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Making & Sustaining Change from Psychotherapy: A Mixed Method Study

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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 the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This mixed method study explored both (1) how changes are made and (2) what encourages the maintenance of change after psychotherapy. Literature has called for further exploration into what helps clients to make and sustain change from their perspectives. While the effectiveness of approaches such as: psychodynamic, cognitive behavioral, and other disorder-specific treatments has been demonstrated broadly, less is known about individual variables, and specifically about how individuals participate in and support their recovery. This study used a mixed method sequential design. Wampold & Imel's (2015) contextual model was used as a conceptual framework throughout the study. Using secondary data analysis, we used quantitative methods to explore the degree to which clients made and maintained progress using an empirical measure: the OQ-45.2 (using a longitudinal, within subjects design). Fourteen (N = 14) qualitative interviews were reviewed to hear from a sample of former clients about their impressions of what supported their efforts at change and how they maintained these gains 12–18 months post treatment. The findings of the quantitative strand demonstrated clinically meaningful change from pretest to posttest, posttest to follow-up, and from pretest to follow-up with an effect size of d = .5. Qualitative themes emerged within five categories used to describe the findings. These categories included questions asking about: (1) what drives or facilitates change, (2) what participants do to maintain change post-therapy, and (3) what was and was not helpful in their therapy experiences. The findings suggest implications for both practice and policy. Practice implications include the importance of both monitoring client progress and of termination as a distinct phases of therapeutic relationships. Policy implications include the importance of economic and other macro-level variables in supporting or discouraging mental health.

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Arguably the most pressing question is how therapy leads to change. Currently, we do not know the reasons, although many ideas have been proposed.

Kazdin, 2009

Introduction

Mental illness is common cross-culturally with a prevalence that is often underestimated. As evidence of this, the *Diagnostic & Statistical Manual of Mental Disorders (DSM-5)* notes that approximately 20% of people in the United States meet criteria for a diagnosable disorder. The number increases to 29% if substance-related disorders are included (Pettus, 2006). Similarly, the American Psychological Association (2016) has reported that more than a quarter of adults in the United States struggle with depression, anxiety or another mental disorder. A significant number of those suffering will go without or will wait even years before seeking treatment. In a given year, only one-half of the 43.6 million American adults struggling with a mental illness receive some sort of mental health care (Substance Abuse and Mental Health Services Administration, 2015). While many Americans receive some form of treatment for mental health conditions, less is known about the types of treatments they receive. For instance, while antidepressants remain among the most prescribed medications by internists and family physicians, only three-percent of the United States population is estimated to participate in psychotherapy (Nordal, 2010). Even though psychotherapy paired with medication is often a recommended standard of care, psychotherapy remains, in many ways, under-utilized. This is despite research findings suggesting that psychotherapy often produces a prophylactic or protective effect that medications may not (Oestergaard & Moldrup, 2011).

Psychotherapy is often referred to as "talk therapy." It can be defined as a particular type of conversation, offered in a professional context, which gives attention to cognitive, emotional, behavioral and interpersonal variables, each of which offer points of intervention. A key factor

in this kind of collaborative relationship is the alliance, or sense of connection, between the clinician and the client. This is thought to be a vehicle to help clients work to address their problems within the context of a supportive dialogue (American Psychological Association, 2016).

Evidence exists that psychotherapy works and some form of psychotherapy has been thought to exist for over 100 years (Garfield, 1982). One meta-analysis reviewed 375 studies evaluating the extent to which psychotherapy is effective. This study found that 75% of psychotherapy clients were better off than the untreated control groups (Garfield, 1982). The American Psychological Association (2016) notes science has established psychotherapy's effects are potentially even more enduring (with an effective therapist) than medication alone when attending to long-term outcomes. Psychotherapy has been found to be associated with fewer relapses of anxiety and mild to moderate depression than medication alone (Brownawell & Kelley, 2011).

Despite this, the field of mental health lacks research exploring what aspects specifically in psychotherapy bring about change, and to what extent this change endures. Authors such as Kazdin (2009) of Yale suggest little is known about what specifically produces the changes clients experience and the extent to which change is maintained. According to Kazdin (2009) "we do not know why or how therapies achieve therapeutic change… the requisite research to answer the question is rarely done, and fresh approaches are needed in conceptualization and research design" (p. 418).

Researchers are now calling for exploration into what components of psychotherapy most matter. Kazdin (2009) argues research needs to be conducted to not simply describe *what* is happening (where current research focuses) but to explain *why* change happens. He states "we

do not have a clear picture or set of studies that test how putative mechanisms of psychotherapy unfold in such a way as to alter symptoms, (or of) what happens that leads to symptom change (Kazdin, 2009, p.421)." This could be due in part to the fact that psychotherapy is often highly individualized. It is not a "one size fits all" intervention and is challenging by nature to study. Some components of psychotherapy could be more effective than others, but it is difficult to standardize and the skills practiced by therapists vary from case to case **(**Hainer, 2008). The dodo bird hypothesis has argued that different established approaches to psychotherapy work equally well and the simple act of receiving therapy is better than not. (O'Neill, 2002). The "dodo bird" in this hypothesis refers to the Alice in Wonderland story, where this character announces that "all have won, and all must have prizes." Psychotherapy researchers have treated this as a literary metaphor for understanding the equivalent outcomes often found when studying competing schools of psychotherapy.

Though psychotherapy has been established as broadly effective, less is known about (1) what specifically drives change within it (the "key ingredients"), particularly from the clients' perspectives, and (2) the extent to which change is maintained after psychotherapy ends. (3) Lastly, more recent studies have begun to explore the question of what strategies clients take with them in order to sustain the changes they initially make in the context of this formal intervention. The field of mental health lacks follow-up research in general.

With these questions in mind, this study used a mixed method design, one that authors such as Haight and Bidwell (2016) have called for social workers to embrace. We used it in order to ask the above three questions. Specifically, we used a secondary data analysis of quantitative and qualitative data to better understand these mechanisms of change from the clients' perspectives. The quantitative strand focused on examining the extent to which results from

psychotherapy persist over time. The qualitative strand of this study explored Kazdin's "why" question: that is, what drives change in psychotherapy, from a sample of former clients' perspectives "in their own voices," and additionally, what do they "take with them?" What strategies do they use to maintain these changes they initially made?

Literature Review

How Effective is Psychotherapy?

With few exceptions (Driessen, Hollon, et al., 2015), meta-analyses and systematic reviews of psychotherapy suggest that psychotherapy is an effective intervention, broadly, for people with a variety of mental health conditions and presenting problems. One prominent review of such studies conducted by Asay & Lambert (in Hubble, Duncan, & Miller, 1999) reviewed sixty years of such studies and concluded that two-thirds of those who undertake psychotherapy are better off than those who do not. Fifty-percent of participants benefit in 10 or fewer sessions, while 70% of people will benefit after twenty or more sessions. Effect sizes for established interventions such as psychodynamic and cognitive behavioral psychotherapies offered in community mental health clinics are in the range of .47 and often higher in university counseling and research centers (Wampold & Imel, 2015). In a review of meta-analyses, Shedler (2010) noted effect sizes associated with cognitive behavioral and psychodynamic approaches ranging from .6 to 1.8, with a median of .75. Norcross, Campbell, et al., (2013) similarly noted that while self-help books have been associated with symptom improvement on their own, these approaches often have greater success and associated effect sizes when carried out in the context of psychotherapy.

While research evidence demonstrates the effectiveness of psychotherapy broadly, identifying effective approaches, or "what works for whom" remains a more complicated

question. Several authors researching psychotherapy outcomes have concluded that psychotherapies, across theories and models, have performed with near equivalence, indicating no specific modality of psychotherapy offering substantially better outcomes when compared to others, adding evidence to the dodo bird hypothesis (Seligman, 1995; Luborsky, Slinger, & Luborsky, 1975). Specifically, Duncan, Miller, Wampold & Hubble (2010) identify many factors that seem to matter, including: the client and their particular life circumstances, the therapist, their relationship, and the treatment method and context, all of which factor into the success of psychotherapy. Because so many different components come together to constitute a psychotherapy session, it is sometimes difficult to define what the specific intervention is. Authors such as Jerome Frank have argued that psychotherapy is a highly individualized offering and have cautioned against comparisons of psychotherapies with the assumption that they are comparable experiences.

Studies examining the benefits of psychotherapy sometimes have ambiguous results primarily due to the difficulty of measuring the significant influences on therapeutic outcomes. As Seligman (1995) points out, studies are not always representative of what psychotherapy looks like in "real life" clinic settings in that formal studies of psychotherapy often select participants with only a single diagnosis. Participants in these studies are unable to choose their therapist or treatment approach. In contrast to this, psychotherapy in clinic settings often incorporates a variety of strategies and techniques to best fit a particular client. Similarly, while psychotherapy in clinic settings similarly works toward improving overall functioning of the client in regard to the disorder but also presenting concerns (e.g. "problems in living"), Seligman (1995) notes that traditional efficacy studies often focus specifically on reducing symptoms for a single condition and conclude when the initial diagnosis resolves.

"Because many facets of the relationship are not subject to randomization and experimental control, it is more difficult to determine a strong, causal relationship between relational elements and treatment outcomes" (Duncan, Miller, Wampold & Hubble, 2010, p. 132). Research does show that responsiveness from the therapist has a positive effect on the psychotherapy relationship. "Effective psychotherapists are responsive to the needs of their clients, providing them with varying levels of relationship elements in different cases and, within the same case, at different moments" (Duncan, Miller, Wampold & Hubble, 2010, p. 135). Because the therapy relationship contributes so significantly to the outcome, it is important for therapists to respond to what clients are saying and to meet them where they are, while adapting the relationship uniquely to the needs of each client. Cooper's (2008) book *Essential research findings in counselling and psychotherapy: the Facts are friendly* notes that successful outcomes in psychotherapy are less associated with variables such as therapists' gender, age, stable characteristics, and level of training than they are with "the way in which they relate to their clients" (p. 96).

Studies dating back to the 1960's speak to the centrality of the therapeutic alliance in a successful outcome (e.g. Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). For instance, when clients were asked what was effective in their psychotherapy, a common identified theme was the therapeutic relationship. Many studies show clients do not focus on technique but instead view the relationship with the therapist as the most important factor in successful therapy (Elliott & James, 1989; Strupp, Fox, & Lessler, 1969), suggesting the therapist should continue to tend to and build a therapeutic relationship with the client in the course of every session. These studies suggest that techniques are delivered in a relational context and that the two cannot be

easily parsed apart. Recent studies such as those reported by Duncan, Miller, Wampold & Hubble (2010) continue to support this conclusion.

How Enduring are the Results? The Durability of Psychotherapy Outcomes

Individuals seek psychotherapy in order to get better, stay better, heal, or make changes. It is perhaps tempting to conclude that because psychotherapy is generally effective that its effects are lasting. However, fewer studies have explored this question. The extent to which changes from psychotherapy endure is a more difficult question to answer than it may first appear. For instance, if a client maintains many but not all gains, is this counted as a success? Miller (2000) argued that questions about the effectiveness of psychotherapy suggest an easy answer to a difficult question. Because psychotherapy is such an individualized and personal offering, what works for one person may not work for another. Along with the difficulties in measuring success, there are other potential variables that need to be considered such as attendance and the duration of treatment (Mueller & Pekarik, 2000).

In general, when studied, the changes made in psychotherapy tend to endure and gains are typically maintained (Miller, 2000). As cited in Smith, et al. (1980), the average person who has received psychotherapy treatment is 80 percent more likely to maintain gains than those who have not. Research focusing on the endurance of psychotherapy is largely produced from meta-analytic data. Meta-analysis allows for results of other studies to be compared by converging findings into a common metric. It also allows for a method of "summarization" and "synthetization" findings from independent studies (Shedler, 2010). A survey that was conducted in 1994 by the Consumers Union (1995) asked subscribers who had utilized mental health treatment if they felt psychotherapy helped them (Miller, 2000). The findings included responses from approximately 4,000 individuals who indicated, as a group, that psychotherapy did in fact

help and that individuals, particularly those in longer term treatment, reported gains (Miller, 2000).

Psychodynamic therapy has been found to be an effective intervention that utilizes a range of strategies that are based on psychoanalytic concepts. According to Shedler (2010), there is empirical evidence that supports the effectiveness and endurance of gains from psychodynamic therapy. Multiple meta-analyses have been conducted evaluating the efficacy of psychodynamic psychotherapy. These studies found benefits from treatment that both endure and sometimes even increase over time (Shedler). This is sometimes referred to as an "incubation effect," referring to the idea that psychotherapy may produce and set in motion positive changes that develop a momentum and take on a life of their own after psychotherapy ends. Findings relating to the treatment of personality disorders has been found to be specifically promising in this regard (Shedler, 2010).

Cognitive Behavioral Therapy (CBT) is another intervention that has been shown to be an effective form of treatment with results that tend to endure. Clinical trials demonstrate that CBT is not only effective in the treatment of anxiety disorders, but that the gains appear to continue to be maintained as reflected in follow-up studies (Di Mauro et al., 2012). One study completed by Kawaguchi, et al. (2012) demonstrated that participants (N = 113) in an outpatient group cognitive behavioral therapy for social anxiety largely maintained their gains when given a posttest up to a year following their completion of the group (ES = .68) (p. 267). A related study (Hedman, et al., 2011) used a mixed model design and found similar gains maintained for 80 participants who completed an internet-delivered treatment for social anxiety at a five-year follow-up (ES = 1.3 – 1.4).

Studies that have explored the extent to which changes from psychotherapy endure in relation to particular disorders are similarly generally encouraging. Dugas & Robichaud (2006) note that cognitive behavioral treatment for generalized anxiety disorder (GAD), when studied, has been found to have an effect size of .86 and the majority of participants (50 – 95%) remained asymptomatic from two to fourteen years. (An effect size is a statistic that measures the strength of a treatment effect, measured in units of standard deviation. This allows comparisons across studies that might use different measures. Standard deviations here are used as a shared metric). This treatment has been found superior to medication alone.

Similarly, 75% of clients with obsessive compulsive disorder (OCD) undertaking exposure and response prevention (ERP, an exposure-based treatment) were found to maintain gains from 6 months to six years following treatment (Foa & Kozak, 1996). This has also held true for the treatment of post-traumatic stress disorder (PTSD), with symptom improvement being maintained at three, six, and nine months for a group of women who had experienced sexual trauma (Resick, et al. 2002) and then again at "long term follow-up," ranging from five to ten years after treatment (Resick, et al., 2012), with maintenance of gains being defined as a "substantial reduction of symptoms."

What Works in Psychotherapy Broadly?

The majority of studies since the earlier work of Hans Eysenck, a psychologist studying psychotherapy in the 1950's, have concluded that psychotherapy is effective and provides lasting change for clients (Silverman, 2005). Studies also suggest what broad components of psychotherapy have been shown to have the greatest effect on outcomes. With more than 250 different therapeutic methods available and many producing comparable outcomes for clients (Duncan, 2010), researchers have gone on to study the commonalities between the methods to

discover the factors that make psychotherapy work (Ogles, Anderson, & Lunnen, in Hubble, Duncan, & Miller, 1999). In his research, Lambert found four common factors to be key components that make therapy work. These include: client variables (sometimes called "extratherapeutic effects"), alliance, hope and expectancy, model and technique. Other researchers have included client feedback as an additional common factor important to therapeutic outcomes (Duncan, 2010). These five common factors provide "a big-picture view of what works" in psychotherapy (Duncan, 2010, p. 19).

Client variables. Client variables are those things the client brings to psychotherapy and the external environment they are impacted by outside of the clinical relationship. These variables include things such as: employment, relationship status, stress, and degree of social support. Lambert (1992) suggests client variables account for 40% of the therapeutic outcomes (as cited by Maione & Chenail, in Hubble, Duncan, & Miller, 1999), while Wampold (2001) suggests that these account for up to 87% of the outcome (as cited by Green & Latchford, 2012). While client variables differ with each client, common characteristics include client strengths, severity of disturbance, struggles, motivation, distress, capacity to relate, ego strength, support available in the environment, and ability to identify the issue for which they are seeking help (Asay & Lambert, in Hubble, Duncan, & Miller, 1999; Duncan, 2010). Cooper (2008) has pointed to a number of client-related variables associated with a positive prognosis in a clinical relationship. Those that have been researched include, but are not limited to: a high level of motivation, the client's expectation of a positive result, congruence between clinician and client in terms of the expectation each has for the process of therapy (that is, how change will be achieved), a lack of resistance, and being closer to (but not necessarily in) the action stage of change. Among these, Cooper emphasizes the client's "active participation in therapy" (p. 62) as

possibly the strongest predictor of change. Clients' level of motivation has been found to have a positive prognostic value for clients presenting with clinical complexity, such as those with OCD and with personality disorders as two examples.

Three variables from this larger list stand out as having particular relevance to psychodynamic therapy. Cooper (2008) notes that clients with (1) psychological mindedness, (2) broad social support, and (3) a secure attachment style tend to have better outcomes as well. He speculates or interprets the latter as having an important impact on the therapeutic relationship or alliance, which as previously noted carries significant predictive power. Finally, Cooper (2008) notes that when looking at demographics, clients tend to do well in psychotherapy with few notable differences. Clients tend to benefit regardless of age, gender, and socioeconomic status. Cooper notes two stand-out differences: gay and lesbian clients tend to utilize psychotherapy more (and for longer periods) than the general public, and younger clients tend to be more at risk of premature attrition. This increased risk of attrition among younger clients is a finding also noted by Roseborough, McLeod, and Wright (2016) in a recent published study.

Alliance / therapeutic relationship. The therapeutic alliance is one of the best contributors to a positive therapeutic outcome (Duncan, 2010, p. 23). Gelso and Carter (1985, 1994) define an alliance as the "feelings and attitudes that a therapist and client have toward one another, and the manner in which (they are) expressed" (as cited by Norcross & Lambert, 2011, p. 5). Caring, warmth, acceptance, empathy, engagement, and understanding are common characteristics found in a positive therapeutic relationship (Maione & Chenail in Hubble, Duncan, & Miller, 1999). Similarly, Norcross (2002), in his book *Psychotherapy Relationships that Work*, has written about those traits that both further and those that threaten the therapeutic alliance, including a clinician being critical toward the client. Cooper (2008) describes the

additional benefit for client outcomes when the clinician can go beyond the Rogerian values of: warmth, congruence, and positive regard. Cooper found superior outcomes for clients who have a sense that their therapist goes "the extra mile" and "genuinely cares for the client" beyond the responsibility of this role (p. 109). Related to this, Cooper points to superior outcomes for clients whose therapists use a degree of self-disclosure, noting it as a way of validating clients' experiences, a form of "real relationship" and an important relational variable related to outcome. In his research, Lambert (1992) found that an alliance accounts for 30% of client improvement (as cited by Asay & Lambert in Hubble, Duncan, & Miller, 1999). Krupnick, Stotsky, Simmins, Moyer, Elkin, Watkins & Pilkonis (1996) studied the therapeutic alliance of individuals with depression who were receiving either psychotherapeutic or pharmacological treatments and found that alliance had a significant impact on the outcome in both groups (as cited by Asay & Lambert, in Hubble, Duncan, & Miller, 1999).

Placebo, hope & expectancy. Placebo, hope, and expectancy all refer to a client's expectation and belief in the benefits and potential positive outcome of therapy. Lambert (1992) found that the client's expectation contributes 15% of the statistical variance in outcome. "Frank, Gliedman, Imber, Stone, and Nah (1959) also found that the expectations that the client brings into therapy have an important influence on the outcome of therapy" (as cited by Asay & Lambert, in Hubble, Duncan, & Miller, 1999, p. 37). The placebo effect refers to the finding that the client may see improvement simply from knowledge of being treated by a credible therapist (Hubble, Duncan, & Miller, 1999). Others have noted the importance of placebo effects in relation to medicine as well, with Dr. Herbert Benson (1997) referring to this phenomenon as "remembered wellness." Cooper (2008) has noted that clients benefit from not only a shared expectation of a positive outcome, but from congruence with the therapist about "how" change

will happen. Researchers such as Duncan (2010) have pointed to the importance of understanding and taking seriously the client's philosophy of change. Attention to the client's understanding of "how change will happen" is central to Cooper & Norcross' 18 item Inventory of Preferences (C-NIP). Expectancy thus seems to have a connection to treatment congruence. That is, it seems to be important for both client and clinician to agree on the approach to treatment.

What Works in Psychotherapy Specifically?

Client feedback. Client feedback can improve treatment outcomes by up to two-fold, compared to approaches that do not incorporate client feedback to the clinician (Duncan, 2010). Norcross (2010) notes the importance of requesting feedback, particularly focusing on the therapy relationship. He writes, "The benefits of doing so include empowering clients, promoting explicit collaboration, making mid-therapy adjustments as needed, and enhancing treatment successes" (p. 117). This effort has been found to improve the therapeutic alliance and to reduce the risk of attrition (i.e. the client dropping out of psychotherapy prematurely) (Lambert & Shimokawa, 2011; Maione & Chenail, in Hubble, Duncan, & Miller, 1999; Duncan, 2010). In addition to the focus on client improvement, client feedback provides an important opportunity for therapists to focus on their own development (Duncan, 2010).

In research by Hannan, et al. (2005), 48 therapists attempted to predict which of their 550 collective clients would end therapy with negative outcomes (defined as attriting or becoming more symptomatic). In their predictions, the therapists were only successful in guessing one of the forty clients who ended with a negative outcome (as cited by Green & Latchford, 2012). This finding has been noted by Lambert as well: that it is often difficult for mental health clinicians to predict a client's outcome and that formal measures improve the recognition of clients at risk of

(1) deteriorating and/or (2) attriting (i.e. ending prematurely). While a number of existing studies offer clear support for the value of obtaining feedback from a client throughout sessions, it should be noted that a recent study featured by the Cochrane Collaborative has pointed to these effects as being potentially less than has been thought (Vaz, 2016).

Therapists can obtain feedback by utilizing paper or electronic brief ratings, such as the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), before and after each session. The ORS and the SRS are two different scales that are commonly used to measure clients' progress and the therapeutic alliance (as cited by Green & Latchford). The Outcome Questionnaire (OQ-45.2) is another measure with strong empirical properties that can be used on a session by session basis. The OQ can similarly be administered electronically and has software designed to help clinicians recognize when clients show evidence of deterioration and/or early risk of attrition, in the form of the *OQ Analyst*. Other such software-based client-outcome measures exist, such as the 34 item British measure: CORE (See CoreIMS.co.uk) (Cooper, 2008).

Model / technique. Technique refers to and includes things like the therapist's interventions, interviewing techniques, their ability to communicate, and their ability to encourage the client's story-telling (Maione & Chenail, in Hubble, Duncan, & Miller, 1999). Lambert found technique to contribute 15% toward therapeutic outcome and defined it as the factors that are considered unique to specific therapies (Asay & Lambert, in Hubble, Duncan, & Miller, 1999). Associated techniques vary by theoretical approach. They may take the form of: behavioral experiments or guided discovery in cognitive behavioral therapy (CBT) or following affect and working with transference in psychodynamic psychotherapy. Because every client is unique, a clinician must be aware of a variety of strategies and techniques to support their

progress and growth. This point is reinforced by psychologists such as Dr. John Norcross who has articulated a form of "integrative therapy" and by Duncan (2010) who has spoken to the importance of clinicians being versed in more than one theoretical perspective.

Truscott (2010) notes that when mental health therapists consistently operate from a specific model or orientation, they often become more confident in their ability to determine when it is time to try something new with a client. Orlinsky and Ronnestad take this a step further and propose that a therapist has greater ability to respond to clients when they have greater "theoretical breadth," (p. 14) meaning that the therapist has knowledge of several different theoretical models (as cited by Duncan, 2010).

Norcross (2002) and Wampold (2011) similarly conclude that adapting psychotherapy to each specific client is associated with positive outcomes. The American Psychological Association (APA) summarizes the following eight variables as reasons for and ways of customizing sessions: considering "reactance/resistance level, stage of change, preferences, culture, coping style, expectations, attachment style, and religion/spirituality" (as cited by Green & Latchford, 2012, p. 80). A clinician may choose to adapt to the client by using a different model such as psychodynamic or cognitive behavioral therapy, or by shifting their approach such as changing the structure of their sessions. The APA's summary above has some strong parallels with Norcross' articulation of the kinds of client-related preferences that a clinician needs to consider. Cooper & Norcross used such considerations in creating an 18-item list of client preferences and 11 follow-up questions, which they call the "Cooper Norcross Inventory of Preferences" (C-NIP). These include tending to client preferences such as the degree to which a client expects or prefers that their clinical work focus on: the past vs. present, the desired degree of structure of the sessions, the role of homework (if any) and even those things the clinician

should not do. Norcross has found that giving attention to such variables improves outcomes significantly (Vaz, 2016).

Psychodynamic models. The psychodynamic approach is often thought of as one giving significant attention to affect, history, and to relational patterns, often enacted in the form of transference (Shedler, 2010). This is an approach that relies strongly on the clinical relationship or alliance as a common, curative factor. In this approach, the relationship is a primary generator of change and can serve as what Alexander & French labeled a corrective experience. While Cooper (2008) notes that little research exists regarding a non-directive stance (shared across a number of theoretical orientations), several psychodynamic concepts are associated with positive client outcomes. These include: increasing clients' emotional awareness, "deepening levels of emotional processing," (p. 142) and offering well-timed interpretations. Interpretations have been found to be effective (Orlinsky, et al., 2004, as cited by Cooper, 2008), particularly when offered tentatively and in the context of a strong therapeutic alliance.

Cognitive behavioral models. These therapies often look more directive in practice, with the clinician acting as a sort of coach. Historically this approach has emphasized technique as a common factor, with recent writings giving more attention to the importance of understanding and working with the relationship (Beck, 2011). Several associated strategies have been studied and found to be effective within this approach. These include: weekly activity monitoring and scheduling, which by itself is associated with an effect size of d = .87 (Cooper, 2008, p. 133). Behavioral Activation (BA) has similarly been found to have client outcomes equivalent to those in cognitive therapy (Martell, Dimidjian, & Herman-Dunn, 2013). Exposure-based treatments in particular, have been found to be particularly powerful and effective for clients with anxiety disorders (Abromowitz, Deacon, & Whiteside, 2011).

Diagnosis-specific treatments. Certain approaches, strategies, and techniques have emerged as important in the literature when looking at what clients presenting with particular diagnoses may need. These include things like: modifying thinking in depression, and countering avoidance in anxiety (Abromowitz, et al., 2011). Some specific treatments appear to be more successful at treating specific disorders than others. Chronic depression has been most successfully addressed by using both psychotherapy and medication (Silverman, 2005). In a study by Robinson, et al. (1990), cognitive and behavioral approaches had a better outcome with depressed clients than a more general talk therapy approach; however, when it was further reviewed the difference between the approaches diminished (as cited by Lambert, 2013). Broad consensus seems to exist that exposure is an important component in treating anxiety and that behavioral activation (including recent attention to the importance of exercise) is important in treating depression.

What Do Clients Say about What Works?

A surprisingly small number of studies have explicitly examined the question from the perspective of clients of "what leads to change?" and "what supports the maintenance of change?" in psychotherapy. Historically, research has instead relied primarily on the perspective of mental health clinicians, as providers, in determining "what works." As noted earlier, people seek psychotherapy for a range of reasons. However, in this review, we noted a number of articles that gave explicit attention to clients' and former clients' perceptions about what supports and what helps to sustain change after psychotherapy. The existing studies are primarily qualitative and often focus on what clients experienced as particularly salient features or meaningful moments in psychotherapy. Other studies focused on the use and perceived value of things like self-disclosure from the clinician in both individual and in couple's therapy.

One classic study is particularly noteworthy and offers a logical starting point. In 1988, Dr. Robert Wallerstein published the 748-page book: *Forty-two lives in treatment, a study of psychoanalysis and psychotherapy*. The book summarized an early, pioneering, and unprecedented 30-year longitudinal study conducted at Menninger Clinic, which was carried out from 1954 to 1985. The study stands as prime example of a large scale, longitudinal qualitative study, giving attention to "process and outcomes" in psychotherapy (Richards, 1988). These stories of change, however, are entirely from the therapists' and analysts' perspectives. The book ends with a chapter devoted to a call for future research in this area: to what leads to change in psychotherapy. Like the present study, Wallerstein sought to follow-up with former clients and was primarily qualitative in nature. Wallerstein gathered hundreds of pages of case material related to each of the 42 adults (ages 17 – 50, m = 31) whose lives and experiences in psychotherapy and psychoanalysis he featured. He also sought a random sample of patients on Menninger's waitlist, controlling for gender and for the two treatments (analysis versus psychotherapy). He sought and featured an equal number of patients by gender and by type of treatment. This work can be understood as a transitional study in that while it gave significant attention to patients' experiences qualitatively (giving detailed attention to their individual stories) and "over time," it continued to do so solely from the analysts' and therapists' perspectives. More recent studies have gone on since to explicitly ask clients broadly, and former clients specifically, about their understanding of what helps promote and support positive change in psychotherapy. One recent qualitative meta-analysis here is particularly noteworthy. Levitt, Pomerville, & Surace (2016) published an "omnibus review," which used 109 studies to generate themes describing clients' experiences in psychotherapy. They reviewed qualitative studies, focusing on what clients within these studies identified as helpful, from their

perspectives and in their own words. Themes included: psychotherapy providing a structured curiosity, a professional structure, an explicit negotiation of roles, and a sense of being "deeply understood," in which therapist's positive messages are internalized by the client. The authors found that effective psychotherapy creates an opportunity for clients to recognize their own sense of agency and a format inviting the analysis of "thoughts and assumptions" and the practice of new behaviors in the context of strong support.

Clients' perceptions of the therapeutic alliance. When asked directly, clients speak to the importance of a therapeutic alliance as being a necessary precondition to change in a therapeutic relationship. In published studies, clients, like their clinicians, emphasize the importance of a strong sense of connection within psychotherapy. This relationship is generally built over time and is described as one based on cooperation, understanding, and trust. Norcross (2010) states "When clinicians ask clients what was helpful in their psychotherapy, clients routinely identify the therapeutic relationship. At least 100 studies have appeared in the literature with similar conclusions. Clients do not emphasize the effectiveness of particular techniques or methods. Instead, they primarily attribute the effectiveness of their treatment to the relationship with their therapists" (p. 115). Odell, Butler, & Dielman (2005) similarly note "(The) therapeutic alliance generally refers to the process by which the client feels understood and accepted by the therapist, and is sufficiently trusting of the relationship to disclose deeply personal concerns…an aspect of psychotherapy that is essential to a positive therapeutic encounter is the development of a positive working relationship between the therapist and the client, commonly referred to as the therapeutic alliance" (p. 2).

Clients' perceptions of the common factors. Researchers such as Thomas (2006) have reported that the client's perception of therapy has been largely ignored in psychotherapy

research. Thomas interviewed both clients and their mental health therapists about their perceptions regarding the degree to which each of the common factors contribute to change in the therapeutic process, from the perspective of each. These four factors were defined in a way consistent with Asay & Lambert's (in Hubble, Duncan & Miller, 1999) description, including: extra- therapeutic factors, model/techniques, therapeutic relationship, and hope/expectancy. The results revealed that while the therapists sampled perceived the therapeutic relationship as the most important in contributing to change for the client (35%), clients reported believing that hope and expectation ["which refers to the client becoming hopeful and believing in the credibility of the treatment" (Thomas, 2006, p. 203)] to be the leading contributor to change, estimating it at 30%. The significance clients attribute to expectancy effects is a potentially important one, in that these clients are attributing twice as much significance to this variable as is the literature. This particular variable of expectancy also bears out as particularly important in the work of Bruce Wampold (2015). Overall, the research offered by Thomas concluded that therapists and clients often have different perceptions as to what contributes to change in the therapeutic process. Thomas used this method to help draw mental health therapists' attention to clients' perceptions about which common factors most matter to them, and concluded that "common factors could help the therapist understand what is deemed important to the client and establish a starting point to bridge the gap of communication in the therapy session" (2006, p. 209).

Clients' perceptions of the value of self-disclosure. One area of particular controversy within psychotherapy is regarding the use of self-disclosure. Traditionally, therapists often limit their self-disclosure during time with clients due to the perception of potential negative effects it is believed to have (such as risking taking the focus from the client). However, recent studies

have shown the potentially positive effects its judicious use can have. Cooper (2008) notes research suggesting that low level disclosure, used to reassure and to offer the client a sense of universality or shared experience is associated with positive client outcomes. When using this intervention more freely, it can help develop the real relationship and the sense of the clinician being personally involved that Cooper (2008) notes as so important above and beyond an alliance as it has historically been defined as an agreement about goal(s), task, and bond, more generically. Levitt, et al. (2016) similarly note this tension, finding that while professionalism can create "clarity" (p. 819), it can also create dependence, or alternately distance and doubt about the clinician's genuine care for the client as a person.

Client perceptions seem to bear this out. Farber, Berano, & Capbianco (2004) note that "the concept of self-disclosure has been central to psychotherapy. Psychodynamically oriented therapists still adhere to the belief that revealing hidden thoughts, feelings, and experiences is an essential aspect of the therapeutic process and a critical component of healing" (p. 340). These authors speak to the therapeutic value *of clients' disclosures* to their therapists, noting that clients experience disclosing something important to them as generating a sense of relief from emotional as well as physical tension. Immediately following disclosures of difficult material, clients reported feeling a mix of positive and negative emotions, though positive ones tended to be more predominant. Psychodynamic practitioners similarly make use of some self-disclosure toward therapeutic ends, with examples including the judicious sharing of countertransference (that is, how a clinician experiences the client as a form of potentially useful feedback).

What matters to clients in psychotherapy is highly individualized. Gallegos (2005) argues that "psychotherapy research relies too heavily on quantitative analysis" and in so doing "does not adequately capture (its) richness and complexity of change" (p. 355). In his qualitative

and phenomenological study, Gallegos speaks to the challenge of understanding what matters to clients from their perspectives. As evidence of this, while he interviewed nine former participants in psychotherapy, he found this number of transcripts "unwieldy" (p. 364) to analyze, and decided instead to use only the first three. In order to explore "the lived experience of symptom relief in psychotherapy as perceived by client participants" (p. 355) he sought to identify what he refers to as the core "common constituents" (p. 368) of symptom relief (i.e. common ingredients clients identified as helpful).

His analysis speaks to the highly individual nature of what helps or is experienced as therapeutic. Across these interviews, he identified nine variables that were identified by clients as therapeutic. Effective providers were described among this sample as "accommodating, attuned, foster(ing) a felt sense of safety and trust…supportive, and (having) positive attributes" (p. 368). All three clients in the sample mentioned this sense of accommodation, describing it as taking the form of things like offering options such as phone counseling, not charging, and going over scheduled time. This is interesting for at least two reasons. First, it is both (a) consistent with Wampold & Imel's assertion that effective clinicians are personally invested in their clients and go "above and beyond" their role. (B) It also potentially contrasts with components of clinical training and conceptions of traditional boundaries such as staying within the clinical hour.

Former clients who described success in achieving symptom relief identified other variables such as: adjunctive therapy (e.g. pharmacology and group or couples therapy), extra-therapeutic events and growth (a partner seeing a therapist or the client returning to a hobby or interest), and insight and awareness (regarding one's "psychosocial history" p. 369). Effective clinicians were perceived as knowledgeable and credible, and as able to offer support, safety, and

a sense of trust. Trust was experienced particularly in the form of the clinician's ability to "contain frightening and painful emotions" (p 375).

Finally, effective providers were perceived as those who brought certain personal attributes to the clinical relationship, such as a sense of authenticity, an "expression of care" (p. 369) and as people able to generate an "immediate personal connection" (p. 369). Clients spoke to successful therapies being perceived, on balance, as a positive experience. The identification of these traits is consistent with other authors such as Duncan (2010) and Norcross & Lambert in books such as *Psychotherapy Relationships that Work* (2011) who speak to the importance of these relational capacities, and to the ability to match their interpersonal style to the particular needs of each individual client.

Similarly, authors such as Helmeke & Sprenkle (2000) reported that clients who were interviewed about successful outcomes in couple's therapy identified the importance of "pivotal moments" (p. 5) being highly individualized, but a commonality across respondents is that these moments were experienced *early* in therapeutic relationships (p. 8). For instance, among three couples interviewed, 24 such moments were identified. Among these, nine occurred in the first three sessions and six during sessions four through six. Examples of such pivotal moments are discussed below.

What matters to clients in couples therapy. The majority of studies reviewed showed that while the therapeutic alliance has been commonly studied with individual clients, comparatively little attention has been given to couples. "One area of particular difficulty in understanding the therapeutic alliance with couples is found in that either member of the couple may perceive and respond to the therapist's relational behaviors differently" (Odell, Butler, & Dielman, 2005, p.3). Eight couples were interviewed in this qualitative study, after they had completed couples

therapy, about their experiences in treatment. The participants unanimously expressed positive evaluations of their therapist but negative comments were directed at the treatment itself. One example included the perception that the clinician "took sides." "There similarly seemed to be an unspoken expectation from one or both of the partners that the therapist was expected to change the other partner. When counseling did not happen the way one partner expected, there was little hope for a continued alliance" (p. 11).

An example of variables couples consider important raised in this study included "worldview congruence." Several clients expressed the desire to have a therapist more aligned with their own worldview such as, for strongly identified Christians, a Christian counselor. Cooper (2008) has noted this preference as well, referring to it as the need clients express for ideological and values-oriented agreements between clinician and client, whether explicitly stated or not. Cooper has found this to exert a small, but notable positive effect in client outcomes.

Another example the authors noted was labeled "within-couple differences." These can be understood as situations "when a client is brought into therapy by another individual, he may be more of a visitor who is not necessarily committed to therapy, and only involved in the process under some kind of duress" (Odell, Butler, & Dielman, 2005, p. 12). Overall, "The triadic component of marital/couple therapy appeared to be a significant factor in determining a positive therapeutic alliance, and the treatment's subsequent outcome" (p. 18). This finding is congruent with Cooper (2008), who similarly notes that being a voluntary client, and having a high level of client participation correlate with positive outcomes.

Conceptual Framework

This study used Wampold & Imel's contextual model as a conceptual framework with which to approach, in particular, our qualitative data. Wampold & Imel articulated this model in the most recent edition of their now classic text: *The Great Psychotherapy Debate* (2002, 2015). The model offers three core ingredients that are associated with successful outcomes in psychotherapy (those with clinically significant improvement) and is offered as a "compelling alternative to traditional research on psychotherapy, which tends to focus on identifying the most effective treatments for particular disorders" (unpaginated forward, 2015). This model instead emphasizes *the characteristics of successful psychotherapies over and above types of psychotherapies.*

Dr. Bruce Wampold is currently the Patricia Wolleat Professor of Counseling Psychology at the University of Wisconsin – Madison. Dr. Zac Imel is a counseling psychologist who teaches at the University of Utah. Originally educated as a mathematician, Wampold taught high school math before becoming interested in psychology. His pathway and eventual transition to studying and going on to teach psychology came out of his own observations of resilience among the children he taught (Vaz, 2016). He has publicly acknowledged his experience of psychotherapy as a formative influence in his own life, his commitment to multiculturalism, and his belief that psychotherapy can "advantage the disadvantaged." By this he suggests that psychotherapy can be understood as a resource and tool that can help augment for challenges clients may have that arise from structural (versus personal) deficits.

Wampold's work is often associated with the dodo bird hypothesis (i.e. that is, the belief in treatment equivalence). However, this is sometimes presented in a way that unfairly simplifies his argument. In the book, *The Great Psychotherapy Debate* (2015), Wampold

clarifies that he came to his conclusions based on research suggesting that, when formally compared, different "empirically supported" treatments often have comparable outcomes. He notes, though, that he does not argue that "any treatment works" but that effective treatments only show equivalence when they are: provided by a competent clinician and when both the clinician and client share a faith or 'belief" in the effectiveness of the treatment provided. He similarly makes allowances that for some diagnoses, particular treatments show superior outcomes to others (for instance, the use of exposure in relation to anxiety disorders). Related to this, Wampold has noted "real differences in therapist effectiveness" (that is, between-group statistical differences) when therapists are compared (Vaz, 2016).

As a result of this and as a synthesis of much of his research, Wampold and Imel (2015) have gone on to articulate research-based conclusions about what works or is curative in psychotherapy. The co-authors refer to this as the contextual model. They conclude that effective therapies involve certain core ingredients that can be taught, learned, refined, and improved upon throughout a clinician's career with what Wampold refers to as "deliberate practice." This model asserts that effective treatments are generally characterized by the following core features:

- *Structure.* Treatments with a structure tend to be more effective than open-ended therapies without an accompanying structure or plan. Similarly, effective forms of psychotherapy generally socialize the clients to a "plan or rationale" that makes sense to and is credible to them. Structure can include such things as the client and therapist articulating goals and a treatment plan. While such therapies may be open-ended (that is, not limited to a number of sessions), there is a sense that the therapy has a plan, a direction, and continuity between sessions.

- *Belief and investment in the treatment approach.* Effective treatments involve both a sense of buy-in by the client and therapist, and engage the clients in "getting (them) to do something important in their lives in order to experience a sense of 'agency and self-efficacy' in their own lives" (Vaz, 2016). This can take a variety of forms including using strategies like behavioral experiments in cognitive behavioral therapy or new ways of relating to a family member in a dynamic treatment. Clients have not only a sense of investment in the treatment, but an understanding of their role in the process.
- *Genuine empathy and "real relationship."* Effective treatments are characterized by a strong initial and enduring alliance. Wampold notes the strong correlation between the experience of loneliness and psychiatric distress. Successful treatments, across theoretical orientations, are generally marked by the client's subjective experience of warmth, empathy and understanding from the clinician. Wampold describes this experience, in itself (of repeatedly meeting each person with "care and concern"), as therapeutic and as a necessary condition for therapeutic change.

Wampold has identified other correlates with successful psychotherapies. These include the clinician seeking and making use of client feedback and the importance of the emotional intelligence of the clinician. In a recent interview, he describes effective therapists as being "clear, understandable, verbally succinct..and (able to) accurately read the affective state of their clients…they show calmness, even when anxious" and a strong ability to modulate their own affect (Vaz, 2016). Related to this, he describes effective clinicians as having a "laser focus on their patients in overcoming their difficulties." These clinicians maintain a focus on their clients over and above themselves." (Ibid.). Lastly, he speaks to the importance of clinicians making use of routine monitoring of clients' progress and to the importance of their continuing to seek

ways to improve their own practice, often through the use of taping sessions and seeking real-time feedback, versus supervision that relies entirely on self-report. He and others have noted how often supervision neglects the explicit question of whether the client is improving.

The contextual model was chosen as a conceptual framework for this research for a number of reasons, including its currency and the emphasis it places on understanding (consistent with Katz, 2009) *how* people improve in psychotherapy. We see this study's emphasis on and use of qualitative data, in particular, as lending itself well as a point of comparison with Wampold & Imel's model. We read and coded the qualitative transcripts using the above ideas as "sensitizing concepts." As part of our analysis, we read the interviews for the extent to which former clients at this clinic identified these components as central to their achieving and maintaining therapeutic change. Lastly, we see Wampold's strongly relational perspective and his own theoretical orientation (his orientation toward psychodynamic, structural and what he calls "pragmatic concerns," or attention to what each person uniquely needs) as a particularly good fit with the theoretical and relationally-based practice orientation of this particular clinic which these data reflect.

Method

Design

This study used a sequential mixed methods design. Mixed methods research (MMR) is used across disciplines as a systematic approach to answering complicated, multi-layered questions. While quantitative and qualitative research are established, longstanding and widely accepted methods, MMR emerged in the 1980s and has only recently become recognized as a third methodological option (Tashakkori, Teddlie, & Johnson, 2015). The key component in MMR is the *integration* of data. MMR integrates qualitative data (i.e. interviews) and

quantitative data (i.e. questionnaires such as the OQ-45.2) within one study to obtain a stronger, more in-depth understanding of the phenomenon being studied (Griensven, Moore, & Hall, 2014; Tashakkori, et al., 2015). There are five common reasons that the MMR methodology is used in a study: (to achieve) methodological triangulation, complementarity, development, initiation, and expansion (Griensven et al., 2014). Triangulation is a term commonly used in qualitative research and refers to looking at how multiple sources of data converge and lend understanding to a phenomenon (in this case, change and maintenance of change in psychotherapy). It has some parallels to the idea of convergent validity in psychological measurement. In both cases, researchers give attention to how different data sources suggest or "converge upon" similar conclusions.

There are four different mixed method designs: sequential, parallel, conversion, and fully integrated (Creswell, 2015). In a sequential design, questions emerge as a result of the study and may elicit additional data collection (Creswell, 2015). A parallel mixed methods study utilizes two independent forms of data collection (these may be from the same or from different samples) and analysis (Creswell, 2015). In a conversion mixed method design, the data are analyzed both quantitatively and qualitatively (Creswell, 2015). Finally, in the fully integrated design a combination of the sequential, parallel, and conversion designs come together (Creswell, 2015).

As previously noted, MMR provides an opportunity to ask complicated and multi-layered questions. When research is asking a question like "'what and how' or 'what and why'" (Tashakkori et al, 2015, p. 620) a specific situation or outcome may occur, the integration of the qualitative and quantitative data is understood as the best way to provide answers to the question(s). By integrating the two different types of data, MMR looks at how the two data sources are related and offers a more thorough understanding by indicating how the individual

data from each source complement each other, add more depth, or confirm each other (Tashakkori et al., 2015).

MMR can be challenging and complex. A researcher using MMR must have knowledge and skills to conduct both quantitative and qualitative research, as well as the ability to integrate these methods. While MMR does not come without challenges, the benefits are significant. MMR provides an "understanding from multiple perspectives, deeper and wider than the two traditional approaches might be capable of providing" apart (Tashakkori et al., 2015, p. 622). In addition to this benefit, social workers deal with complex social problems that are multi-layered, and as a result, social workers often discover that they naturally using a mixed method way of thinking in their search for solutions (Haight & Bidwell, 2016). Haight and Bidwell (2016) suggest that this natural fit is due to the fact that social workers are considering many different types of sources of data, including asking questions and observing, in order to discover possible solutions.

The purpose of this study was to explore both the therapeutic outcomes and what clients identify as components helpful to their success in therapy. As indicated, a mixed methods approach collects both quantitative and qualitative data and then analyzes the two together in order to obtain a stronger understanding of the research question (Creswell, 2015). This research used a mixed methods explanatory sequential design. In the first phase, quantitative scores from the OQ-45.2 were used to describe the clients' outcomes from therapy, where pre, post, and follow-up scores were compared. In the second phase, the qualitative data build on the quantitative data further. The qualitative data consist of fourteen interviews that were reviewed to explore what clients found as important in their therapeutic relationship. These interviews were conducted with the goal of gaining a deeper understanding of what works in therapy.

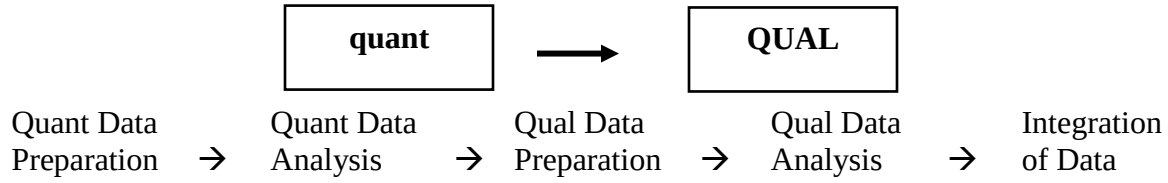


Figure 1. Explanation of Mixed Methods Analysis

Research Questions

Quantitative Research Questions

1. Did the clients improve from pretest to posttest?
2. Did the clients improve from posttest to 12-18-month follow-up?

Qualitative Research Questions

1. What do former clients report "drove" or facilitated their change?
2. What do they do to maintain these changes?
3. To what extent do we see the three core concepts from the contextual model reflected in the data?

Mixed Methods Question

1. When therapy goes well, how do former clients describe it?
2. When therapy goes well, what do they say both supported their change and the maintenance of their gains?
3. When it did not go as well, what seemed to characterize those experiences?
    a. We used this last question as a form of intentional negative case analysis, or a way of looking for exceptions to dominant themes or for cases that did not fit.

Procedure

Describing the clinic. The clinic is located in a major metropolitan area within the Twin Cities. It is also an APA-approved training site that provides outpatient mental health services for approximately 740 adults annually. The clinic sees primarily adults and has formal outreach programs for both Spanish-speaking and older adults**.** The clinic serves a variety of clients. While the majority are Caucasian, clinic clients include: Hispanic (7%), African American (4%), multi-racial (1%), Asian/Pacific islanders (1%), and native American/Alaskan (< 1%)**.** The clinic

provides direct services, training, and conducts research, all as part of its primary three-part core mission. Central to the clinic's mission is the delivery of high quality mental health services for uninsured and underinsured clients, providing services to individuals without insurance using a sliding-scale fee. The clinic's history is long-standing, having been founded in 1954. While the clinic now has a community board, it was initially created from a family endowment that identified mental illness as a nationwide problem. The clinic stands as one of the original outpatient community mental health clinics nationwide. The family's vision continues today as the clinic utilizes a multi-disciplinary approach to mental health care by offering a wide range of outpatient mental health services including diagnostic assessment, psychotherapy (individual, group, couple and family), psychiatric assessment and treatment, psychiatric consultation, psychological assessment and testing as well as consultation. The clinic strives to provide accessible direct patient care to all individuals in need of mental health services, regardless of ability to pay.

Describing the intervention. Wampold & Imel (2015) define psychotherapy as:

> "a primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint." (p. 37).

Psychotherapy offered at this clinic can be characterized as relationally-based, interpersonally focused, and increasingly integrative in nature. The clinic offers both short and, when called for, longer term psychotherapy. The clinic's theoretical orientation has historically drawn on psychodynamic psychotherapy, as articulated by authors such as Gabbard (2014) and Shedler (2010). Specifically, the clinic has drawn on both attachment and object relations as dominant theoretical perspectives informing its approach to treatment. The clinic continues to prioritize the importance of establishing and fostering a strong therapeutic alliance. The clinic is similarly integrative, though, in the sense that clinicians are open to, consider, and make use of evidence -

of those things that are known to be important in the treatment of specific disorders (for instance, exposure in treating anxiety and behavioral activation in treating depression). The clinic values offering both a thorough assessment and, as part of this, consultation with internal and external providers, as needed. Staff clinicians (n = 14) and graduate trainees and fellows (n = approximately 6) all participate in both weekly group case consultation and trainees receive weekly individual supervision. Clients are seen as "clinic clients," meaning that clinicians across disciplines (psychiatrists, social workers, psychologists, marriage and family therapists, and a nurse) are available to consult as to how best to serve each individual client. This treatment model has been described as democratic and minimally hierarchical, with practitioners across disciplines being represented on each team, and psychiatrists being available on-site and communicating regularly with primary therapists. The clinic has also recently piloted Duncan's PCOMS or "partners in change" measures such as the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) as a form of explicitly seeking feedback from clients both early and on an ongoing basis with clients in psychotherapy. This is based on Duncan's finding that this both reduces attrition and improves outcomes. The clinic is completing an IRB-approved study regarding this and will analyze these data shortly. The use of the PCOMS is not reflected in this data set.

Data Collection

Quantitative data collection. The quantitative data set is comprised of archival secondary data from this clinic. All eligible former clients from the clinic who had completed psychotherapy in the 12 – 18 months preceding the 2010 study were mailed the Outcome Questionnaire (OQ-45.2) with an introductory letter, orienting them to the study and inviting them to participate.

The quantitative measure. The OQ-45.2 is a widely used and accepted measure for evaluating the effectiveness of psychotherapy and has been used by other outpatient mental health settings that undertake outcome research. It can be used for both clinical and research purposes. The OQ-45.2 is a self-report tool designed to assess participants' functioning with an overall score as well as three subscales, which give attention to: symptom distress, interpersonal relations, and social role performance (Rice, Suh, & Ege, 2014; Boswell, White, Sims, Harris & Romans, 2013). It contains 45 items assessing the three categories in which participants rate their responses using a four point Likert scale, ranging from 0 (Always) to 4 (Never). The scores for each item are then added to generate both sub-scores and a total score. When contrasted with other self-report measures, the OQ has shown good concurrent validity. In a research study of a university sample the test-retest coefficients for the OQ-45.2 were .82 for social role performance, .80 for interpersonal relations, .78 for symptom distress and .84 for the total score. In a clinical sample internal consistency reliabilities were .70, .74, .92 and .93 for total score (Boswell et al., 2013). Through these findings it is evident the OQ-45.2 displays good reliability.

The Outcome Questionnaires were sent out in January of 2010. There was a total of N = 182 mailed, of which 165 were English versions and 17 were in Spanish. Forty-seven were undeliverable. Of those delivered, 42 were completed and returned (40 English, 2 Spanish). 140 were not returned, leaving the researchers with a response rate of 31% (182-47=135 and 42/135=31%). The OQ-45.2 was mailed to participants 12-18 months post treatment at this clinic with the goal of being able to provide for each former client a pretest, posttest, and follow-up score. Each OQ-45.2 mailed out also provided a letter of consent and an invitation to participate in an in-person interview. Fifteen of the 42 people, or approximately one-third, agreed to interview. Fifteen adults completed in-person interviews at the clinic, providing a

retrospective perspective about their experience of psychotherapy there. The interviewers asked these former clients questions about what had been helpful and unhelpful, what they take with them from their experiences in psychotherapy, and what recommendations they might have for their therapists for their future work with clients.

Qualitative data collection. There were 15 in-person interviews conducted (n=15), 14 in English and one in Spanish, which was translated into English at the clinic. A $15.00 stipend was provided as an incentive for a completed and returned OQ-45.2. A $25.00 retail gift card was given as an incentive for the in-person interview completed by Dr. Nancy Bottorff, a staff psychologist or with Ms. Kim Sauvageot, a former intern and clinical social worker. The 15 interviews were recorded and transcribed on site at the clinic by a support staff person. While most interviewees had participated in individual psychotherapy, one had been in group therapy and another in couple's therapy. The interviews were comprised of 11 questions that were informed by a focus group of clinic therapists who were asked about what they would benefit from learning and about what they would be interested in hearing from former clinic clients. Therapists did not interview any of their own former clients. The original interview questions are attached as Appendix I.

The interview questions focused on discovering what participants found helpful, what they took away from their therapy, what obstacles emerged in therapy, and how the experience created change in their lives. Questions 5-8 from the transcribed interviews were used to operationalize our first qualitative research question during our analysis. Question 5 asks "What did you take away from therapy?" Question 6 asks participants "What parts of therapy were the most significant to you? What parts were the most and least helpful?" and "When you look back, how do you think the changes came about?" This question highlights what participants believed

to be the most influential in their change process and provides insight about how they believed their change was achieved. Question 8 asks "If you encountered any roadblocks or obstacles in therapy, what were they?" This question seeks to gain an understanding of what participants encountered that might have acted as a deterrent to achieving desired change.

The research team also sought to understand how change was maintained and what participants did or continue to do in order to maintain their change. We used questions 3, 5, 9, and 10 to help us speak to this question. Question 3 asks "What is different in your life now than when you began therapy?" Question 5 asks "What did (do) you take away from therapy?" and "What do you use in your daily life as a result of therapy?" These questions were targeted to help understand what perspectives, tools and/or supports participants use to sustain positive change. Finally, question 9 asks "What would you like your therapist to know that would help them in working with future participants?" This question gave former clients an opportunity to express what they found effective (or ineffective) in their work with their therapist and can help clinicians to better understand how to support their clients attempting change. We anticipated that answers to this question, in particular, would suggest potential practice implications we could note and speak to in the final paper's discussion section.

Data Analysis

Quantitative data analysis. The analysis was conducted as a secondary data analysis from archival data from the clinic. From the quantitative data we were able to describe the demographics of the participants through descriptive statistics (describing variables such as the sample's age, ethnicity/race, gender, relationship status, and change in mean scores over time). OQ scores were collected for all 42 former clients, including a pretest (baseline), posttest, and

follow-up score to offer three time points for each person (from baseline to 12 – 18 months following completion of treatment).

Using inferential statistics, we were able to look at the statistical significance of change over time, using paired sample t-tests. To look at the strength of effects associated with this treatment, we calculated effect sizes (Cohen's d) from the quantitative data, looking at effect sizes across the three time points. The follow-up scores provide insight into the strength of the treatment effect and into the extent to which the changes achieved during treatment were described as enduring over time. We also analyzed the descriptive statistics for the 14 adults who went on to interview (and whose interviews we used) in order to get a sense of how representative their trajectories (pre and post-test scores) and maintenance of gains (the 12 – 18 month follow-up scores) are as a sub-group to that of the larger sample of N = 42.

Qualitative data analysis. The qualitative data were analyzed using three separate, but related strategies. The interviews were all first reviewed and coded by all seven graduate students and by the instructor individually. Each person analyzed the data for themes across the interviews associated with positive and negative outcomes, to determine which (themes) correlate with successful change and what clinicians can do to support positive change. We asked, "When a therapy goes well, how do former clients describe it? What do they say both supported their change and the maintenance of their gains?" Second, as a form of negative case analysis, each person was asked, "when it did not go as well, what seemed to characterize those experiences?" We also read the interviews inductively, listening for what former clients said both helped them to make changes and read for any strategies they described utilizing in continuing to maintain their progress.

Third, each individual used selective coding to listen for evidence of the three components of effective psychotherapy as described by Wampold and Imel (2015) in the contextual model that we chose for our conceptual framework. We listened for evidence of former clients speaking to the importance of the three characteristics of successful treatments that the model predicts (i.e. that psychotherapy is effective if certain factors are present within the therapeutic relationship. These factors include structure, belief in the treatment approach that encourages them to have a role in producing this change, and genuine empathy or real relationship). Finally, each rater was invited to do some "open coding." This can be understood as an inductive process in which each person listens for other themes or ideas that emerge from the data, apart from those we were initially looking for. Each coder was invited to look for ideas that simply stand out across the interview transcripts more broadly, apart from any of our initial hypotheses.

After each person completed analyzing the transcripts, we all met as a group and reviewed our findings in each category as a group, over two sessions, spaced a week apart. We wrote out categories of questions on a blackboard and began to assign our emerging themes to each category. This allowed for some discussion of similarities and differences in our observations and to a "conference committee" structure where we worked together to identify what recurring ideas could be labeled as dominant themes and what ideas should be conceptually folded into these larger themes. We identified what we saw as strong, exemplar quotes that captured these ideas well and looked for exceptions in trends in the data to identify as negative cases. This process sought to serve as a form of a reliability check. We were struck in our initial analysis by how much agreement independent raters had. We found a high degree of agreement in identifying and in labeling our themes, subthemes, and exceptions.

Lastly, our analysis included triangulation in that we compared our findings with the themes Dr. Nancy Bottorff found based on her interviews with eight other former clinic clients. This original study was not published but its results were presented to the clinic's board of directors in 2008. We used Dr. Bottorff and Dr. Jordan's executive summary as a source of triangulation (that is, comparison) between our findings with those of this earlier follow-up study at the clinic. This earlier data set was later analyzed by two doctoral students interning at the clinic and formed the basis for their Psy.D. capstone projects. A two-page summary of our data analysis plan is attached as Appendix II.

Protection of Human Participants

There are several protections in place to protect participants in this mixed-method study. Since we used a secondary data analysis of existing data, our study was reviewed at the exempt level by the IRB chair at the University of St. Thomas. The IRB categorized the study at this level in that we were not collecting any new data or interacting with the original participants in this study. We were instead analyzing two de-identified forms of existing data. The chair of the IRB also joined our group seminar to discuss HIPPA and the protection of data privacy in relation to the qualitative data analysis we went on to conduct.

The clinic also had protections put into place when collecting the data. All of the data at this clinic is kept in a locked cabinet in a locked room. The quantitative data (the aggregated OQ-45.2 scores) do not have participants' names on them and are all kept in the same filing cabinet at the clinic. The results from the OQ's were compiled into an Excel spreadsheet which is kept by the IT specialist at Hamm clinic. There are also no client identifiers on this Excel spreadsheet.

The materials originally mailed to former clients invited them to complete an OQ and to interview, if interested. The clients received a letter describing the study which served as a consent for those who completed and mailed their OQ back to the clinic. Former clients were reminded in the letter that they were not required to complete this and that OQ's would come back anonymously. Envelopes were opened by support staff to avoid return addresses being connected to the scores. All former clients who received the OQ's were given fifteen dollars, whether or not they completed and returned the OQ. Those who agreed to be interviewed received, reviewed, and signed a written consent in person with the interviewer (a licensed mental health practitioner). This consent noted explicitly that responses, including quotes, could be used by Dr. Bottorff and by other researchers who might use the data in the future with the clinic's permission, including for potential publication. They were reminded that if they completed the interview they would be moving from anonymity to confidentiality. As a direct benefit their parking was paid for during interview. Former therapists were also given the chance to review a list of former clients to receive the mailing. They then had the ability to flag anyone for whom they thought receiving a mailing might be considered intrusive, a painful reminder, or not in their best interest (for instance, if a former client was seen as a vulnerable adult).

As a seminar we also put some additional protections into place to continue to ensure the confidentiality of this data. David Roseborough stored the paper copies of the interviews (qualitative data) and kept them in a single locked cabinet in his office at the University of St. Thomas. Related to this, in his initial review of the interviews, he judged one interview to be potentially too identifiable and not able to be sufficiently redacted. This interview was removed, leaving 14 interviews (100 single-spaced pages in total) to be analyzed by the group. Dr.

Roseborough also kept a single electronic copy of the aggregated quantitative data on his password protected desktop . Only the seminar participants had access to the data and the data analysis occurred entirely on campus, in one building, at the University of St. Thomas under the supervision of David Roseborough as the project chair. Each student had access to one paper copy of each interview to review on campus, in one building where Dr. Roseborough offices. Each student checked out and checked back in each interview after reviewing it. The copies of the paper interviews were returned to the clinic by David Roseborough to shred in the clinic's confidential recycling. This was done on May 15th, 2017. The quantitative data (SPSS spreadsheet) were electronically deleted as well. An original, electronic copy will be maintained by the clinic's research coordinator (Dr. Hammond) and by Mr. Dungan Seaver, the head of information technology (IT) at the clinic who is also a member of the clinic's research (CORC) committee. Lastly, all of the researchers named in this study completed CITI program training. CITI program training is a web based educational tool designed to educate researchers about how to maintain protection of human subjects in research.

Strengths/Limitations

Quantitative data. One of the strengths of this study is its use of a mixed method design. The qualitative data speak to and contextualize the quantitative data to help us to understand each more deeply. Another strength is the strong validity and reliability of the OQ-45.2 that was used for the quantitative data. While this is the only measure used in the quantitative portion, it has strong psychometric properties. There was also a fairly large sample size of 42 completed OQ's.

There are also some limitations to the quantitative strand of this study. Since this is secondary data analysis, the research seminar did not have a choice in the quantitative measure.

The study is limited to a single measure which decreases our ability to dimensionalize the findings by way of using multiple measures. The 31% response rate also means that the majority of former clients (n = 140) did not return an OQ or interview. This raises the question of the extent to which these clients who responded are representative of the larger clinic population. A surprisingly large number of mailings to former clients (which included the OQ and an invitation to interview) were returned as undeliverable, after a year to eighteen months post-treatment. This suggests the clinic population of former clients may be a fairly mobile one.

Qualitative data. There are many strengths in the qualitative strand of this study. The qualitative data offer information that can help contextualize and better understand the nature of the change we see evidenced in the quantitative data. The interview questions were also strengthened by way of their being created by a focus group consisting of mental health providers at the clinic. These clinicians met to formulate questions based on what they would want to know about what works in psychotherapy, from the perspective of former clients. The follow-up interviews were also conducted by two licensed mental health professionals. Another strength is the number of people reviewing the qualitative data (N = 8) and the reliability check that was used by the seminar group to compare codes and themes found in the interviews. Having more than one researcher to cross-check identified themes, and the degree of agreement we found, strengthens our faith in what we found as genuine themes.

There were also some limitations to the qualitative strand. Because our group did not create the interview questions, we did not have the opportunity to ask the questions we are explicitly exploring in this study more directly. Our analysis is in this way one step removed. Lastly, there was no baseline for data in the qualitative strand. We did not have the opportunity to hear qualitatively from participants before or as they began psychotherapy at this clinic. It is

possible that people's stories of how change happens over time could have changed in the interim year to eighteen months after they ended psychotherapy in that memory is in many ways a constructed phenomenon. Authors such as Newberg & Waldman (2006) remind us that people are prone to remember partially and with narratives that can change over time. Another limitation was the response rate of only 14 for the usable interviews. Many past clients of the clinic could not be reached and did not respond to either of the clinic's invitations. Despite these limitations we were able to hear from a group of former participants, initially first-hand, about their experiences and we had the chance to contribute to filling a gap in the literature, speaking to Kazdin's (2009) question about the need to better understand (1) what produces change in psychotherapy, (2) how enduring this change is, and (3) strategies clients use to maintain positive change, all from the perspectives of former clients.

Findings: Quantitative Strand

The quantitative strand of this research sought to answer two primary questions: 1) Did these former clients improve, as a group, from pre-test to posttest, and 2) Did the former clients, as a group, improve from posttest to 12-18-month follow-up? In this study, we looked not only at the group as a whole, but also ran subgroup analyses to look at how those who interviewed might be similar to or different from those who did not. The research team hypothesized that those who interviewed might represent participants (that is, former clients) who were particularly pleased with their services, or those who had made especially good progress. This is in keeping with a popular understanding that people who respond to surveys tend to be those who are particularly pleased or displeased with their services. We found instead that those who interviewed made change that were consistent with those who did not and with the sample as a whole. However, those who interviewed also tended to begin psychotherapy more symptomatic

than those who did not, and remained so even at posttest. Former clients made statistically significant change over time. This was seen from pre-test to posttest and from posttest to follow-up, descriptively, and by a statistically significant paired sample t-test when comparing mean OQ total scores between pretest (M = 65; SD = 22.48) and follow-up (M = 53; SD = 19.97) t (39) = 3.87, p = .001.

Descriptive statistics were run first to better understand and to begin to describe the sample. We looked initially at variables such as: age, gender, and at mean OQ-45.2 scores at each time point. Among the 42 participants, twenty-seven (64%) of the participants were female and 14 (33%) were male, while one participant's gender was not reported. The mean age of the 42 participants is 46.88 (SD=12.27), ranging from age 23 to 75. There was a significant portion of missing data for the following variables: employment status, race/ethnicity, relationship status, and mental health diagnosis which prevented analysis of these variables. We can note that the primary and secondary diagnoses included in the data set were typical of outpatient mental health clinics and included: major depressive disorder, persistent depressive disorder, generalized anxiety disorder, unspecified anxiety disorder, PTSD, and bereavement. We were also unable to retrieve number of sessions attended. While these data would be helpful to describe the participants, they are not essential to our analysis.

All 42 participants who returned OQ's were invited to interview. Thirty-three percent (n=14) of the 42 survey respondents participated in the follow-up interview. Fifty-seven percent (n=8) of the interviewed participants were female and 42% (n=6) were male. The mean age of the 14 interviewed participants is 46.64 (SD=11.98), ranging from age 27 to 62. The 14 participants interviewed were found to be a representative sample of the 42 respondents in that

those who interviewed were similar to those who didn't in mean OQ scores at each time point, and in descriptive variables such as gender and age.

The mean score of the OQ at pre-test for the entire sample was 64.55 (shown in table 1). The mean score of the OQ for the sample as a whole at posttest was 53.13. The decrease in mean OQ score at posttest indicates that participants tended to improve (reporting being less symptomatic and less distressed over time). Former clients in all three groups had mean OQ-45.2 scores below caseness (a clinical cut-off, designated as a score at or below 63) at both posttest and at follow-up. The pretest or baseline scores for each group were all above caseness, but were on average, lower than the clinic average of 73 – 76 (on a scale from 0 – 180) (Lambert, et al., 2004). This raises the question of whether those who returned the surveys were a less symptomatic group *in general* within the larger clinic population.

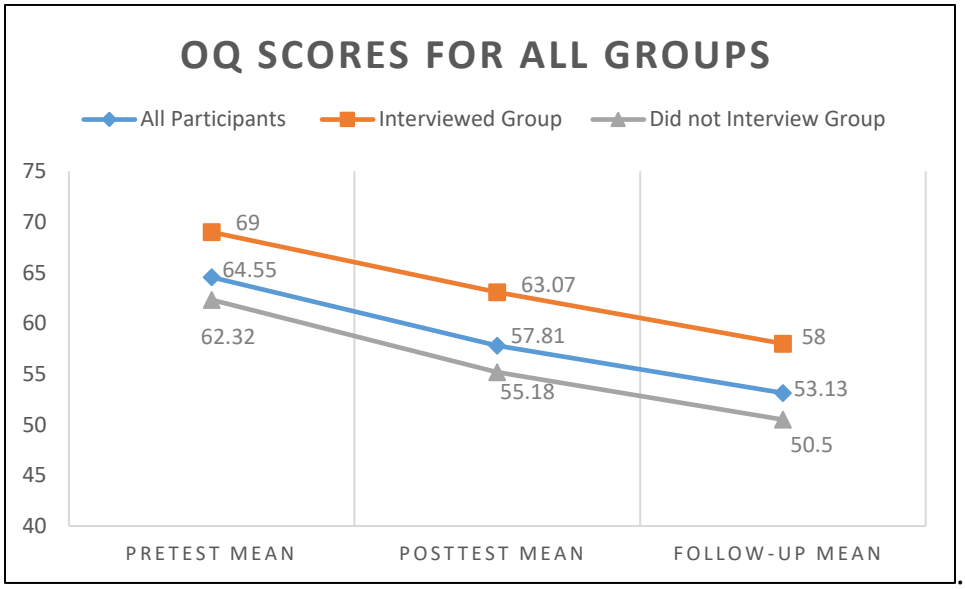
Effect sizes, using OQ scores at each time point, were calculated to get a sense of the strength of the treatment effect at each time point (shown in table 1 and table 2, from pretest to follow-up). We similarly compared the gains of the interviewed group as a sub-group of the larger sample (n=42). The effect size of the interviewed group, from pretest to follow-up was .55 and the effect size of the non-interviewed group was quite similar, at d = .49. We did not find a significant difference between the interviewed group and non-interviewed group in relation to their change trajectories or in their associated effect sizes.

Table 1. OQ Scores

	All Participants		Interviewed Participants		Non-Interviewed Participants	
	M	SD	M	SD	M	SD
Pre-Test	64.55	22.66	69.00	19.96	62.32	23.92
Posttest	57.81	22.94	63.07	27.37	55.18	20.42
Follow-Up	53.13	19.97	58.00	21.10	50.50	19.24
Effect Size (pre-f/u)	.50		.55		.49	

Note: Higher mean scores indicate greater severity in mental health symptoms

Figure 2. Mean OQ scores for the group and as sub-groups



The effect sizes (shown in table 1) are in the moderate range, suggesting that most of these clients moved, on average, nearly a half standard deviation from where they were when they began treatment. The sample, as a whole, showed evidence of maintaining their gains after treatment. As shown in figure 2, participants showed progress from pre-test to posttest as well as from posttest to follow-up. While both sub-groups show progress, those interviewed were more symptomatic initially and remained so at the end. These are different results than found in an earlier unpublished study using a different sample from the same clinic. Notably, former clients

in this sample tended to achieve decreases in OQ-45.2 scores between posttest and follow-up, whereas in the initial study, mean follow-up scores were within a point of mean posttest scores.

Findings: Qualitative Strand

Why Participants Sought Psychotherapy Initially

People who interviewed reported pursuing psychotherapy for a variety of reasons, including relationship issues, mental health conditions, and major life changes, such as divorce and unemployment. The main qualitative findings fell into five categories, with the first being what drives or facilitates change (a sense of being seen, heard, understood, accepted), second, what participants are doing to maintain positive changes they made (including practicing/using skills, not letting things build up, and expressing sentiments such as *I have a plan for what to do*). Third, these previous clients described what went well in therapy (having an alliance with their therapist, being heard, and seeing things from a different perspective). Fourth, a minority of former participants also spoke to what didn't go well in therapy (describing a therapist not offering enough feedback or a client not disclosing enough). Lastly, these participants spoke to variables associated with the contextual model, including the importance of a structure in therapy, a sense of a "real relationship," and a belief in the approach.

The fourteen interviewees were asked about reasons for seeking psychotherapy. Consistent with the literature, most identified relationship issues (divorce, family), mental illness (depression, anxiety, posttraumatic stress disorder), sexual abuse, and substance use disorders as presenting concerns and sources of distress. People used language such as: things being *out of control*, *losing myself*, and *going down the drain*. One person said, *I couldn't do it on my own.* Consistent with existing literature, depressive episodes (including seasonal) and anxiety were among the most common presenting concerns. Two related points emerge in this sample

description. First, these presentations of depression and anxiety were often in the context of relational discord (problems in relationships they were in at the time). Second, although a minority, a number of respondents were unable to remember the exact reasons for having attended psychotherapy. These tended to be interviewees who had experienced positive changes in the course of psychotherapy. A number of clients described having had therapy since their time at the clinic. Some participants needed time during the interview to remember or to clarify which psychotherapy they were describing.

The vast majority of former participants, twelve out of fourteen, described their experience in psychotherapy at the clinic as a positive one. Participants used words such as a *hidden treasure* and *resource* to describe the clinic, and gave endorsements such as *all and all it was a good experience,* and even *He kept me safe; he kept me alive until I could take care of that myself*. Interviewees were asked, "How are they doing now since therapy ended here?" The majority described doing well, overall, often describing a sense of greater agency in their lives, self-acceptance, and a change in thinking and perspective. Several spoke to a sense of gaining new ways of seeing things differently. For instance, one person remarked, *I realized I'm not wrong about everything.* Another spoke to her therapist's *ability to help me look at myself and not be so rigid*. One interviewee said of her life now: *everything's pretty well balanced; things are under control because I have a map, because I don't know how I'm getting there but I have to check the map every once in a while to make sure I'm on the right road*. This statement, among others, referenced a sense of psychotherapy providing a "map" and then applying this guide (with accompanying *tools*) to current challenges. Another interviewee stated, *it's not puddle jumping, essentially (I'm) following a stream and that's what I find particularly helpful and I think without therapy I can just continue the stream.*

Others acknowledged significant present challenges, including unemployment and even a looming threat of foreclosure. More than one individual stated that the economy and financial challenges played a key role in their current mental status. While several spoke to gratitude for psychotherapy being *affordable* and *accessible* at the clinic, this was contrasted with others speaking to terminating in the context of being unable to afford continuing, most often at other clinics. Lastly, a number of participants (five of the first six interviews, for instance) described therapy endings that were in some way either unexpected or perceived as on the clinic's terms more than their own. Examples included internships ending, staff leaving the clinic, and a sense of "enough improvement" from the clinic's perspective. One participant spoke to the clinic changing its aim in terms of who it serves: *I felt sort of like, oh gosh, have I been taking advantage of services here and I didn't know that there was a target clientele...it was a little bit of a rejection thing*. This reminded us of the importance of termination as a distinct phase of psychotherapy. It is something we take up in the discussion section as a practice implication.

Despite this, the vast majority of participants described psychotherapy as an overwhelmingly positive and often transformative experience (*I've had great experiences here)*. Several spoke to having internalized the significance of this experience and the person of their therapist, even gradually. Both were appreciated over time, often in the context of aging, with one respondent speaking to becoming *older and wiser*. We noted a correlation: that those who found it difficult to describe just what psychotherapy had offered them would simultaneously often say that the experience could not easily be reduced or described, but was nonetheless meaningful, and even more so with time. One person described this by saying, *There are things I can't put into words. It was powerful but I don't feel able to say how*. Another said *it was a very powerful experience*. Similarly, a match in personalities was noted as important and

similarly difficult to describe: *so much is a personality thing. I think we had a good personality match.*

Psychotherapy was described as at times challenging and sometimes involved uncomfortable emotions. Stigma was referenced as well, in the context of seeking out psychotherapy as somehow a sign of weakness or as associated with some shame, or sometimes even something others might see as *a waste of time*. However, these former clients acknowledged psychotherapy can and often had provided a long-lasting benefit that went beyond symptom relief. When it went well, it psychotherapy was described as offering new perspectives and tools (*I'm using a lot of skills on a regular basis)* that sometimes transformed their lives. It was similarly described as offering specific skills that helped to buffer the challenges that followed its completion.

What Psychotherapy Looks Like When It Goes Well

In analyzing how former participants thought about and viewed what psychotherapy looks like and how it functions when it is effective, several main themes emerged. These included: attention to the alliance, accessibility of the clinic and clinician, feeling challenged, a treatment where progress was monitored, the use of a team approach, not feeling rushed, a chance to practice, and being heard with a sense of deep listening.

Alliance. Participants were asked to speak to what it looks like when therapy went well from their perspectives. One strong component that emerged was participants feeling they could connect with the therapist and work together to achieve a common goal. Those who had good experiences described their therapist as someone who knew them and was genuinely invested in them as a person (*I felt like I was an individual to her... I was more than a collection of symptoms).* Knowing the participant well, listening deeply, and caring all helped in establishing

a good alliance between the client and therapist. A therapist who was *adaptable* was critical to the alliance. One spoke to the strength gained from the therapist, noting his *attentiveness had power for me.* Many felt when it was going well, the therapist was perceived as accessible and available. Another noted feeling supported and stated the therapist was *available for whatever.* Two participants indicated they did not feel any judgement which allowed them to build "*trust"* and believe the therapist was *really there for me. I'd tell her things and she didn't seem shocked. She'd say, "thank you for telling me these things." I thought she was really good at what she does. I was able to trust her.*

A good alliance was described as involving not just support but sometimes challenge. One participant said of her therapist: *she wouldn't let me procrastinate too much.* Participants spoke to their own role as well, noting that when therapy went well, they were *putting in the work*. This seemed to involve both a sense of investment in the process from the client as well as a willingness to share and offer sufficient information for the clinician to conceptualize accurately versus *kind of manipulating the session*. If they arrived to the session in the *right frame of mind* they were able to disclose and work with the therapist to make strides and meet goals. One described this as *making a commitment to engage in that, to do the work.* Participants reported when they were able to be open and honest, they were more successful and had a better experience.

Accessibility of the clinic and a team approach. The importance of the therapeutic alliance is crucial and can be characterized by not only the clinician but the clinic being experienced as accessible. First, this clinic was described as offering an affordable option to individuals who may not be able to otherwise afford mental health services. One participant stated they had to end therapy at another agency due to loss of income and found this clinic so

she was able to continue to receive services. People used words to describe the clinic such as *safe* and *welcoming.*

Five participants specifically discussed the team approach the clinic offered them indicating, *they all consulted together.* This clinic offers a shared philosophy and values working together as a team to provide mental health services to individuals they see. One participant noted that during a session, the therapist worked with a psychiatrist to ensure the individual could meet with this psychiatrist right after their session, stating the clinic *immediately addressed (her concern) and very actively… flexibl(y).* Another stated *the fact that he could go down the hall and talk to (therapist's name) or my other therapist… it was just nice to know that it was all coming from the same place, same philosophy and everyone knew.* Another example occurred when a therapist needed to make a referral to a day treatment program. The participant remembered the therapist calling afterward to check in on this transition, noting that this was something he did not have to do but went "above and beyond" to ensure the client's needs were being met. *He was genuinely concerned about my well-being.*

Being seen, heard, understood, and accepted. An aspect that fostered success for many interviewees was a clinician offering understanding, and in tandem, sometimes a different way of looking at the presenting problem, with several noting their therapist offered a way to broaden and even sometimes expand their thinking. Several interviewees described the client gaining a new perspective or new ways of seeing things. One participant stated the therapist was *listening to my problems and my perspective and viewpoint.* Respondents spoke to effective clinicians offering *a different level of listening* and *nonjudgmental interest.*

Three participants used the word *friend* when describing their therapeutic relationship with their therapist. One stated it *felt like he was a friend* another perceived the therapist as a

friend in my corner. This likely allowed the client to feel welcome and comfortable during the sessions. They were able to feel relaxed enough to open up to this professional. Being able to disclose "enough" emerged as an important and related idea.

In addition, many spoke to feeling unconditionally accepted in therapy and treated in ways these former clients perceived as non-judgmental. One interviewee tied this to developing more confidence during psychotherapy: the ability to try new things and even to accept occasional failure. *I failed at them, but, it was okay because I learned from them.* The interviewee described feeling supported enough by the therapist to hear feedback, to be understood, and to be comfortable enough to try some new ways of doing things. Offering the client a new perspective allowed them to change their attitude as one summarized: *I think that something I use every day is that I can't change what's happening, but I can change my attitude about it…So you have to calm down, think about what you can do…. I always use that.*

Importance of evaluating progress. Participants noted it is important for therapists to check in frequently with their clients. Participants occasionally indicated they *wanted more structure* or *wanted to be pushed more by (my) therapist.* Throughout most the interviews, it was identified as important for the clinician to give direction so the client knew what to expect. Therapists were encouraged by these former clients to explicitly monitor progress and to seek feedback from clients to best meet their needs: to better understand what they are seeking and getting from the experience and how they can best meet the client's goals. Clients who did well spoke to a clear sense of the therapy and of their role in it. Clients who described positive experiences similarly tended to describe this relationship and the clinicians as focused. One respondent described her therapist's strong sense of focus, saying *she didn't let me procrastinate too much.* When psychotherapy didn't go as well, former clients described this focus and sense

of monitoring progress as lacking. One person said, *I'm having a hard time describing the structure.* One other past client noted that she thought her psychotherapy could have ended sooner, and been more efficient with this kind of monitoring: *it could have been a little shorter.* Interestingly, the majority of clients who experienced this lack of monitoring and/or feedback did not raise this with their clinician. One representative respondent said: *She was very nice; she was very pleasant. And maybe that's part of the (reason) I didn't say to her "I need more feedback… because I respect her.* Another client was asked if she raised a problem she described in the interview with her clinician. She responded, *no, it was just kind of something I felt but I never spoke about it.*

What It Looks Like When It Doesn't Go Well

Unexpected endings. This theme regarding how participants perceived the ending of their therapeutic process emerged as an important and in some ways an unexpected finding. For five of the first six interviewees, the endings of the therapy appeared to be unexpected or surprising in some way, meaning that the participant did not feel entirely prepared for their therapy to end. Multiple participants indicated that their treatment ended unexpectedly or that they were unclear as to why therapy was ending. One participant stated *I didn't (end), they tell me to do it.* The participant implied that she did not choose to end their therapeutic process, but from her perspective, the decision had been made for her. The same participant was asked about her feelings regarding being told their therapeutic process was ending. She stated, *I didn't like it. I was…too… dependent even on a therapist.*

Another participant voiced a sense of being *kicked out*. She went on to say:

"I was sort of-I was let go. I didn't – it was really kind of awful…I didn't fit the profile of the clientele that the clinic was trying to serve any longer in that I was employed…I wasn't

bad enough off or something…I felt sort of like, have I been taking advantage of the services here and I didn't know there was a target clientele…but it was a little bit of a rejection thing and you know [therapist's name] handled this as sensitively as he could."

This participant appeared to be surprised by their therapeutic relationship ending, but may have also been unclear as to why it was ending. For this participant there seemed to be a misunderstanding of individuals who are served by the clinic. When asked how this participant felt that their situation could have been handled differently she stated *When it came to start therapy and that would seem like it would be a really basic thing and now maybe the policy is more clear…* People who were surprised by the nature of the ending often described the ending as in some way therapist or clinic-initiated. They offered examples such as: internships or employment ending, a perception of the clinic's mission changing, or a clinician relaying to them a sense of "enough" improvement. When one participant was asked what she would like to ask her therapist, she said, *I'd like to know why he left.* For most participants, their assessment of progress aligned with the clinic's, but for some it did not.

Lack of feedback and information. Another theme that appeared frequently was the participants' desire for more structure, feedback, and information (commonly, about their diagnosis). A minority of participants indicated that there was sometimes an overall lack of information and said they would have preferred more communication regarding their progress throughout therapy. One particular participant stated:

I don't feel she offered enough healing ideas or alternatives…I didn't feel like I was being given directions…I was coming in and talking to somebody a lot and yes there were questions about this feeling or that feeling, but I didn't feel there was some feedback coming in.

A couple of the participants described a desire for specific information regarding their diagnosis and for specifics such as homework. One person asked for *some things to try over the week.* The notion of needing more from the process aside from a client-led conversation appeared to be particularly important to one participant. When asked how their therapist could improve with future clients, this person said, *I'll go back to maybe some more feedback…I felt that was not there or maybe her feedback was so subtle I missed it…maybe setting some goals to achieve this or achieve that this week…you're going to work on that next week.*

Another participant shared their insight as to how they felt their clinician could work with future clients. Their answer also appeared to revolve around this theme of structure and the lack of it they felt in their experience. This participant stated:

> *talking to clients a little more about diagnosis or goals to get about what they're working on because that was something we never discussed and there was a part of me that wondered so much what he actually thought about…what he actually put down.*

This participant not only mentioned the desire for a structured therapeutic process, but also the desire to talk about what the therapist was observing.

Assumptions. The theme of assumptions appeared subtly, but was none the less important. Two former clients spoke to an "assumption of progress" in therapy. This theme arose from participants who remained in therapy, while also indicating that they were not receiving as much as they hoped from the process. One participant stated: *…so I felt like this connection wasn't there, but again I didn't really understand that I have the right to say this is not enough, so it took a year, so that was frustrating.* This participant continued to attend psychotherapy despite an awareness that something was not working well. This could also indicate that the therapist may have not noticed that the participant was not progressing. This was

similarly discussed by another participant as a risk for attrition. This past participant encouraged clinicians not to assume progress or to take the client's acquiescence as a sign of progress. In response to a question asking what could have been done differently, a participant stated *I guess to find out within the first couple of sessions am I being helpful, is my method helping you, not just assume that what we're doing is working. Check in maybe even having questionnaire about the last session.* Another suggested, *maybe more of that along the way.*

An absence of, or a sub-optimal, therapeutic alliance. The therapeutic relationship also emerged as an important theme, while reviewing data regarding what did not go well for participants. The lack of a therapeutic alliance was raised by past participants regarding what did not allow the therapeutic process to advance. Across the interviews, participants described varying degrees of alliance. Few respondents were overtly critical, and most described a strong sense of positive connection. A group emerged "in the middle," who used language such as: *He seemed like a real nice person, He is very professional, or he was very polite…genuinely interested.* Participants who used this more neutral language tended to describe more modest outcomes.

Former clients were able to contrast these degrees of alliance. One articulated this difference, describing her experience with two providers: *I never felt connected with [therapist's name]*. This person went on to compare a previous alliance with her most recent therapist, *I was here prior to [therapist's name] too and it was a gentleman…I connected better with him, but he was no longer here, but I connected better with him.* This participant stated, when asked about her experience with a different therapist, *did I feel she was competent? Yeah. Do I feel we connected? On a certain level. Do I feel like I got out it as much as I possibly could? No.* This participant went on to share that *[therapist's name] listened, but I don't know if she felt, well,*

was she empathizing enough with what I felt whereas the gentleman I had, I felt he understood my feelings better. What struck us here is the absence of the language associated with a positive alliance, where (when present) the clinician is described as listening deeply, being genuinely interested and the client experiences a sense of being really understood.

Finally, clients noted threats to the alliance like a clinician making an assumption that a client was more ready for change than the client's own appraisal. One participant described a related impasse: *I did not feel understood at all. She (therapist) gave me a list of dating sites or something. I know where to go and I know what to say; I can't do it.* Another participant stated *…I just think we got to a point where I was frustrating and for him I wasn't showing enough progress…* Lastly, a participant shared *I just felt that she rushed, that she didn't care…I just didn't feel her…it just didn't connect. Not a good fit.* We were struck that one former client relayed waiting a year or more to speak up and to request a transfer. She encouraged clinicians not to assume things are progressing in the absence of a client "saying something." Interestingly, this former client described a good outcome, with a transfer being experienced as therapeutic in itself. She said simply, *don't be afraid to change therapists*. She spoke to feeling that that clinic took her preference seriously and that this was an important and positive part of her experience.

What Encourages Change

Monitoring progress. Many of the interviewees felt their change was supported by having the opportunity to monitor their individual progress. Seeing the change(s) that developed as psychotherapy progressed allowed interviewees to continue to want to work toward improving, creating a kind of momentum. As a result, one interviewee felt as if he is now *willing to take the change and do things, and say things, and go places and be my own person*. One former client spoke for others when she encouraged mental health therapists to simply *keep*

checking, noting that things like reviewing the OQ-45.2 *once a year was too infrequent.* This former client encouraged clinicians to continue to ask, *are we on the right track?*

Gender. Another aspect that drove change for many of the participants was gender. This was something that was described as important for many, but was not true for everyone. Women in this sample tended to express a preference for a female therapist. This seemed to emerge as particularly important for women who identified as having had either difficult prior relationships with men, or abuse or trauma, where men had been the perpetrators. One woman described choosing a male therapist over a female, despite her initial reservations, and doing so with a therapeutic aim. She stated *things happened when I was a kid. I just don't trust men; it's something I have to adapt to in everyday life, deal with it, but it's not going to change.* She discussed how things were different for her in therapy at this clinic by way of choosing to work with a man because *I approached it from a different attitude and mindset and this time I had to go through with it, finish it, or it would finish me*. She described working with him as a success, noting *his attentiveness had a power for me.* When asked about what was especially helpful in this relationship, she described both having a voice with him and *…being seen, being heard, being accepted….* This interviewee was also notable in noting her value for a lack of session structure: *He didn't have structure in his sessions. He just kind of sat down and was endlessly patient*.

Professionalism. Interviewees commented on change being related to the level of professionalism their therapist displayed. Most respondents voiced faith in their provider and in the clinic as resources they trusted and could rely upon. One former client said *She had a very good sense of what I needed.* Another said *I needed help from someone who can help me find my way through this maze.* Others spoke to clinicians who helped them to stop smoking cannabis

and *to get on the right meds.* When asked what he would like to say to his former therapist, another said *keep doing exactly what he did with me because he kept me alive.* Clinic therapists were described as balancing the personal and the professional well. *They know you but they are not your family.*

Several talked about appreciating the benefits of this relationship with more depth, over time, saying things like *I'm older and wiser now.* Another interviewee felt as if his therapist *just had his back* and described the therapist as *attentive, listening, and available*. In this sense, a sense of professionalism correlated with the strength of the alliance. Former clients who described strong alliances with their therapists uniformly experienced these clinicians as both warm and as professional: as being *available* but also having an expertise to rely or lean upon. When a perception of professionalism or experience was lacking, this diminished the alliance. This can be heard in quotes such as *she seemed a little green – maybe new* and in a clinician being described as *too much a friend… she liked me too much.* Therapists who were seen as professional were described as: appreciated, believed, trusted, knowledgeable, and judicious in how they intervened. Therapists who were not experienced as "professional enough" were described as young, inexperienced, too comfortable, or as too much like a friend. This experience of being like a friend was described as a mixed experience. While it was appreciated and experienced as positive, it tended to be associated with the perception that the clinician was reluctant to challenge a client or to disagree.

Participants who spoke to considering medication as part of their treatment similarly referenced a perception of professionalism and a respect for the client's autonomy. One participant commented on appreciating that medication was a part of his treatment plan but was not pushed or required. This was experienced as helpful in facilitating change for this individual

in that his psychiatrist and therapist were both at this same clinic and could regularly communicate regarding his treatment plan. The role of psychiatry was mentioned explicitly as *thorough and really good… not just sorta like shoveling out the pills*. People who were pleased with their experience spoke to a sense of coordinated care. One person described the clinic's strong interdisciplinary nature, saying *same place, same philosophy, and everyone knew… it seemed like it was actually some attention and assessment.* More than one client mentioned the clinic's attention to careful and thorough assessment.

Increased confidence. Several interviewees described an increasing sense of confidence which they attributed to their experience in psychotherapy. One person said, *I depend on myself more and am less dependent on what other people think.* Others noted *I know where I'm going and how to get there* and *It's o.k.to trust myself.* They spoke to several things that helped them to feel more "in charge" of their own lives and to have an increased sense of agency. Former clients identified a few things as particularly helpful. These included being accountable to another person (a professional who was perceived as available, supportive, and non-judgmental) and being provided with tools that they were able to understand and to practice in their lives. As an example, one participant described learning to have a less negatively charged relationship with a parent, using a cognitive strategy her clinician provided (in this case, learning to separate "like" and "love" and learning to be less reactive *by thinking of her in those moments like a friend's mom*). Another interviewee talked about how *I felt as if I had a plan for what to do*. One described being more able to *better take care of myself, physically, and psychologically*, while another interviewee stated, *I'm a little bit wiser about relationships – what to take and what not to.* Finally, another interviewee stated that "perseverance" is what motivated him to continue in therapy. He described circumventing avoidance and discussed his strategy of *just show(ing) up*

every week and because I'm having a bad day or whatever doesn't mean I have to shut everything down. Several people spoke to making better decisions with age, and connected this increased ability not only to maturation but to their experiences in psychotherapy as well. Past participants consistently described a sense of their own progress: *I think I process things a lot better. I still have some impulsivity issues but they're nothing like in the past… I'm much better able to handle periods of disappointment.*

Maintaining Change after Psychotherapy

While existing literature discusses psychotherapeutic strategies that can be used in psychotherapy to promote change, less is known about *how* change is maintained. In analyzing how participants maintained change, eight main themes emerged from the data: focus on and shifted perspective of self, enlarged perspective, stability, internalizing the therapeutic relationship, effects of time and acceptance, recognizing triggers and making healthy decisions, utilizing DBT and other therapeutic skills, and perseverance.

Focus on and shifted perception of self. When the researchers asked the participants, "What has changed for you since your psychotherapy?" many described both explicit and implicit strategies they have gone on to use in order to maintain change(s) initially made. Several participants spoke to their increased ability to focus on themselves, including trusting onself and becoming self-reliant. One said, succinctly, *I am my own person.* Participants described gaining self-esteem through the therapeutic process, and ultimately having more confidence in themselves. One participant stated, *I'm learning that I can be a round peg in a square world and I don't have to do everything the way they are doing it. I gained more confidence to believe in myself…*

Many spoke about becoming more self-reliant through receiving psychotherapy and having an altered positive perception regarding how they thought others perceived them. One participant stated, *I'm less, how can I say it, more dependent on me and less dependent on what other people think of me…* Two participants stated in regard to their change, *I'm not such a scum after all. More self-esteem you could say*, and *I have a lot more confidence*.

Enlarged perspective. Eleven of the fourteen participants stated they have utilized their enlarged perspective from psychotherapy to help in maintaining their gains. These participants described this as having achieved a better sense of themselves and their needs. They reported being able to better handle depression, having increased stability and thus are *safer and calmer*. One client said in relation to his current life, *It's a lot calmer now...and it's safer too. I'm not doing a lot of like...therapy interfering behaviors. I was doing a lot of those. Now I'm using a lot of skills on a regular basis so I'm not hurting myself.* Interviewees spoke to understanding depression better stating, *I think I understand the nature of depression, the signs, that whole thing much better.* Additional findings regarding gaining an enlarged perspective are noted in the table below. As seen in table 2, enlarged perspective was described in relation to achieving a better understanding of oneself, other people, and one's diagnosis.

Table 2. Enlarged Perspective

Enlarged Perspective	• *I listen to what other people say and I take into consideration as to how it fits into my life but it's not, I'm not taking it as, 'oh this is the way it's supposed to be or this is the way it has to be,' it's another option.* • *And then you realize...that you're suffering is real but that there's a lot of other people who are in the same boat and you're not the only one.* • *(I'm) recognizing that when things are starting to get difficult that I need to step in and be really proactive and just be a little easier on myself.*

Three of the participants did not explicitly indicate gaining an enlarged perspective after psychotherapy at the clinic. Two of these three participants stated they had a negative therapy experience due to a lack of a therapeutic alliance, a perceived lack of empathy and care from the therapist, and lack of structure. One of these three described a desire for more structure, which she described as *some healing techniques,* and *other things to try.* Participants also sometimes reported they were not challenged enough by their therapist. One described some ambivalence, saying *she was my champion…she didn't maybe challenge or push me enough on some of the harder stuff.* Two of the fourteen former clients transferred from their initial therapist to a second therapist and reported increased satisfaction as a result.

Stability. Several participants spoke to having stability in varying areas of their lives which helps them to maintain their change. They cited gaining stability in areas concerning their financial health, mood regulation, and physical health. One client stated *So (my) mood has improved and I'm a lot more stable.* Another stated in relation to finances, *I'm more financially stable. I wasn't making much of any money and so the sliding fee scale and the sort of flexibility about the payment and that sort of thing is what made it basically possible for me to come to*

therapy. And I'm making more money now. Another client stated *my mood is stable…it would be fine and then usually stress would get really bad or other situations...I would be depressed, I would get full blown depression and then it stabilized.*

As seen above, several participants connected stability to factors such as: being older and achieving more financial stability that, for some in the sample, came with age. They also connected it to their experience at the clinic as foundational. *It was really crucial to where I am now… (the clinic) created a sense of stability.* Maintaining gains were, for many, connected to a sense of economic well-being, and to what Lambert and others have described as extra-therapeutic factors (Asay & Lambert, 1997).

Finally, another participant contrasted this sense of current wellbeing with his *younger self*. He described his therapist as instrumental in helping him stabilize:

> *So that created a sense of stability and it was the first person I could totally trust and (the therapist) kind of showed me how I could, I don't know, it's hard to explain, like I felt like he provided this stable force in my life and besides that he pointed out all the stuff that I was doing that was hurtful to myself that I didn't realize was that bad and he pointed that out and then we worked on goals and things like that but it was more that it kind of stabilized me.*

This person expressed empathy for their clinician, in hindsight, saying *Poor (name)…I scared the crap out of him on a regular basis.*

Internalizing the therapeutic relationship. All participants, with the exception of two, described having a largely positive experience with their therapist and most spoke to internalizing their therapeutic relationship in some way. The impact of the alliance was described as carrying forward after the majority of clients had completed therapy. While several female participants noted their preference for a female therapist, one woman, in particular, described seeing a male therapist as offering a corrective experience. She described feeling supported by him, which in turn helped her to gain another perspective, stating *I internalized the*

experience I had with a male figure that was not only not judging me but very much had my back for the first time. Several participants, regardless of gender, spoke to being able to reflect on and to make use of an internalized relationship as a means of maintaining change. One person said simply, *I can still hear her laugh.*

Effects of time and acceptance. When thinking of their experiences to carry forward with them for future use, several participants spoke to being *older and wiser*, stating that with time they had gained maturity and increased wisdom. One participant stated, *I think I'm just a little wiser about relationships and interpersonal issues, ways of communicating*. Participants spoke to accepting "what is," stating, *what made the change possible is the fact that I accepted that there was no cure. And that I accept the problem as is and I have to live with it...Yeah, the acceptance of who and what I am.* This quote speaks to the interrelatedness of factors that these participants referenced as important in maintaining change. Both psychotherapy and age were associated with a sense of greater perspective, agency, and confidence.

Recognizing triggers and making healthy decisions. Three of the fourteen participants stated they are now more aware of triggers when they arise that can send them into a depressive state. A participant stated, *I know especially some of the things I have to avoid because there are times when I do go back into depression….it only gets bad for a few hours...and then I can get it back under control because there are things that do trigger (me). The memories (are) associated so I tend to get away from that sort of thing*. Regarding triggers another participant stated, *I know how to manage my depression better, but I wouldn't say that it's better. I know when to watch out and what I have to do for it*. A third stated, *I can identify things which are coming up, that cause problems and just be prepared and I try not to let things build up.*

Many participants stated that they are able to recognize what is healthy for them in relationships and what is unhealthy in their current relationships. Through this recognition, the participants described gaining the ability to make better relationship choices impacting their overall well-being. Several participants discussed surrounding themselves with supportive people who could help them when they felt it was needed and who provide ongoing support.

DBT and other therapeutic skills. Three of the fourteen participants spoke to the effects of DBT and other therapeutic techniques that specifically helped them to maintain change. One participant stated, *I didn't think I needed it and I didn't think I had any problems... (the therapist) got together with the DBT therapist and psychiatrist and they created this chain link...I was really out of control. So, at the time I hated it but looking back it's what kept me alive*. Utilizing therapeutic tools to help ease anxiety was employed by one of these three clients to help maintain change. This person specifically attributed the breathing exercises they learned in therapy as a tool to help maintain change, stating *But what I did learn here is I did learn breathing exercises, learned options to deal with anxiety and to address those feelings when they came*. Another spoke to continuing to practice the skill of being *proactive.*

Perseverance. Lastly, participants listed perseverance and *doing the work* as a method to maintain their change. They understood the necessity of coming to therapy and working on their goals with another person who focused and supported them, and to whom they were accountable. When asked how they handled roadblocks in therapy one participant stated, *Perseverance, let's just keep talking, let's just keep going through it. Let's just show up every week…. I just push myself through it and keep going because of the purpose of my coming here was to benefit, to help me get better. So, that was my motivation*. Clients here spoke to psychotherapy as often being "more than one thing (quotes mine)" and not easily reduced into its

component parts. Several described a greater understanding of its significance that came with time.

The Contextual Model

The last question that we asked was, to what extent did we see components of Wampold & Imel's contextual model in the interviews? As a reminder the contextual model names three core components thought to be associated with successful psychotherapy outcomes. These three components are: structure, belief and investment in the treatment approach, and genuine empathy or a real relationship between therapist and client. We found evidence of all three components in the data analysis; however, interviewees varied in how much priority was ascribed to each component.

Structure. Structure emerged as a theme throughout the data, though not as strongly as belief and a sense of real relationship. Structure varied in terms of how it was defined. It took forms such as: giving attention to what was talked about in the session, timing, freeform, goals, and frequency of meetings. It was widely agreed that some sort of structure is important, but the participants were in disagreement about what kind of structure was best. Several former clients agreed that setting structured goals in psychotherapy was beneficial and that when it was lacking, or when progress wasn't explicitly monitored, it was an impediment to progress.

Table 3. Structure as Favorable

Structure as Favorable	• *I'd reached my goals and I felt better and I was willing to go on.* • *The most helpful I always think was the fact that she always kept me on point, you know, where are we going this week?* • *They set goals and when I reached these goals they tell me.* • *She wouldn't let me procrastinate too much, She would always…about the point.*

As shown in the above table, certain interviewees appreciated and spoke to the importance of structure in their sessions as opposed to a less structured or "free form" approach. These participants felt their psychotherapy sessions had purpose and this was a common theme when asked about what helped. In support of this theme there were many quotes that described when structure was not present, it was considered unhelpful.

Table 4. Not Having Structure

Not Having Structure	• *The thing that shocked me about it, that I wasn't really prepared for at first was that it was a little more freeform.* • *I guess I just expected my hand held through the process and instead it was like I was guiding it.* • *She did allow me the flexibility to come every other week but actually thought that was harder and made it more difficult on the both of us.*

It was also apparent, as evidenced in the table above, that structure around the process and even frequency of visits was desired by participants. When therapists left room open for *free-form* discussion, some respondents spoke to uncertainty and even to *feeling lost* or unsure of where they were in the therapeutic process. One respondent said simply, *I didn't get direction.* Consistent with the contextual model, structure arose as an important component to

psychotherapy and appeared to serve as a guide for the client throughout the process. Even a review of progress as part of termination was mentioned as a valuable form of structure.

Belief and investment in the treatment approach. The majority of participants agreed that having a belief and investment in the treatment approach was important in making the psychotherapy process work. There was a common theme of participants feeling they had to "buy into" the process and that this involved both self-disclosure and some belief that things could improve. Many participants spoke explicitly to the recognition that their degree of motivation mattered: that they would get more out of the experience if they put more into the therapy. Several participants described psychotherapy as "work" or something that *you just have to do regardless of enjoyment.* Former clients often spoke here to their own role in this process and in so doing echo Norcross and others who have spoken to the importance of client variables such as, in this case, motivation and degree of participation. One respondent said simply, *I didn't disclose enough.*

Table 5. The Importance of Belief and Motivation

The Importance of Belief and Motivation	• *I wanted to get better, that was motivation.* • *I had to go through it or it would finish me.* • *I really going to do the work or just play around here.* • *I need some help, I need help from someone who can help me make my way through this maze.* • *I think the same things that make it work is the wanting to make something happen, wanting to create something you know.*

As seen in the table above it is apparent that an early understanding of what it will take for the client to be successful in psychotherapy or the "buy in" is a factor former clients in this sample identified as important to a successful experience. One client even stated *it's just gonna take*

some risks. One of the two interviewers summarized a participant's point, saying *it's really a process isn't it? The person is the one who has to do all the work, the one who has to reflect, and that's the way insights come.* While most people agreed that having a belief in the therapy process is important, a few clients identified not having or being tentative in their belief in the process and value of psychotherapy. These clients also tended to be more likely to report problems and negative outcomes.

Table 6. Not Buying In

Not Buying In	• *I didn't think I needed help even though I wanted it; I didn't think I needed it and I didn't think I had any problems so it kind of created this web.* • *I mentioned that he didn't understand me but I kind of was using the hour a week I had with him in kind of a manipulative way, It was almost like I didn't want it to work.* • *I think the roadblocks were probably me not working hard enough at it and then also not disclosing enough information. I'd always just give him just bits and pieces…so it was like preventing myself from getting better quicker.* • *I thought I was showing that well you can't help me so we're just going to play a game here.*

As identified in the table above, a few of the clients reported that their lack of success in therapy was due to them not putting in the effort and not having the belief that therapy could work for or be helpful to them.

Genuine empathy and real relationship. Among the three components of the contextual model participants spoke mostly to the alliance or real relationship. It was apparent from the qualitative data that having trust and a connection with the therapist was foundational to meeting

participants' needs. Many who said psychotherapy was helpful described the alliance as the primary contributing factor. The alliance was often described as a friendship, and the clinician as someone who listened without judgment, who really cared, offered kindness, patience, and a good understanding of their situation. Former clients described not only the need for an alliance, but for a sense of being known and appreciated as an individual: *…not X's client today is…that wouldn't have worked.*

Table 7. Real Relationship

Real Relationship	• *It was a very warm, very comfortable relationship.* • *I think about the attachment issues and being seen, being heard, being accepted, different facets at different levels.* • *It was the first person that I could totally trust.* • *I kind of thought that is someone I would like to know, someone I'd like to be connected to.* • *I felt like I had a friend in my corner and I believe that and it was someone who really took an interest in what was going on in my life and that was really important to me.* • *I can tell her anything I want to say, you know, something even I can't tell nobody else but I can tell her and she doesn't laugh at me.*

It is apparent as seen in this table that clients often felt trust in their therapist and connected on different levels. One participant described the relationship as *…almost like my big brother, almost, or like my parent or something*.

Participants balanced this desire for a genuine connection by speaking to the importance that the therapist was professional as well. Some examples of this were found in quotes such as*: She's very professional, she's friendly but she's not familiar* and *I would say that it was*

professional but friendly…I really could say anything and it was going to be taken in the spirit that I mean it to be. It is apparent that not only does the relationship need to be genuine but the participants need to see professionalism to have trust and confidence in the therapist's abilities. The clinician needs to be available, but also someone with perceived strength that can be leaned on and perspective that can be borrowed. One participant described this as *having someone that I trusted in a professional capacity that was very calm and could listen with an objective ear*.

A final theme that emerged from the data in relation to this idea of "real relationship" was the need for therapists to ask for feedback and the need for clients to give feedback when things were going slower than expected or not going well in therapy. The data suggested that clinicians should be asking for feedback and that participants were often not comfortable giving it unless asked. Some examples of this from the interviews included quotes such as: *checking in, maybe even having a questionnaire about the last session*. And *not to just assume that what we're doing is working*. Many participants reported not providing this feedback to their therapist and, when asked, suggested that it may have helped for them to give feedback or for the therapist to ask for feedback early on. This idea was evidenced by one participant who reported not making sufficient progress in psychotherapy saying: *maybe I wasn't directive enough in what I wanted to talk about*. Another said, *I talked a lot but didn't get a lot of ideas back.* Former clients seemed to describe feedback as a "loop" where clients both offered and received information with the goal of refining their process to better meet the client's needs.

Discussion

While there is much research concerning the effectiveness of psychotherapy, less is known about how long-term change is achieved and maintained. This study explored both of these latter two questions, using a mixed method analysis with both quantitative and qualitative

secondary data. The former clients represented in this sample sought psychotherapy due to presenting concerns such relationship issues, mental health conditions, abuse, and addiction. Those who interviewed were asked about what encouraged the changes they made, how they maintain those changes, what occurs when psychotherapy does and doesn't go well, and the presence or absence of Wampold and Imel's contextual model.

Interpretation of Findings

In the quantitative strand, we sought to understand if the participants improved from pre-test to posttest and if improvement was shown from posttest to a 12-18-month follow-up. We found participants did improve and evidenced significant gains based upon OQ-45.2 scores decreasing from pre-test to posttest, and from posttest to follow-up. The 0Q-45.2 scores evidenced the continued maintenance of gains and even improvement after psychotherapy ended. Similar progress and a comparable trend line were evident for those who interviewed, for those who did not, and for the sample as a whole. Differences between these groups were minimal, other than the subsample who interviewed demonstrating more distress in their OQ-45 total scores at each time point. Overall, we found that all three groups showed evidence of maintaining their gains after treatment. Our findings indicated that the group who interviewed were more symptomatic initially based upon pre-test scores and remained more symptomatic at both posttest and follow-up.

The qualitative analysis produced several dominant themes in relation to each of our broader questions. Former clients described a sense that when psychotherapy went well, it included a strong therapeutic alliance, genuine empathy, being heard and listened to deeply (*a different level of listening*), and often produced a sense of an enlarged perspective. These clients described benefits associated with: being challenged, the accessibility of the clinic and their

clinician(s), continually monitored progress, participation in their own recovery and the use of a team approach. Participants spoke to the power of the alliance, with most stating they felt they could connect with their therapist, worked together, and viewed their therapist positively. Contributions to a strong alliance included a sense of being attended to, provided with genuine empathy, and being challenged by their therapist (*a little more challenging)*. Each of these was described as creating a sense of investment in the process.

The majority of the participants who interviewed spoke to gaining an enlarged perspective due to their psychotherapy, which helped them to change ways of thinking. Former clients stated they felt they had gained a better sense of their needs and ultimately, themselves, with one person saying simply, *I am my own person*. This enlarged perspective helped to manage depression better and increased people's overall sense of stability, in turn creating a greater sense of calmness and safety. Participants stated that in addition to an enlarged perspective helping them to maintain their gains, they sought out supportive people outside of psychotherapy, learned to accept parts of their circumstances, recognized the impact of time in gaining wisdom, and utilized skills learned in psychotherapy.

Many participants spoke to the accessibility of the clinic and the offering of affordable options for mental health services. One participant stated they had to terminate therapy at another setting due to financial strain from a loss of income. Having an affordable option and even a sense of being temporarily *carried* by the clinic, were described as invaluable. Slightly over one-third of the participants interviewed spoke to the use of the team approach at the clinic (saying, *they all consulted together)* and felt their needs were met particularly well due to the staff consulting, often across disciplines.

When psychotherapy did not go well for participants it was characterized by having unexpected endings (generally therapist-initiated and sometimes experienced as confusing), a lack of structure, assumptions, and a sub-therapeutic or absent alliance. A surprise finding was the number of participants who described psychotherapy as ending unexpectedly. These interviewees all spoke to emotion associated with these endings. At least one person described a sense of rejection. Some participants stated they wished for more structure, continued monitoring of progress, and explicit feedback from their therapist. These interviewees described a lack of communication and "tools" provided from the therapist during their treatment. These participants also described a lack of direction given to guide the process and recommended more feedback about clients' progress. This minority of participants noted they felt their therapist made assumptions about the treatment process and wished for more dialogue regarding the extent to which the person was improving and the extent to which the approach was working. One person noted that this process need not take a lot of time and can take the form of reviewing the treatment plan. This client said, succinctly, *once a year is not enough*. While most participants described strong alliances with their clinicians, people across the sample described degrees of alliance. Those "in the middle" describing weaker alliances would comment positively about their therapist, stating they were professional or nice, but noted they felt there was not enough of or an absence of connection. Clients who noted this absence were able to speak to their own role in such impasses, including things like not disclosing *enough.*

Links to the Literature

Our findings regarding the power of the therapeutic alliance are consistent with the literature of Levitt, Pomerville and Surace (2016) who found that genuine empathy and a sense of being deeply understood and accepted by one's therapist contributed to therapeutic

alliance. Consistent with our findings, Levitt et al. (2016) found the alliance played a crucial role for participants in facilitating their success. Across studies, their qualitative meta-analysis pointed to the importance of clients experiencing: a. "being deeply understood and accepted" (p. 819) as something encouraging non-defensive reflection, and b. the internalization of an accepting clinician. Levitt, et al. identified each of these as primary drivers of change in a clinical relationship. Jerome Frank's description of psychotherapy as a highly individualized experience that is not easily categorized or reduced to component parts really bore out in our qualitative data as well.

Both our findings and those of Levitt, et al. (2016) support Wampold and Imel's (2015) contextual model in that all three of these sources identify the importance of balancing a personal and professional relationship. Levitt et al. speak to the need to offer clients both "authentic caring" (p. 819) and a "professional structure" (p. 820). This also lends support to the importance of training mental health clinicians to take a stance with clients of having "one foot in and one foot out." This has been described as encouraging clients to both offer (1) empathy and identification (one foot in), and (2) to stand back with the goal of conceptualizing and holding a broader perspective (one foot out).

Lastly, we saw overlap in Levitt, et al.'s finding that mental health clinicians need to be attentive and responsive to clients' goals, the "fit of the process" and the "content of the sessions" (p. 821). One example of this emerged in an interview from our study where a client described a mismatch between her stage of change and the clinician's suggestion that she explore dating sites (assuming a more action-oriented stage of change). This reminded us also of the importance of assessing and considering the client's stage of change as a form of alliance-building (Norcross, Prochaska, and DiClemente, 1994). Finally, Levitt, et al. note that when a

client becomes invariably "stuck," clinicians can help by increasing structure – for instance, by offering a number of options and/or potential solutions.

Our findings were also consistent with Wampold and Imels' (2015) finding that effective treatment is characterized by three core components: structure, belief in the treatment approach, and genuine empathy and real relationship. Successful therapies in this sample were characterized by a strong focus on the client and her or his goals (e.g. *She didn't let me procrastinate too much).* We were reminded in these transcripts of Wampold's description of successful therapists' "laser-like focus on the problem and on change." In our findings, the few participants who stated their psychotherapy treatment did not go well tended to connect this to a lack of structure. These participants reported they perceived their therapy to lack direction, a monitoring of progress, and a lack of communication between themselves and their therapist regarding the process and effectiveness of the therapy. At least one exception existed with a client describing appreciating the clinician allowing her to lead and "not having an agenda" imposed upon the client.

Participants sometimes explicitly noted that both belief in the treatment and a sense of their own role helped to make the experience effective. They spoke to *putting in the work* and often described a high level of motivation. Interestingly, these clients tended to express satisfaction with how psychotherapy ended, using statements such as *our work was done.* A couple participants were explicit in taking partial responsibility for a poor outcome, noting their own lack of effort, limited disclosure, or a sense of not believing in the therapeutic process. This is a finding consistent with Norcross (2002) speaking to the client and their level of motivation as an additional "common factor." Most consistent with our findings was Wampold and Imel's (2016) emphasis on the importance of genuine empathy and real relationship. Participants

clearly indicated they achieved successful therapeutic outcomes when there was a strong working alliance, often characterized as a real relationship, formed with their therapist as a personable professional. Former clients even used the language of friendship, describing these alliances as characterized by a person who genuinely knew and cared for them as an individual.

Related to this, we were able to compare and contrast our findings with those reported in an unpublished executive summary of data from a similar follow-up study from within the clinic that served as a pilot to this one (Bottorff & Jordan, 2008). This summary of findings from the original, unpublished study offered a form of methodological triangulation. In short, we saw evidence of similar quantitative trends and of qualitative themes emerging. The authors of that earlier study interviewed eight former clients, who similar to these 14, pointed to the importance of *a good therapist-client match.* Those former clients supported this with statements such as *we clicked* and *I connected right away* (p. 2). That original study also noted some former clients *prefer(ing) a structured or directive approach* (p. 2). Those interviewees similarly spoke to the importance of a real relationship, reporting that *most clients interviewed expressed a longing to connect with their therapists on a more personal level.* Lastly, this group of eight former clients similarly spoke to the importance of professionalism and to changes in perspective that they associated with growth and with successful outcomes.

Implications for Clinical Social Work Practice

A number of potential practice implications are suggested by these findings. These include things like the importance of frequently monitoring (versus assuming) progress. Such efforts can be done with minimal effort and can take the form of asking a concluding question at the end of each session such as “how did this go today? Is there anything we didn’t get to and is there anything I got wrong, or failed to understand?” This is an approach suggested by authors

such as Beck (2011). It can also take more formal forms, such as using measures like the OQ-45.2 or the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS), both of which are reviewed in session with a client. Such efforts have been described in the literature as associated with decreased attrition and increased improvement. They are similarly ways of increasing structure. This appears important in that increased structure was associated with more positive outcomes as well in these interviews. Again, authors such as Beck (2011) have pointed to ways to do this such as setting an agenda and doing some "bridging" between sessions as a way of building in a sense of continuity between sessions. We saw successes in this expressed by clients making comments such as *we weren't puddle jumping.* Former clients sometimes expressed interest in gaining information specific to the nature of their diagnosis and appreciated reviewing their treatment plans.

Several participants stated they had unanticipated endings with their therapist for a variety of reasons including the therapist's internship ending, not meeting criteria for services, or a transfer to another setting (in one case with a DBT-specific therapist). Some described being unclear as to why therapy ended. This was in some ways a surprise finding in that this is a clinic that provides trainings specific to termination and thinks about its therapeutic importance. It may reflect a time of employment change in the clinic's history. It is, though, a potential reminder of the power and importance of doing terminations well for psychotherapists across settings. Clients in this sample consistently had feelings about how their endings went: positive and negative. It reminds even clinicians who prepare the client in advance for an eventual ending, of the need to revisit this topic along the way and to consider that clients may not remember or anticipate the endings as clearly. This likely applies to transfers as well. A second and related surprise finding was found in an interviewee reminding clinicians and clients that *it's o.k. to*

change therapists. This former client spoke to waiting to speak up about the lack of an alliance. When she did she was transferred, which she described as therapeutic in itself in that she experienced it as her having a voice and her preference being honored and taken seriously by the clinic. The findings remind clinicians of the importance of tending to and monitoring a therapeutic alliance throughout a psychotherapy. This was largely described as a strength of the clinic by those interviewed.

One other surprise finding with practice implications is worth mentioning. While the literature (Cooper, 2008) speaks to gender as a variable accounting for minimal variance in treatment outcome, it was described in this sample as something important to many of these clients. Most who spoke to this expressed a preference for a therapist of their own gender, with the exception of a couple participants who expressed preference for a clinician of another gender. This preference of a same-gender clinician seemed to be particularly important for women in the sample. These were most often women who spoke to or who alluded to trauma histories or to having been victimized by men in some way. However, one woman spoke to the therapeutic value of having a male therapist who was *gentle*, listened well and *had my back.* She described his patience and attentiveness and this as offering a positive corrective experience. In all of this, the honoring of a preference, when there is one, seems important.

Implications for Policy

A policy implication we found involved the importance of macro level variables pertaining to clients' mental health. While most former clients described doing well since therapy (and this is consistent with the decreased OQ scores at follow-up that remained, on average, below "caseness" or a clinical cut off score of 63), those who continued to struggle consistently described economic and financial stress. This is a reminder of the importance of

social determinants in health. This was powerfully evident in one person describing currently facing foreclosure. Others who continued to struggle described degrees of social isolation and relational conflict (e.g. divorce or complicated relationships with friends or family members). This speaks to the importance of social work's person-in-environment (PIE) perspective and to Asay & Lambert's (1999) attention to extra-therapeutic factors. Our findings were consistent with literature suggesting that such factors exert significant influence in therapeutic outcomes. It should be noted as a point of historical context that these interviews took place in the context of what has been since referred to in the United States as the Great Recession.

Strengths & Limitations

This study had several strengths. One such asset was being able to hear from these participants in their own voices about their own experiences. This study gave voice to former participants in relation to both their role in their own recovery and to their strategies in maintaining therapeutic gains in the way called for by authors such as Kazdin (2009). It was able to do so using a mixed method design. This is something that has been missing in the literature. Individuals seek psychotherapy in order to get better, stay better, heal, or make change. However, few studies have explored this question by asking the participants, themselves, their opinions as to what benefit therapy has had for them. Through reading the participants' interviews we were able to begin to understand what components were central to achieving and maintaining therapeutic change by adults participating in psychotherapy at a community mental health clinic. Psychotherapy is highly individualized. It is not a "one size fits all" intervention and it is helpful to see what contributes to ongoing maintenance and success for individuals utilizing this service. The interview questions focused on discovering what

participants found helpful, what they took away from their experience, what obstacles emerged in therapy, and how this professional relationship created change in their lives.

In addition to being able to directly hear from these clients who participated in psychotherapy, another strength of this study is that the data obtained are from a real-life clinic setting (versus a study or clinical trial), with these clients reflecting on their personal therapy experiences in a community mental health practice setting utilizing non-manualized and open-ended therapies. Much of the existing literature regarding the efficacy of sustaining change after participating in psychotherapy does not come directly from such settings. Similarly, settings such as Menninger Clinic and this clinic are among a minority of clinics nationally that utilize empirical measures such as the OQ-45.2 on a clinic-wide scale. The questions for the interviews were generated directly from therapists at this same clinic to ask their previous therapy clients. This points to an additional strength, which is the mixed method nature of the study and the availability of both quantitative and qualitative data as convergent sources and perspectives to bring to these questions.

Some limitations also arose. This study was a secondary data analysis, and therefore the writers of this paper did not craft the questions themselves. Many of our limitations are due to our utilization of secondary data analysis of existing data to conduct this study. We did not have the opportunity to tailor the questions specifically to our broad research questions. Our study also lacked baseline qualitative data. It would have been strengthened by the opportunity to hear qualitatively from participants before or as they started their engagement in psychotherapy at this clinic. We similarly used only a single quantitative measure (the OQ-45.2), which prevented the dimensionality that multiple measures would have afforded.

A final limitation of our study was a response rate of only 14 interviewees. Many of the past clients of the clinic could not be reached and most did not respond to the invitations from the clinic to participate in the interviews. Most interviews were conducted one year to eighteen months after the participants ended their psychotherapy at the clinic. It would have aided our study to have more demographic background information in relation to the interviewees, as some underlying themes that emerged in our data analysis could be associated with demographic diversity. We were able, though, to compare our findings with an executive summary that summarized the themes from a previous group of interviews as a form of triangulation.

Recommendations for Future Research & Conclusion

Further research could be utilized to expand upon the findings from this study. One recommendation would be to consider utilizing a single interviewer to reduce some of the variability we saw in interviewing across the transcripts. It would be advisable to continue having multiple individuals code the interviews after they have been transcribed. Any future researchers replicating this study could ask their own, original questions, to really hone in on the specific questions we asked (specifically, about how people participate in their recovery and strategies they use to maintain their gains). This secondary data analysis offered a strong place from which to start. We would suggest that future studies consider prospective and/or longitudinal methods to enhance their rigor. Lastly, we noted in the interviews that a number of people referred to their therapies as going back farther than eighteen months. We are not sure of the accuracy of these perceptions. If some of the services were farther back than targeted by the clinic, this could offer both a strength and a limitation. It would offer the strength of an even longer-term follow-up, but a potential limitation in that people would be reflecting on an experience even further back.

A final recommendation that would benefit further research in the efficacy of psychotherapy would be to include baseline qualitative data. It would improve the quality of research to hear qualitatively from the participants at the time they started psychotherapy. In the time between beginning psychotherapy and participating in the interview, participants could have reconstructed their reasons for attending, their goals in therapy, and their evaluation of their progress. To some degree, memory is constructive and having baseline qualitative data would further accuracy and the validity of the results. This was suggested to us by a mixed method researcher: Dr. Laurel Bidwell. Related to this, future research could more directly compare the OQ-45.2 change trajectories for those interviewed (the minority), who described poor experiences versus the majority who described positive experiences as an additional and explicitly mixed method question.

That said, we want to express our gratitude to the participants of this study who took the time and effort to provide insight into what supported the changes they made and into what these former clients "took with them" from this experience – one that the vast majority described as positive and meaningful. We heard evidence, both quantitatively and qualitatively, that people largely benefitted from psychotherapy and that the result have endured.

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Appendix I. Original Interview Questions

Former Client Interview

1. How are things going for you right now?
    a. Life in general, work, relationships?
2. What was going on in your life that made you come to therapy?
    a. What brought you to therapy?
    b. What was your life like then?
3. Is your life different now than when you first began therapy? If so, in what way?
    a. What parts of your life have changed since being in therapy?
    b. How do you think differently now vs. when you began therapy, and about what types of things?
4. How did it come about that you ended your therapy experience?
    a. What led you to stop going to therapy?
5. What did you take away from your therapy?
    a. What stands out to you about your therapy process?
    b. What do you use in your daily life as a result of therapy?
6. What parts of therapy were the most significant to you?
    a. What parts of therapy were the most helpful?
    b. What parts of therapy were the least helpful or frustrating?
    c. When you look back on your time in therapy, how do you think the changes came about?
7. Describe your therapist:
    a. What was your relationship with your therapist like?
    b. What were they like?
    c. What did you think about them?
    d. What would you say your therapist is like as a person?
8. If you encountered any roadblocks or obstacles in therapy, how did you overcome them?
9. What would you like your therapist to know that would help them in working with future clients?
    a. What do you think therapists should know about what it's like to be a client?
    b. If you had the chance to ask your therapist something, what would it be?
10. Was therapy what you expected?
    a. What parts of therapy were different than what you expected?
    b. What parts of therapy were similar to what you expected?
11. Is there anything else you want to tell me about your therapy experience that you think would be helpful to know?

Appendix II. Data Analysis Plan

Quantitative: Descriptive (Describing the sample and subsample of interviewees)

For N = 42

(Mean, median, modal)

- Age
- Number of sessions
- Pre, post, follow-up scores on OQ-45.2

(Frequencies)

- Number of sessions
- Race/ethnicity
- Insurance status
- Relationship status
- Diagnosis/diagnoses

For N = 14 who interviewed

(Mean, median, modal)

- Age
- Number of sessions
- Pre, post, follow-up scores on OQ-45.2

(Frequencies)

- Number of sessions
- Race/ethnicity
- Insurance status
- Relationship status
- Diagnosis/diagnoses

Quantitative: Inferential (Paired sample t-tests and calculation of effect sizes)

Paired sample t-tests and effect sizes

- Pre – post
- Post – follow-up
- Pre – follow-up

Qualitative:

Qualitative Research Questions

1. What do former clients report "drove" or facilitated their change?
2. What do they do to maintain these changes?
3. To what extent do we see the three core concepts from the contextual model reflected in the data?
    a. Structure, belief in and participation in process, an "above & beyond" alliance?

Mixed Methods Questions

1. When therapy goes well, how do former clients describe it?
2. When therapy goes well, what do they say both supported their change and the maintenance of their gains?
3. When it did not go as well, what seemed to characterize those experiences?

Open Coding:

1. Apart from what we thought to ask and to focus on, do we note any other significant findings or trends in the data worth capturing or noting?

Appendix III. Detailed OQ Score Tables

Table 8.a All Participants – OQ-45.2 Scores

	N	Min	Max	**Mean**	**SD**
Pre-test	42	13.00	125.00	**64.55**	**22.66**
Posttest	42	14	120	**57.81**	**22.94**
Follow-up	40	22.00	97	**53.13**	**19.97**

Table 8.b Interviewed Participants – OQ-45.2 Scores

	N	Min	Max	**Mean**	**SD**
Pre-test	14	13	91	**69.00**	**19.96**
Posttest	14	14	120	**63.07**	**27.37**
Follow-up	14	22	97	**58.00**	**21.10**
ES = (58-69)/9.96=-0.5511, ES=.55					

Table 8.c Non-Interviewed Participants – OQ-45.2 Scores

	N	Min	Max	**Mean**	**SD**
Pre-test	28	23	125	**62.32**	**23.92**
Posttest	28	17	90	**55.18**	**20.42**
Follow-up	28	22	94	**50.5**	**19.24**
ES = (50.50-62.32)/23.92=-0.4941, ES=.49					