The Experience of Forming a Therapeutic Relationship from the Client's Perspective:

A Metasynthesis

Abstract

Objective: This review aimed to synthesise qualitative research exploring clients' perspectives of forming a therapeutic relationship with their therapist or counsellor. **Method:** Noblit and Hare's meta-ethnographic approach was used to guide the synthesis of 13 studies meeting inclusion criteria. The quality of each study was rated using the CASP quality rating checklist. **Results:** Findings demonstrated that clients create a hierarchy of desired therapist characteristics to assess how well the therapy can meet their needs (theme 1: assessing client-therapist match). The formation of the therapeutic relationship is facilitated by an openness from both the therapist and client (theme 2: facilitating openness) and helps to develop a connection through which the client can be fundamentally understood (theme 3: connecting on a deeper level). Displays of disrespectful or disempowering behaviour generate barriers in the formation of a therapeutic relationship (theme 4: empowerment through respect).

Conclusions: The meta-ethnographic approach extended the findings from each individual study to highlight some significant discoveries, including that clients across different settings created a hierarchy of therapist characteristics which were of varying importance to them depending on their perceived needs. Additionally, clients reported that they preferred their therapists to disclose information in order to facilitate the therapeutic relationship.

Keywords: therapeutic relationship, alliance, qualitative research, metasynthesis, empowerment, therapist self-disclosure

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The therapeutic relationship has long been the focus of significant attention within the psychodynamic approach to therapy from both theorists (Freud, 1912/1966; Sterba, 1929; Zetzel, 1956) and researchers (Hartley & Strupp, 1982; Horvath & Greenberg, 1985; Horwitz, 1974), and continues to be considered predominantly from this perspective. Indeed, the initial concept of a working relationship between client and therapist tends to be attributed to Freud (Gaston, 1990; Horvath, 2006).

Outside of the psychodynamic arena, other prominent figures have also recognised the importance of the therapeutic relationship. For example, Carl Rogers, a founder of humanistic approaches to psychotherapy, argued that "significant positive personality change does not occur except in a relationship" (Rogers, 1957, p. 241). More recently, empirical support for these claims has emerged through consistent findings from reviews of quantitative research (Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). These studies have demonstrated the modest yet reliable association between the quality of the therapeutic relationship and positive outcomes in therapy.

What is the Therapeutic Relationship?

Despite such theoretical and empirical interest, the term 'therapeutic relationship' remains a poorly defined concept that is hard to explain in terms which suit all practitioners of psychological therapy (for a historical review and further discussion, see Horvath & Bedi, 2002). Terminology is also diverse including phrases such as working alliance, helping alliance, therapeutic alliance, working relationship, or just alliance, making thorough analysis

of this concept somewhat difficult[1]. The struggle to provide a fully encompassing definition for the therapeutic relationship has been compounded by the use of multiple research instruments designed to measure this construct, each based on a slightly different understanding of what constitutes the therapeutic relationship. One meta-analysis cited over 30 different alliance measures, not including different versions of the same instrument (Horvath et al., 2011).

In an effort to address this problem, attempts have been made to define the therapeutic relationship and the following broad definition was adopted by the American Psychological Association's (APA's) Presidential Task Force for evidence-based psychotherapy relationships: "The relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed" (Norcross & Lambert, 2011, p. 5). Despite the terms 'relationship' and 'alliance' appearing to have been used interchangeably at times in the research literature, it does appear that they have fundamentally different meanings. The Task Force proposed that the therapeutic alliance is one component of the relationship and listed other, more specific, elements such as empathy, goal consensus, collaboration, positive regard, and congruence. Horvath and Bedi (2002) also regarded the therapeutic alliance as a subsection of the relationship alongside still-active components of past relationships. Therefore it seems that the relationship is an over-arching construct within which the alliance is one aspect, or "a basic ingredient" (Horwitz, 1974, p. 250).

Research on the Therapeutic Relationship

Despite the construct and terminological challenges noted above, significant progress has been made on researching the therapeutic relationship. The extensive Psychotherapy Research Study used a longitudinal methodology to explore the processes and outcomes of

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[1] When referring to particular studies in this review, their own terminology will be adopted.

psychoanalysis and psychotherapy (Horwitz, 1974). The researchers found no marked difference in outcome between the two treatment modes; there were, however, significant findings in relation to the therapeutic alliance which led the researchers to conclude that "the therapeutic alliance is not only a prerequisite for therapeutic work, but often may be the main vehicle of change" (Horwitz, 1974, p. 254-255). Moreover, the findings of an early review (Horvath & Symonds, 1991), which provided significant empirical support for the power of the therapeutic relationship, has been replicated in more recent reviews (Hewitt & Coffey, 2005; Horvath et al., 2011; Martin et al., 2000).

It is worth noting here that, despite the evident power of the therapeutic relationship, it is not the only aspect which contributes to a positive outcome in therapy. Therapist technique continues to play a significant role in positive therapy outcomes (e.g. Barber et al., 2006). In fact, rather than being viewed as two distinct entities, it has been argued that "the value of a treatment method is inextricably bound to the relational context in which it is applied" (Norcross & Lambert, 2011, p. 5). Nevertheless, there is value in attempting to explore their individual contributions to the therapy process.

The Present Study

Over the last decade, qualitative research into the therapeutic relationship has increased, allowing for a more in-depth understanding of the construct. In particular, understanding the client's experience of therapy and forming a therapeutic relationship is fundamental for identifying ways to engage clients in therapy (Eyrich-Garg, 2008; Rodgers, 2003) and potentially reduce attrition rates. The research base on the client's perspective of forming a therapeutic relationship is now at a stage where it would benefit from a review and integration into one coherent report. Similar to a meta-analysis, metasynthesis is a method of bringing together the findings from multiple studies to inform clinical practice and provide direction for future research. However, more than just simply combining the data,

metasynthesis involves a higher level of analysis to "produce a new and integrative interpretation of findings that is more substantial than those resulting from individual investigations" (Finfgeld, 2003, p. 894). In order to aid the technique of synthesising qualitative data, numerous approaches for conducting a metasynthesis have been outlined (see Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004).

One of the more well-known and often-used frameworks in health research (Bondas & Hall, 2007) is the meta-ethnographic approach developed by Noblit and Hare (1988). Emphasising the importance of using interpretive explanations to guide qualitative synthesis, they propose seven phases through which the synthesis develops, providing researchers with a clear and structured procedure to follow. Despite their original focus on ethnographic research, this process has been used to synthesise research from different theoretical perspectives (Downe, 2008) as it provides a method for translating concepts between studies. For these reasons it was decided that this was the most appropriate framework to guide the current review.

Consequently, this review aimed to synthesise the findings of systematically-searched qualitative studies exploring the formation of the therapeutic relationship from the client's perspective. The review question for this study was: How does the client perceive and experience the formation of the therapeutic relationship?

Method

Procedure

The metasynthesis was primarily conducted by the first author (RN) and key stages of the process were reviewed in detail with the second author (JS). Noblit and Hare's seven-step meta-ethnographic approach (1988) was used and phase 1 (identifying a topic area) has been described above. A literature search (phase 2)was conducted in May 2014 using the following databases: Academic Search Complete, AMED, CINAHL, EMBASE, Medline,

IBSS, PsycINFO, Web of Science. The databases were selected to cover medical, health and social science research. Keywords, used in combination and with the appropriate wildcard symbols, were: alliance formation, therapeutic alliance, therapeutic relationship, engag*, client perspective, client experience. Where possible, related terms were sought using each database's search engine thesaurus. There were no date restrictions employed in this search as it is a relatively new field of research. The initial search resulted in 1,828 articles (see Figure 1) whose titles and abstracts were scanned for relevance using the inclusion criteria listed in Table 1. If it was unclear from the title and abstract whether the study met the inclusion criteria, then the full paper was accessed and checked. Further potential studies were identified by searching the reference lists of relevant articles.

All studies included in the metasynthesis used an interview or focus group format to obtain the majority of the data, providing direct quotations from participants which were used to anchor the interpretations within raw data. Only qualitative research studies employing either a named content-based qualitative method or using thematic coding in the analysis were included. Studies used a range of methodologies (e.g. grounded theory, narrative analysis), however they all appeared to be grounded in an interpretivist/constructivist understanding. Case studies were not included. The therapeutic approach of the therapy detailed in the studies was not always made explicit, however those studies that did attempt to categorise the therapeutic approach evidenced a wide range of approaches and techniques. These included cognitive-behavioural; psychodynamic; narrative; humanistic; feminist; person-centred; EMDR; and individual, family and group counselling approaches.

The search produced 13 qualitative studies which were read thoroughly to gain an understanding of their context (phase 3). Once the individual studies had been read in detail, concepts from each study were then identified and noted on different pieces of card, ultimately numbering 178 'codes' across the 13 studies (phase 4). This involved breaking

down the main themes identified in the studies and isolating the concepts that specifically related to the aims of this metasynthesis (i.e. client perspectives of the experience of forming a therapeutic relationship). Phase 5 involved the development of a common language to allow the translation of concepts between studies. This relates to the idea that different authors may use different words to explain a concept, or conversely use the same words when meaning something different, and therefore some of the names of the words or phrases were changed to reflect the meaning behind them. The studies were then compared using these 'translations', allowing an additional layer of synthesis to develop across the studies (phase 6). In order to facilitate this, codes that seemed to illustrate the same or similar concepts were grouped together and a phrase identified to capture the theme of the codes in each group. Four main themes were identified in total and are presented in the findings section. Finally the synthesis was presented in the current report (phase 7). The studies included in the metasynthesis have been highlighted in the reference section using an asterisk. Table 2 highlights the demographic and methodological details of each of these studies and Table 3 shows an extract of the coding synthesis.

Quality and Rigour

Debate about the quality and methodological rigour applied to qualitative research is ongoing (Barbour, 2001; Yardley, 2000). Poor quality studies can raise doubts that the findings are truly representative of the phenomenon under investigation and naturally affects the trustworthiness of metasyntheses. In an effort to address this problem, quality checklists have been developed as a way of assessing – albeit crudely – the quality of individual studies. One such checklist is the Critical Appraisal Skills Programme (CASP, 2010) tool which allows researchers to assess studies against ten quality criteria, such as 'Was there a clear statement of the aims of the research?' and 'Was the data analysis sufficiently rigorous?' Duggleby and colleagues (2010) adapted the CASP tool to rate each study as either weak (1

point), moderate (2 points) or strong (3 points) on each of the eight main domains (excluding the two initial screening questions). This method produces a maximum score of 24 which can be used to compare studies quickly and efficiently.

It is acknowledged that the use of quality checklists is contentious. Nevertheless, it was considered necessary to provide some assessment of the quality of individual studies in this metasynthesis as previously criticism has been levelled at studies which do not make this aspect clear (Walsh & Downe, 2005). Therefore the CASP tool was employed (see Table 4 for ratings). In response to the inherent subjectivity of this exercise, it was decided that no studies would be excluded on the basis of quality alone as, amongst other reasons, this would involve selecting an arbitrary cut-off point, as has been adopted in some systematic reviews (e.g. Bressington, Coren & MacInnes, 2013). Rejecting this approach is in line with previous arguments that "studies might be mislabelled but still be useful for synthesis purpose" (Bondas & Hall, 2007, p. 117). Instead, the CASP tool had three functions in the study: a) to provide a framework for analysing and critiquing each of the studies, enabling the researchers to gain a greater depth of familiarity with them than would have been likely from solely reading through each of them, b) to provide contextual information for the studies in order to appraise their quality (directly informing phase 3 of Noblit and Hare's seven-step approach), and c) to provide a rudimentary quantitative rating of quality to allow for comparison across the studies.

Findings

The metasynthesis produced 178 individual codes which were organised into four themes: 1) assessing client-therapist match, 2) facilitating openness, 3) connecting on a deeper level and 4) empowerment through respect. The overall themes are separated out here for ease of understanding, however in reality they overlap both conceptually and temporally. Each theme is described in more detail below using quotes from the original participants.

Theme 1: Assessing Client-Therapist Match

Clients described evaluating the therapist and the therapy approach from the beginning, assessing how well they thought the therapy would meet their needs. Clients considered a number of different factors when initiating therapy; for some, how well they matched on personal characteristics with their therapist was considered extremely important, while others emphasised their desire to find successful techniques (i.e. matching on therapeutic approach). Individual preferences were influenced by previous experiences of therapy, the importance of different factors in the client's life and how relevant they were to their therapeutic needs.

Personal characteristics. The majority of clients voiced a preference for having similar personal characteristics to their therapist. Some of the characteristics on which clients assessed their level of matching were gender, socioeconomic status, religious beliefs, race/ethnicity or cultural background, and overall life experiences. These clients believed that therapists who shared similar backgrounds to them were more likely to have an implicit understanding of their difficulties and would therefore be more effective as a therapist. One client with substance misuse difficulties expressed the significance of this in the formation of his therapeutic relationship:

> I guess no matter what the race, you know, I know you been involved [past drug
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> user], you know, you have a first hand knowledge and that's you know, that was real
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> comfortable for me because I wasn't just talking to somebody who got it from a book
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> [*sic*] (Ward, 2005, p. 478).
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> Similarly, a Black client explained her reasons for wanting a Black therapist by

stating that "someone of your own cultural background would understand it better" (Chang & Yoon, 2011, p. 576). Thus, therapists without similar experiences were often considered to lack a fundamental understanding of their clients' world. Indeed, some therapists were

accused of only having a 'textbook knowledge' of issues such as race, rather than subjective experience, which created a barrier to establishing a therapeutic relationship.

Conversely, a small number of clients argued that matching in certain ways with their therapist was likely to impede therapeutic progress. For example, one Black gay male client commented that "a Black female [therapist] would have been out of the question primarily because most of the time they are church-going females and it would have been difficult for me. I have sexuality issues that I'm dealing with" (Chang & Yoon, 2011, p. 577). This client, and others in this category, appeared to be making assumptions about the therapist (e.g. attitude to homosexuality) based on certain characteristics (e.g. race) which meant they did not feel that particular therapist could meet their needs adequately. In this way, clients almost seemed to be developing a hierarchy of desired therapist characteristics based on their own idiosyncratic needs. This strategy allowed them to assess the 'goodness of fit' dependent on which characteristics were most important to them at that time.

Some clients described the value in having a therapist from a different background because they provided an alternative perspective. This situation was viewed as especially beneficial if the client held a positive stereotype of their therapist's demographic group. For example, a Black male client described the first impressions of his female therapist as "the little, Jewish grandmother… she's going to give you some soup to soothe your pain and aches" (Chang & Yoon, 2011, p. 575). Thus, in this scenario, a 'mismatch' was viewed as facilitative to the formation of a therapeutic relationship.

Finally, some clients stated that they found any comparison between them and their therapist to be unhelpful or inconsequential. One Hispanic client explained that:

> If I go in to see a [non-Hispanic] psychiatrist, and I'm having problems with a
> relationship, I don't understand how, like, them giving me advice is going to be any

different than a Hispanic person telling me the exact same thing (Chang & Yoon,

2011, p. 575).

Rather than the desire to share an ideology or experience, these clients tended to prioritise the

technical ability of the therapist in implementing effective interventions.

Professional ability. Most clients expressed an overall desire to receive practical

strategies from their therapist and some prioritised finding a therapist who could execute a

therapeutic approach which fitted for them, rather than the desire to match on personal

characteristics. If the approach was unsuccessful, clients reported feeling like they were "a

little bit like … a square peg trying to be pushed into a round hole" (Barnes et al., 2013, p.

362). In a way these clients were looking for a 'match' with the therapeutic process, rather

than their therapist *per se*. The benefits of gaining insight into their situation and behaviour

meant that the therapy could be viewed as helpful even in the absence of a strong therapeutic

relationship.

Additionally, many clients described their desire for a therapist to have good clinical

knowledge about their particular experiences, such as domestic violence, trauma or racial

oppression. As one African-American client explained,

You want some experience in this. Sometimes you don't even have a chance to ask

these questions, you know, how many people of colour have you worked with?

(Ward, 2005, p. 477).

In this way, a therapist who was considered 'experienced' seemed desirable. Indeed, some

clients commented that a young or less experienced therapist created a barrier to establishing

a therapeutic relationship as they were assumed to be less effective at working through

problems that arose in therapy.

In summary, this theme details how clients judge the suitability of the therapist and/or

the therapy itself in helping them with their difficulties. This process starts from the very

beginning of therapy and significantly contributes to the formation of the therapeutic

relationship.

Theme 2: Facilitating Openness

Clients emphasised the importance of being allowed time to form a trusting

relationship with their therapist where they felt safe and comfortable discussing sensitive

issues. In order to build trust, clients described the need for openness and honesty between

the therapist and client, without which it was difficult for clients to disclose personal

information.

Some clients felt their therapist had a natural ability to respond to their wishes,

demonstrating their ability to be open and receptive to their client's needs. For example, one

client explained that they were "looking at diagrams… and I thought, 'Well I can do this at

home… I want you to come over my shoulder'… and there was the chair, she came over"

(Fitzpatrick, Janzen, Chamodraka, Gamberg, & Blake, 2009, p. 659). This intuitiveness on

behalf of the therapist was considered by clients to be significant in the formation of the

therapeutic relationship.

Other clients reported that their therapeutic relationship was enhanced when their

therapist shared something meaningful with them. For example, one client reported that his

therapist "said his wife left him and basically opened up to me so I felt that to show him

respect I would pay attention and open up to him as well" (Brown, Holloway, Akakpo, &

Aalsma, 2014, p. 199). Indeed, some clients reported specifically wanting to know

information about their therapist, seeing disclosure as a two-way process: "You tell me a little

about yourself, and I'll tell you a little about myself" (Eyrich-Garg, 2008, p. 379). Clients

felt this strategy helped them to assess whether their therapist was authentic and trustworthy.

This request for therapist self-disclosure related to both professional credentials and more

personal information (e.g. whether the therapist had children) and may be associated with

Theme 1: Assessing client-therapist match. For example, one client described how her therapist

> Told me about his childhood and all the stupid things he did in his childhood and all that kind of stuff, and things he goes through and things he does to help himself as well and says how it works for him. So he gives me an idea like 'Oh, maybe I could try that and it would help' (Gibson & Cartwright, 2013, p. 345).

This desire for therapists to disclose information about themselves to their clients was particularly strong for adolescent clients (and is likely to be related to *Theme 4: Empowerment through Respect*), although it was also evident in studies involving adult clients. As clients developed a level of trust in their therapist, their confidence in the therapeutic process increased. A client's belief that their therapist could help them seemed to aid the formation of the therapeutic relationship.

Moreover, clients reported that in order to form a trusting relationship they too needed to be open with their therapists. That is, they needed to be willing to disclose sensitive information but also to be open to suggestions about how to deal with their difficulties. One study (Fitzpatrick, Janzen, Chamodraka, & Park, 2006) labelled this process 'productive and receptive openness' and explained how it was circular in nature: as each party started to trust and open up to each other, the relationship developed further, increasing the level of self-disclosure and so forth. This process was exemplified by a client who described that his therapist:

> …asked me questions, which I might have felt they haven't got anything to do with what I'm talking about, but I'm willing to say, 'Okay, I'll go there' [receptive], and I went there… and after talking about it I realised, 'Yeah, there was a good reason for us to talk about that thing' [productive] (Fitzpatrick et al., 2006, p. 491).

The theme of *Facilitating Openness* is encapsulated by this reciprocal trusting which seemed to spiral and develop as each person became more open to the enriching relationship.

Theme 3: Connecting on a Deeper Level

This theme describes the process by which clients and therapists start to form a deeper level of connection within the therapeutic relationship. Clients described their experiences of feeling truly understood by their therapist and 'fundamentally known'; a concept which involved completely opening up to the therapist in a way that made the client vulnerable. If this submission was met without judgement from the therapist, it allowed the pair to move towards a deeper understanding of the client as a whole. Thus, one client said about her therapist:

I think she knew there was more to what I was saying than I was actually admitting or she could read between the lines and she gave it back to me and I was like 'O Jesus you really know me, ahh, did I really want that? Well you know me now so here, have the rest!' (Roddy, 2013, p. 57).

Some clients felt that having an empathic therapist, who was able to view the situation from the client's perspective, was facilitated by a good client-therapist match (see *Theme 1: Assessing client-therapist match*). Others reported that their therapist had taken a holistic approach and explored all aspects of their difficulties thoroughly in order to 'know' them. However it was achieved, clients who felt listened to and understood reported that this enhanced the formation of a therapeutic relationship (conversely, clients who did not feel heard regarded this as a lack of respect which damaged the therapeutic relationship – see *Theme 4: Empowerment through respect*). Indeed, clients particularly appreciated occasions when their therapist showed they were interested or cared about them: "She said, 'You know what you did was something great, it was important'. It showed she cares and understands what's happening here" (Fitzpatrick et al., 2006, p. 491). Some clients reported feeling

special within their relationship, and one client simply explained that "With her, I did not seem like a number" (Marich, 2012, p. 412). This depth of connection highlights the uniqueness of the relationship, with many clients reporting that they had not had the experience of being fully known and understood before.

The essence of this theme is in the depth of understanding between the therapist and client which appeared to be facilitated for most by a strong emotional connection. Feeling special and properly heard were factors which positively impacted on the formation of the therapeutic relationship.

Theme 4: Empowerment through Respect

This theme was present to some degree in all studies included in this metasynthesis, however it was particularly prevalent for adolescent client populations or those from minority ethnic groups. Clients in these studies commented that therapists who actively worked at reducing the power differential in therapy and establishing a level of mutual respect significantly aided the formation of a therapeutic relationship.

Fostering an egalitarian relationship. Many clients seemed to value the concept of an egalitarian relationship with their therapist, where both parties were viewed as equals. One adolescent said of her therapist: "Usually when you go to adults they talk down to you. 'Oh you're just a kid.' She talks to me like I'm an adult – that really helps me" (Hollidge, 2013, p. 282). This sense of equality aided client disclosure, thereby helping the formation of the therapeutic relationship, and could be seen as another 'match' between therapist and client (see *Theme 1: Assessing client-therapist match)*. Clients described the importance of therapists adopting a person-centred approach by being flexible and allowing the client to pace the therapeutic process themselves. One client described how her therapist encouraged her to take time to regain trust in their relationship, following a distressing dream:

> She said that if what you need is for me to regain your trust that is what I'll do. So for
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> a short time I didn't share with her … she didn't push me and waited til I was ready. I
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> eventually knew she wasn't that person in my dream and I trusted her again (Hollidge,
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> 2013, p. 282).

This aspect of maintaining safety in the therapeutic relationship connects with *Theme 2:*
Facilitating openness. If therapists were perceived to be following their own agenda or
delved into the client's past too quickly, clients reported that they were less likely to disclose
personal information.

Some therapists had apparently explained to their clients about their rights and
responsibilities at the start of therapy, including such things as confidentiality clauses,
allowing them access to information which served to empower them (relating to *Theme 2:*
Facilitating openness). One client who had suffered sexual abuse as a child said:

> It (the contract) was very clear, and I think that gives people a lot of power because a
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> lot of people who suffer from any sort of abuse, they need to be told that they have the
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> permission, to… interrupt, the permission to speak out, the permission to say "No"
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> and permission to do what they think is right (McGregor, Thomas, & Read, 2006, p.
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> 44).

Similarly, another client described feeling confident that her private information
would not be shared outside of the therapeutic setting: "He kept everything confidential. My
dad would always try to take him out for lunch and ask him to tell him stuff and he wouldn't.
That was a huge thing" (Everall & Paulson, 2002, p. 82).

Examples where this did not happen included therapists conducting assessments
without explaining their purpose, resulting in clients feeling stupid, angry and disempowered.
These clients recommended that therapists explain the overall process of therapy including
what they are doing and why. Some clients highlighted note-taking as a practice which they

found to be particularly anxiety-provoking and disempowering. They suggested that it would be respectful for clinicians to "ask my permission to take notes" or "just show me what you're writing" (Eyrich-Garg, 2008, p. 379).

One client commented that if they had known they were entitled to leave at any point, they would not have continued attending a therapy which they considered to be unhelpful: "I didn't know that I could say… I think I need to see someone else because I'm not making any connection with you" (McGregor et al., 2006, p. 44). In this way, clients demonstrated the importance of agency in the therapeutic process and highlighted the significance of making the initial decision to attend therapy. Clients who reported pressure to attend therapy tended to find it harder to establish a therapeutic relationship.

A sense of empowerment seemed to propel clients towards taking control and implementing positive action to foster their own emotional well-being. As one client explained, "These are my life experiences and figuring things out for myself and finding links for myself, I think it's healthy. I need to be able to do that when I'm outside the counselling sessions" (Fitzpatrick et al., 2006, p. 491). Similarly, another young client explained her realisation that therapists were "not really there to fix your life. They want you to fix your own life, and they want to be there for support" (Gibson & Cartwright, 2013, p. 347). Some clients described actively engaging with the therapeutic process to develop idiosyncratic techniques in collaboration with their therapist. In one study, adolescent clients described feeling like their therapists had benefitted from the therapeutic encounter in terms of enjoying their company and also learning "how to do counselling" (Gibson & Cartwright, 2013, p. 345), further enhancing the client's own feeling of empowerment.

Demonstrating acceptance. A few clients reported initially feeling fearful about being judged by the therapist or being 'analysed' and this fear became a reality for some who felt attacked or, alternatively, dismissed by their therapist. One adolescent client described

her experience where "the first thing [counsellor] opens her mouth with is 'Why did you do that? You shouldn't do that'" (Eyrich-Garg, 2008, p. 381). This approach left the client feeling judged by the therapist and created a significant barrier to the formation of a therapeutic relationship (relating to *Theme 3: Connecting on a deeper level).*

Conversely, therapists who demonstrated acceptance and validated their clients' experiences were able to establish a respectful relationship in therapy. For example, one adolescent said that her psychiatrist "would just sit there and listen… just letting me say it however I wanted to say, that was a big comfort… It is really good to have someone listening to you who isn't judging you" (Everall & Paulson, 2002, p. 82). Therapists who were able to demonstrate respect by fostering an egalitarian relationship and displaying a non-judgemental attitude significantly impacted on the formation of a positive therapeutic relationship.

Discussion

One of the key findings from this metasynthesis was the complex assessment of the therapists' personal and professional ability to meet the client's needs. The meta-ethnographic approach extended the findings from each individual study by demonstrating that clients created an idiosyncratic hierarchy of therapist characteristics which were of varying importance to them, depending on their own individual needs. The concept of 'matching' for many clients involved the therapist having experienced similar difficulties to the client and as such was assumed to possess a greater level of implicit knowledge. If the therapist did not appear to understand the client's experiences or was perceived as inadequate in some way, the client's confidence in the therapist's ability was reduced. Previous work by Luborsky (1976) has highlighted that the client's belief that the therapist will be able to provide the required help is an essential part of forming the therapeutic alliance (termed Type 1 alliance).

A belief that the therapist had the ability to understand fully their experiences paved the way for clients to connect with their therapist on a deeper level. How this was achieved relates to a further important finding made possible by the metasynthesis approach: the requests from clients for therapists to disclose both professional and personal information to demonstrate honesty and openness. This was evident in a number of studies across the dataset indicating a shared concern for clients despite their many differences in presenting problems, therapeutic settings and types of therapy. Therapist self-disclosure has previously been found to have a positive effect on clients as research shows they tended to view their therapist as warmer, had a stronger liking for them, and were willing to disclose more in therapy (Henretty & Levitt, 2010). This review adds to these findings as clients described feeling that their relationship with their therapist was more open and connected on a deeper level if the therapist used self-disclosure techniques.

The collaborative nature of connecting and working together was particularly powerful for many of the adolescents in this review who advocated for an egalitarian relationship with their therapist. Despite some authors arguing for the inappropriateness of this stance (Eyrich-Garg, 2008), it likely reflects these clients' wider experience of feeling powerless during a phase in their lives where they are striving to become more autonomous (Oetzel & Scherer, 2003). This sense of powerlessness and the emphasis on mutual respect were also apparent in the studies involving clients from a racial or ethnic minority background.

Finally, one further important finding of this metasynthesis was that some clients described benefitting from therapy despite the lack of a strong therapeutic relationship. This finding supports previous suggestions that a good therapeutic relationship aids therapeutic work by creating an optimal environment to instigate change; however a poorer relationship

does not mean that progress cannot be made with the implementation of appropriate and useful psychological techniques (Barber et al., 2006).

Clinical Implications

Given the understandable desire of many of the clients in this review to feel safe with their therapist before discussing their difficulties, it seems crucial that a trusting relationship is given time and space to form. Some of the clients suggested this took place over the first six sessions. For therapists who work in services offering brief psychological interventions, this may seem impractical. However, the findings from this review suggest that increasing the time at the beginning of therapy dedicated to establishing a relationship may allow for increased client productivity later on.

Learning from clients' descriptions of unhelpful practices within the primary studies may also encourage clinicians to adapt their approach. For example, one adolescent described not being aware that her personal disclosures would be discussed with her parents (Everall & Paulson, 2002). Being very clear on the limits of confidentiality from the beginning is likely to buffer the effects of these perceived 'breaches' and allow the therapeutic relationship to form nonetheless. Furthermore, some of the clients highlighted note-taking as a barrier to the formation of the therapeutic relationship. As note-taking is often more prevalent at the beginning of therapy, when the client is unknown to the therapist and much factual information is required (e.g. past history, genogram, etc.), this could easily impact on the newly-forming relationship. Therefore, clinicians may like to consider more creative ways of gaining this information without the client feeling unheard. For example, clinicians could offer to audio-record these sessions (with the appropriate consent) instead of writing notes. Creative approaches have been used in child and learning disability work, such as asking young clients to help draw their own genogram within the therapy session (Carr, 2006), and could act as a template for more collaborative work with other client populations.

Significantly, some of the clients in this review emphasised the importance of therapist self-disclosure in order for them to ascertain how well they 'matched' with their therapist. Developing an appropriately considered information sheet about the therapist prior to an individual initiating therapy could hasten that decision-making process. Providing this information on therapeutic websites would mean potential clients could access it quickly and may allow for comparison between multiple therapists (for example, working in the same clinic or agency), empowering potential clients to choose someone whom they feel would best meet their needs. In a context where resources are limited, this may enable better allocation of therapist time by reducing the number of clients who initiate but subsequently drop out of therapy.

Limitations and Recommendations for Future Research

Initially, the literature review was intended to focus specifically on the formation of the therapeutic relationship; however, in reality it was very difficult to separate out articles concentrating on the formation of the relationship as opposed to the therapeutic relationship overall. In order to maintain this aim, some articles focusing predominantly on the therapeutic relationship as a whole, or those where the focus was not clear, were excluded. Future empirical research would benefit from attempting to explore the therapeutic relationship at different stages of therapy.

In searching for relevant published data for this review, it became clear that studies had been conducted across a wide age range of participants, from 11 – 61 years old. However, there were no studies exploring the formation of the therapeutic relationship with children younger than 11. Children are increasingly being used in qualitative research studies and recommendations on how to adapt interviews for children have been published (Clark, 2011). With this in mind, attempts should be made to identify the salient aspects of forming a therapeutic relationship for children, and how these compare to older clients.

Finally, this developing area of qualitative research requires more carefully-designed research studies to enhance our understanding of the formation of the therapeutic relationship by teasing out different client preferences. For example, findings from this metasynthesis suggest that some clients are looking to connect with their therapist during the therapeutic process whereas others would prefer to focus on developing concrete strategies. Future research might help to distinguish between the clients that fall into each of these categories and allocate therapists accordingly.

Rating the quality of research. Rating each of the studies using a quality measure raised some interesting observations that could inform future research. Two (Brown et al., 2014; Hollidge, 2013) of the three lowest scoring studies were published in relatively short reports compared with the other studies, implying they may have been restricted on the amount of information they could present. This reflects concerns by researchers that it is the quality of the research report that is being judged, not the quality of the research undertaken (Murray & Forshaw, 2013), and therefore highlights the risks of excluding studies on quality ratings alone. However, it is worth acknowledging that length of report did not correlate neatly with the quality ratings and some shorter studies achieved higher scores (e.g. Roddy, 2013).

One particularly interesting observation was that the highest-scoring study (Chang & Yoon, 2011) dedicated the largest proportion of its report to the method section compared with all other studies included in the metasynthesis. This suggests that allowing space for a more detailed description of how the study took place provides researchers with a platform to demonstrate the trustworthiness of their findings. It was also interesting to note that the lowest scoring domain in the CASP across the studies was that of 'reflexivity'. This indicates that researchers tend not to place as much significance on exploring how their personal background may impact on the study compared with, for example, detailing how the data

were analysed. The value of providing this information for the reader is perhaps

underestimated. However, deciding what level of personal detail to include in the report can

be difficult, and potentially exposing, and may account for the number of studies that avoided

this topic all together.

Conclusion

Understanding clients' experiences of forming a working relationship with their

therapist or counsellor is fundamental to improving therapeutic practice. The aim of this

metasynthesis was to collate research findings on the formation of the therapeutic relationship

from the perspective of clients and, additionally, to synthesise those findings using a higher

level of interpretation to generate a more holistic understanding. The metasynthesis produced

four over-arching themes: assessing client-therapist match, facilitating openness, connecting

on a deeper level, and empowerment through respect.

Using the metasynthesis approach, it was possible to discern that clients appeared to

create a hierarchy of therapist characteristics, the importance of which were assessed based

on the client's perception of their own needs. In this way clients could rapidly ascertain

whether the therapist and their approach fit with their own idea of what they needed.

Additionally, a strong theme across many of the studies was a request by clients that their

therapist shared both professional and personal information with them, and some suggestions

have been made about how to do this in an appropriately professional way. It is hoped that

this review will provide clinicians with tools to inform their therapeutic practice and

encourage researchers to continue exploring this crucial area of investigation.

References

Barber, J. P., Gallop, R., Crits-Cristoph, P., Frank, A., Thase, M. E., Weiss, R. D., &

Connolly, M. B. (2006). The role of therapist adherence, therapist competence, and

alliance in predicting outcome of individual drug counselling: Results from the

National Institute Drug Abuse Collaborative Cocaine Treatment Study.

Psychotherapy Research, 16(2)*,* 229-240. doi: 10.1080/10503300500288951

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: a case of the

tail wagging the dog? *British Medical Journal, 322*(7294)*,* 1115-1117. doi:

10.1136/bmj.322.7294.1115

*Barnes, M., Sherlock, S., Thomas, L., Kessler, D., Kuyken, W., Owen-Smith, A., … Turner,

K. (2013). No pain, no gain: Depressed clients' experiences of cognitive behavioural

therapy. *British Journal of Clinical Psychology, 52*(4)*,* 347-364. doi:

10.1111/bjc.12021

Bondas, T., & Hall, E. O. C. (2007). Challenges in approaching metasynthesis research.

Qualitative Health Research, 17(1), 113-121. doi: 10.1177/1049732306295879

Bressington, D., Coren, E., MacInnes, D. (2013). The effects of training mental health

practitioners in medication management to address nonadherence: a systematic review

of clinician-related outcomes. *Nursing: Research and Reviews, 3,* 87-98. doi:

http://dx.doi.org/10.2147/NRR.S44366

*Brown, J. R., Holloway, E. D., Akakpo, T. F., & Aalsma, M. C. (2014). "Straight up":

Enhancing rapport and therapeutic alliance with previously-detained youth in the

delivery of mental health services. *Community Mental Health Journal, 50*(2)*,* 193-

203. doi: 10.1007/s10597-013-9617-3

Carr, A. (2006). *The Handbook of Child and Adolescent Psychology: A Contextual Approach.*

(2nd ed.) London, UK: Routledge.

*Chang, D. F., & Yoon, P. (2011). Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research, 21*(5), 567-582. doi: 10.1080/10503307.2011.592549

Clark, C. D. (2011). *In a younger voice: Doing child-centred qualitative research*. Oxford, UK: Oxford University Press.

Critical Appraisal Skills Programme (CASP). (2010). Critical Appraisal Skills Programme: making sense of evidence about clinical effectiveness: 10 questions to help you make sense of qualitative research. Retrieved from http://www.casp-uk.net/wp-content/uploads/2011/11/CASP_Qualitative_Appraisal_Checklist_14oct10.pdf

Downe, S. (2008). Metasynthesis: A guide to knitting smoke. *Evidence Based Midwifery, 6*(1), 4-8. Retrieved from https://www.rcm.org.uk/ebm

Duggleby, W., Holtslander, L., Kylma, J., Duncan, V., Hammond, C., & Williams, A. (2010). Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research, 20*(2), 148-158. doi: 10.1177/1049732309358329

*Everall, R. D., & Paulson, B. L. (2002). The therapeutic alliance: Adolescent perspectives. *Counselling and Psychotherapy Research, 2*(2), 78-87. doi: 10.1080/14733140212331384857

*Eyrich-Garg, K. M. (2008). Strategies for engaging adolescent girls at an emergency shelter in a therapeutic relationship: Recommendations from the girls themselves. *Journal of Social Work Practice, 22*(3), 375-388. doi: 10.1080/02650530802396700

Finfgeld, D. L. (2003). Metasynthesis: The state of the art – so far. *Qualitative Health Research, 13*(7), 893-904. doi: 10.1177/1049732303253462

*Fitzpatrick, M., R., Janzen, J., Chamodraka, M., Gamberg, S., & Blake, E. (2009). Client

    relationship incidents in early therapy: Doorways to collaborative engagement.

    Psychotherapy Research, 19(6), 654-665. doi: 10.1080/10503300902878235

*Fitzpatrick, M. R., Janzen, J., Chamodraka, M., & Park, J. (2006). Client critical incidents in

    the process of early alliance development: A positive emotion-exploration spiral.

    Psychotherapy Research, 16(4), 486-498. doi: 10.1080/10503300500485391

Freud, S. (1912/1966). The dynamics of transference. In J. Strachey (Ed. & Trans.), *The*

    standard edition of the complete psychological works of Sigmund Freud (Vol. 12).

    London: Hogarth.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and

    empirical considerations. *Psychotherapy, 27*(2), 143-153. doi: 10.1037/0033-

    3204.27.2.143

*Gibson, K., & Cartwright, C. (2013). Agency in young clients' narratives of counseling:

    "It's whatever you want to make of it". *Journal of Counseling Psychology, 60*(3),

    340-352. doi: 10.1037/a0033110

Hartley, D. E., & Strupp, H. H. (1982). The therapeutic alliance: Its relationship to outcome

    in brief psychotherapy. In J. Masling (Ed.), *Empirical studies of psychoanalytical*

    theories (Vol. 1, pp. 1-37). Hillsdale, NJ: Erlbaum.

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy:

    A qualitative review. *Clinical Psychology Review, 30*(1)*, 63-77. doi:

    10.1016/j.cpr.2009.09.004

Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with

    schizophrenia: Literature review. *Journal of Advanced Nursing, 52*(5), 561-570. doi:

    10.1111/j.1365-2648.2005.03623.x

*Hollidge, C. (2013). Adolescents' perceptions of the factors that enhance the therapeutic

relationship: A qualitative study in school-based health settings. *Adolescent*

Psychiatry, 3(3)*,* 277-287. doi: 10.2174/2210676611303030009

Horvath, A. O. (2006). The alliance in context: Accomplishments, challenges, and future

directions. *Psychotherapy: Theory, Research, Practice, Training, 43*(3), 258-263. doi:

10.1037/0033-3204.43.3.258

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy*

relationships that work: Therapist contributions and responsiveness to patients. (pp.

37-70). New York: Oxford University Press.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual

psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work:*

Evidence-based responsiveness (pp. 25-70)*.* New York: Oxford University Press.

Horvath, A., & Greenberg, L. (1985). The development of the Working Alliance Inventory.

In L. Greenberg, & W. Pinsoff (Eds.), *The psychotherapeutic process: A research*

handbook. (pp. 529-557). New York: Guildford.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in

psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.

doi: 10.1037/0022-0167.38.2.139

Horwitz, L. (1974). *Clinical prediction in psychotherapy*. New York: Jason Aronson.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. Cleghhorn (Ed.), *Successful*

Psychotherapy (pp. 92-116). New York: Brunner/Mazel.

*Marich, J. (2012). What makes a good EMDR therapist? Exploratory findings from client-

centered inquiry. *Journal of Humanistic Psychology, 52*(4), 401-422. doi:

10.1177/0022167811431960

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-450. doi: 10.1037/0022-006X.68.3.438

*McGregor, K., Thomas, D. R., & Read, J. (2006). Therapy for child sexual abuse: Women talk about helpful and unhelpful therapy experiences. *Journal of Child Sexual Abuse, 15*(4), 35-59. doi: 10.1300/J070v15n04_03

Murray, C. D., & Forshaw, M. J. (2013). The experience of amputation and prosthesis use for adults: A metasynthesis. *Disability and Rehabilitation, 35*(14), 1133-1142. doi: 10.3109/09638288.2012.723790

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies.* Newbury Park, CA: Sage.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*(1), 4-8. doi: 10.1037/a0022180

Oetzel, K. B., & Scherer, D. G. (2003). Therapeutic engagement with adolescents in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 40*(3), 215-225. doi: 10.1037/0033-3204.40.3.215

*Roddy, J. K. (2013). Client perspectives: The therapeutic challenge of domestic violence counselling – a pilot study. *Counselling and Psychotherapy Research, 13*(1), 53-60. doi: 10.1080/14733145.2012.711340

Rodgers, B. (2003). An exploration into the client at the heart of therapy: A qualitative perspective. *Person-centered and experiential psychotherapies, 2*(1), 19-30. doi: 10.1080/14779757.2003.9688290

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103. doi: 10.1037/h0045357

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship

     variables in child and adolescent therapy: A meta-analytic review. *Journal of*

     Consulting and Clinical Psychology, 71(3), 452-464. doi: 10.1037/0022-

     006X.71.3.452

Sterba, R. F. (1929). The dynamics of the dissolution of the transference resistance.

     Psychoanalytic Quarterly, 9, 363-379. Retrieved from

     http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)2167-4086

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., & Sandelowski, M. (2004). Qualitative

     Metasynthesis: Reflections on Methodological Orientation and Ideological Agenda.

     Qualitative Health Research, 14(10), 1342-1365. doi: 10.1177/1049732304269888

Walsh, D, & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature

     review. *Journal of Advanced Nursing, 50*(2), 204-211. doi: 10.1111/j.1365-

     2648.2005.03380.x

*Ward, E. C. (2005). Keeping it real: A grounded theory study of African American clients

     engaging in counseling at a community mental health agency. *Journal of Counseling*

     Psychology, 52(4), 471-481. doi: 10.1037/0022-0167.52.4.471

Yardley, L. (2000). Dilemmas in Qualitative Health Research. *Psychology and Health*, *15*(2),

     215-228. doi: 10.1080/08870440008400302

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of*

     Psychoanalysis, 37(4-5)*,* 369-376. Retrieved from

     http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1745-8315

Table 1

Inclusion and Exclusion Criteria for Metasynthesis

Inclusion criteria	Exclusion criteria
Primary empirical data obtained via a research study	Secondary data, such as that obtained through reviews of the literature, or anecdotal evidence
Qualitative research (or mixed methods) using a content-based approach to guide analysis with a significant enough component to allow for synthesis	Quantitative research or very little qualitative data analysis
The majority of data collected using an interview format (either individual or group), possibly supplemented by other written text	Data collected via observation or through methods where it was unclear how much the client perspective had been obtained
More than one participant in the study, resulting in themes being developed across the data	Case studies
Client perspective/experience (or dyadic) with enough individual data to allow analysis	Therapist or observer perspective only
Significant findings regarding alliance formation/engagement in therapy	Lack of findings regarding alliance formation/engagement in therapy
Focus on a working relationship with professional acting as a therapist or counsellor	Focus on relationships with other health professionals or service providers not in a counselling role
Current (at the time of participation in the study) or previous engagement in individual or group therapy focusing on a mental health difficulty	Engagement in alternative support mechanisms, such as domestic violence support groups
Evidence of direct quotations	Paraphrasing or lack of substantial or clear quotations
Written in English	Published in a language other than English
Published in a peer-reviewed journal	'Grey' literature

Table 2

Demographic and Methodological Characteristics of the Studies Included in the Metasynthesis

Authors	Sample	Age of participants	Ethnicity	Reason for therapy	Therapeutic approach	Method of data analysis
Barnes, Sherlock, Thomas, Kessler, Kuyken, Owen-Smith, Lewis, Wiles & Turner (2013)	26 adult clients (16 females); UK	Mean age = 47yrs	All White British	Depression	Cognitive-behavioural therapy (CBT)	Qualitative data analysis informed by the Framework approach
Brown, Holloway, Akakpo & Aalsma (2014)	19 adolescent clients (7 females, 12 males); USA	Age range = 11-17yrs (median age = 16yrs for females; 15.5yrs for males)	Females = 3 Black, 4 White Males = 7 Black, 4 White, 1 Hispanic	'Mental health concerns'	Not stated	Grounded theory approach
Chang & Yoon (2011)	23 adult clients (13 females, 10 males); USA	Age range = 19-55yrs (average age = 33.7yrs)	5 Asian American, 9 African American, 5 Hispanic American, 4 multiracial/ multiethnic	Multiple - mood swings and depression, loneliness and isolation, family conflicts, career and work related stress, feeling anxious, dating concerns, traumatic experience, alcohol or drug abuse, sexual orientation, academic stress, interpersonal difficulties, social anxiety	Not stated	Consensual qualitative research approach (CQR)
Everall & Paulson (2002)	18 adolescent clients (15 females, 3 males); Canada	Mean age = 16.3yrs	16 Caucasian, 1 Aboriginal, 1 East Indian	Multiple – emotional difficulties, depression, family issues, eating disorders, school problems, gender identity issues, suicidal concerns	Individual/family/ group counselling - theoretical orientation not known	Qualitative data analysis using a combination of methods
Eyrich-Garg (2008)	5 adolescent female clients; USA	Age range = 13-17yrs	2 Caucasian, 2 African-American, 1 Biracial	Not stated	Individual counselling and family therapy	Qualitative data analysis using an inductive approach

Authors	Sample	Age of participants	Ethnicity	Reason for therapy	Therapeutic approach	Method of data analysis
Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake (2009)	15 adult clients (12 females, 3 males); Canada	Age range = 20-61yrs (mean age = 27.2yrs)	8 Caucasian, 2 Canadian, 1 Persian / Iranian, 1 Armenian, 1 South-East Asian, 1 Chinese / Mauritian (1 unknown)	Depression	Mixture of humanistic, cognitive-behavioural, psychodynamic, feminist, narrative	Consensual qualitative research approach (CQR)
Fitzpatrick, Janzen, Chamodraka, & Park (2006)	20 adult clients (16 females, 4 males); Canada	Age range = 20-54yrs (mean age = 28.26yrs)	11 Canadian, 4 European, 3 Biracial, 1 Asian, 1 Caribbean	Multiple – relationship difficulties, self-esteem, existential concern, academic concerns, substance abuse, eating disorder	Counselling psychology	Consensual qualitative research approach (CQR)
Gibson & Cartwright (2013)	22 adolescent clients (15 females, 7 males); New Zealand	Age range = 16-18yrs	11 New Zealanders of European Ancestry, 6 Immigrants from other English-speaking countries, 5 Maori and /or Pacifika	Not stated	Range of models including humanistic, cognitive-behavioural and narrative	Narrative analysis
Hollidge (2013)	42 adolescent clients (33 females, 9 males); USA	Age range = 14-18yrs (mean age = 16.3yrs)	16 European American, 16 African American, 7 Hispanic, 2 Asian, 1 Native American	Not stated	Individual psychotherapy	Grounded theory framework
Marich (2012)	10 adult female clients; USA	Age range = 27-52yrs (mean age = 41.7yrs)	4 African-American (Black), 5 Caucasian, 1 mixed European / Iranian	Addiction	Eye movement desensitisation and reprocessing (EMDR) therapy	Giorgi's descriptive phenomenological psychological method
McGregor, Thomas & Read (2006)	20 adult female clients; New Zealand	Age range = 26-57yrs (mean age = 40.5yrs)	13 New Zealand Europeans, 6 Maori, 1 Samoan	Childhood sexual abuse	Not stated	Grounded theory approach

Authors	Sample	Age of participants	Ethnicity	Reason for therapy	Therapeutic approach	Method of data analysis
Roddy (2013)	4 adult female clients; UK	Age range = 30-50yrs	All White British	Domestic violence	Person-centred, psychodynamic or integrative counselling (including CBT)	Adapted grounded theory and narrative approach
Ward (2005)	13 adult clients (8 females, 5 males); USA	Age range = 26-53yrs (average age = 39.9yrs)	All African American	Multiple – drug and alcohol abuse, parenting issues, stress and coping, bipolar disorder, children's behavioural problems, court mandate	Not stated	Grounded theory methodology and dimensional analysis

Note. All information in this table has been taken from the available information in the primary source material.

Table 3

Extract of the Coding Synthesis: Table Used to Develop Four Main Themes from Individual Study Codes

Theme 1: Assessing Client-Therapist Match	Theme 2: Facilitating Openness	Theme 3: Connecting on a Deeper Level	Theme 4: Empowerment through Respect
Barnes et al (2013)	**Barnes et al (2013)**	**Barnes et al (2013)**	**Barnes et al (2013)**
- CBT seen as helpful despite difficult relationship	- feeling uncomfortable	- relating to therapist	- fear of being analysed
- impact of CBT on problem	**Brown et al (2014)**	- not being listened to, not understood	**Brown et al (2014)**
- feeling like not giving right answer	- being 'straight up'	**Brown et al (2014)**	- client-directed care and sequencing
- age/perceived experience of therapist is a barrier	- therapist self-disclosure indicates authenticity	- too much emotional attachment, too close	- perceived level of self-governance
Brown et al (2014)	- build trust to confide in therapist	- connecting emotionally to build trust	- staying in here and now, following client
- therapist been through what client has	- sense of safety	- empathy	- therapist putting own agenda first
Chang & Yoon (2011)	- rapport	- deeply caring and understanding	**Chang & Yoon (2011)**
- match as a facilitator to therapy	- feeling comfortable	- seeing situation from client's perspective	- dismissive of experiences of racial oppression
- better understanding of key experiences	- sense of humour	**Everall & Paulson (2002)**	**Everall & Paulson (2002)**
- appreciated uniqueness of individual experience	- sense of credibility	- uniqueness of therapeutic relationship	- egalitarian relationship (trust and respect)
- could offer insider's perspective of client's difficulties	**Chang & Yoon (2011)**	- feeling listened to/heard	- discussing/explaining context of therapy
- ability to work through differences that arose	- easier to discuss sensitive issues	**Eyrich-Garg (2008)**	- non-judging
		- not feeling listened to	**Eyrich-Garg (2008)**
			- labels and offensive descriptions
			- respect, egalitarian relationship

Table 4

Appraisal of Study Quality using Critical Appraisal of Study Programme (CASP) Tool

Study	Authors	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score
1	Barnes, Sherlock, Thomas, Kessler, Kuyken, Owen-Smith, Lewis, Wiles & Turner (2013)	1	2	2	1	2	2	2	2	14
2	Brown, Holloway, Akakpo & Aalsma (2014)	2	2	2	1	2	1	2	1	13
3	Chang & Yoon (2011)	3	2	2	3	2	3	2	3	20
4	Everall & Paulson (2002)	1	2	1	2	2	2	2	2	14
5	Eyrich-Garg (2008)	2	1	2	1	2	1	2	3	14
6	Fitzpatrick, Janzen, Chamodraka, Gamberg & Blake (2009)	2	1	2	2	2	3	2	2	16
7	Fitzpatrick, Janzen, Chamodraka & Park (2006)	2	2	2	2	2	2	2	2	16
8	Gibson & Cartwright (2013)	2	3	2	2	2	2	2	2	17
9	Hollidge (2013)	1	2	2	1	2	1	2	2	13
10	Marich (2012)	2	2	2	2	2	3	2	2	17
11	McGregor, Thomas & Read (2006)	2	2	1	2	1	2	2	1	13
12	Roddy (2013)	3	2	2	1	2	2	2	2	16
13	Ward (2005)	2	2	2	2	1	3	3	3	18

Title and abstract search completed for all papers identified using keyword search

AMED = 126

CINAHL = 511

EMBASE/MEDLINE = 444

IBSS = 136

PsycInfo = 436

Web of Science = 175

1,681 papers excluded due to duplications or not meeting inclusion criteria

Full text of the study was obtained and thoroughly checked against inclusion criteria

134 papers excluded due to not meeting inclusion criteria

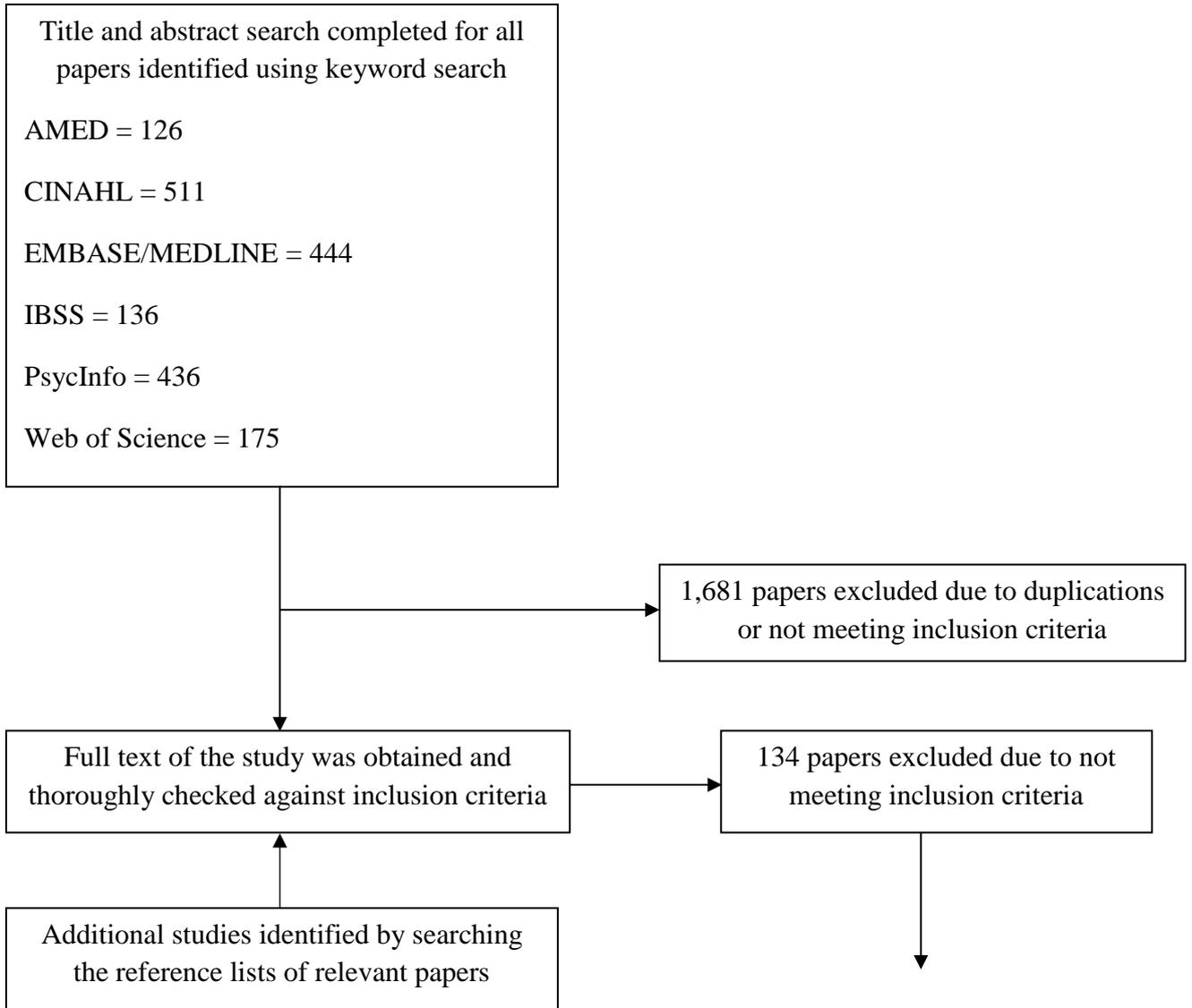Additional studies identified by searching the reference lists of relevant papers

Figure 1. Flow diagram to illustrate the literature searching process.