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Sudden Gains: A Pluralistic Approach to the  
Patient and Therapist Experience

Brian P. Hansen

A dissertation submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the degree of  
Doctor of Philosophy

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## ABSTRACT

### Sudden Gains: A Pluralistic Approach to the Patient and Therapist Experience

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Qualitative and quantitative research methods were used to study instances of sudden gains within the case load of a private practice practitioner. Five clients whose progress was marked by such changes were contrasted with the views of five clients whose progress was marked by significant setbacks. Results from the quantitative analyses indicated that clients who experienced sudden gains during therapy tended to retain their therapeutic gains over a 2-year time period. In contrast, individuals who experienced setbacks in therapy generally continued to be distressed at the 2-year reassessment. Clients who experienced sudden gains were more distressed prior to treatment and were more satisfied with their experience looking back. A stronger working alliance was found amongst those who experienced sudden gains, although there was no difference between the groups' ratings regarding the strength of the therapeutic bond. Qualitative results suggested that therapy was helpful in bringing about many changes in clients' lives, but clients who experienced sudden gains generally recalled more positive aspects of therapy, demonstrated greater utilization of therapeutic techniques, endorsed more long-term changes, accepted more responsibility for their treatment outcomes, and were less likely to react negatively to therapeutic techniques. Clients who experienced setbacks in therapy were generally less optimistic about the future, felt that they had regressed since termination, and demonstrated more resistance to therapeutic techniques.

Keywords: sudden gains, rapid response, rapid responders, therapy outcome, working alliance, off-track, deteriorators, therapist factors, satisfaction, blue, red, interpretative phenomenological analysis, case-based, pluralistic, super shrink, outcome questionnaire, phenomenology, measuring change, helpful factors

## TABLE OF CONTENTS

<u>Abstract</u> .....	ii
<u>Introduction</u> .....	4
<u>Background</u> .....	4
<u>Clarification of Terminology</u> .....	4
<u>Frequency and Occurrence of Sudden Gains</u> .....	6
<u>Hypotheses Regarding Mechanisms of Sudden Gains</u> .....	7
<u>Rationale and Contribution to the Literature</u> .....	8
<u>Case Context and Method</u> .....	8
<u>Procedures</u> .....	8
<u>Measurement and Key Constructs</u> .....	10
<u>Measures</u> .....	12
<u>Interpretative Phenomenological Analysis</u> .....	15
<u>Process of Selecting Themes</u> .....	16
<u>The Clinical Setting</u> .....	17
<u>Description of Participants</u> .....	19
<u>Results</u> .....	31
<u>Empirically-Validated Measures of Change</u> .....	31
<u>Client Change Interview Protocol Analysis</u> .....	36
<u>Discussion</u> .....	52
<u>Themes of Changes</u> .....	54
<u>Satisfaction and Outcome</u> .....	62
<u>Working Alliance</u> .....	64

<u>Therapist Variables</u> .....	65
<u>Tracking and Monitoring</u> .....	66
<u>Methodology</u> .....	67
<u>Limitations</u> .....	68
<u>References</u> .....	72
<u>Appendix</u> .....	92

## Sudden Gains: A Pluralistic Approach to the Patient and Therapist Experience

### **Introduction**

The current study used pluralistic case-based methods to explore a phenomenon that was discovered through large-scale psychotherapy outcome studies, that of dramatic and sudden treatment response. During the last twenty years, a subset of researchers began focusing on the timing and sequence of patient change in psychotherapy, instead of merely measuring pre and post therapy outcomes. Some have observed that an individual's recovery path in therapy is likely to differ significantly from the mean change trajectory (Ilardi & Craighead, 1994; Tang & DeRubeis, 1999a). In other words, similar disorders, similar clients, and similar psychotherapies can all produce vastly different patterns of change from one client to another. An often observed phenomenon that takes place within this wide variation of uniquely individual responses to therapy is that of sudden and rapid improvement. This pattern of change is profoundly different when compared to small incremental session-by-session changes traditionally assumed to take place in psychotherapy.

### **Clarification of Terminology**

Despite the presence of this frequently observed phenomenon, there is currently a significant lack of agreement within the discipline when it comes to operationally defining this type of treatment response. Various terms have been used synonymously, such as "sudden gains", "early gains", and "rapid response" to describe the phenomenon. Fennel and Teasdale (1987) were two of the first researchers to study this pattern of change while observing different change responses to psychoactive medications, and utilized a median split to determine dramatic early

response. Guy (2000) measured progress from a single point in therapy in relation to the client's initial distress level. Others, such as Quitkin, F. M., McGrath, P., Amsterdam, J., Fava, M., and Fawcett, J. al. (1998) based their definition of rapid response on a therapist's rating that the client had little or no psychopathology by the first or second session of treatment. Two other studies, headed by Beckham (1989) and Renaud J, Axelson D, and Birmaher B. (1998) believed 50% improvement over two sessions to be an adequate measure of rapid response. Other terms used to define this phenomenon include "Large Sudden Improvements" (Gaynor, S. T., Weersing, V. R., Kolko, D. J., Birmaher, B., Heo, J., & Brent, D. A., 2003), "Rapid Early Response" (Hass, Hill, Lambert, & Morrell, 2001), and "Early Sudden Gains" (Stiles, W. B., Leach, C., Barkham, M., Lucock, M., Iveson, S., Shapiro, D. A., Hardy, G. E., 2003), and have been used to describe similar change trajectories in response to psychotherapy.

### **Frequency and Occurrence of Sudden Gains**

Aside from the discipline's use of various terms and definitions of this phenomenon, different studies also report varying frequencies of this occurrence. Tang and DeRubeis (1999b) found that 39% of clients met their criteria for sudden gains by the end of treatment. They also observed that of those who experienced sudden gains, 79% also displayed sub-clinical symptomology by the completion of treatment, as compared to only 41% in the contrast group. Other researchers, using similar criteria to Tang and DeRubeis (Gaynor et al., 2003; Hardy, G. E., Cahill, J., Stiles, W. B., Ispan, C., Macaskill, N., & Barkham, M., 2005); Hofmann, Schulz, Meuret, Moscovitch, & Suvak, 2006; Stiles, et al., 2003; Tang, DeRubeis, Beberman, & Pham, 2005; Tang, Luborsky, & Andrusyna, 2002; Vittengl, Clark, & Jarrett, 2005) demonstrated similar results. Gaynor and colleagues (2003) found that 50% of treated clients met criteria for having

experienced sudden gains. Stiles and colleagues (2003) found that 17% of treated clients had experienced sudden gains. Several studies have discovered the trend that approximately 50% of the total change during the course of therapy takes place during the period of sudden gains (Gaynor, et al., 2003; Hardy, et al., 2005; Hofmann, et al., 2006; Stiles, et al., 2003; Tang & DeRubeis, 1999b; Tang, T. Z., DeRubeis, R. J., Beberman, R., & Pham, T., 2005; Tang, T. Z., DeRubeis, R. J., Hollon, S. D., Amsterdam, J., & Shelton, R., 2007; Tang, et al., 2002; Vittengl, J. R., Clark, L. A., & Jarrett, R. B., 2003). With the exception of Stiles and colleagues' 2003 study, the amount of change experienced during sudden gain periods was typically between 50% and 65% of total change. Multiple studies also showed that individuals who experienced sudden gains tended to maintain their dramatic treatment responses when measured during follow-up time periods (Gaynor, et al., 2003; Hardy, et al., 2005; Haas, et al., 2001; Stiles, et al., 2003; Tang & DeRubeis, 1999b; Tang, et al., 2007).

Contrary to the discipline's traditional beliefs regarding the timing, necessary dosage, and response to psychotherapy, the phenomenon of sudden gains challenges many of our assumptions about what happens during just a few sessions of psychotherapy that can bring about such lasting change (see Stiles, et al., 2003). Nearly one third of patients experience sudden gains, a finding which goes against the belief that response to psychotherapy change is linear, gradual, and similar between clients. The untested assertions inherent in “evidence-based treatments,” which typically have fixed session limits, which assume that the entirety of the protocol to must be implemented in order for change to take place, run contrary to the finding that individuals require vastly different dosages of therapy and often respond to therapy much quicker than would be expected (Pham, T., 2005; Stiles, et al., 2003).



## **Hypotheses Regarding Mechanisms of Sudden Gains**

Although the current literature contains very few studies that have empirically examined the causes of rapid response or sudden gains, many have hypothesized regarding causative factors (see Pham, T., 2005). Illardi and Craighead (1999) proposed that rapid and early response to therapy may be best explained by common factors rather than theory-specific interventions, since in these instances change occurs before the bulk of the therapeutic work has been accomplished, and the changes lead to better long-term outcomes (see also Rachman, 1999). Tang and DeRubies (1999), who are avid supporters of CBT, argued the opposite position, in that specific cognitive techniques could account for rapid decreases in symptomology. Other authors (Orlinsky, D. E., Ronnestad, M., & Willutzski, U., 2004) suggested that a better fit between the client's and therapist's predilections may lead to rapid response in therapy, while Finch, Lambert, and Schaalje (2001) suggested that rapid response may be due to a “flight into health.” Other explanations given by these authors included the possibility of medications beginning to work, or significant life events resolving for the client outside of the therapeutic encounter.

## **Rationale and Contribution to the Literature**

Clearly there is considerable debate about the mechanisms of dramatic response and a need for further investigation of this phenomenon. It is here that a case-based approach can make a contribution. Since so many possibilities for explaining dramatic response exist, and the phenomenon has been largely identified in large-scale group studies, more in-depth examination of a few selected cases may further our attempts to understand this phenomenon—thus the current study was undertaken. The investigator sought to flesh out the question of what therapeutic and client characteristics are responsible for early-response in a small sample of

patients. As some even consider the case study to be the basic unit of psychological practice and research (Fishman, 2005), it is the investigator's belief that a case-based approach may contribute to the literature's understanding of this phenomena. Fidel (1984) suggested that the case study strikes a balance between exploring the uniqueness of each participant's experience, while also placing these experiences within the theoretical frameworks of psychological theory. The current study sought to understand the question of what therapist, client, and common factors might be driving early positive-response by contrasting clients who manifested such a response with clients who manifested the opposite response, i.e., they had unusually negative recovery curves. The rationale for choosing two extreme groups was based on the belief that mechanisms for sudden and rapid change would be clearer and stands out better in contrast to individuals who did not experience such gains. The explicit purposes of the study were three-fold:

1. Qualitatively compare dramatic positive response with dramatic negative response: i.e. How do patients with varying courses of treatment response describe the ways they have changed (or failed to change) over the course of and after therapy?
2. Examine whether treatment gains were retained at two year follow up
3. Explore and propose possible mechanisms for dramatic-response (therapist, client, and common factors)

By pragmatically combining traditional quantitative paradigms with qualitative methods, this study used what Elliot and Klein (2007) refer to as a “pluralistic approach” (see also Clark, Rees, & Hardy, 2005). Following these authors' precedents, the current investigator measured certain variables (e.g. alliance, general distress, and satisfaction) through the use of valid and reliable psychological measures. Qualitative aspects of their experiences in therapy were

measured through open-ended coding of interviews, using Interpretative Phenomenological Analysis as the method of analysis (to be discussed in more depth in the methods section below).

### **Case Context and Method**

#### **Procedures**

The chair of this dissertation came into contact with a psychotherapist from a clinic in Sydney Australia following a presentation. She questioned him about the typical treatment response curves as captured by the OQ-45. After examining Dr. Vlass' full year of clients from 2009 to 2010 ( $N = 248$ ), 69% had signaled as having experienced sudden gains and were reliably improved by the end of treatment. Compared to previous studies which found that 17-50% of clients experience sudden gains (Haas, Hill, Lambert & Morrell, 2001; Tang & DeRubeis, 1999b; Stiles, et al., 2003), the primary investigator determined that Dr. Vlass would be an interesting therapist to study given her unusually high level of successful therapeutic outcomes. Although the results may not apply to all patients, there can still be principles gleaned from her patients' experiences regarding the mechanisms of sudden gains.

The primary investigator gained access to Dr. Vlass' entire caseload of clients, all of whom she had administered the OQ-45 to at every session. He randomly selected from Dr. Vlass' entire caseload from the previous year 5 clients who had flagged on the OQ-45 as having experienced dramatic treatment response (hereafter referred to as Blue cases, based on their OQ-45 status where Blues are in the top 10% of improvers) and five patients who signaled as being off-track (referred to as Red cases, based on OQ-45 status, where a Red label refers to the bottom 10% of responders) from clients who terminated between the fall of 2009 and the fall of 2010. Their end-state in therapy was not taken into account; in other words, we selected for study individuals who had either flagged Blue or Red during the course of treatment. The primary

investigator simply picked a name at random, and if they were still living in Australia, they were included for participation in the study pending their consent. In our case, every individual who was randomly selected consented, with the exception of one who had moved off of the continent. Clients were approached by Dr. Vlass well after they terminated treatment. She called these 10 previous clients to invite them personally to participate in the study. She asked if they would complete some forms and an interview as she was hoping to write-up his/her case for publication. Dr. Vlass explained the rationale behind the study in a non-scripted manner, stating that it was her intent to find out what each client's experience was like in relation to how they rated themselves on measures of mental health functioning. In particular, she told them that she would be looking at changes they made in therapy, specifically identifying what was most helpful, and asking the clients to what they might attribute their changes in distress. The accompanying risks, potential benefits, purposes of the study, as well as confidentiality were carefully outlined before the study began to ensure that clients were protected. Name and other identifying details and places were changed to maintain confidentiality. After the feasibility of the study was ascertained, the authors submitted a prospectus to the university's institutional review board (IRB).

Dr. Vlass sent consenting participants two documents in addition to the battery of questionnaires: the first was the formal Consent for Research Participation document. Each client was assigned a pseudonym to replace their actual name in order to protect confidentiality. The second form contained directions on how to fill out the battery of questionnaires, indicating which assessments were to be filled out first. The patients received these measures in an envelope that was pre-postpaid and addressed to Dr. Erigoni Vlass. After Dr. Vlass compiled the assessments, she sent the material to the authors for data analysis.

## Measurement and Key Constructs

Fishman (2005) noted that the term “triangulation” is used to describe a technique that employs using multiple assessments to measure similar constructs, thereby increasing validity and strengthening generalizations. In other words, if one wishes to measure distress, they may use two different measures that converge on the construct on interest, thus lending support to the strength of the conclusions. The following constructs were assessed in the current study:

1. Outcome of treatment was assessed through personal narratives by patients as obtained through the client change interview, as well as quantitative scores on two measures (OQ-45 and CRSS-4).
2. The OQ-45 was also used to measure mental health functioning at the inception of treatment, throughout treatment, at termination, and at follow-up.
3. As previously stated, some have hypothesized that sudden gains could be related to the strength of the therapeutic alliance, with the alliance being significantly better in dramatic positive responders than in off-track cases. Measuring the strength of the therapeutic relationship has been a consistent area of study for over 40 years (see Martin, D. J., Garske, J. P., & Davis, M. K. (2000); Gaston, 1990; Martin & Horvath, 2011; Wampold, 2001). Horvath and Greenberg (1994) define the working alliance as the extent to which a patient and therapist meet treatment goals through the establishment of a positive interpersonal relationship. Positive therapeutic outcomes are generally moderately correlated with stronger working alliance. Fennel and Teasdale (1987) gave their hypothesis that a strong interpersonal therapeutic relationships may lead to more rapid response in therapy; therefore it was included in the study to test the hypothesis whether

working alliance played a role in producing positive dramatic change. Both groups were measured regarding their retrospective perspective of this variable, and we were looking for differences between groups. This hypothesis was tested using the Working Alliance Inventory (Horvath & Luborsky, 1993), which was administered at follow-up. The client was asked to fill out the measure according to how they felt about the quality of the therapeutic relationship throughout therapy. It is possible that the lapse of time may alter the findings; therefore the results of this measure were interpreted cautiously and conservatively.

4. Mechanisms for change were assessed through the clients' personal recall of curative factors captured by excerpts of actual written interviews.

## **Measures**

**Outcome Questionnaire 45 (OQ-45).** The OQ-45 is a measure of mental health functioning, and has been found to have adequate psychometric properties. Lambert and colleagues (2013) found that the summary score for three-week test-retest reliability was .84, with an internal consistency of .93. The OQ-45 has also demonstrated adequate concurrent validity. The measure correlates at .63 with the Inventory of Interpersonal Problems, .62 with the Beck Depression Inventory, .64 with the State Anxiety Scale of State Trait Anxiety Inventory (STAI), .72 with the General Severity Index of the Symptom Checklist-90, .88 with the Zung Self-Rating Depression Scale, and .80 with the Trait Anxiety scale of the STAI (Lambert et al., 2013). The OQ-45 is able to detect true changes in psychopathology, in that multiple items change when individuals receive treatment, and these items tend to remain constant without treatment (Vermeersch, Lambert, & Burlingame, 2000).

**Consumer Report Satisfaction Survey (CRSS-4).** *Consumer Reports* magazine sent out the CRSS-4, a self-report outcome and satisfaction questionnaire, in their 1994 review of psychotherapy outcomes in order to measure their readers' satisfaction, pre-therapy, and post-therapy functioning in relation to psychotherapy. The questions of the CRSS-4 are as follows: a) A six-point therapy satisfaction rating; b) a six-point rating of how well treatment had helped with their primary mental health complaint; c) a five-point rating of overall emotional state previous to treatment; d) a five-point rating of overall emotional functioning upon completion of therapy, and e.) a five-point rating of their current overall emotional functioning. Nielsen and colleagues (2000) reviewed these results: four thousand readers responded, having been seen by a general practitioner, therapist, or had joined a mental health group.

Nielsen and colleagues (2000) administered the CRSS-4 in combination with the OQ-45 in a follow-up study of counseling center clients. They found that the CRSS-4's rating of pre-therapy distress, rating of emotion at follow up, and perceived changes were correlated significantly with OQ-45 scores. The CRSS-4 scores did tend to overestimate the amount of change found on the OQ-45. The scores on students' CRSS-4 correlated with first OQ-45 at .52, follow-up OQ-45 at .65, and total change scores at .57, respectively. CRSS-4 ratings of distress and symptomatic change were also correlated with changes measured by the Beck Depression Inventory with the same strength as the OQ-45.

**Working Alliance Inventory (WAI).** The Working Alliance Inventory (WAI) is a self-report instrument that is used in measuring the strength and quality of the relationship between client and therapist. It has 36 items, divided between three sub-scales, namely Goals, Tasks, and Bond (Horvath & Greenberg, 1989). The questions are scored on a 7-point likert scale. The authors of the scale note that the Goals sub-scale measures how well the therapist and client

agree on the therapeutic goals. The Tasks sub-scale is believed to be a measure of agreement between therapist and client, measuring how well they are on the same page regarding the content of therapy, while the Bond sub-scale measures the strength of a client and therapists' mutual trust and acceptance of the other. Horvath and Greenberg (1986; 1989) observed that the WAI has positive associations with many outcome measures. The scales' internal consistency estimate was .88 (Horvath, 1989). The internal consistency estimates ranging from .87 to .93. The scale has good reliability at .93. Horvath (2011) conducted a meta-analysis of a multitude of studies examining the relationship between working alliance and outcome. His study reaffirmed previous findings, in that the therapeutic alliance demonstrated a clinically significant, albeit moderate ( $r = .28$ ) association with therapeutic outcome.

**The Client Change Interview Protocol.** The CCIP is a structured interview protocol. The measure entails open-ended questions that prompt patients to describe elements of therapy that were helpful, while also commenting on aspects of therapy that were painful, unhelpful, or confusing (Elliot, 1999). Elliot, Slatick, and Urman (2001) argued that multi-variate studies have indelible worth in studying the effects of certain treatments with a large number of individuals. Interview schedules such as the CCIP can complement such studies by capturing the real-life human perspective on change phenomenon. The questions were arranged as follows:

1. What changes, if any, did you noticed in yourself after therapy started?
2. In general, what do you think has caused any rapid or sudden changes you have experienced? In other words, what do you think might have brought them about?
3. Are you doing, feeling, or thinking differently from the way you did before?
4. What specific ideas, if any, did you get from therapy, including ideas about yourself or other people?



5. Did any changes in how you felt throughout therapy happen as a result of outside events, or would you attribute the changes to things that happened in therapy?  
Please elaborate.
6. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you?
7. Were there things in the therapy which were difficult or painful but still OK or eventually helpful?

For an example of this methodology, see Israel, Gorcheva, Burnes, and Walther (2008). Elliot (2010) noted that a retrospective account can have the unforeseen benefit of allowing participants to reflect on and examine their past experiences, possibly leading to a more accurate and full account of the phenomenon (see also Clark, Rees, & Hardy, 2003). These authors also noted that at the end of the analysis, there is a hierarchy of themes and sub-themes that are based on the grouping of certain frequently appearing patterns within the responses. The current study used Interpretive Phenomenological Analysis as its means of systematically analyzing the qualitative, semi-structured interviews in an attempt to coalesce themes regarding helpful and unhelpful aspects of therapy. This particular methodology, and its rationale for use in the current study, will be discussed below.

### **Interpretative Phenomenological Analysis**

Interpretive Phenomenological Analysis (IPA) focuses on examining meanings, experiences, and events (Smith & Osbourn, 2006). It is thus both a methodology and a philosophy for exploring human phenomena. Smith and Osborn (2003) noted that IPA is rooted philosophically to hermeneutics. Eatough, Smith, and Shaw (2008) posited that IPA and case-based research have similar goals in two ways: first, each approach examines the personal

experiences and meaning-making of the participants, while also placing these experiences into the context of the greater culture and environment (see also Elliot, Fischer, & Rennie, 1999). They further noted that observers cannot interpret the world in a completely objective fashion. Thus IPA strives to find a balance between the objective certainty of empiricism and the relativism of subjective experience (see Kvale, 1996; Elliot, Fischer, & Rennie, 1999). These authors concede that the lens through which we view the world is affected by our cultural assumptions, traditions, and biases; likewise, the observer cannot remove him or herself from the phenomenon being studied.

Smith (1996) recognized that the investigator's perspective on the personal experiences of others can ironically be equal parts limited and complex. While the researcher eschews the role of an omnipotent narrator, he or she can openly postulate and hypothesize about the experiences themselves, the interpretations thereof are open to debate, discussion, and revision. Patients' descriptions of phenomena are thus placed within the general social, cultural, and theoretical constructs of the time, place, and history of these experiences (Smith & Osborn, 2003). The first phase of the process seeks to preserve the original intent of the interview transcripts. With each successive combing through of the data contextualizes the comments within broader psychological theories, or serves to challenge such long-held beliefs. Researchers employing this methodology also are interested in *why* certain words and phrases were used by the participants (Larkin, Watts, & Clifton, 2008). These authors also summarized the spirit of IPA in stating that the final product is a coherent narrative that prizes participants' inner experiences while attempting to aggregate themes that either fit in or disagree with current psychological theories. When the interpretative and phenomenological components have been synthesized, there follows a dialogue between the patients' experiences and the investigator's interpretation of the

phenomena (Clare, 2003; Smith, 1996; Smith & Osborn, 2003). Studies often have somewhere between 1 and 30 participants (Eatough & Smith, 2008). With our current sample size ( $N = 10$ ), IPA is considered to be an appropriate method of analysis. One can look to Mann and Abraham (2006) as well as Clare (2003) for recent examples of this methodology.

### **Process of Selecting Themes**

One of the greatest, albeit infrequently mentioned, limitations of this study is one that is inherent in all qualitative and quantitative studies: the investigator cannot remove himself abstractly from the research. Given that science is ultimately a human behavior, there will always be an element of subjectivity in the observing, reporting, and interpreting of the data. The variables the primary author chose to study, the lens through which the themes were observed and gathered, and certain conclusions drawn from the data are all, to some extent, biased based on the background and experiences of the investigator. In other words, it is impossible for the current author to approach the study with the ruse of a “blank slate.” As part of the natural process of researching the background of certain topics, one comes into contact with previous articles that shape and form opinions that cannot be erased from the investigator's mind. Thus certain themes may have appeared obvious only after having developed a schema and a paradigm from which to operate by reading other articles which sought to answer similar questions. Likewise, the language the author used to describe the themes and explain the results is a subjective, non-absolute medium that assumes every other person shares the same vocabulary and interpretation of words. In the end, the accuracy of the final product is ultimately left up to the reader to judge, while debate and disagreement regarding the conclusions should be welcomed and celebrated. Given that the process of deriving themes was organic and necessarily influenced by the investigator's world view and paradigm, these results are contextualized within

the confines of the primary investigator's experiences as a therapist, researcher, and human being, and are not to be seen as dogmatic or absolute.

### **The Clinical Setting**

Dr. Erigoni Vlass is a clinical psychologist with a background in language and education. She shares a practice in Sydney Australia with a small group of general practitioner physicians from whom she receives referrals for individual and couples counseling. Dr. Vlass begins every session with the following assessments: OQ-45, Sleep for Health Questionnaire, and Clinical Interview. Dr. Vlass continues to give the OQ-45 at every session. She then spends a major portion of the first session educating patients on several different aspects of mental health. The following steps take place in every first session of therapy:

1. Dr. Vlass gives all of her patients a handout on her brain-based therapy approach. The graphical handout highlights the stress response cycle, the function of the amygdala and hippocampus in storing emotional memories, and the body's ability to acquire new information thereby reducing high stress responses
2. Every patient is then educated regarding the cognitive behavioral model of emotions. She explains how physiological arousal is linked with cognitive patterns, which then culminate in a behavioral response and associated emotional reaction.
3. Patients are then educated on the allostasis stress response, with simplified explanations of the ANS and HPA axis in regards to stress.
4. Dr. Vlass also educates her patients regarding sleep hygiene, and provides principles for increasing quality and quantity of sleep. She also explains the relationship between poor sleep and mood problems/lack of motivation.

5. Finally, she ends the psycho-education phase by explaining the role of nutrition, counseling her patients about the effects of alcohol, coffee, and other drugs. She also stresses proper bed-time nutrition and its effects on restful sleep.

Dr. Vlass uses a multimodal approach to therapy, combining two therapeutic orientations: Cognitive Behavioral Therapy and Compassionate Mind Training. Compassionate Mind Training (CMT) is an intervention aimed at alleviating high levels of shame and self-criticism (Gilbert, 2000; Gilbert & Irons, 2005). The founders of this modality postulate that early childhood experiences with primary caregivers potentiate a disposition towards guilt, shame, and poor self-images of oneself. Thus CMT employs both cognitive and psychoanalytic approaches, in that it emphasizes the importance of early childhood experiences, while helping the patient become aware of ineffective protective mechanisms that have been erected to help patients cope with the emotional pain (Mayhew & Gilbert, 2008). Gilbert and Procter (2006) argued that self-condemning approaches to one's perceived weaknesses can actually be un-learned. CMT has been shown to decrease both anxiety and depressive features in patients.

Dr. Vlass also utilizes standard cognitive behavioral therapy (CBT). Beck (1993), one of the founders of CBT, suggested that the purpose of CBT lies in identifying and challenging irrational beliefs. As a result, a patient can develop a new schema with a resultant change in affect, mood, and behavior. Practitioners of CBT view assessment, psycho-education, cognitive restructuring, and exposure as the four most important domains in this treatment modality (Southam-Gerow & Chorpita, 2007). CBT also relies on relaxation, exposure, and modeling techniques (Kendall, 1993). Dr. Vlass combines CBT and CMT in a way that she perceives as maximally responsive to the specific needs of the individual clients.

## **Description of Participants**

Dr. Vlass reviewed her case files for the cases under study, and produced the following descriptions of her clients. The descriptions presented here are in the words of Dr. Vlass herself, in order to preserve the authentic quality of her observations. She wrote these descriptions before she sent out the measures to her patients. Naturally, her insights are influenced by hind-sight bias and can be viewed only as her current conception of these cases. The validity of such recollections is thus guarded, and her descriptions may be influenced by the patients' response to therapy. Her descriptions were based on a review of the patients' clinical file two years after termination.

**Blue case 1, Brent.** Brent is a middle-aged trade union official with a very stressful time-consuming and thankless job. He had a tendency to take his stress out on his family. He reported that he lost it when he had a fight with his wife and he checked into a hotel close to work. Brent presented with a diagnosis of Major Depression. His father reportedly had a very strong work ethic, and Brent left home at 18 and became financially independent. Brent was highly motivated and eager to change; he had a fear of repeating history. Brent came into therapy with a high degree of subjective distress, and an urgent need to decrease this emotional distress.

### *Client Variables:*

- Brent was initially hesitant about leaving his job as he feared that it may not change the relationship issues
- He was prepared to do what it would take to bring about change
- He appeared to have the ability to sustain and maintain change. Brent was resilient although he reported experiencing a great deal of stress in his life

- The rationale for treatment made sense to him hence he immediately commenced to make lifestyle changes - namely taking natural supplements to assist with anxious symptoms and sleep deprivation and also following the sleep routine
- He also implemented the compassionate mind training into his daily routine

**Blue case 2, Barbara.** Barbara is a 30-year old female. She is intelligent, with good communication skills. She presented to treatment diagnosed with Major Depression with comorbid sleep disorders of Initiating sleep, Circadian Rhythm, Maintaining Sleep (REM) and Somnolence. She was also diagnosed with Alcohol Abuse Disorder. She reported feeling depressed with no motivation to study, which was her prime concern seeing as she was a student. Psycho-education regarding allostasis and the role of alcohol and sleep deprivation in development of depression and anxiety was given in the first session. The role of nutrition in reducing levels of anxiety was also explained, as was the role of protein in the production of amino acids and subsequent conversion to neurotransmitters. Initially, I took a practical common sense approach and the client was motivated enough to put the sleep routine plan into action which included taking natural supplements such as 5HTP, Pre Gaba, Co Enzyme Q10, and magnesium. The second session involved compassionate mind training and CBT. The third session involved deeper compassionate mind training, identifying fears recording of the training process on CD and subsequent daily repetition of the treatment strategies.

#### *Client Variables*

- She presented with a high degree of subjective distress
- However she was motivated to change due to the urgency of her distress
- She also had a strong work ethic

- The client was very motivated and following the first session she was able to dramatically reduce alcohol consumption (which is often a cause of sleep deprivation) and was committed to taking the natural supplements and subsequently felt less depressed and anxious, and more confident

**Blue case 3, Bailey.** Bailey is a 36 year old female who was referred by her GP with acute anxiety. She is of moderate socioeconomic status. Clearly the distress was work related, looking at the OQ45-2 scores. The client reported that she had always been ambitious and driven. Her mother had a history of Bi-Polar Disorder and the client and her brother were financially responsible for mother, which had gradually become a burden over time. The goal of treatment was to reduce the high levels of distress. Treatment approach involved psycho-education regarding allostasis/allostatic load memory systems, behavioral changes, compassionate mind training, identifying fears, and recording of the training process on CD for daily repetition of the treatment strategies. Interpersonal relationships as assessed on the OQ45-2 showed that family relationships were strained, particularly the client's relationship with her mother which had always been difficult.

*Client Variables:*

- The client reported a history of high levels of stress
- However, she had the capacity to manage negative emotions (albeit her current situation seemed unmanageable)
- The client was willing to implement strategies to improve the way in which she related to her mother.
- Able to implement treatment strategies, and sustain treatment gains.



- Temperamentally, patient was very resilient

**Blue case 4, Beatrice.** Beatrice is a 37 year-old Caucasian female presenting with extremely high levels of anxiety. Clearly the symptom distress score was the result of the relationship break-up. Treatment involved psycho-education regarding allostasis and homeostasis, relaxation and breathing techniques, nutrition, sleep hygiene, and schema focused therapy, once again the focus being on the emotions and fears. The client's greatest fear was not being loved.

*Client Variables:*

- Highly motivated to change and eager to accept help offered
- Commitment to change
- Flexible in character
- Intelligent
- Overall a history of a calm and resilient temperament
- Evidence that she has the capacity to manage negative emotions

**Blue case 5, Brenda.** Brenda was a forty-one year old female referred by her GP with acute anxiety. The client was experiencing extremely high levels of distress on all domains of the OQ-45. The client reported that she had been living in a public housing commission flat for the past three years and in May 2008 a drug dealer/user moved in to the unit next door. She consequently became exposed to drug addicted people moving about in the corridor - buying drugs from the drug dealer and hearing loud music which continued throughout the night. The client reported making a complaint nine months ago and received no response.

The client reported that she had never experienced such high levels of distress and that normally she would be able to manage. She had developed fears of being attacked, fear of becoming seriously ill, and fear of not being heard or understood by the department of housing. Treatment was initially focused on psycho-education, giving the client an understanding of why she was feeling so anxious. Explaining that she was experiencing an acute phase of allostasis, which is normal given that she had not slept for the past nine months and was constantly in a state of preparedness. Scores on the OQ-45 dropped when the client was told that she would be transferred to another housing commission unit. Treatment approach involved psycho-education regarding allostasis/allostatic load, memory systems, arousal reduction techniques, behavioral changes, compassionate mind training, identifying fears, recording of the training process on CD for daily repetition of the treatment strategies, and problem solving (finding ways to ensure that the client was able to move to another location).

*Client Variables:*

- High degree of emotional distress
- Ready for change, prepared to do what it takes
- She was able to change current circumstances through psycho-education, managing her fears and re-locating.
- Able to implement treatment strategies, and sustain treatment gains
- Modest socioeconomic status however the client was able to manage on less rather than more
- Highly intelligent
- Temperamentally client was resilient

**Red case 1, Robert.** A 39-year-old Caucasian male presented for treatment. He reported having been diagnosed with Bi-Polar Disorder six months prior and had been on medication for four and a half months and was doing well and then he reverted back to previous coping strategies which were destructive to his relationship. Prior to his diagnosis he had self-medicated with drugs and alcohol and clearly it would take time for him to train himself to change his behavior. Memory systems were at play. The client was motivated to change and realized that maintaining a state of homeostasis in the body would ultimately lead to milder manic episodes. It was during severe manic episodes he would binge drink use drugs and visit sex workers. He reported feeling very ashamed of his behavior however was unable to stop the addictive cycle, hence the reason for therapy. Scores on the OQ45-2 show the erratic initial stages of treatment and the second session a red alert status signaled a more manic mood state and a reliably worse condition. The third session showed a drop in scores as well as the fourth. On the fifth session there was another elevation, however not as severe as the second. Each time there was an elevation in scores critical item status always reported frequent substance abuse, suicidal thoughts, and thoughts of violence at work. The feedback was very helpful to the client as he was able to view his erratic mood swings and reflect on cause and effect. Once again the OQ45-2 had identified the interpersonal domain as the most common critical client variable in the non-responders. Treatment focused primarily on stress management and more behavioral strategies in the initial stages and then schema focused work looking at core beliefs or fears.

*Client Variables:*

- The client has managed to abstain from alcohol and drugs for the past two years and is aware of the mood swings and manages them in more functional and less destructive ways
- Motivated to change, however unable to sustain behavioral changes as a consequence of prior procedural memory
- Extremely flexible
- Loyal partner
- Temperamentally unstable
- Difficulty managing emotions

**Red case 2, Reilly.** This 28-year-old female client was referred by her GP following an accident in the workplace (an industrial warehouse). She was a partner in a family business. A hand-rail fell from the staircase and landed on the client's head. It was the first accident to occur on the premises since she had been working there. The client suspected that it was not an accident. The client reported experiencing severe migraines since the accident although she did report a history of migraines. The client in this case deteriorated rather than improved. She had no trust in those whom she was working with, while the partner decided to sell his share of the business, leaving the client to run the business on her own. He was planning on taking all the customers with him as he had set up a new business in other premises. The client reported she had no support from her husband or family.

*Client variables:*

- Inability to change her current circumstances

- High level of functional impairment
- Desire to change, however was emotionally unable to sustain any changes achieved
- High degree of subjective distress
- Tertiary education
- Intelligent
- Difficulty regulating emotions

**Red case 3, Rebecca.** A 23-year-old Caucasian woman presented for treatment as a result of prolonged complicated grief reaction. She was referred by her treating GP for insomnia and unresolved grief. Initial scores on the OQ45-2 indicate moderate levels of distress with elevations on symptoms distress and social role. The elevations on social role were clearly a result of the client taking on more work than she could actually manage. The client reported working at a day job as well as working night shifts at a bar while she was studying full-time.

She reported some difficulties in interpersonal relationships as she had fears relating to loss of loved ones. This was understandable, given that her mother died when she was six years old and her grandmother had recently suffered a catastrophic stroke, which has left her unable to care for herself. Treatment approach included psycho-education regarding allostasis/allostatic load, sleep hygiene, and CBT model focusing on the core beliefs underlying the cognitive responses to triggered events. She has an avoidant style of attachment in relationships. When scores showed deterioration, the client realized that allostatic load was the primary cause and when she lessened the load her scores improved.

Scores prior to the commencement of the third session were elevated with a yellow alert status indicating deterioration in all three domains particularly the social role score. Scores prior to the

commencement of the sixth session were very elevated on all domains. The client has returned for treatment and each time it is about heavy work load.

*Client variable:*

- Contemplative stage of change – not quite ready to move to the action stage
- Resistant to change, as keeping very active was the way in which she had coped with her mother's death
- The degree of subjective distress fluctuated, therefore not such a motivating factor
- Moderate socio-economic status, although she did not want to depend on her father financially.
- Highly intelligent
- Difficult to change her current circumstances as she was studying full time and she felt compelled to work to support herself
- Insecurity, hence inflexibility in interpersonal relationships as a result of fear of loss

**Red case 4, Rachelle.** A 29-year-old Caucasian woman presented for treatment in 2004, referred by her treating GP for severe symptoms of depression. Initial assessment clearly indicated an extremely high level of depression both on the OQ45-2. The OQ45-2 was able to give a clearer assessment of which domains were causing distress and the scores on the interpersonal domain were very high. As the client began to talk about her distress it was evident that her interpersonal relationships had always been problematic, particularly her relationship with her mother. The client showed Borderline Personality characteristics. The client described her mother as emotionally and verbally abusive and had experienced physical abuse from her father who was deceased. History taking and psycho-education regarding allostasis, allostatic

load, benefits of healthy nutrition and fitness in maintaining healthy balance in the body were given in the first session. The client was encouraged to make changes to her sleep routine. She reported going off to sleep at 3 am and waking at 11 a.m. Unfortunately the client was inflexible with regards to making changes in lifestyle. Schema therapy helped identify core beliefs, which were often related to fears. Her expectation of others was that her emotions would not be validated which invariably had been her experience and hence she had a more negative view of her emotions. However the client had difficulty disciplining herself to keep rules and to complete behavioral homework. She had never had a love relationship, and she had been unemployed for some time.

*Client Variables:*

- Interpersonal domain was poor, which is the strongest client variable in the deteriorators
- Inability to self soothe
- Treatment Approach
- High level of subjective distress
- Expectation of treatment is a magical fix without putting strategies into practice
- The client was not prepared to do what it takes to change
- Anxious, unstable temperament
- Rigidity of character
- Unable to change current financial hence unable to change home situation
- Inability to manage negative emotions
- Resistant to making lifestyle changes such as sleep routine
- High level of functional impairment

- Intelligent

**Red case 5, Ruby.** This 45-year-old female presented for treatment when referred by her GP for severe symptoms of depression as a result of single motherhood issues, relationship breakdown, and parenting issues. Initial assessment according to the OQ45-2 showed high levels of symptom distress and the score on interpersonal relationships was highly elevated. The presenting problem was constant rumination about the past, excessive guilt concerning the impact of her separation with her partner on her two daughters and excessive self-criticism and feeling overwhelmed by the financial struggle of single motherhood. She reported feeling that way for two years. She reported that her youngest daughter was extremely anxious and had been diagnosed with Obsessive Compulsive Disorder. She endorsed historically difficult relationship with mother, who was dismissive of the client and disliked her, favoring her three brothers.

Treatment approach included psycho-education regarding allostasis/allostatic load, sleep hygiene, and CBT focusing on the core beliefs underlying the cognitive responses to triggered events. She had an anxious/ambivalent style of attachment in relationships. The client would require long-term treatment in order to begin to develop a stable sense of identity and to be able to self-regulate. When scores showed deterioration to a red alert status at session seven the elevations were in the interpersonal domain. The client will require ongoing support over the next few years in order for her to develop an internal self-regulatory system. Once again the OQ45-2 has identified the interpersonal domain as the most common critical client variable in those who deteriorate.

*Client Variables:*

- Inability to change her current circumstances



- High level of functional impairment
- Expectation that there would be a magic fix without putting in the necessary effort into changing
- Desire to change, however was emotionally unable to sustain any changes achieved
- High degree of subjective distress
- Tertiary education
- Intelligent
- Histrionic style of personality
- Difficulty regulating emotions
- Difficulty setting limits with her children
- Low socioeconomic status
- The client has since returned for treatment and has been diagnosed with hypothyroidism, hence her lethargy and inability to maintain motivation

## **Results**

### **Empirically-Validated Measures of Change**

**OQ-45.** The average intake OQ-45 score for Blues was 111.4 (an extremely high score—99.7%ile), while the average intake score for Reds was lower at 92 although still quite high (98.6%ile), indicating that Reds actually reported less disturbance at the beginning of therapy. The average post-treatment OQ-45 score was 37.6 (34.5%ile) for Blues, a remarkable drop of 73.8 points, while the Reds dropped an average of 8.4 points with an average post score of 83.6, indicating that Blues experienced substantially greater improvement over the course of therapy. After two years, participants were reassessed to determine whether they had maintained their

therapy gains or had deteriorated. Between the last session of therapy and the final assessment, Blues remained stable with a slight drop of .4 points on average. The Reds were similarly unchanged, with an average drop of 1.6 points. In other words, Reds and Blues, on average, remained at a similar level of distress compared to their last session of therapy after a two-year time period. Four out of the five Blue cases demonstrated improvement on the OQ-45 between their final session and the two-year follow up. Brenda was the only exception, as she deteriorated from a 36 to a 73 after two years. Two Reds, namely Rachelle and Ruby, deteriorated by 9 and 43 points respectively, while the other three Reds also demonstrated some reduction in distress as measured at the two-year follow-up.

Table 1. *Mean Change Scores on OQ-45*

	OQ <sup>Pre</sup>	OQ <sup>Post</sup>	OQ <sup>Follow-up</sup>	OQ <sup>Pre-Post*</sup>	OQ <sup>Post-Final*</sup>
Blues	111.4	37.6	37.2	-73.8	-0.4
Reds	92	83.6	85.2	-8.4	+1.6

*Note.* \* A change of +/- 14 points on the OQ denotes reliable change

**CRSS-4.** The CRSS-4 was administered at the follow-up time point in order to assess the participants' retrospective beliefs and attitudes about their experience in psychotherapy. While the measure is relatively simple, Nielsen and colleagues (2000) found it to be a reliable and valid measure of psychotherapy outcome and satisfaction. Several interesting patterns emerged from our sample's responses on the CRSS-4. In response to the first question, "*How much did treatment help with the specific problem that led you to therapy?*" all 5 Blues agreed that their experience in therapy "made things a lot better." However, 4 of the 5 Reds indicated that therapy only "made things somewhat better," while 1 Red case (Reilly) agreed that therapy made things a

lot better. In general, the Reds found therapy to be less helpful for their specific problem as compared to Blue cases.

On the second question, all 5 Blues chose the first choice “completely satisfied,” in response to the question “Overall how satisfied were you with this therapist's treatment of your problems?” Only Reilly of the Reds answered similarly. Rachelle marked “very satisfied,” while two Reds (Robert and Rebecca) chose “fairly well satisfied” to describe their therapy experience. Finally, Ruby chose “somewhat dissatisfied” in response to this question. Overall, the Reds, with the exception of one subject, were less satisfied with their experience in therapy as compared to the Blues.

A somewhat surprising and interesting pattern emerged from clients' answers to question 3, which assessed the following: “*How would you describe your overall emotional state when you started counseling?*” All 5 Blues rated their pre-therapy functioning as “*very poor: I barely managed to deal with things.*” Reilly, Rachelle, and Robert, from the Reds, also chose this option. However, two of the Reds rated their pre-therapeutic functioning as being relatively better than the rest of the cohort, namely Ruby (who chose “*fairly poor: Life was usually pretty tough for me*”) and Rebecca (“*so-so: I had my ups and downs*”). This finding however correlates with the Blues' rating of their initial distress as captured by the Outcome Questionnaire-45, given that Blues actually came into therapy with a higher overall rating of distress. It is interesting to note that two years after their experience in therapy, their answers on the CRSS-4 were consistent with their initial scores on the OQ-45.

Question 4 of the CRSS-4 asked the participants: “*How would you describe your overall emotional state at the end of treatment?*” Four of the five Reds answered the question with “*so-so: I had my ups and downs,*” with only Rebecca responding with “*quite good: I had no serious*

*complaints.*” In other words, Rebecca, of all the off-track patients, came into therapy least distressed and terminated therapy feeling better than the others. Three Blues responded similarly on this question, namely Brenda, Brent, and Bailey. Barbara rated her post-therapy emotional state as “*very good: Life was much the way I liked it to be,*” while Beatrice rated herself as doing the worst of the rapid-responders, namely “*so-so: I had my ups and downs.*” The Reds were, unsurprisingly, least optimistic about their rating of post-therapy functioning, with 4 rating their emotional state as “*so-so*” and only Rebecca rating her post-therapy functioning at “*very good.*” This finding corresponds with their relatively poor response in therapy and their status of being off-track during therapy and their poor treatment response on the OQ-45.

The fifth question asked the respondents “*What is your overall emotional state at this time?*” Of the rapid-responders, Brenda rated her current emotional state as “*quite good.*” Three (namely Brent, Bailey, and Barbara) rated themselves as “*very good,*” while Beatrice rated herself as “*so-so*” (note that she also had the lowest score of the Blues on post-therapy emotional state as measured by the CRSS-4). Three Reds (Rachelle, Robert, and Rebecca) rated themselves as “*very good,*” while Reilly and Ruby decided they were only “*so-so*” currently. In summary, Blues tended to maintain their gains over the course of two years post-therapy, while Reds in general continued to struggle emotionally. This finding is also in harmony with previous work examining the long-term outcomes of rapid-responders, in that they tend to remain better after treatment termination (Hass, Hill, Lambert, & Morrell, 2001).

In summary, several interesting patterns emerged from the retrospective self-report CRSS-4 data. Universally, the Blues rated their pre-therapy functioning as being poorer than reds. Blues in general also rated treatment as being more helpful than the Reds. The Blues were much more satisfied with therapy, and they also rated their “overall emotional state” at end of therapy

more positively than Reds. Blues also appear to retain the gains made in therapy, as they generally rate their current emotional state as better compared to their off-track peers even two years after the termination of therapy. This finding supports the notion that rapid-response in therapy is associated with greater long-term benefits from treatment. See Table A in the appendix for a full review of scores.

**WAI-R.** The Working Alliance Inventory (WAI-R) was given to each participant, and each was asked to retrospectively rate their overall perception of the therapeutic alliance from their time in therapy with Dr. Erigoni Vlass. With the exception of one Red (Reilly, who also rated her relationship higher than the other non-responders), all Blues rated the quality of the therapeutic working alliance higher than their non-responding counterparts. T-tests were conducted in order to examine differences between the Reds and Blues. The difference in variability in WAI total scores appears remarkable. T-tests were also computed for each of the sub-scales on the WAI-R (Tasks, Bond, and Goals). Results are summarized in Table 2.

Blues rated their overall working alliance with Dr. Vlass as being significantly stronger than the Reds. Blues scored higher on the Task sub-scale. In other words, Blues on average believed that they and the therapist were better at agreeing on the therapist's behaviors and cognitions that defined the content the counseling process. Likewise, Blues also scored higher on the Goals sub-scale, indicating that they retrospectively perceived that the outcomes they were working towards throughout therapy to be line with their desired results. Interestingly, the Bond sub-scale was not significantly different between groups, indicating that both Reds and Blues rated Dr. Vlass as offering similar levels of trust, acceptance, and confidence within the therapeutic relationship.

Table 2. Mean Scores on WAI-T, WAI-B, WAI-G, and WAI-Total

	<i>WAI-T</i>	<i>WAI-B</i>	<i>WAI-G</i>	<i>WAI-Total</i>
Blues	81.4 ( <i>SD</i> = 3.29)	78.6 ( <i>SD</i> = 2.59)	82.2 ( <i>SD</i> = 2.49)	242 ( <i>SD</i> = 7.11)
Reds	63 ( <i>SD</i> = 10.49)	71.4 ( <i>SD</i> = 10.21)	76.6 ( <i>SD</i> = 11.44)	202 ( <i>SD</i> = 3 0.91)
<i>t</i> -value	3.74 ( <i>df</i> = 8)*	1.43 ( <i>df</i> = 8)	2.78 ( <i>df</i> = 8)*	2.82 ( <i>df</i> = 8)*

Note: \* $p < .05$ ,

### Client Change Interview Protocol Analysis

**Self descriptions - Blue.** Patients were asked to describe themselves at the time of follow-up. Before commenting on the themes related to their therapy, a brief overview of patients' self-descriptions is provided to give context to their respective experiences in therapy. Blue cases were notably more positive in describing their self-images as compared to Red Cases. For example, Brenda described herself as "optimistic, intelligent, funny, anxious, loving," although she added that she needs to "look after myself better." She wants to "Not to worry so much." Bailey described herself as feeling "fabulous," and believes she is "capable." Yet she did note several areas she would like to improve, as she observed that she was "initially over-worried about being a competent mother" and would "like to be less stressed...be a little more relaxed about big changes in life, and [not be] as fearful and not coping because of bi-polar mother." Barbara said of herself that she has always been "a very strong person." She described herself endearingly as "loud, caring, obnoxious, and very social. My weakness is my strength. I'm very opinionated, and open about what I think. Don't know when to hold back, holding my ground...in a work environment I tend to be a bit standoffish. I tell them what I think." Later she noted "I'm very much an open book. I don't like to bullshit people. You just know when someone's genuine,

and then you can't. I just move on, people come and go.” She commented on some areas for self-improvement, such as “I just I think I am little too giving at most times. I need to learn to hold back with my time and emotions. I tend to put people in front of myself.” Beatrice was also gentle with herself in describing her personality, stating that she is “stronger emotionally,” and generally “friendly, reliable, consistent hard working, affectionate, thorough, loving, kind, generous, well mannered, and private,” later adding “perfectionist.” She said she would like to change her “poor attitude towards exercise,” and “be a little less private, and suffer less from anxiety.”

**Self descriptions - Red.** In general, Red cases appeared to describe themselves with more negative adjectives, and noted substantial areas for improvement. Ruby described herself as “mentally unstable and very tired,” later stating “I used to be happy go lucky, outgoing person – does not feel like that now.” She noted that she would like to “return to mental stability,” and become “slimmer, happier.” Rachelle described herself as “traumatized, anxious, stressed, depressed, lacking confidence, quirky, unconventional.” She also stated that she would like to change her “mental health.” Rebecca however displayed greater ego strength and stronger self-esteem, with a personal description of herself as “reliable, loyal, committed, busy, organized, caring, supportive, approachable, and independent.” However, she did note many changes she would like to make to herself: “Am I just allowed one thing? I would make myself smarter, thinner, more light-hearted. But seriously – just one thing would be smarter – to just know more stuff without the effort of having to learn and remember! My whole job, or all my jobs actually, would be less challenging if I were naturally more intellectual.” Robert was also fairly self-deprecating, stating “I think generally my opinion of myself is lower than what others think of me. That describes the problem...I'm more nervous. It's like low self-esteem.” However, he

noted that others see him differently than he sees himself “People would describe me as fearless, confident, outgoing. I think I'm a good actor. I've learned it's a life-long thing I've done.”

### **Interpretative Phenomenological Analysis of Client Change Interview Protocol**

The first theme that emerged from the open-coding of the interview transcripts encompassed comments related to the patients' general experience in therapy. Two sub-clusters emerged: Cluster 1 entails The Therapeutic Encounter, describing patients' interaction with the therapist (Unique Therapist Qualities, Potent and Specific Ingredients of therapy, and What Didn't Work, or unhelpful aspects), somewhat reminiscent of findings by Clarke and colleagues (2004). Cluster 2 entails Attitudes Towards Therapy, with sub-categories of Resistance to Therapy, Taking Personal Responsibility for Change Process, and Painful But Worth It. The second major theme that arose from client interviews was related to changes made in therapy. Similar to Elliot and Klein (2007), the authors found two broad Clusters: Personal Changes (with sub categories of Putting Things in Perspective, and I am just doing better (changes in affect and mood), and Acceptance of Self and Situation), and Changes to Life (with sub categories of Interpersonal Effectiveness and Life Skills). The results are summarized below in Table 3. One of the Red cases, namely Reilly, refused to fill out self-descriptions or complete the change interview protocol, thus the qualitative results do not reflect her opinions about therapy. The results are presented in Table 3.

**Unique therapist qualities – Blue.** Every Blue case commented on factors related to the therapist's personality and approach in therapy that they found helpful in making changes. Brent highlighted the importance and ease of connecting with Dr. Vlass in order to be able to discuss things that needed to be worked on: “I struck an easy rapport with my therapist which quickly established the trust necessary to identify issues.” Barbara commented on personal characteristics



of Dr. Vlass, particularly her manner of being in therapy: “She's lovely. She's very welcoming, even her voice, is very soothing. She's very open and welcoming...like I said before, she's a really beautiful person. I can't put my finger on it.” Other clients spoke to Dr. Vlass' ability to help them accept the reality of painful emotions. Barbara commented “with Eri, she sort of reassured it was okay to be upset. It was okay to feel the way I was feeling. Why am I getting anxious, or annoyed, or crying. It was okay to have emotions, and be sad.” Brent emphasized Dr. Vlass' affinity for validation: “I think that I always suspected that the happiness of others depended more on my psychological well-being; what I needed was someone to confirm this for me.”

**Unique therapist qualities – Red.** Red cases were equally appreciative of their therapist's way of being with them. Similar to Blues, Robert commented on Eri's spiritual nature: “I live a spiritual life, that's really important. I got a lot of that from Eri, I think she's a spiritual brain, she has this aura about her.” He also spoke to the importance of feeling comfortable in order to talk about things that were difficult: “I felt comfortable, so I took the risk...I had a lot to get out once I felt safe and comfortable.” He noted Eri's ability to empathize based on her past experiences “Maybe in her life, she [Dr. Vlass] has had a lot of pain and struggle. We connect because of the pain. That's my belief, we connected to the pain...the suffering, compassion and empathy gets through the head, gets to the heart. I can know it from a hundred miles away.” Ruby said that she “felt understood in therapy.” Others spoke to the importance of feeling connected. Robert noted “Connecting with a human on a deep level is what it's all about, that's where you get healing,” and later noted “I think Eri was the type of person that I needed in my life at that time. It wasn't until I sat on her couch, and sat across from her, and started talking...it just felt right for me. I had someone on my side. I didn't feel alone.” Rachelle also emphasized Eri's ability to be compassionate and validating, noting that she enjoyed “having someone to

understand and not to discriminate and judge.” Rebecca also mentioned Eri's ability to understand and advocate for her, as she said “it also made me feel supported, like there was someone on my side no matter what.”

**Potent and specific ingredients – Blue.** Blues appeared to make stronger comments related to specific, potent ingredients of therapy as compared to their red counterparts. Several patients highlighted change mechanisms related to cognitive restructuring. Barbara noted “She got me to write things down. I can't remember the specifics: what was important to me, what I enjoyed, and what was doing well in my life, what was bad.” Although patients did not use technical terms or phrases, it was apparent that several of them understood the basic concepts of cognitive therapy and compassionate mind training. In particular, several Blue cases indicated the importance of stepping back from the situation and evaluating the cause of their distress. Barbara noted “She taught me to stop, and think about things. And evaluate what is going on.” Beatrice mentioned that Dr. Vlass was helpful with “understanding why I felt the way I did and the reasons why I got to that point and state of mind.” It appears that linking thoughts with emotions helped patients comprehend why they felt the way they did, and this brought with it relief as they now understood their painful emotions better. Brenda summed her experience in this domain simply with the word “Reflection,” with Bailey noting that therapy was helpful by “taking a good look at what I experienced.” Barbara was helped by the connection between past experiences and her present reactions, a mechanism of change in line with CBT's assumptions regarding the power of core beliefs: “It was more working on things from my childhood. I didn't consciously recognize that they were bothering me, but she sort of picked up on those things. We went back

*Table 3. Open-Coding of Client Change Interview Protocol*

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Theme I: Therapy Experience

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Cluster 1: The Therapeutic Encounter

- Category A: Unique Therapist Qualities
- Category B: Potent and Specific Ingredients
- Category C: What Didn't Work

Cluster 2: Attitude Towards Therapy

- Category A: Resistance to Therapy
- Category B: Personal Responsibility in Change Process
- Category C: Painful but Worth It

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Theme II: Changes

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Cluster 1: Personal Changes

- Category A: Putting Things in Perspective
- Category B: I am just doing better (mood and affective changes)
- Category C: Acceptance of Self and Situation

Cluster 2: Changes to Life

- Category A: Interpersonal Effectiveness
- Category B: Life Skills

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through stuff that happened in my childhood. I didn't realize it. A lot of things I had to deal with emotionally (I get bad anxiety), came from my childhood.” Others noted techniques that appear to be specific to Eri's particular brand of therapy, which includes making a meditation CD that

reminds her patients of the work they do in therapy as an act of consolidation and practice: “She gave me a recording, I still actually have it, sort of like a meditation for me to listen to in the afternoon or before I went to sleep. A reassurance of, I don't know, sort of like a meditation. That really helped” (Barbara). Bailey noted the importance of the recording: “I used the CD both times I came to therapy, felt a whole lot better.” Barbara also commented specifically on the utility of mindfulness-based interventions, mentioning that she was helped by the “...breathing techniques, and the meditation.” Brent noted he was now “able to plan ahead.” Barbara noted an increase in health behaviors, such as “She helped me get my sleeping patterns back in order. I'm in bed at 10 or 11,” later adding “I do yoga quite regularly. I keep quite fit...I eat well, the clean living sort of thing happening.”

**Potent and specific ingredients – Reds.** Reds also mentioned specific cognitive strategies that they found helpful in therapy. Robert mentioned that “pen and paper are important for me as well. On days, I can see the distortions, and go 'geez, come on mate...’” Later he commented “One of the things Eri did for me was that she challenged my thinking about what I thought about myself...she tapped into something and told me: 'this is who you are, you need to look at this.' It didn't happen straight away. I can look back now, it was good for me to be told that my thinking was distorted.” Two mentioned being able to care for themselves better and make their life a priority: Ruby noted that Dr. Vlass was good at “helping with decision making.” She also began to understand where her stress came from as she “realized that [she was] unable to say 'no' to others” and was “never thinking about self.” Rebecca also commented on the helpfulness of Dr. Vlass' problem-solving, as she wrote “I think I was struggling with Uni and my decision to do a PhD – something which with time I managed to get my head around anyway. I think therapy helped the process along.” Rebecca also saw therapy as symbolic of taking care of

her needs, noting “It always felt great to be in therapy because I felt that I was doing something to help myself.” Interestingly enough, the only Red that mentioned the OQ-45 actually had a positive experience with it. Robert noted “I tell you one thing that stands out was that she made me do a questionnaire on a computer each time I got there. And it would show me in a color of where I was. What it did was, it showed me I was improving. This was one of the places I got hope from. Eri would say “that's really good.” Reds also mentioned skills that they acquired through therapy that did not have to do with specific therapeutic techniques. Robert noted “I follow the disciplines of yoga, and a spiritual faith, some prayer... I live a spiritual life, that's really important,” later adding “I find that when I relax and meditate and breathe properly, things slow down, the answers come.” Ruby noted that therapy “...help[ed] with decision making.”

**What didn't work (negative factors) – Blue.** Blue cases were, in general, were very sparse in commenting on negative aspects of therapy. However, Beatrice did voice disappointment from certain techniques: “hypnotism was disappointing for me,” while Barbara commented on the OQ-45: “The computer score meant nothing to me, you don't remember the things you didn't talk about.” Barbara's other negative comments could actually be seen as a strength of therapy, stating that there was “Not enough time.” The other patients did not make any negative comments.

**What didn't work (negative factors) – Red.** Red cases were much more likely to make negative comments about their experience in therapy. Some of the complaints centered on Dr. Vlass' techniques. For example, two mentioned specific aspects of therapy that they found unhelpful or even repugnant. Rebecca wrote “Disappointing would probably be when my behavior was justified, eg 'no wonder you have been taking drugs when you have all this going on' when really I felt there was no excuse and I was probably looking for the slap on the wrist

that I wasn't getting at home.” Rebecca mentioned “I really hated the meditation and relaxation techniques. I'm sure it's very helpful to many people but it honestly drives me crazy! If I am going to lie down and be that still – I would just rather go to sleep!” Although several patients had noted this quality as a positive experience in therapy that lead to greater self-compassion and awareness, Red cases did not seem to glean the same benefit from such interventions. Rachelle noted the ineffectiveness of trying “to 'stay with the feeling,' which I find a little hard to understand and implement.” Several Reds also commented on their lack of hope in the future, such as Rachelle mentioning that she had made “seemingly little or no progress. Sometimes it seems pointless.” Rachelle commented in a similar vein, noting “I am progressively less and less hopeful.” Reds were also more likely to note regression in their symptoms, such as Rachelle: “If any changes, they were very briefly lived,” later noting that she was “better than 2 years ago, but starting to deteriorate again.” Ruby also commented that she was “Feeling more depressed.” Rebecca added: “Since then I have probably reverted back to old ways a little.” Rachelle noted that therapy was “only rarely helpful.” Rachelle replied, when asked whether she was doing, feeling, or thinking differently than she had before, with “hardly.”

**Resistance to therapy – Blue.** Several patients noted having initial resistance to disclosing information. Brent noted his difficulty in being fully open initially: “At first I avoided some issues but gradually developed the confidence and trust to expose and examine these issues in a healthy way.” Barbara mentioned being unsure at first, but eventually understood the general purpose behind therapy: “I was very skeptical, like 'this isn't going to help. ' All in all it was quite positive, nothing bad about it.”

**Resistance to therapy – Red.** One Red case(Robert) commented on several occasions regarding the apprehension he felt in being completely transparent in therapy. Robert noted “I

didn't tell her everything..." Robert also highlighted the impotence he felt when trying to make changes initially, saying "I tried to change, move everything outside yourself. All you get is frustration, anger and guilt. Lots of negativity." However, he was able to transcend his initial apprehension at the therapeutic experience, stating that therapy "seems sort of a bit, weird stuff, but it works."

**Painful but worth it – Blue.** Although all blue cases made substantial improvements through the course of therapy, several commented on the inherent difficulty of making changes in their life. Barbara noted that she had to work through the initial pain of therapy in order to see her self-worth: "It was a hard time, it was a learning curve for me, mentally and emotionally, to realize that I am a strong person." Others spoke specifically to painful aspects of therapy, but recognized that the pain was a necessary element in change. Bailey said: "Actually being in therapy is painful – if therapy is not painful, there is no point in going." Bailey also noted that it was "painful when talking about my mother and my PTSD, kind of a journey." Interestingly, Blue cases also shared that therapy can be a painful process, while also highlighting that they had appropriate attitudes towards therapy. Bailey commented that "Everybody wanted like a quick fix – therapy is not a quick fix - not a realistic expectation." Although one might assume that individuals who experience sudden gains in therapy would find the process immediately enjoyable, it was surprising to find a running theme throughout the interviews that therapy is painful, but worth the effort. Brenda had realistic attitude towards change, noting "One day at a time, [I am] hopeful things will improve."

**Painful but worth it – Red.** Although Red cases also mentioned aspects of therapy that were painful but worth it, they generally appeared to be less certain about the necessity of struggle during their change processes. Robert noted that he had come to a place where the pain

finally pushed him over the edge to receive treatment, stating: “I was dying. I cry out to something outside of myself, 'fuck I can't do this anymore.' From that point on, things change.” He also noted the benefits of finally disclosing painful emotions: “There was a lot of stuff that was painful...it was just painful for me to talk about it to someone anywhere, stuff that I haven't spoken to anyone about - guilt and shame, and things I'd done. Stuff you'd take to the grave, those secrets make you sick. Getting them out is really good. I didn't tell her everything, but for the first time I was really honest. I learned how to be honest.” Another commented on painful events, Rebecca, stating that she could not remember, recalling “I'm sure there were things that were painful or difficult, but I honestly cannot really remember – it was years ago!”

**Taking personal responsibility for change processes – Blue.** Blue patients were surprisingly realistic in their realization that they had to take responsibility for any changes they would make in life. Bailey noted: “You can tell someone how to do things, but if you do not take them on board and practice, you're never going to change.” Some commented on their pre-therapy realization that they were in charge of their lives. Brent stated “I made a firm decision at the outset that I wanted to resolve my problems – without this commitment I really believe that CBT is a waste of time for all parties.” Brent also noted “For most people there is a stigma attached to seeking help, however I reached a point whereby self-treatment was no longer an option or effective.” Blues tended to be more aggressive in searching out help for their problems, with Bailey noting she was “Always proactive about getting help.” Two commented on the non-mystical aspect of therapy, reaffirming their beliefs that therapy involves a high level of personal responsibility: “It would be easy to take a pill everybody would like that, everything would be better,” said Bailey, while Brent stated: “I believe no matter how good the therapist is, magic does not happen.” Brenda noted she is “trying to stay positive.”



**Taking personal responsibility for change process – Red.** Red Cases also mentioned the need to take responsibility in therapy, although their comments were generally less realistic, and tended towards ambiguity or ambivalence. Again, Robert was the most positive, and made comments related to the need for responsibility, stating “The only thing I can change is me, my behavior, my attitude.” He also noted “A positive way is to change myself, not the world. I don't do it perfectly.” The rest of the Red cases made less enthusiastic statements regarding the need for responsibility, with Rebecca noting without much assurance: “Perhaps the situations changed or I learned to cope with them better.” She also questioned “I guess the reasons I was in therapy in the first place were due to my coping with situations in my life?”

**Putting things in perspective – Blue.** Blue patients tended to place substantial emphasis on the helpfulness of gaining a new perspective through therapy. Brent noted “I am far more detached from previous issues and this distance has enabled me to put a range of issues in perspective.” Later he noted “Basically my new philosophy is that I can make no one happy unless I am happy.” Two spoke to the necessity of recognizing the need to take time for themselves. Brent wrote: “My priorities have changed and I now place greater importance on myself without feeling guilty,” and Bailey stated she learned to “not to place too many pressures on self.” Others spoke to the importance of thinking in a more rational manner. Beatrice noted that she was “less confused,” while Barbara noted that therapy was helpful by “Putting things in perspective.” Bailey made changes in her ability at “Being rational...scientific and rational.” Others spoke to the calming effect of understanding why they were having certain reactions, and this new learning changed their outlook on life. Brent noted that he “developed a clarity of purpose,” while Bailey had a “more positive outlook.” Barbara attributed changes, saying she “put that down to a right frame of mind, a better frame of mind. It was a domino effect,” later

stating “I learned to understand myself and thoughts better, and to be accepting of this.” Beatrice mentioned that one of the most helpful aspects of therapy was “understanding why I felt the way I did and the reasons why I got to that point and state of mind...I'm more aware of the physical reactions of my body to the stress as it's happening.”

**Putting things in perspective – Red.** For Red cases, the adoption of a new perspective was also one of the most frequently mentioned changes that resulted from therapy. Several patients articulated an increased understanding of and awareness for problematic behaviors: Rebecca noted “I have a problem saying no to many things, to over-committing, and I think this is because I know how easily I get depressed/lonely.” Rebecca later mentioned “I think I became better at recognizing the emotions that were behind certain behaviors, and hence became better at dealing with emotions and improving behaviors: eg recognizing that if I was using (rarely) recreational drugs it was because I needed an outlet.” Ruby noted that she gained “the realization that putting my needs on hold, going into enormous debt for the sake of others” was problematic. Others mentioned the importance of understanding the true cause of their symptoms: “I look at the situation, and realize I've been wounded. I look at it from the other side,” said Robert. Rebecca stated: “I learned that I am in control of what I do – it's my responsibility to examine my thoughts, feelings, behaviors and to address them if I need to make changes.” Rebecca also asserted that “therapy helped make me aware to the connections between my emotions and behaviors.” Robert focused on the instillation a more optimistic future, noting “I was able to get hope. It was very important to have hope in my life. They'll tell you it's all gone to shit. The reality is, only your thinking and feelings have changed. Your situation hasn't changed that much.” He later noted that his ability to see his improvement has helped him gain a new perspective “I still suffer from some depression, but I also see where I've come from. It's a

miracle where I've come from." Rebecca drew connections between her behavior and her emotional state, noting "I was having trouble getting out of bed it was not because I was tired but rather because I was avoiding things."

**I am just doing better (mood and affective changes) – Blue.** Blue patients made several references to general relief of symptoms. Several patients addressed non-specific affective changes, such as Brent being "calmer," and "less overwhelmed." Beatrice described herself by saying "I was calmer," and "clearer thinking once therapy started." Others spoke to an increase in resiliency and coping abilities: Brenda said it was "A little easier to handle extremely anxious times." Beatrice described herself as being "stronger emotionally," while Bailey noted that therapy "helped PTSD, get over it more quickly." Some directly addressed the issue of feeling happier, with comments such as Brent's: "found myself happy for the first time in many years," and Bailey's: "[feeling] fabulous." Barbara summarized her experience by stating "I think I'm a happier being."

**I am just doing better (mood and affective changes) – Red.** Reds also commented in changes in their mood and affect. Two mentioned a newfound ability to relax, with Robert noting how others "saw a calmer, slower, somewhat more relaxed me. Not relaxed, it's like I'd slowed down a bit" and later mentioned "I felt calmer, I felt safe." Rebecca noted an increase in her psychological robustness: "I am better equipped at dealing with the stress/anxiety that comes with being very busy than I am at dealing with depression/anxiety." However, Rebecca was also ambivalent about her affective changes, commenting "I guess I started to feel better? I don't really remember, this is a few years ago now." Robert noted a paradoxical effect of admitting to things he was embarrassed about "some of the feelings I felt I can give you anxiety, shame, and guilt. But also relief at the same time." Ruby stated that she was "feeling more depressed."

**Acceptance of self and situation – Blue.** Another notable category that emerged was that of accepting oneself and one's experiences. Barbara commented: “It was okay to feel the way I was feeling,” and later hinted at the relief she experienced by realizing “I'm not a crazy person.” Others noted changes in their ability to confront and accept life's challenges: one patient said she developed the perspective that “...you are a stronger person, and if you do get faced with a challenge, everything will be okay again,” and later mentioned that she will “...take every day as it comes.” Others noted the importance of an increased ability to accept their own need to be happy, with Brent noting that he makes an effort to “Consider my needs...” and later “My happiness is paramount and that I don't need to feel guilty or selfish about this.”

**Acceptance of self and situation – Red.** Only two of the Red cases mentioned changes in therapy that centered on both acceptance of their problems, and acceptance of themselves. Some profited from self-statements regarding their ability to deal with difficult circumstances, such as Robert's maxim: “No matter what's happening, I'm okay,” and later mentioning “Whatever the way life is today, I accept it...I just let it go.” Ruby realized that it was okay to take care of herself noting that she was “never thinking about [her]self.” Robert also noted that accepting the inevitability of pain can help one see their problems from a new perspective: “Everything serves a purpose...It opened up those parts that are blocked off mate. That's what it's all about.”

**Interpersonal effectiveness – Blue.** Blues commented on the changes he was able to make through therapy that effected the manner in which he related to others. Brent spoke to an increased awareness of the needs of others, specifically stating that therapy helped him “take the time to listen” and “...[consider needs] of others.” He also spoke to a newfound fulfillment in their relationships, namely “I am able to discuss things more easily with others”, later noting “I

also live in the moment more and enjoy the people I'm with and what I am doing...This has enabled me to extract a lot more joy from life and the people close to me.”

**Interpersonal effectiveness – Red.** Red cases also asserted that therapy had changed the way they related to others. Robert mentioned how therapy helped him to “not think about myself as much, to think about others...to put others first.” Others seemed to emphasize boundaries, with Ruby stating she “realized that [she] was unable to say no to others.” Rebecca mentioned her understanding that she was needed by her loved ones, stating “I got the idea that people around me (both family and friends) rely on me a lot.” Rebecca also suggested that therapy helped to quell fears about relationships, saying “I have much more of an open heart now to relationships, whereas before I was petrified of getting hurt, of loss.”

**Life Skills – Blue.** Several comments were made in reference to general life changes that they experienced through therapy. Although they had previously commented on specific affective and cognitive changes, it appears that therapy was also helpful in making basic lifestyle changes. Brent stated that he “developed a plan for the future which involved leaving a very stressful job and undertaking full-time study.” He later commented similarly on the domino effect of therapy in making life changes: “The reduction in stress has allowed me to stock take on my life and set priorities.” Barbara recognized similar life changes, namely to her career path: “I’m working on a bachelors of entertainment management,” while later noting a newfound comfort with her current situation: “Now I’m really good, settled, in work and home.” Some commented on the relationship between therapy and outside events changing in their life, such as Beatrice mentioning “Outside events improved because of confidence gained through therapy,” while later noting “Outside events also improved on their own over time.” Barbara mentioned she “also graduated, and got an amazing job which I am loving.”

**Life Skills – Red.** Red cases were more likely to make ambivalent or negative comments regarding their general changes to quality of life. For example, Rebecca expressed her doubt that she even made any changes, “It's hard to say as I don't really remember what I was feeling/thinking before.” Rebecca also noted “Perhaps the situations changed or I learned to cope with them better,” which seems to emphasize the lack of self-efficacy experienced by her. Ruby was similarly ambivalent, saying that she has made “positive and negative changes.” Again, Robert was very positive about certain life changes, with statements such as “I don't even have the obsessions about drinking anymore!” while stating that he was working on “Gratitude, humility, being open-minded.” Rebecca mentioned some regression, in her improvements, stating “Therapy really helped me to recognize this and work towards maintaining balance – although since then I have probably reverted back to old ways a little.” Rachelle noted that she had since received a new job. Robert also mentioned life changes such as “I'm trying to be that person that I wanted to be,” clarifying “I've been able to remove a lot of it to be more giving, not be as selfish. Not think about myself as much, to think about others. To put others first....To make amends, to forgive you. Make amends for my behavior in the past. That's a pretty humbling experience.”

### **Discussion**

In this study a small sample of patients (10) were selected from the larger case load of an independent practitioner in order to better understand the phenomenon of dramatic positive treatment response. Therefore the “extreme” patient groups were not selected on the basis of their end of therapy outcomes (good outcome cases versus poor outcome cases), but rather based on manifesting either dramatic positive or dramatic negative response to therapy during the course of treatment (compared to the expected response based on normative data from patients who had

similar levels of initial disturbance (Finch, et al 2001). These patients who were referred to as either “Blue” cases (dramatic early positive responders) or “Red” cases (early dramatic negative responders, predicted deteriorators) were contacted 2 years following their therapy experience and asked to complete a measure of their mental health functioning (OQ-45), a post therapy satisfaction survey (CRSS-4), a therapeutic alliance measure (WAI-R), and a set of open-ended questions that were meant to explore hypotheses from the literature that could account for dramatic change (i.e. strength of therapeutic relationship, flight into health, or cognitive changes in line with CBT theory). It was hoped that the information obtained would further discussions and research on the unexpected finding that a large subset of patients benefit from treatment well before it has been completed.

Since patients in this study were given the OQ-45 prior to treatment and throughout the course of therapy, it was possible to make a quantitative evaluation of their change from pre-therapy levels, to post-therapy functioning, as well as at follow-up. In addition the session at which the dramatic change occurred could be tracked. On average, Blue cases started treatment about three standard deviation units above the mean of normal functioning, showed dramatic positive change following their first session of treatment, and ended therapy below the mean of normal functioning. These clients, as a group, and as individuals, showed an impressive degree of change which was maintained at follow-up. This finding is also in harmony with previous work examining the long-term outcomes of rapid-responders, in that they tend to maintain their gains (Hass, Hill, Lambert, & Morrell, 2001).

The 5 Red cases showed a different pattern of change on the OQ-45 than Blue cases. At intake they were less disturbed than the Blue cases although they still manifest a degree of disturbance characteristic of outpatients and about two standard deviations above the normative

sample mean. As a group they improved by the end of treatment, albeit to a much smaller degree than blue cases, and remained in the clinical range as a group. Only 1 in 5 individuals met criteria for recovery with the remaining 4 categorized as manifesting no reliable change. At follow-up two years post therapy two patients showed reliable improvement, one showed reliable worsening and two did not change. The study of dramatic gains was confounded to an unknown degree in this study because at the follow-up point the Blue cases' mental health functioning was much better than that of Red cases.

The median number of sessions to produce sudden gains in this study was two. This finding appears to be exceptional when compared to other studies throughout the literature. Across other studies, the median session at which sudden gains occurred was much later. The time at which they first signaled red was later in treatment than for those signaling blue, although the therapy as a whole was quite short for both groups. This dramatic and early response was quite short compared to other studies, which typically found that an average of five sessions were required to produce such gains (Hardy, et al., 2005; Stiles, et al., 2003; Tang & DeRubeis, 1999b; Tang, et al., 2005). In two other studies, the median occurrence was session eight (Tang, et al., 2005; Vittengl, et al., 2005). Even in RCT trials of 12-20 sessions, sudden gains typically occur early in treatment. Ironically, patients tend to make their most substantial gains before the bulk of the therapeutic work has been undertaken. In this small sample, changes appeared to happen within a very quick period of time, certainly before the majority of specific cognitive or behavioral interventions were implemented.

### **Themes of Changes**

Although Red and Blue patients demonstrated dramatically different treatment trajectories, there was a surprising degree of common experiences shared amongst Red and Blue



cases. Patients from both groups made comments about changes outside of themselves as well as changes within themselves. These results are similar to Klein and Elliot's (2007) review of client changes, who also found that patients tend to make change comments regarding their own self-improvement which is separate from change experiences brought about in their interpersonal relationships and general life functioning. While the two general categories (Life Skills and Interpersonal Effectiveness) were similar to Klein and Elliot's study, some differences did arise in the personal change category. While Klein and Elliot noted personal changes in the domains of experiential processing, self-improvement, and affective changes, the personal changes in our sample highlighted mood and affective changes, improvements in perspective/understanding, as well as increases in self and life situation acceptance.

Interpretative Phenomenological Analysis was used to explore themes regarding the therapeutic encounter. Patients made comments regarding the importance of the therapeutic relationship, specific potent ingredients of therapy, and they spoke to aspects of therapy that were disappointing or unhelpful. Many patients in our sample highlighted the importance of taking personal responsibility, emphasized acceptance of self and situation, and recognized that the change process is often necessarily painful but worth it. Participants also commented on how the adoption of a new perspective that shifted their world views and ameliorated their pain. Boscaglia and Clarke (2007) referred to this factor as an increase in a “pervasive and enduring sense of meaningfulness, manageability, and comprehensibility” (p. 192). Specific differences between sudden-gainers and off-track patients will be discussed in greater detail in the following sections.

Regardless of whether patients flagged as off-track or had significant and sudden positive responses to therapy, all patients reported significant changes to themselves and to their lives

(Elliot & Klein, 2007). When examining the themes related to changes made in therapy, our findings echo those of Clarke and colleagues (2005), who found that clients valued ingredients of therapy that were in harmony with the theory guiding Dr. Vlass' treatment (theoretical orientation), as well as factors that are considered ubiquitous across all modes of therapy. In their qualitative review, Clarke and colleagues noted three categories of change, including increased confidence, increases in personal responsibility, and obtaining positive feedback from others. The subjects in our sample, speaking from their own expertise as subjective individuals, did not separate the helpful aspects into categories according to therapeutic modalities. It was only after aggregating the meaning units that the investigators noticed that both specific (i.e. CBT or CMT) ingredients were viewed as being just as helpful as common factors (validation, acceptance, etc.), while also valuing specific characteristics of their therapist. Clarke and colleagues noted that while some authors believe patients only benefit from common factors (see Paulson et al, 1999; Imel & Wampold, 2008), patients also found elements of specific models of therapy, such as challenging distorted thinking, accepting oneself regardless of performance, and mindfulness approaches were equally valued (see J. S. Beck, 1995; Gilbert, 2000; Gilbert & Irons, 2005; Hanh, 1996).

Our results also suggest that there are no one-size-fits-all interventions in psychotherapy, in that some patients find certain therapeutic techniques more helpful than others. Frank (1974) believed that patient attributes actually interact dynamically with therapeutic interventions. Thus, no one intervention is suited for all clients. He summarized his view by noting that the closer interventions align and harmonize with the “predilections” of the patient, the more successful the outcome is likely to be. This conclusion was somewhat supported by the findings of our study, given that patients who improved quickly were more likely to comment on the helpfulness of

certain aspects of the therapy/therapist, while others found the same methods to be unhelpful.

This finding also poses a challenge regarding the discipline's emphasis on empirically-supported treatments, given that large minorities of patients are still outperforming peers treated by interventions considered inferior to CBT.

Clarke, Rees, and Hardy (2005) reviewed previous studies that examined helpful aspects of therapy. They first looked to a ground breaking study by Elliott and James (1989), who through qualitative interviewing compiled the following themes as the most helpful factors: facilitative therapist characteristics, client self-understanding/insight, client self-expression, a supportive relationship, and that the therapist would help clients engage in new learning experiences outside of the therapy room. They also reviewed Paulson, Truscott, and Stuart's (1999) review of helpful factors, which identified helpful factors including emotional relief, gaining new knowledge, accessibility of therapist, and problem solving. Our findings were somewhat reminiscent of Clark and colleagues own review of therapeutic experiences, who included characteristics of the therapist (safety, resistance/fear, and excited/absorbed), as well as specific ingredients of therapy (cognitive change, practice, the CBT model, and understanding core beliefs). In our sample however, patients highlighted helpful therapist factors that were unique to her own personality and style, as well as specific potent ingredients of therapy, unhelpful aspects, and general attitudes towards therapy of taking responsibility for their healing and the necessity of pain in the change process. This finding somewhat echoes Clark and colleague's 2003 findings that taking personal responsibility is often a positive outcome that is derived from therapy, although in our sample it appeared to be an actual mechanism of change as well as a natural outcome.

Generally speaking and even though it is speculative to draw general conclusions from such a small number of clients, off-track clients tended to make more ambivalent statements regarding their improvement in therapy. Their comments reflected a stronger tendency to endorse negative aspects of therapy. In particular, areas that were helpful for other clients (empathy and affirmation and meditation, for example) seemed to react negatively with Red cases. Their off-track status could thus possibly be due to their inability to utilize specific skills taught within the therapeutic encounter. Dimidjian and Hollon (2010) noted that the same treatment can paradoxically have beneficial *and* harmful effects. They used a study by Whittington et al. (2004) to demonstrate that using some SSRI's for treating depressed adolescents can lead to both improvements in symptoms while also increasing the risk of suicide. Thus, they note that drawing certain conclusions about “helpful” or “unhelpful” aspects of therapy is a complex and at times self-contradictory process. Individual variation and response in terms of treatment outcomes may be washed out by large-scale studies. Future research should continue to seek out possibilities for examining patient's characteristics prior to therapy in order to find good fits with therapeutic interventions.

Hollon and Dimidjian also drew attention to a study by Strupp and Hadley (1977), who found that the perceived effectiveness of the same outcome can be seen from two different perspectives. Strupp and Hadley offered the example of a couple divorcing after marital therapy: one partner may perceive this as a positive outcome, while the other may see this outcome as devastating. This is applicable in our current study as well, as it is thus difficult to ascertain whether patients actually were harmed by certain interventions that they expressed dislike for. One may also posit that the interventions were even helpful *despite* the patients' distaste. Hollon and Dimidjian ultimately suggest that systems should be put in place for monitoring treatment

failure throughout psychotherapy, including symptomatic checklist inventories like those employed in this study. The current investigators agree with their conclusion that future research should continue to examine potential active ingredients in therapy, mechanisms of change, and moderating variables.

Another trend was for Blue cases to emphasize the importance of “difficult but worth it,” highlighting the necessity of aggressive engagement with the therapy and realistic expectations of inevitable pain in order to produce results. Blues had a tendency to realize that changes in therapy would only occur if they invested themselves in the treatment, and more strongly commented on their realization that therapy was not magic and that changes would only occur if they exercised their will in the process. Reds, on the other hand, were less likely to comment on the necessity of struggle in therapy, and more likely to speak to their lack of hope in the future. These findings, in combination with the Reds' self-descriptions, leads to the observation that Red cases may be naturally more vulnerable to stress, and that Blue cases are generally more resilient. This hypothesis would have to be tested in the future by measuring participants with characterological and personality measures before and after therapy.

It was also interesting to note how expectations and attitudes towards therapy possibly potentiated better outcomes. Individuals who were flagged as off-track tended to have more negative statements about therapy, and displayed a lesser degree of hope in the therapeutic process in general. Frank (1973) believed that “mobilization of hope” and the engendering of positive expectations in therapy are a foundational part of the therapeutic success. Joyce, Ogrodniczuk, Piper, and McCallum (2003) were able to find a strong relationship between patient expectations of therapy and their final therapeutic outcome. Other studies have also demonstrated strong correlations between outcome and patient expectations. When a patient

gives up hope in a better future, they may be more likely to continue to be distressed and symptomatic (Clarke & Kissane, 2002). These authors also noted that “For patients adjusting to a life...[problem], a re-appraisal of life’s goals in a way that gives coherence with global meanings, hopes and beliefs, and empowerment through attainment of these objectives will increase morale” (p. 739). Thus deterioration in therapy may be due, in some degree, to the expectations patients hold regarding the responsibility they have in making therapy work for them, and the belief that therapy will help them improve. Future studies could measure incremental improvements in patients whose therapists place a greater emphasis on “selling” the viability and helpfulness of psychotherapy.

Both Blues and Reds commented on a lack of complete transparency with their therapist. In harmony with Clarke and colleagues findings, there did not appear to be a strong trend favoring Reds or Blues when it came to the need for honesty or disclosure. Indeed, members from both groups endorsed difficulty with sharing their innermost thoughts and feelings, and tended to censor some of their innermost insecurities. This finding however is not surprising; patients are occasionally prone to mislead their therapists either through exaggerating their pain or competence, distorting their experience, deceiving the therapist, omitting important details, and even fictionalizing aspects of their life (Cotler, 2011; Hill et. al., 2012). This finding can serve as a potent reminder for therapists to check in with their patients frequently on their level of comfort with disclosure, and seek to maintain a strong therapeutic bond that encourages honesty and openness instead of secrecy and shame. Cotler, as well as Clarke and colleagues' studies are harmonious with our findings, in that complete disclosure does not appear to be a necessary ingredient of change as both groups made significant changes without being completely transparent.

Both Blues and Reds stressed the helpfulness of therapeutic factors related directly to the therapist's way of being. In particular, both mentioned Dr. Vlass' ability to validate, an ability to relate to their pain, kindness, her personal nature, her acceptance of them as people, and a degree of spirituality. Previous research has found that both validating a patient's response and reflecting the patients' own words can lead to a greater bond in therapy. Indeed, Kim and Eunha (2013) found that validating patient's concerns, in that the therapist can articulate accurate empathy for what a patient is feeling and be able to express this to the client, in particular, has been connected with increases in self-esteem. Validation was also found to be more effective than reflection in improving mood and lowering aggression. The way our therapist under study handled pain is also significantly valuable in understanding what clients perceive to be helpful. Some of the subjects in our sample noted that there was evidence in the therapist's life that she had experienced pain, which also tended to communicate to patients that facing and learning to handle pain may be an important aspect of therapeutic change. Also, the importance of the therapist's "spirituality" appeared several times in the interview transcripts. Given that spirituality is afforded little space in the current psychological literature, future studies could examine the relationship between a therapist's ability to talk about spiritual issues and satisfactory patient outcomes.

Both groups noted the importance of gaining insight into the roots of their suffering, while also accepting themselves and the situation that caused the suffering. In Castonguay and colleague's (2010) review of helpful factors, they noted that both clients and therapists perceived the continued development of self-awareness as being specifically helpful. Clark and colleagues (2003) also recognized that *understanding* plays a key role in improvements. When patients experiment with new ways of thinking and are successful at self-soothing, there may be a

resurgence of dignity and self-worth (Connor & Walton, 2010). Such changes can be reciprocal, in that a sense of hope in the future becomes self-fulfilling and leads to a renewed vitality for life (Kirmayer, Simpson, and Cargo 2003).

Somewhat ironically, Reds made more comments about aspects of the therapist herself which they found helpful. This finding could be somewhat skewed due to one Red case's tendency to glorify the therapist. However, there was still a trend in favor of Reds in commenting on the power of the therapist's characteristics. Blues, on the other hand, tended to stress the importance of potent ingredients in therapy, paying slightly less attention to the power of the therapist. This may also link up to Blue's propensity for assuming more responsibility for their change in therapy, and taking advantage of certain potent ingredients of therapy. The Blue cases' tendency to engage with therapy better, utilize certain interventions, and eventually speak the “language” of therapy may highlight that Blue cases were a better fit of the broader “therapy culture.” As individuals come in to therapy with different backgrounds, values, and cultural identities, they may clash with the prevailing vogues and assumptions with current psychological theories and techniques. As individuals who experienced sudden gains appeared more likely to buy into certain therapeutic values, such as “acceptance” or “vulnerability,” it is possible that therapy is merely more effective with people who share similar values and goals with the therapist. Future studies could examine how the prevailing zeitgeist of psychotherapy interacts with certain demographics of patients who may hold different values than psychology in general about what it means to live the good life.

### **Satisfaction and Outcome**

We found that patients who made sudden gains in therapy were also more satisfied with their experience in therapy, while those that deteriorated or became off track were generally less



satisfied with their therapy. This finding echoes previous research, which has repeatedly demonstrated a significant positive relationship between satisfaction and good outcomes in psychotherapy (Ankuta, 1993; Nielsen et al, 2000; Hasler and colleagues, 2004; Beretta et al., 2005). Although there may be skepticism of this finding, in that client's high ratings of therapy satisfaction is merely indicative of social desirability, Gaston & Sabourin (1992) controlled for social desirability and concluded that satisfaction is still a legitimate outcome dimension of psychotherapy in itself and is not related to patients "faking good." The subjects in our sample generally rated therapy as being more satisfying and helpful when they made significant and substantial improvements in their symptoms. However, their ratings of satisfaction may also be due to a third variable, such as a participant's pervasive negative outlook on life or a tendency towards optimism. Another possibility is that patients who improve in therapy tend to be more grateful for their experiences, and rate the therapy as being more satisfactory. We concur with the previously cited authors that future studies could examine the direction of the relationship between satisfaction and outcome by measuring satisfaction concurrently with outcome throughout the treatment process.

Another surprising finding involved the level of distress of Blue cases on intake. They were substantially more distressed than their Red peers, yet improved quicker in therapy. Contrary to previous findings (Holcomb et al., 1998; Ward, Wood, & Awal, 2013), our results indicate that very high initial distress was actually a strong predictor of satisfaction and positive outcome in therapy with blue cases. These findings run contrary to other authors as well (Miklowitz, 2006), who found that more severe symptomology at the onset of therapy actually required longer treatment lengths. This supports the possible conclusion that the phenomenon of sudden or rapid gains in therapy is unique when compared to typical positive response in therapy.

One possible explanation is that patients who became off-track suffered more from characterological or personality disordered symptoms, whereas the patients who witnessed sudden gains were more likely to be in a crisis situation that could be resolved in a shorter period of time. Indeed, Red cases were much more derogatory in their self-descriptions. This possibility may account for the consistency of the longitudinal data that indicated Reds were generally more symptomatic over a two-year period, while those who experienced sudden gains were able to maintain their symptomatic improvements over time. Also, their impressive response to treatment may underscore the possibility that their improvements occurred in a time of acute crisis, whereas Reds' distress was due more to long-standing personality factors that remain consistent over time.

### **Working Alliance**

Our small study also highlighted the importance of the working alliance in therapeutic outcomes. Individuals who responded more favorably to therapy generally had higher ratings of the therapeutic alliance. Specifically, Blues scored higher on Goals and Tasks constructs, indicating that individuals who experienced sudden gains felt that the therapist was in agreement about treatment goals, and that they stayed on task throughout therapy. Wampold (2002) concluded that the relationship between the client and therapist is a consistent and reliable predictor of treatment outcomes. Meta-analyses have found that the overall relation of therapeutic alliance with outcome is of moderate strength, with a median effect size for alliance of  $r = .28$  (Martin, Garke, & David, 2000; Horvath, 2011). Our results underscore the importance of paying careful attention to task and goal agreement rather than bond as related to early and dramatic treatment response. These findings suggest blue cases are more likely to work

collaboratively with their therapist. Future research could explore whether therapists can be taught to strengthen task agreement in the service of more positive and dramatic outcomes.

Interestingly enough, Blues and Reds did not differ on the Bond scale, indicating that both off-track and sudden-gainers reported being equally connected with their therapist on an emotional level. This may highlight Dr. Vlass' particular ability to form bonds even with difficult, off-track patients. These findings also emphasize the possible importance of checking in with clients throughout therapy on whether the tasks and goals involved in therapy are in harmony with the patients' expectations. Measuring the therapeutic alliance throughout therapy may also be beneficial in helping the therapist know when the client is off-track, and could complement measures of well-being specifically tied to a poor therapeutic alliance, agreement on tasks, or inability for therapists to help their patients reach their goals (see Shimokawa, Lambert, & Smart, 2010, for an example of these procedures).

### **Therapist Variables**

The current study lends some qualitative support to the importance of studying successful therapists. Given Dr. Vlass' unusually high rate of dramatic treatment response across hundreds of clients, her style of therapy and the way she interacts with her patients takes on added significance and becomes an important variable to study. Crits-Christoph et al. (1991) highlighted the importance of studying therapist variables as well as therapeutic modalities, as the explanatory power of therapist characteristics may be greater than certain techniques when evaluating outcomes. Ahn and Wampold (2001) noted that the average therapist effects can account for 9-49% of variance in change scores. They also noted that the variance between therapists is often greater than the variance between different treatment modalities, a finding that warrants further exploration of therapist variables. Wampold and Serlin (2000) also argued for a

renewal of research that focuses on the qualities of successful therapists. Lambert and Ogles (2004) noted that ignoring the therapist factor can lead “some investigators [to have] have reported differences between treatments that were actually a function of the therapist differences.” Wampold (2001) also made a bold claim, stating that factors in therapy common to all modalities account for nine times more change in outcomes when compared to specific ingredients.

Orlinsky, Grave, and Parks' (1994) review of 2,000 process-outcome studies found that the following therapist factors were reliably related to positive changes: therapist credibility, skill, empathic understanding, and affirmation of the patient. They also found that aggressive engagement with the clients' concerns typically resulted in better outcomes. In particular, they noticed that therapists who direct the patient's attention to their own personal internal experiences are more likely to have successful outcomes. Bergin and Garfield (2004) clarified these findings by noting that technique is not irrelevant. However, these authors noted that a modality's power for change is always limited in comparison to the personal influences of the therapist. They found that better outcomes were associated with a strong therapeutic relationship, creative approaches to patient problems, as well as giving a credible rationale and ritual that matched their symptom presentation. The discipline's almost “fetishistic” agenda of comparing modalities of treatment may be driven more by “funding patterns and political agenda than by true promise for improving psychotherapy” (Beutler et al., 2004, p. 291). Viewing common factors and specific ingredients as mutually exclusive or distinct may lead to a more limited picture of the actual change mechanisms inherent in therapy. It is important to note that the Blue cases (with one exception) had their largest improvement following their first treatment session which to a large degree was psycho-educational and contractual. Our study, similar to Klein and Elliot's (2007)

study, supported the finding that patients value specific ingredients of therapy and common factors that are ubiquitous to all forms of psychotherapy.

### **Tracking and Monitoring**

Two clients (one Red, one Blue) mentioned taking the OQ-45. Somewhat ironically, the patient who had the most positive experience with the measure was a Red case, while the negative comment was made by a Blue case. Future research could examine patient's reactions to completing the measure. Also if a more substantial sample size was used, one could assess overall attitudes towards having symptoms measured on a regular basis. Their attitudes towards filling out the measure did not appear to affect their outcome, although with such a small sample size it is too early to draw any conclusions on the relationship between attitudes towards the OQ-45 and outcome.

### **Methodology**

As Elliot and Klein (2007) articulated, the diversity of responses and wide array of unique treatment outcomes demonstrated that symptomatic outcome measures may be too reductionistic and are not fully capable of describing the complexity of the therapeutic experience. According to Ward, Wood, and Awal (2013), qualitative methods may have external and face validity and thus complement quantitative measures of change. Indeed, Irvin Yalom spoke to our impermanent attempts at understanding complex human experiences by noting that our perceptions of client change are at best a "...feeble approximation of the rich images that once coursed through one's mind" (Yalom, 1985, p. 180). Through qualitative and quantitative measures of client change, the full context and complexity of their experience is better captured, and the client's experience is preserved in their own language (Kazdin, 2003; Fishman, 2005). However, we must remain intellectually honest in recognizing that our descriptions and

observations of patient responses give us only an incomplete understanding of the incredibly complex experience of being in psychotherapy.

As noted by Fishman (2005), Elliot and Klein (2007), and Clarke and colleagues (2003), we also found that triangulating data by measuring the same construct with multiple measures can bolster the legitimacy of our conclusions. For example, patient's retrospective analysis of their pre-therapy functioning as measured on the CRSS-4 was deemed accurate when judged against their intake OQ-45 score. Their approximations of post-therapy functioning were also congruent between the CRSS-4 and OQ-45. This finding supports the concurrent validity of both measures and the conclusions drawn there from. Our study echoes the conclusions of previous authors, in that quantitative measures of symptom change (eg. OQ-45, WAI-R, and CRSS-4) as well as subjective assessments (the Client Change Interview Protocol) are supplementary and complementary in the task of understanding the patient's experience in psychotherapy (Elliot & Klein, 2007).

### **Limitations**

Like many case studies, the greatest limitation of our current study remains the small size of the sample. A low  $N$  naturally limits the generalizability of the findings, the validity of which are compromised given that conclusions were drawn from a very select few respondents. Our findings must be cautiously contextualized and ultimately guarded given this significant limitation, and our conclusions should be seen as hypothesis-generating rather than definitive statements on the nature of psychotherapy. Given the prohibitively expensive cost of conducting a similar study with a larger  $N$ , we were limited in this regard. It thus behooves future researchers to conduct comprehensive interviews while also collecting aggregate data to bolster conclusions with much larger sample sizes. Another limitation was that one of the Red cases did

not complete the Client Change Interview Protocol, thus the results do not reflect her responses to therapy, and the investigators may have missed out on key aspects of her experience. Future studies could utilize massive cohorts of participants in order to study certain hypothesized variables of client change, and thereby draw more certain conclusions about the mechanisms of sudden gains (Elliot & Klein, 2007; Clark, Hardy, & Reese, 2003). We also recognize that the patients in one group could have possibly had co-morbid diagnoses that conflated their outcomes. The decision to divide groups based on on or off-track status, instead of matching for gender, age, or diagnoses, came with benefits and disadvantages. Given that the diagnoses were given by their primary care physicians and merely carried over by Dr. Vlass degraded the possible accuracy of such diagnoses, and thus any comparisons may not have generalized. We also preferred to sample from a wide variety of cases in order to more fully explore the phenomena of sudden gains across many different domains. However, we recognize that this small, unmatched sample is limited in its generalizations for these same reasons.

Another weakness of this study is the obvious issue of conflating causation with correlation (Ankuta, 1993; Hasler et al., 2004; Elliot & Klein, 2007). Two variables in particular are subject to skepticism in this regard, namely the satisfaction and working alliance constructs. It is unclear at this time whether a better outcome in therapy leads to better satisfaction and stronger sense of working alliance, or vice versa. The alliance and satisfaction would need to be measured throughout therapy to draw more certain conclusions. When asking clients to retrospectively evaluate their experiences in therapy, we may be measuring some degree of artifact given that patient's perspectives of therapy can be affected by the lapse of time and by other experiences during the interim (Clark, Rees, & Hardy, 2003; Nielsen et al., 2000). In other words, the direction of change is unknown. The patients also presented with a multitude of

differing diagnoses, thus limiting the possible generalizability of the findings (Elliot & Klein, 2007). We agree with these authors in proposing that future studies examine patients according to diagnoses in order to observe whether different presenting problems are more or less amenable to sudden gains.

The strength of this study's conclusions, as well as its generalizability, is limited given that the study was retrospective in nature (Clark, Hardy, & Reese, 2005). In a prospective study the proposed procedure might be quite different. This would allow a researcher to examine client traits such as resilience prior to entering treatment. The psychotherapy itself could be tape recorded and the process of therapy examined in real-time. Special emphasis could be placed on therapeutic events that proceeded dramatic gains, which could also be examined in a prospective study. The study could also have been improved by measuring changes, satisfaction, and working alliance throughout the process of therapy, in order to gain an understanding of certain variables are causative, or precede other change variables. As noted by Elliot and Klein, this could lead to a possible understanding of the timeline of the change process. We do know that the passage of time affects client reports (Nielsen, et al. 2004). Future studies could also video or tape record segments of therapy for future analysis, and examine differences between the client's perception of the process and the therapist's perspectives.

A common problem with all qualitative (and many quantitative methods as well) is the likelihood that patients are often poor historians of their personal experiences. Patients may develop narratives that are not in keeping with their real-time response to therapy. Thus positive retrospective assessments of therapy may be due to current level of distress at the time of the follow-up, since some patients noticeably improved between their final session and the current measuring of symptoms (Clark, Rees, & Hardy, 2003). However, this was somewhat controlled



for by having measured distress at each session of therapy, a natural check that should be incorporated into future studies to ensure accurate, real-time assessment of symptoms. Also, given that patients will generally speak as a “layman,” not as a psychologist, some degree of subjectivity is inevitable in the assessment process (Strupp, Fox, & Lessler, 1969). These authors also noted that hind-sight bias may infuse self-deception or wishful thinking into the patient's retrospective narrative. Although in our study qualitative and quantitative measures were generally agreeable, this may not always be the case. However, as noted by Strupp and colleagues, reports from the patients themselves can be just as helpful as statistics at “revealing not only pain, but disappointment, suffering, and despair.” They also posited that patients are more fully capable of commenting on variables that are rarely studied in prospective studies, such as gratitude for having received help, acknowledging that they have changed, and that they were able to develop a “sense of new courage and strength in facing the problems of life” (p. 20).

The therapist was also not randomly selected and her work may not be representative of typical practices. Dr. Vlass also used a combined therapy approach that includes an emphasis on two theoretical approaches—one a mainstream approach (CBT), the other an approach labeled Compassionate Mind Training, to be described shortly. Thus the findings may not generalize to other theoretically-driven psychotherapies and therapeutic combinations. Although the cases were sampled from Dr. Vlass’ files, the clients were not randomly sampled from other possible therapists and the findings regarding these clients may not generalize to all clients or clients selected from other clinicians’ case loads. The final sample of ten patients may not be representative of other populations due to volunteer effects. In other words, those who accepted the invitation to participate may have a characteristic that is not shared by the general population, thus the findings may be limited in generalizability to others who share similar characteristics

with the volunteers. An infinite number of measures could not be given, thus the variables of study are somewhat arbitrarily based on the investigator's rationale and preferences.

Because the clients were assessed by a woman that they potentially have a unique and powerful relationship with, they may have a tendency to under-report poor experiences in therapy and over-report good experiences so as to protect the relationship. We tried to control for this type of “error variance” by ensuring the participants that Dr. Vlass would not have direct access to their responses, seeing as sealed their responses before they were mailed directly to Michael Lambert in the United States. However, it is still impossible to entirely control for this type of evaluation apprehension. The candidness of participants' recollection of therapy, including statements about what they didn't like, lends support to the belief that the qualitative portions were by and large authentic and representative of participants' experiences, but the possibility of hindsight bias cannot be controlled for. Future research could also examine whether sudden gains or the becoming off-track are better explained by acute symptoms versus characterological issues. Patients could be evaluated for personality disorders prior to therapy, and researchers could examine whether the presence of a personality disorder prohibits the likelihood of sudden gains and tends to lead to becoming off-track in treatment and eventually being a “treatment failure.”

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## Appendix

Table A. *Subjects OQ-45 Score, by Session; Total Change in OQ-45 Score*

<i>Subject</i>	1	2	3	4	5	6	7	8	9	$OQ^{Final*}$	$OQ^{Pre-Post**}$	$OQ^{Post-Final***}$
Brenda	150	148	130	<u>31</u>	36	-	-	-	-	73	-77	+37
Brent	110	<u>40</u>	30	21	20	-	-	-	-	19	-89	-1
Bailey	72	<u>32</u>	33	-	-	-	-	-	-	14	-39	-9
Barbara	117	<u>87</u>	65	45	-	-	-	-	-	34	-83	-11
Beatrice	108	<u>84</u>	54	-	-	-	-	-	-	46	-62	-8
Reilly	87	<u>102</u>	108	114	-	-	-	-	-	111	+27	-3
Ruby	91	91	91	77	61	65	<u>104</u>	70	-	113	-21	+43
Rebecca	69	78	<u>80</u>	69	58	83	-	-	-	62	+14	-21
Robert	104	<u>124</u>	110	72	106	76	85	80	72	52	-32	-20
Rachelle	109	101	110	78	75	<u>123</u>	79	-	-	88	-30	9

*Note.* The Outcome Questionnaire 45 (OQ-45) is from Lambert (1994)

\*  $OQ^{Pre} - OQ^{Post}$  measures overall change on OQ-45 between first and last sessions of therapy. Clinically significant change is indicated by +/- 14 points

\*\*  $OQ^{Post} - OQ^{Final}$  measures overall change on OQ-45 between last session of therapy and follow-up assessment at 2-year interval

\*\*\* OQ scores with a    denotes the session that client either went off-track or made sudden gains

Table B. *Subjects' CRQ Scores*

<i>Subject</i>	<i>CRQ1*</i>	<i>CRQ2</i>	<i>CRQ3</i>	<i>CRQ4</i>	<i>CRQ5</i>
Brenda	1	1	1	4	4
Brent	1	1	1	4	5
Bailey	1	1	1	4	5
Barbara	1	1	1	5	5
Beatrice	1	1	1	3	3
Reilly	1	1	1	3	3
Ruby	2	4	1	3	3
Rebecca	2	3	2	4	4
Robert	2	3	3	3	3
Rachelle	2	2	1	3	3

*Note.* The Consumer Reports Questionnaire 4 (CRESS-4) is from Seligman (1995)

\*CRQ1: How much did treatment help with the specific problem that led you to therapy?  
1=made things a lot better; 5=made things a lot worse

\*CRQ2: Overall how satisfied were you with this therapist's treatment of your problems?  
1=completely satisfied; 5=completely dissatisfied

\*CRQ3: How would you describe your overall emotional when you started counseling? 1=very poor: I barely managed to deal with things; 5=very good: Life was much the way I liked it to be

\*CRQ4: How would you describe you overall emotional state at the end of treatment? 1=very poor: I barely managed to deal with things; 5=very good: Life was much the way I liked it to be

\*CRQ5: What is your overall emotional state at this time? 1=very poor: I barely managed to deal with things; very good: Life was much the way I liked it to be

Table C. *Subjects' WAI Scores*

Subject	WAI-T*	WAI-B*	WAI-G*	WAI-Total*
Brenda	84	78	84	246
Brent	76	75	79	230
Bailey	81	77	83	241
Barbara	84	78	84	246
Beatrice	82	83	82	247
Reilly	79	81	81	241
Ruby	53	60	57	170
Rebecca	55	61	60	176
Robert	61	75	61	197
Rachelle	67	80	79	226

\* WAI-T: The Tasks sub-scale measures the extent to which a client and therapist agree on the “in counseling” behaviors and cognition that form the substance of the counseling process

\* WAI-B: The Bond sub-scale measures the extent to which a client and therapist possess “mutual trust, acceptance, and confidence”

\* WAI-G: Goals (outcomes) that are the target of the intervention

\* WAI- Total: Overall global working alliance

Table D. *Open-coding Analysis of Red's Interview Transcripts: Therapy Experience*


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I. The Therapeutic Encounter

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*A. Unique Therapist Characteristics*

1. I had someone on my side. I didn't feel alone.
2. Therapy is your first foot in the door to connection.
3. She was a good fit for me.
4. Connecting with a human on a deep level is what it's all about, that's where you get healing.
5. Anytime I wanted to, I could ring her. I met a wonderful friend as well. I think she would be there for me.
6. I qualify that by saying that I'd seen other people who were too clinical.
7. I live a spiritual life, that's really important. I got a lot of that from Eri, I think she's a spiritual brain; she has this aura about her.
8. The big one is sharing what's going on with me, not for advice, just for getting it out of my head.
9. I don't know how you describe it. Her manner, I believe the sound of her voice - but you can't teach people what she's got.
10. When I was in her presence, I felt calmer, I felt safe. I had the ability to be open and honest with her.
11. I had a lot to get out once I felt safe and comfortable.
12. I felt comfortable, so I took the risk.
13. I was put there, ready to go, and she was there with enough skill or whatever she had.
14. I don't know how it works, mate, it's like the twilight zone. But it works mate, no one can deny me.
15. Maybe in her life, she [Erigoni] has had a lot of pain and struggle. We connect because of the pain. That's my belief, we connected to the pain. That's where it's at. The suffering, compassion and empathy gets through the head, gets to the heart. I can know it from a hundred miles away.
16. No matter what's happening, I'm okay. I think that's very powerful for people with mental illness.
17. Ya I think Eri was the type of person that I needed in my life at that time. It wasn't until I sat on her couch, and sat across from her, and started talking. I just felt like...it just felt right for me.
18. Having someone to understand and not to discriminate and judge.
19. Felt understood in therapy
20. It also made me feel supported, like there was someone "on my side" no matter what

*B. Potent and Specific Ingredients*

1. I was able to get hope. It was very important to have hope in my life.
2. Pen and paper are important for me as well. On days, I can see the distortions, and go 'geez, come on mate, you need to...'

3. One of the things Eri did for me was that she challenged my thinking about what I thought about myself. I just think she was...she tapped into something and told me: “this is who you are; you need to look at this.” It didn't happen straight away. I can look back now; it was good for me to be told that my thinking was distorted.
4. In therapy, I can cry a lot of tears. It opened up those parts that are blocked off, mate. That's what it's all about.
5. I think I was struggling with uni and my decision to do a PhD – something which with time I managed to get my head around anyway. I think therapy helped the process along.
6. It always felt great to be in therapy because I felt that I was doing something to help myself.
7. I know that now, it's distorted, it's not the truth. And to have it positively reinforced by someone you relate to and trust and like is good.
8. I tell you one thing that stands out was, she made me do a questionnaire on a computer each time I got there. And it would show me in a color of where I was. What it did was, it showed me I was improving. This was one of the places I got hope from; Eri would say “that's really good.”
9. Helping with decision making. Realized that unable to say “no” to others. Never thinking about self.

### *C. Unhelpful Factors*

1. When I'm pulling the layers back, I can't handle it, I break down. I did that without even knowing it.
2. If any changes, they were very briefly lived
3. Are you doing, feeling, or thinking differently from the way you did before? Hardly
4. Can't recall
5. Better than 2 years ago, but starting to deteriorate again
6. To “stay with the feeling, which I find a little hard to understand and implement
7. Seemingly little or no progress. Sometimes it seems pointless.
8. Yes, but only rarely helpful.
9. Feeling more depressed
10. Since then I have probably reverted back to old ways a little.
11. I really hated the meditation and relaxation techniques. I'm sure it's very helpful to many people but it honestly drives me crazy! If I am going to lie down and be that still – I would just rather go to sleep!
12. Disappointing would probably be when my behavior was justified, e.g. “no wonder you have been taking drugs when you have all this going on” when really I felt there was no excuse and I was probably looking for the slap on the wrist that I wasn't getting at home.
13. I am progressively less and less hopeful

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## II. Attitude Towards Therapy

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### *A. Resistance to Therapy:*

1. I didn't tell her everything...
2. Seems sort of a bit, weird stuff, but it works.



3. I tried to change, move everything outside yourself. All you get is frustration, anger and guilt. Lots of negativity.
4. I can look back, and realize if I'm not open and honest, I might as well not be here.
5. That's what we do; we don't solve it by butting our head.

*B. Taking Responsibility for the Change Processes*

1. Sharing is two directions.
2. The only thing I can change is me, my behavior, my attitude.
3. A positive way is to change myself, not the world. I don't do it perfectly.
4. When the student was ready, the teacher appeared. I was at a point where I was ready for someone to help me.
5. It's time to do a bit more work on myself, to look inside and see.
6. Perhaps the situations changed or I learned to cope with them better.
7. I guess the reasons I was in therapy in the first place were due to my coping with situations in my life?

*B. Painful but worth it*

1. You don't fall straight into someone who understands you, it's a search.
2. I'm sure there were things that were painful or difficult but I honestly cannot really remember – it was years ago!
3. I was dying. I cry out to something outside of myself, fuck I can't do this anymore. From that point on, things change.
4. Everything serves a purpose. Being honest, what's going on for you, it's all good.
5. There was a lot of stuff that was painful. Yeah, it was just painful for me to talk about it to someone anywhere, stuff that I haven't spoken to anyone about - guilt and shame, and things I'd done. Stuff you'd take to the grave, those secrets make you sick. Getting them out is really good. I didn't tell her everything, but for the first time I was really honest. I learned how to be honest.

Table E. *Open-coding Analysis of Blue's Interview Transcripts: Therapy Experience*I. The Therapeutic Encounter*A. Unique Therapist Characteristics*

1. I struck an easy rapport with my therapist which quickly established the trust necessary to identify issues
2. I think that I always suspected that the happiness of others depended more on my psychological well-being; what I needed was someone to confirm this for me.
3. I don't know if 'spiritual' is the right word, but there was a calming sense about her, she's a very interesting lady.
4. She's lovely. She's very welcoming, even her voice, is very soothing. She's very open and welcoming. I don't know, like I said before, she's a really beautiful person. I can't put my finger on it.
5. With Eri, she sort of reassured it was okay to be upset. It was okay to feel the way I was feeling. Why am I getting anxious, or annoyed, or crying. It was okay to have emotions, and be sad.
6. Once I speak to my doctor, I feel better
7. I always think the benefit of a stranger; I don't care what you tell them. They don't know anyone, or the situation. Basically, it's nice to talk to someone and not know somebody else's side of the story. Nice to have someone to talk to and hear your side.

*B. Potent and Specific Ingredients*

1. She taught me to stop, and think about things. And evaluate what is going on.
2. I think that through therapy I was able to talk through a number of issues which together had overwhelmed me
3. Understanding why I felt the way I did and the reasons why I got to that point and state of mind
4. Therapy confirmed a number of things I needed to change in my life and to support me as I formed a plan for my future
5. Developed a plan for the future which involved leaving a very stressful job and undertaking full-time study
6. She got me to write things down. I can't remember the specifics: what was important to me, what I enjoyed, and what was doing well in my life, what was bad.
7. She gave me a recording, I still actually have it, sort of like a meditation for me to listen to in the afternoon or before I went to sleep. A reassurance of, I don't know, sort of like a meditation. That really helped.
8. It was working on things from my childhood. I didn't consciously recognize that they were bothering me, but she sort of picked up on those things. We went back through stuff that happened in my childhood. I didn't realize it. A lot of things I had to deal with emotionally (I get bad anxiety), came from my childhood, I'm not a crazy person.
9. Also breathing techniques, and the meditation.
10. She did give me supplements to sleep, the sleeping. She helped me, I didn't have insomnia, but I did have difficulty sleeping. She helped me get my sleeping patterns back in order. I'm in bed at 10 or eleven. Kind of keeping that going, which has really helped.

11. taking a good look at what I experienced
12. I used the CD both times I came to therapy, felt a whole lot better.
13. Reflection
14. I think understanding how the brain works; I'm that sort of person that I want to know scientific theory and how to overcome it, it helped.
15. I find that when I relax and mediate and breathe properly, things slow down, the answers come.

### *C. Unhelpful Factors*

1. Hypnotism was disappointing for me
2. Not enough time.
3. The computer score meant nothing to me, you don't remember the things you didn't talk about.
4. At the time, it was a strange concept. I didn't really understand, I can't think of what it was it helped a lot.

## II. Attitude Towards Therapy

### *A. Resistance to Therapy:*

1. At first I avoided some issues but gradually developed the confidence and trust to expose and examine these issues in a healthy way
2. I was open and honest with her to a point. There's always something...I tend to hold back.
3. I was very skeptical, like "this isn't going to help." All in all it was quite positive, nothing bad about it.

### *B. Painful but worth it*

1. It was a hard time; it was a learning curve for me, mentally and emotionally, to realize that I am a strong person.
2. Actually being in therapy is painful – if therapy is not painful, there is no point in going.
3. [It was] painful when talking about my mother and my PTSD, kind of a journey.
4. It is difficult to talk about circumstances, the realization [you are] not coping as well as could be expected.
5. Everybody wanted like a quick fix – therapy is not a quick fix
6. Therapy is not a quick fix - not a realistic expectation.
7. One day at a time, [I am] hopeful things will improve

### *C. Taking Responsibility for Change Processes*

1. You can tell someone how to do things, but if you do not take them on board and practice, you're never going to change
2. Sometimes all the therapy applies to everybody and you realize that you are not just an individual, that the theory can apply to everybody
3. It would be easy to take a pill everybody would like that, everything would be better
4. All part of a process in therapy.
5. I didn't mind being in therapy

6. For most people there is a stigma attached to seeking help, however I reached a point whereby self-treatment was no longer an option or effective.
7. I made a firm decision at the outset that I wanted to resolve my problems – without this commitment I really believe that CBT is a waste of time for all parties
8. Always proactive about getting help
9. I believe no matter how good the therapist is, magic does not happen

Table F. Open-coding Analysis of Red's Perception of Therapeutic Changes

I. Changes in Self*A. Understanding and Perspective Taking*

1. I was able to get hope. It was very important to have hope in my life.
2. I still suffer from some depression, but I also see where I've come from. It's a miracle where I've come from.
3. The only thing I can change is me, my behavior, my attitude.
4. A positive way is to change myself, not the world.
5. This is who you are, you need to look at this.
6. I look at the situation, and realize I've been wounded. I look at it from the other side.
7. They'll tell you it's all gone to shit. The reality is, only your thinking and feelings have changed. Your situation hasn't changed that much.
8. The realization that putting my needs on hold, going into enormous debt for the sake of others
9. I think I became better at recognizing the emotions that were behind certain behaviors, and hence became better at dealing with emotions and improving behaviors: e.g. recognizing that if I was using (rarely) recreational drugs it was because I needed an outlet.
10. If I was having trouble getting out of bed it was not because I was tired but rather because I was avoiding things.
11. Therapy helped make me aware to the connections between my emotions and behaviors.
12. I have a problem saying no to many things, to over-committing, and I think this is because I know how easily I get depressed/lonely
13. I learned that I am in control of what I do – it's my responsibility to examine my thoughts, feelings, behaviors and to address them if I need to make changes.
14. I still suffer from some depression, but I also see where I've come from. It's a miracle where I've come from.
15. On days, I can see the distortions, and go 'geez, come on mate, you need to...'

*B. Affective and Mood Changes – I feel better*

1. Some of the feelings I felt I can give you anxiety, shame, and guilt. But also relief at the same time.
2. They saw a calmer, slower, somewhat more relaxed me. Not relaxed, it's like I'd slowed down a bit.
3. I felt calmer, I felt safe.
4. I guess I started to feel better? I don't really remember, this is a few years ago now.
5. I am better equipped at dealing with the stress/anxiety that comes with being very busy than I am at dealing with depression/anxiety.
6. Feeling more depressed

*C. Acceptance of Self and Situation*

1. When I do practice it well, people can call me whatever they want, but I have the serenity. Fuck you, whatever you're doing doesn't do anything to me, calling me names.
2. I just let it go.

3. I cry out to something outside of myself, fuck I can't do this anymore. From that point on, things change.
4. Everyone has good stuff that they cover up with all the shit.
5. But it's about acceptance, patience, tolerance. That's not the type of person I am, I'm not Jesus standing on a hill giving a sermon. The other points I aim to be.
6. Whatever the way life is today, I accept it.
7. No matter what's happening, I'm okay.
8. Everything serves a purpose. Being honest, [with] what's going on for you – it's all good.
9. never thinking about self.
10. It opened up those parts that are blocked off mate. That's what it's all about.

## II. Outside Changes

### *A. Interpersonal Effectiveness*

1. I share with people who have the same experience, and I get knowledge
2. I've been able to remove a lot of it to be more giving, not be as selfish. Not think about myself as much, to think about others. To put others first.
3. To make amends, to forgive you. Make amends for my behavior in the past. That's a pretty humbling experience.
4. Realized that unable to say “no” to others
5. I have much more of an open heart now to relationships, whereas before I was petrified of getting hurt, of loss.
6. I got the idea that people around me (both family and friends) rely on me a lot.

### *B. Life Skills*

1. Psychic changed happened in my thinking. Honestly, something guided me. God - that's what I call it every morning. Help me stay sober, that faith is what carries me.
2. I don't even have the obsessions about drinking anymore!
3. A big things is practicing the principles of the 12 step program. Principles of change, surrendering not to my own will, but I choose to go with God.
4. Gratitude, humility, being open-minded.
5. I'm trying to be that person that I wanted to be.
6. New job
7. Therapy really helped me to recognize this and work towards maintaining balance – although since then I have probably reverted back to old ways a little.
8. Perhaps the situations changed or I learned to cope with them better.
9. It's hard to say as I don't really remember what I was feeling/thinking before.
10. Positive and negative changes
11. Follow the disciplines of yoga, and a spiritual faith, some prayer... I live a spiritual life, that's really important.
12. Helping with decision making.

### *Self-Descriptions*

1. Mentally unstable and very tired
2. I used to be happy go lucky, outgoing person – does not feel like that now.

3. Return to mental stability, slimmer, happier.
4. Traumatized. Anxious, stressed, depressed, lacking confidence, quirky, unconventional
5. Change: my mental health
6. Reliable, loyal, committed, busy, organized, caring, supportive, approachable, independent
7. Am I just allowed one thing? I would make myself smarter, thinner, and more light-hearted. But seriously – just one thing would be smarter – to just know more stuff without the effort of having to learn and remember! My whole job (or all my jobs actually) would be less challenging if I were naturally more intellectual
8. I think generally my opinion of myself is lower than what others think of me. That describes the problem. Ya, I think I have anxiety, you know? I'm more nervous. It's like low self-esteem.
9. People would describe me as fearless, confident, and outgoing. I think I'm a good actor. I've learned it's a lifelong thing I've done. I had an alcohol and drug problem, but the alcohol and drugs helped me do that. I've been sober 4.5 years.

Table G. *Open-coding Analysis of Blue's Perceived Therapeutic Changes*


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I. Changes to Self

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A. *Understanding - Putting things in Perspective:*

1. Developed a clarity of purpose
2. Less confused
3. My priorities have changed and I now place greater importance on myself without feeling guilty
4. Basically my new philosophy is that I can make no one happy unless I am happy
5. Therapy confirmed a number of things I needed to change in my life
6. I am far more detached from previous issues and this distance has enabled me to put a range of issues in perspective
7. Positively, clearer [outlook]
8. I learned to understand myself and thoughts better, and to be accepting of this
9. Understanding why I felt the way I did and the reasons why I got to that point and state of mind
10. I think very differently now - putting things into perspective.
11. Why am I getting anxious, or annoyed, or crying.
12. I put that down to a right frame of mind, a better frame of mind. It was a domino effect.
13. I think, the last year after that I needed a touch point, sort of a touching base. So you can reflect back on it
14. Putting things in perspective
15. More positive outlook
16. Brighter outlook in terms of being a mom
17. Being rational
18. Not to place too many pressures on self
19. Being able to understand them, to deal
20. [I think] scientific and rational
21. I'm more aware of the physical reactions of my body to the stress as it's happening

B. *Affective and Mood – I feel better:*

1. Calmer
2. Less overwhelmed
3. Found myself happy for the first time in many years
4. Stronger emotionally
5. I was calmer
6. Clearer thinking after therapy started
7. I think I'm a happier being.
8. I am doing a lot better.
9. More positive about things now after giving birth
10. Helped PTSD, get over it more quickly
11. [feeling] fabulous
12. More confident after birth of son



13. Put things right
14. A little easier to handle extremely anxious times
15. Once I speak to my doctor, I feel better

*C. Acceptance of Self and Situation:*

1. Consider my needs
2. My happiness is paramount and that I don't need to feel guilty or selfish about this
3. I'm a very strong person.
4. I take every day as it comes.
5. It was a hard time, it was a learning curve for me, mentally and emotionally, to realize that I am a strong person; I was doubting myself, which was a change for me.
6. It was okay to feel the way I was feeling
7. It was okay to have emotions, and be sad
8. I'm not a crazy person.
9. You are a stronger person, and if you do get faced with a challenge, everything will be okay again.
10. Able to plan ahead
  1. She taught me to stop, and think about things. And evaluate what is going on.
  2. She got me to write things down: What was important to me, what I enjoyed, and what was doing well in my life, what was bad.

## II. Changes Outside Self

*A. Interpersonal Effectiveness*

1. Take the time to listen
2. [consider needs] of others
3. I am able to discuss things more easily with others
4. I also live in the moment more and enjoy the people I'm with and what I am doing
5. This has enabled me to extract a lot more joy from life and the people close to me

*B. Life Skills*

1. Developed a plan for the future which involved leaving a very stressful job and undertaking full-time study
2. Outside events improved because of confidence gained through therapy
3. Outside events also improved on their own over time
4. Now I'm really good, settled, in work and home.
5. I'm working on a bachelor's of entertainment management.
6. Life is good.
7. I also graduated, and got an amazing job which I am loving.
8. The reduction in stress has allowed me to stock take on my life and set priorities
9. I do yoga quite regularly.
10. I keep quite fit
11. I eat well, the clean living sort of thing happening.
12. She helped me get my sleeping patterns back in order. I'm in bed at 10 or eleven.

*Self-Descriptions*

1. optimistic, intelligent, funny, anxious, loving
2. look after myself better
3. Not to worry so much
4. fabulous
5. capable
6. Initially over-worried about being a competent mother”
7. Like to be less stressed...be a little more relaxed about big changes in life, and [not be] as fearful and not coping because of bi-polar mother.
8. [I am] a very strong person; naturally I always have been
9. Loud, caring, obnoxious, very social. My weakness is my strength. I'm very opinionated, and open about what I think. Don't know when to hold back, holding my ground
10. In a work environment I tend to be a bit standoffish. I tell them what I think.
11. I'm very much an open book. I don't like to bull shit people. You just know when someone's genuine, and then you can't. I just move on, people come and go
12. I just I think I am little too giving at most times. I need to learn to hold back with my time and emotions. I tend to put people in front of myself
13. Stronger emotionally
14. Friendly, reliable, consistent hard working, affectionate, thorough, loving, kind, generous, well mannered, and private
15. perfectionist
16. poor attitude towards exercise
17. be a little less private, suffer less from anxiety