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Research on Client Experiences of Therapy: Introduction to the Special Section

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Abstract

I introduce this special section of research on client experiences of therapy by looking at the six studies reported here from three different angles. First, I summarize each study and characterize them in terms of the current research genres they represent. Next, I analyze the studies in terms of the Five Dimensional Model of therapy process (Elliott, 1991). Finally, I briefly summarize what we have learned about the three main questions addressed by these studies: What clients find helpful or hindering in therapy? How do clients see themselves as having changed over the course of therapy?, and, How do clients deal with difficulties in the therapeutic process?

Running head: Client Experiences

Research on Client Experiences of Therapy: Introduction to the Special Section

Why study client therapy experiences? To begin with, examination of client experiences is central to advancing theoretical understandings of mediational processes in therapy (i.e., how therapeutic processes get translated into postsession and posttreatment change); this in turn has implications for predicting outcome. Furthermore, understanding the potential range and forms of client experience is an important component of therapeutic skill and can be assumed to lead to greater understanding of particular clients and to more effective interventions. Specifically, knowledge about key overlooked aspects of client in-session experience (especially regarding covert processes such as hidden dissatisfaction or conscious avoidance) can be used to help therapists work more effectively with their clients.

In fact, research on client experiences of therapy dates back 60 years, to Lipkin's (1948) study of client experiences of early person-centred therapy. Elliott and James (1989) carried out a meta-synthesis of the first 40 years of this literature; among the wide range of domains of client experience reviewed, two are most relevant to the present special section, helpful aspects and post-therapy changes. The two most common perceived helpful aspects of therapy (based on 13 studies) were relational: facilitative therapist characteristics and client self-expression. Experiencing a supportive therapeutic relationship, achieving self-understanding or insight, and therapist encouraging extratherapy practice were also reported in a smaller number of studies. In five studies reporting client descriptions of post-therapy changes, increased self-esteem, improvement in interpersonal relationships, and greater sense of mastery were most common.

In the ensuing 20 years, the research literature on client experiences has continued to grow, fuelled in part by the rapid expansion of systematic qualitative research methods. In 2007, this journal published at least five studies with client experiences of therapy as a key element (Fitzpatrick & Chamodraka, 2007; Jim & Pistrang, 2007; Nilsson et al., 2007; Ramnerö & Öst, 2007; Vanaerschot & Lietaer, 2007); most of these used qualitative or mixed methods. In addition, *Psychotherapy Research* has also recently published a qualitative meta-synthesis of a subset of this recent literature, client experiences of the impacts of helpful significant therapy events (Timulak, 2007). In this introduction, I take the present set of six articles as a sample of current client experience research and use it to comment on current research and emerging knowledge in this area.

What Research Genres and Research Questions Do These Studies Exemplify?

The six studies highlight several of the main genres of research on client experiences, each focusing on one or more scientific questions.

First, Henretty, Levitt and Mathews (in press) and Williams and Levitt (in press) report *events-based* studies using the Rennie's (Rennie, Quartaro & Phillips, 1988) interpretation of Grounded Theory Analysis (Strauss & Corbin, 1998), including the tape-assisted recall as a qualitative data collection method. Henretty et al. and Williams and Levitt each took common therapeutic issues and used qualitative methods to throw new light on them, documenting respectively that expressing sadness was a complicated and difficult process for clients and that culture was not the only or even the most salient form of difference confronted by clients. Both of these studies take us inside clients' moment-to-moment in-sessions experience to document how they face different kinds of threat or discomfort (getting lost in sadness or losing faith in the therapist) by actively assessing the situation and using multiple strategies to reduce or resolve the threat. Reading these two studies together suggests that it may be scientifically useful to focus further events-based research on the nature of *client difficulties with the therapeutic process*.

Second, three of the studies exemplify variations on one of the other main genres of client experience research, that is, *qualitative mental health service evaluation*. In terms of scientific questions, this genre of research lends itself to looking at (a) helpful and hindering aspects and (b) client perceptions of change over therapy. Israel, Gorcheva, Burnes and Walther (in press) documented effective and ineffective processes experienced by clients with lesbian, gay, bisexual or transgender sexual identities, using a large sample (n = 42). Safren (in press) applied qualitative methods to understand what HIV-positive clients found useful or problematic in a brief cognitive-behavioral treatment geared at helping them cope better with their illness. Moertl and Wietersheim (in press) looked at a partial hospitalization (day treatment) program using a narrative-focused interview and drawing on a broad range of methods, both qualitative and quantitative, in order to evaluate what clients found helpful and how the service could be improved.

The results of these three studies point to ways of improving psychological therapy for these three populations: Israel et al. (in press) documented a range of poor practices (hindering aspects); but what is striking is the degree to which LGBT clients primarily emphasized quality of therapeutic relationship over technique as the predominant helpful aspect. On the other hand, Safren (in press) found that HIV clients liked everything the therapy had to offer (helpful), except the homework (hindering), but wanted more sessions and highlighted difficulties in getting to therapy sessions. In the context of a broad range of findings similar other studies, Moertl and Wietersheim (in press) identified an important but overlooked helpful aspect of partial hospitalization programs: how the client managed the transition between home and

program, and the therapeutic obstacles and opportunities that paying attention to this process provided. None of these three studies focused strongly on client post-therapy changes, but Israel et al. (in press) and Safren (in press) found relatively common client perceptions of improvement in presenting issues and increased self-acceptance.

The third genre, exemplified here by Farber and Pattee (in press) is a conventional *quantitative survey predictor* study, driven by specific hypotheses about pre-therapy predictors of some aspect of therapeutic process, in this case, gender and gender role predictors as predictors of client self-disclosure. This study makes an interesting contrast to the five qualitative studies. Instead of examples in the Results section, there are tables of statistical analysis; hypotheses were set up in the Introduction and explored in detail in the Discussion; and a large sample (n=223) was used. In comparison to the qualitative studies in the special section, this study was much more tightly focused and allowed more room for exploration of theory, while still retaining the ability to surprise the reader. Thus, in contrast to their hypothesis that women would disclose more, Farber and Pattee found small effects indicating first that androgynous (not exclusively feminine-identified) clients disclosed more; and, second, that when they disclosed, female clients worried more about the impression they were making when they had female therapists.

What Kinds of Therapy Process Do These Studies Address?

The studies presented in this special section can also be characterized in terms of the kinds of therapy process addressed, using the Five Dimensional Model of therapy process (Elliott, 1991). Being clear on the different types of process involved is important for reviewing and synthesizing this research literature. Here is an analysis of the six studies in this special section, using the lens of the Five Dimensional Model:

1. The first dimension of therapy process is the *Perspective* from which the information derives. In this special section, all of the studies used data taken from the *client* perspective (as opposed to the *therapist* or *observer* points of view).
2. In terms of the *Person* focused on the research, we see that the studies are quite varied. Henretty et al (in press) and Farber and Pattee (in press) looked exclusively or predominantly at the client; William and Levitt (in press) had a primary focus on perceptions of the therapist, but were also interested in how the client coped with perceived difference. The other three studies, probably because of their broad goal of service evaluation, take in the whole range of possibilities: *client*, *therapist*, *therapeutic relationship*, and *group members*.
3. The six studies spread themselves over a wide range of key *Units* of therapy process: Henretty et al. (in press) and Williams and Levitt's (in press) use of tape-assisted recall gave them access to subepisode units roughly on the order of *speaking turns*, i.e., moments at which the client stopped the recording to comment of a particular experience. Israel et al. (in press) and Moertl and Weisersheim (in press) used a mid-size basic unit, which they labelled respectively as a "situation" or "difficulty"; this corresponds to what Elliott (1991) referred to as an *episode*, that is, a discrete interactional episode centering on a given topic or piece of interactional work. Because of an interest in particular therapeutic modules, delivered one per session, Safren (in press) worked with *session* units, one level up from the episodes. Farber and Pattee (in press), on the other hand, worked at the top end of the spectrum of therapy process units, that is, the *therapeutic relationship* as a whole, asking clients to evaluate their global experiences of self-disclosure over the entire course of their therapy.
4. *Temporal Phase* refers to whether the focus is on a particular therapeutic *process* in itself, on its *context*, or on its *effects*. Taken together, the three temporal phases provide a basic

narrative structure (past – present – future). Here, two of the three qualitative service evaluation studies (Israel et al., in press, and Moertl & Weisersheim, in press) bring in all three phases in their attempt to paint a picture of an area of practice (working with LGBT clients and a day treatment program respectively). The other four studies focus primarily on therapeutic process, but bring in a secondary focus on the effects of that process. For whatever reason, context is ignored in these studies.

5. The fifth dimension is the *aspect* of process examined, and includes *content* (what is talked about), *action* (what client or therapist is trying to do, including intentions and tasks), *style/state* (how the person is saying or doing something and what emotional experiences or interpersonal stances accompany that), and *quality* (how skilful the therapist's responses or how hard or deeply the client is working). In these studies, style/state and action was most commonly studied (5 studies). In three studies, content was also a topic of study; for example, Farber and Pattee (in press) asked clients to rate the importance of their self disclosures. Only Israel et al. (in press) focused on the quality of therapist responses, by looking at unhelpful situations (i.e., therapist errors).

This analysis points to the wide range of therapeutic process that can be studied by asking clients about their experiences of therapy, a boon to researchers working with client informants. The qualitative mental health service evaluation research studies appeared to be quite comprehensive in the range of information they were able to obtain from clients. Two elements, however, appear to be somewhat neglected and warrant further exploration: clients' understandings of the context of important therapeutic processes and their assessments the quality of their own or their therapists' responses.

What Have We Learned about Client Experiences in Therapy?

When we put these six studies together with the research literature on client experiences, what answers are emerging to the scientific questions they address?

What do clients find helpful or hindering? The qualitative mental health service evaluation studies in this special section illustrate some of the common findings on helpful and hindering processes: the therapeutic relationship (e.g., Moertl & Weisersheim, in press; Safren, in press); the therapist listening or being empathic, affirming or validating (e.g., Israel et al., in press); and the therapist offering specific techniques for dealing with problems (e.g., Safren, in press; Israel et al., in press). In contrast, hindering processes included the therapist imposing their views on the client or being judgemental or invalidating (e.g., Israel et al., in press). These three studies involved on very different client populations, but they are very consistent with both Elliott and James' (1989) meta-synthesis and also with more recent general reviews, such as Cooper (in press). This suggests these common findings are robust and generalizable and can thus be usefully incorporated into mediational models of the change process in therapy. It also seems to me that this literature is now mature enough to offer a kind of general baseline against which to look for issues specific to particular client populations: For example, the HIV-positive clients in Safren complained about problems with difficulties getting their electronic pill-bottle caps open, while Moertl and Weisersheim documented the important role in their day treatment program of the transfer of learning between program and home, both factors specific to clients studied. Israel et al.'s results appear to fall almost entirely within the baseline of previous research, but as those generally helpful processes apply to work with LGBT clients, e.g., clients appreciated therapist being knowledgeable and affirming regarding their gender identity.

How do clients see themselves as changing over the course of therapy? Although it is too soon to draw substantive conclusions, a welcome trend in the recent literature (e.g., Klein & Elliott, 2006) is the growing appreciation for the client's individualized perspective on outcome, which provides a useful balance to the continuing emphasis on quantitative outcome. None of the studies in this special section focus strongly on this topic, but Israel et al. (in press) and Safren (in press) touch on client-perceived outcome, with clients often reporting improvement in presenting issues and increased self-acceptance, both common outcomes reported in Elliott and Jame's (1989) review. This literature is probably not well-developed enough yet to draw general substantive conclusions; currently, the real potential here is methodological: improving outcome assessment by making it more client-centered and pointing out areas of change that are not measured by common outcome measures. Studies such as those by Israel et al. and Safren thus also have the potential to more precisely specify the outcomes of the therapies studied in such a way that they can be linked more readily to in-therapy mediating processes, as it done in Hermeneutic Single Case Efficacy Design research (Elliott, 2002).

How do clients deal with difficulties in the therapeutic process? In my view, however, the most important development in client experience research over the past twenty years is the emergence of research documenting the client as an active change agent. Beginning with Rennie's ground-breaking studies of clients' experiences of deference (Rennie, 1994a) and narrative (Rennie, 1994b), and developed further by Hill and colleagues (e.g., Knox, Goldberg, Woodhouse & Hill, 1999; Rhodes, Hill, Thompson & Elliott, 1994), researchers have begun to unpack clients' use of therapy to change themselves in the face of internal and external obstacles, many of which are beyond most therapists' awareness or understanding. For example, Rennie (1994a) documented the extent and complexity of client deference in the face of unwanted therapist actions or stances, showing how clients assess their immediate situation in order to best meet their needs. Similarly, Rhodes et al., described clients' strategies for dealing with important therapist misunderstandings, while Knox et al. provided an account of how clients privately but deliberately construct an mental image of their therapists in order to carry forward therapeutic work between sessions and after therapy is over.

In this special section, the articles by Henretty et al. (in press) and Williams and Levitt (in press) advance this growing literature by suggesting that client agency maybe most apparent when clients confront difficulties in the therapeutic process. Henretty et al. and Williams and Levitt broaden the range of client difficulties to include disclosure of painful, sad emotions and the emergence of points of difference with the therapist. Parallel to the analysis of therapist-identified tasks by Greenberg and colleagues (e.g., Greenberg, 2007), analysis of client identified process difficulties is important emerging research front, suggesting the value of further research to identify a taxonomy of client process difficulties, along with descriptions of common client coping strategies, and lists of therapist responses that can help or hinder clients in resolving these difficulties. This approach is capable of specifying helpful and hindering processes in particular situations within therapy, where it should be able to offer much greater precision than post-therapy interviews or questionnaires. For example, it would quite interesting to follow up on Farber and Pattee's (in press) study by using this approach to study the process by which clients decide to disclose a difficult or embarrassing experience to their therapist. This research area thus offers the exciting possibly of taking us into the complex mediating processes by which clients actively use therapy to overcome obstacles to change.

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