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Client perspectives on effective psychotherapy: a systematic review and foundation for a consilient psychology

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CLIENT PERSPECTIVES ON EFFECTIVE PSYCHOTHERAPY: A SYSTEMATIC REVIEW AND FOUNDATION FOR A CONSILIENT PSYCHOLOGY

A clinical dissertation submitted in partial satisfaction

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by

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CLINICAL EXPERIENCE

Texas A&M Counseling & Psychological Services — College Station, TX (2023-2024)
Psychology Intern

- Sports Psychology work with the student athletes
- Interpersonal Relationship Dynamics Group Therapy
- Individual Psychotherapy
- University Outreach

Cal Lutheran University Counseling & Psychological Services — Thousand Oaks, CA (2021-2023)
Advanced Psychologist Trainee

- Sports Psychology/Mental Health programming in collaboration with the athletic department
- Athlete/Coach consultation, psychoeducation, and seminars
- Drop-in group therapy
- Sports psychology focused individual psychotherapy with student athlete population

Clinical Psychologist Trainee

- Individual and Couples psychotherapy
- Short-term psychodynamic, CBT, and humanistic modalities utilized
- Crisis interventions and management
- Outreach programming, monthly on-campus events

Irvine Community Counseling Center — Irvine, CA (2020)
Clinical Psychologist Trainee

- Individual and Couples psychotherapy
- Complete comprehensive intake evaluations
- Develop case conceptualizations and present cases during case conferences
- Generate and execute evidence-based treatment plans

Depression Grand Challenge, UCLA Semel Institute — Los Angeles, CA 2020
Innovative Treatment Network

- Trained licensed professionals on using STAND and Rainfrog digital therapies
- Trained doctoral students on building clinical skills via improv exercises and films

Aftercare Clinic, UCLA Department of Psychiatry — Los Angeles, CA 2019
Assessment Team

- Certified and conducted full panel of assessments for Psychotic disorders including BPRS, SANS, PANNS, and SCID-V
- Completed comprehensive screenings, evaluations, intakes, developed case conceptualizations, presented cases during case conferences, and facilitated enrollment of first-episode patients

Creative Care Mental Health Treatment Program — Woodland Hills, CA 2019
Student Counselor

- Lead and facilitate process groups
- Assisted with DBT skills group
- Case Management
- Social milieu rapport and relationship skills building

RESEARCH EXPERIENCE

Dissertation, Pepperdine University — Los Angeles, CA 2020 (Ongoing)
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- Client Perspectives on Effective Psychotherapy:
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Depression Grand Challenge, UCLA Semel Institute — Los Angeles, CA 2020
Innovative Treatment Network

- Scrip writing/copywriting/voiceover for Rainfrog digital therapy suites
- R&D of evidence-based treatment and outcomes podcast ft. leading professionals of the field
- R&D of STAND (The Screening and Treatment for Anxiety & Depression) digital therapy modules

UCLA Department of Psychiatry and Biobehavioral Sciences — Los Angeles, CA 2019

Senior Research Assistant, Assessment Team

- Certified on a full panel of assessments for Schizophrenia and related psychoses
- Lead author on pending publication for sex differences in first-episode Schizophrenia
- Lead author on poster abstracts for APA and WPA conferences
- Presented poster on sex differences in first-episode Schizophrenia at WPA Conference 2020

USC Brain & Creativity Institute — Los Angeles, CA 2019
Research Assistant

- Data analysis and coding of behavior for social cognition and neuroscience
- study on abstract vs moral construals
- Co-author on pending findings publication for a social cognition and gaze aversion study

TEACHING EXPERIENCE

Graduate Assistant — Pepperdine University, CA 2018
Academic Writing Consultant

- Guided clients with tools designed to develop and improve personal writing skills
- One-on-one sessions addressing specific academic writing opportunities
- Provided education on professional and academic writing
- Developed and implemented personalized writing exercises
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Teacher/Mentor — Brentwood, CA 2016
Homeschool Teacher

- One-on-one focused attention on student using guided curriculum with an emphasis on mathematics, reading, reasoning, and critical thinking
- Administered memory and recall exercises including digit span and sequencing
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RESEARCH PUBLICATIONS

Ventura, J., Subotnik, K., **Han, S.**, Hellemann, G., Green, M., & Nuechterlein, K. (2023). The relationship between sex and functional outcome in first-episode schizophrenia: The role of premorbid adjustment and insight. Psychological Medicine, 1-10. doi:10.1017/S0033291723000442

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ABSTRACT

This study will explore client perspectives on what works in psychotherapy in an effort to elucidate critical ideas for more consilience, or the unity of knowledge, in the field of clinical practice. The objective is to generate a theory from the data that can serve as a foundation for an eventual unified model of psychotherapy. A qualitative narrative synthesis approach was taken using grounded theory principles to analyze data from common factors outcome research. The results appear to confirm prior findings on the importance of interpersonal dynamics and the therapeutic relationship. The data demonstrates a potential connection between interpersonal factors and technique-based factors in that both need to coexist for optimal outcomes. However, due to various methodological limitations in the studies sampled that led to untrustworthy data, no solid conclusions can be drawn regarding the interpretation of the results. Future research would need to rectify the present methodological gaps before a viable narrative for a unified model can be constructed.

Keywords: consilience, psychotherapy, common factors, client perspectives

Chapter 1: Background & Rationale

Statement of the Problem

The goal of psychotherapy can generally be agreed upon as increasing the subjective and objective states of wellbeing for a client. What might be the best approach to achieve such a goal? This aim of this qualitative systematic review is to investigate this issue from a client's perspective, as a key data point not often considered, to add to the developing body of literature aimed at improving psychotherapeutic practice. This chapter aims to provide a historical and foundational overview of the origins of psychotherapy and development of treatment modalities or theoretical orientations, eventually narrowing the focus on common factors, the call for a more consilient psychology, and the value of the client's perspective on what works in psychotherapy. The evolution of mental health has been one of inclusion and collaboration, elevating the importance of client participation and feedback in research and application. Furthering the field's understanding of what clients find helpful in the therapeutic space will benefit both practitioners and researchers in their ongoing collective quest to improve clinical work.

A Brief History of Theoretical Orientations

Since its inception, the field of psychology, and more specifically orientations of psychotherapeutic intervention, have traveled down paths that have all forked from Freud's magnum opus, psychoanalysis (Paris, 2013). More broadly, psychology was founded on three separate notions, consciousness (Wundt), the unconscious (Freud), and the study of adaptation (e.g., James; Henriques, 2004), and the study of these disparate topics using independent theories and methodologies eventually lead to an ingrained partisanship along practical, analytical, and theoretical lines (Rand & Ilardi, 2005). As a result, practitioners have long been trained into championing a single theoretical orientation, sometimes selectively incorporating, and sometimes decrying other schools of thought. This type of ingroup vs. outgroup philosophy may

have profound implications on psychology's ability to conceptualize and treat mental health as a unique facet of the individual. Some argue that clinicians have found themselves listening for elements of a client's narrative to fit into the paradigm of their choice modality rather than listening to a client's story with an open and inquisitive stance (Chodorow, 2003). As Abraham Maslow deftly put it, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail" (Maslow, 2002, p. 15 [originally published 1966]). The focus on specialization within the field seems to have sprouted from two major considerations.

The first being that the origins of the concept of "theoretical orientations" were rooted in a desire, and perhaps necessity, to expand upon and/or contest Freud's clinical model of psychoanalysis and his beliefs about psychology as a science of the mind (Norcross & Newman, 1992, as cited in Wampold, 2015). As Freud began to establish Psychoanalysis as the original orientation, he inevitably garnered faithful followers and skeptical dissenters. The contemporaries and successors that took issue with the principles of psychoanalysis reacted by innovating, creating, and establishing new models (Paris, 2013). As an example, Aaron Beck's cognitive behavioral therapy (CBT) modality formulated as a response to the behaviorists' notion that humans were essentially defenseless against their historical conditioning (Brewin, 1996). Later empirically supported, cognitive therapists at the time believed that conscious thought could influence one's feelings and behaviors. However, despite the mounting empirical evidence, behaviorists continued to reject the idea that conscious thought could have an impact on feelings and behaviors, and thus the theoretical consilience between the two orientations were practically nonexistent (Brewin, 1996). This stimulus and response pattern of clinical progress led to the development of numerously distinct frameworks of conceptualization and practice rather than the expansion, integration, and unification of collective knowledge.

Freud's theories of metapsychology also lacked the evidence-based empirical data that has forever ruled as the gold standard of scientific inquiry (Colby, 1960), though they have recently seen some empirical validation (Carhart-Harris et al., 2008). At the time of emergence, critics of psychoanalysis insisted that it could not be considered a science because many of its principles were not falsifiable via standard experimental methods (Popper, 1986). Psychoanalysts lacked the proper tools, instruments, and knowledge to rigorously investigate its claims per the accepted scientific standards. As technology and experimental methods progressed, subsequent modalities such as CBT (Hoffmann et al., 2012) and its ever-multiplicative derivatives (Hayes & Hoffmann, 2017) have attempted to rectify that blemish, one which has kept psychology outside the gates of the scientific community (Valone, 2005).

This leads to the other crucial element, the ideology of science as an endeavor and the expectations of it as a profession. Science, as a method, has theoretically been shielded from external influences on its paradigm (Wilson, 1998). This rigidity results a priori from a methodology so rigorous that it fortifies itself from contamination and corruption. In other words, there is no room for other models/ideas on how to acquire knowledge to be integrated. Such a quality, inherent to science (Kuhn, 1996 [original, 1962]), is reflected through the proclivity towards a devout adherence to the newest "standards" of any field of exploration[1]. For clinical psychology, that scripture is theoretical orientation. Ehrlich and Wilson (1991) suggests that science, as a career path, has always been one that rewards specialists over generalists, the unknown over the known, and discovery over synthesis. One is measured by the number of publications they've authored. One is remembered only if their footprint exists on an uncharted moon. Put another way, researchers' clout, success, and reputation are largely dependent on if,

[1] The hindrances to scientific progress created by this proclivity are discussed by Feyerabend (1993 [original, 1975]) and by Lochhead (1987, pp. 174-182).

and how many, novel contributions they can make. The motivation and incentives for researchers and scholars are bias towards the never-ending pursuit of the original with minimal attention to the cost.

This lethal combination has seemingly produced a new therapeutic technique or intervention every week that claims to be different than those that came before and better for it (Paris, 2013). With countless therapeutic orientations emerging and the jingoistic identification with them, the attention to clinical benefit seems to have been made a third wheel, sitting on the sidelines while scholars furiously coin new jargon, and practitioners' debate the merits for their subscribed orientation.

Norcross and Prochaska (1983) conducted a study with 479 clinical psychologists, surveying their use of and satisfaction with their selected theoretical orientations and found that a majority of practitioners were satisfied with their chosen orientation (77.1%, $N = 368$) and that an overwhelming majority reported that they frequently use their theoretical orientation in therapy (94.1%, $N = 435$), (Norcross, et al., 1993; Norcross, et al., 2002; Norcross & Rogan, 2013). The variables that influenced their satisfaction and decision to select their chosen orientations included clinical experience, graduate training, and personal values. Out of 18 possible variables on therapeutic outcome, theoretical orientation was rated as the most influential. Thus, it appears that practitioners are prone to theoretical alignment and perceive their choice orientations have the most profound impact on their clients (Strupp, 1978), but what does the evidence suggest?

Luborsky et. al (1975) found that most comparative studies of different modalities of psychotherapy found insignificant differences in outcome between the distinct approaches. Miller, Hubble, and Duncan's (2008) review of literature similarly supports the claim that different therapeutic modalities are in general no more effective than one another. However, the

overall effect size of meta-analyses investigating patients who receive therapy versus untreated controls ranges from .75 to .85, suggesting that a form of psychotherapy is still better than none (Wampold, 2015).

Consilience in Psychology

Now the question arises, why consilience and what is its connection with common factors? The answer is an extension of the presupposition of the original purpose of psychotherapy, as a practice. To move forward, we return to the assumption that the initial and continuing aim of psychotherapy, simply put, is to increase both the subjective and objective wellbeing of the client (Bobbitt et al., 2012; Van Deurzen, 2006; Winter Plumb et al., 2019). Some argue that this super objective is best achieved through consilience, as opposed to scission. From there, consilience in psychotherapy appears better pursued through common factors, as a unifying, effective, and evidenced-based foundation, rather than disparate theoretical orientations. The potential of consilience within psychology is illustrated in the following examples from the fields of ethics and medicine.

Before the turn of the millennium, the field of ethics had arrived at the core juncture of two opposing positions, empiricism, or man-made versus transcendentalism, or universal/religious. Without consilience, it struggled to progress any further, which explained why the field had made little advancement since the 19th century (Wilson, 1998). However, if we then inject evolutionary biology's notion of social cooperation and its necessity for survival as potentially responsible for birthing the rules and principles that eventually morphed into moral and ethical codes, the field is now unlocked and primed for further exploration.

Medicine is built upon a consistent foundation of molecular and cellular biology. Whether the pursuit is neurology, virology, or genetics, they all start from a base of biophysical chemistry and inform each other's shared vision to understand and improve the elements of

health and illness (Wilson, 1998). The success of their individual research depends on adherence to fundamental principles, which are consistently strived towards across all levels of biological organization from the entire organism down to the molecular components.

A recent movement towards integrative approaches and a consilient psychology attempts to address the aforementioned concerns and shine a light back on the purpose of psychotherapy. Integrative perspectives can be viewed as the natural extension of the fundamental biopsychosocial philosophy of psychology. George Engel (1977) first coined the term *biopsychosocial* to describe an integrative theory that would factor in a patient's social context, psychological and behavioral expressions of a disease, as well as the biological determinants when formulating a treatment plan. The implication being that treatment cannot be optimized without a comprehensive understanding of a client's presentation. The biopsychosocial models of psychotherapy emerged from a collective awareness of the necessity for context and a holistic case conceptualization in response to the biomedical model (Engel, 1977).

The biomedical model was established with molecular biology as its basic tenet. Disease was assumed to be a deviation from the norm of measurable biological variables, thus ignoring the social, psychological, and behavioral elements of illness. According to Rasmussen (1975), the origins of the biomedical model stemmed from two considerations. The first was the Christian Church's edict to direct scientific research towards the human body and away from the mind and human behavior, as the Church considered the latter to fall within the jurisdiction of religion and the soul. The second was the reductionistic movement lead by Galileo, Newton, and Descartes which resolved that phenomena were to be understood at their most basic level by causal units that, when synthesized, constituted the whole. Although hugely successful in the diagnostics and treatment of specific diseases, the biomedical model has its limitations.

1. The laboratory documentation of a biochemical deviation may only indicate disease potential, not necessarily an active illness. Thus, determining a biological defect only certainly accounts for one of a multitude of factors that, via complex interactions, may ultimately manifest into the expression and experience of a disease or illness (Kety, 1974; Engel, 1977).

2. "Rational treatment" targeted specifically towards the rectification of biochemical defects does not necessarily usher a patient into wellbeing. Unsurprisingly, the other variables that continue to afflict a patient after biological elements have been addressed are psychological and social.

3. The therapeutic relationship between the patient and the practitioner can influence the treatment outcome. The psychological effects of the relationship may either directly impact the experience of sickness or indirectly influence the development and trajectory of a disease via the symbiosis between psychological and biochemical processes.

In the 1970's, psychiatry and medicine were at odds with one another, each unclear on what mental illness meant, how it was to be categorized, and who was responsible for providing treatment (Engel, 1977). Psychiatry was unsure of whether it should become its own discipline or be subsumed by medicine. Medicine was unsure of whether it should concern itself with the treatment of "problems of living" if there was no clear somatic or neurological abnormality to align the issue with the accepted definition of a "disease". Engel's suggested approach was in direct response to what he called "medicine's crisis", which was the medical fields' failure to meet the evolving scientific and social responsibilities of healthcare by continuing to adhere to a model that is solely concerned with the biological parameters of illness.

The emergence of the biopsychosocial model delivered the concept of disease from the orthodoxy of biochemical determinants to include the notions of distress and impairment,

allowing the patient more agency over the states of "sick" and "well". The addition of psychosocial attention has activated the participation of the patient towards the effort of understanding how a particular condition is experienced, and what features unique to the individual must be considered when formulating a treatment plan. The biopsychosocial philosophy has expanded our understanding of mental health beyond the capacity of traditional medicine and thus demonstrates the transcendent potential of consilience.

This shift in the collective consciousness of psychology has also been aided by the expansion of our understanding of the human brain and the context in which we have evolved as a species through the exploration of anatomy, neurology, evolutionary biology, anthropology, and sociology (Henriques, 2003). We now know that humans have evolved with a "social brain" (Cozolino, 2017, Ch. 11). That is, our brains have been wired to organize our experiences within the context of our social environment. Our triumphs, failures, joys, and fears do not exist in individual isolation. Rather, they are dependent on the response of those around us and our perceptions of that response. Thus, the individual development of any human being is dependent upon and inextricably connected to the symbiotic relationship between them and their social milieu. With this understanding of the human brain, we must now concede a psychological approach that solely focuses on the mind of the individual in isolation for a multidisciplinary conceptualization that proceeds from our core social nature.

Integrative Psychotherapy

Integrative psychotherapy, by semantic deduction, implies the incorporation of multiple theories, orientations, and techniques to one's therapeutic approach. However, even the term *integrative psychology* has yet to standardize its operational definition within the field (Baucal & Krstić, 2020). Instead, psychotherapy has produced several concepts of integration such as

theoretical integration, technical eclecticism, assimilative integration, syncretism, multimodal therapy, and common factors (Gaete & Gaete, 2015; Lebow, 2008; Zarbo et al., 2016).

A broad perspective on integrative psychotherapy denotes a general flexibility and inclusive mindset towards the range of psychotherapeutic models in existence currently, with unlimited hypothetical space for the continued incorporation of novel ideas (Greben, 2004 as cited by Zarbo et al., 2016). Technical eclecticism involves the isolation and usage of the most effective elements from different approaches (Zarbo et al., 2016). Assimilative integration prefers primarily a single orientation approach but allows the weaving in of components from others when needed. Theoretical integration attempts to eclipse all theoretical models by forming a single but different approach. A common factors philosophy homes in on effective therapeutic elements that are shared among all approaches. Syncretism allows for clinicians to formulate a technical approach by drawing from their own intuitions rather than theoretical tenets (Gaete & Gaete, 2015). Finally, multimodal therapy relies on the utilization of empirically based treatments selected for effectiveness rather than for theoretical accuracy (Lebow, 2008). The aforementioned are but a sample of the divisional branches underneath the umbrella of integrative approaches. This raises the question, where is the integration of all of these disparate "integrative" approaches? With the pool of psychotherapeutic approaches becoming ever more saturated, a clinician's decision to utilize and ability to execute any of these treatments may be proportionately increasing in difficulty.

To bridge the gap between theory and application a study by Cook et al. (2010) surveyed 2000 licensed therapists and asked them to rate the percentage of use of each psychotherapeutic approach in their practice, see Table 1.

Table 1

Percentage of Psychotherapeutic Approaches Utilized by Therapists

Orientation	Percentage
CBT	79%
Family Systems	49%
Mindfulness	41%
Psychodynamic	36%
Rogerian/Humanistic	31%
Integrated	98%

Given that 98% of the sample from this study practices in some integrative fashion, additional considerations arise. Have integrated approaches become the norm, and if so, why is the literature on it so disorganized?

There has long been a trend among practitioners to employ differently theoretically oriented therapeutic techniques in particular clinical situations in an integrative manner (Goldfried, 1980). Gelso (2011) described how the rapid proliferation and coalescence of individually distinct psychotherapeutic theoretical orientation were initially in competition with one another for ultimate vindication as the singular correct orientation. This period of proliferation and conflict, Gelso says, has been followed by various approaches to integrate psychotherapeutic theoretical orientations that grew out of researchers' and practitioners' lamentations of limitation within individual theoretical orientations and their desire to explore psychotherapeutic techniques with respect to their effects on clients. Differing conceptions and practices of theoretical integration have been proposed, and both their practical and epistemological merits and pitfalls have been respectively extolled and decried by practitioners and researchers.

Therefore, it appears the trend towards research into psychotherapy integration may be the precursor to a Kuhnian "transition to extraordinary research" (1996 p. 91 [original, 1962]) which Kuhn associates with scientific revolutions. The ascension and growing respect towards qualitative research are both congruent with Kuhn's notion of the necessity for a paradigm shift and this review's objectives in exploring common factors. Integrative approaches arose from the scientific "crisis" of the apparent lack of a singular correct theoretical orientation among the many that had emerged. Researchers' (and practitioners), becoming aware (perhaps unconsciously in some cases) of the epistemological limitations of individual theoretical orientations, became willing to explore and employ techniques from other theoretical orientations (Gelso, 2011; Goldfried, 1980; Miller et al., 2008; Norcross & Prochaska 1983).

There are different approaches to theoretical integration in research and practice—many of which are discussed later in this paper. The common factors approach to psychotherapy research and practice, unlike the others, appears to root itself in a metaphysical debate over the essential elements of psychotherapeutic success and strives toward consilience. The common factors approach appears to present us with the final Kuhnian "symptom of a transition to extraordinary research" that is associated with scientific revolutions (Kuhn, 1996, p. 91 [original, 1962]). Research into common factors is thus the final "symptom" of "recourse to philosophy and [a] debate over fundamentals" (Kuhn, 1996, p. 91 [original, 1962]). This leads us to the potential conclusion that, of the possible forms of theoretical integration in psychotherapy, common factors integration may be the key to answering the question of what makes therapy work?

Common Factors in Psychotherapy

In 1936, Saul Rosenzweig initiated a movement towards a more consilient psychology by focusing on the elements that existed across all therapies (common factors) which seem to be

most responsible for change in treatment outcome (Rosenzweig, 1936). Rosenzweig coined the term *Dodo bird verdict* to conject that all empirically supported therapies, regardless of specific ingredients, produced equivalent outcomes. This notion was not legitimized until the 1970's when Lester Luborsky et al. (1975) published the results of one of the initial comparative studies revealing few significant differences in outcomes among various psychotherapy modalities. Since then, more critical attention has been given to the topic in the form of seesawing research and debate, birthing a common factors approach and contextual model of psychotherapy (Wampold, 2015).

Drisko (2004) shared meta-analytic findings on common factors research that supported a general conclusion that those shared factors are the most responsible "active ingredients" related to psychotherapeutic outcome and appeared to be more important than specific factors. A few of the most recognized common factors include: the therapeutic relationship, client expectations, placebo effects, therapist characteristics, client context, consensus on goals, therapist adherence to a treatment model, client activity, and client characteristics, with therapeutic technique categorized as specific factors (Frank & Frank, 1991; Lambert & Bergin, 1992; Orlinsky et al., 1994; Rosenzweig, 1936). The therapeutic alliance has been specifically attributed as the greatest healing factor in psychotherapy, followed by empathy/positive affirmation, therapist characteristics, client expectations, and culturally adapted evidence-based treatments (Wampold, 2015). Assay and Lambert (1999) name the most critical common factors as client/extratherapeutic, relationship, placebo, hope and expectancy, and models/techniques. Tschacher et al. (2012) produced a taxonomy of common factors by creating a list of all factors described by at least two authors and ended with a list of 22 elements. The factors they found that most contributed to therapeutic outcome are presented in Table 2 below. Our analysis will refer to their taxonomy for standardization purposes in future chapters.

Table 2

Common Factors Most Attributed to Therapeutic Outcome

- Therapeutic Alliance
- Patient Engagement
- Affective Experiencing

Common Factors Versus Nonspecific Variables

Castonguay (1993) pointed out that the terms common factors and nonspecific variables have been used interchangeably in the research, a confusion that will hereby be rectified. Common factors have been defined as a large number of variables across different dimensions that are not specific or unique to one modality of psychotherapy (Castonguay, 1993). Nonspecific variables, on the other hand, have carried three similar but distinct meanings across the literature. The first refers to the universal variables that may exist across many forms of psychotherapy, similar to the common factors' definition (Appelbaum, 1978; Stone et al., 1966, as cited in Castonguay, 1993). Bergin & Lambert (1978) described the second definition as supplemental factors of therapy that may contribute to the process of therapy (interpersonal and/or social factors) but differ from specific elements of the treatment protocol (silence to facilitate free association in psychoanalysis or systematic desensitization in exposure therapy). The third way nonspecific variables have been used refers to potentially contributive factors whose precise nature and therapeutic effect have yet to be understood (Mahoney, 1977; Shapiro & Morris, 1978; Wilson, 1980, as cited in Castonguay, 1993). Although it's possible to find variables that simultaneously fit into all three definitions of nonspecific variables, it doesn't solely contain the meaning of common factors as has been defined. Thus, for this review the term common factors will be used accordingly.

Research on Client Perspectives

Studies that inquire about client perspectives have existed throughout the field's history, including the work of Lipkin (1954) who interviewed nine clients about their experiences in client-centered therapy (Timulak & Keogh, 2017). However, the studies have been sparse. Only in recent decades have researchers been activated regarding the potential value of investigating client experiences for the improvement of clinical practice. Client perspectives literature has generally fallen into two categories: studies that evaluate various aspects of a client's experience in therapy and those that focus on the client's perspective regarding a specific theoretical construct (e.g., therapeutic alliance; Timulak & Keogh, 2017). Such studies are often administered via an open-ended qualitative format (i.e., allowing the client to freely respond to questions regarding their experiences) or by utilizing psychometric measures, which are then categorized as quantitative data.

Most qualitative studies on client perspectives incorporated in-depth interviews. Sometimes the interviews were supplemented by recall tools such as footage of prior therapy sessions. The analysis of qualitative formats typically attempts to "bracket" the client's responses into categories that are representative of the essence or meaning of the client communication (Rennie, 2012). David Rennie (1990, 1992, 1994) invited clients to review tape of their sessions and comment on moments that deemed particularly meaningful or impactful and found that clients tended to defer to their therapists. This would often lead to a client utilizing defensiveness in sessions because they were afraid to criticize the therapist openly. This limitation may have impacted the validity of those studies but serves as a key consideration for free-form qualitative inquiries.

Strupp et al. (1964) and Orlinsky and Howard (1975) conducted studies that were critical to the examination of various aspects of client experiences. Strupp et al. (1964) found positive

correlations between therapist warmth and regard and positive therapeutic outcome. They also found clients were able to discriminate between a therapist's personality and specific therapeutic techniques utilized, and that personality was rated as the more important of the two. Orlinsky and Howard (1975) used questionnaires to evaluate client and therapist experiences in session across a myriad of elements within the therapeutic process (e.g., session content, behavior in session, feelings in the session, session goals, client satisfaction, etc.) and found a considerable variability in client and therapist perceived experiences.

Several quantitative studies were conducted to evaluate specific theoretical constructs such as therapeutic alliance, client expectations, client experiences of empathy, client preferences regarding therapist or treatment, and group cohesion in group therapy (Burlingame et al., 2011; Elliott et al., 2011; Horvath et al., 2011; Swift et al., 2011). Positive ratings on therapeutic alliance and therapist empathy were found to be predictive of positive outcome in therapy from the client's perspective. Respect for a client's therapeutic preferences were also found to be significantly associated with lower drop-out rates.

The literature on what client's felt were most helpful or unhelpful in therapy largely consists of quantitative studies utilizing questionnaires formulated with specific psychotherapeutic factors in mind (Gershefski et al., 1996; Levitt et al., 2006; as cited in Timulak & Keogh, 2017; Lietaer, 1992; Paulson et al., 2001). These studies consistently found that clients valued a supportive and caring therapeutic relationship where the clients felt heard and understood. Clients appreciated awareness or insight-oriented work and found some of their own characteristics to be helpful within therapy (e.g., willingness to engage, openness). Some additional helpful elements are noted in Table 3 below. A few unhelpful elements of the therapeutic experience that were identified included feeling stigmatized, unsafe, and emotionally overwhelmed. Other studies that investigated adjacent elements of therapy from a client's

perspective (e.g., significant events, client experiences) are outside of the scope of this paper but may be referred to in subsequent chapters for contextual purposes.

Table 3

Client Perspectives & Experiences Related to Therapy

Therapist's Personality	Therapist's Techniques
Therapist's Warmth and Regard	Respect for Client's Therapeutic Preference
Therapist's Empathy	Positive Therapeutic Relationship

Rationale, Primary Aims, and Key Research Questions

This systematic review will aim to understand what works in therapy from a client perspective against the backdrop of psychology's longstanding relationship with singular theoretical approaches to therapeutic practice. The hope is to provide more knowledge to sharpen a clinicians' process towards best practices by integrating the other half of the therapeutic equation and lay further foundation for the genesis and development of an eventual unified, consilient approach to psychotherapy. A clinician's marriage to a single school of thought may not optimally serve a client's needs and does not adequately respect the unique and nuanced nature of mental health. We will aim to address this concern by operating from a foundational presupposition that the goal of therapy is to improve a client's objective and subjective states of wellbeing. This investigative approach will be rooted in a common factors/contextual philosophy as this study believes it represents the most direct path towards consilience. The research questions are as follows:

1. What elements of therapy do clients report as being helpful?

2. Are there client characteristics that align with certain aspects of therapy that they find most helpful? If so, what are they?

Chapter 2: Methods

Systematic Review Approach

A qualitative narrative synthesis approach was utilized to analyze, identify themes, and summarize the data from the client perspective literature. This method was chosen because qualitative research, philosophically, places the client's subjective experience as the most valued source of information. Prioritizing a client's voice and agency, unrestricted by quantitative parameters, mirrors psychotherapy's tenet of being a co-constructive and collaborative endeavor (Bohart & Tallman, 1999). Quantitative methods, while valuable in providing standardized outcome measures, are limited by their specificity, and assumed uniformity across measurements that often result in a single score which fails to capture the dynamic process of psychotherapy (Swift et al., 2017). Thus, a qualitative review approach was determined to be most appropriate to honor client perspectives on what is helpful in therapy by aiming to capture the truest representation of their narratives. The methods applied in this systematic review are informed by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-P).

Eligibility Criteria

All studies included in this review were written or translated into English and sourced from peer-reviewed journals. To capture the entire scope of relevant articles given the sparse qualitative research on the topic, all articles after 1954, the year of the earliest known work on client perspectives, were included for initial screening. The studies included participants who have attended an evidenced-based form of psychotherapy. All participants of the studies were eighteen years of age or older. This age range was selected to focus this study on an adult population. Specific modalities of psychotherapy are not excluded because this review aims to capture a full scope of client perspectives on what works in therapy regardless of theoretical orientation or intervention utilized. Similarly, the format of the psychotherapy is flexible and

includes group-based, individual, and family therapy. The participants must have attended at least one session of psychotherapy prior to response collection. As the initial session typically consists of an intake, which some may not deem as therapeutically viable by itself for a client to experience the intended nature of therapy, identifiable helpful factors may exist, nevertheless.

The selected studies included a wide range of adult sample sizes regardless of gender identity, cultural background, socioeconomic status (SES), ethnicity, race, sexual orientation, or religious affiliation. The current review includes studies that provide client perspectives on what they found to be helpful in therapy. Studies that investigate client perspectives on other elements of the therapeutic process but do not include direct data about what clients found helpful/useful in session were not included. Studies that contained clients who did not find psychotherapy helpful were also included, however the unhelpful perspectives data were not extracted nor analyzed for the purposes of this review but will be mentioned in the discussion section. Meta-analyses and reviews were not included due to the potential overlap of data; however, they will also be referenced for consensus and discussion in later chapters. All quantitative studies, regardless of client perspectives data, were not included.

All study settings were reported including, but not limited to, community clinics, private practices, case studies, schools, and in-patient and out-patient facilities. Studies from outside of the United States, that were published in English, were also considered for review because there may be cultural factors that are relevant in their influence on client perspectives. The general principle was to cast as wide a net as possible with the inclusion criteria due to the limited nature of research specifically on client perspectives regarding what's helpful in therapy.

Search, Screening, and Selection Process

The search for articles was conducted following the procedures and recommendations specified by Timulak (2009; 2013), Levitt (2018), and Ladmanová et al. (2021). The following

electronic databases were used: PsycInfo, PsycArticles, and Scopus. Keywords were determined through a preliminary literature search. The following search string was used to represent the interests of the review based on the research variable: AB (client OR patient) AND AB (perspectives OR opinions OR views OR attitudes OR perceptions) AND TI (psychotherapy OR psychological therapy) AND AB ("what works" OR helpful OR effective OR positive OR curative OR beneficial). All search terms were assigned a corresponding identification (ID) number, and variations and synonyms of the search terms are provided in the search plan. Additional reviews through the references in primary studies and previous meta-analyses and systematic reviews were not included as the sample size for screened articles (n = 35) exceeded the minimum recommended number (n = 12) for qualitative studies (Paterson et al., 2001). The extended literature review is included in Appendix A. Due to this study utilizing archival data, IRB approval for human subjects was not required. However, an IRB documentation form for non-human research is included in Appendix B. A PRISMA flow diagram identifying the study selection process is included in Appendix C.

The purpose of the search plan was to document the gathering of the potential literature to be used in this systematic review. The search plan was executed by inputting each search term sequence, with Boolean operators, into each of the online databases. The results yielded for each search trial were then moved into the screening phase, described below. The appendix for the search plan is a google excel spreadsheet with columns for search type, database used, search term ID numbers, search syntax or instructions (the combination of keywords used and how), fields to search, specifiers, and plan notes. The search documentation spreadsheet was formatted to track the variations in keyword combinations as well as the search date, a full search ID number, the type of database used, the database source, the search term ID number, search

syntax, fields searched (i.e., Title, Abstract, References), search specifier of peer-reviewed, number of records produced via that search, and notes.

The spreadsheet screening and selection record was used to track articles that were in consideration for inclusion in the study. The screening and selection process consisted of three distinct phases. During phase one the title, abstract, and keywords of each article were screened for inclusion. During phase two, the abstract of the articles were reviewed for initial appropriateness and, if so, a full text review followed to determine eligibility. Inclusion and exclusion criteria (i.e., qualitative study, evidence-based psychotherapy utilized, etc.) were considered during the full text review. During phase three, a final decision to include or exclude the article was made based upon previous selection procedures. Any issues in the reviewer's selection of articles were brought to the dissertation chairperson for resolution.

Data Collection and Extraction

The data extraction tools have been developed, tested, and improved-upon by the author, before being reviewed by the dissertation chairperson. The data form was developed by adopting and customizing the "Data Collection Form for Intervention —RCTs and Non-RCTs" of The Cochrane Collaboration. The form is designed to be compatible with studies regardless of methodology. The form was filled out for each article that had successfully been filtered through the screening process. The following information was extracted from each article: publication details, eligibility characteristics, methodology, participant characteristics, outcomes/findings, limitations and mitigation strategy, and conclusion and additional information. To reduce potential reviewer bias, a second reviewer assessed the data extraction procedures for each article.

Quality Appraisal

A mixed methods appraisal tool form (MMAT), revised by Hong (2018) with consideration for updated findings from a literature review on critical appraisal tools, was selected to assess the quality and appropriateness of the studies to be included in the review. Note that only the portions relevant to qualitative studies were utilized. The following categories were assessed: methodology, research questions, data collection, data analysis, researcher's position, findings, interpretations, and coherence of the entire process. Each of the categories ask specific questions of the reviewer for assessment of appropriateness. Studies were assessed and assigned a category (Yes, No, or Can't tell) for whether the study being reviewed answered the quality screening questions for each category. An additional comments section was included with each determination for further notes. Each category was rated separately, allowing for specified data on the critical appraisal process for evaluation and discussion in later chapters.

Data Management, Synthesis and Analysis Plan

To organize and code the data extracted from the articles, a table was created via google documents using information imported from the Data Extraction document. This database was used to facilitate the analysis of client responses from the studies for common patterns, themes, and frequency of the most common responses. Any client response denoting helpful aspects or elements of psychotherapy served as the main variable of interest. Additional variables included client characteristics such as sex, race, and cultural factors, and the inclusion of these variables in the final analysis will be dependent on data availability. The variables from each study were examined to provide overviews of the conclusions and identify key findings.

The analysis procedure was rooted in the inductive principles of grounded theory methodology. Birks and Mills (2015) define grounded theory as a process by which theory is generated from the analysis of data. A grounded theory approach was chosen as it places

emphasis on the discovery rather than the verification of theory (Alvesson & Skoldberg, 2017). Common patterns that emerge from the analysis were clustered into thematic categories determined by the nature of the client responses. The specific steps for the coding and analysis procedures are described below.

1. Each response that identifies a helpful factor from each article was coded as a single unit.
2. All units were logged verbatim in the coding table mentioned previously.
3. Four separate researchers independently reviewed all logged units and separated them into 3-5 major themes or categories.
4. The lead researcher reviewed all themes/categories generated and unified them into 3-5 final themes/categories via consolidation and consensus.
5. All units within each theme/category were tallied and ordered by the frequency of responses.

All units that share similar meaning (i.e., similar phrasing, similar idea) within each theme/category were clustered together and the top two were identified by frequency.

It is hypothesized that most client responses will be similar enough to be represented by a few common themes that mirror findings within common factors literature regarding the most helpful/effective elements of therapy. A conclusion (discussed later) was drawn from the analysis to inform and support a foundation upon which a consilient model of psychology can emerge. Common themes and specific examples from client responses served as the key data recorded in the Evidence Tables. Visual models, such as graphs or charts, are provided to supplement the analysis as necessary.

Limitations and Potential Contributions

Potential Contributions: This systematic review aims to analyze, summarize, and evaluate the elements of psychotherapy that clients find to be most helpful. The goal of this review is to

provide information and considerations for clinicians, regardless of modality or theoretical orientation, to improve their practices. This study will contribute to the growing body of client-perspectives literature with a specific target towards beneficial therapeutic elements (common factors). It may paint a clearer picture of what elements of psychotherapy seem to be the most beneficial from the perspective of the receiver, which may help crystallize the broader discussion of what works in psychotherapy.

Limitations: Data extraction will be primarily performed by one researcher, with review from another, so validity and human errors must be considered. Qualitative studies are often smaller and lack randomization, increasing the potential for additional researcher bias. Because the studies investigated will be narrative in nature, rapport with the researcher/assessor may also play a role in how clients choose to respond to open-ended questions about their experiences. A more complex limitation is the variable population characteristics of a study that may or may not be analyzed in each specific article. Differences in characteristics include but are not limited to sex, age, race/heritage, socioeconomic status, religious beliefs, sexual orientation, and cultural norms.

Chapter 3: Results

The objective of this study was to review the literature on common factors to identify and aggregate the most helpful factors of the psychotherapeutic experience from the client's perspective. The synthetization of these findings hopes to lay further groundwork for an eventual consilient model of psychotherapy to emerge. Such a model would theoretically focus the practice of psychotherapy on universal effective factors, incorporating them as a foundation upon which more specified techniques would be layered on to as appropriate. Following the presentation of the results will be a discussion on the validity of common factors research and their implications for psychotherapeutic practice.

Overview of Findings

Following the finalized search string protocol, a total of 1,703 articles were screened across three digital databases (PsycArticles, PsycInfo, and Scopus). A total of 36 articles passed the final screening and selection process. Most of the excluded articles were inappropriate due to a focus different from the research questions this study aimed to explore. During the data extraction and quality appraisal processes, 4 additional articles were excluded due to inappropriate study methodology, and a focus on outcome or extraneous factors of therapy rather than what clients found useful during therapy, leaving a final sample of 32 articles for analysis. The list of articles included can be found in Appendix A.

A total of 171 meaningful units were coded from the 32 articles sampled. Using grounded theory principles, the responses were separated into four major umbrella categories (Glaser & Strauss, 1967). The categories are as follows: Technique-Based Factors, Client-Based Factors, Interpersonal Factors, and Therapist-Based Factors. Technique-Based Factors accounted for the most reported responses, followed by Interpersonal Factors, Client-Based Factors, and Therapist-Based Factors respectively. Each helpful factor was then consolidated into similar themes and

the top two themes (in terms of frequency of responses reported) were identified under each umbrella category and will be expanded upon below. Table 4 below highlights some examples of responses that were filed under each major umbrella category.

It is important to note that there is inherent overlap between several reported factors and what categories they might be appropriate for due to the complex nature of the psychotherapeutic process and the interplay between human psychology and relationships. For example, empathy or empathic attunement may represent Interpersonal Factors, Technique-based Factors, and Therapist-Based factors, however in this case it will be filed under Interpersonal Factors because of the general, universal, and positive quality of empathy in relational dynamics. A Technique-Based factor is differentiated from Interpersonal Factors by the inherent neutral and specific quality of the intervention, such as assigning a client homework. That technique may be more common in CBT orientations and clients may or may not find it helpful. A Therapist-Based Factor are qualities that are unique to the individual therapist (i.e., their personality, their level of expertise on a particular disorder, etc.). Ultimately, the delineation of factors is subjectively dependent on the perspectives of the individual and this limitation will be further discussed later.

Table 4

Overview of Responses Per Umbrella Category

Category	Examples of Responses
Technique-Based Factors	Contain participant's process when going off topic
	Psychotherapist giving exercises, homework, and other concrete tools
	Psychotherapist providing psychoeducation
	Attempting to do things to get in touch with emotions like two-chair work
	Therapeutic tools: diagrams, letters to client, relaxation tape
Client-Based Factors	Ability to be open
	Client engaging in therapeutic acts outside of session
	Identifying emotions and listening to therapist feedback
	Asking therapist questions
Interpersonal Factors	Collaboration
	Positive image of the therapist
	Positive therapeutic relationship
	Feeling trusted and valued
	Being seen, heard, understood, and accepted
Therapist-Based Factors	Therapist experience
	Cancer knowledge
	Positive therapist relational qualities and skills
	Therapist awareness of poverty-related stressors
	Therapist shows authenticity

Categorical Details

Specific psychotherapeutic structuring, skills, and interventions performed by the therapist were labeled as Technique-Based Factors. These factors were differentiated from Interpersonal Factors by the specific nature of the skills/interventions reported, their roots in certain theoretical orientations, whether manualized or not, and the prerequisite or assumption of prior training involved to develop the skill/intervention. Helpful psychological and behavioral processes engaged by the client, whether motivated by the clinician or not, were labeled as client-based factors. Many of these factors may still be generally therapeutic when practiced outside of the session frame, a consideration that will be further discussed later.

A substantial portion of meaningful units reported were representative of the dynamics between the therapist and client, and thus labeled Interpersonal Factors. Oxford University Press (n.d.) defines interpersonal as "connected with relationships between people", and the term was chosen because it precisely captures this set of data. Qualities or characteristics that were inherent or unique to the clinician were labeled as Therapist-Based Factors. Many of these units seemed to be linked to a clinician's knowledge and expertise in specific areas or populations. The rest of the factors reported seem to be dependent on the subjective perception of the therapist by each client, a consideration that will be explored in detail later.

Table 5 below presents a breakdown of the subcategories and proportionate number of responses. The top two subcategories that emerged based on frequency of similarly themed units for Technique-Based Factors were "core therapeutic skills" and "structural components of therapy". Core therapeutic skills describe interventions that appear to be more universal in psychotherapeutic practice rather than specifically coupled to a particular theoretical orientation or treatment modality. Examples of these skills include empowering the client, normalizing the client's situation, providing psychoeducation, challenging the client, discussing goals with the

client, remaining calm in the therapeutic space, and active listening. Structural components of therapy encompass factors that are related to the session structure or progress of therapy as facilitated by the therapist. Examples of these factors include therapist flexibility in therapy structure, therapist discussing session process, therapist facilitating an evaluation of progress, the focus of treatment, and the therapeutic environment.

The top two subcategories identified for Client-Based Factors were "vulnerability and willingness to be open" and "effort and initiative". Vulnerability and willingness to be open described factors of emotional expression, honesty, authenticity, and courage to participate in difficult therapeutic work. Effort and initiative represent factors of proactivity, motivation, and intentional actions/behaviors by the client before, during, and after the therapy session. Ultimately it appears that client's find it helpful to be effortfully engaged, open, and expressive in therapy.

The top two subcategories identified for Interpersonal Factors were "therapeutic alliance" and "empathic attunement/visibility". Therapeutic alliance denotes the positive rapport or relationship between the therapist and the client, and empathic attunement/visibility represents a client's sense of feeling seen, heard, and understood. This finding for the qualitative review is in alignment with previous findings from quantitative meta-analyses that identified therapeutic alliance as a crucial factor for successful therapeutic outcomes.

The two subcategories that encompassed all of the Therapist-Based Factors were "expertise/qualifications" and "communication skills/disposition". Expertise and qualifications represented a therapist's unique training, knowledge, and understanding of certain areas of mental health and working with specific populations. Communication skills and disposition reflected a therapists' training on how to speak with clients and the way a clinician was subjectively perceived by a client with respect to their personality, likeability, and authenticity.

Table 5

Overview of Helpful Factors Umbrella Categories & Subcategories

Category	Top Two Subcategories	No. of Responses
Technique-Based Factors	Core therapeutic skills	41 of 79
	Therapy structure	18 of 79
Client-Based Factors	Vulnerability & openness	11 of 29
	Effort & initiative	11 of 29
Interpersonal Factors	Therapeutic alliance	13 of 38
	Empathic attunement	11 of 38
Therapist-Based Factors	Expertise/qualifications	10 of 25
	Communication/disposition	15 of 25
[Total]		[171]

Note. The total number of studies (n = 32).

Comparative Analysis to Prior Research

Previous quantitative meta-analyses and reviews on common factors research have consistently demonstrated that nonspecific or "non-active" factors (i.e., therapeutic alliance, warmth, empathy, and congruence) tend to be reported in the highest frequency versus specific ingredients or "active factors" such as therapeutic techniques and skills (Ardito & Rabellino, 2011; Horvath & Luborsky, 1993; Luborsky, 1976). Lambert and Barley (2001) delineated four major categories of factors that contribute to therapeutic outcomes: extratherapuetic/client factors (40%), common factors (30%), specific therapy techniques (15%), and expectancy effects/placebo (15%), additionally revealing that elements outside of therapy and the therapist contribute to a large proportion of beneficial outcomes. The findings of this qualitative review are seemingly in contrast with prior conclusions. Client-Based Factors (17%), Interpersonal Factors (22%), and Therapist-Based Factors (15%) were spread relatively evenly, but Technique-

Based factors or specific ingredients accounted for the largest proportion of meaningful units aggregated (46%).

A closer analysis of the results may demonstrate that this review is congruent with prior literature. There are two explanations for the apparent discrepancy. First, the top subcategory coded under the Technique-Based Factors was core/basic therapy skills. Many of these skills (active listening, encouragement, reassurance, guidance, creating space for the client to express themselves, etc.) are general therapeutic skills that transcend theoretical orientation and could thus be considered "common" versus specific techniques. These universal skills can also be viewed as operational components of the process by which rapport/alliance are established and increased and thus have significant overlap with Interpersonal Factors. So, several of the core/basic therapy skills identified also fit into this review's coded definition of Interpersonal Factors and can be thought of as common rather than specific factors.

Second, the semantics of "technique" as it's been used in prior research versus its meaning in Technique-Based Factors may also contribute to further confusion. Recall that the catalyst for common factors research was Rosenzweig's (1936) assertion of the Dodo Bird verdict claiming that all psychotherapies were essentially equal in their effects, so common elements within the orientations must be the responsible agents of change. Since then, the word "technique" has generally referred to skills and interventions that are specific or unique to particular psychotherapies (i.e., a thought record for CBT), whereas the word "common" referred to universal elements (i.e., unconditional positive regard, active listening; Castonguay, 1993). However, the present issue is that Technique-Based Factors encompass both specific and common skills. Notably, the findings in this review have identified more common skills than specific ones, thus still congruent with the prior literature despite the Technique-Based Factors category accounting for the largest portion of responses analyzed.

Chapter 4: Discussion

A Consilient Model of Psychotherapy

From a client's perspective, the most helpful elements of psychotherapy seem to be the common factors that exist independent of affiliation with any particular theoretical stance. The results of this review seem to reinforce prior common factors literature and potentially expand it by bridging the notion of common factors with the proposed idea of a consilient or unified model of psychotherapy. The data of this review appeared to reveal two major findings, however because of methodological issues within the sampled articles, solid conclusions cannot be drawn. A theory for a consilient model and how the findings for this review have the potential to support it, but ultimately do not, will be discussed presently.

Informed by the categories created via grounded theory principles, this review seems to suggest that the most helpful components of psychotherapy seem to be the relational factors (empathy, therapeutic alliance, collaboration, etc.) and general/core therapeutic skills (goal setting, open-ended questioning, active listening). Upon closer analysis, the combination or interplay of these two elements may be critical to perceived successful outcomes and that one of the facets, by itself, is not sufficient. Prior literature has demonstrated interpersonal or relational factors to be the most helpful. This review found general/core techniques to be the most frequently reported helpful factor. Although factors that have traditionally been labeled "techniques" imply a specific ingredient, this review has demonstrated that the techniques reported in highest frequency are actually common factors as they do not belong to any singular orientation or treatment intervention. It can be hypothesized that due to the overlapping and connected nature of general techniques and relational factors, the semantic categories created for this review highlight the critical relationship between the two.

A proposed consilient model of psychotherapy could use the analysis from this review to suggest that the two major common factors (Interpersonal and Technique-Based) serve as a foundation for the approach and represent the bulk of therapeutic work. The initial task of the therapist would be to develop a safe and supportive therapeutic relationship with the client by utilizing elements such as warmth, compassion, unconditional regard, collaboration, self-disclosure, and explicit goal orientation and session structure. Then, while maintaining the rapport, the therapist will begin to recruit core/general therapeutic skills to produce a space for the client that allows for verbalization, examination, observation, and participation in their own experiencing. This process of working may eventually result in growth, insight, and integration in the form of improved emotion regulation, identity, and behavioral and cognitive patterns.

A crucial element of a consilient model is the consistent and frequent elicitation of feedback from the client by the therapist. A consilient model, in concert with the philosophy of client perspectives research, values a client's subjective perception of well-being. It is important, arguably in any modality, to have a shared understanding of client progress during the course of treatment. If a client's progress becomes stagnated and the foundational tenets of a consilient model are no longer adequate to move treatment forward, additional specific ingredients should be introduced. This is the space where specific techniques and interventions originating from various theoretical orientations can fit into a consilient model. It's the responsibility of each practitioner to use their clinical judgment or administer assessments as needed to decide which specific interventions are the most appropriate for the case at hand.

As is implied in its name, the strength of a consilient model is in its commitment to recruit the most effective aspects of psychology and all related fields, not based on orientation or affiliation but rather on appropriateness and goodness of fit, for the chief purpose of honoring psychotherapy's primary goal of increasing wellness. This philosophy extends to case

conceptualization and psychoeducation as well. A consilient model does not aim to conceptualize a client's presentation from any particular theory, but rather remains open and willing to conceptualize from several different perspectives, ultimately deferring to one that resonates most with a client. Once again, this stance promotes client agency and empowerment, works in harmony with a client's values, beliefs, and views, and places primacy on the client's own experience and understanding.

Data Analysis

Returning to the data generated by this review, the question of whether there is a beneficial connection between Interpersonal Factors and Technique-Based Factors remains. This study's findings do not confidently reveal whether clients require both factors to produce successful outcomes. Although logic, general consensus among practitioners, and common sense may agree that the aforementioned elements must both be present for optimal therapy, it's not clear that the data explicitly supports such a conclusion.

The studies included in this review did not provide detailed information on which participants gave which responses. Thus, this review was not able to discern whether the same clients who reported relational factors as being helpful also reported core therapeutic skills as being necessary. It's possible that some clients only reported Interpersonal Factors as being helpful and that others only recalled Technique-Based Factors as being effective. This leaves the interpretation of the data open to several possibilities but no certainties. For example, it's possible that a majority of participants did report both major elements as being helpful, which would support a consilient model using those elements as a foundation. However, it's also possible participants found different factors helpful and the ones that reported Interpersonal Factors did not report Technique-Based Factors and vice versa. That conclusion would suggest

that effective therapy does not necessitate the simultaneous existence of both of those factors and that a consilient model may not be the best way forward.

Client Perspectives

Although the data doesn't confidently support the foundation for a consilient model, it does provide valuable insight regarding the focus of outcome research. The findings and generated theory from the data highlight the importance of incorporating the client's perspective into the continuous development of more effective clinical practicing. This review can be framed as an exploratory or pilot study that focuses on prioritizing the subjective experience of the client and reveals the need for additional research that focuses on more than one dimension of client perspectives data, which parallels the need and movement towards more culturally competent treatments. It may also be a call for the field to shift focus towards more curiosity about the client's experience as this study demonstrates we don't know much about the clients subjective experience because we haven't given it the proper attention and respect.

Chapter 5: Limitations & Future Directions

Methodological Analysis

Across the 32 articles sampled for this review there existed a myriad of methodological variables that cast doubt on the interpretation of the results. When beginning to gather information from the studies, the hope was to find data to support the narrative of a consilient model. Unfortunately, after a thorough analysis of the results, the study simply did not find solid enough data to build a consilient model from. This section will highlight some of the issues identified within the studies for a discussion on limitations and then propose what changes would make for future research that could more confidently provide the data for a unified model.

Lack of Cultural Sensitivity & Client Characteristics

As shown in Table 6, age and gender were the only two client characteristics that were consistently reported. Race/ethnicity was reported on roughly half of the articles. No other cultural factors were reported or subjected to subgroup-specific analysis. Because of the absence of client characteristics data, correlational analysis with helpful factors was not available for this review.

Table 6

Articles Reporting on Specific Client Characteristics

Client Characteristics	Number of Studies
Age & Gender	32
91-100% White/European American	12
Multiple Ethnicities Included	5
Race/Ethnicity Not Reported	15

In this qualitative review, the value of the data hinges upon the participants subjective reports. While this type of data theoretically provides a more nuanced understanding of the issue

at hand, the overall deficit of culturally adapted psychotherapy and cultural sensitivity in common factors research may impact validity. For example, in Chinese cultures a professional or authoritative figure is expected to behave in a prescriptive manner towards their client/patient (Comas-Díaz, 2012). If a therapist utilizes skills such as silence, reflection of feelings, or summarization of content or other nondirective interventions, it could be perceived as clinician incompetence or laziness as opposed to empathic attunement, warmth, and skillful facilitation. This type of discrepancy may be abundant in outcome research, especially in studies that did not attempt to control for client characteristics to that degree. This consideration is especially relevant for this review because it impacts the specific factors clients reported as being helpful. Depending on how many clients in the sampled articles identify as multicultural, the results may or may not be representative of certain groups, making it difficult to generalize and use for future consilient objectives.

The absence of client characteristics data in the common factors literature at large has severe implications on validity and generalizability. A majority of the studies sampled in this review did not report client characteristics beyond gender, age, and sometimes race/ethnicity, let alone use any client characteristics as variables in their analysis. This raises questions about the research community focused on this topic and how important or meaningful they deem these characteristics to be. Without including client characteristics in their analysis, the field is implying that psychotherapy seems to be generally important regardless of potential mediating or moderating variables. Common factors research appears to be operating in a bubble of its own assumptions about what makes psychotherapy work and who it will work for.

Types of Therapy Administered

As shown in Table 7, there were a variety of theoretical orientations/modalities utilized across the sample but psychodynamic, cognitive behavioral, and integrative therapies represented

a majority of the studies that reported this data. Assuming that the studies that reported either psychodynamic or cognitive therapies were strictly adhering to the unique principles of practice for those theoretical orientations, it appears that there is considerable overlap in general techniques and factors that exist across both modalities. Almost a fourth of the studies (n=7) did not report the modality of therapy utilized by the clinicians, which raises questions about the consistency of treatment applied to their sample population and whether or not integrative treatments were use.

In one of the studies, a participant's response included the mentioning of working with a "cognitive counselor", however it's unclear whether the other counselors who worked with other participants practiced similarly or differently thus making it unreportable. It's possible the researchers of those seven studies were operating with a priori assumptions that the clinicians included in their sample were licensed practitioners utilizing evidence-based models. It's also possible that they simply did not ask the participants if they knew what type of therapy their clinician practiced or did not have the data. Regardless, not having an explicit understanding of what types of treatments were used on participants in an outcome study makes drawing conclusions about mechanisms and efficacy difficult.

Table 7

Types of Psychotherapy Utilized

Type of Therapy	Number of Studies
Psychodynamic	5
CBT	6
Group CBT	1
Group Therapy	3
Integrative	6
EFTT (Emotion-focused therapy for trauma)	1
CfD (Counseling for depression)	1
Humanistic/Existential/Gestalt	3
Brief Solution-Focused Therapy	1
PST (Problem-solving therapy) & ST (Supportive therapy)	1
Person-Centered	4
EMDR (Eye-Movement Desensitization & Reprocessing)	1
Family Systems	1
Violence Counseling	1
Couples/Marriage Counseling	2
Not Reported	7

Note. Studies that reported more than one type of therapy were tallied once for each different therapy. The total number of studies (n = 32).

Length of Therapy

The frame of therapy across the studies included individual, group, and couples/martial counseling. As shown in Table 8, the number of sessions spanned from at least one to over sixteen years of continual treatment. Around one-fifth of the studies (n = 7) either reported at least 1 session attended or did not report the number of sessions attended and thus it was assumed that at least 1 session was attended to be able to gather the data. This consideration could potentially skew the interpretation of the data for the frequency of common factors that

were reported. Deducing from the assumption that the first couple of sessions are typically focused on rapport building and information collecting, specific therapeutic interventions/techniques may be less likely to have been utilized or perceived by the client the fewer the number of sessions they attended. This wide range of attendance data makes it difficult to discern whether the factors that were reported as being helpful by participants who attended fewer sessions are still as helpful in future sessions as compared to participants who attended therapy for a lengthier term.

Table 8

Number of Therapy Sessions Attended by Clients

Number of Sessions	Number of Studies
At least 1	7
10 or less	7
11 to 20	11
More than 20	7

Note. The above figures are an approximation due to some studies reporting client's therapeutic engagement in time span of months/years versus number of sessions.

Clarity of Definitions

The aim of this qualitative synthesis was to review the literature on common factors to clarify what's helpful in therapy from a client's perspective. However, research in this area has been assuming the meaning of several notions to be ubiquitously understood such as the words "helpful", "effective", "curative", and "significant" to name a few. What does it mean for something to be helpful to a client? To what end is a factor helpful? How was a factor helpful to a client? How does a client know when a factor was helpful beyond a felt sense? These words are often not operationally defined, and thus may vary in meaning from study to study and participant to participant. Some studies may be measuring "helpfulness" by symptom reduction,

others by psychometric assessments, and others still may simply leave it at a client's abstract subjective report.

The studies included in this review that did not specify what types of therapy were administered to their participant sample used phrases such as "counseling and psychotherapy" but did not define or explicitly differentiate either. It's unclear if they are using the terms interchangeably or if there are clear differences between the two words. If there are differences, without a precise definition it makes it difficult for researchers analyzing the data to understand if they are digesting research on psychotherapy outcomes or some other type of "therapy" outcome. If the field is not clear about how we operationalize and define terms, how can we accurately discern the mechanisms that could lead to better psychotherapeutic practice?

Mechanisms Versus Concepts

A major set of obstacles for the validity of common factors research are the difficulties of identifying, defining, labeling, and differentiating the common factors from specific factors and nonspecific variables. To illustrate, the notion of therapeutic alliance, the most referenced factor apparently responsible for positive therapeutic outcomes, will be deconstructed with a discussion on mechanisms versus concepts. Therapeutic alliance is a concept. It is a feature of the psychotherapeutic experience that is informed by innumerous components and not easily consensually defined. Broadly, the therapeutic alliance can be thought of as the relationship between the therapist and the client (Bordin, 1979). The consensus is that productive or effective psychotherapy can only occur from a foundation of a strong therapeutic alliance (Aridito & Rabellino, 2011). What makes that relationship positively connective and safe can be reasoned as specific mechanisms that contribute to the development of the overall concept.

The aforementioned core/common therapeutic skills such as empathy, warmth, active listening, collaboration, goal-setting, and unconditional positive regard are examples of potential

mechanisms that may facilitate the development of an effective therapeutic alliance (Aridito & Rabellino, 2011). However, other more specific techniques such as interpretations, silence, giving homework, challenging maladaptive thinking, and expertise/knowledge for relevant psychoeducation are also mechanisms that may lead to increased rapport and trust between the client and therapist (Swift et al., 2017). So, is therapeutic alliance a product of specific mechanisms or common mechanisms? Other nonspecific variables such as therapists' personality, demeanor, frequency and content of self-disclosure, style of dressing, vocal qualities, and aesthetic of the therapeutic environment may all have interactions with the development of rapport that are yet unknown, rendering the issue even more opaque.

To deconstruct further, frequently reported factors such as empathy, compassion, warmth, and positive regard are all concepts that are difficult to operationalize and understand the true nature of. While some of the neurological processes of such concepts have been elucidated, we have yet to fully grasp the behavioral mechanisms of such factors and how they work in therapy. It's unclear how a particular clinician can be responsible for the existence of these concepts in their therapeutic work thus making it difficult to categorize these reported factors and reach conclusions based off them. Whether a client feels they've received empathy or warmth ultimately depends on subjective perception.

Insight

Regarding client perspectives research, an individual may not always have insight into why something was helpful for them beyond an intuitive sense. It's possible then that the most common facets of interpersonal experience take primacy during a client's reflection of therapy. Their comfort with, and accessibility of, these memories may motivate the recall and positive association of them, even if the reality is that they were neutral or not hindering but not necessarily helpful either (Knox, 2001). Many of the elements of the psychotherapeutic process

may also be too complex, nuanced, or beyond the scope of knowledge for a client to understand in the moment, and thus, they might only be able to report on more universal elements such as communication skills, advice giving, and compassionate regard. Lastly, some of the included studies sampled participants that were asked to reflect on past therapy experiences that ranged from several months to several years from the study date. Several of the earlier participants remarked that they could not recall specific details from their experiences because it had been so long.

Subjectivity Versus Objectivity

An argument can be made that a client's felt sense of positivity and helpfulness is what's ultimately important and a deeper understanding is not always necessary. Recall the overall goal of psychotherapy, as this review sees it, is to increase both the subjective and objective well-being of a client. From this perspective, the subjective accounts for at least half of the picture and is not easily measured beyond a client's report. Objective well-being, on the surface, appears to be more easily qualified and quantified. However, the psychometric assessments created to measure outcomes such as symptom reduction, job satisfaction, social life satisfaction, and other functional domains have their limitations as well.

Higher scores on objective measures do not always correlate with increased subjective well-being. For example, studies on the correlation between happiness and money demonstrate an inverse correlation after a certain salary figure per year (Jebb et al., 2018). At this stage, it's well known that symptom reduction doesn't necessarily equate to an increased felt sense of well-being (van Os et al., 2019). Symptom reduction research has been even more difficult to make sense of when we consider the notion of the mind-body connection (Burnett-Zeigler et al., 2016; Kessler et al., 2001; Wolsko et al., 2004). It's possible and even likely that several objectively measurable physical symptoms are spawned by subjective mental states.

Bringing this consideration to its terminus is the philosophical relativity of subjective well-being. Economically speaking, well-being could be measured by the number of resources one has and the material elements one possesses. Temporally speaking, well-being could be measured by the amount of time one can afford in their life to do with however they please, rather than having to work or care give to others. Functionally speaking, well-being could be measured by one's physical and mental abilities to perform tasks that they enjoy or that enable them to survive. However, one person's conditions of well-being may function as another's conditions of depression. For example, having endless amounts of unstructured time may be paradise for one but prison for another. People who are self-motivated and possess a myriad of interests may find that type of lifestyle a gift that they will continue deriving meaning from, whereas people who crave structure and direction may suffer in the void of free time. This makes it difficult to understand the relationship between symptomology and mental health.

True Impact of Therapy

Several studies over the years have validated the idea that psychotherapy, as an intervention, produces a net positive effect on clients and is generally better than not receiving therapy (Elliott et al., 2015; Jakobsen et al., 2011). This returns us to the notion of helpful factors and their validity. Assuming that a consensual understanding of what constitutes factors as helpful exists, and that a client's subjective report is both honest and informed, the issue of whether those factors are responsible for the perceived helpful outcome remains. It's possible that other components of a clients' life such as external relationships, lifestyle habits, intentional self-therapy, placebo effect, and time may be responsible for positive outcomes that are then misattributed to factors within therapy during a client's reflection.

A couple studies included in this review discuss the perceived helpful impact of factors based on orientation. For example, Llewelyn (1988) found that a focus on problem/solution and

reassurance were helpful factors in CBT and awareness and personal insight were helpful factors in Psychodynamic therapy. Participants of psychodynamic therapy also reported hindering aspects of therapy to be unwanted thoughts, misdirection, and repetition. This raises the issue of whether a client's perception of an aspect being undesirable due to feeling uncomfortable about it in the moment equates to it being ultimately helpful. Many psychodynamically-oriented therapists may even argue, and their clients may eventually agree, that purposefully unearthing unwanted thoughts and engaging in repetitive emotional experiencing is the path of progress. The notion of a factor being "helpful" in this case is complicated by potential discontinuity between perception versus true impact.

Future Research

For future client perspectives research on common factors and what works in therapy, the study design wants to address the aforementioned methodological holes by following the guidelines for qualitative studies set by Nancy Burns (1989) in her paper "Standards for Qualitative Research". In the article she lays out considerations and standards for how to properly conduct each of the following sections: statement of phenomenon, purpose, research questions, significance of the topic, literature review, identification of assumptions, identification of metatheories, researcher credentials, the context, researcher role, ethics, sampling and subjects, data gathering strategy, data analysis strategies, conclusions, implications, and suggestions for future research. What follows is a brief description of the changes that would need to be made to the relevant sections based on the limitations discussion above.

The first category to be addressed is the identification of assumptions. The suggestion for this section is that the preconceptions, presuppositions, and assumptions are identified and the researcher's view is made explicit. The aforementioned issues with the clarity of definitions and terms would be addressed. The study would try to define the key terms that it will be using

during the study and the assumptions that the researchers, and the field, are making about the usefulness, effectiveness, and impact of psychotherapy and common factors.

In the sampling and subjects section, the first issue to be addressed is an adequate sample size. Creswell and Creswell (2018) have suggested that most researchers aim for between 10 and 50 participants depending on the context of the research objectives. Other studies may opt to continue sampling until it appears that no new information is being revealed (theoretical saturation). Assuming the availability of resources, the latter option would be chosen, to continue gathering data until it seems that the inductive constructs resulting from the participants responses stabilize from saturation of the various themes.

The data gathering strategy section would focus improving two aspects, the initial interview process, and the response collection phase. During the initial interview process, the clients would be asked to record as many personal characteristics information as they are willing to provide. This would include but not be limited to age, gender, sexual orientation, race, socioeconomic status, religious affiliation, education level, disabilities, national origin and languages, and cultural attitudes towards mental health and well-being. This would allow for characteristic-specific analysis later on.

The data collection phase would focus on being thorough and detailed with the types of information the clients are asked to provide. Ideally, data is gathered on where the client received treatment, what format of treatment they received (individual, group, in-patient, etc.), when the sessions/treatment that they are asked to reflect on occurred, what modality/orientation of treatment was utilized, the credentials and basic identifying characteristics of the treating clinicians, the duration and number of sessions attended, previous history with psychotherapy, major life changes before, during, or after the course of treatment prior to data collection, and any other elements of the client's life or identity that they feel could impact their responding.

The data analysis strategies phase would make sure that each client's full response is coded separately into themes and categories and presented in clear tables so detailed exploration of the content and potential patterns can be done. For example, this would allow for the identification of whether or not clients who reported interpersonal factors as being helpful also reported technique factors as being helpful and which, if any, clients only reported monothematic factors. The availability of these details would enable full transparency and a more precise interpretation of the results.

For the conclusions, limitations, and suggestions for future research section the study would make sure to thoroughly discuss the how and the why of all the possible interpretations of the data. It would prioritize honesty about the limitations of the study, the information that was unable to be collected and note how that may have impacted the study rather than assert a conclusion absent solid data. It would explain to readers and other researchers why certain elements were not addressed (i.e., if the data was not available) so they understand that it was at least considered and understood to be relevant.

General Considerations

Although common factors and the relational components of psychotherapy seem to account for a larger proportion of the outcome effect from a client's perspective, specific ingredients should not be overlooked. In one of the included studies, Lombard (2020) concluded that therapists who work in primarily a relational, non-directive way could benefit from reflection on how they can allow for more directive activities into their practice. Inversely, clinicians who use a more direct, solution-focused approach may improve by increasing awareness of the importance of facilitating a space for the client to talk and express themselves in a supportive environment. This review echoes that recommendation for balance and finding a

middle ground between solution-focused and person-centered philosophies as both appear to be salient.

This study demonstrated the value of focusing on the client's perspective in outcome research. The data suggests that what client's find helpful may not consistently align with what clinician's believed to be effective. It also revealed that to understand the client's subjective experience requires more nuance than has previously been exercised in client perspectives research. The idea of consilience and unifying knowledge to advance the field of psychotherapy aptly applies to the integration of client-centered data. The gaps in understanding reflected by this study can serve as a roadmap for future studies.

More research is needed to provide specific data about the interplay between cultural/subgroup characteristics and helpful/hindering factors as that remains a large confounding variable in outcome research. In lieu of additional studies, practitioners may benefit from frequently and consistently eliciting feedback from their clients regarding cultural components to increase their ability to discern case-specific relevant factors and incorporate them into treatment. Regular check-ins with clients about how therapy is going and what seems to be working/not working is also advisable as a general best practices protocol. As with the previous call for balance, the intentional focus on a client's subjective experience of wellbeing may be a valuable addition to the traditional reliance on clinical diagnoses and symptom reduction.

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APPENDIX A

Extended Review of the Literature

Author/ Year	Research Question/ Objectives	Sample	Variables/ instruments	Research Approach/ Design	Major Findings
Bende & Crossley(2000)	The aim of the study was to give patients an opportunity to reflect on therapy and help trainees evaluate their therapeutic style and the therapy they provided.	25	Questionnaire	Survey	Qualities of therapist: understanding and listening neutrality Patient internal issues: finding own pace, ventilation of feelings, attention focused on self, not alone with problem Change-related issues: belief that change is possible, insight, identification of patterns Therapeutic tools: diagrams, psychotherapy file, letters to patient, relaxation tape Structure: of sessions, taping of sessions
Berke, Maples-Keller, & Richards (2016)	The current study aimed to investigate contextual and ideo-graphic factors that contribute to LGBTQ experiences in therapy and to address gaps in the current literature by accounting for points of view that are either marginally	13	Interview	Survey	Results of thematic analyses revealed five core ideas derived from the nine domains of inquiry which can be summarized as follows: (a) participants were generally attuned to the difficulties of defining mental health and identified authenticity as a dimension of mental health uniquely salient to LGBTQ experience; (b)participants saw their sexual and/or gender identity as one part of

	represented or absent. Furthermore, we aimed to privilege client perspectives on the associations between identity and the therapeutic encounter by utilizing CQR methodology.				an intersecting set of identities and values that both conflicted and converged to inform mental health and treatment outcomes; (c)both affirming and negating therapeutic experiences were described by most participants, (d) all of whom displayed evidence of significant resiliency in coping with minority stressors elicited in the context of treatment; and (e) regardless of their unique values, experiences, and context, participants articulated particular preferences in the content and characteristics of psychotherapy. Services that emphasize authenticity in expression, intersectionality of identities, active affirmation, client strength, and individual preferences are requisite for professional psychologists to build a reputation of trust and the privilege of serving LGBTQ individuals.
Brownlee & Chlebovec (2004)	examined the subjective perceptions of men	88	Questionnaire	Survey	In total, the following nine categories emerged from the data: skills develop-

	attending a group treatment program to address their violent and abusive behaviors.				ment, anger, recognition of abusive behaviors, admission of wrongdoing, learning/educational experience, empathy, focus on oneself, safe environment, and accepting responsibility.
Christensen et al. (2022)	How do patients describe the therapists' role in group CBT and what are the helpful and hindering aspects related to the therapists behaviour?	23	Interview	Survey	The resulting themes were (1) the co-therapists, (2) the way to communicate, (3) the session structure, and (4) the therapists as group facilitators. helpful aspects of therapist behaviour included: concise communication delivered in an empathic way, ability to structure sessions flexibly and the facilitation of group cohesion.
Chui et al. (2019)	In this study, our first purpose was to examine what therapists and clients thought was helpful and what they wished to have happened in their therapy. Our second purpose was to examine the relationship between	18	interview	survey	Therapists and clients agreed moderately that exploration of the therapeutic relationship, therapists' use of challenges, and therapist validation and support were helpful. In contrast, there was low agreement on wishes. Whereas clients wished that therapists had provided more structure and direction, therapists did not mention any typical wishes. Using multilevel modeling, a

	agreement between therapists' and clients' responses and therapy outcome.				high level of agreement on what was helpful was associated with reductions in psychological symptoms and interpersonal problems, although no relationship was found between agreement on wishes and outcome. The findings underscore the importance of therapist– client agreement about helpful aspects of therapy for successful therapy.
Dakin & Areán (2013)	The future of psychotherapy research lies in the development of easy-touse, efficient treatments that target specific characteristics and needs of patients with a given disorder. Meeting this aim will involve understanding why people seek psychotherapy and the therapeutic features that they feel are	22	interview	survey	The data from this study suggest that treatments that work toward active solutions for problems, integrate spirituality, proactively address. stigma concerns, incorporate patient choice, and target features of depression common in late life may provide more efficient methods for treating depression in older adults

	most helpful in their recovery. Identifying key features of treatment that patients feel lead to improvement may help identify the active ingredients of psychotherapy and further refine treatment.				
Dale, Allen, & Measor (1998)	The purpose of the research from which this paper is derived was to explore two key questions. First, what do clients and counsellors perceive to be helpful and unhelpful factors in counselling adults who were abused as children? Second, are there any important ways in which counselling this group	30	Interview	Survey	Analysis of the interview data revealed that respondents believed the benefits of counselling were predominantly reflected in four main areas: improved general day-to-day coping with life; ability to express and contain feelings; a re-ordering of relationships, particularly with their own children, families of origin and current partners; the development of understanding and meaning for abuse experiences.

	differs from counselling the general population of clients who have experienced a wide range of other unhappy life events and circumstances?				
De la Rie et al. (2006)	This study investigated the evaluation of treatment of eating disorders (EDs) from the patient's perspective in a large community based sample in the Netherlands. It investigated perceived helpfulness of different types of treatment. Furthermore it investigated which patient and treatment characteristics contribute to the evaluation of treatment.	304	Questionnaire	survey	Beneficial components of treat-ment reported in specialized ED centers refer to the communication skills of pro-fessionals, the therapist–patient working alliance, the contact with peers, and the focus of treatment on both ED symptoms as well as underlying issues.

Geschwind et al. (2020)	The aim of the study was to examine clients' experience of positive CBT and to contrast this with their experience of traditional CBT.	12	interview	Survey	Qualitative analysis showed that, despite initial skepticism, clients preferred positive CBT and indicated experiencing a steeper learning curve during positive, compared with traditional, CBT for depression. The popularity of positive CBT was attributable to 4 influences: feeling good and empowered, benefitting from upward spiral effects of positive emotions, learning to appreciate baby steps, and (re)discovering optimism as a personal strength.
Goldman, Brettle, & McAndrew (2016)	The aims of the study were twofold: (1) to explore and evaluate CfD from the perspective of the client, determining what was found to be helpful and unhelpful, thus identifying what they believed to be effective therapy, and (2) to inform the counselling profession of what takes	12	Interpretative Phenomenological Analysis	narrative	Four superordinate themes were identified: A helpful process, Client's view of a counsellor, Gains and Negative aspects.

	place in this therapy as perceived by the client.				
Holowaty & Paivio (2012)	To identify what clients found to be helpful events in emotion-focused therapy for child abuse trauma	29	Questionnaire/interview	Archival data	Event focused, abuse/neglect focused, emotion expression
Jock & Bolger et al, (2013)	The present study compares clients' perspectives on therapy across cultures.	12	Interview	Cross-cultural	Argentine participants had a great deal more responses about change, which fell into several categories that U.S. participants' much smaller number of responses about change did not. These included emotional change, intrapersonal change, attitudinal change, behavioral change, cognitive change, change related to the past, and change related to reason for consultation. There were only three uniquely U.S. categories: increase in insight, improvement in self-image, and internalization of the therapist/therapeutic model.
Knox et al. (2001)	To determine client's perceptions of therapist self-disclosures	13		Consensual qualitative research (CQR)	All 13 cases had an example of helpful therapist self-disclosures. Responses were grouped by typical (occuring >

	and its consequences on the "real relationship", universality, and modeling				50%) or variant (< 50%, but at least 3). Categories included: therapeutic relationship - mixed (typical); antecedent - personal story from client (typical); intent - normalize/reassure (typical); intent - help client make constructive change (variant); intent- client unsure about intention (variant); Event - therapist disclosed nonimmediate personal information (general); Event - family (variant); Event - Leisure (variant); Event - similar experience (variant); Consequence - positive (typical); Consequence - insight to make changes (typical); Consequence - therapist seen as more real (typical); Consequence - normalized (typical); Consequence - client used therapist as a model (variant); Consequence - negative (variant); Consequence - neutral (variant)
Levitt, Butler, & Hill (2006)	To identify not only components of psychotherapy experience but also	26		Grounded theory	analysis produced 1,673 meaning units. The hierarchy consisted of seven levels. To distinguish these levels, a specific vocabulary is used:

	principles that can be used to guide the moment-to-moment process of therapy.				One “core category” encompassed six “clusters,” which were above a “category” level that subsumed a level of “subcategories.” Cluster 1: Commitment to Therapy - Honesty is Negotiated for Success (23 participants) Cluster 2: The Therapy Environment as a Reflection of the Therapists’ Care (9 participants) Cluster 3: Out-of-Session Processing - Structuring Transitions Between Worlds (10 participants) Cluster 4: The Therapeutic Relationship: Building Trust That Self-Exploration can Be Sustained, Even in the Face of Threat (21 participants) Cluster 5: Therapist Characteristics: Caring the Right Amount yet Providing Firm Direction When Needed (26 participants) Cluster 6: Therapeutic Intervention: Structuring a Focus in Which to Encourage Reflexivity and Client

					Self-Discovery (26 participants) Core category: Clients are Needing Just Enough Structure to Facilitate Reflexivity While Needing to Feel Special Enough to Risk Revealing and to Be Known
Lilliengren, (2005)	Explored clients' perceptions of curative and hindering factors in psychoanalytic psychotherapy, as reported at termination of therapy	22	Interview: semi structured Private Theories Interview	Survey	The curative factors found included talking about oneself, having a special place and a special kind of relationship, and exploring together. The hindering factors indicated were talking is difficult, and something was missing. The positive therapeutic impacts were new relational experiences and expanding self-awareness. The negative impacts included self-knowledge is not always enough and experiencing mismatch.
Ilewelyn, (1988)	Compared impact of helpful and hindering events, as perceived by clients in two forms of psychotherapy: an exploratory, relationship-oriented therapy and a	40	Questionnaire: Helpful Aspects of Therapy Questionnaire	Survey	The factors deemed "helpful" included personal insight (see something new about oneself), awareness (more in touch with previously warded-off feelings), problem clarification (clearer about what needs to change), problem solution (possible coping mechanisms are rehearsed),

	prescriptive, cognitive/behavioral therapy				involvement (more involved in therapy tasks), understanding (client feels understood), reassurance (client feels supported, relieved, more hopeful), and personal contact (client experiences contact with therapist). Some of the hindering factors reported were unwanted thoughts (made to think about uncomfortable ideas in unhelpful way), unwanted responsibility (feels pressured to do something or feels left on own by therapist), misperception (client feels misunderstood), negative therapist reaction (feels attacked, judged, put-down), misdirection (feels confused or side-tracked), and repetition (feels bored, impatient, or doubtful of therapy value).
Lombard, (2020)	Identify what family members and caregivers of individuals with cancer found helpful in therapy	6	semi-structured interviews	qualitative thematic analysis	The helpful client factors found included talking (expressing, opening up, offloading, processing emotions, exploring, reflecting) and the ability to be open. The helpful therapist factors reported were connection outside the family, therapist qualities (calm, caring, present, comfortable,

					human/natural, welcoming, nice), relational qualities (non-judgemental attitude, therapeutic alliance, empathic, congruent, non-directive), core therapy skills (listening, noticing, analyzing, engaged, reassuring, non-directive, questioning), self-disclosure, therapist experience, self-help resources, cancer knowledge, contained process, therapist acting in client's best interests, and CBT utilization.
MacFarlane, (2015)	Examined clients' perceptions of the early formation of the working alliance.	54	Questionnaire	Archival data	Four clusters of clients' perceptions were noted. Cluster 1 included clients' initial misgivings about psychotherapy, such as difficulty talking, concern about psychotherapist, difficulty going to psychotherapy, apprehension due to novelty of situation, revisiting past events, the idea that just being there says something negative about client, and crying during session. Cluster 2 included organization and meaning making in sessions - psychotherapist responding to make clarifications, psychotherapist asking

					for clarifications, giving client understanding, psychotherapist clarifying client, and psychotherapist reiterating. Cluster 3 was psychotherapist supportive activities: psychotherapist reassuring client, empowering client, normalizing client's situation, being calm when client was not, instilling hope, and offering praise. And finally, cluster 4 included client appreciation of techniques, such as promising to help or helping, exercises, homework, and other concrete tools, psychotherapist offering suggestions, specifically discussed goals, psychoeducation, offering assistance, client sense of progress, and showing client options.
Manthei, (2007)	Ascertain client's experiences of their counseling, including effectiveness, quality of therapeutic relationship, in-counseling events that were helpful or not, how	20	Questionnaire and semi-structured interviews	Survey	When asked "how well did you and your counselor get along and why?" clients were able to clearly state what factors improved relationship, which tended to be described as how well therapist met client's needs. The question "how successful was counseling and why?" was responded by

	counseling was terminated				clients looking at reasons for improvement, which included things clients did themselves and things counselor did that had positive impacts. When asked "what things did counselor do that client found unhelpful?" clients included poor technique, not being listened to, counselor forgot things they previously talked about, and counselor talking too much about themselves. The topics clients were reluctant to talk about were often due to fear, shame, not wanting to hurt others, or not wanting to be criticized. Finally, when clients were asked if they would recommend counseling to others, they gave reasons such as the benefits of talking to someone professional, neutral, and outside a person's own circle.
Morgan, (2015)	Investigate what clients found helpful and unhelpful in counseling following breast cancer	14	Questionnaire: Helpful Aspects of Therapy (HAT)	Grounded theory	The helpful aspects of counseling reported were focusing on self, problem solving, expressing and exploring feelings, positive therapist relational qualities and skills, understanding other(s), and unburdening self. The

					unhelpful aspects of counseling included unwanted thoughts, feelings, and behaviors, and poor fit.
Musher, (1989)	Examined therapeutic perceptions of recently discharged in-patient group members	72	Questionnaire: "Helpful Event" Questionnaire	Survey	The helpful therapeutic factors reported by in-patient participants were (in this order) universality, hope, vicarious learning, acceptance, self-understanding, self-disclosure, altruism, catharsis, learning from interpersonal actions, and guidance. The helpful therapeutic factors reported by out-patient participants were (in this order) self-understanding, universality, altruism, acceptance, catharsis, vicarious learning, hope, learning from interpersonal actions, self-disclosure, and guidance.
O'Leary, (1993)	Recorded most helpful aspects of therapy from women who received marital therapy and cognitive therapy for	31	Open-ended interview: "What would you say has been the most central in helping you feel better over	Survey	Clients' perceptions of the most helpful aspects of therapy included a positive change in spouse, better communication, both put in effort, insight into own problems, increased control over thoughts,

	co-occurring depression and marital discord		the course of therapy?"		feelings, behaviors, decreased self-blame and increased self-esteem, support of therapist, decreased external blame / taking responsibility, less dependent, and increased acceptance and hope.
Olivera, (2013)	Investigate former clients' perception of change, reasons for consultation, therapeutic relationship, and termination	17	semi-structured interviews	consensual qualitative research (CQR)	Four domains were categorized from the results. Domain 1 was "change perception": a majority of participants reported change in therapy and that they found solutions to the problems they sought out therapy for; change reported included cognitive, emotional, and behavioral change; change attribution: therapist's variables, therapist's interventions, and being able to talk about their problems. Domain 2, or reasons for consultation, included interaction found between reasons listed for seeking therapy and type of change reported. Domain 3, which was about the therapeutic relationship, included the correlation between perceived change and therapeutic relationship (positive and negative). And finally, domain 4 was about therapy

					termination - a large preponderance of participants proposed termination; most clients agreed with termination even when the therapist made the proposal.
Paulson, (1999)	Clarify clients' scope and interrelations among elements of the retrospective experience of helpfulness	36	concept mapping (qualitative and quantitative strategies)	survey	Nine clusters of helpful therapeutic factors were reported by participants: counselor facilitative interpersonal style, counselor interventions, generating client resources, new perspectives, emotional relief, client self-disclosure, gaining knowledge, accessibility, and client resolutions.
Paulson, (2002)	Describe key therapeutic processes that facilitated overcoming suicidal ideation and behaviors in previously suicidal clients	44	concept mapping (interviews and card sorting)	survey	The aspects of counseling that clients found beneficial were developing self-awareness and personal responsibility, understanding suicidal behavior, developing a new identity, overcoming helplessness and despair, using emotions for change, positive therapeutic relationships, and feeling trusted and valued.
Pugach, (2015)	Explore low-income women's subjective experiences of outpatient	10	Interviews	qualitative content analysis	The first helpful therapeutic factor identified was awareness: therapist is aware of the nature of poverty-related

	psychotherapy				stressors, and the therapist has exposure to low-income communities. The second factor was practices: structure of therapy is flexible, therapist provides instrumental support, and therapy builds on strengths. The final factor identified was relational quality: participants feel heard, therapists attempt to share power, and therapists show authenticity.
Roddy, (2013)	Identify a preliminary client-preferred domestic violence counseling approach	4	interviews and narrative analysis	survey	The reported factors that helped build trust with therapist were understanding (counselor understanding client's story and sharing knowledge of domestic violence behavior, models and situations; client understanding more about their situation and why they respond in the way they do), empathy (consistent and non-judgemental counselor), and ability to move into a new phase of the therapeutic relationship.
Roseborough, (2018)	Explored how changes were made and what encourages maintenance of change after	57	questionnaire and interviews	survey	The characteristics identified for successful therapy were alliance (therapist invested in client), accessibility of the clinic and a team approach, being seen,

	psychotherapy				heard, understood, and accepted, and evaluating progress. Characteristics reported of unsuccessful therapy were unexpected endings, lack of feedback and information, assumption of progress, and an absence of, or a sub-optimal, therapeutic alliance. The factors found to influence change were monitoring progress, gender of therapist compared to client and professionalism of therapist. Finally, the factors identified as helping maintain change after psychotherapy were a focus on and shifted perception of self, enlarged perspective, stability, internalizing the therapeutic relationship, the effects of time and acceptance, recognizing triggers and making healthy decisions, and DBT and other therapeutic skills.
Simon & Thorana, (2008)	Analyzed clients' thoughts on what was helpful, what would have been more helpful, if physical	91	Interview	Survey	Results showed clients found therapy helpful, had few suggestions for improvement, found physical arrangements acceptable, described therapy in terms non-specific to SFBT,

	arrangements were adequate, how helpful therapist was, how they would describe therapist to friends or relatives, if between-session suggestions were helpful, and if they would recommend therapy to family and friends.				found therapists helpful, found suggestions helpful, and would recommend therapy to others.
Swift, (2017)	Used a micro-process approach to test whether clients experience more variability in the helpfulness and hindrance of a single session than what might be captured by an end-of-session measure. Also aimed to learn how clients would describe their most helpful and hindering	16	reviewing psychotherapy session	qualitative survey; dial rating system;	The results suggest that clients perceive both specific treatment and common factors techniques as being helpful. Further, some of the same therapist actions were rated as both helpful and hindering, but they differed in the timing and the client's experience of feeling heard and understood versus judged or given advice that was not perceived as relevant to them. The results suggest that clients find benefit from both specific treatment techniques (e.g., skills training, offering insight, emotion processing) as well as more common factor techniques (e.g.,

	moments in therapy.				nonjudgmental listening, empathy). The helpful segments were associated with obtaining new information or insight that was perceived as valuable and feeling heard and understood by their therapists. In contrast, the hindering events were associated with being off-track or clients feeling judged by their therapists.
Wail, (2012)	to identify the factors that motivated (recovered) ED patients to recover	13	qualitative interviews	survey	The results found that recovery self-disclosures may increase recovery motivation in patients with EDs. Patients believed that conversations with recovered peers and therapists made recovery seem more possible, more desirable, and more realistic. Both RTSDs and RPSDs may increase recovery motivation for patients with EDs. Some patients with EDs find RSDs motivating, suggesting that therapists may wish to consider using RTSDs or RPSDs in interventions.
Watson, (2012)	to explore helpful processes in therapy, focusing on the specific	10	relationally oriented therapy	survey (Post-Session Form)	Clients identified talking about their emotions and experiences as the principal helpful client activity. The most

	client and therapist activities that can lead to helpful effects				frequently reported helpful contributions from therapists were questioning, direction, and the therapists' specific relational qualities. The effects of these activities were increased insight, completion of therapeutic tasks, and changes in clients' feelings. The findings from this study suggest that, within a relational pluralistic therapeutic practice, the main things that clients find helpful are talking about their experiences and emotions, trying things out, and being honest with themselves. The findings from this study indicate that clients find a wide range of therapist activities helpful, and that the same helpful effect, such as enhanced understanding, can be achieved through a multiplicity of therapist and client activities. This study shows that clients perceive themselves as making clear contributions to the process of change.

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APPENDIX B

IRB Documentation

PEPPERDINE IRB NON-HUMAN SUBJECTS NOTIFICATION FORM FOR RESEARCH THAT DOES NOT INVOLVE HUMAN SUBJECTS

Pepperdine University's Institutional Review Board (IRB) is required to review and approval all research that meets the definition of human subjects research. The code of federal regulations provides the following definitions:

- **For the purposes of the IRB, research is defined as a systematic investigation designed to develop or contribute to generalizable knowledge.**
- **Human subject means a living individual about whom an investigator (whether professional or graduate student) conducting research obtains**

  (1) Data through intervention or interaction with the individual, or
  (2) Identifiable private information.

IMPORTANT INSTRUCTIONS: If your research does ***not*** involve the participation of human subjects ***and*** you are ***not*** using/collecting any data that has been obtained from individual participants, then your research is **not** subject to IRB review and approval.

EXCEPTION: If you are not certain whether your proposed activity meets the definition of non-human subjects research, or if your study requires a formal written determination (e.g., as requested by sponsors, funding agencies, and/or journals), please complete this form and submit it along with either **1)** a one page abstract (outlining the study's research design and methodology), or **2)** a draft of your research project (does not need to be finalized) by email to andrea.quintero@pepperdine.edu and copy gpsirb@pepperdine.edu.

We may reach out with clarification questions as needed; otherwise, if your research's non-human subjects status is confirmed, the Pepperdine IRB office will issue a confirmation of non-human subjects verification.

Investigator Name: Sam Han
Status (Check One): ☐ Faculty ☑ Graduate Student ☐ Undergraduate Student
Faculty Chair (if applicable): Dr. Louis Cozolino
Proposal Research Title: CLIENT PERSPECTIVES ON EFFECTIVE PSYCHOTHERAPY

I verify that this proposed research does not involve the use of human subjects, either directly or indirectly.

Principal Investigator(s)/Student Signature — Date: 7/25/2023

Faculty Chairperson Signature — Date: 7/28/23

Revised 05/16/2023

APPENDIX C

PRISMA Flow Diagram

PRISMA Flow Diagram