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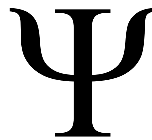

How did therapy change me?
– a meta-synthesis of patients' experiences of change and mechanisms of change in individual psychotherapy

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Abstract

The purpose of this meta-synthesis was to investigate what patients experienced as contributing to their change processes and what they saw as changed when engaging in individual psychotherapy. A literature search and quality assessment of peer-reviewed qualitative inquiries up to September 2020 was conducted, resulting in 30 articles being included. Findings highlight a therapeutic relationship built over time and founded on trust as central to self-exploration and expansion of patients' self-awareness. This facilitated understanding of what needed changing and brought direction to patients' change processes, within a co-operative therapeutic environment. Increased mental, emotional, and physical stability as well as increased acceptance of selves, experiences, and own situation was identified as central outcomes of psychotherapeutic change processes as seen from the perspective of patients. Central contributions to patients' experiences of change from psychotherapy are discussed in light of existing psychotherapy research, and clinical implications and methodological reflections are considered.

Sammendrag

Formålet med denne metasyntesen var å undersøke hva pasienter opplevde bidro til deres endringsprosesser og hva de opplevde som endret ved deltakelse i individuell psykoterapi. Litteratursøk og kvalitetsvurdering av fagfellevurderte kvalitative undersøkelser frem til september 2020 ble gjennomført, som resulterte i 30 inkluderte artikler. Funnene understreker en terapeutisk relasjon bygget over tid og basert på tillit som sentral for utforskning av selvet og i å utvide pasienters selvforståelse. Denne fasiliterte forståelse for hva som er i behov av endring og gav retning til pasienters endringsprosesser, innenfor et samarbeidende terapeutisk miljø. Økt mental, emosjonell og fysisk stabilitet, i tillegg til økt selvaksept, økt aksept for erfaringer og for egen situasjon ble identifisert som sentrale utfall av psykoterapeutiske endringsprosesser, sett fra pasienters perspektiv. Sentrale bidrag til pasienters erfaringer av endring fra psykoterapi diskuteres i lys av eksisterende psykoterapiforskning, kliniske implikasjoner fremheves og metodologiske refleksjoner drøftes.

Preface

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Contents

Abstract ... **iii**

Sammendrag ... **iv**

Preface ... **v**

Introduction ... **1**

Method ... **7**

Design ... 7

Data Collection and Search Strategy ... 8

Inclusion Criteria ... 10

Quality Assessment ... 11

Data Analysis ... 15

Results ... **17**

Study Characteristics ... 17

What Changed? ... 19

1 A) Improved Relationships With Self and Others ... 19

1 B) Increased Acceptance ... 21

What Made Change Possible? ... 24

2 A) Co-Creating a Therapeutic Relationship Based on Trust, Connection, and Collaboration ... 24

2 B) Committing to Change as a Gradual, Challenging, and Continuing Process ... 30

2 C) Increasing Self-Awareness to Understand What Needs Changing ... 33

Discussion ... **35**

A Summary of Change Processes from the Standpoint of Patients 36

Findings in View of Psychotherapy Research.. 37

Clinical Implications 43

Methodological Reflections 44

Reflexivity... 47

Limitations 49

Strengths.. 50

Conclusion.. 52

References 53

Appendix A 70

Table A1 70

Characteristics for Articles Included in Meta-Synthesis 70

Appendix B 82

Table A2... 82

Themes and Categories from Original Articles Included in Meta-Synthesis.................. 82

Appendix C 93

Table A3... 93

Quality Assessment of Eligible Articles to Meta-Synthesis 93

Appendix D 101

Table A4... 101

Identified Themes Represented in Original Articles 101

Introduction

During the 1950s and 1960s, when psychoanalysis still was figuring prominently, Hans Eysenck controversially suggested that psychotherapy does not work (Eysenck, 1964). Since then, the use of quantitative methods, and crucially meta-analyses, has consistently shown that psychotherapy indeed can make changes in patients (Lambert, 2013; Munder et al., 2019; Wampold, 2015a). While the number of treatment methods have increased exponentially, research on their relative effectiveness reveal only small differences (Wampold, 2015a). Although establishing that psychotherapy works is important, such quantitative knowledge may yield limited value for therapists in how to work with patients (Hill et al., 2013). Outcome studies might tell us that the therapeutic approach being used is effective, but not what about it that produces the changes (i.e. mechanisms of change). Recent work on the concept of psychotherapeutic responsiveness might be one contribution toward understanding how psychotherapeutic relationships might effect changes (Hatcher, 2015; Stiles & Horvath, 2017). It involves how therapists adjusts strength, timing and use of interventions suited to patients' unique needs at different moments during psychotherapy (Goodwin et al., 2018). Understanding more about what patients experience as helpful in therapy could therefore be useful for therapists wanting to meet each patients’ unique difficulties adequately.

While it is established that psychotherapy works, knowledge about how psychotherapeutic processes contribute to change in patients is still sparse (Binder et al., 2010; Kazdin, 2007; Silberschatz, 2017). Finding mechanisms of change in psychotherapy is inherently challenging, since there are likely many pathways toward a given outcome, and one identified mechanism might influence multiple outcomes (Kazdin, 2007). Finding change mechanisms quantitatively requires finding mediator variables relating to outcome variables. Mediator variables are not change mechanisms in themselves but guides to what they might

be. Different theories of change as they pertain to different treatment models are viewed as such mediator variables (Kazdin, 2009).

In the search for mechanisms of change in psychotherapy, some argue for the role of specific factors, that is factors that relate to a treatment models' specific ingredient of change, e.g., correcting maladaptive cognitions in Cognitive Behavioral Therapy (CBT; Beck & Beck, 2011). These treatment models assume that therapists utilize a set of interventions derived from the treatment model causing changes in patients. This might be likened to a medical view of therapeutic changes where it is understood that what therapists "give" patients causes change (Mulder et al., 2017). In a contextual model the change process is thought to emanate from the therapeutic situation, including characteristics of the therapist, the patient, the relationship that is developed and the social and physical context this interaction is a part of (Wampold, 2007). Those advocating the contextual model (see, e.g., Wampold et al., 2001) emphasize the role of common factors, which can be considered factors that are non-specific to different treatment models, such as the therapeutic alliance (Horvath et al., 2011) and therapists' interpersonal skills (Cuijpers et al., 2019). Factors within the patient are also viewed as important (Duncan & Miller, 2000), such as patients' positive expectations (Lambert & Barley, 2001) and patients' beliefs in treatment rationales (Carter et al., 2011), which are all associated with better therapeutic outcomes. Reviews of outcome studies show that 30% of the variance related to positive outcome is explained by variables within the patient. This is greater than variables such as the therapist, treatment approach and therapeutic relationship (Swift & Parkin, 2017). The relative importance of patient characteristics is in accordance with approaches emphasizing patients' own resources, beliefs, values, and goals (Bohart, 2000; Bohart & Tallman, 2010) which are core values within humanistic approaches to therapy (Coleman & Neimeyer, 2015). Increased attention

has therefore been given to adapt therapy to each patient (Norcross & Cooper, 2021) as therapists are met with the challenges of being able to adapt their responses to emerging contexts in different timescales; from moment to moment, that is the dialogical and dynamic nature of therapy, short term (for each session) and over many sessions in the long term (Constantino et al., 2020; Kramer & Stiles, 2015). One study found that therapists' abilities to address patients resistance flexibly over treatment courses were associated with better outcomes (Hara et al., 2015). This indicates the importance of therapists developing skills at identifying treatment obstacles and how to deal with them. In addition, therapists must negotiate adaptations to patients' needs within frameworks set by different health care systems, e.g., limits to length of therapy courses, further complicating their tasks of adapting to patient needs. This indicates the importance of understanding more about factors within patients that are important for change.

While factors pertaining to the patient might be more important than previously thought for the outcomes of psychotherapy, the patient might be neglected in other respects as well. The most frequent way of defining outcome in psychotherapy research has been the difference between symptom level measurement, pre- and post-treatment (De Los Reyes et al., 2011). Several qualitative studies suggest that although patients do value symptom reduction, other change factors are also highlighted by patients, such as improved self-understanding, greater self-definition, new ways of interacting with others and affect-change (Binder et al., 2010; Connolly & Strupp, 2010). Interestingly, one study found that although patients received different treatments, namely CBT (see, e.g., Beck & Beck, 2011) vs. Psychodynamic Therapy (see, e.g., McWilliams & Weinberger, 2003) and reported roughly equal amounts of symptom change, they qualitatively reported differences (Nilsson et al., 2007). These findings therefore suggests that researchers' predetermined categories of

"good" outcomes might not encompass the complexity of what psychotherapy patients experience as important changes.

Psychotherapy researchers seem, in accordance with the medical model, to value symptom reduction and may forget the values and resources within the recipient of psychotherapy when assessing outcomes (Binder et al., 2010). This underpins the complexity of understanding the healing process in psychotherapy, which might be seen as different from for instance the treatment of somatic ailments, for which symptom reduction alone may be viewed as appropriate goals or outcomes (Wampold, 2007). Better insight into patient experiences represents an important avenue to further improve and enlighten therapists' work, then. It could also serve to elucidate important phenomena ripe for operationalization of quantifiable variables, and how they in turn might co-vary with established therapeutic outcome variables. Studies investigating the patient perspective in psychotherapy should therefore be sought after, both by clinicians as well as health care providers and policy makers.

These considerations illustrates important reasons for adopting methodological pluralism, that is, the view that one should embrace different research methodologies to increase relevant knowledge (Elliott, 2010). In the parable of the blind men and the elephant, the blind men are curiously trying to figure out what animal they are in the vicinity of. One man touches the trunk and therefore thinks the animal is a snake, the second blind man touches the leg and thinks it is a tree, and the third man touches the tail and thinks it is a fan. This parable shows the inherent opportunity and simultaneous limitation of information gathered from different viewpoints. This might not be a problem as long as one is willing to integrate different perspectives. Translating this conclusion to research on psychotherapy outcomes means striving for the inclusion of different methodologies to achieve better and

more nuanced understanding of change processes in psychotherapy. This includes studying psychotherapies through single-case studies, outcome studies and process studies, conceived within qualitative as well as quantitative study paradigms.

What is distinctive of qualitative methodology is that it offers data and findings with rich descriptions of patients' experiences. Qualitative research, in contrast to quantitative research, focuses on understanding more of the context in which data was conceived and its inherent complexity (Elliott, 2010). It also represents an avenue to investigate refutational or contradictory data within comparable contexts, to increase understanding of complex phenomena (Edwards & Kaimal, 2016), e.g., in understanding specific needs of different patient populations. Qualitative research is potentially "closer" to particularities within psychotherapeutic processes, including patients' unique viewpoints, life stories and contexts (Levitt, 2015). It also might serve to increase therapists' awareness to patients' own theories of what caused their problems and what they see as contributing to beneficial changes (Duncan & Miller, 2000; Rodgers, 2002) . Hence, it might inspire new ideas about mechanisms of change, one example of which is the assimilation model. This model is based on the assumption that patients have different parts within themselves, and that they need help to strengthen those that have been suppressed (Stiles et al., 1990).

Qualitative research has been used to study psychotherapy, both from therapists' as well as from patient's perspectives. Though case studies have been used to inform development of clinical practice since the beginning of psychotherapy, qualitative research has only gained traction more widely as a research paradigm for this study area in recent decades (Levitt, 2015). Rennie's (1994) study of how patients perceived an hour of therapy represents an early endeavor. Recorded sessions of psychotherapy have also been subject to qualitative analysis, identifying significant moments for change in therapeutic processes as

identified by patients (see, e.g., Pascual-Leone & Greenberg, 2007), as well as diary studies (see, e.g., Mackrill, 2009), Interpersonal-Process-Recall (Belser, 2017), and focus groups (see, e.g., Shelton & Delgado-Romero, 2011). The increasing number of qualitative studies calls for synthesizing knowledge acquired from individual studies. While richness, nuances and context-sensitivity are some of the strengths of qualitative studies, the generalizability of those studies are limited as findings from one context only are transferable to similar contexts. Meta-synthesizes or systematic reviews may alleviate these limitations by combining the results of many individual studies. Systematized reviews can serve as powerful analytic tools in investigating and presenting knowledge for this purpose (Walsh & Downe, 2005). One critique of earlier attempts is that results from qualitative research may be emotionally compelling at best, without having any practical utility, e.g., for therapists (Edwards & Kaimal, 2016). Combined, the need for more and systematized knowledge on patient's perspectives of the experience of psychotherapy and increasing the practical utility in presenting the results has served as motivation for designing this study.

A previous meta-synthesis exploring patient-identified impact of helpful events in psychotherapy yielded eight categories: self-understanding, behavioral change, empowerment, relief, emotional experiencing, feeling understood, client involvement, safety and personal contact (Timulak, 2007). The goal for this meta-synthesis has been to investigate more specifically what patients experienced as contributing to their change processes in individual psychotherapy, and what they saw as changed from these processes. It has sought to answer two related research questions, which also has influenced the construction of the findings: What do patients report changing when engaging in psychotherapy? And to what do patients attribute these changes in their psychotherapy processes? To the authors' knowledge this study represents the first meta-synthesis

specifically looking into the question of patient's understanding of what brings about beneficial change when engaging in psychotherapy.

Method

Qualitative research is founded in the assumption that knowledge is situated within contexts. This limits the transferability of qualitative findings only to other similar contexts (Onwuegbuzie & Leech, 2006). Context-specificity are controlled for or excluded in quantitative research to achieve generalizability from findings. The concept of validity is therefore different in qualitative and quantitative methods. In qualitative research, the goal is to construct new knowledge based in interview data, whereby the knowledge attained ideally is more than the sum of what participants report, as inferences are drawn from participant statements (Thorne, 2017). This entails a constructive process involving double hermeneutics, whereby pre-conceived ideas of the interviewers are scrutinized and compared with the raw interview data in an iterative process (McKemmish et al., 2012). Patients' reports are also subject to biases, since humans readily make fallacious attributions to why something happens (Nisbett & Ross, 1980). Participants' reports may be reliant upon cultural scripts of why therapy changed them when external factors might be more important, e.g., changes in life circumstances or medication. Participants may also lack the ability to verbally express subtle aspects of what happens during therapy, which can get worse if the qualitative interviews are of a poor quality, such as fails to be founded in proper interview guides or researchers not following up or exploring patients' reports in ways to bring out relevant information.

Design

Meta-synthesis entails gathering relevant studies, extracting, as well as closely re-examining their findings, and then analyzing and creatively combining them into a new,

cohesive and substantial whole (Schreiber et al., 1997). The goal is to allow for the emergence of overarching concepts in findings from a diverse sample of studies, possibly adding to existing knowledge (Sherwood, 1999). The idea of meta-analyzing qualitative research is likely to have been proposed for the first time by Stern and Harris (1985) under the term meta-analysis but made more widespread and influential by Noblit and Hare (1988) through their work on meta-ethnography. Today the term meta-synthesis is a more widely used term for qualitative meta-analysis (see, e.g., Thorne et al., 2004). Proponents of the term meta-synthesis highlight the interpretive, rather than aggregative, nature of the analytical work underlying this procedure, making for the possibility of drawing new inferences and conclusions (see, e.g., Finfgeld, 2003).

In investigating patients' experiences of what contributes to beneficial change, meta-synthesis serves as a way of gathering a rich array of data, combining them and interpreting them jointly with the intent of bringing rich insight into what patients' highlight as important aspects of their therapies. In this way a better understanding of helpful aspects of psychotherapy as understood from the patients' perspective may be formed. Ultimately this can contribute to the improvement of existing treatments and give both clinicians, health care providers as well as policymakers valuable insight into how to make practice better, that is, what to focus on in both making clinical decisions in and in shaping health care practices (Finfgeld, 2003).

Data Collection and Search Strategy

This meta-synthesis is based on published and peer-reviewed articles only. Studies focusing on specific aspects of therapy have been included (e.g., agency, alliance formation), if participants have been given open-ended questions, seeking to explore their experiences of what was helpful in bringing about beneficial change when engaging in psychotherapy.

Searches into qualitative literature poses several challenges. A wide variety of terms are used to label qualitative methods in the research literature, that is, qualitative research may be presented using different terms (see, e.g., University of Washington, 2020). For instance, the word "qualitative" may not be used in the presentation of interviews, but data would still be qualitative at its core. It is therefore unlikely that all relevant studies may be found in any one given search strategy. In this meta-synthesis different search strategies were therefore used to increase the likelihood of including more relevant studies. Within the field of qualitative meta-analysis there is an ongoing discussion pertaining to the number of studies to include in a meta-synthesis. Some recommend including all relevant studies, whereas others subscribe to the concept of "saturation", that is, halting analysis at a point where it seems like adding more studies is viewed as superfluous (Timulak, 2009). In this meta-synthesis however, the goal has been to include as many primary studies as possible, and still be within a reasonable limit to be able to conduct a cohesive analysis, which is suggested to be under 100 (Paterson et al., 2001).

Data were collected from three different searches in PsycINFO, PsycARTICLES and Web of Science. A selection of terms covering possible signifiers of qualitative research were settled based on preliminary searches in co-operation with a research librarian with long experience in the field of psychology. Further, a list of possible relevant terms focusing in on the patient and on their experiences in going to therapy were developed. Search terms pertaining to qualitative research tends to yield an unsurmountable number of hits, as there are several possible signifiers of qualitative methods. Where possible, search strategies were tailored around the design of different databases to focus the number of hits. In PSYCINFO the selection of "map term to subject heading" represents a way to limit hits in anchoring findings in the search to an established term curated by the staff of the search engine. In Web

of Science findings were refined by including relevant journals. In PsycARTICLES no refinement settings were selected. Though a truly exhaustive search into qualitative studies is difficult, a diversified strategy like the one presented should bring about a sizable and adequate selection. In addition, relevant articles were mined for other relevant articles in their reference sections, further increasing representative sampling.

For the search in PsycINFO the established term “psycotherapeutic outcomes” were used with “map term to subject heading”. In all searches the following terms were used to cover possible qualitative research: qualitative or interview* OR “phenomenolog* OR findings OR "discourse analysis" OR narrative* OR unstructured OR "in-depth" OR indepth OR "grounded theor*" OR ethnograph* OR "thematic analysis". Terms pertaining to the patient/patient experiences using the AND operator were: (client* OR patient* OR user* OR “first-person” OR “first person”) ADJ2 (report* OR experience* OR perspective OR opinion OR evaluation OR belie* OR view* OR apprais* OR thought OR said). Terms pertaining to therapy using the AND operator were: (therap* OR psychotherap* OR treatment* OR counsel*). Terms pertaining to the experience of outcome/change using the AND operator were: (change* OR outcome* OR recover* OR improv* OR help* OR symptom* OR problem* OR suffering) ADJ2 (reduction OR relief OR betterment OR improvement).

In this search all studies up to September 2020 were included. The three different searches yielded 7282 findings combined. After duplicates were removed, the total was 6906 articles (see Figure 1).

Inclusion Criteria

For this meta-synthesis, to be able to uphold an exploratory focus, it was important that findings in the original studies were informed by the same process; that is, letting original data from interviews of the patients inform formation of categories/themes, not by

imposing pre-defined ideas onto the data. For the data analyzed in the original studies to be as true to the patients' experience as possible, the selected original studies should contain a clear statement of open-ended and exploratory questions being asked to participants pertaining to the experience of therapy and what was helpful in bringing about change. To better be able to find common, emerging themes from somewhat comparable patient experiences, the authors decided to include only data collected on patients participating in individual therapy (or where analysis of data pertaining to individual therapy would be discernable from participation in other types of therapy, e.g., group therapy). Also, only articles presenting results including quotes exemplifying and anchored to themes/categories were included, so that categories/themes in each study could be openly assessed and then re-assessed for the purposes of this meta-synthesis, both with regards to inherent meaning as well as in being able to assess the quality of the analysis in each of the original studies (with the quality evaluation standards presented below). Discernable qualitative data from mixed methods studies was also included. Further, only peer-reviewed articles presented in the English language with a sample containing adults (from age 16) were included.

All 6906 titles and abstracts were manually screened for potential inclusion by the authors using the above stated inclusion criteria. Additionally, articles assessed for inclusion were screened for other relevant articles in their reference sections. In total 50 articles were found to match the defined inclusion criteria, eligible for the proceeding quality assessment.

Quality Assessment

Within the field of qualitative research there is an ongoing discussion on how quality might be assessed (see, e.g., Morrow, 2005; Stige et al., 2009). The different nature of the process of qualitative research compared to quantitative research, calls for a different approach in assessing quality. The effect of the researcher interpreting the data calls for a

degree of openness on the process, from the epistemological and theoretical standpoint of the researcher, to how the process and selection of participants might affect the findings, to how participants' statements are being interpreted and organized (Malterud, 2001). We chose to apply the *CASP Qualitative Studies Checklist* (Critical Appraisal Skills Programme, 2018) to assess the quality of the 50 included articles. CASP provides a standardized, commonly used, ten categories breakdown of aspects considered to be of importance for the quality of qualitative research. In considering the ten categories the authors were further informed by the 4 R's to evaluate research (Finlay & Evans, 2009), focusing on rigor (properly managed research and systematic approach in analyzing data), relevance (research adding to existing knowledge), resonance (compelling interpretations drawing readers in) and reflexivity (openness on research process and self-scrutiny on influence from researchers on their own research). The authors read a selection of four articles jointly, and quality assessments of these were discussed until consensus. The remaining selection of studies were divided in two similar sized samples, each author assessing one half each. A randomized selection of four assessed studies then were discussed by the authors with their supervisor, further calibrating consensus and disambiguating differences in judgements of inclusion and quality criteria. Articles were then reassessed by the authors and the quality assessment was finalized with a high degree of consensus.

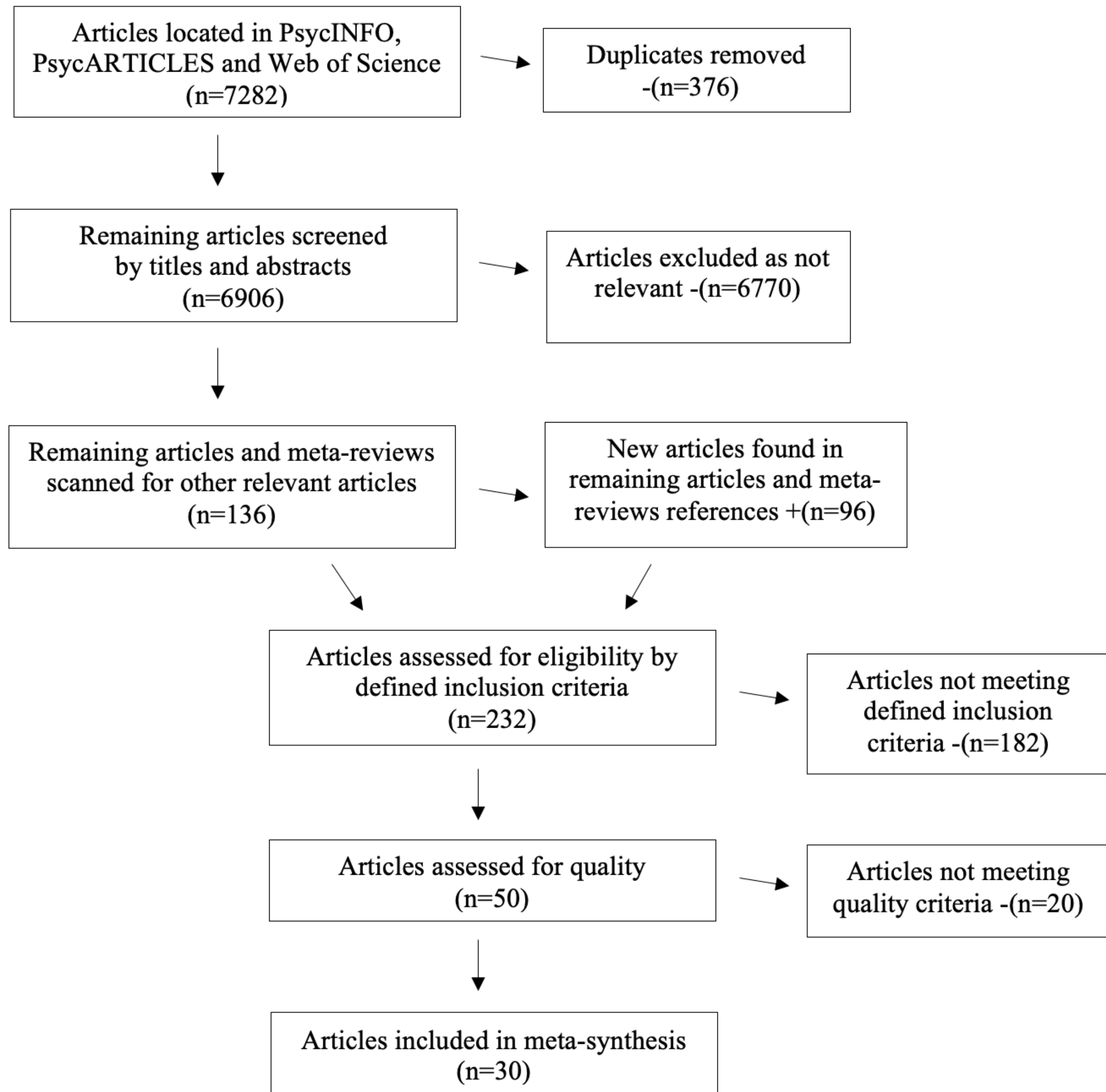
To be included in the meta-synthesis, the study would not have to pass all ten quality criteria defined in the CASP checklist (Critical Appraisal Skills Programme, 2018). Rather, particular emphasis was put on criteria in the checklist pertaining to whether the data analysis was performed with a satisfying degree of rigor, whether the method of analysis was justified, and findings presented in a clear way. Also, whether presentation of analysis and findings held a degree of openness, that is, whether there was a clear presentation of

qualitative interpretations, clearly anchored in explicit statements from participants in the original data. A guiding principle was to assess whether the reader is able to "see" the analytic process, that is to be able to assess the analytic thread from participant's statement, its connection to a theme or a category and subsequently, and where applicable, a connection to an overarching category. This pertains to the reflexivity in the original studies, that is how transparently authors communicate construction of knowledge from their findings (Malterud, 2001). For this meta-synthesis, the goal was to aspire for transparency throughout the analysis, keeping the phenomenological "gist" alive throughout, thus the original studies providing the basis for this analysis was deemed to withhold the same criteria. An overview of the quality assessment can be found in Table A3 in Appendix C.

The total number of articles meeting inclusion and quality adequacy criteria, and thus being included in the final analysis, were 30 (see Table A1 in Appendix A). For an overview of the workflow of the search, eligibility and quality assessment, see the proceeding Figure 1.

Figure 1

Flow Diagram of Search, Eligibility, and Quality Assessment



Data Analysis

Different qualitative approaches can be used in order to perform a meta-synthesis (Barnett-Page & Thomas, 2009). In considering methods for analysis the authors assessed the field to find an appropriate method suited to the stated goal of this meta-synthesis. Evaluations of meta-ethnography as a method highlight its ability to produce findings better suited for explaining phenomena, compared to other types of reviews (Britten et al., 2002; Campbell et al., 2003). Meta-ethnography was first introduced by Noblit and Hare (1988). They founded their approach on a definition by Strike and Posner (1983) on synthesis that entails a constructive process, with certain creative and innovative elements, adding to a result where a new whole emerges that is greater than its separate building blocks of data. Meta-ethnography is also founded on the idea of building understanding through comparing data, inspired by theory of social explanation (Turner, 1980).

This meta-synthesis leans on one of several possible ways of performing meta-ethnography labelled *Reciprocal Translational Analysis*, first conceptualized by Noblit and Hare (1988), then extended on by Sandelowski and Barroso (2007). In this process themes, categories and concepts are translated onto one another, in a process of integrating findings from disparate studies as they are interpreted alongside each other. Emerging from this comparative and interpretative process are new, and overarching concepts, founded and anchored in a vast array of original data. The idea of *bricolage* (Lévi-Strauss, 1966), which could be understood as "any spontaneous action that builds on the material effects of previous actions" (Kinn et al., 2013, p. 1285) has further influenced the analytical process. In this, the authors have strived to free themselves from the original interpretations in the original studies (original findings extracted and presented in Table A2 in Appendix B), though at the same time, remaining as much of the original context for the hermeneutical

meaning in the findings as possible. The goal has been to creatively construct new meaning by taking a step back from the original material, and not letting original findings serve as preconceived ideas in the process. Further, to engage in "… a playful movement between imagination and reality, between experiences of losing oneself and being absorbed by the rules of research" (Kinn et al., 2013, p. 1291). Consequently, the analysis will be substantially influenced by the vantage point of the authors, as also argued by Noblit and Hare (1988), stating that "…a meta-ethnographic synthesis reveals as much about the perspective of the synthesizer as it does about the substance of the synthesis" (p.14). It has therefore been important to focus on the reflexivity of the process, that is to be self-conscious about the research process, while being transparent about the steps of it (Sandelowski, 2006).

In performing this meta-synthesis, the goal has been to preserve meaning, and stay close to patients' phenomenological experiences when translating findings into a cohesive, new whole. Further, the goal has been to formulate distinctive and descriptive categories which can inform clinical practice and perhaps also processes of improving health care about what patients find helpful when engaging in therapy. Studies from a vast array of different therapeutic orientations, as well as in patient's diagnostic profiles have been deliberately included to identify common aspects in patient's experiences across, but also to potentially identify important nuances in understanding specific needs of patients. In doing so, this meta-synthesis potentially could allow for a broad understanding of answers to the research questions and might, in the same vein, meaningfully inform clinical practice across different therapeutic orientations.

In this study, what could be interpreted as a good or beneficial outcome has solely been indicated by the patient, directly or by inferring this from their statements. Quantitative measures, or qualitative findings alluding to therapist's understanding of the same has only

been considered supplemental, and no assessment of eventual discrepancies has been made in this analysis (but could be considered focus for other, subsequent analyzes). The interpretation of the concept of beneficial change rests therefore solely on patient's own understanding of this, or inferences drawn by the authors based on patient's statements.

Relevant information from eligible studies were plotted into Table A1 available in Appendix A and themes and categories identified from each study were plotted into Table A2 available in Appendix B. Some articles in the selection were based on data from participants from a single study. Consequently, they are considered and weighted as one study in the final selection. A synthesis of findings from across the same studies were performed before entered into the analysis along with the rest of the sample. From the 30 included articles 27 studies were identified.

Results

Study Characteristics

In this meta-synthesis 27 studies were included from 30 articles with a total number of 371 unique participants between the ages 18 and 79. Binder et. al. (2009, 2010), De Smet et. al. (2020; 2020) and Ekroll & Rønnestad (2017, 2018a, 2018b) based their articles on the same study and participants from these studies were therefore only counted once, except that participants in the study Ekroll and Rønnestad (2018a) were counted as unique participants as they were not reported in a way making it possible to distinguish whether they were some of the same participants drawn from the same sample as in the studies Ekroll and Rønnestad (2017, 2018b). 242 participants were females (65% of the total sample) and 97 were males (26% of the total sample). 32 participants' gender were not reported (9% of the total sample). Studies were conducted in Belgium, Canada, Germany, New Zealand, Norway, Sweden, The United Kingdom and The United States.

Participants in the included studies met a variety of diagnostic criteria, although some articles did not report diagnostic assessment of their participants. Diagnostic criteria and assessment included depression and anxiety symptoms and related disorders such as Major Depressive Disorder, Generalized Anxiety Disorder and Obsessive Compulsive Disorder. Furthermore, Post-Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, various eating disorders and personality disorders. Patients with various symptoms, problems and behaviors reported by themselves or others such as self-harm, relationship problems, existential problems, grief and loss, career concerns, low self-esteem, alcohol dependence, family difficulties, suicidal and self-harming behaviors and psychosis were also included. So were patients having suffered child sexual abuse, domestic violence and trauma. Patients having clinically significant scores on the Global Severity Index from Symptom Checklist-90 were also included.

Participants were subject to individual therapy under different approaches to psychotherapy, although not all articles reported psychotherapy orientation. Reported psychotherapy orientations across studies included Low Intensity Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Cognitive Analytic Therapy, Psychoanalytic Therapy, Psychodynamic Therapy, variants of intensive psychoanalytic therapy, Lacanian Psychoanalysis, Humanistic Therapy, Person-Centered, Existential Therapy, Solution-Focused, Gestalt, Dialectical Behavior Therapy, Motivational Interview, integrative therapy, Cognitive Analytic Therapy and Emotion Focused Therapy.

Research designs across studies included Interpretative Phenomenological Analysis, Content Analysis, Hermeneutical-Phenomenological, Consensual Qualitative Research, Grounded Theory, Inductive Content Analysis, Idiographic Analysis, Discourse Analysis,

Narrative Analysis, Template Analysis and Inductive Category Formation. A complete overview of study characteristics can be found in Table A1 in Appendix A.

This meta-synthesis identified similarities across studies in how patients experienced processes of change when going to therapy. The focus for this meta-synthesis was to investigate to what patients attributed change in psychotherapy processes and what they identify as changed. Therefore, findings were sorted into the two broad main themes "What Changed?" and "What Made Change Possible?" In total five sub-themes were constructed, grounded in the primary data presented in the original studies. From the main theme "What Changed?" two sub-themes were constructed: 1. A) "Improved Relationships with Self and Others" and 1. B) "Increased Acceptance". Under the main theme "What Made Change Possible?" three sub-themes were constructed: 2. A) "Co-Creating a Therapeutic Relationship Based on Trust, Connection and Collaboration", 2. B) "Committing to Change as a Gradual, Challenging, and Continuing Process" and 2. C) "Increasing Self-Awareness to Understand What Needs Changing".

In the following, themes identified in the meta-synthesis are presented. An overview of articles and how they were connected to the different themes can be found in Table A4 in Appendix D.

What Changed?

1 A) Improved Relationships With Self and Others

Patients across studies shared how therapy made them change relationships to themselves and others in beneficial ways. As a result, they reported achieving mental, emotional, and physical stability, thus increasing their ability to stand through challenges. Associated to this was an increased confidence in being able to cope with difficulties and flexibility in developing constructive ideas on how to face them: "I'm now stronger and

know more, and I see more clearly. I know I can manage my problems by myself, and that what you do depends on the situation" (Palmstierna & Werbart, 2013, p. 31). They expressed feeling better able to pick themselves up after setbacks, and more able to let go of debilitating thoughts and emotions: "I still sometimes go down in the cellar. The difference is that I do not stay there" (Binder et al., 2010, p. 290). Several patients expressed increased ability to utilize inner and outer resources in dealing with challenges in their lives:

> I'm much more creative now than I used to be. I spend a lot of time doing art work, or even if it's not something specific like that, like the way I do my job, the way I fix a meal, it's all much more creative. There's part of me that was clearly there before but that did not express itself. (Murray, 2002, p. 176)

Patients across studies also described engaging more in activities they found meaningful and in relationships they saw as good for them:

> I want to be myself and I really will not put any more energy into people who do not have good intentions. That's my motto for the moment: I'm not investing in things that will gain me nothing. I do not think that's selfish, but more like healthy selfishness. It means considering yourself as well. (De Smet, Meganck, De Geest, et al., 2020, p. 32)

Patients across studies expressed feeling better about adhering to their own needs, thus increasing their ability to negotiate relationships in beneficial ways. They felt better able to stand up for themselves and draw more beneficial boundaries within relationships, expressing thoughts and feelings more freely with others: "I've become better at telling people what I think, even when it's negative (…) or talk back (…) I've always been afraid to hurt or offend people, or afraid of their reactions (…) I'm not so afraid of that anymore" (Ekroll & Rønnestad, 2018b, p. 296).

Some patients expressed liking themselves better and increasingly compared themselves in more beneficial ways to others, including considering themselves more equal, rather than inferior, to them: “I think by the end or over the years I really began to realize that I did have a voice and that I was valuable and I absolutely had every right to express my feelings” (Toto-Moriarty, 2012, p. 843). Many patients developed more positive and secure views of themselves: “In some way it gave me some strength or some values for myself. It made me feel better about myself” (Marcus et al., 2011, p. 453). They expressed taking better care of and feeling more compassion toward themselves, thus feeling better able to relax, more positive emotions, less worry, and feeling less tired:

> I didn’t like open time where there was nothing planned. I would get restless and feel like I should be productive. But now I am okay with downtime, like to spend a Sunday in my sweats, stay at home and watch movies, I never did that before. It feels good because I feel calmer. I am definitely less tired than I was. (Khattra et al., 2017, p. 29)

1 B) Increased Acceptance

Patients across studies shared how engaging in therapy helped them increase acceptance of themselves, their emotions, experiences, and circumstances.

Several patients described how increased acceptance of various aspects in general made them feel more able to exist more presently in the moment, less judgmental about aspects within and outside of themselves: “I feel that I can accept things the way they are (…) it’s nice to think about it, that’s the way it is, and that’s ok” (Ekroll & Rønnestad, 2017, p. 459). Patients across studies shared how they increasingly tolerated own perceived flaws and shortcomings, consequently making them less strict and more forgiving of themselves:

> I had very high standards for myself and I was very, very upset when I didn't meet them. And then I realised that nobody is perfect, and I was not about to be the first one. It took me a long time to be able to say that, and really mean it. (Rodgers, 2002, p. 190)

Several patients described how they increased acceptance to aspects of their circumstances and life situation that they previously had a hard time reconciling with. They mentioned this in relation to aspects of their situation not likely to improve, such as declining conditions of their own or relatives' somatic health:

> I'm feeling less guilty about not doing enough. The therapist helped me realize that my [somatically ill] mother has lived a lot longer than me, and that I have my own life as well (…) I have gotten more used to her being the way she is. (Ekroll & Rønnestad, 2018b, p. 297)

Several patients described realizing many aspects in life to be out of immediate control, seeing greater complexity in reasoning about outcomes to events in life: "At work there are a lot of changes going on, and normally I would really try to sabotage them and fight against it but yeah I now just try to accept it" (De Smet, Meganck, De Geest, et al., 2020, p. 33). Several patients shared how they increasingly accepted experienced outcomes from life events, and accepted associated difficult thoughts and feelings as normal reactions to challenging events they had lived through, becoming more accepting of emerging feelings emanating from lived experiences:

> I guess my views of my family became more forgiving during treatment because when I entered treatment I was pretty angry at my mom, so that changed as a result of treatment seeing her more as a person who had reasons for doing the insane things she had done in my childhood. (Toto-Moriarty, 2012, p. 843)

Patients across studies shared how they became more accepting of a wider array of emotions. They allowed themselves to feel and express feelings they previously tended to avoid or try to push away, mentioning anxiety, anger, sorrow, and grief. They described how this helped letting these emotions pass and allowed them to move on:

> Finally, she said, do you think we should talk about this? As it got closer and closer, I would come in and start crying. But I think that taught me a lot. First of all, it stopped me from pushing everything away. And it helped me to deal with her leaving and grieve it and eventually understand that I can be really upset but that everything is going to be okay. (Toto-Moriarty, 2012, pp. 840-841)

Several patients described how difficult feelings had less impact on how they viewed themselves or how they anticipated future situations to be like: “Even though I’m feeling sad, I manage to keep in mind that I’m still a worthy person” (Ekroll & Rønnestad, 2017, p. 459). Some patients described how they to a lesser degree substituted unpleasant emotions with pleasant ones, such as forcing themselves to feel and appear happy, when harboring feelings such as sadness or grief. They described experiencing and expressing feelings more genuinely:

> My cheerful moments feel genuine now. Before I often played to be happy to hide my sadness. But now, if I feel sadness I can seclude myself for a while, but not uhm. It’s sincere happiness, it’s less exuberant as before, but you know, before it was fake, I would act crazy, play the “crying clown”. (De Smet, Meganck, De Geest, et al., 2020, p. 32)

One patient experiencing flashbacks from a traumatic event, described how reexperiencing these within therapy made for greater acceptance of these, consequently making them feel less intrusive and out of control:

> If a flashback happens, ok it's happened, but I've allowed, like I've kind of put myself through that anyway, and I've done it in my control and this isn't really that different (…) like I know that with the reliving I can stop at any point, so the flashbacks don't feel as uncontrollable. (Shearing et al., 2011, p. 465)

In allowing unpleasant feelings to stay present within them, not necessarily trying to push them away, patients described how this allowed for feelings to be thoroughly felt, without judgment:

> [When] your sad emotion is your enemy (…) you react to it with distance and you are like, "I don't want to cry." "(…) I want to get away from it (…)" [But if] you make friends with your emotions, then you are like, "Crying is okay." (…) It just has this really remarkable effect, in the sense that, you know, you are not running away from it. You are not angry at yourself for doing it. You are not trying to stop yourself and trying to hold back because that is who you are at the moment (…) I am happy to be with the crying cause that's what I need to do right now. (Levitt et al., 2006, p. 321)

What Made Change Possible?

2 A) Co-Creating a Therapeutic Relationship Based on Trust, Connection, and Collaboration

Patients across studies saw trust in the therapeutic relationship as central to their change process. They valued certain qualities in therapists making it easier for them to open up about their difficulties, such as therapists meeting them non-judgmentally, validating their thoughts, experiences and feelings. Across studies, patients considered mutual collaboration in the therapeutic relationship, working on common goals, as paramount in achieving changes.

Patients across studies described an initial phase of discomfort before gradually getting used to the therapeutic situation. They expressed doubt about whether they could trust their therapist, finding it difficult to open up to a stranger: “Yeah, she’d ask me questions like how have you been feeling this week and everything and stuff like that. It’s hard when you’re talking to a stranger and everything, it’s hard to say what you actually feel as well” (Bury et al., 2007, p. 86). At the same time, they found it helpful opening up to someone they did not share a relational history with, not feeling restricted by relational patterns developed over time:

> If you are talking to a family member or something like that, there is always those preconditions, you’ve got and you always, whereas in a sense if it’s a stranger (…) you have the ability to just, say what you’re thinking in a non-judgemental way, and I think, I think that’s really useful. (Amos et al., 2018, p. 574)

Patients across studies reported that their feeling of trust and being accepted increased when getting a sense that therapists heard them out, understood and met them in non-judgmental ways, for example when therapists helped them organize and clarify what they said: ‘‘The therapist put my ramblings into coherent sentences, so I felt like she got me and that was really nice’’ (Marcus et al., 2011, p. 454). Several patients appreciated therapists checking in on whether their understanding was in line with what they tried to express, rather than supposing so:

> I was really annoyed with her interpretation. I didn’t go back to her. It was very controlling telling me what my experience meant without me having any input into it. I thought she was arrogant, condescending, misguided, and she wasn’t listening to me at all really. Because, people can not like their jobs for valid reasons in the present, not because of some childhood trauma! (McGregor et al., 2006, p. 54)

For some patients trust increased when therapists retained and referred to information specific to them and expressed thinking of them outside of sessions. Several patients grew trust when therapists endured standing through difficult and uncomfortable therapeutic phases with them: "It's about developing that trust. I think for me the (…) the testing out was, if I fell apart, could [therapist] bring me back up, because I was frightened, I couldn't do it myself" (Rayner et al., 2011, p. 305). Patients with a history of abuse highlighted being particularly sensitive to whether therapists would harm them and be respectful of their boundaries:

> She became the security that I never had as a child. When she sat in her chair, and I was lying on the couch (…) I crumbled together on that couch, because I turned into the little girl when I came in there. She became my mother, in a way. The mother that I always had missed. But she should just be there, and never touch me. I was afraid of hands. (Binder et al., 2009, p. 253)

Furthermore, patients who had experienced trauma were sensitive to having their painful experiences genuinely validated by their therapists:

> I can remember starting to tell her about the pain when my grandfather was abusing me and how much he hurt me (…) There is physical pain for a little seven or eight year old girl–huge physical pain when she's sexually abused and that needed to be talked about (…) I said to her "It really, really hurt me" and she just shut off! She just shut off! I remember going home feeling quite distraught (…) weepy and feeling pretty disgusting because it hadn't been followed through and it's not something that's going to be picked up next week (…) I never brought it up again. (McGregor et al., 2006, pp. 50-51)

As patients across studies established a sense of trust, they felt like therapy could serve as a safe space to share thoughts and emotions they often had not shared with others, free of fearing repercussions. For many patients the therapeutic relationship represented previously unexperienced relational security and profound acceptance:

> (…) being able to share parts of myself that I was uncomfortable with and that had been met with all sorts of negative responses in my life, being able to share those in therapy, little by little, and have my therapist respond in a really accepting way, helped me to feel for the first time a deep sense that there were people who accept me. (Murray, 2002, p. 174)

With time, several patients felt trust enough to speak their mind more truthfully about the therapeutic relationship, such as in disagreeing with therapists, in reacting to therapists' responses, as well as in expressing genuine emotions toward therapists:

> I have grown as a person by attending therapy and having an alliance that allowed me to be openly angry and confronting towards the therapist, without feeling nervous. I've grown through experiencing that it wasn't dangerous to be so direct in my anger. Very important. I wouldn't have dared this without the alliance. (Ekroll & Rønnestad, 2018b, p. 296)

Patients across studies found it easier to share difficulties when feeling like their therapists was on par with them. Some expressed how being treated as a "patient" rather than an equal human being, impeded them from being open and honest with their therapists. For several patients, therapists' self-disclosure increased a sense of connection: "If she dares to open up to me, then it's easier for me to open up to her. She told me "It's like this, and I feel like (…) "(…) for me that's a trust thing" (Ekroll & Rønnestad, 2017, p. 455). Several patients expressed how a sense of connection with their therapists was important to invest

deeper in therapy: “I didn’t know that I could say, after one session or two sessions or even ten sessions (…) I think I need to see someone else because I’m not making any connection with you and I don’t think that it [therapy] is being very helpful” (McGregor et al., 2006, p. 44). In experiencing closeness and connection with therapists, some patients were motivated to develop the same in other relationships:

> I feel an enormous gratitude for having had this opportunity. For me it is to look back at an encounter with a very special person, and we came very close. It is a meeting where you come deep down in your emotions, and say [inside] ‘I am extremely grateful that I had the opportunity to meet this person, and I feel that this is a place where I need to go to again with others.’ What happened there was a kind of purification of myself that came from the inside. (Binder et al., 2010, p. 291)

One patient described how a sense of care from a therapist was experienced as too much, violating autonomy and privacy, negatively affecting the therapeutic relationship and process:

> I do feel bad because I feel like he kind of formed a relationship with me, but it was too much of a relationship (…) he cared about me too much (…) He really started taking things personally. He started calling me, like from home to check up on me and stuff like that (…) He thought of me as more like his child (…) he got a little too close to where he couldn’t be unbiased. He couldn’t be that person to listen to my problems (…) I do care about him, but I just, you know, it wasn’t helping. (Levitt et al., 2006, p. 320)

In trusting therapists and leaning into the therapeutic relationship several patients increased hope that their life could change for the better. They upheld motivation for change

when calling the therapeutic relationship to awareness, both between sessions and after ending therapy:

> It was the therapist that represented hope through all those years (…) during those periods when I had no hope myself (…) that it [the relationship] continued, without it being said (…) but you feel it (…) the strength that I feel has been there (…) and it still is there [after therapy has ended]. (Binder et al., 2009, p. 253)

In the therapeutic collaboration patients valued certain contributions from therapists. Patients across studies found it helpful when therapists helped to bring problems and experiences into focus, offered perspectives, helped define or redefine goals and served as a guides in discovering or rediscovering internal and/or external resources:

> She gave me ideas that led me into good directions, but I never felt like she gave me advice and tell me "This is what you need to do (…) " I think that it was helpful not to set a goal [for me] (…) That would have given me more of a sense of failure if I couldn't accomplish that goal or if I decided, "Well maybe that isn't the goal that I want to accomplish anymore," because my goals definitely changed. (Levitt et al., 2006, p. 319)

Patients across studies found it helpful when therapists flexibly met their needs along the way, e.g., in adding extra sessions in times of crisis, in challenging them when appropriate or in giving time to voice challenges: "[The therapist] also understood the importance of the fact that I needed to come to things myself (…) Even though she knew where I was going (…) she knew that it was important for her to sit there and let me come to them" (Levitt et al., 2006, p. 321). However, patients who had experienced trauma emphasized the need for negotiating clear boundaries in therapy. They wanted to feel like they were in control of when and how to express their traumatic experiences:

> It [the contract] was very clear, and I think that gives people a lot of power because a lot of people who suffer from any sort of abuse, they need to be told that they have the permission, to (…) interrupt, the permission to speak out, the permission to say "No" and permission to do what they think is right (…) [clients] need that (…) especially (…) [those who experienced] child trauma. (McGregor et al., 2006, p. 44)

Patients across studies thus considered trust as fundamental to the therapeutic relationship. They saw it as built incrementally over time, co-created with their therapists. Adjusting to the forum of therapy took time. Patients gradually mustered courage to speak their minds openly, and in feeling received and accepted by their therapists. Feeling an equal to, and ultimately a connection with their therapist made patients invest deeper in therapy. As such, patients across studies found mutuality within the therapeutic relationship central for working out goals and achieving them.

2 B) Committing to Change as a Gradual, Challenging, and Continuing Process

Patients across studies described therapy as a gradual and challenging process in which they increasingly committed to making changes, emanating from the therapeutic relationship. Most patients gradually realized what they could address in therapy, what they wanted to work on and how. Some patients felt confused and lost when not always knowing where to begin, what to say, or what to focus on. They experienced discomfort when uncertain of what therapy could be:

> I wanted to know what was going on. And I think a lot of that was I just didn't know what therapy was. I just, I didn't know what we were doing here. I didn't know where we were going. I wasn't against it because I didn't know about it. But I had a lot of questions. I had no clue how we were gonna go about solving my, you know, depression issues. I don't know how you do that. (Hoener et al., 2012, p. 70)

Some patients found it helpful to get information initially about what therapy would entail. They appreciated getting an outline of the process, preparing them for therapy to be a challenging, gradual and sometimes lengthy process, where they would be expected to be actively involved:

> I had no idea what it [therapy] involved and I kind of felt I was lost (…) I would have loved for her [first therapist] to have sat down and explained the process of counseling, what was expected of me, the fact that I was expected to do some work (…) and it would be painful at times (…) what she could do and couldn't do (…) that it can be a really lengthy process. (McGregor et al., 2006, pp. 43-44)

Most patients described their change process as progressing in small steps, rather than in big leaps. They expressed understanding gradually what their difficulties were and that their processes of change would take time: "It's like a weight being lifted of your shoulders, it's like a little bit lifted, and it was little bits at a time, each and every time" (Amos et al., 2018, p. 577). As their process unfolded, patients across studies gradually discovered how therapy could be of help, shifting perspectives on what could be important to work on along the way, for example when understanding how certain issues could be more important to work on than previously thought:

> Yeah, like knowing where to begin and like how to say it and what to say. It was just difficult. And then after about three or four weeks I finally started getting the hang of it I'd just say the first thing that came into my head. An event that might have happened a week or go or something that just popped into my head I'd just talk about it and say what happened. I might say how it made me feel and then it did take some time to get used to it. The first month I thought this isn't really going to help me at all.

> It's not doing anything, but I mean I did get used to it after it after a while, so. It was good. (Bury et al., 2007, p. 87)

Several patients believed confronting their difficulties would be hard and wanted to avoid sessions, as they could be experienced as exhaustive, overwhelming, discomforting, and painful. At the same time, most described feeling better and a sense of achievement for having gone through challenging experiences in therapy:

> Sometimes I was almost going to cancel and then at the last minute I'd get the determination and I thought just do it, get this done, you know, and I'd be running down here sometimes just because I needed to make it, and I'd come out and I was so proud that I'd done it. (Roddy, 2013, p. 58)

Some patients described how increased understanding of their problems was not enough to change. They described how they gradually committed to implementing changes in their daily lives, both during the time they went to therapy but also after it had ended. They described how they acquired insights, experiences, tools, and skills from therapy, necessary for implementing changes in their everyday lives:

> I also kept trying it in public, I mean I became more open in public, when meeting new people, I stopped always being the (…) wallflower in the group and started to go up to people, to men in this case, and talk to them and maybe drink a beer or whatever. (Wucherpfennig et al., 2020, p. 745)

Patients across studies also shared how they found it helpful engaging in a mutual collaboration, developing and working toward common goals with their therapist. They realized how taking responsibility for their own therapy process was fundamental for changing: "You don't just sit back and let it all happen, you know your therapist isn't going to wave a little magic wand and it's all going to be okay. It's working alongside" (Rayner et

al., 2011, p. 305). Several patients thus found it helpful to stay actively involved in their own change process, realizing the limits to what therapists could provide:

> The person who needs the therapy needs to exercise it themselves. It's like physical therapy – if you just sit there and let the person bend your arm, you're not going to get better. You have to build up your muscles and strengthen – it's like strengthening your mind and soul. You have to be involved in it; you have to care about yourself. (Hoener et al., 2012, p. 72)

As patients succeeded in implementing changes, several grew confidence and motivation to invest deeper in their change processes:

> Ok, um. I mean, it makes you feel like you accomplished something and you walk away from the session and you're able to take that with you and say, you know I did something today and you know, this is really awesome. I feel better, I can do something. I'm able to help myself, I've been able to help myself all this time (…) you get, you know, this new sense of, like, wow, I can do this. I'm pretty awesome. (Hoener et al., 2012, p. 74)

2 C) Increasing Self-Awareness to Understand What Needs Changing

Patients across studies shared how talking about, reliving, and reflecting on their challenges in therapy helped them better understand aspects of themselves that were sometimes not previously clear to them. They saw this understanding as an important vehicle for change, as they more readily could work out where they needed to go next in their process and understand more about what it would take to get there.

Patients across studies thus described how therapy helped them increase their ability to observe their own thoughts, feelings, and experiences. In doing so, they gained more clarity on thought patterns, attributional styles, emotional reactions, and behavioral

tendencies: “The difference is that I can now reflect logically, like “Whoops, I’ve done something to make this person angry. Have I just done something pretty stupid?” (Palmstierna & Werbart, 2013, p. 32). From this position patients better could work out what they needed changing: “The more we talked about what was that thought? Why did you think that way? I started seeing, oh okay, I can stop, look at it, slow it down, and try to reframe it” (Khattra et al., 2017, p. 29).

Patients described how they increased understanding of themselves in going through different therapeutic experiences, such as when therapists helped them connect and create new meaning from seemingly disparate experiences, as well as explored what emerged in the therapeutic relationship with them. In better observing themselves and their situation also outside of the therapeutic setting, patients across studies generated constructive ideas on how to act differently going forth:

> I am one of those who overly compensate. And, I didn’t realize I was doing it, and one day I brought her candy (…) She said, “See, you are doing it to me.” That was kind of like a true example. It was just like a turning point I think, because I really believed her because it was right there in front of me. (Levitt et al., 2006, p. 321)

Several patients described how internalizing a therapeutic dialogue was helpful in observing themselves in everyday life. Some “heard” their therapists’ voice in everyday situations helping them to question current thoughts, feelings, and impulses:

> I actually started hearing the questions [that the therapist made] in the back of my head, and that lasted throughout therapy (…) It still happens. So, when I experience situations where it is hard to make decisions, then I see the pattern where I always had to follow what others wanted me to choose. Then I hear, ‘‘Hello, what do you want?’’ (Binder et al., 2010, p. 290)

Patients described how increased ability to observe themselves ultimately gave more freedom to act differently on a moment-to-moment basis: "Instead of going with it, I stop and think, why is it that I'm tense now?" (Marcus et al., 2011, p. 453). Several patients described how they increasingly would monitor more and frequently assess their situation to recount intermediary changes:

> Every day I ask myself, what kind of a situation is this? Then I try to assess it. If it's affecting me, why is it affecting me, how is it affecting me? What are you going to do with it? How are you going to deal with it? (Wucherpfennig et al., 2020, p. 744)

Several patients described how observing themselves better over time made them better able to stake out long-term goals in their change process: "Pause and just recount what had happened during the week (…) and sort of to reflect on where I was at each point in my development" (Rodgers, 2002, p. 188).

Some patients expressed how an expanded understanding of themselves also made them feel like they understood more of other peoples' behaviors and reactions: "I think if you start understanding, how you're functioning, then you can, sort of appreciate how other people are functioning as well" (Rayner et al., 2011, p. 306).

Discussion

In the following, a summary of change processes from the standpoint of patients is provided. This serves as a superordinate interpretation of patients experiences of what changes and how change happens when engaging in psychotherapy, based in the overall findings of this meta-synthesis. This is followed by a section where we relate our findings to the field of psychotherapy research, and clinical implications are then suggested. Finally, methodological reflections as it pertains to this meta-synthesis are presented.

A Summary of Change Processes from the Standpoint of Patients

The process of change in going to therapy from the patient perspective can be summed up as: “Understanding where I came from, where I am and where I need to go”. In exploring and connecting past and current experiences patients expressed expanding perspectives on themselves and increasing their self-awareness. In doing so, they could more readily work out what they needed from therapy and in their lives, and which goals they wanted to move toward.

At the center of this change process was the therapeutic relationship, which patients saw as co-created together with their therapist. Patients expressed how they found trust to be the foundation of this relationship and saw it as built over time. Patients took time in easing into the therapeutic relationship and daring to express what was challenging. They highlighted how they found it easier to open up about their challenges when they felt like their therapist understood them and met them in a non-judgmental way, and validated their thoughts, emotions and experiences. Patients expressed how trust also was increased when therapists showed that they could stand through difficult phases of therapy with their patients and was experienced as genuine and on par with them.

Patients considered the therapeutic relationship to serve as a unique vantage point for exploring their experiences. As patient’s understood more of their own feelings, thoughts, and behaviors, they felt like they more readily could work out what needed changing. As patients’ self-awareness increased, needs and values appeared more tangible for them, allowing them to move in the direction of these. During therapeutic exploration patients saw their therapist serving as a guide, attuned their changing needs, providing perspectives and support, as well as representing hope in a process where they might feel disjointed. When patients expressed experiencing acceptance and connection with their therapists, they

engaged deeper in therapy and increased commitment to their own change process. Patients expressed valuing mutuality within the therapeutic relationship and saw it as a collaboration where they got qualified guidance to work out and work toward approaching goals. They also found it helpful to get an understanding of the process in advance, preparing them for it to be gradual, piecemeal, and challenging.

In engaging in therapy, patients expressed becoming more honest toward themselves and others. They also highlighted being better able to express needs and draw beneficial boundaries around themselves. Patients also expressed becoming more accepting of themselves, their experiences, and their own situation. When self-acceptance in patients increased, positive and more forgiving attitudes and feelings toward the self and others emerged. Patients highlighted how they became more confident in asserting themselves and to act in accordance with their own needs. Consequently, they expressed how mental, emotional, and physical stability increased, and fostered more beneficial ways of relating to themselves and others.

Findings in View of Psychotherapy Research

Patients in this study expressed wanting to feel accepted and understood by therapists and was wary of whether therapists were able to genuinely express that. Although they were seeking help from someone they could consider experts, they also wanted to meet someone they experienced as “real” and equal to them (Gelso, 2011). In this respect the findings are in line with the conceptualization of ‘the real relationship’ (Gelso, 2011), meaning a relationship based on genuineness and authenticity and where both participants have positive views of each other (Gelso, 2009). Patients reported that the genuineness that they had in the therapeutic relationship, in some cases even motived them to be more genuine in other relationships. Our findings suggest that patients experience this genuineness when therapists

are validating, caring, and non-judgmental, which could be considered expressions of empathy (Elliott et al., 2011; Klein et al., 2001; Norcross, 2002; Wampold, 2015b). Research indicates patients' experiences of whether therapists' responses are empathic to be highly subjective, some patients seeming to value cognitive empathic responses while others value more affective ones (Bachelor, 1988). Psychotherapy research has shown that there are many types of empathic responses (Elliott et al., 2011) that are suited for different patients, and also in different contexts within a treatment session with the same patient. Collectively, our findings might support the notion that patients need different kinds of empathic responses. Whether these are due to individual differences or changing needs at different stages of therapy is difficult to discern due to the current design of our study. Our findings, along with findings in other research, also suggest that therapists' self-disclosing might be considered empathic responses when openness of their own thoughts and feelings were experienced as genuine, and making patients feel like therapists' were equal persons (Gelso, 2011).

Empathic responses from therapists seemed to increase patients' trust in the therapeutic relationship and to motivate patients to express themselves more openly, thus bringing them deeper into their therapeutic process. This can be viewed in light of humans' innate need to belong, as humans learn about themselves, regulate their distress, and express who they are in a relational context and might be motivated to seek relationships and co-operation with others in times of distress (Baumeister, 2005). The therapeutic relationship can therefore also act as an antidote to loneliness, a risk factor for mortality equal to or higher than smoking, obesity and lack of exercise (Wampold, 2015b), and serve to motivate patients to seek connection with others outside of the therapeutic setting, as expressed by patients in our findings. The therapeutic relationship might furthermore be viewed as an attachment relationship, where the therapist serve as a safe base from where to explore and express

thoughts and emotions, and modify inner working models established in former attachment relationships, e.g., with caregivers (Bowlby, 1982). Several patients in this study expressed how they were being met and were able to express themselves within a caring, trusting relationship and how this might have served as a form of corrective emotional experience (Alexander, 1950), thus modifying existing inner working models (Bowlby, 1982).

Besides finding that patients wanted genuine and equal relationships, they also appreciated collaborative relationships for achieving their changes. Our findings suggest that a collaborative therapeutic relationship is one where therapists are seen as experts providing frameworks for patients to understand their difficulties. Therapists were helpful when they served as guides for patients to work out and work toward goals in how to meet their difficulties in new and more adaptive ways. Patients reported that they needed to experience that information provided by therapists was credible, which is related to the construct epistemic trust, whereby learning requires the willingness to adopt a relational stance of believing in what the other person communicates (Fonagy & Allison, 2014). Patients in our study highlighted how they found therapists credible when they seemed to convey insight and connection based in a profound understanding of them as persons, with the combined will to co-operate on working toward goals anchored in this understanding. Patients' experiences of needing a collaborative therapeutic relationship relates to the concept of a therapeutic alliance, on settling on therapeutic goals, the therapeutic task and the accompanying emotional bond that is created between the therapist and patient (Bordin, 1979). One meta-analysis suggest that the correlation between the therapeutic alliance measured early, namely in the third or fourth session, and outcome measures are at .27 (Horvath et al., 2011), even when you control for patient characteristics (Baldwin et al., 2007) such as attachment history (Del Re et al., 2012). While our findings are in line with research pointing to the significance

of the level of alliance early in therapy to understand change mechanisms in psychotherapy, our findings also contribute with important nuances by showing that there are many challenges for both parties in a therapeutic relationship, highlighted in the following.

Patients expressed wanting therapists who were able to provide frameworks or perspectives that they experienced as personally relevant and believable. Since the measurement of the therapeutic alliance only taps into patients' experiences of the relationship, it begs the question of how such a relationship is achieved. To obtain a genuine relationship and consensus on goals and task, therapists need interpersonal skills in listening and communicating their understanding in ways that patients accept. *Facilitative Interpersonal Skills* (FIS; Anderson et al., 2009) is likely to be essential in this process. FIS are subdivided into several underlying skills: verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and alliance rupture-repair responsiveness. FIS might be considered a way of measuring whether a therapist is real and genuine (Gelso et al., 2018; Rogers, 1977) which is tapped by the underlying skills of emotional expression, warmth, empathy. FIS also taps into therapists' skills at creating productive therapeutic alliances: verbal fluency, persuasiveness, hopefulness, alliance-bond capacity, and alliance rupture-repair responsiveness (Bordin, 1979). By exploring thoughts, feelings and behaviors, patients in our study expressed becoming more self-aware on how their difficulties manifested. The therapeutic relationship therefore serves as a safe space for patients to face what they usually avoid (Sullivan, 1956). Increased capacity to attend to inner experiences seemed important for developing and trying new and more adaptive ways to meet their difficulties. Different therapeutic models highlight different theoretical explanations of what patients need to become aware of as a base for change, from maladaptive cognitions (CBT; Beck & Beck, 2011), to inauthentic and incongruent

expressions of emotions and the self (Emotion-Focused Therapy; Greenberg & Goldman, 2019), to maladaptive relational patterns (Psychodynamic Therapy; McWilliams & Weinberger, 2003), and lack of self-observational capacities and how they contribute to psychological inflexibility (Acceptance and Commitment Therapy [ACT]; Hayes et al., 2013). Our findings cannot address the relative importance of the ingredients of different therapeutic models for patients change process, but could arguably be in line with the role emphasized of patients' increased awareness common across therapeutic traditions going back to Sigmund Freud (Goldfried, 2019), such as mentalization (Fonagy & Allison, 2014), psychological-mindedness (Beitel et al., 2005), and affect-consciousness (Solbakken et al., 2011).

Patients reported establishing consensus on goals and therapeutic tasks as challenging. They expressed needing time to understand what they wanted out of therapy and to commit to going through challenging processes. These findings are in accordance with the view that patients come to therapy with a sense that their psychological explanations of their difficulties are no longer adaptive and hope that they can work together with therapists in finding new ones (Wampold, 2007). The importance of therapists' ability to flexibly adapt their explanations, interventions and measures in ways that patients accept (Stiles et al., 1998), is highlighted by our findings. This supports findings of the importance of patients developing preferences, goals and getting in contact with needs for beneficial therapeutic outcomes (Swift & Parkin, 2017). Our findings indicate that patients needed to believe that they could do something about their difficulties in order to bring about change. Thus, the framework developed in collaboration with therapists must give patients a sense of agency, as it seems essential for increasing and sustaining patients' hope and positive expectations, found to be related to treatment outcomes (Constantino et al., 2011). This can furthermore be

seen in light of the concept of self-efficacy and how it is positively related to beneficial inter- and intrapersonal functioning (Bandura, 1997). Patients expressed finding it challenging to stay committed to the actual work of implementing changes. This highlights the importance of patients' willingness to engage in therapeutic work in a collaborative manner, rather than from a dependent position, in order to bring about beneficial changes (Bohart & Tallman, 2010).

Patients expressed that they wanted a therapeutic relationship that was genuine and collaborative, where they were able to construct an explanation of how to deal with their difficulties effectively. The importance patients in our meta-synthesis put on genuineness, trust and collaboration as mechanisms of change is in line with the contextual model (Wampold, 2007). In this model, the whole therapeutic context, consisting of the patient, the therapist, and the relationship, including its rituals and physical context, are considered important for bringing about change. This implies that psychotherapy might have some change mechanisms in common with other practices with the goal of healing, such as religious or indigenous practices. The similarity lies in the fact that an intimate relationship is created between two people where the active participation of each party is crucial, agreeing on how to understand the "illness". This shared understanding in itself causes expectations and positive changes. In contrast to the medical model, where the medicine is assumed to be the main solution to a desired outcome, the contextual model posits that the whole healing context produces beneficial outcomes. Patients in this study reporting that meeting genuine therapists able to nurture collaborative relationships underscores the many processes that work together holistically in psychotherapy. The contextual model therefore implies that the change mechanisms in therapy are based on the effects of many interacting variables

common across therapeutic traditions, namely common factors, of which at least 90 are presumed to exist (Grencavage & Norcross, 1990).

The contextual model proposes three pathways toward change: the real relationship, expectations and specific ingredients (Wampold, 2015b). The first pathway is through the real relationship, that is a relationship based on genuineness and accurate perceptions of each other (Gelso, 2011). The second pathway involves therapists giving patients new explanations for their difficulties that patients believe in (Constantino et al., 2011). This promotes positive expectations in patients and promotes therapeutic actions in them. The third pathway is the explanation provided by therapists which are regarded as ingredients. The contextual model can encompass any “ingredient” for patients’ difficulties within treatment methods, but states they are not end solutions to specific psychological deficits. The mechanism of change is rather that each treatment method, through persuasive explanations by therapists, provide a rationale patients can understand and accept, promoting change toward healthy behaviors.

Clinical Implications

One central implication from our findings is that therapists need to strike a balance between being experts and equal persons to their patients. As experts they need to provide structure for patients, while at the same time meeting them as human beings, with their unique aims, strivings and motivations.

Patients reported that they needed time to ease into the therapeutic relationship, some expressed needing more time than others, to find out what they wanted out of therapy. This implies that therapists should be mindful of the fact that patients hold a great deal of uncertainty about what they need and how to go about the process of engaging in therapy. Patients might benefit from therapists explaining how the therapeutic process works, prepare

them for the challenges and work needed, and give realistic outlines of what can be achieved in therapy.

From the therapist's perspective, the adjustments to patients needs also have to be reflected upon within the mandate provided by the health care system or the clinical context therapists are part of. Therapists have to find a balance between the interests of the systems they are a part of, e.g., a public health care system, for fast and efficient services and the patients developing processes to understand what they need changing. The issue is even more pressing today, where the duration of therapy courses globally seems to be decreasing (Olfson & Marcus, 2010).

Methodological Reflections

Although there might not be broad consensus around the adequate number of participants needed to conduct a thorough meta-synthesis, there seems to be agreement on the fact that investigations which are broad and explorative in scope benefits from a diverse and substantial sample (Finfgeld, 2003), as could be considered the case for this synthesis. With its total of 30 included articles of 27 studies, this meta-synthesis includes more studies than found to be the average for comparable meta-syntheses, namely 12 studies (Timulak, 2009). Some have claimed that too large samples might make for shallower analyses, as too broad and sweeping generalizations might be drawn (Kearney, 1998; Paterson et al., 2001). This could be considered a trade-off when aiming to identify commonalities across studies. Identified commonalities might have the power to make for more convincing conclusions, which for example might be better suited to sway decisionmakers (Finfgeld, 2003). On the other hand, context-specific information pertinent to making better informed decisions might then be overlooked, reducing overall utility of findings.

In this analysis, the authors decontextualized original findings to reconsider them under the pre-defined overarching foci of “What changed?” and “What Made Change Possible?”. This is one way important context-specific information may have been overlooked, and consequently not made sufficiently explicit in the findings. This could be considered ameliorated by the fact that certain aspects of unique patient populations’ backgrounds stood out in the material, such as patients with experience of trauma and physical abuse highlighting specific care and validation needs in their therapeutic relationships. Patients’ reports of iatrogenic experiences in therapy highlighting what should be sought avoided have also been included (e.g., lack of humility on the part of therapists).

In decontextualizing findings, the authors have not assessed whether original findings of studies are reciprocal or refutational, that is whether they could be considered comparable or opposing one another. This is called for pertaining to the analytic process in metaethnography, to build a more comprehensive and nuanced picture in the resulting analysis (Noblit & Hare, 1988). In this meta-synthesis, statements expressive of specific needs or negative therapeutic experiences have been considered alongside within categories, to ameliorate and explicate findings, serving to highlight possible hinderances in therapeutic change processes. Collectively, this made for important distinctions and nuancing in interpreting, presenting, and enhancing the specificity of findings. Considering different diagnostic criteria with the same research question could further help to identify unique needs and experiences related to these in future studies, e.g., in specific experiences and needs related to depressed or substance abuse patients.

Some would argue that whether a meta-synthesis has the right sample size also will become apparent during coding of statements, when authors might get a sense of saturation (Finfgeld, 2003). This was found to be the case during this analysis as statements largely fell

in line with defined categories when around 2/3 of patients' statements had been coded. No further measures were therefore taken to extend the selection of studies, e.g., in performing added purposive sampling. The authors decided to continue past this point of perceived saturation in the analysis and found that subsequent added statements did indeed contribute to the creation of substantial categories. Findings were further nuanced by added important and less frequently occurring statements on specific therapeutic needs and negative experiences for some patients after this point. In the author's opinion this also speaks for the value of adding findings into a meta-synthesis beyond the point of perceived saturation in an analysis.

Within the literature on meta-synthesis some researchers propose only interpreting findings that can be considered based in the same epistemological tradition, to preserve what is unique to the theoretical underpinnings of these and what they bring into focus. Some highlight how this can be difficult to do right, and express concern about the risk of misrepresenting findings from original studies if mixing epistemological traditions within the same analysis (Estabrooks et al., 1994; Jensen & Allen, 1996). Others see this as an unnecessary consideration, and view including studies from a wide range of epistemological traditions as a source of strength to the analysis, as they can be considered to complement each other, e.g. as argued in the study by Field and Marck (1994). Some argue that this can serve as a way of triangulation, and thereby increase credibility of findings when supported by a rich variety of original data to support interpretations, as when original statements are provided alongside (Lincoln & Guba, 1985). Mindful of the possible limitations highlighted in this debate, the authors have tried to ameliorate this by striving for transparency about their process. In addition, original statements are of course accessible for the reader to look up in the original studies, and those that are quoted in the results section remain verbatim to the way they were presented in the original studies.

For this meta-synthesis, the authors have engaged in an exploratory process, putting patients' statements at the center. The goal has been to let definition of categories be substantially informed by original statements of patients. The authors have strived to remain open and to use creativity in seeing connections and finding meaning across findings. Discerning descriptions of products of change, that is, what changed, from descriptions of how change happened, proved challenging. At the same time, it also turned out to be a fruitful separation as it instigated reflections on central questions pertaining to patients experiences of engaging in change processes, how therapy can be understood as a cultural process and values attributed to therapy as an endeavor. The authors did not always agree on what category to place patients' statements, e.g., on where to put statements indicating increased self-understanding or self-awareness. Increased self-awareness could be considered both prerequisite for change and a result of therapeutic work. Furthermore, the authors were often struck by the fact that many statements could fit in more than one category, but ultimately decided to sort them in only one to keep categories as non-overlapping as possible. It enlightened the authors to the fact that their study object was fuzzy, and that the construction of categories might reduce complexity of findings.

Reflexivity

In reflecting on the process, the authors have tried to be open about potential influences on their interpretations and categorizing of patient statements, and subsequently what narratives they were drawn to in interpreting data. The authors have tried to excavate pertinent information from their backgrounds and theoretical interests which might have affected them in the analytic process.

Both authors have grown up in a middle class setting, one in a primarily Norwegian household, the other in a Norwegian/Vietnamese household. This might have influenced the

authors to interpret data from the standpoint of the middle class, overlooking variables, or not striving to seek out more data, pertaining to experiences of patients from other social strata. Both authors also have experience in working within the Norwegian Mental Health Care system. This might have elevated their sensitivity to interpret data in view of the author's perceived flaws and limitations within the system, as e.g., in seeing it as being subject to suboptimal time- and resource constraints for patients engaging in therapy.

Also, reflecting on how the authors constructed their findings they see how their own clinical leanings might have been important for how they judged patients´ statements as "high" quality. Both authors are interested in many of the same treatment methods, namely those that could be considered relationally founded, such as Intensive Short-Term Dynamic Therapy (see, e.g., Davanloo, 2000), humanistic approaches with the Rogerian condition (see, e.g., Rogers, 1957) and Emotion-Focused Therapy (see, e.g., Greenberg, 2010). The authors also are inspired by Buddhist teachings and philosophy as well as third wave cognitive treatment paradigms (Hunot et al., 2013) such as ACT (see, e.g., Hayes et al., 2013). These backgrounds might have influenced the authors to emphasize the therapeutic relationship as central for changes, and to see self-observational capacities, considered an extension of mindfulness, as important vehicles to and products of change. The influence from ACT might also be directly apparent in that two of our findings highlight the concepts of "accept" and "commitment" as important variables in patients' change processes.

In the process of coding statements, the authors strived to let patient statements and the way they expressed their experiences lead the way. At several points in this process the authors reminded themselves to let this be the guiding principle, to avoid categorizing findings based in established professional terms, and to use language close to patients' expressions throughout the process. The authors see that even at this level, their background

and theoretical leanings could have impacted on what was considered comparable and expressive of the same phenomena. At the same time, the authors did not directly code statements based in any pre-defined theoretical framework and held categories on every level of the analysis free of jargon associated with established professional concepts, all the way up to the defined overarching themes. In reporting findings, the authors also strived to let a wide selection of patients' statements inform descriptions of categories for the reader to assess, to balance and make apparent for the reader how the authors considered statements to be expressive of and exemplifying descriptions. What studies informed the different themes of this meta-synthesis are also available for readers in Table A4 in Appendix D. Themes identified in the original studies are presented in Table A2 in Appendix B. The authors also frequently discussed findings with their supervisor who was not directly involved in the day-to-day immersive process of the analysis. She challenged the authors to refine and further explicate findings and brought attention to inconsistencies and unclear aspects in the presentation of them.

The authors are mindful to the fact that their way of performing a meta-synthesis was just one of several possible, and that their backgrounds and professional vantage point necessarily influenced on their findings. Within the field, a multitude of approaches to meta-syntheses collectively will contribute to increase the knowledge base. Other meta-syntheses on the same subject should therefore be welcomed, as comparisons and investigations into differences across syntheses further could increase understanding within a complex field.

Limitations

In analyzing data, variables pertaining to patients, such as gender, age or cultural background were not taken into consideration. Potential differences in patient experiences on a group level associated with these variables were therefore not explored. Also, the total

sample contained an overweight of female participants (65%) and all studies included were performed in Western countries with an assumed overweight of participants from Western cultures (no accurate calculation of this was made possible as ethnicity were only reported happenstance across included studies). This further limit transferability of the findings across populations and cultures. Also, variables pertaining to therapists were not assessed and accounted for in interpreting how e.g., therapy orientation or length of therapist experience might have affected patients' experiences of psychotherapy. In this sense, it might be difficult to tell whether some of the variation in patients' experiences were due to variation in patients' preferences or variables pertaining to therapists or therapeutic methodologies. The current study design also entailed including studies of patients engaging in individual therapy, to make able comparisons of somewhat similar experiences pertaining to the mode of therapy. This limits the transferability of this study's findings to individual therapies, excluding experiences from other modes of therapy, such as group-, family-, or couples' therapies. Further, this study's design did not include quantitative measures (e.g., from studies with mixed method designs). Considering quantitative measures alongside our findings, e.g., in comparing quantitative measures on good outcomes in therapy considering qualitative interpretations of the same, could increase convergent validity, but was decided beyond the scope of this study.

Strengths

The authors have tried to answer to findings in the literature that several studies fail to adequately account for search and sampling strategy (Bondas & Hall, 2007; Dixon-Woods et al., 2005). Great care has therefore gone into providing transparency regarding search strategy, the analytical process, and how original articles contributed to the reported thematic structure. A broad literature search was performed for this meta-synthesis, with a search

strategy aiming to increase likelihood of finding relevant studies. The search strategy diversified ways of finding the right studies and was developed with a librarian with long experience in developing viable search strategies within the research field of psychology.

In presenting findings, the authors have tried to be as jargon free as possible to achieve a presentation as close to patients' phenomenology as possible. Furthermore, to engage with the original data with a "readiness" to draw comparisons on a deeper level, also with what might appear seemingly unrelated at first, anchored in and presented with patient statements (Shotter, 2011). The authors have worked alongside and deeply immersed themselves in the analytic process and drawn on each other's creativity and discussed until consensus to further strengthen validity of findings. They have also co-operated closely with their supervisor who has elaborate experience in performing meta-syntheses. She oversaw the process, served as a critical gaze, and steadily tutored the authors in the method of meta-synthesis.

The authors also have tried to strike a balance between merely reporting findings and finding a "whole", which have been highlighted as lacking in many meta-syntheses (Thorne, 2017). In this the authors sought to interpret patients' statements and present findings in such a way that commonalities and pertinent nuances across was made apparent, as well as rich and concise descriptions both on an ordinate level with the presented sub-categories and in the summarizing interpretation on a superordinate level. This could be considered in line with the tradition of metaethnography as a way of analysis, which includes a lines-of-argument synthesis after a reciprocal translational analysis and refutational synthesis has been performed (Edwards & Kaimal, 2016). In this, an overarching interpretation of the findings from across created categories was made, to enhance the practical utility, in e.g., informing clinical practice and to inform policy making on a system level.

Conclusion

This current meta-synthesis analyzed 30 articles reporting on the patient perspective on change and change mechanisms in individual psychotherapy. Findings indicate that patients view the therapeutic relationship as central for exploring themselves and expanding their self-awareness. Patients expressed how these processes facilitated their understanding of what needed to change and in which direction they wanted to move in their change processes. They highlighted trust as an important foundation for the therapeutic relationship and emphasized how they needed time to build this. Furthermore, they expressed how they viewed mutuality and co-operation within the therapeutic relationship as vital to invest deeper in their therapy process and in committing to making changes. Patients highlighted increased mental, emotional, and physical stability as well as increased acceptance of themselves, their experiences, and their own situation as central outcomes of change processes when engaging in psychotherapy.

This study highlights important factors for facilitating beneficial conditions for psychotherapy, including sufficient time for patients to build trust and a co-operative relationship as one central condition for bringing about beneficial change processes in psychotherapy.

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Appendix A

Table A1

Characteristics for Articles Included in Meta-Synthesis

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
Amos et al. (2018)	Clients' experiences of one-to-one low-intensity interventions for common mental health problems: An interpretative phenomenological analysis	F=4, M=4	Interpretative phenomenological	Low-intensity Cognitive Behavioral Therapy intervention for anxiety/ depression	Levels of depression and anxiety		White British=7 Caribbean=1	United Kingdom
Binder et al. (2009)	Why did I change when I went to therapy? A qualitative analysis of former patients' conceptions of successful psychotherapy	F=9, M=1	Phenomenological, content-analysis	Cognitive Behavioral, intensive psychoanalytic, undefined	Anxiety attacks, compulsive rituals, dysthymic mood, stuck in behavioral patterns	27-61		Norway

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
					experienced by patients or others as problematic			
Binder et al. (2010)	What is a ‘‘good outcome’’ in psychotherapy? A qualitative exploration of former patients’ point of view	F=9, M=1	Hermeneutical-phenomenological	Cognitive Behavioral, intensive psychoanalytic, undefined	Anxiety attacks, compulsive rituals, dysthymic mood, stuck in behavioral patterns experienced by patients or others as problematic	27-61		Norway
Bury et al. (2007)	Young people’s experiences of individual psychoanalytic psychotherapy	F=4, M=2	Interpretative phenomenological analysis	Individual psychoanalytic	Depression, eating disorders, self-harm, behavioral difficulties, relationship and	17-21		United Kingdom

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
					emotional problems			
Chui et al. (2020)	Therapist–Client Agreement on Helpful and Wished-For Experiences in Psychotherapy: Associations With Outcome	F=9, M=9	Consensual qualitative research	Psychoanalytic/ Psychodynamic, Humanistic/ Existential, Cognitive Behavioral	Depression, anxiety, relationship problems, meaning in life, grief, loss, career concerns	Mean = 29.22	European American=12 African American=3 Asian American=2 Biracial=2	USA
De Smet et al. (2019)	No Change? A Grounded Theory Analysis of Depressed Patients' Perspectives on Non-improvement in Psychotherapy	F=12, M=7	Grounded theory	Cognitive Behavioral, Psychodynamic	Major Depression Disorder	21-59	Belgian=18 Dutch=1	Belgium
De Smet, Meganck, De Geest, et al. (2020)	What «Good Outcome» Means to Patients: Understanding Recovery and Improvement in Psychotherapy for Major Depression	F=18, M=10	Grounded theory	Cognitive Behavioral, Psychodynamic	Major Depression Disorder	20-60		Belgium

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
	From a Mixed-Methods Perspective							
De Smet, Meganck, Truijens, et al. (2020)	Change processes underlying "good outcome": A qualitative study on recovered and improved patients' experiences in psychotherapy for major depression	F=18, M=10	Grounded theory	Cognitive Behavioral, Psychodynamic	Major Depression Disorder	20-60		Belgium
Dulsster et al. (2019)	Lacanian Talking Therapy Considered Closely: A Qualitative Study	F=4, M=2	Interpretative phenomenological analysis	Lacanian psychoanalysis	Various	23-59		Belgium
Ekroll and Rønnestad (2017)	Processes and changes experienced by clients during and after naturalistic good-outcome therapies conducted by	F=10 M=6	Inductive content analysis, Grounded theory	Humanistic, Existential, Psychoanalytic/ Psychodynamic, Cognitive Behavioral	Various, mostly depression	Mean = 39.00		Norway

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
	experienced psychotherapists							
Ekroll and Rønnestad (2018a)	Exploring Associations Between Therapy Factors and Post-therapy Development After Naturalistic Psychotherapies	32	Inductive content analysis, Grounded theory	Humanistic, Existential, Psychoanalytic/ Psychodynamic, Cognitive Behavioral	Various, mostly depression			Norway
Ekroll and Rønnestad (2018b)	Pathways towards different long-term outcomes after naturalistic psychotherapy	F=10, M=6	Inductive content analysis, Grounded theory	Humanistic, Existential, Psychoanalytic/ Psychodynamic, Cognitive Behavioral	Various, mostly depression	Mean = 39.00		Norway
Falkenström et al. (2007)	Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy	F=15, M=5	Idiographic analysis	Psychoanalysis, long-term	Measures of GSI from SCL-90	Mean = 42.70 (psycho-analysis) and 42.30		Sweden

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
						(long-term)		
Hoener et al. (2012)	Client experiences of agency in therapy	F=6, M=5	Grounded theory	Cognitive Behavioral, Exploratory, Dialectical Behavior	Eating disorders, Borderline Personality Disorder, suicidal and self-harming behavior, Post-Traumatic Stress Disorder, mood and anxiety disorders	18-23	American Caucasian=9, half Caucasian and half Puerto Rican=1, European (Spanish)=1	USA
Khattra et al. (2017)	Client Perceptions of Corrective Experiences in Cognitive Behavioral Therapy and Motivational Interviewing for	F=2	Grounded theory	Cognitive Behavioral, Motivational Interview	Generalized Anxiety Disorder	28-53	Caucasian=2	Canada

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
	Generalized Anxiety Disorder: An Exploratory Pilot Study							
Levitt et al. (2006)	What Clients Find Helpful in Psychotherapy: Developing Principles for Facilitating Moment-to-Moment Change	F=20 M=6	Grounded theory	Various	Problems concerning familial issues, assertiveness, depression, rape, anxiety, anger, Attention Deficit/ Hyperactivity Disorder, eating disorders	18-79		USA
Lilliengren and Werbart (2005)	A Model of Therapeutic Action Grounded in the Patients' View of Curative and Hindering Factors	F=19 M=3	Grounded theory	Psychoanalytic	Depression, Anxiety, various personality disorders	Avg= 22.50	Swedish=18, Adopted to Sweden from Asia=1, Scandinavia= 1, Asia=1,	Sweden

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
	in Psychoanalytic Psychotherapy						Latin-America=1	
Marcus et al. (2011)	Client experiences of motivational interviewing for generalized anxiety disorder: A qualitative analysis	F=6 M=2	Grounded theory	Motivational Interview	Generalized Anxiety Disorder	27-62	European=3, Latin-American=3, South-Asian=2	Canada
McGregor et al. (2006)	Therapy for Child Sexual Abuse: Women Talk About Helpful and Unhelpful Therapy Experiences	F=20	Grounded theory		Childhood sexual abuse	26-57	New Zealand Europeans=13, Maori=6, Samoan=1	New Zealand
Messari and Hallam (2003)	CBT for psychosis: A qualitative analysis of clients' experiences	F=1 M=4	Discourse analysis	Cognitive Behavioral	Psychosis	28-49	White British=2, Black African=1, Afro-Caribbean=1, White Irish=1	United Kingdom
Murray (2002)	The Phenomenon of Psychotherapeutic	F=6 M=1	Phenomenological					USA

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
	Change: Second-Order Change in One's Experience of Self							
Palmstierna and Werbart (2013)	Successful psychotherapies with young adults: an explorative study of the participants' view	F=9 M=2	Grounded Theory	Psychoanalytic	GSI from SCL-90 exceeding mean for Swedish non-clinical sample of young adults	Mean = 22.00		Sweden
Rayner et al. (2011)	Clients' experience of the process of change in cognitive analytic therapy	F=8 M=1	Grounded theory	Cognitive Behavioral case formulation	Depression, psychosis, low self-esteem, Post-Traumatic Stress Disorder	25-60	White British or Irish=9	United Kingdom
Roddy (2013)	Client perspectives: The therapeutic challenge of domestic violence counselling – a pilot study	F=4	Narrative and Grounded theory	Person-centered, Psychodynamic, Integrative, Cognitive Behavioral	Victim of domestic violence	30-50	White British=4	United Kingdom

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
Rodgers (2002)	An investigation into the client at the heart of therapy	F=4 M=5	Grounded theory	Psychodynamic, Person-Centered, Solution-Focused, Gestalt	Relational and marital problems, family difficulties, depression, anxiety, stress	21-72		Scotland
Shearing et al. (2011)	How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder?	F=6 M=1	Interpretative-phenomenological	Trauma-Focused Cognitive Behavioral	Post-Traumatic Stress Disorder - single event trauma	20-50	White British=4, Afro-Caribbean British=3	United Kingdom
Shine and Westacott (2010)	Reformulation in cognitive analytic therapy: Effects on the working alliance and the client's perspective on change	F=4, M=1	Template analysis	Cognitive Analytic	Anorexia, depression, alcohol dependence, bulimia, depressions, Post-Traumatic Stress	22-63	White British=5	United Kingdom

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
					Disorder, anxiety, low self-esteem			
Toto-Moriarty (2012)	A retrospective view of psychodynamic treatment: Perspectives of recovered bulimia nervosa patients	F=14	Grounded theory	Psychodynamic	Bulimia nervosa	22-46		USA
Westra et al. (2010)	Therapy was not what I expected: A preliminary qualitative analysis of concordance between client expectations and experience of cognitive-behavioural therapy	F=14 M=4	Grounded Theory, Consensual Qualitative Research	Cognitive Behavioral	Generalized Anxiety Disorder	21-59	European=9, Caribbean=4, Arab=1, Filipino=1, Jewish=1, Latin-American=1, South-Asian=1	Canada
Wucherpfennig et al. (2020)	What sticks? Patients' perspectives on treatment three	F=14 M=16	Inductive Category Formation	Cognitive Behavioral augmented with Emotion-	Major Depression Disorder, Obsessive	18-62		Germany

Article	Title	N	Method for Data Analysis	Psychotherapy Orientation	Diagnostic Assessment	Age	Ethnicity	Study Country
	years after psychotherapy: A mixed-methods approach			Focused and Interpersonal elements	Compulsive Disorder, Dysthymia, anxiety disorders, adjustment disorders			

Note. Abbreviations: Avg=average, F=Female(s), M=Male(s), GSI=Global Severity Index, SCL-90=Symptom Checklist-90.

Appendix B

Table A2

Themes and Categories from Original Articles Included in Meta-Synthesis

Article	Relevant Themes/Categories
Amos et al. (2018)	Goals and expecatation of therapy • Individual goals for therapy • Diverse expectations of therapy • Stigma Beneficial aspects of therapy • Talking as beneficial • Sufficient time for therapy • Personal therapeutic approach • Normalization Non-beneficial aspects of therapy • Insifficient time for therapy • Non-personal therapeutic approach Experience of psychological change • Change as gradual • Change as continuous • Gaining perspective • Idiosyncratic approaches to dealing with problems
Binder et al. (2009)	Having a relationship to a wise, warm and competent professional Having a relationship with continuity, safety and hope when feeling inner discontinuity Having beliefs about oneself and one's relational world corrected Creating new meaning and see new connections in life patterns
Binder et al. (2010)	Establishing new ways of relating to others Reduction in symptoms or change in patterns of behaviour that used to bring suffering Better self-understanding and insight To accept and value oneself
Bury et al. (2007)	Seeking help and engagement • Being in difficulty • Feelings about referral and stigma • Expectations of therapy Beginning therapy • Mixed feelings • Therapist's response The therapeutic process • Learning the ropes

Article	Relevant Themes/Categories
	• Facilitative aspects • Power Endings • Ambivalence • Feelings of separation and loss • Moving on
Chui et al. (2020)	Helpful aspects of therapy: Client perspective • Therapists being supportive, validating, and affirming • Therapists offering new perspectives, including the connection between previous and current relational patterns • Therapist's facilitating an exploration of the therapeutic relationship, including helping clients explicitly talk about their feelings about the relationship • Therapists' challenges • Therapist self-disclosure
De Smet et al. (2019)	Core Category: Stuck Between "Knowing vs. Doing" Positive changes • Mental stability and personal strength • Insight Facilitating factors • Therapy offers self-reflection and guidance • Benevolent therapist approach • The context as an important impetus Remaining issues • Ambition to change • Inability to change Impeding Factors • Therapy hits its limits • The patient's resistance and impossibility • The context as a source of distress
De Smet, Meganck, De Geest, et al. (2020)	"Good outcome" Contains Experiences of Empowerment, Finding Personal Balance, and Ongoing Struggle • Experiencing outcome: Improvement and/or remaining difficulties indicate an ongoing process and variety in experiences • Feeling empowered, finding personal balance, and ongoing struggle • Feeling empowered • Increased self-confidence • Emancipation • Obtaining new coping skills • Finding personal balance

Article	Relevant Themes/Categories
	• Interpersonal harmony • Insights and self-understanding • Feeling calmer • Ongoing struggle
De Smet, Meganck, Truijens, et al. (2020)	Main Factor I: Psychotherapy's Stimulating, Relieving yet Unclear Role • An empowering (inter)active process • Uncertain effects: insufficient, combined or unclear process Main Factor II: Patient's Helping and Hindering Involvement Main Factor III: The Therapist's Predominantly Fuelling Approach Main Factor IV: Facilitating and Impeding Extra-therapeutic Influences
Dulsster et al. (2019)	"I experienced a surprising reframing" "I learnt about myself by hearing my own speech" "I met someone who really listened to what I said" "I see myself in a new light" "I started to wonder what I really want"
Ekroll and Rønnestad (2017)	Types of processes reported by clients • Relational aspects • Relational quality • Relational form o Therapist personally involved o Active therapist o Neutral therapist o Supportive therapist o Challenging/confronting • Procedural aspects • Therapeutic operations o Expert interventions o Monitoring progression o Exploration o Working with affects o Other interventions • Expectations challenged • Processes after termination • Processes not directly linked to therapy • Post-therapy processes o Therapy process continues o Working with others o Client carries something from therapy Types of changes reported by clients

Article	Relevant Themes/Categories

	• Conditions for change
	• Role engagement
	• Intermediate changes
	• Cognitive change
	  o Ways of thinking
	  o More understanding
	• Affective/experiential change
	  o Better regulation of affects
	  o More awareness/sense of self
	• Attitudinal change
	  o Changed attitudes
	  o Normalization
	  o Accepting "reality"
	  o More open
	• Interpersonal change
	  o Self-other adjustments
	  o Benefiting from others
	• Other intermediate changes
	  o More autonomy
	  o More empowerment
	  o Catharsis/relief
	Outcome
	• Explicit outcome
	  o Symptom reduction
	  o More positive affect
	  o Improved interpersonal relations
	  o More positive self-concept
	  o Changed behavior
	• Situational changes

Ekroll and Rønnestad (2018a)	Themes Recurrently Associated with Post-therapy-movement • Therapeutic bond • Active therapist • More positive affect • Therapy not complete
Ekroll and Rønnestad (2018b)	Possible pathways towards different long-term outcomes • Reflective route towards regulation of affects • Gaining autonomy through a secure holding relationship • Opening up as a new relational/emotional experience • Lasting acceptance of reality • Residual problems grow and overshadow progress • Core problems remain beneath superficial change

Article	Relevant Themes/Categories
Falkenström et al. (2007)	Post-treatment Practice on Problematic Patterns Identified in Treatment Self-analysis Self-supporting Strategies Other Causes of Continuing Development
Hoener et al. (2012)	Doing the work Being informed Clients may experience agency differently in different approaches Clients may value agency for empowerment and accomplishment Experience in therapy differed from expectations Experiences of compromised agency
Khattra et al. (2017)	Client-Identified Shifts in Therapy • More adaptive interpersonal relationships due to therapy o Experiencing old interpersonal patterns with a new outcome in the therapeutic relationship o Increased independence in interpersonal relationships • Positive shifts in the experience of anxiety o New awareness about the nature of anxiety: From feeling stuck in a box to expanded perspectives o Change in anxiety-related behaviors that are observable in everyday life: Feeling more calm and present centered • Feeling a sense of hopefulness about changes accomplished in therapy o Feeling confident in sustaining progress accomplished in therapy through reliance on inner self-efficacy o Feeling confident in sustaining progress accomplished in therapy by learning and applying CBT tools Clients Accounting How Shifts Occurred in Therapy • Therapist's positive role in facilitating shifts in therapy o Therapist as an expert and guide in therapy o Positive therapeutic relationship enhanced therapy experience • New intrapersonal and interpersonal awareness derived from therapy o Insight into previously unacknowledged thoughts and emotions in therapy o Self-realization to give priority to one's own needs before others: Shift from other focused to self focused • Learning helpful CBT exercises and tools to manage anxiety on an everyday basis o Muscle relaxation exercises useful in recognizing bodily tension o Thought records helpful due to their practical value in organizing anxious thoughts in stressful situations

Article	Relevant Themes/Categories
Levitt et al. (2006)	Commitment to Therapy: Honesty Is Negotiated for Success The Therapy Environment as a Reflection of Therapists' Care Out-of-Session Processing: Structuring Transitions Between Worlds The Therapeutic Relationship: Building Trust That Self-Exploration can Be Sustained, Even in the Face of Threat Therapist Characteristics: Caring the Right Amount yet Providing Firm Direction When Needed Therapeutic Intervention: Structuring a Focus in Which to Encourage Reflexivity and Client Self- Discovery 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 and Werbart (2005)	Talking About Oneself Talking Is Difficult Having a Special Place and a Special Kind of Relationship New Relational Experiences Exploring Together Expanding Self-Awareness Self-Knowledge Is Not Always Enough Something Was Missing Experiencing Mismatch
Marcus et al. (2011)	I Have Direction, Momentum, and Motivation • I've changed o Increased awareness o I feel much better o I'm dealing with things differently now o I still have things to work on • I'm different with others now • I'm motivated o I need/want to change o I'm looking forward to further treatment o I'm committed to therapy The Therapist was Understanding and Warm • She was really with me o She really got me o She helped me to understand o She guided me • She was caring, warm, and nonthreatening • She made me feel comfortable It was Safe to Open Up and Explore • It was safe to open up o I felt free to express myself

Article	Relevant Themes/Categories
	○ I expressed painful, hidden emotions • The process of therapy was really helpful • Therapy really got me thinking • Some things in the process could have been better MI Wasn't What I Expected • At first, I was nervous about the process. • I didn't know what to expect and was pessimistic at first • I thought I would be told what to do • I didn't think it would help as much as it did • I had positive expectations
McGregor et al. (2006)	Establishing a Therapeutic Relationship • Being given information about the process of therapy • Experiences of equality in the therapeutic relationship • Experiences of rapport and being listened to • Effective assessments Talking about experiences and effects of CSA (Childhood Sexual Abuse) • Therapists were knowledgeable about abuse-focused therapy • Therapists were able to normalize the effects of CSA • Therapists were able to listen to accounts of CSA • Therapists provided client-directed therapy Dealing with Errors in Therapy • Therapists being passive • Therapists exaggerating their objectivity • Therapists misinterpreting meaning • Therapists being angry Overall assessments of therapy
Messari and Hallam (2003)	CBT as a healing process CBT participation as compliance with the powerful medical establishment CBT as an educational process' (educational discourse) CBT as a respectful relationship between equals' (friendship discourse) This is truly happening I am ill Contradiction between "This is truly happening" and "I am ill" discourses
Murray (2002)	Transedence of Relationship to Self • Self-Acceptance • Personal Power • Inner Peace

Article	Relevant Themes/Categories
	Therapeutic Experiences that Facilitated Transcendence • Instruction in Self-Reflection • Corrective Emotional Experience • Catharsis • Uncovering the Self Collateral changes • Natural Congruence • Relationship With Others • Sense of Well-Being • Spiritual Transformation • Creativity
Palmstierna and Werbart (2013)	Core category: a growth-promoting and secure relationship • In-therapy factors o Appreciating the therapist's way of working o Appreciating the therapeutic relationship o Feeling safe due to continuity and therapeutic frames o Experiencing obstacles in therapy o Overcoming obstacles in therapy • Helpful factors in the patient's everyday life o Getting support outside of therapy o Getting support in close relationships • Positive impacts and experienced changes o Managing strains in life o Feeling stronger and more confident o Becoming reconciled with oneself and one's past o Acting differently o Reflecting and gaining insight o Applying experiences from therapy after termination
Rayner et al. (2011)	Core conceptual framework: "doing with": • Being with a therapist • Understanding and feeling • Keeping it real • The role of CAT tools in clients experience of therapy and understanding of change • CAT tools and "being with the therapist" • CAT tools and "keeping it real" • CAT tools and "understanding and feeling"
Roddy (2013)	In the beginning Gaining trust: The importance of "understanding" Continuing the process Endings Life after counseling

Article	Relevant Themes/Categories
Rodgers (2002)	Permission Engagement Transparency Restructuring

Shearing et al. (2011)	Overcoming ambivalence
	• Desperate for change
	• Fear
	  o of facing the trauma
	  o of getting it wrong
	  o of getting worse and going mad
	• Trusting the therapist
	  o Becoming ready for reliving
	  o Timeliness of reliving
	  o Preparation versus procrastination
	  o Looking after yourself
	  o Determination
	  o Sharing versus privacy
	  o Belief versus scepticism
	Painful but achieveable
	• Feeling like the trauma was happening again
	• Reliving taking over my life
	• Unfounded fears
	Postitive change
	• Changing symptoms
	• Changing relationship with trauma
	• Regaining sense of agency in the world
	• Worth the pain

Shine and Westacott (2010)	Feeling heard Understandning patterns Space to talk Feeling accepted Having something tangible Working together Feeling exposed
Toto-Moriarty (2012)	Engagement and building the therapeutic alliance • Building trust and safety • Validation • Empathic attunement • Listening and continuity • Identifying and verbalizing difficult thoughts and feelings • Providing a direct and/or challenging stance Decoding the adaptive and psychological meaning of the symptom

Article	Relevant Themes/Categories
	• Exploring and discussing family preoccupation with food, weight and appearance • Exploring traumatic experiences related to the past • Exploring bulimia as a coping mechanism to provide control over difficult thoughts and feelings • Exploring triggers related to the symptom The therapeutic relationship • Working through resistance • Authentic and respectful interactions • Internalizing the therapeutic relationship Signs of progress as the therapy work deepened • Developing insight and the capacity to self-reflect • Demystifying food • Positive and sharing experiences • Shifting to a more positive and realistic body image • Shifting to a more positive and realistic self-image • Shifting to a more realistic and empathic view of others Adjunctive treatments within psychodynamic work • Journaling • Food diaries • Medication
Westra et al. (2010)	Therapy Was Not What I Expected • I Was Pleasantly Surprised: The Therapist Surprised Me • The therapist was collaborative/we worked together • I had the freedom to direct things/it was about me • I was comfortable with the therapist • The therapist was nonjudgmental • The Experience Surprised Me • I could trust the process o I overcame my initial sceptisism o The process was full of surprises o I was surprised that focusing on painful things could be helpful • I didn't expect to change/learn so much • I was unexpectedly comfortable • I actually did the work • Therapy didn't fit the stereotype • I Was Disappointed o But it's no one's fault o But it's my fault o But it's not the therapist's fault o But therapy is never a waste of time o And it is the therapist's fault

Article	Relevant Themes/Categories
	Therapy Was What I Expected • I Trusted the Process • Therapy Was What I Thought It Would Be • I Didn’t Have Any Expectations
Wucherpfennig et al. (2020)	The therapeutic relationship • Positive regard of the therapist • Perceiving the therapist as a competent expert Activating resources • Recognizing resources • Building and strengthening resources Motivational clarification and insight • Clarifications of goals, norms and motives • Positive reevalution of self Action-oriented coping strategies • Understanding symptoms by applying psychoeducation • Coping via self-competence • Coping via self-management and emotion regulation Healing therapeutic setting • Opportunity to regularly discuss problems

Appendix C

Table A3

Quality Assessment of Eligible Articles to Meta-Synthesis

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
Amos et al. (2018)	+	+	+	+	+	-	+	+	+	+	+
Angus and Kagan (2013)	+	+	+	+	+	-	+	-	-	-	-
Barnes et al. (2013)	+	+	-	+	+	-	+	-	-	+	-
Beitel et al. (2007)	+	+	-	+	+	-	-	-	-	-	-
Binder et al. (2009)	+	+	+	+	+	-	+	+	+	+	+

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
Binder et al. (2010)	+	+	+	+	+	-	+	+	+	+	+
Bury et al. (2007)	+	+	+	+	+	+	+	+	+	+	+
Carey et al. (2007)	+	+	+	+	+	-	+	-	-	-	-
Chang and Berk (2009)	+	+	+	+	+	+	+	-	+	+	-
Chang and Yoon (2011)	+	+	+	+	+	+	+	-	+	+	-
Chui et al. (2020)	+	+	+	+	+	+	+	+	+	+	+
Dakin and Areán (2013)	+	+	+	+	+	-	-	-	-	-	-

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
De Smet et al. (2019)	+	+	+	+	+	+	+	+	+	+	+
De Smet, Meganck, De Geest, et al. (2020)	+	+	+	+	+	+	+	+	+	+	+
De Smet, Meganck, Truijens, et al. (2020)	+	+	+	+	+	+	+	+	+	+	+
Dulsster et al. (2019)	+	+	+	+	+	-	-	+	+	+	+
Edmond et al. (2004)	+	+	+	+	+	-	+	-	-	+	-
Edwards and Loeb (2011)	+	+	+	+	-	+	+	-	-	+	-

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
Ekroll and Rønnestad (2017)	+	+	+	+	+	-	+	+	+	+	+
Ekroll and Rønnestad (2018a)	+	+	+	+	+	-	+	+	+	+	+
Ekroll and Rønnestad (2018b)	+	+	+	+	+	-	+	+	+	+	+
Elder (2016)	+	+	+	+	+	-	+	-	-	+	-
Falkenström et al. (2007)	+	+	+	+	+	-	-	+	+	+	+
Gallegos (2005)	+	+	+	+	-	-	-	-	-	+	-
Hoener et al. (2012)	+	+	+	+	+	+	+	+	+	+	+

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
Khattra et al. (2017)	+	+	+	+	+	-	-	+	+	+	+
Klasen et al. (2017)	+	+	+	+	+	+	+	-	-	+	-
Klein and Elliott (2006)	+	+	+	+	+	+	-	-	-	-	-
Levitt et al. (2006)	+	+	+	+	+	+	-	+	+	+	+
Lilliengren and Werbart (2005)	+	+	+	+	+	+	-	+	+	+	+
Marcus et al. (2011)	+	+	+	+	+	+	-	+	+	+	+
McElvaney and Timulak (2013)	+	+	+	+	+	-	-	-	-	-	-

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
McGregor et al. (2006)	+	+	-	+	+	-	-	+	-	-	+
Messari and Hallam (2003)	+	+	+	+	+	+	+	+	+	+	+
Murray (2002)	+	+	+	+	+	-	-	+	-	-	+
Nilsson et al. (2007)	+	+	+	-	+	+	+	-	-	+	-
Olivera et al. (2013)	+	+	+	+	+	-	-	-	-	-	-
Palmstierna and Werbart (2013)	+	+	+	+	+	-	+	+	+	+	+
Paulson et al. (1999)	+	+	+	+	+	+	-	-	-	-	-

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
Poulsen et al. (2010)	+	+	+	+	+	-	+	-	-	+	-
Rayner et al. (2011)	+	+	+	+	+	+	+	+	+	+	+
Roddy (2013)	+	+	+	+	+	-	+	+	+	+	+
Rodgers (2002)	+	+	+	+	+	+	-	+	+	+	+
Shearing et al. (2011)	+	+	+	+	+	+	+	+	+	+	+
Shine and Westacott (2010)	+	+	+	+	+	-	-	+	+	+	+
Timulak et al. (2017)	+	+	+	+	+	-	-	-	-	-	-

Article	Clear statement of research?	Qualitative method appropriate?	Appropriate research design to address aims of research?	Appropriate recruitment strategy to aims of research?	Data collected in a way that addressed the research issue?	Researcher and participant relationship adequately considered?	Ethical issues considered?	Data analysis sufficiently rigorous?	Clear statement of findings?	Value of research	Overall assessment of quality
Toto-Moriarty (2012)	+	+	+	+	+	-	-	+	+	+	+
Watson et al. (2012)	+	+	+	-	-	-	-	-	-	-	-
Westra et al. (2010)	+	+	+	-	+	-	-	+	+	+	+
Wucherpfennig et al. (2020)	+	+	+	+	+	+	+	+	+	+	+

Note. Based on the *CASP Qualitative Studies Checklist* (Critical Appraisal Skills Programme, 2018). Abbreviations: + = adequate, - = inadequate.

Appendix D

Table A4

Identified Themes Represented in Original Articles

Theme	Articles with Statements Connected to Theme
1. A) Improved Relationships with Self and Others (11)	Binder et al. (2010)
	De Smet, Meganck, De Geest, et al. (2020)
	Dulsster et al. (2019)
	Ekroll and Rønnestad (2017)
	Ekroll and Rønnestad (2018a)
	Ekroll and Rønnestad (2018b)
	Falkenström et al. (2007)
	Khattra et al. (2017)
	Marcus et al. (2011)
	Murray (2002)
	Palmstierna and Werbart (2013)
	Toto-Moriarty (2012)
1. B) Increased Acceptance (15)	Binder et al. (2010)
	De Smet, Meganck, De Geest, et al. (2020)
	Ekroll and Rønnestad (2017)
	Ekroll and Rønnestad (2018b)
	Levitt et al. (2006)
	Lilliengren and Werbart (2005)
	Marcus et al. (2011)
	Messari and Hallam (2003)
	Murray (2002)
	Rayner et al. (2011)
	Rodgers (2002)
	Shearing et al. (2011)
	Toto-Moriarty (2012)
	Westra et al. (2010)

Theme	Articles with Statements Connected to Theme
	Wucherpfennig et al. (2020)
2. A) Co-Creating a Therapeutic Relationship Based on Trust, Connection, and Collaboration (27)	Amos et al. (2018) Binder et al. (2009) Binder et al. (2010) Bury et al. (2007) Chui et al. (2020) De Smet et al. (2019) De Smet, Meganck, De Geest, et al. (2020) De Smet, Meganck, Truijens, et al. (2020) Ekroll and Rønnestad (2017) Ekroll and Rønnestad (2018a) Ekroll and Rønnestad (2018b) Hoener et al. (2012) Khattra et al. (2017) Levitt et al. (2006) Lilliengren and Werbart (2005) Marcus et al. (2011) McGregor et al. (2006) Messari and Hallam (2003) Murray (2002) Palmstierna and Werbart (2013) Rayner et al. (2011) Roddy (2013) Rodgers (2002) Shearing et al. (2011) Shine and Westacott (2010) Toto-Moriarty (2012) Westra et al. (2010)

Theme	Articles with Statements Connected to Theme
2. B) Committing to Change as a Gradual, Challenging, and Continuing Process (16)	Amos et al. (2018) Bury et al. (2007) Chui et al. (2020) De Smet et al. (2019) De Smet, Meganck, De Geest, et al. (2020) Ekroll and Rønnestad (2017) Ekroll and Rønnestad (2018b) Falkenström et al. (2007) Hoener et al. (2012) Lilliengren and Werbart (2005) McGregor et al. (2006) Rayner et al. (2011) Roddy (2013) Rodgers (2002) Westra et al. (2010) Wucherpfennig et al. (2020)
2. C) Increasing Self-Awareness to Understand What Needs Changing (20)	Binder et al. (2010) Bury et al. (2007) Chui et al. (2020) De Smet et al. (2019) De Smet, Meganck, De Geest, et al. (2020) De Smet, Meganck, Truijens, et al. (2020) Dulsster et al. (2019) Ekroll and Rønnestad (2017) Ekroll and Rønnestad (2018b) Khattra et al. (2017) Levitt et al. (2006) Marcus et al. (2011) Murray (2002) Palmstierna and Werbart (2013)

Theme	Articles with Statements Connected to Theme
	Rayner et al. (2011)
	Rodgers (2002)
	Shearing et al. (2011)
	Shine and Westacott (2010)
	Toto-Moriarty (2012)
	Wucherpfennig et al. (2020)