

RESEARCH ARTICLE

# Who are we studying? Reporting practices and sample characteristics in psychotherapy research

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## Abstract

Psychotherapy research informs clinical practice and mental health policy. However, limited and inconsistent reporting of sample and contextual characteristics makes it difficult to determine who is represented in psychotherapy research and to assess the generalizability of findings. Objectives. To assess the reporting of PTTC characteristics (patients, therapists, treatment, and context) in psychotherapy research and to describe who is being studied. Method. Descriptive review of 100 psychotherapy studies using a standardized codebook—later used to inform a PTTC questionnaire—with independent reviewers extracting PTTC data. Results. Patients' age and gender were reported in 83.8% and 95% of studies, respectively, whereas education was reported in 46% and race in 50%. Sexual orientation (12%), SES (12%), immigration (5%), rurality (3%), and disability (2%) were rarely reported. Therapist demographics were reported infrequently, including gender (32%) and profession (35%), while years of experience were reported in 15% of studies. Treatment delivery characteristics were moderately reported (modality 56%, session frequency 50%, number of sessions 58%), whereas contextual indicators (care system 59%, level of care 24%, setting 46%) were reported inconsistently. When characterized, patients were primarily adults (97.9%), female (67.7%), urban (81.1%), and tertiary educated (79.4%); therapists were mostly female (81.0%) psychologists (46.0%) working under supervision (67.0%), with an average of 9 years of experience. The context favored individual (66.5%) outpatient treatment (78.3%), most commonly delivered in tertiary-level settings (52.1%) in Europe (46%) and North America (33%). Conclusions. Psychotherapy research overrepresents adults, women, urban residents, and tertiary-educated participants from higher-income settings. Current reporting practices obscure for whom, by whom, and under what conditions psychotherapy is most effective, limiting generalizability and clinical applicability.

**Keywords:** reporting standards; demographic characteristics; therapist variables; treatment context; generalizability; PTTC characteristics

**Clinical and methodological significance of this article:** This study systematically documents how psychotherapy research reports PTTC characteristics (patients, therapists, treatment, and context), revealing substantial gaps in information essential for interpreting and generalizing findings. These omissions weaken external validity, reduce reproducibility, and limit the field's capacity to conduct moderator analyses or make fair cross-study comparisons, with downstream implications for clinical decision-making and service planning. Because psychotherapy research often emphasizes “what works,” inconsistent reporting of PTTC characteristics obscures “for whom,” “by whom,” and “under what conditions” treatments are effective, reducing the usefulness of evidence for clinicians, policymakers, and diverse patient populations. To improve reporting practices in psychotherapy research, the authors suggest measuring PTTC characteristics and offer the PTTC Questionnaire as a step in that direction.

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## Introduction

### Psychotherapy Research and the Challenge of Generalizability

Psychotherapy research plays a fundamental role in shaping clinical practice, training, and health policy. The goal of conducting such research is to improve the quality of psychotherapy and enhance patients' mental health across diverse settings (Norcross & Wampold, 2019). The accumulated body of research in psychotherapy has led to the development of clinical practice guidelines by international organizations, such as the World Health Organization (2023a), and professional associations, including the American Psychological Association (APA, 2023). These guidelines are designed to support clinicians in selecting effective treatments based on the best available evidence. Complementing the disorder-specific guidelines, APA provides professional practice guidelines to work with specific populations considering gender, socioeconomic marginalization, disability, age, and cultural identity (APA, 2021), and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2016) provides guidelines on how to consider patients' race, ethnicity, and culture.

Clinicians must integrate these two sets of tools—disorder-specific treatment recommendations and population-specific practice guidance—when working with real-world patients, whose identities, diagnoses, and contexts rarely align perfectly with those studied. This underscores the relevance of understanding who is included in psychotherapy research. When research publications do not include relevant information about patients, therapists, treatment, and context, clinicians, health services administrators, and policymakers may lack essential information to determine whether the reported findings apply to the realities in which they work.

A persistent issue in the field is the *illusion of generalizability*—the assumption that research findings apply universally, regardless of the population or context in which they were studied. One factor contributing to this illusion is that many psychotherapy research publications do not adequately describe the patients and psychotherapists who participated in the studies, nor the treatment settings in which psychotherapy was delivered (Hook et al., 2015; Smith et al., 2010). This lack of detail can give the false impression that samples are broadly representative, when in fact they may not be (Simons et al., 2017).

### Reporting Standards and the Need for Greater Transparency

There has been increased awareness of the lack of inclusion of social contextual variables and indicators

(social determinants) in mental healthcare research (Alegria et al., 2018; Andermann, 2018). For example, APA's Journal Article Reporting Standards (JARS) emphasize the importance of including detailed demographic and contextual characteristics of research participants, such as age, gender identity, sexual orientation, race, ethnicity, socioeconomic status (SES), and language preference (APA, 2020). These reporting standards promote research transparency and facilitate the translation of findings to varied clinical settings.

Other international standards echo these priorities. The Consolidated Standards of Reporting Trials (CONSORT) statement underscores the importance of describing participant characteristics for interpreting outcomes (Schulz et al., 2010). Similarly, the International Committee of Medical Journal Editors (ICMJE) advises researchers to use respectful and accurate language when describing participants (ICMJE, 2025). ICMJE recommendations explicitly state that authors should report how race/ethnicity data were collected (or explain why they were not collected) and interpret any race-related findings in the proper context, using neutral, non-stigmatizing terminology.

Describing participants in detail is not only a matter of transparency but also essential for internal and external validity. According to APA, the Methods section of a scientific article should include enough information to allow replication, particularly through a clear account of participant characteristics (APA, 2020).

### The Need for More Specific Reporting in Psychotherapy Research

While the previously cited guidelines provide important information and highlight the need for better measurement of demographic variables, they lack specificity and/or are not adequate for the field of psychotherapy research. Thus, a concrete proposed format for characterizing samples in psychotherapy research remains lacking and is particularly important given international efforts to coordinate routine clinical data collection through regional networks, global outcomes initiatives, and national monitoring systems (e.g., American Psychiatric Association, 2023; Australian Mental Health Outcomes and Classification Network, n.d.; De Bienassis et al., 2021; Despaul, 2015; Delgado et al., 2016; Gonçalves et al., 2024; International Consortium for Health Outcomes Measurement, n.d.; Organisation for Economic Co-operation and Development, n.d.; Society for Psychotherapy Research—Latin America initiative, n.d.; Te Pou o te Whakaaro Nui, n.d.).

Collecting high-quality demographic and contextual data is a prerequisite for making meaningful cross-clinic or cross-country comparisons. Without transparent metadata about who is being treated, by whom, how, and in what setting, apparent differences in outcomes can simply reflect differences in patients, therapists, therapy characteristics, or context rather than genuine performance or effectiveness. For example, a recent systematic review and meta-analysis found that several indicators of SES—including income, education, employment, and neighborhood deprivation—were associated with poorer psychological therapy outcomes, illustrating how clinics serving more socioeconomically disadvantaged communities may appear less effective despite providing comparable care (Finegan et al., 2018). Without information on these social indicators, the moderating effect of SES could easily be misattributed to other factors.

### **PTTC Characteristics (Patients, Therapists, Treatment, and Context)**

Decisions about what we measure determine who becomes visible and influential in evidence and policy: the things we count become the basis for decisions and resource allocation, while what we leave uncounted is effectively rendered invisible (D'Ignazio & Klein, 2020). Reporting who receives psychotherapy (patient -P), who delivers it (therapist—T), what the intervention is (treatment -T), and under what conditions it took place (context—C), which we will call PTTC characteristics, directly shapes which populations become visible in evidence syntheses and, in turn, who is ultimately considered in clinical guidelines and policy decisions.

Research consistently demonstrates that demographic variables are related to mental health outcomes and treatment processes. For instance, SES is strongly associated with exposure to stress and prevalence of mental disorders (Baum et al., 1999; Lund et al., 2010). However, SES is often neglected in psychotherapy studies (Blackshaw et al., 2018). Race and ethnicity also influence access to and quality of mental health care, with individuals from minoritized racial groups receiving lower quality services and being less likely to seek care (Lipson et al., 2018; U.S. Department of Health and Human Services, 2019).

Gender and age further intersect with mental health prevalence and treatment-seeking behaviors. Women experience higher rates of depression and anxiety and are more likely to seek treatment than men, while men are underrepresented in service utilization (Kessler et al., 2005; Lipson et al., 2018;

Seedat et al., 2009). Further, intersectionality research (e.g., Bauer et al., 2021) shows that some demographic variables—such as gender, age, race/ethnicity, and socioeconomic status—jointly shape mental health needs, access, and outcomes. Nevertheless, the effect of the intersection between demographic variables is rarely controlled for (Bauer et al., 2021).

Beyond patient characteristics, some therapist variables also significantly influence psychotherapy outcomes. For example, whether the therapist receives supervision appears to play an important role in promoting interpersonal aspects of therapists (Rønnestad et al., 2025), as well as therapists' technical competence, reflective capacity, and ability to adapt to diverse patient needs (Orlinsky et al., 2004).

The therapeutic context has also been found to be relevant. For example, in England, Delgado and colleagues (2016) found that poorer areas had lower average recovery rates in mental health care, which they hypothesized were likely related to employment status, baseline symptom severity, functional impairment, and therapist variability. In Chile, Fischer and colleagues (2019) found that a complex treatment context within public health can affect therapists' perceptions of their patients and patients' adherence to treatment.

### **The Present Study**

Given the relevance of reporting PTTC data, and of having research represent our diversity as humans, we aimed to systematically examine how contemporary psychotherapy research reports on these variables and to describe who is being studied. Specifically, we aimed to assess what information is commonly reported about patients (e.g., age, gender, SES, education), therapists (e.g., age, gender, theoretical orientation, training, years of experience), treatment (e.g., frequency of sessions, and type of intervention), and treatment context (e.g., clinical setting). The coding framework developed for this task also served as an initial step toward future efforts to standardize the reporting of PTTC characteristics in psychotherapy research.

## **Methods**

### **Design**

This study used a descriptive review design to systematically analyze 100 psychotherapy research articles published in four leading journals in the field. A set of standardized procedures was applied to ensure the validity and reliability of the findings.

## Journal Selection

In August 2022, we searched the SCImago platform (subject area: Psychology; subject category: Clinical Psychology; and all regions/countries) and identified 73 Q1 journals, all published in English. From these, we selected the four highest-ranked peer-reviewed journals that included the term “Psychotherapy” in the title and were not restricted to a specific disorder, condition, subfield, or theoretical orientation. This approach allowed us to focus on journals that broadly represent the field of psychotherapy research while maintaining a manageable and comparable corpus of articles for detailed coding. The selected journals<sup>1</sup> were “*Psychotherapy*” (ISSN 0033-3204), “*Psychotherapy Research*” (ISSN 1050-3307), “*Psychology and Psychotherapy: Theory, Research and Practice*” (ISSN 2044-8341), and “*Clinical Psychology & Psychotherapy*” (ISSN 1063-3995).

## Search Strategy and Article Retrieval

We queried APA PsycInfo (EBSCO) in September 2022, restricting results to the four journals via their ISSNs and limiting publication years to 2019–2022. The search targeted empirical psychotherapy studies and excluded reviews based on the information provided in the methodology and title fields. The query was: IS (0033-3204 OR 1050-3307 OR 2044-8341 OR 1063-3995) AND TX (“Psychotherapy” OR “Therapy” OR “Counseling” OR “Intervention” OR “Treatment”) NOT MR (“meta-synthesis” OR “literature review” OR “systematic review” OR “meta analysis”) NOT TI (“scoping review” OR “meta-analysis” OR “systematic review” OR “narrative review”). The search yielded 863 records: 170 (Psychotherapy), 250 (Psychotherapy Research), 169 (Psychology and Psychotherapy), and 274 (Clinical Psychology & Psychotherapy).

## Screening and Eligibility

Article metadata (authors, title, journal, year, volume, issue, pages, abstract, keywords, DOI) were organized in a master table and sorted in descending order (2022 → 2019). Three licensed psychologists and research assistants independently screened the first 60 abstracts from each journal against pre-specified criteria. The inclusion criteria were: (1) empirical articles focused on psychotherapy research, (2) studies involving patients of any gender or age group, (3) the use of qualitative, quantitative, or mixed-methods designs, and (4) a longitudinal or cross-sectional design. The exclusion criteria included: (1) meta-analyses, systematic reviews, or literature reviews, (2) single-case studies, (3)

studies without patients as participants, (4) clinical guidelines, and (5) author commentaries. Discrepancies about whether an article met the inclusion criteria were resolved in group discussions. From eligible records, the first 25 articles per journal were selected for data extraction (total  $n=100$ ). A PRISMA-style flowchart is shown in Figure 1.

## Data Extraction and Quality Checks

A data extraction table<sup>2</sup> and codebook were developed by the research team and organized into four sections: (1) Study information, (2) Patient characteristics, (3) Treatment setting, (4) Therapist characteristics.

Each variable consisted of two columns: (1) whether the article reported the information, and (2) if so, what specific information was provided. For example, regarding patients’ educational level, the data extraction table captured: (1) whether this information was reported in the article, and (2) if so, the educational level of the patient sample.

To standardize procedures, we developed a codebook<sup>3</sup> with operational definitions and detailed entry instructions. Included articles were randomly assigned to pairs of assistants who independently extracted data from full texts. The assistant pairs then met to discuss and resolve these differences. If discrepancies remained, a team member reviewed them and adjudicated unresolved items.

After extraction, we conducted a final audit. Outliers in all numeric variables (e.g., the number of participants per gender) were flagged using the interquartile range (IQR) method: Q1 (25th percentile), Q3 (75th percentile),  $IQR = Q3 - Q1$ ; lower bound =  $Q1 - 1.5 \times IQR$ ; upper bound =  $Q3 + 1.5 \times IQR$ . Values falling below the lower bound or above the upper bound were considered as potential outliers. Two newly recruited assistants independently reviewed potential outliers, and a team member resolved disagreements.

## Data Analysis

We performed descriptive analyses to (1) quantify how frequently each target variable was reported and (2) summarize patterns in the reported values. Analyses were conducted in RStudio (Version 2025.05.0 + 496).

## Results

### Patient Demographics

While 83.8% of studies reported the mean age of patients, only 66.7% reported the corresponding

Articles Selection Method and Data Extraction

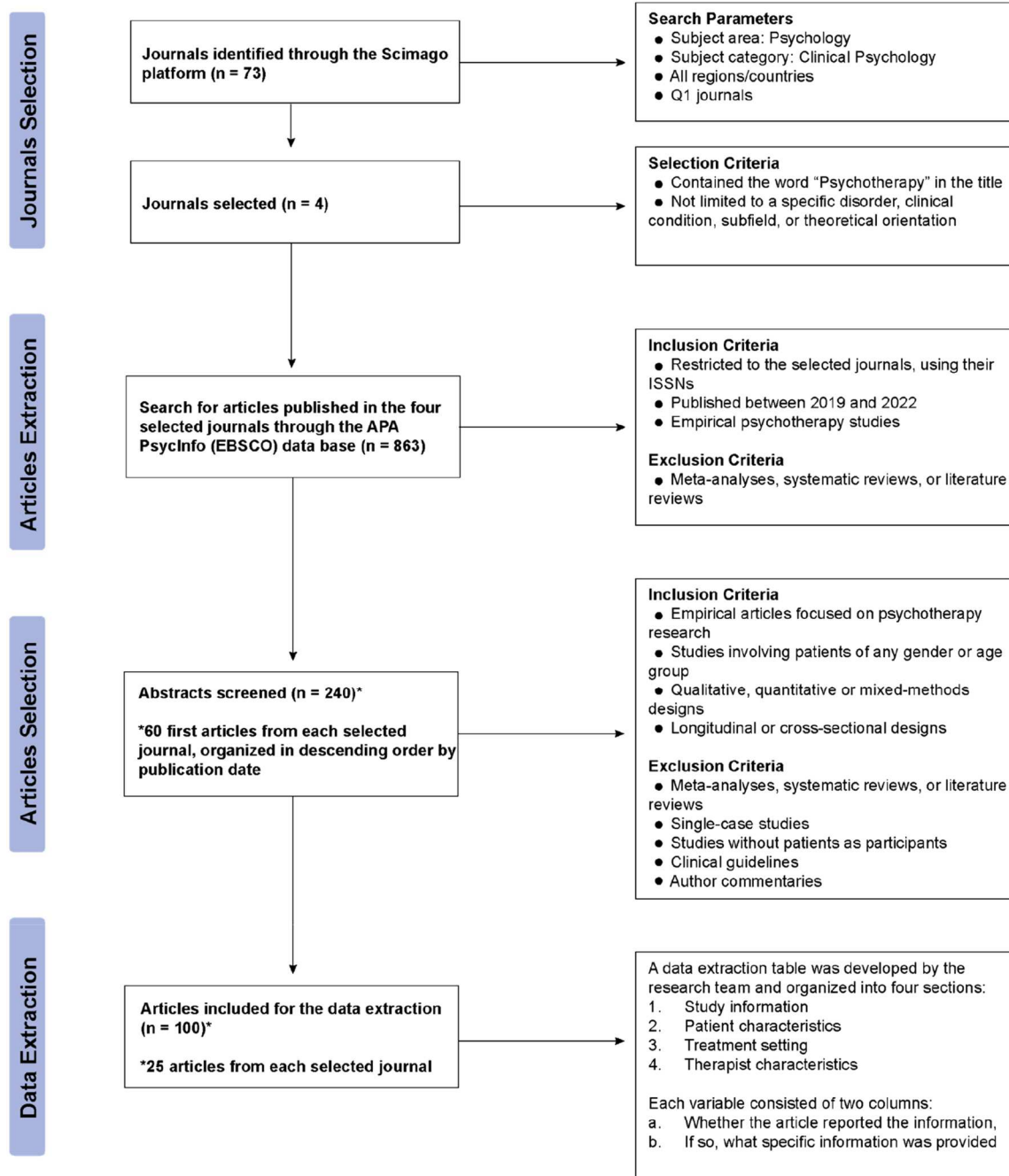


Figure 1. Articles selection method and data extraction.

Note: A member of the research team examined any discrepancies in inclusion or exclusion decisions. These discrepancies were subsequently addressed and resolved through group discussions.

standard deviation. Age group was reported or reasonably inferred in 76.8% of studies. Pooled across reporting studies, children (<12) accounted for 0.01%, adolescents (12–17) for 3.04%, adults (18–59) for 22.39%, older adults (60+) for 0.02%, and 18+ (adults & older adults not distinguished)

for 75.54%—illustrating that samples were overwhelmingly adult.

Reporting on gender was relatively common, with 95% of studies including gender data. However, only 67% of studies explicitly reported the number of male participants, 90% the number of female

participants, and 60% included participants identified as “other” genders. Among reporting studies, samples were 67.74% female, 32.01% male, and 0.25% other/non-binary.

By contrast, sexual orientation was rarely described (12%). Among those who did report it, participants were predominantly heterosexual (72.43%), with non-heterosexual individuals representing 27.57%. SES showed a similar pattern: only 12% reported SES; among these, low SES predominated (66.03%), followed by middle (33.97%), with high SES absent. Area of residence (urban/rural) was reported in only 3% of studies; when present, urban residence highly predominated (81.07%) over rural (18.93%).

Educational attainment was somewhat better covered (46% reported years of formal education or the highest level of education). Among reporting studies, the highest completed level was tertiary for 79.36% of participants, secondary for 19.32%, primary for 1.28%, and only early childhood for 0.04%—suggesting that samples were skewed toward higher educational attainment. Employment status was reported in 33% of studies; among these, 54.72% were employed, and 45.28% were not.

Immigration-related variables were rarely reported: immigration status in 5% of studies and nationality in 20%. Ethnicity (46%) and race (50%) were reported about half of the time. Relationship status was reported in 38% of studies, and among those, participants were single (19.96%), married (32.21%), dating/living with a partner (26.50%), or divorced/separated/widowed (21.32%). Household composition was reported in only 5% of cases; among those who reported it, 78.92% lived with others and 21.08% alone. Finally, disability was rarely reported (2%); among those, 17.73% of participants had a disability, and 82.27% did not (Table I).

Therapist characteristics were reported much less frequently than patient variables. Half (50%) of the studies stated the number of therapists, averaging 21.12 (SD 22.12; range 1–85) per study. The therapist’s age was reported in only 19% of studies; among those, the mean was 37.06 years (SD 6.61; range 28.79–47.55). Therapist gender appeared in 32%; among reporting studies, therapists were 80.96% women, 18.62% men, and 0.42% other.

Regarding professional background, 35% of studies reported therapists’ profession: among these, psychologists made up 45.96%, followed by counselors (35.58%), social workers (11.71%), and psychiatrists (6.76%). An academic degree was likewise reported in 35% of the studies; among those, 79.29% held a graduate/college degree, 18.44% a PhD, and 2.27% a master’s. Years of experience were reported in

15% of studies (mean 8.87 years, SD 4.41; range 3–15), and clinical supervision was reported in 34%; where reported, 67.01% of therapists received supervision during the study. Finally, theoretical orientation was described in 24% of studies: among those, psychodynamic approaches were most frequent (40.71%), followed by cognitive–behavioral (33.20%), integrative (25.27%), humanistic/experiential (0.82%), and systemic (0%) (Table II).

### Treatment Delivery and Context of Care

Treatment modality and “dose” were reported more often than therapist details, but less comprehensively than core patient demographics. Psychotherapy modality was specified in 56% of studies; among these, individual therapy predominated (66.52% of participants), followed by group therapy (29.42%), with couple (0.57%) and family (3.50%) treatments used infrequently. Session frequency was reported by 50% of studies, with a mean of almost a week between sessions ( $M = 6.81$ ,  $SD = 2.09$ ) and a range of 1–14 days. The total number of sessions was reported by 58%, averaging 13.36 sessions (SD 5.31); and session duration by 26%, most commonly 45–60 min (45.46%), followed by 90 min (27.27%) and 120–150 min (22.73%).

Contextual features were variably documented. The care system (public/private/university) appeared in 59% of studies; among reporting studies, distributions by studies/patients were public: 40.30% / 35.18%, private: 22.39% / 43.85%, and university: 37.31% / 20.97%—suggesting a sizable share of patients were seen in private systems even when studies were more often situated in public or university settings. The level of care (primary/secondary/tertiary) was reported in 24% of studies; among these, primary accounted for 26.32% of studies / 34.26% of patients, secondary for 42.11% / 13.64%, and tertiary for 31.58% / 52.10%, indicating that while fewer studies were set in tertiary care, over half of the reported patient volume came from those settings. Care type (setting)—inpatient vs outpatient—was reported in 46% of studies; among them, outpatient care predominated (83.33% of studies / 78.25% of patients), with inpatient accounting for 16.67% / 21.75%.

Finally, the geographic distribution of data-collection sites (by studies) showed a concentration in Europe (46%) and North America (33%), with far fewer studies from Oceania (3%), Asia (2%), South America (2%), and Africa (1%); 1% involved multiple countries, and 12% did not report the country (Table III).

Table I. Reporting of patient demographic characteristics.

Whether the article reported the variable or not		When a variable was reported, the results for the total participants across articles	
Variable reported	%	Variable levels	%
Average age	83.00%	Mean ± SD (range)	33.83 ± 9.87 (14–72.19)
Age group	77.00%	Children (<12)	0.01%
		Adolescents (12–17)	3.04%
		Adults (18–59)	22.39%
		Older Adults (60+)	0.02%
		Adults & Older Adults (18+)	75.54%
Gender	95.00%		
Male gender explicitly	67.00%	Male	32.01%
Female gender explicitly	90.00%	Female	67.74%
Other gender explicitly	60.00%	Other	0.25%
Sexual orientation	12.00%	Heterosexual	72.43%
		Non-heterosexual	27.57%
Socioeconomic status	12.00%	High	0%
		Medium	33.97%
		Low	66.03%
Area of residence	3.00%	Urban	81.07%
		Rural	18.93%
Years of education	46.00%	Early childhood	0.04%
		Primary	1.28%
		Secondary	19.32%
		Tertiary	79.36%
Employment status	33.00%	Employed	54.72%
		Not Employed	45.28%
If immigrant	5.00%		68.3%*
Nationality	17.00%		**
Ethnicity	46.00%		***
Race	50.00%	White	71.82%
		Non-white	28.18%
Relationship status	38.00%	Single	19.96%
		Married	32.21%
		Dating/Living with partner	26.5%
		Divorced/Separated/Widow	21.32%
Living situation	5.00%	Lives alone	21.08%
		Does not live alone	78.92%
Disability status	2.00%	Disability	17.73%
		No disability	82.27%

Note. In the two left columns, this table summarizes the proportion of psychotherapy studies ( $N = 100$ ) that reported key demographic patient variables. The two right columns present the results for the total participants across articles that reported each variable. \*Of the 5% of articles ( $n = 5$ ) that reported immigration, only two reported the total number of immigrant participants from the total sample, and thus were used for this calculation. One of these two studies was specifically focused on immigrants. \*\*Of the 17% of articles ( $n = 17$ ), in 15, the participants' nationality coincided with the country of data collection. Of the remaining two papers, one focused on the mental health of the immigrant population in Germany, comprising participants from Afghanistan, Iran, Syria, Africa, and other Arab countries. The other was conducted in Australia and included participants from Australia, Asia, New Zealand, and Africa. \*\*\*Due to the vast possibilities of ethnicity, we did not code this variable.

### Discussion

Using a descriptive review of 100 international psychotherapy studies (2019–2022) across four journals and applying a standardized codebook, we found a clear pattern in reporting practices. Core patient descriptors (age, gender) and treatment delivery characteristics were the most consistently documented (e.g., age reported in 83%; gender in 95%; treatment modality in 56%; total sessions in 58%). By contrast, other relevant patient characteristics were

rarely reported: sexual orientation (12%), SES (12%), immigration status (5%), area of residence (3%), and disability (2%). When these characteristics were provided, samples were skewed toward adults, predominantly female, largely urban, and highly educated (e.g., 79% of patients had tertiary education). While the participants in the psychotherapy studies reviewed do not represent those in most need of mental health treatment, these are likely the samples most often studied because they are the ones most accessible to researchers and easier to

Table II. Reporting of therapists' characteristics.

Whether the article reported the variable		When reported, the results for the total participants across articles	
Variable	% reported	Variable levels	% of total participants
Number of therapists in the study	50.00%	Mean $\pm$ SD (range)	21.12 $\pm$ 22.12 (1–85)
Age	19.00%	Mean $\pm$ SD (range)	37.06 $\pm$ 6.61 (28.79–47.55)
Gender	32.00%	Male	18.62%
		Female	80.96%
		Other	0.42%
Career	35.00%	Psychologist	45.96%
		Psychiatrist	6.76%
		Social Worker	11.71%
		Counselor	35.58%
Academic Degree	35.00%	Graduate	79.29%
		Masters	2.27%
		PhD	18.44%
Years of experience	15.00%	Mean $\pm$ SD (range)	8.87 $\pm$ 4.41 (3–15)
Supervision	34.00%	Therapists receiving supervision	67.01%
Theoretical orientation	24.00%	Psychodynamic	40.71%
		Cognitive-behavioral	33.2%
		Integrative	25.27%
		Humanistic/Experiential	0.82%
		Systemic	0%

*Note.* In the two left columns, this table summarizes the proportion of psychotherapy studies ( $N = 100$ ) that reported key demographic variables for therapists. The two right columns present the results for the total participants across articles that reported each variable.

study (e.g., they miss fewer sessions and are more likely to understand questionnaires). Structural and institutional factors may also contribute to these patterns. Prior work has emphasized that health research often fails to adequately capture social determinants and contextual variables relevant to mental health outcomes (Alegría et al., 2018; Andermann, 2018). Limited collaboration between researchers and community-based services and uneven research capacity across regions may also constrain the inclusion of diverse populations.

Reporting on therapist characteristics was sparse beyond headcounts: number of therapists (50%), gender (32%), profession (35%), academic degree (35%), years of experience (15%), supervision (34%), and theoretical orientation (24%). Where reported, therapists were mostly women (81%), commonly psychologists (46%), with supervision present for 67% of therapists and an average of 9 years of clinical experience.

Context favored outpatient care (83% of reporting studies), individual treatment (67% of participants), and substantial patient volume in tertiary-level settings (52% of reported patients), with most studies originating in Europe and North America.

When data were not reported, it was unclear whether this was because the subgroup was not present in the sample or because it was not an answer option. For example, only 67% of studies explicitly reported the number of male participants, 90% the number of female participants, and 60%

included participants identified as “other” genders. Thus, it was unclear whether a gender was not reported because it was not asked about or because it was absent from the sample. If a paper reported that 68% of the sample were female, it was not clear whether the remaining 32% were male or whether the researchers had not included gender options beyond male and female. Ideological reasons may explain such omissions in attributes such as gender or sexual orientation. Nevertheless, it is also possible that certain characteristics only become visible to researchers when they are evident, for example, not reporting disabilities because they are not obvious attributes of participants, or not reporting educational status because participants seem well educated.

From our results, we conclude that it is necessary to report more comprehensive information than is typically provided on patient demographics, therapists' characteristics, the treatment provided, and the setting in which it took place. This descriptive information is essential because we cannot assume that accumulated research knowledge automatically applies to patients from diverse socioeconomic backgrounds and demographic groups. Readers need to understand which populations are represented in a given study, so that they do not overgeneralize the findings, such as the effectiveness of a particular therapy, to all individuals. Of course, systematic reviews, meta-analyses, and clinical guidelines should also consider these variables.

Table III. Reporting of treatment and context characteristics.

Whether the article reported the variable		When reported, the results for the total participants across articles	
Variable	% reported	Variable levels	% of total participants
Therapy type	56.00%	Individual	66.52%
		Group	29.42%
		Couple	0.57%
		Family	3.5%
Session frequency	50.00%	Mean ± SD (range)	6.81 ± 2.09 (1.00–14.00)
Number of sessions	58.00%	Mean ± SD (range)	13.36 ± 5.31(2–48)
Session duration in minutes	26.00%	45–60	45.46%
		90	27.27%
		120–150	22.73%
Context of care system (studies / patients)	59.00%	Public	40.3% / 35.18%
		Private	22.39% / 43.85%
		University	37.31% / 20.97%
Care level (studies / patients)	24.00%	Primary	26.32% / 34.26%
		Secondary	42.11% / 13.64%
		Tertiary	31.58% / 52.1%
Care type (studies / patients)	46.00%	Inpatient	16.67% / 21.75%
		Outpatient	83.33% / 78.25%
Country where the data was collected	88%	Europe (Denmark, Finland, Germany, Italy, Netherlands, Portugal, Spain, Sweden, UK)	46%
		North America (Canada, US)	33%
		Oceania (Australia)	3%
		Asia (China)	2%
		South America (Brazil)	2%
		Africa (Egypt)	1%
		Multiple Countries (US, Canada, Israel, Japan, Sweden)	1%

Our findings show that current psychotherapy studies tend to overrepresent adults, women, urban residents, and tertiary-educated participants from higher-income settings, a profile that diverges from global population patterns—where a substantial share of people live outside major metropolitan areas and most adults worldwide have not completed tertiary education (United Nations, Department of Economic and Social Affairs, 2018; UNESCO Institute for Statistics, n.d.). At the same time, groups central to global mental-health need and policy are underrepresented or poorly described—including people with disabilities, international migrants, and rural communities—all of whom face well-documented health and access inequities (International Organization for Migration, 2024; World Health Organization, 2023b; World Health Organization, n.d.; World Health Organization, 2022). Although women experience a higher burden of common mental disorders globally, the absence of consistent reporting on other equity-relevant characteristics (e.g., disability, migration status, rurality) means the literature risks systematically overlooking children and adolescents, older adults, migrants, rural populations, sexual and gender minorities, and persons with disabilities when translating findings

into practice and public policy (World Health Organization, 2022).

Our results from four major psychotherapy research journals show that most of the 100 studies originated in Europe and North America, and the least from Asia, South America, and Africa. These results are in line with findings from the Psychotherapy Research journal alone: submissions were concentrated in Europe and North America, while Africa and Asia had very limited representation. In addition, high-income countries accounted for far more submissions than low-income countries, and acceptance rates were highest for North America and Europe and lowest for Africa and Asia/Southeast Asia (Solomonov et al., 2025). The current results also align with broader structural biases in psychological science. Prior work has shown that 96% of participant samples in leading psychology journals come from WEIRD countries—that is, Western, Educated, Industrialized, Rich, and Democratic contexts (Arnett, 2008; Henrich et al., 2010)—and that research from non-Western contexts faces higher barriers to publication (Tindle, 2021). These systemic biases narrow the diversity of published evidence, even further than how the *illusion of generalizability* was initially described—as the

appearance that findings are global simply because they span multiple countries, even when samples remain sociodemographically homogeneous (Ghai et al., 2024).

Our findings expose a central tension in psychotherapy science: the field aspires to produce generalizable knowledge, yet often omits the descriptors needed to test such claims. The illusion of generalizability flourishes when samples are thinly described; we have very little information about who is being studied, but we typically write research results and conclusions as if our findings were universal. Underreporting of SES, immigration status, disability, rurality, sexual orientation, race/ethnicity, and other relevant characteristics forecloses moderator tests, weakens meta-analytic inferences, and obscures whether effects travel across populations and contexts. In a field that emphasizes equity and population health, failing to specify who is studied creates an evidentiary gap, not a mere stylistic lapse.

Equally limiting is how little we learn about therapists and contexts, despite evidence that provider and contextual characteristics impact treatment outcomes. When years of experience, discipline, level of health care, and other key factors are inconsistently reported, we cannot accumulate knowledge about provider-level moderators or understand when (and for whom) particular configurations of therapist and clinic factors matter. The result is a literature optimized to answer “what works,” but underpowered to answer “by whom” and “under what conditions”—the very questions that determine external validity and implementation.

Contemporary standards—JARS, CONSORT, and ICMJE—converge on transparent, respectful, and reproducible characterization of participants and settings, which require collecting and reporting PTTC data to enhance the interpretability of research findings and facilitate cross-national comparability. Nevertheless, our findings show that these standards, which most researchers would likely endorse, are not being followed.

### **Development of a Standardized Demographic Questionnaire**

Our results indicated the urgent need to report more comprehensive information than is currently provided and to reach consensus in the field of psychotherapy research on which demographic information should be reported. Psychotherapy research has presently-lacks an integrated, internationally standardized instrument for reporting participants’ demographic characteristics, therapists’ professional backgrounds, treatment characteristics, and contextual variables

needed for cross-study comparability and informed implementation. Existing tools—such as clinical intake forms, national datasets, and outcome measures—either address narrow domains or are designed for administrative or clinical purposes rather than harmonized research reporting.

To contribute to this endeavor, we began developing a standardized demographic questionnaire for international research with two main objectives: (1) systematically gather key sociodemographic variables to enable a comprehensive characterization of psychotherapy samples and to identify factors that may influence or contextualize study outcomes; and (2) enhance cross-study and cross-regional comparability by aligning the selected indicators with internationally recognized demographic standards. The proposed instrument needs to be culturally adaptable yet internationally relatable.

To development a first version of the questionnaire, we reviewed guidelines and recommendations from various international organizations (e.g., the Pew Research Center, the Demographic and Health Surveys (DHS) Program, the United Nations, the World Health Organization, the U.S Office of Management and Budget, the European Commission, the International Social Survey Programme, the Washington Group on Disability Statistics, the World Values Survey Association and ESOMAR) on best practices for collecting demographic information.

The first version of the questionnaire we created, called PTTC-1, aims to characterize patients (P), therapists (T), treatments (T), and care context (C). All the items have standardized response options for cross-site comparison, and most have been taken verbatim or adapted from internationally recognized sources.

The PTTC-1 requires socialization within the psychotherapy research community to gather feedback from researchers worldwide, thereby improving it and creating more comprehensive versions that will also help characterize patients, therapists, treatments, and contexts. Researchers can access the PTTC-1 and a user’s guide, as well as provide their feedback, at [www.psiconecta.org/pttc-questionnaire](http://www.psiconecta.org/pttc-questionnaire). In the future, this link will hold further developments of the questionnaire.

### **Implications for Research**

Our results indicate that important demographic and contextual variables required to determine how and why psychotherapy effects vary across patients, therapists, institutions, and regional contexts are systematically omitted or underreported in studies.

When key moderators are absent or unevenly measured, apparent differences in outcomes may be misattributed. For example, Deisenhofer et al. (2025) demonstrated that incorporating clinic-level variance substantially reduced the estimated therapist effect on symptom change—from 7.8% to 0.9%—while revealing a significant institution effect of 6.3%, indicating that contextual characteristics were previously misassigned to therapists. Such misattribution is likely magnified when demographic and contextual variables are missing or inconsistently measured, particularly across countries and health systems with substantial structural differences in access, resources, and population composition.

A collective effort to increase reporting of demographic and contextual variables will enable psychotherapy researchers to examine moderation effects more systematically and meaningfully at different levels. For example, patient-level characteristics (e.g., educational level) may moderate outcomes within therapists and within clinics; therapist-level variables (e.g., profession) may explain differences between therapists; and contextual or institutional factors (e.g., neighborhood deprivation) may explain differences between settings.

At the meta-analytic level, it is also essential to account for both sample-level and study-level effects by estimating within- and between-study moderations. Although these analytic strategies are well established, they have not been applied systematically, possibly because the field lacks consensus on which sociodemographic and contextual variables should be collected, how they should be measured and analyzed, and for what purposes. A contribution of this paper is to highlight the need for PTTC data so that meta-analytic methods—already available—can be used appropriately and consistently.

In this regard, the Bayesian approach is particularly valuable for studying specific sociodemographic characteristics, disabilities, and contextual factors as moderators, as the subgroups defined by them often have small sample sizes, high variability, and complex interactions (Skinner et al., 2025; Wang et al., 2024). Traditional frequentist methods can struggle in such cases, producing unreliable parameters or failing to detect meaningful effects due to low statistical power. Bayesian methods, by contrast, allow the incorporation of prior knowledge from previous studies or theoretical expectations, improving estimation precision and interpretability even in small samples (Wagenmakers et al., 2017). In this context, meta-analyses may provide empirically grounded priors that will enhance the accuracy and credibility of Bayesian models (Gronau et al., 2021; Weber et al., 2021). For example, if prior studies

suggested that visual impairment slightly reduced the effectiveness of certain therapeutic interventions, that information could be considered in the previous distribution for the moderation effect.

Moreover, Bayesian frameworks easily accommodate hierarchical and multilevel models, which are essential when accounting for nested data structures and contextual moderators (Pennello, 2013). Bayesian inference provides posterior distributions for all parameters, allowing researchers to make probabilistic statements such as: “With the knowledge we have so far, there is a 90% probability that the effect of a given therapeutic process on outcomes is smaller among patients from a specific sociodemographic or contextual subgroup.” These kinds of probabilistic interpretations of treatment effects across diverse populations can inform personalized interventions and improve equity in psychotherapy research and delivery.

### Implications for Clinical Practice

Incomplete demographic and context reporting reduces clinicians’ ability to judge fit (for whom, by whom, and under what conditions). The observed skew towards adult, urban, higher-educated samples and individual outpatient treatments cautions against assuming applicability to children/adolescents, rural communities, patients with lower education, or those with disabilities. In the future, we hope more complete reporting will enable clinicians to make better-informed, context-sensitive decisions and tailor care to underserved groups.

### Implications for Policy and Health-Systems Planning

Policymakers and service leaders need reliable information on who receives psychotherapy and how and where it is delivered to allocate resources appropriately and design effective services. Underreporting of demographic and contextual variables limits the ability to identify gaps in service access and to monitor how well services reach different population groups. Without systematic information on PTTC characteristics, health systems cannot adequately assess whether psychotherapy services are reaching the populations they intend to serve, nor can they determine whether differences in outcomes across services reflect treatment quality or differences in patient, therapist, or contextual characteristics. More complete reporting would support more accurate benchmarking across services and better-informed decisions about workforce development, service planning, and resource allocation.

## Limitations

Our review is confined to four journals over 2019–2022 (English-language), which may overrepresent higher-income regions and certain editorial norms; results may not generalize to all outlets or earlier other time periods. We sampled the first 25 eligible papers per journal, which—while systematic—may introduce selection effects. In addition, because our focus was on reporting practices rather than outcomes, we cannot draw causal inferences about how reporting completeness affects reported treatment outcomes.

## Conclusion and Future Directions

To our knowledge, this is the first study to assess who is being studied in psychotherapy research systematically. As we have shown, many groups are underrepresented, and we lack adequate reporting to understand the generalizability of our findings. The lack of recognition of this gap has contributed to the perpetuation of an illusion of generalizability.

Thus, we recommend agreeing on an ideal (and minimal) reporting set of PTTC descriptives in every paper, with quantification and clear definitions (e.g., how race/ethnicity, SES, and disability will be measured). As explained in this paper, our team has assembled a first version of a possible consensus questionnaire, the PTTC Questionnaire v1. In addition, we urge journals, funders, and ethics boards to require reporting of PTTC characteristics—in the article or supplementary materials—linking compliance to publication, approval, and funding decisions.

As it is, psychotherapy science robustly addresses what works, but too often leaves unanswered for whom, by whom, and under what conditions. Systematic, quantified reporting of PTTC characteristics—who receives psychotherapy, who delivers it, what the intervention is, and under what conditions—is essential to enhance the generalizability of findings, to inform clinical decision-making and policy-making better, and ultimately improve patient care across diverse populations.

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## Author Contributions

Paula Errázuriz: Conceptualization, study design, supervision, data interpretation, manuscript drafting, manuscript review, and corresponding author; Stephanie Vaccarezza: Study design, data extraction, manuscript drafting and editing; Sebastián Opazo: Data management, supervision, and manuscript review; Danilo Moggia: Drafting of methodological discussion and manuscript review; and Candice Fischer: Conceptualization and manuscript review.

All authors reviewed and approved the final manuscript.

## Declarations and Ethics Statements

This study involved analysis of previously published research articles and did not involve human participants or the collection of identifiable personal data. Therefore, ethical approval, informed consent from participants, clinical trial registration, and a consent-to-publish statement were not required.

## Disclosure Statement

No potential conflict of interest was reported by the author(s).

## Use of Generative AI

Generative artificial intelligence (AI) tools were used to do a preliminary search of information, which we carefully reviewed and take full responsibility for, and aid in the editing of this manuscript.

## Data Availability Statement

The dataset underlying this study consists of coded information extracted from publicly available published articles and can be shared upon request to the corresponding author.

## Supplementary Material

Supplemental data for this article can be accessed online at <https://doi.org/10.1080/10503307.2026.2653991>.

## Notes

- <sup>1</sup> For information about each selected journal included refer to Table 1 in supplementary material.
- <sup>2</sup> Refer to Supplementary Table 2 for a comprehensive list of all the variables evaluated in each section for data extraction.
- <sup>3</sup> The codebook can be accessed as supplementary material.

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