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Factors Influencing Successful Psychotherapy Outcomes

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Submitted by Margaret McCoy Lynch
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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

Previous research indicates that the therapeutic alliance is a main factor in determining successful outcomes of psychotherapy. The goal of this study was to expand the understanding of not only the therapeutic alliance, but also how other contributing factors such as empathy, experience of the therapist, therapeutic modality, client's level of motivation, personality, and symptomology increase positive therapeutic outcomes. The present study explored the following research question: What are the key factors to producing successful therapeutic outcomes in individual psychotherapy? This is an exploratory study with a qualitative research design. The findings of this study appear to correlate closely with the literature reviewed. The therapeutic alliance remains a key component of creating successful outcomes in psychotherapy. Empathy also continues to be an integral factor to not only forming the alliance, but also increasing a client's ability to feel validated and understood. It appears that experience does not always increase the odds of creating successful outcomes in therapy, and no one type of therapeutic modality is superior to another. The findings also concur that a client's level of motivation, personality characteristics, and symptomology do play a role in their therapeutic outcomes.

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Table of Contents

Introduction

Throughout the history of psychotherapy, the relationship (also referred to as the therapeutic alliance, working alliance, and collaborative alliance) between therapist and client has been examined and explored many times over. Freud, as cited by Copper & Lesser (2011) was one of the first to address the concept that the client is an active collaborator in the treatment process. Bordin also agreed with Freud, viewing the relationship built, and the collaboration between therapist and client as, "one of the keys, if not the key, to the change process" (Cooper & Lesser, 2011, p.33). Teyber & McClure (2011) define the therapeutic alliance as a partnership where both therapist and client agree on shared goals, work together on tasks designed to bring a positive outcome, and establish a relationship built on trust, acceptance, and empathy.

With the understanding that the therapeutic alliance is a main factor in successful treatment outcomes, there also appears to be other overlapping components that may affect therapy outcomes. Empathy has been shown to be another indispensable element of the therapeutic process.   Although a therapist's empathy toward their client may have a part in forming the alliance, its influence on the relationship has been shown to be essential (Moore, 2006). Moore (2006) suggests empathy is not only communicated verbally, but also with increased eye contact, body posture, tone of voice, and listening skills. Therapists are encouraged to consider not only the therapeutic alliance, but also the ways in which they show empathy as an influence on outcome (Moore, 2006).

Another component linked to the successful outcome of therapy is the experience of the therapist. One may assume due to the old saying "practice makes perfect" that the

longer a therapist has been practicing the likelier they are to have a successful outcome. Although a few studies have found a small association between therapist experience and successful therapeutic outcome, the majority of the evidence supports the notion that a more experienced therapist does not automatically generate more successful results (Hersoug, Hoglend, Monsen, & Havik, 2001).

Over the years, researchers have made numerous attempts to produce empirical results about which therapeutic modalities create the best therapy outcomes (Lantz, 2004). Again, this area has also been researched extensively in relation to therapeutic outcomes with seemingly limited results. Past research indicates that relationship factors, such as the therapeutic alliance, correlate more highly with success than do specialized treatment techniques or individual therapeutic modalities (Lantz, 2004).

If the therapeutic alliance and empathy are key ingredients to successful outcomes, and the significance of the therapist's experience and modality are still open to question; one could ask if a client's level of motivation, personality characteristics, and symptomology have any effect on the therapeutic outcome. Bachelor, Laverdiere, Gamache, & Bordeleau (2007) have proposed that there is in fact a correlation between a client's current symptoms, level of motivation, ability to form relationships, and personality characteristics with successful outcomes in relation to psychotherapy.

This research study will focus on identifying factors that contribute to a successful outcome in individual therapy. The researcher chose this topic in order to expand the understanding of not only the therapeutic alliance, but also how other contributing factors such as empathy, experience of the therapist, therapeutic modality, client motivation,

personality characteristics, and symptomology have an effect on the therapeutic outcome. The present study attempted to answer the following research question: What are the key factors to producing successful therapeutic outcomes in individual psychotherapy? This question was addressed though qualitative research by interviewing 12 Licensed Independent Clinical Social Workers (LICSSW's) currently practicing individual therapy with adults.

Literature Review

The present study highlights some important factors that generally encourage the successful outcome of psychotherapy. This literature review is divided into five sections that will cover the therapeutic alliance, empathy, experience of the therapist, therapeutic modality, and client motivation/personality characteristics/symptomology. All of these areas have been found in past research to have a significant impact on therapeutic results and relate well to the research question being posed.

Therapeutic Alliance

Gellhaus Thomas, Werner-Wilson, & Murphy (2005) define the therapeutic alliance as "the extent to which a client and therapist work collaboratively and purposefully and connect emotionally, and is conceptualized as a common, or generic, factor in that it is believed to cut across various treatment approaches" (p.1). The therapeutic alliance between psychotherapist and client is one topic that has been continually researched. Although the alliance between therapist and client emerged historically from psychodynamic literature as Summers & Barber (2003) suggest, it has been recognized as a crucial component to successful therapy outcomes from all different theoretical backgrounds. The literature suggests that both therapist and client alike have similar explanations of what makes therapy successful, and one consistent finding is the quality of the therapeutic alliance is predictive of positive treatment outcome (Black, Hardy, Turpin, & Parry, 2005). Newer research has started to focus more on the interaction between client and therapist as in how they align and collaborate with each other as being the primary mode of effective therapy. One study reported by Sharpley,

Jeffrey, & McMah (2006) stated that over 80% of the positive outcomes of therapy may be due to the therapeutic relationship with the contributing elements being the manner in which the therapist exhibits warmth, empathy, and respect for the client.

Horvath and Greenberg, as cited by Sharpley et al. (2006) infer the therapeutic alliance can be separated into three categories; bond, goals, and task. Bond between therapist and client includes trust and emotional closeness. Goals include the changes in behavior that the client and therapist set and work on together. Task is the method that both therapist and client use to achieve their goals. The researchers in this study maintain that in order for goals and task to be accomplished, there must first be the relationship (bond) between therapist and client (Sharpley et al., 2006). Another study found similar results when researching the components of the therapeutic alliance also identified the same three categories of therapeutic alliance as goal, task, and bond. This study found that therapeutic alliance is mutually constructed between therapist and client and includes shared goals, accepted recognition of the tasks each person is to perform, and a trusting bond between the two parties (Summers & Barber, 2003).

Many studies suggest that the words and actions that the therapist uses to promote a healthy and working alliance have proven to be an important contributing factor to change for the client (Sullivan, Skovholt, & Jennings, 2005). The data does indicate that some therapists are consistently better than other therapists, and that the therapeutic outcome is enhanced through the therapeutic alliance (Carr, 2011). Carr discusses a study that found that the effectiveness of antidepressant medication had more to do with the particular psychiatrist prescribing the medicine (or placebo) than to the treatment itself (2011). The more effective psychiatrists helped their patients more when using a

placebo than the less effective psychiatrists did when using antidepressants. Although

psychiatry and psychotherapy differ in their approach, this study supports the finding that

both the person delivering the treatment and the relationship they have built with the

client is a very powerful indicator of outcome.   There have been similar findings in

general medicine, education, and politics, and it could also demonstrate a direct link to

the effectiveness of the psychotherapeutic relationship as well (Carr, 2011).

The literature does suggest that the personal qualities of the therapist and their

ability to form a warm and supportive relationship are extremely important factors in the

alliance (Black et al., 2005). Attachment styles or the ability to make relationships by

both the client and the therapist may have a direct correlation to forming the therapeutic

alliance. For example, when a client is feeling vulnerable, the way in which the therapist

responds as a caregiver has an impact on the relationship being formed as suggested by

Black, et al. (2005). A relationship can also decrease client drop-out. Client drop-out

rates continue to be a widespread problem; several studies have found that clients will

often discontinue the therapy if they are dissatisfied with the therapist or the therapist's

techniques (McCarthy & Frieze, 1999). It has also been indicated by Sharpley, et al.

(2006) that effective therapists can increase their rapport with clients by showing interest,

engaging with the client, understanding the client's intentions, and taking pleasure in the

experience of sharing the client's issues and emotions.

Bruce Wampold reviewed hundreds of empirical studies regarding the 13 qualities

to look for in an effective therapist. Whitbourne (2011) then condensed those 13

qualities down to 6 practical categories. The therapist must have possession of a

sophisticated set of interpersonal skills, the ability to help the client build trust in the

therapist, and have a willingness to establish an alliance with the client. They must also

have the ability to provide an explanation of the client's symptoms and adapt this

explanation when circumstances change, have a commitment to developing a consistent

and acceptable treatment plan, and lastly, be able to communicate confidence about the

course of therapy (Whitbourne, 2011). It would appear that when taken into account

those therapists who possess these qualities may have the ability to foster better

therapeutic rapport and increase their effectiveness with the clients that they see

(Whitbourne, 2011).

The literature supports the fact that the quality of the therapeutic alliance is

directly related to the outcomes of treatment and that the relationship alone can even lead

to therapeutic changes (Langhoff, Baer, Zubraegel, & Linden, 2008). Early alliance also

appears to be a better predictor of outcome than alliance measured across sessions or later

in treatment (Hersoug et al., 2001). Littauer, Sexton, & Wynn (2005) report that a good

connection or alliance between therapist and client tends to stabilize quite rapidly for

many clients within the first session, and with some clients even reporting the connection

happening within 10 minutes of a session. Many therapists focus on building the alliance

more than anything else, believing that a client's investment and commitment to the

relationship may be one of the biggest motivators for change (Littauer et al., 2005). It

does appear that if the client is fully vested in the therapeutic alliance, it may foster a safe

environment not only to pursue difficult work, face and understand pain, but also hold the

client accountable for their actions (Sullivan et al., 2005).

A study conducted by Langhoff et al. (2008) on therapeutic alliance found that

different perspectives emerged indicating that different people will have different ideas of

what the therapeutic alliance requires. Therapists need to be aware of this fact and

remember that their interpretation of the alliance is only one among others (Langhoff et

al., 2008). In one study, the way in which therapists responded to the client appeared to

help with the therapeutic alliance (Sullivan et al., 2005). Therapists who were sensitive

to clients at the beginning of therapy, used specific techniques that suited the client's

needs, and were open and non-defensive when hearing clients' constructive feedback, all

experienced enhanced therapeutic relationships (Sullivan et al., 2005).

     Therapists agree that the initial contact with the client, even if it is just a phone

call, must be done in a sensitive and responsive way in order for the client to feel

understood and respected from the beginning stages of the relationship (Sullivan et al.,

2005). The results of one study as reported by Schnellbacher & Leijssen (2009)

concluded that the way in which the clients experienced the therapist's attitude or

acceptance was the most beneficial to the therapeutic process. A client needs to feel that

his or her needs are the central focus, that the relationship between client and therapist is

a secure base in which the client may express feelings and explore new behaviors

(Sullivan et al., 2005). Overall, as suggested by Sullivan et al. (2005) the client needs to

be able to feel the empathy and concern of another person who is worthy of the client's

trust. The use of self by the therapist in the relationship is key to being able to

authentically relate to the client in order to create trust and support (Sullivan et al., 2005).

Helpful self-disclosures are expected during therapy and the way in which they are

handled by the therapist can have positive effects on the immediate process which will

also influence the therapeutic relationship and outcome (Schnellbacher & Leijssen,

2009).

Collaboration on treatment planning is imperative for the relationship. Sullivan et al. (2005) suggest by collaborating with the client, the therapist will focus the therapy agreement or treatment plan around the client's understanding of the problem, mutually resolve any confusion that may arise, and work with the client to form meaningful termination from the therapy. In one study, therapists that were facing a lack of progress in therapy openly discussed the issue with the client, this in turn helped to foster a joint solution and reaffirm the mutual alliance (Sullivan et al., 2005). It remains essential that therapists remain mindful of the unique interpersonal relationship between therapist and client as the central and most significant factor in psychotherapy (Erskine, 1998). In a study of 36 clients who were asked following their second session of psychotherapy what qualities they found most important in establishing the therapist-client alliance, Littauer et al. (2005) reported they found the following qualities as most helpful: be warm, calm, and responsive, be prepared and have a plan, listen attentively, be understanding, and balance specific questions and comments with conscientious listening.

Empathy

Therapists are aware of how important it is to establish rapport with clients, not only is the relationship important to the therapy process, but another component of the relationship is empathy shown by the therapist toward the client (Moore, 2006). An anonymous English author as cited by Moore (2006) once said, "To empathize is to see with the eyes of another, to hear with the ears of another, and to feel with the heart of another" (p.1). Although empathy has been, and is currently, being studied scientifically, the portion of the theory that therapists tend to most relate to in regards to empathy is linked to one's emotions (Moore, 2006). Moore (2006) also describes empathy as, "an

emotional state of being which allows each member of a communication dyad to understand how the other is feeling" (p.1). Empathy is not only communicated by the words that we speak. Research indicates that a person's emotional state can be expressed without the use of words, and also understood just by tone of voice alone (Moore, 2006).

There is a long history of the role of empathy in the effectiveness of psychotherapy and the therapeutic alliance (Elliott, Bohart, Watson, & Greenberg, 2011). Empathy and its usefulness was proposed by Rogers and his followers as cited by Elliott et al. (2011) in the 1940s. However, in the late 1970s claims of its effectiveness came under scrutiny by psychotherapist researchers. By the 1990s, empathy had once again resurfaced as a key component in support of increasing rapport and the therapeutic alliance. Empathy has also become so significant that a new field of neuroscience has emerged to investigate its process (Elliott et al., 2011).

It has been found that psychotherapy is ineffective unless the person delivering the therapy is genuinely caring, empathetic and has the ability to form a solid bond with the client (Carr, 2011). Empathy can be demonstrated in many different ways. A study on attunement, which is part of how empathy is shown, as referenced by Erskine (1998) is a two-part process that begins with empathy, sensitivity, and identifying another's needs and feelings, and then the ability to communicate those feelings back to the other person. It is more than just understanding it is showing that the therapist feels what is being stated.

Not only do therapists show empathy with words and understanding, it has also been noted by Sharpley et al. (2006) that facial expressions also convey meaning and

have a direct influence on therapeutic alliance. Facial expression is another way that therapists are able to express empathy for what a client is discussing and feeling. As previously mentioned, a therapist's nonverbal behavior has been directly correlated as a powerful means to project a message of caring to the client. Of all the nonverbal behaviors that take place in a session, such as eye contact and posture, Sharpley et al. (2006) suggest that facial expression contributes most to the therapeutic alliance and the feeling of well-being by the client.

Schnellbacher & Leijssen (2009) have also indicated that both genuineness and therapeutic responsiveness increase the empathy that is felt by a client as well as strengthen the therapeutic alliance. A genuine therapist always expresses a sincere involvement in the therapeutic process. They do not put on a façade, but fully participate with empathetic listening. Therapist genuineness may be described as being self-aware, being present and emotionally involved in the client's story, and having a willingness to intentionally and verbally reveal personal feelings, thoughts, views, and facts. Therapist genuineness is an overall inner attitude and relational experience that a therapist expresses to a client (Schnellbacher & Leijssen, 2009). Therapeutic responsiveness, like genuineness, occurs when the psychotherapist recognizes, attends, and empathically responds to the client's needs during a session (Fauth, Gates, Vinca, Boles, & Hayes, 2007).

It has been shown by Fauth et al. (2007) that poor therapeutic responsiveness can have negative effects on the outcome of therapy, and research suggests that adding therapeutic responsiveness to training of therapists may increase the therapeutic alliance and overall outcome of therapy. It has been recognized that a strong, healthy, meaningful

relationship provides an environment in which the natural process of healing can take place. If the therapeutic alliance is strong and empathy has been established between therapist and client, healing will occur because of the safe environment that has been fostered (Hoglend, 1999).

Experience of the therapist

Although veteran therapists may disagree, Hersoug et al. (2001) found that experience, professional training, and professional skills do not have a significant impact on the working alliance when rated by patients. The research in this area appears inconclusive in that variables such as age, personality, profession, formal training, years of clinical experience, personal psychotherapy, or amount of supervision do or do not have any significant relationship to the therapist's skill level or the outcome of therapy (Hoglend, 1999). One study did indicate a small positive relationship between the therapist's experience and the quality of the relationship; however, in a more recent study, the therapist's level of experience was not found to be predictive of patient's alliance ratings (Hersoug et al., 2001). It should be noted that the frequency of premature dropout rates of patients from therapy has been more associated with inexperienced than experienced therapists, which could explain the finding that experience does make a difference in the therapeutic alliance (Hoglend, 1999).

Regardless of background, it has been found that medical doctors and clinical psychologists with many years of training do not consistently achieve better outcomes of therapy than inexperienced social workers or psychiatric nurses (Hoglend, 1999). The review of the literature in this area still stands to be tested, although many of the articles

continue to reiterate that more experience as a therapist is not a consistent guarantee of a better quality working alliance (Hersoug et al., 2001). It has been found that skillful therapists tend to use techniques that follow certain methods, but even within these methods they continue to remain flexible and open (Hoglend, 1999). Skillful therapists, despite methodology, adjust interventions according to client needs, maintain optimistic yet realistic expectations of their client, and do not intervene in critical, unfriendly, or unclear ways even when confronting difficult issues (Hoglend, 1999).

Therapeutic Modality

Different therapeutic methodologies have different concepts and positions regarding the therapeutic alliance. Langhoff et al. (2008) suggest that in client-centered psychotherapy the therapeutic alliance is deemed the primary treatment component, and in psychoanalysis both transference and countertransference are viewed as indispensible treatment factors. At times, behavior therapy can be seen as more automatic and less personal in which the therapeutic alliance tends to be seen as less crucial, yet in order for clients to cooperate and trust in the therapeutic process of behavior therapy, an alliance must first be established.   Empirical evidence has suggested that cognitive behavioral therapists, even though technical and directive at times, continue to foster emotional support, empathy, and positive regard in order to form a therapeutic alliance (Langhoff et al., 2008). Numerous studies have concluded that regardless of the therapeutic modality, most approaches can produce positive change and that there is no one superior method for effective therapy (Sullivan et al., 2005).

Although therapists can be trained to adhere and follow a particular therapeutic method or manual, it does not appear that there is a clear-cut way of improving the alliance through a specific modality (Hoglend, 1999). This could also suggest that treatment methods may underemphasize clinical judgment and leave more room for flexibility. There continues to be a chronic tension in the field of psychotherapy as referenced by Hoglend (1999) to find a balance between clinical judgment, creativity, and flexibility when working with clients. Both current research and clinical experience suggest that knowledge of more than one specific treatment model enhances the therapist's ability and skill, which benefits the client (Hoglend, 1999). Research by Fauth et al. (2007) has indicated that traditional psychotherapy training practices which emphasize the adherence to one particular modality with manual guided techniques does not increase effectiveness of the psychotherapist, which in turn may be detrimental to the therapeutic alliance. As Carr (2011) suggests, when clients are accounting for their improvement they do not emphasize particular treatment modalities, but primarily emphasize the relationship they formed with their therapist.

Client Motivation/Personality/Symptomology

Past research that has focused on which client characteristics have an impact on the therapeutic alliance, such as a client's motivation level and their ability to form relationships, has shown that these traits and characteristics have an impact on both the alliance and the therapy outcome (Black et al., 2005). It has also been argued by Black et al. (2005) that a client's capacity to form a relationship could quite possibly provide the foundation for the alliance, but it also appears that a therapist's capacity to form relationships is just as important. As in other dyadic relationships such as student/teacher

or roommates, the overall personality similarity or particular personality traits may have

an effect on the nature and outcome of the therapist/client relationship (Coleman, 2006).

The client's participation, quality of their interpersonal relationships, attachment,

pretreatment expectations, and early therapeutic alliance may have a direct effect on the

success of therapy (Summers & Barber, 2003).

The evidence supports the notion that suitable patients who are open and have the

ability to establish a positive working alliance with a therapist who skillfully

demonstrates a well defined therapeutic method will achieve favorable results (Hoglend,

1999). Suitable clients for therapy are generally characterized by less problematic

personality traits, an ability to establish stable relationships, and an ability to verbalize

and cooperate. It has been suggested by Hoglend that these clients appear to achieve

more successful outcomes from therapy three times as often as less suitable or more

challenging clients (1999). One study with a primarily self-selected client sample did

strongly indicate that psychotherapy does help those that seek it out themselves

(Hoglend, 1999). It has been suggested by Bachelor et al. (2007) that a client with

increased symptomology may have a decreased ability to become engaged and work

productively together with the therapist. Overall, it appears that the client's

collaboration, motivation, personality characteristics, and active involvement in the

treatment tasks and formation of the alliance has a direct association with a successful

outcome of therapy (Bachelor et al., 2007).

In conclusion, the review of the literature appears to support the notion that the

therapeutic alliance, empathy, experience of the therapist, therapeutic modality, client

motivation, personality, and symptomology all play a role in the effectiveness of

successful therapy outcomes. This study is focused on learning common factors

experienced therapists identify that contribute to the success of therapy.

Conceptual Framework

The conceptual framework for this research study is embedded in the therapeutic alliance theory. As noted in the literature review, the therapeutic alliance remains a constant and invariable force for therapeutic success across all theoretical models (Summers & Barber, 2003). This concept is related to this study, which is an exploratory study of the factors that contribute to the successful outcomes of therapy from the perspectives of the therapist. From the literature, the therapeutic alliance must clearly be established before a client is able to successfully shift throughout the treatment process. Horvath & Luborsky (1993) state that the therapeutic alliance is more predictive of outcome than empathy; however, research results do indicate that when the alliance has been established, clients tend to perceive the empathy shown by the therapist in a much more straightforward way.

Teyber & McClure (2011) defined the therapeutic alliance as a partnership where both therapist and client agree on shared goals, work together on tasks designed to bring a positive outcome, and establish a relationship built on trust, acceptance, and empathy. Overall, the therapeutic alliance has continually been found to be fundamentally critical to the success rates of psychotherapy. This consistency has been shared between both differing therapeutic modalities as well as with a diverse range of clients (Carroll, Nich, & Rounsaville, 1997). It would appear that the concept of the therapeutic alliance correlates with this research study in that if the alliance is established it will provide an environment in which specific interventions may be administered (Carroll et al., 1997).

Due to the importance of the therapeutic alliance on successful outcomes of therapy, there are at least eleven, if not more, alliance assessment methods and psychotherapy alliance scales that are used in order to measure not only the alliance, but also components that increase the alliance (Horvath & Luborsky, 1993). These tools have been created by those with differing therapeutic modalities, yet continue to have many of the same underlying factors. These assessment tools, although not the same, do hone in on some key aspects of the alliance including collaboration, willingness to invest in the process, shared or agreed goals, capacity to form relationships, acceptance, and active participation (Horvath & Luborsku, 1993). As Horvath & Luborsku (1993) suggest we have many studies that focus in on the impact of the quality of the alliance and successful outcome, but less that concentrate on specific therapist techniques that improve the relationship. This notion is not surprising in that psychotherapy involves such integrated processes that it is difficult to separate exactly what factors contribute to successful outcomes and exactly when (Horvath & Luborsku, 1993). It may be concluded that many factors clearly contribute to successful psychotherapy, and that this research study aims to only discuss a few of the many possibilities.

This study strives to more fully understand what other factors contribute to the already theoretically established therapeutic alliance and empathy. If the therapeutic alliance is intact, and empathy is shown, does the experience of the therapist, the therapeutic modality used, and the motivation, personality characteristics, and symptomology of the client matter? The research on the therapeutic alliance suggests that all other contributing factors aside, if an alliance is made therapy will be successful (Summers & Barber, 2003).

In summary, the conceptual framework for this paper is the therapeutic alliance theory which is seen as the most positive factor in outcome success. The interviews that will be completed for this project will aim to address not only the research question, but also more fully explore what additional factors increase successful therapeutic outcomes.

Methods

Research Design

This was an exploratory study with a qualitative research design which examined the impact of the therapeutic alliance on positive therapy outcomes, as well as several additional factors that influence successful outcomes involving the role of empathy, experience of the therapist, therapeutic modality, client motivation, client personality characteristics, and client symptomology.

Sample

The sample for this study was 12 current LICSW's practicing individual psychotherapy with adult clients. The sample used was a nonprobability snowball sample (Berg, 2009). The researcher contacted 4 current LICSW's in the field to see if there was any interest in participating in the study. In turn they asked others if they would want to participate. A large number of potential participants both called and emailed the researcher. Although the researcher appreciated the overwhelming support for the study, it was decided that 12 participants would be the maximum amount due to both time and availability restrictions. In effect, the sample came from a chain of referrals all meeting similar criteria (Berg, 2009). Of the participants, 50% have their own private practice, and the remaining participants worked for various mental health clinics.

Protection of Human Subjects

The participants of this study were each given detailed consent forms outlining the study (Appendix A) and all of the measures were taken to ensure confidentiality. For interviews conducted by telephone, the consent form was mailed prior to the interview, and participants signed and returned. The participants were informed of the risks and also that there were no direct benefits for participating in this study. The interviews were audio taped, transcribed, and locked in a secure file cabinet.   The participants were informed that both the audiotapes and transcriptions would be destroyed by June 2012. Participants were informed that their participation was voluntary, they may skip any questions they did not wish to answer, and they were able to stop the interview at any time. Participants were encouraged to call both the researcher and the researcher's advisor should any questions arise.

Data Collection and Analysis

The data collected for this research was obtained over a 5 week period, and the average length of the interviews lasted 25-50 minutes. Although the researcher made every effort to do the interviews in person, due to limited time and availability of the participants, five of the interviews were done face to face, with the remaining seven done over the phone.   Out of the twelve participants, one whose information is included in the study does primarily work with children. This information was unknown to the researcher before the interview began. After careful consideration it was decided that the results of the data collected from this interview would remain in the study because the main ideas discussed were reflective of working with clients of all ages, not just children.

The interviews were transcribed and then prepared for content analysis. Content analysis as reported by Berg (2009) is a comprehensive and systematic assessment and interpretation of certain material in order identify patterns, themes, biases, and meanings. The raw data was then open coded for different themes that emerged from the interviews (Berg, 2009). After all data had been coded and themes had emerged, it was organized into different categories that reflected what had been reviewed in the literature (Berg, 2009).

In the beginning of each interview three demographic questions pertaining to gender, years of experience, and theoretical modality were asked followed by ten interview questions (Appendix B). Out of the ten interview questions, half also included intentional probing questions in order to draw out more information from the participant. The data was analyzed for common themes relating to the therapeutic alliance, empathy, experience of the therapist, therapeutic modality, client motivation, personality characteristics, and client symptomology. Common themes were then coded into categories to reflect what had been reviewed in the literature. Specific examples and quotes were also extracted in order to better understand the perspective of the participant and how their experience was consistent or not consistent with past research.

Results

Interviewee Characteristics

The three demographic questions obtained for the study were: the gender of the interviewee, the interviewee's years of experience practicing individual psychotherapy as an LICSW, and the theoretical modality the interviewee used. Of the twelve interviewees in the study, ten were female, and two were male. Experience of the therapist ranged vastly between eight months to thirty-nine years.

With reference to the theoretical modality used by interviewees, only one of the twelve stated that he "exclusively" used one specific modality with all clients he saw, and also mentioned he only took on clients that would benefit from Cognitive Behavioral Therapy. Of all the interviewees, eleven out of twelve made reference to using Cognitive Behavioral Therapy techniques and half of the interviewees made reference to using Dialectical Behavioral Therapy techniques. Four out of the twelve interviewees made reference to using a Psychodynamic approach. Overall, eleven out of the twelve interviewees stated they use an eclectic and integrative approach depending on the client's symptoms, but all appeared to have a basic understanding of several different types of theoretical modalities. One female interviewee stated, "I use psychosocial therapy especially in the beginning because it follows the social work model and encompasses many different areas of the client's life." Several other types of therapy were also mentioned, including Supportive Therapy, Solution Focused Therapy, Narrative Therapy, Task Orientated Therapy, Strength Based Model, Stress Model, Motivational Interviewing, Hypnosis, and Holistic methods.

Interview Item Analysis

What factors do you believe contribute to the therapeutic alliance? Probe: How long does it take to make an alliance with a client? Probe: How do you know when you have formed an alliance?

The interviewees agreed that starting where the client is at and being able to address what the client wants with an open approach is one of the main factors seen as fostering the therapeutic relationship. Another common theme that emerged was not only the client's willingness to do therapy, but also their level of motivation for change. One interviewee stated, "Clients need to first of all be in a place where they are ready to attend therapy…" Overall, the interviewees showed agreement on the factors they believe, from their perspective, contribute to the alliance, such as showing interest in the client's concerns, being approachable, relaxed, conversational, and demonstrating warmth. In addition, interviewees agreed that clients need to feel that they are heard, validated, and respected. One interviewee stated, "Clients who believe their therapist likes them or feels warmly toward them do better in therapy than when clients feel things are very sterile." The ability to create a collaborative relationship and interaction was also a common theme, as well as the personality of both the client and therapist needing to complement one another. One interviewee stated, "I really think people have gut feelings and there is chemistry between people." Another interviewee noted that "…you have to fit in order to get an alliance."

When discussing how long it takes to form an alliance with a client, one interviewee stated, "It depends on what you are going to call an alliance, an impression is made the moment you meet them and it's just building from there, but it starts the second you meet them."   Although many of the interviewees agreed that the formation of the

alliance can happen within the first session, seven out of the twelve gave an average of 2-4 sessions for the client to really feel comfortable, trusting, and have an alliance with the therapist. One of the interviewees suggested that it can take between 4-6 sessions and another suggested between 3-6 months.

Overall, interviewees agreed that a client's willingness to share and be forthcoming was one of the main ways in which the therapist measured therapeutic rapport. Another common theme among interviewees was when they had the feeling of being more comfortable and connected with the client during a session, that's when they knew rapport had been established. One interviewee stated, "I don't feel successful if I don't connect with a client, this is also how I measure if we have formed an alliance, because if I can't connect I don't feel like I can do good work." Other common characteristics interviewees looked for when trying to measure therapeutic rapport were the client's body language, their ability to recall previous sessions and apply past work to the current session, their willingness to be involved in the treatment planning process, and when clients show up on time and look forward to coming to therapy. One interviewee described doing therapy with a client where the relationship has not been formed like this, "I feel when you don't have an alliance it's like playing a game of chess where one person is avoiding or trying not to answer a particular question."

What other factors do you believe contribute to successful therapy? Probe: Can you list a few?

From the interviewees' perspective they believed being grounded in a particular type of therapy is important, as well as using evidence based approaches to help increase successful therapeutic outcomes. The interviewees agreed that receiving advanced

training, being open to new ideas, and getting good supervision are also imperative. One interviewee stated, "…not being complacent, going to trainings, reading books, expanding your skills and ways of thinking, using consultation, and recognizing your own countertransference," all help to foster successful therapy outcomes.

The interviewees felt that having clear treatment plan goals that are consistent with the client's goals is essential to successful outcomes, as well as setting both short and long term objectives. Another theme that is related to setting clear goals is also a continued check in with clients to make sure they like the direction the therapy is going and that they feel comfortable. Overall, nine out of the twelve interviewees mentioned the client's motivation to change when answering this question as a main contributing factor to a successful therapeutic outcome. One stated, "Client's have to have the willingness to be vulnerable and want to see the change for them, not for other people, but for themselves."

Other factors that contribute to successful therapy mentioned include: being collaborative, teaching skills and giving tangible assignments, consistency of the therapist, higher number of sessions, client's personality, and client's ability to feel safe. The interviewees also mentioned the client's level of insight as a contributing factor to successful outcomes, as well as outside support and financial resources.

How do you show empathy toward your clients?

All of the interviewees referred to using body language as one way in which they show empathy. Facial expressions and eye contact also were mentioned by the interviewees. One interviewee stated, "It's very visual, being attentive, looking like you

care, having expressions on your face; I think people can instinctively tell when you are with them."   Active listening is another common theme, reflecting back to the client, using phrases like "that must be really difficult," not only stating that you understand, but being able to explain how you understand. Being genuine, validating, clarifying, present, and mindful during each session also contribute to showing empathy toward clients. One interviewee stated, "The less you speak when trying to show empathy the better, just listen." The interviewees implied that there is a time and a place for self-disclosure and overall it appeared to be used infrequently. It is used; however, when clients are having a hard time expressing themselves or when it appeared to be a helpful teaching tool. One interviewee stated, "I use self-disclosure when appropriate, because people want to see you as human, and it's a way to show that I am not perfect which I think helps them feel validated."

How does experience of the therapist increase successful outcomes in therapy?

When it comes to experience of the therapist increasing the odds of successful therapy outcomes, seven of the interviewees do *not* believe you need experience to be successful, whereas five of the interviewees believed it increases the rate of success. Of the seven who did not believe you need experience, many still believed as the years went on that they became more confident in what they were doing, but do not feel they were any less effective when they were just starting out. One interviewee stated, "I have learned it's not really about your book knowledge, it's about really being able to connect with people." There was agreement that it is important that you follow a therapeutic modality, but new therapists can be just as helpful as more seasoned ones. Of those who thought that experience was not a critical factor in success agreed that life experience,

relationship building skills, being in touch with your own feelings, the ability to be empathic and communicate, as well as present and loving are all natural attributes that help increase successful therapeutic outcomes. One interviewee stated, "…for certain kinds of problems you need experience, but in order to be effective at helping someone feel better about their problems, which I think is so much what therapy is, that [therapy] requires a degree, or a lot of experience…"

On the other hand, five of the interviewees conclude that experience of the therapist increases successful therapy outcomes. One interviewee stated, "I can see the difference between where I started and where I am now, you have to be taught a model and get feedback on how you are working with your clients." Another interviewee stated, "I think it helps, although that does not mean that someone right out of graduate school can't be successful, but I do believe experience increases the odds and increases the possibility for change." All interviewees in this group did recognize that therapists have to start somewhere, but do not feel that just listening is sufficient. One interviewee stated, "I think without experience it can be dangerous at times and can have side effects just like a medication, if you open up people's wounds and you don't help them navigate through them then it can actually cause more problems than what you are able to solve."

Can therapy be successful without an alliance?

All of the interviewees agreed that forming an alliance is imperative to producing a successful therapy outcome. As one interviewee stated, "In the short term I think it's possible, but in order to make long term changes, it can be very difficult." One of the interviewees did make reference to the fact that some of your relationships may not be as

strong with some of your clients, but having some form of a relationship is essential even

when just trying to teach skill building, or when working with a client that does not relate

to others well.

What clients do better in therapy than others?

Overall, the interviewees agreed that those clients who are motivated and willing

to do the work to make positive change will have the best success rate for lasting results.

"A client that is willing to do the work, even if it's scary work…," is how one

interviewee stated it. Another stated, "The ones that are more motivated, want to be

there, can tolerate discomfort, and really look at their thoughts and behaviors..."

Interviewees also agree that clients who are healthier, have increased cognitive abilities

and have less severe symptomology will have more successful outcomes. One

interviewee stated, "Highly motivated, and frankly the less intense, and less severe the

problem, the more likely a successful outcome."

Another common theme that emerged was the subject of voluntary versus

involuntary clients and how it influences success. The interviewees made reference to

court-ordered clients and/or mandated clients who made minimal gains from attending

psychotherapy sessions. Interviewees also described less successful clients as those who

were coming to therapy to please others, or those who were referred by a primary doctor

or psychiatrist with no investment in the therapeutic process.

**Is therapy more successful when a particular theory is used? Probe: Do you use a
particular type of therapy when dealing with particular symptoms?**

Out of the twelve interviewees, eleven believe that therapy is more successful

when theories and certain modalities are used. It became clear that all of the interviewees

have general guidelines they have used when dealing with particular symptoms, but still

use an eclectic approach in most sessions. Only one respondent adhered to a particular

theory stating, "I believe so, and I would say CBT." Another interviewee responded

with, "If you're not going about it [therapy] the right way then you are not going to be

successful, so you have to use some theories, you have to use the right kind of therapy

with the symptoms the client is having." Yet another interviewee reiterated that, "The

diagnosis really does inform the treatment…," and another brought up the fact that

evidence based practice has clear results that have been proven to work. The one

interviewee that stated, "No" to this question felt that success was more dependent on the

client's personality, symptoms, level of motivation, and beliefs, than when a specific

theory was used to treat those symptoms.   Another contributing factor to the

interviewees usage of particular theories on the treatment plan, especially those with

evidence based research such as CBT and DBT, is in part due to the guidelines insurance

companies put forth for reimbursement, this was referenced by the interviewees.

How do you measure success with a client? Probe: When or how do you know a client is done with therapy or has been successful? Probe: Do you measure success differently for different clients?

All of the interviewees agreed that success is measured by how the client feels

they have succeeded. If clients feel they have been successful in making change, learning

new behaviors, learning something new about themselves, have increased coping skills,

and have fewer symptoms of their mental illness, then the goals have been accomplished.

Out of the twelve interviewees, eight stated that reviewing the treatment plan is helpful in

maintaining and increasing success, and when clients feel they have made progress

toward their goals or achieved their goals then that again is success. One interviewee stated, "…it's up to the client, not the therapist" when it comes to measuring success. Another added, "Are they having better relationships, and fewer symptoms, do they feel like the issues they came in about have been resolved or are they less invasive."

Another common theme that was noted by the interviewees was whether the client has been able to demonstrate behavior change. One interviewee described an interesting way in which she measures success is by asking clients, "Has a loved one noticed, or if not, how will a loved one notice you have made change, what will you be doing differently?" Interviewees agreed that they are alerted that a client may be done with therapy when they run out of things to discuss or when clients stop scheduling appointments. Overall, the interviewees agreed that success is measured by the client, and that each individual is unique; therefore, success has to be measured differently for each person.

What qualities do you believe clients look for in a therapist? Probe: What do you believe your clients would say about you?

It would appear from the interviewees' perspective that most clients look for a therapist with good listening skills, out of the twelve interviewees eight mentioned it as being helpful. Another main factor appears to be the match or mismatch of the therapists' and clients' personalities. One interviewee noted, "Clients look for someone they can relate to, sometimes that is by age, sometimes by gender, this can be especially important when dealing with teens and adolescents, …nor at times do older people want to see the youngest therapist in the clinic." The interviewees believe that clients will look for therapists that have experience with their type of symptomology, while others are just

looking for a therapist that is genuine. As one interviewee suggested "You learn all these

different modalities and skills, but really you are just in a room with another human being

and I realize I just need to be myself." Other common characteristics that were

mentioned were honesty, direction, intelligence, ability to set good boundaries,

understanding, supportive, and approachable.

**Have you received any feedback from clients in the past that has helped you
increase your therapeutic skills? Probe: How about a time when therapy was not
successful? Probe: When do you feel therapy does not work? Probe: How would
you describe less suitable clients?**

        Overall, the interviewees agree that while it is difficult to gain constructive

feedback from clients in order to increase skills, they do acknowledge that when they

received feedback it has been very helpful and useful in their practice. Some of the areas

interviewees have received feedback have more to do with the therapists actions than the

actual therapy process itself. Interviewees stated, "I've heard that I talk too fast," "I look

at the clock a lot," "I yawn a lot," "I need to dust more," "I need to update my furniture."

One interviewee stated, "Sometimes feedback is given that is painful to listen to, but then

you realize it's more about their pathology, than it is about you." Another interviewee

stated constructive feedback may be received, "If your goals are not congruent with the

client's goals, or with what they want to see happen, I think that it can make things

muddy and interfere with rapport." Along that same line another interviewee believed,

"One of the things that certainly during sessions may occur is sometimes I make

assumptions about what I think is going on with a client, or what the problem is, and I

assume that I know what they think about a certain situation, and nope, nope, nope, I

have it all wrong. It's really important to clarify and really check out what is being said."

When discussing occasions when clients were not successful in therapy several themes emerged. These themes were also related to clients that may be described as less suitable for individual psychotherapy. The main themes were clients that are intoxicated during a session, or abusing substances, clients that are off their medications or those that need medications because they are so psychotic, clients that can't make connections or lack insight, and again those whose personalities did not fit with the therapist's. Several interviewees mentioned that therapy can be difficult for clients with significant personality disorders due to their lack of tolerance for pain, as well as their inability to be consistent.

Resources, or lack thereof, was also a frequent response to this question. Clients whose basic needs were not met or those that were extremely disregulated have a harder time in psychotherapy. Other barriers to participating in therapy mentioned were lack of transportation, finances, childcare, or insurance. One interviewee stated, "The ones I see the most and the ones that make the most progress are those that can make therapy a priority, and make sure they get in here and do the work." Although lack of insurance appears to be a barrier, it was also mentioned that those with insurance face adversity at times when trying to get into therapy. "It can be difficult for middle class people who already may hold some bias about psychotherapy to navigate the insurance process and what is and is not covered, they also face high deductibles and high out of pocket costs," said one interviewee. Another stated, "It's been really frustrating, I've lost a lot of clients to insurance, they want to come but they can't afford the weekly co-pays, the whole insurance process is confusing, and it seems to continue to get worse."

Discussion

The discussion section reiterates and elaborates on several of the key points made by the interviewees regarding possible factors that contribute to successful psychotherapy outcome and how those findings correlate with the literature reviewed. It will also address the main research question of this study: What are the key factors to producing successful therapeutic outcomes in individual therapy? Finally, the limitations of the study and its implications for future social work practice will be discussed.

Therapeutic Alliance

Overall, the themes that emerged from this study support the past literature reviewed regarding therapeutic alliance, empathy, experience of the therapist, therapeutic modality, and client motivation, personality characteristics, and symptomology. It should be noted that all of the interviewees in the study had a firm grasp on the meaning of the therapeutic alliance and its importance in psychotherapy. All of the interviewees agreed that forming an alliance with the client is an essential part to creating successful outcomes in therapy.

One dominant theme that emerged was the interviewees' agreement that starting where the client is at, being open, and being able to create a collaborative relationship all contribute to forming a therapeutic bond with the client. The interviewees also concluded that showing an interest in the client's concerns, being approachable and relaxed, being warm, inviting, validating, and respectful all increased therapeutic rapport. As discussed in the literature review, Sharpley et al. (2006) stated that therapists can increase rapport

by showing interest, being engaging, understanding the client's intentions, and taking pleasure in sharing both the client's issues and emotions. Sharpley et al. (2006) also suggested that over 80% of positive outcomes may be due to key elements such as the therapist exhibiting warmth, empathy, and respect for the client.

Participants believed that, on average, the therapeutic alliance takes between 2-4 sessions to form. One interviewee did suggest that it starts the moment you meet the client, and other interviewees believe it can happen in the first session. The literature does lead us to believe that a good connection between therapist and client can happen quite quickly, even within the first 10 minutes, but on average may take a little longer (Littauer et al., 2005). One interviewee stated, "On average it takes 2-3 sessions, but sometimes I can feel a bond already after 1 session, but for good measure I would say three in order for them to feel safe and vulnerable." It would appear that regardless of how long it takes to form the relationship, or the exact techniques therapists use to increase the alliance, both interviewees of this study and existing research continue to confirm that the relationship built with the client is indicative of successful outcomes.

Empathy

The effects of empathy on the therapeutic relationship have been studied since the 1940s when first researched by Rogers (Elliott et al., 2011). All of the interviewees in the study appeared familiar with ways in which they use empathy with their clients; the main approach mentioned were body language, along with facial expression, and eye contact. Active listening and reflecting back were also commonly indicated, as well as being genuine, validating, and mindful. As referenced in the literature, Carr (2011) found

that psychotherapy was not effective when coming from a therapist that was not able to show genuine caring and empathy, and Sharpley et al. (2006) reiterated that a therapist's nonverbal behavior has a direct and powerful impact on a client's feeling of well-being. One interviewee in the study concluded that, "the less you speak when trying to show empathy the better, just listen." It may be concluded from both past research and the present study that the use of empathy, through both verbal and nonverbal behaviors, has a direct link to a client's feeling of being validated and understood, which in turn contributes to the successful outcome of psychotherapy.

Although several of the interviewees mentioned using self disclosure during therapy to build rapport, it appeared to be used infrequently by most of the interviewees, and only as an appropriate teaching tool. This was one of the only inconsistencies between the literature reviewed and the thoughts of the interviewees. The literature suggested that the use of self by the therapist not only increases the authenticity of the relationship with the client, but also that helpful self-disclosures are expected in therapy and have been shown to have positive effects on outcome (Sullivan et al., 2005; Schnellbacker & Leijssen, 2009). This discrepancy between the literature and the interviewees' responses may be due to the lack of definition of self-disclosure in the present study, and the fact that each interviewee may not view self disclosure in the same way.

Experience of the therapist

It does appear from both the research and the present study that the impact of the therapist's experience on the successful outcomes in therapy remains inconclusive. Of

the interviewees in the study, seven did not believe you need experience to be successful, and five did believe it increases the odds of success. As noted in the literature reviewed, past studies have also raised debate on this subject with support on each side. Of the seven interviewees that did not believe you needed experience to be effective, they did mention that they have become more confident in their skills, but did not believe they were any less effective when starting out. Also mentioned were natural attributes that the interviewees believed would also help with success rates such as life experience, relationship building skills, ability to be empathetic and communicate, and the ability to connect with another. As Hersoung et al. (2001) found in one study of articles about this topic, the more experience a therapist has does not guarantee a better working alliance.

On the other hand, five of the interviewees in this study do believe that the more experience you have professionally as a therapist, the higher your chance of fostering a successful outcome with a client. It would appear from the participants' perspective that the longer you practice, and the more situations you are exposed to, the more confidence you gain, and this impacts your work with clients in a positive way. This finding is also consistent with some of articles reviewed in the literature. Interviewees agreed that regardless of theoretical background, it was noted that each therapist has to start somewhere. Therefore, it may be proposed that skillful therapists remain flexible despite years of experience, adjust interventions accordingly, are optimistic, communicate effectively, and build valuable relationships, which in turn increases the chance of successful outcomes in therapy (Hoglend, 1999).

Therapeutic Modality

The research has demonstrated that no particular therapeutic modality used increases the chance for a successful outcome and most approaches can produce positive change (Sullivan et al., 2005). It does appear that the results of the study align with the existing literature. Out of the twelve interviewees, eleven believed that therapy is more successful when a certain modality is used, especially when dealing with specific symptoms, but overall they continue to use an eclectic approach, and no certain therapeutic method appeared to be superior. One interviewee suggested, "I think there is a type of therapy for everyone, you just need to figure out what works for whom." Only one of the interviewees believed that success was more dependent on the client's personality, symptoms, level of motivation, and beliefs, and not on what theory was used to treat those symptoms. It may be concluded from both past research and the present study, that therapists believe using a therapeutic modality as a guideline is essential, but not one particular method increases positive results.

 Client Motivation/Personality/Symptomolgy

Interviewees implied that a client's level of motivation is a key factor to increasing a successful outcome. The interviewees referenced this belief when asked many of the questions, not just ones specific to this notion. The ability to form relationships on both the therapists' and clients' behalf was also another frequently suggested theme by the interviewees throughout the interview. Another common theme was the interviewees' beliefs that there is a particular chemistry between people, and that

both the personality of the client and the personality of the therapist need to fit together in order to form the therapeutic relationship.

It would also appear that the interviewees agreed that clients who generally seek out therapy are healthier, have increased cognitive abilities, and less severe symptomology. These clients tend to have the most success in therapy, a finding commonly noted throughout the literature. Additionally, the interviewees also identified other barriers that may get in the way of successful therapy such as whether the client is voluntary or involuntary, court ordered, or those that are attending therapy in order to please others.

It would appear that the statements made during the interviews regarding a client's level of motivation, personality, and level of symptomology confirm past research on the same topics. Black et al. (2005) implies that a client's characteristics, motivation level, and ability to form relationships all have an impact on both the alliance and the therapy outcome. From the literature review, Coleman (2006) also reiterated that overall personality similarity or particular traits of both therapist and client may have an effect on the nature of successful outcome. Participants of the study confirmed that intoxicated clients, clients that are off their medications, clients that lack insight or struggle to make connections, or clients with significant personality disorder traits may be less suitable for therapy. The literature suggests that clients with less problematic personality traits, an ability to establish relationships, as well as the ability to verbalize and cooperate, largely achieve more success from individual psychotherapy (Hoglend, 1999).

Client Success

This study recognized that the ability to measure a client's success in therapy may in fact be much too subjective, and the way in which success is measured for each client is as unique and individual as the person attending therapy. When interviewees were asked to describe how they measured success with a client it was unanimous that all interviewees measure a client's success by how the client feels they have succeeded. From the interviewees' experience there is no definitive means to answer this question, but several themes emerged regarding signs and skills interviewees look for when measuring success. The use of maintaining and reviewing a client's treatment plan and shared goals may assist in the ability to evaluate and review a client's progress both in a concrete and tangible way. Overall, interviewees agreed, when clients begin to feel better, they have learned new behaviors, increased coping skills, increased self-esteem, or are having fewer symptoms, these can all be viewed as successful outcomes.

In summary, this study attempted to answer the following research question: What are the key factors to producing successful therapeutic outcomes in individual therapy? The information articulated by the interviewees and the themes that emerged from the study are comparable to past research and existing literature. The therapeutic alliance remains to be one of the most, if not *the* most important factor in increasing successful outcomes in therapy. Although the therapeutic alliance continues to remain key to producing favorable outcomes, it may be concluded from both past research, as well as the data analyzed from this study, that empathy, experience of the therapist, therapeutic modality, client motivation, personality, and symptomology, all contribute to successful psychotherapy outcomes.

Limitations

One of the main limitations for this study was its small sample size. Although

there was overwhelming support from potential participants, both time and availability

limitations became an issue. The sample is not random and not reflective of the general

population of therapists. The data was collected through non-standardized, semi-

structured interviews, which means that even though there was a schedule of questions

and follow-up probes, the interview remained conversational (Monette, Sullivan, &

Dejong, 2005). This type of data collection may be difficult to replicate in future studies.

Interviews also come with certain disadvantages when collecting data; they take a

significant amount of time, and pose the threat of interviewer bias (Monette et al., 2005).

As stated by Monette et al. (2005) a researcher may try to remain as objective as possible,

yet runs the risk of misinterpreting a interviewees answers due to personal feelings about

the topic. Also, an interviewer's characteristics may affect the way in which a

interviewee answers, likewise the interviewee may affect the way in which the

interviewer shapes the conversation (Monette et al., 2005). Another limitation was that

seven out of the twelve interviews were conducted over the phone. It was the

researcher's intent to do as many face to face interviews as possible knowing that

interviews over the phone depersonalize the process. Since seven of the interviews had to

be completed over the phone, it could be questioned whether some valuable information

was left out due to not being able to read body language and facial expression.

Lastly, the data collected is based on the opinions of the interviewees' own

experiences and may not be reflective of the clients' view on what makes therapy

successful. Also the population for the study was all LICSW's which may not reflect on

perceptions of those from different disciplines that practice individual therapy. Also, the ability to measure "success" is subjective.

Overall, the interviewees appeared to show pride in their knowledge of the topics, and took joy in being interviewed and sharing their experiences. There were a large number of responses to the snowball sampling method which could indicate an excellent opportunity for future research on this topic, and a willingness of those in the field to participate in improving understanding and increasing expertise.

Implications for future social work research, policy, and practice

Although the topic of the therapeutic alliance and factors that contribute to successful therapy have been extensively researched, new information can always be obtained about a particular subject. The researcher chose the topics that were believed to help contribute to successful therapeutic outcomes; however, within each of those topics future research would be able to not only expand the knowledge base, but also enhance what has already been learned. The information gained from this study will not only increase awareness for those in the social work field practicing psychotherapy, but for all social workers regardless of setting.

As social workers we continue to face barriers not only when helping our clients, but also when trying to navigate the systems already in place. Many of the interviewees brought up the fact that there are barriers both for those *with* as well as those *without* health insurance coverage, and it would appear that each face adversity when trying to take care of their mental health. As social workers we have an opportunity to help

advocate for policy and programs that are less complex and convoluted in order for all in need of service to get the help they require to live healthy, productive lives.

      The interviewees for this study were chosen because of their background in social work theory. Many of the interviewees referenced how their social work education and perspectives have enhanced not only their skills in the field, but also their ability to work with clients more effectively. Each interviewee in this study conveyed something unique to the data collected, yet all seemed to be very aware of how much more there is to working with a client than just the person sitting in front of you. Social workers need to be aware and proud of the distinctive qualities they bring to the field of psychotherapy, and not only use those skills to bring about change in their clients, but also within the larger community.

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Appendix A

CONSENT FORM
UNIVERSITY OF ST. THOMAS/
ST. CATHERINE UNIVERSITY

Factors Influencing Successful Psychotherapy Outcomes

I am conducting a study about contributing factors that influence the successful outcome of individual psychotherapy. I invite you to participate in this research. You were selected as a possible participant because of your background as an LICSW that is currently practicing individual therapy with adults. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Margaret McCoy, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Philip AuClaire, Ph.D.

Background Information:
I am a graduate student at St. Catherine University/University of St. Thomas, and am conducting this research as part of my Clinical Research Project for my Master of Social Work degree. This research project seeks to better understand, from a clinician's perspective, factors influencing successful therapeutic outcomes.

Procedures:
If you agree to be in this study, I will ask you to do the following things: Answer interview questions pertaining to individual psychotherapy. The interview will take approximately 30 minutes and will be completed via telephone or in person. Our entire conversation will be audio taped and then transcribed by the researcher. The data collected will then be analyzed and displayed in the results section of the project paper, and also discussed in a presentation in May 2012.

Risks and Benefits of Being in the Study:
The study has no risks and no direct benefits.

Confidentiality:
The records of this study will be kept confidential. Research records will be kept in a locked box. There will be no identifying information on the audio tape recording or transcription. The consent form, audiotape, and transcription will be destroyed on June 1, 2012.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, information that you provided will be destroyed.

Contacts and Questions
My name is Margaret McCoy Lynch. You may ask any questions you have now. If you have questions later, you may contact me at (612) 799-1142 or my research supervisor Dr. Philip AuClaire at (651) 962-5800. You may also contact the University of St. Thomas Institutional Review Board at (651) 962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audio taped.

_____   _____
Signature of Study Participant   **Date**

_____
Print Name of Study Participant

_____   _____
Signature of Researcher   **Date**

Appendix B

Factors Influencing Successful Therapy Outcomes
Interview Questions

1. Gender?

2. Years of experience?

3. Theoretical modality used?

4. What factors do you believe contribute to the therapeutic alliance?

    -How long does it take to make an alliance with a client?

    -How do you know when you have formed an alliance?

5. What other factors do you believe contribute to successful therapy?

    -Can you list a few?

6. How do you show empathy toward your clients?

7. How does experience of the therapist increase successful outcomes in therapy?

8. Can therapy be successful without an alliance?

9. What clients do better in therapy than others?

10. Is therapy more successful when a particular theory is used?

-Do you use a particular type when dealing with particular symptoms?

11. How do you measure success with a client?

   -When or how do you know a client is done with therapy or has been

   successful?

   -Do you measure success differently for different clients?

12. What qualities do you believe clients look for in a therapist?

   -What do you believe your clients would say about you?

13. Have you received any feedback from clients in the past that has helped you increase

your therapeutic skills?

   -How about a time when therapy was not successful?

   -When do you feel therapy does not work?

   -How would you describe less suitable clients?