically contextualized responsiveness, wherein intensification of the technique occurs at critical moments to help patients overcome emotional impasses despite temporary discomfort (Greenberg, 2016; Pos *et al.*, 2017). This interpretation underscores the complexity of technical intervention, process phenomena, and clinical outcome relationships, especially in brief and clinical training interventions.

Hypothesis 4, namely that psychologists' average levels of persuasiveness would predict patients' average levels of emotional experiencing at each corresponding moment of the session (beginning, middle, and end), was confirmed for the initial and intermediate moments. It was during the first 15 minutes and between 15 and 30 minutes of the sessions that psychologists' persuasiveness emerged as a statistically significant predictor of patients' emotional experiencing. The significant results obtained through the two multilevel linear regression models for the first two session moments theoretically suggest that higher average levels of persuasiveness are associated with higher average levels of emotional experiencing. However, this tendency was not observed at the final moment of the sessions.

This points theoretically to the presence of a consistent pattern of association between these two transtheoretical dimensions in the context of brief psychological interventions. Although the analysis does not establish a causal relationship between the variables, the data suggest that more persuasive psychologists may, on average, tend to be involved in moments of psychological intervention characterized by greater exploration and experiencing of emotions by patients. Taken together, these results appear theoretically aligned with other studies, such as those by Angie *et al.* (2011), Bless *et al.* (1990), Greenberg (2004), Heide (2013), Otterson (2015), and particularly Frank (1961) in his inclusion of the therapist's capacity to elicit emotional activation in the client as a defining feature of a persuasive therapist.

This finding is particularly noteworthy given the exploratory nature of the study and the small sample size. The consistent association between persuasiveness and emotional experiencing at the beginning and middle of sessions – even in a brief intervention context with novice clinicians – suggests that therapist persuasiveness may represent a tractable and trainable interpersonal skill with direct implications for facilitating patient emotional engagement. Future research should examine whether deliberate practice training specifically targeting persuasiveness-related behaviors produces measurable changes in patients' experiential depth across sessions.

From a conceptual standpoint, it is worth acknowledging that interpersonal attunement (Stern, 2004) represents an adjacent theoretical construct that may partially overlap with persuasiveness as measured by the TPRS. Future studies should examine whether attunement-based measures yield convergent or complementary findings and whether the relational depth captured by persuasiveness is better explained by attunement processes in experiential therapy contexts.

The statistical model analyses robustly support the influence of patient-perceived therapeutic alliance – particularly the Tasks and Bond dimensions – in predicting psychological distress reduction, as evidenced in Tables 2 and 3. Negative effects observed between these alliance dimensions and OQ-45 reaffirm the value of collaborative practices and interpersonal engagement as clinical progress drivers, aligning with meta-analyses demonstrating therapeutic alliance's robust impact on positive clinical outcomes (Flückiger *et al.*, 2018; Watson *et al.*, 2011). Controlling for time attenuates but does not eliminate these effects, indicating collaboration and bond remain critical influences on symptom reduction beyond natural therapeutic progression. Patient-reported alliance showed the most robust predictive impact on symptom reduction, while therapist-rated alliance showed a negative but non-significant effect, consistent with international evidence prioritizing the patient's subjective experience as the primary outcome predictor in psychotherapy (Flückiger *et al.*, 2018; Watson *et al.*, 2011; *Supplementary Figure 10*).

Both patients and psychologists reported high and closely aligned therapeutic alliance values across all subscales – Tasks, Goals, and Bond – without marked systematic discrepancies, indicating a generally positive and shared perception of the therapeutic relationship (*Supplementary Figures 6-9*). This pattern aligns with international literature demonstrating that client and therapist typically assign high alliance values, especially in supervised clinical training or collaborative intervention contexts. For instance, Flückiger *et al.*'s (2018) meta-analysis showed alliance ratings are

usually high on both sides, with client-therapist version correlations averaging r=.36 to .50, reflecting moderate agreement yet not redundancy. Similarly, Paap *et al.* (2022), validating parallel WAI versions, found no systematic bias for either party to overestimate the relationship, with generally elevated alliance ratings for both patients and therapists and no consistent directional bias.

However, one trainee psychologist consistently rated the alliance higher than their patients across all subscales (Tasks, Goals, Bond). Literature suggests systematically higher therapist than client alliance ratings may indicate therapist self-assessment bias – overestimation of relational quality by therapists – documented in perception congruence studies (Flückiger *et al*., 2018; Paap *et al.*, 2022). Such a discrepancy is especially relevant regarding the Dunning-Kruger effect – a cognitive bias where less competent individuals tend to overestimate their abilities and performance (Dunning, 2011). Clinically, this may manifest in less experienced or less patient-sensitive therapists providing overly positive alliance ratings while undervaluing subtle client dissatisfaction or discomfort signals (Hill *et al*., 2015). Research also highlights the more frequent pattern of patients rating alliance equal to or above that of therapists. Systematic reversal indicates possible relational discord and elevates risks of therapeutic failure, premature dropout, or unrecognized difficulties (Flückiger *et al.*, 2018; Tschuschke *et al*., 2022). Therapist overestimation may also reduce openness to client feedback, decrease supervision seeking, and hinder ongoing professional development opportunities (Hill *et al.*, 2015).

Finally, descriptive and inferential patterns confirm broadly homogeneous clinical evolution, emotional experiencing, and therapeutic alliance trajectories among patients and therapists, emphasizing that observed sessional variation derives from process dynamics rather than baseline differences. These results underscore emerging pattern robustness in mixed models and support critical interpretation of key variable relationships.

Limitations and future research

The results presented in this exploratory study must be considered in light of several methodological and contextual limitations that constrain the interpretation of observed effects and restrict generalizability. As an exploratory investigation, both the empirical approach and sample were designed to identify trends and generate hypotheses rather than produce definitive or representative evidence of psychotherapy process universes. Notably, while the sample encompasses a total of 60 analyzed sessions – four sessions per each of the 15 included patients – both participant number and sessions per patient impose inherent restrictions.

First, the patient count (n=15) is relatively small for psychotherapy process studies, limiting statistical power to detect small or moderate effects and restricting the assessment of interindividual variability (*e.g.*, clinical profile differences, individual trajectories, or patient characteristic impact). Although session-level analysis (totalling 60 sessions) allows refined intra- and inter-session pattern examination beyond simple pre-post designs, each patient contributing only four sessions – not necessarily equivalent or sequential across participants – limits exploration of detailed trajectories, dynamic process changes, and finer temporal effects. Specifically, with 15 patients and 5 therapists, the study was underpowered to detect small-to-moderate effect sizes (*e.g.*, r<.30) with conventional significance thresholds (α=.05, power = .80). This is particularly relevant for the null findings regarding the association between emotional experiencing and therapeutic alliance (Hypothesis 2) and between emotional experiencing and symptom reduction (Hypothesis 3), which should not be interpreted as evidence of the absence of these relationships. Future studies should conduct *a priori* power analyses and recruit samples sized accordingly – likely a minimum of 40-50 patients across 8-10 therapists for mixed model designs of this type.

Thus, the relatively small client number and limited observed sessions per patient represent important constraints on the result scope. Ideally, future research should employ larger samples with more patients and preferably analyze longer sequential session series to enable more robust change process assessment and broader clinical and statistical generalizability.

The small patient number alone constitutes an important limitation for statistical power regarding the detection of small or marginal effects. This sample was also relatively homogeneous in initial psychological distress: 10 of 15 participants exceeded the clinical cutoff (64 points on OQ-45) at baseline. While enhancing clinical relevance, this restricts variability, potentially obscuring differential symptom evolution patterns or therapeutic effect moderators. Future studies should use larger, more diverse samples – varying in initial symptom severity, problem type, age, and emotional profile – to better understand conditions under which variables like emotional experiencing and therapeutic alliance associate with clinical change.

Another relevant limitation concerns the fact that all interventions were conducted by trainees in early clinical training phases, still acquiring and consolidating core experiential model competencies, particularly emotional depth work. Despite structured training in three EFT competencies over 16 weeks (Empathic Understanding, Rationale for Emotional Work, and Focusing), brief clinical practice and limited Focusing training – specifically aimed at deepening emotional experiencing – may have been insufficient for fluent, effective real-world application. Limited training possibly constrained trainees' ability to facilitate higher experiential activation, contributing to stable EXP levels observed.

A central limitation of this study is the impossibility of isolating the specific contribution of deliberate practice training to the observed results. The absence of a pre-post training design, a control group, or direct measures of trainees' competency acquisition means that no causal inferences can be drawn regarding the impact of the training program on any of the process or outcome variables examined. The five psychologists did not participate in training sessions simultaneously, and no experimental window was defined in which some trainees had completed training while others had not yet begun, further precluding between-group comparisons. This study should therefore be understood as an exploratory investigation of psychotherapy process and outcome in a training context characterized by deliberate practice, rather than as an evaluation of deliberate practice effects *per se*. Future studies should incorporate pre-post training designs, direct session-level measures of EFT competency acquisition (*e.g.*, adherence and competence coding), and, where feasible, comparison groups to enable more rigorous evaluation of training-specific effects on process variables.

Literature emphasizes that experiential competence development requires intensive training and deliberate practice with ongoing supervision and prolonged exposure to diverse clinical profiles (Greenberg, 2016; Watson *et al.*, 2011). Furthermore, therapeutic intervention quality may vary interindividually – especially in clinical responsiveness and relational competence – which develop with experience and continuous training (Hill *et al.*, 2015). These competencies, including clinical responsiveness and technical flexibility, are especially vital in experiential approaches, where adapting to the

client's emotional moment is central for promoting meaningful affective change (Hill *et al.*, 2015).

Less experienced therapists, even after structured initial training, tend toward more rigid or less flexible technique application, potentially impairing emotional experiencing quality and adaptive, responsive use of experiential facilitation strategies (Greenberg, 2016; Watson *et al.*, 2011). Literature reports such limitations, especially in EFT models, where competence in timing and depth adjustment of emotional work – integrating clinical moment and patient profile response – develops mainly *via* deliberate practice, intensive supervision, and accumulated experience (Greenberg, 2016; Hill *et al.*, 2015). Hence, the predominance of trainees and early-career psychologists constitutes a study limitation, possibly restricting experiential training efficacy and contributing to moderate stable emotional depth levels observed (Anderson *et al.*, 2009; Watson *et al.*, 2011).

Therefore, early-career therapist profiles should be considered a conditioning variable on experiential intervention impact, limiting technique expressivity and emotional depth achieved. This limitation may explain the generally moderate and stable emotional depth in this study, as well as the absence of significant associations between EXP and other indicators.

Beyond these limitations, future research should include the training process and clinical supervision's impact on therapist development. International literature highlights professional psychologist development shaped by training, clinical practice, and supervision processes during training, affecting practical competencies and beliefs/perceptions about change mechanisms (Tzur Bitan *et al.*, 2022). It is recommended that future studies examine how training – including experiential methods, clinical exposure, and supervised feedback – shapes therapists' beliefs about clinical change, therapeutic relationship roles, and their own patient work strategies. This focus could guide more effective, responsive training and clinical supervision strategies addressing current mental health service demands, where brief interventions and resource optimization challenge emotional and relational competence development (Crits-Christoph *et al.*, 2013; Gelo & Salvatore, 2016).

Additionally, clinical duration was brief, appropriate to the supervised internship nature, precluding analysis of longer therapeutic cycles or structured emotional turning points. Although sessions spanned the 16-week training, not all process phases were consistent across cases due to varied patient therapy start times. Flexible selection criteria led to varying session choices (*e.g.*, sessions 3, 5, 7, and 9 in some cases and 3, 7, 9, and 11 in others). This, while necessary, limited intraindividual sequential therapeutic process analysis, possibly obscuring relevant variations and true emotional change patterns. Consecutive session analysis with more moments and process stage control will be essential for rigorous emotional and relational evolution studies.

A related methodological constraint concerns session duration. Although sessions were designed to be divided into three equal 15-minute segments – consistent with procedures adopted in comparable studies (Sequeira *et al.*, 2024) – review of session recordings revealed that at least two sessions were shorter than 45 minutes, which means the third segment was coded from less than 15 minutes of material. While this is unlikely to have produced statistically significant distortions in the overall results, it may have partially influenced coding precision at the final session moment, potentially contributing to the absence of significant findings for therapist persuasiveness at the end of sessions. Future studies should ensure that all sessions meet minimum duration requirements prior to inclusion, and that coding procedures explicitly account for segment length variability.

Another important limitation is exclusive reliance on external observational measures by trained coders to assess emotional experiencing depth. While instruments like the EXP can reliably quantify in-session processes (Watson *et al.*, 2011), literature stresses that such measures may not fully capture the subjective richness and complexity of patients' emotional experiences. This is especially true when emotional experience is subtle, implicit, or nonverbally/indirectly communicated – contexts where even experienced coders may struggle to detect important experiential nuances (Greenberg & Pascual-Leone, 2006).

Furthermore, omission of self-report measures (such as post-session questionnaires or subjective activation ratings) limits direct access to clients' internal perception and phenomenology in each session. Psychotherapy process assessment studies recommend integrating complementary observational and subjective measures for a more comprehensive understanding, as concordance between external coding and personal experience tends to be moderate (Elliott *et al.*, 2021). This multimethod approach captures both observable behaviors and internal emotional meaning dimensions, facilitating more precise therapeutic intervention impact evaluation.

In summary, exclusive reliance on external emotional experiencing assessments may have missed significant experiential aspects, especially intimate and nonverbal ones, recommending future studies combine observational scales with continuous self-reports to enrich clinical process analysis of therapeutic change mechanisms.

Statistically, some marginally significant results suggest possible subtle clinical effects that larger samples might confirm. However, mediation analyses between emotional experiencing and symptomatic outcome were not performed, as no direct statistical relationships emerged between these variables. According to mediation analysis assumptions (Baron & Kenny, 1986; Preacher & Hayes, 2008), the absence of an initial independent-dependent variable association precludes mediator exploration. Future research is advised to apply mediation models if direct statistically significant main variable relationships are confirmed.

Conclusions

This study represents a valuable contribution to understanding change processes in brief psychological follow-up conducted by trainees. The investigation adopted a rigorous process-oriented approach, integrating observational data and validated measures of emotional experiential depth, therapeutic alliance, and psychological distress across multiple follow-up moments.

The main findings demonstrated no significant increase in emotional experiencing depth (EXP-M and EXP-P) throughout the evaluated sessions, with low to moderate experiential levels maintained over the process. This stability was interpreted in light of contextual and methodological factors such as non-uniform session selection adapted to varied patient entry points and less intensive practical training in experiential competencies (notably Focusing) responsible for emotional depth. The study also confirmed that psychological follow-up by early-career trainees poses additional challenges, given evidence that clinical experience substantially enhances therapists' competence and flexibility in facilitating deep emotional contact (Greenberg, 2016; Watson *et al.*, 2011).

Although emotional experiencing evolution did not accompany symptomatic improvement, data reaffirmed the central role of

collaborative and relational therapeutic alliance dimensions as robust clinical progress predictors, even in brief follow-up settings. This result aligns with literature emphasizing relationship quality, bond, and collaboration in tasks and goals as universal elements of positive mental health change (Flückiger *et al.*, 2018; Watson *et al.*, 2011).

Furthermore, the study provides important insights for clinical training and supervision program design. Results suggest that asymmetric training time allocation – particularly limited focus on experiential techniques – may constrain trainee experiential capacity development and thus limit emotional work's transformative potential with patients.

The observed positive association between therapist emotional stimulation and reported psychological distress, though potentially counterintuitive, indicates this intervention was primarily applied in sessions marked by heightened symptom activation. This pattern, identified in other process studies, suggests differential and responsive technique use, mobilizing emotional activation efforts during clinical blockages or distress (Greenberg, 2016; Pos *et al.*, 2017). While no direct symptomatic reduction was linked to this intervention, its presence in intense psychological moments underscores the training need to foster sensitive, calibrated, and strategically appropriate technique application, especially during critical intervention phases.

Scientifically, the study underscores the importance of naturalistic, exploratory research in training contexts to validate process constructs in real environments and promote research-practice translation. Empirical validation of emotional experiencing stability and typical thresholds in brief interventions contributes internationally and bridges future intervention, training, and outcome evaluation models in psychology.

Finally, the work highlights the necessity for multimethod, longitudinal designs and research considering patient diversity, increased session counts, sequential analysis, and post-treatment follow-up to elucidate dynamic change mechanisms.

In summary, findings reinforce the therapeutic relationship and collaborative factors' centrality for brief psychological follow-up success while highlighting limits to experiential depth promotion in this format. By doing so, this study advances psychological science and opens pathways for optimizing training and clinical practice in realistic, inclusive mental health contexts.

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Online supplementary material:

Supplementary Table 1. Descriptive statistics for the 5 trainees (psychologists in training).

Supplementary Table 2. Variance estimates associated with the random effects of intercepts across psychologist and patient levels at two points in the psychotherapy session (beginning and middle).

Supplementary Figure 1. Average level of emotional experiencing and stimulation per session.

Supplementary Figure 2. Average level of psychological distress and EXP-P by client.

Supplementary Figure 3. Average level of psychological distress from the first to the last session by the client.

Supplementary Figure 4. Average level of emotional experiencing and stimulation per trainee.

Supplementary Figure 5. Average level of psychological distress and therapeutic alliance per trainee.

Supplementary Figure 6. Comparison of perceived therapeutic alliance between patients and therapists.

Supplementary Figure 7. Comparison of the perception of the Tasks dimension of the therapeutic alliance.

Supplementary Figure 8. Comparison of the perception of the Goals dimension of the therapeutic alliance.

Supplementary Figure 9. Comparison of the perception of the Bond dimension of the therapeutic alliance.

Supplementary Figure 10. Path diagram of the estimated fixed effects of the mixed linear model for psychological distress as a function of therapeutic alliance, perceived by the patient and the psychologist.

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Ethical approval and consent to participate: this study was conducted in accordance with the ethical principles of the Declaration of Helsinki and received approval from the institutional ethics committee of the university. All participants – both trainee psychologists and patients – were fully informed about the nature and purpose of the study, including the audio and video recording of sessions, and provided written informed consent prior to participation.

Consent for publication: all participants provided written informed consent for the use of anonymized data for research and publication purposes. All data reported in this manuscript are fully anonymized, and no identifying information is included.

Availability of data and materials: the data used in this study are currently not publicly available but will be made accessible upon future publication.

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