Pathways towards different long-term outcomes after naturalistic psychotherapy

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Abstract

This study suggests some potential pathways leading towards maintained gains or further growth versus deterioration after naturalistic psychotherapy with experienced clinicians. This is explored in a way that transcends specific theoretical orientations. Sixteen therapies, all showing reliable improvement on OQ-45 at treatment termination but varying in later post-therapy development, were included in this study. Building on previous content- and correlational analyses, individual cases were explored qualitatively in search for developmental patterns of potential relevance for long-term outcome. Patterns re-emerging across several cases were described in light of the OQ-45 trajectories of clients providing them. Six pathways, associated with different long-term outcomes, emerged. Four of these, “Reflective route towards regulation of affects”, “Gaining autonomy through a secure holding relationship”, “Opening up as a new relational/emotional experience”, and “Lasting acceptance of «reality»” re-emerged in clients showing maintained/growing treatment effects. Two pathways, entitled “Residual problems grow and overshadow progress”, and “Core problems remain beneath superficial change”, seemed linked to deterioration after termination of therapy. We suggest the former pathways as some possible routes towards enduring good outcome, and the latter as some patterns to avoid when trying to secure therapy gains will not be only temporary.

Keywords: Long-term outcome, Mixed methods, Process-outcome

Compared to the amount of knowledge accumulated on processes linked to psychotherapy outcome at treatment termination (see Crits-Christoph, Gibbons & Mukherjee, 2013; Orlinsky, Rønnestad & Willutzki, 2004), relatively little is known about what contributes to different long-term outcomes (i.e., outcomes measured more than a year after termination) or post-therapy-movement (i.e., further development after termination of therapy). Some studies have addressed the long-term effects of different forms of psychotherapy, mainly concluding that maintained effects are found after both cognitive behavioral (see Butler, Chapman, Forman & Beck, 2006), psychodynamic (see Town et al., 2012) and humanistic (see Elliott, Greenberg, Watson, Timulak, & Freire, 2013) treatments. Furthermore, some studies have suggested that psychotherapy in general tend to provide more lasting change than pharmacological treatments (De Maat, Dekker, Schoevers, & De Jonghe, 2006; Hollon, Stewart & Strunk, 2006; Imel, Malterer, McKay & Wampold, 2008). Direct comparisons of the long-term effects of different forms of psychotherapy are rare (see Kivlighan III et al., 2015 for some exceptions).

As already suggested in regard to outcome at treatment termination (e.g., Wampold & Imel, 2015), the most important factors for long-term outcome or post-therapy development might not follow established theoretical boundaries in consistent ways, however. Thus, other potential predictors of long-term effects, beyond treatment orientation, also need to be explored. This has to some extent been done, with previous studies linking for instance clients' type of problems (e.g., Ludgate, 2009), level of comorbidity (e.g., Svanborg, Wistedt, & Svanborg, 2008), attributional style (e.g., Liberman, 1978) and level of residual problems at termination (e.g., Paykel, 2008) to maintenance of treatment effects. Treatment length, shape of growth-trajectories, as well as a few therapist- and relational variables have also been explored in relation to long-term outcome (e.g., Knekt et al. 2013; Høgland, 2003;

Leichsenring & Leibing 2003; Tang et al., 2007; Nissen-Lie et al. 2015; Ekroll & Rønnestad, 2017), but more research is needed before general conclusions can be drawn regarding these topics.

A few studies have also discussed more specific therapy processes and mechanisms of potential relevance to variation in long-term outcome or post-therapy-movement. Promoting autonomy (Ulberg, Høgland, Marble & Sørbye, 2009), skills being applied after termination (Strunk et al., 2007), insight (Høgland, Dahl, Hersoug, Lorentzen & Perry, 2011), self-analytical function (Falkenstrøm et al., 2007), and emotion regulation (DeRubeis, Siegle & Hollon, 2008) have been suggested as potentially important, but also within this field clear-cut conclusions seem premature at the moment.

As research and knowledge on factors of relevance to variation in long-term outcome and post-therapy-movement still appear to be at an early stage, inductive and explorative studies might be useful for generating hypotheses and shedding more light on the subject (see Elliott & Timulak, 2005). Thus, in response to the state of the current knowledge base, we wanted to explore aspects of therapy that may be relevant for understanding variation in long-term outcome, and to do so from the observational perspective of the client, using an inductive approach that transcend specific theoretical orientations.

Through a mixed methods project, we set out to explore potential pathways leading towards different long-term outcomes for clients that initially responded positively to naturalistic psychotherapy. As a first stage we conducted a content analysis of what our clients reported as important during and after their therapies (see Ekroll & Rønnestad, 2016). We developed a taxonomy of changes (i.e., any form of impact, intermediate change or outcome being experienced in or after therapy) and processes (i.e., events, activities or therapeutic work of potential relevance for such changes) experienced by improved clients, under and after naturalistic therapy with experienced psychotherapists (see appendix for a

diagram of categories derived from this stage). As a second stage, we explored whether presence or frequency of reported material from different codes and categories within our taxonomy was associated with variation in clients post-therapy-movement on a standardized outcome measure at a group level (see Ekroll & Rønnestad, 2017). We found that mainly reports of material related to *relational aspects* (e.g., therapeutic bond and therapist being active) were associated with post-therapy growth as measured by the OQ-45. On the other hand, reports of material depicting therapy somehow not being experienced as complete was associated with deterioration after therapy. It was also suggested that even though numerous earlier studies have associated positive affect with good outcome at termination of therapy (see Orlinsky, Rønnestad & Willutzki, 2004), reports of *more positive affect* seemed like a poor indicator of lasting change beyond this (Ekroll & Rønnestad, 2017).

Following the previous two stages, we assumed that a more fine-grained, integrated, and temporally sensitive (e.g. minding the sequence of different processes and changes) exploration of our individual cases could help us elaborate and extend on our preliminary (group level) findings. The current study (i.e., stage 3) will explore developmental patterns emerging within our cases from a thorough and contextualized re-reading of the entire raw material, sensitized by –and building on– findings from the former two stages. This final analysis will be informed by the temporal organization of clients’ reported processes and changes from the taxonomy (i.e., from during therapy, immediately following therapy, and at 3-4 years follow-up) described in Ekroll & Rønnestad (2016). Potential developmental patterns re-emerging across cases will then be presented in light of the OQ-45 trajectories of the clients providing them. Thus, as a final stage in our mixed methods project, the current study will offer an integrated exploration and description of potential developmental pathways towards different long-term-outcomes.

Methods

The data used in the current study is drawn from a larger psychotherapy research project called “An intensive process-outcome study of the interpersonal aspects of psychotherapy” (Author 2, 2009). The overarching project contains a range of qualitative and quantitative data with frequent observations from different observational perspectives during treatment, in addition to follow up data collected 3 to 4 years post-therapy. The project is known for its sample of highly acclaimed psychotherapists, being studied in naturalistic settings. The latter entail that treatment was carried out within the therapists’ private practices with no restrictions in methods or duration of therapy. Informed consent and anonymity for all participants have been secured, and the project is approved by the Norwegian regional ethical review board (REK). As stated above, the current article builds on two previous studies from within the overarching project, together making up a three-stage mixed methods exploration of long-term effects of psychotherapy. We refer to Ekroll & Rønnestad (2016) for further explication of underlying procedures regarding the initial content analysis and construction of a taxonomy of processes and changes experienced by clients in our sample (i.e., stage 1). For explication of procedures regarding the following exploration of correlations between post-therapy-movement and reports of material from different codes and categories in the taxonomy (i.e., stage 2), see Ekroll & Rønnestad (2017).

Participants

Psychotherapists. In the overarching project (Author 2, 2009), participating psychotherapists were 15 psychologists and 3 psychiatrists, with an average of 30 years of therapy experience. They also had extensive experience as teachers of psychotherapy (mean number of years as teachers = 20). In addition, many had experience being the therapist for other therapists as well. The theoretical orientation of therapists varied. Most indicated that

their current practice (all but one in private practice) was moderately to strongly influenced by at least three major theoretical orientations, thereby arguably being somehow eclectic or, given their high experience level, also integrative. To measure theoretical orientation, therapists were asked how much, on a scale from 0 (not at all) to 5 (very much), their current therapeutic approach was guided by each of the following theoretical frameworks: Analytic/Psychodynamic, Behavioral, Cognitive, Humanistic/Existential, Systemic, or Other. In rank order the orientations with highest endorsement were: humanistic/existential, psychoanalytic/dynamic and cognitive, with mean endorsement at 3.3, 3.2, and 3.1 respectively (Author 2 et al., 2014). Therapists' private practice was embedded within the public health system with state reimbursement for a substantial proportion of their fees. For clients, this implied that therapy was provided at a low cost.

Clients. Clients included in the study at hand were selected from within the larger practice-based study of psychotherapy (Author 2, 2009). In the overarching project, it was ensured that variation in psychopathology and a sufficient number of clients typically considered “difficult to treat” (Lippe, Oddli & Halvorsen, 2014) were included. Exclusion criteria were: psychosis, a drug diagnosis, known neuropsychological damage and age below 18. From an overall sample of 48 clients in the overarching project, those who showed reliable improvement (measured with OQ-45) at termination of therapy (while varying in post-therapy-movement thereafter), and had complete coded qualitative data, as well as follow-up data (3-4 years post-therapy) available at the time of this study, were included in the current analyses. This totaled 16 clients (10 women, mean age 39) treated by 10 therapists (Highest mean endorsements: Psychoanalytical/dynamic = 3.5, humanistic/existential = 2.8 and cognitive = 2.7, all at least moderately influenced by more than 1 orientation.). The included clients' average number of sessions was 42.6 (SD= 32.7), average OQ-45 total score was 66.3 (SD=19.8) at first assessment, 39.5 (SD=18.7) at termination and 45.1 (SD=18.3) at

3-4 year follow-up. Depression was the most frequently reported target problem.

Researchers. The first author is an early career clinical psychologist and researcher, who graduated from a training program that included diverse orientations, such as psychodynamic, humanistic, cognitive-behavioral and systemic. He has a total of 2.5 years of supervised clinical practice with adult clients, where 1 year has been within a psychodynamic framework, and 1.5 mostly emphasizing CBT. He keeps an open stance towards different schools of treatment and has applied interventions from different theoretical orientations when treating different clients. The second author is an experienced quantitative and qualitative researcher and clinician, with more than 25 years of psychotherapy experience. He was initially trained in client centered and psychodynamic psychotherapy, and has thereafter endorsed an integrative theoretical stance.

Instruments

Outcome Questionnaire 45.2 (OQ-45). OQ-45 (Lambert et al., 1996a) was used to track the level and development of clinical distress in clients. The OQ-45 is a self-report instrument composed of 45 items indicating level of distress, which are assessed with a 5-point Likert scale (0 = *not at all*; 4 = *always*). Higher scores correspond to greater distress. Subjects' answers can be summed up to provide both a total score, ranging from 0-180, and subscores within the three categories of symptom distress (SD), interpersonal relations (IR) and social role functioning (SR). A total score of 63 or more is considered as indicating symptoms of clinical significance and a change of 14 points or more on the total score is considered a reliable change (Lambert et al., 1996a). The OQ-45 has shown good test-retest reliability after 3 weeks ($r = .84$), inner consistency ($\alpha = .93$) and concurrent validity (Lambert et al., 1996b; Umpruss, Lambert, Smart, Barlow & Clouse, 1997).

Session evaluation forms. We also used session evaluation forms, constructed by the research group in the overarching project (see Author 2, 2009). These were inspired by

Llewelyns' (1988) Helpful Aspects of Therapy (HAT) form. Our forms consisted of two open ended questions, intended to obtain information on change events/processes and impacts/changes that were experienced as salient during therapy. Forms were answered by clients, in writing, after every therapy session. The questions were formulated as follows: 1) *What was the most important event during the session?* 2) *Did anything change for you during the session? -If so describe it briefly.*

Semi-structured interviews. Semi-structured interviews were used to gain more information on changes and processes as they were experienced and reported by clients at treatment termination and also at 3-4 years after therapy was completed. Both interview guides were constructed by the research group in the overarching project, and aimed to evoke clients' experience of: conditions (status) before therapy, what they found helpful and not, how changes might have been related to therapy content, status at the time of the interview, thoughts about the future etc. (The interviews were not constructed exclusively for the study at hand). For the follow-up interviews, the guide also included questions on the period after termination. Examples of specific questions were offered (e.g., *Did you find the therapy helpful? Can you tell me more about that? Looking back now, what aspects were helpful?*), but interviewers were allowed to adapt interviews to the individual clients. The interviews were audiotaped and transcribed. Our analysis is conducted on the transcripts.

Data collection

The session evaluation data was collected by the psychotherapists participating in the project, who handed out the session evaluation forms to clients after every therapy session. During treatment, also the OQ-45 was administered by the therapists. This was done within session 3, at sessions 6, 12, 20 and thereafter every 20th session, and at termination. At follow up 1-2 and lastly 3-4 years after termination of therapy, licensed psychologists with a "Specialist in Clinical Psychology" status awarded by the Norwegian Psychological

Association administered additional OQ-45 registrations. These psychologists, who were otherwise not involved in the project, also conducted the semi-structured interviews with clients, at termination and 3-4 year follow-up.

Procedure/analysis

After having conducted analyses at a group level in previous stages (Ekroll & Rønnestad, 2016; Ekroll & Rønnestad, 2017), for the current study we revisited all the available material from our selected therapies, case by case. We both mapped out what kind of processes and changes (from the taxonomy in Ekroll & Rønnestad (2016), see appendix for diagram of categories) individual clients had reported when (i.e., during therapy, immediately following treatment termination, and at 3-4 year follow-up), and looked for themes or patterns that seemed important when considering the sum of qualitative raw material provided by each case. The latter was informed by available contextual information regarding clients' target complaints, demographics, work and relationship status etc.

The mapping of processes and changes reported by individual clients at different phases were based on earlier coding done in cooperation between the first author and an assistant, with the second author serving as an auditor (see Ekroll & Rønnestad, 2016). In short, this coding was performed through five steps: 1) Identification of relevant meaning units; 2) Construction of codes from meaning units; 3) Organization of codes under categories, clusters and levels; 4) Establishing agreement between coders (= 81-82% on which words to be included in meaning units, and Kappa values of 0.76-0.80 for agreement on category assignment); 5) Assigning meaning units with final codes. This procedure allowed for comparison of the frequency or prevalence of material from different codes and categories across cases. This was used to explore correlations between content and post-therapy-movement at a group level in stage 2 of our larger mixed methods project (see Ekroll & Rønnestad, 2017). Furthermore, the procedure also enabled tracking of content within cases at

a general and temporally sensitive level. This was utilized in the study at hand, where processes and changes reported at different assessment points were mapped out to visualize potential temporal patterns (i.e., sequences of processes and changes).

Re-reading of all the qualitative material was then performed by the first author, case by case. This was done to get a holistic view of the individual therapies, while at the same time staying close to the raw qualitative data, allowing particularities and nuances that was lost in former (group level) analyses to surface. Qualitative content that seemed salient to the development of individual clients were noted and summarized. Based on a combination of the mapped processes and changes across time and the latter extracted qualitative content, plausible developmental patterns were suggested. Extraction of salient content and suggestion of patterns were discussed with fellow-researchers from within the overarching psychotherapy project (Author 2, 2009). After every individual case had been analyzed and summarized in this way, cases were then compared to each other, in search of similarities and differences (this procedure resembled ideal type analysis, see McLeod, 2011 or Gerhart, 1994). A couple of central patterns seemed to re-emerge across several cases. The auditor controlled that these were sufficiently founded in the raw material. Informed by our previous findings (i.e., Ekroll & Rønnestad, 2016; Ekroll & Rønnestad 2017) and OQ-45 trajectories of the cases providing them, these patterns will be presented here as possible pathways towards different long-term outcomes.

Findings

Patterns re-emerging across cases: possible pathways towards different long-term outcomes

“Reflective route towards regulation of affects”. In stage 2 of our mixed methods project (i.e., Ekroll & Rønnestad, 2017), reports of more reflection did not correlate with post-

therapy-movement at a group level. Regulation of affects was linked to post-therapy-movement, however, through reports of residual problems in this domain correlating with deterioration after therapy. The current pattern of “reflective route towards regulation of affects” emerged when studying single cases at a qualitative level, through several clients after treatment describing being more able to “take a step back” and avoid losing control in situations triggering affect. This seemed to have been achieved by reflecting (and gaining perspective) on the situation and one’s own reactions. The pattern seemed salient in 4 cases, all showing maintained or growing treatment effects (on OQ-45) after termination of therapy. When investigating the distribution of material from different codes/categories in our taxonomy from stage 1 (i.e., Ekroll & Rønnestad, 2016) being reported by these clients, the current pattern was indicated by many reports of *therapeutic operations* and gained understanding in session evaluation forms during therapy, in addition to *more reflection* being emphasized in interviews at termination, and *better regulation of affects* in interviews regarding the follow-up period. Some representative statements from a client (ID2) showing post-therapy growth on OQ-45 can serve to illustrate this proposed pattern. The first text example, from a session evaluation form (during therapy), suggests that the therapist has helped the client gain more understanding of himself: *-The therapist articulated what happens when I get angry. I understood that the feeling of hopelessness triggers anger and aggression, which I then turn towards others.*

Later, in the interview at termination of therapy, the client confirms experiencing more self-understanding and also to reflect more, through and after the therapy: *-Most of all, I’ve learned to know myself better...I experienced, in the dialogue -the therapist noted this as well- more reflection in a way. In me, all the time.*

Finally, a statement from the follow-up interview indicates that years after termination of therapy, enhanced reflection is still being used to handle affective situations in more

constructive ways: - *I was more angry (before)...Back then I would have just emptied my irritation and frustration at my son...instead of...letting the “head” think and say: Ok, how can we help you with this...have a conversation with him instead of just getting mad.*

“Gaining autonomy through a secure holding relationship”. In stage 2 of our mixed methods project (Ekroll & Rønnestad, 2017), both *relational aspects* in general, and certain more specific relational variables (such as *therapeutic bond*), were associated with positive post-therapy development at a group level. There was also a single correlation linking autonomy (through the code *less concern with evaluation from others*) in the same direction. When looking qualitatively at individual cases, we saw a recurring pattern (most prominently among 3 cases with maintained or growing effects) where relational focus and reports of a strong bond during therapy seemed to be followed by reports of improved autonomy after termination, as if the therapeutic relationship had allowed clients to push limits, enhance initiative, and practice standing up for themselves. This pattern could also be recognized at a more general level (through distribution of reports from different parts of our taxonomy), by these clients emphasizing good relationships with their therapists, who were further reported to be active and supportive, before improved autonomy was reported in the follow-up period. A few text-examples, featuring a client (ID1) showing continued growth (on OQ-45) after termination of therapy may illustrate this proposed pattern. In the first quote, from a session evaluation form (during therapy), the client emphasizes the bond she has with the therapist. - *The therapist showing that she cares about me (was important).*

In the interview at termination of treatment, the client again reports the therapeutic bond or alliance as important for her growth, and specifies how this has given her the courage to show assertiveness towards the therapist (without fear of destroying the relationship): -*I have grown as a person by attending therapy and having an alliance that allowed me to be*

openly angry and confronting towards the therapist, without feeling nervous. I've grown through experiencing that it wasn't dangerous to be so direct in my anger. Very important. I wouldn't have dared this without the alliance.

A third quote, from the follow-up interview, suggests that the same client's strengthened assertiveness or autonomy has grown beyond the therapy room and is still appreciated years after termination of therapy: - *I've become better at telling people what I think, even when it's negative...or talk back...I've always been afraid to hurt or offend people, or afraid of their reactions...I'm not so afraid of that anymore.*

“Opening up as a new relational/emotional experience”. Also this pattern involves relational variables, in addition to client reports of having *expectations challenged*, both correlating with post-therapy-growth at a group level in Ekroll & Rønnestad (2017). By opening up, we refer to clients being less inhibited or reluctant to share experiences and “letting people in”. In some of our cases, this seemed related to a theme of new relational/emotional experiences. This typically unfolded through clients emphasizing how they managed or dared to override interpersonal scripts together with their therapist, opening more up to the other, being less afraid of what the therapist might think of them, as well as participating more actively in the relationship. Later, similar behavior was reported as easier to practice outside of the therapy room as well. This pattern was especially evident in 3 cases showing maintained effects or further growth after therapy. The pattern appeared most prominently when looking qualitatively at the raw material. However, the clients at hand could also be recognized by, along with reporting *new relational/emotional experiences*, all appreciating that their therapist had been active and supportive or personally involved, as well as emphasizing having become more open. Below are some text examples from a client (ID 3) showing maintained effects after termination of therapy. The first example, from a session

evaluation form, illustrates the client (gradually) managing to open more up during therapy. This seems to have contrasted with her usual way of being with others: *-I dared to show the therapist sides of myself that I'm ashamed of...we continued the open form (which is a challenge for me, still I manage to maintain it with this therapist).*

Another quote, from the interview at termination, repeats the emphasis on opening up, as well as this being experienced as a new relational and emotional experience: *-I've experienced how good it feels to interact with someone else, on a more personal level...therapy have helped by giving me the experience of sharing...showing, expressing feelings and showing vulnerability.*

Illustrated by a final text-example from years after termination, the client reports continuing to be more open and sharing, now also towards other people than the therapist, and that this is experienced as constructive. *-The most important part has been daring to present more of myself...let people in and being more open...that has borne fruits.*

“Lasting acceptance of «reality»”. This pattern was not suggested from the previous correlational analyses in Ekroll & Rønnestad (2017), but still seemed important when taking a closer look at qualitative material from certain individual clients. It was most evident in 3 cases having maintained effects after treatment. Seen through the lens of our taxonomy (from Ekroll & Rønnestad, 2016), these cases reported *accepting “reality”* (i.e., current situation or past) as an important therapeutic change, both at termination and follow up. They seemed to have achieved a form of enduring acceptance as a result of working through and gaining more understanding, with therapists experienced as supportive. Some text examples follow, from a client showing maintained treatment effects (ID 4). The first quote, from a session evaluation form during therapy, shows the client having some (existential) insights. The client experiences this as making it easier for her to accept and be present in the moment. -

Acknowledging...that some things don't get better. Some things actually break, and then you have to heal according to that. This removes tension and somehow enables living in the moment/situation.

At termination, the client's gained understanding appears to have helped her accept her mothers' illness and her not being able to undo this: *- I'm feeling less guilty about not doing enough. The therapist helped me realize that my (somatically ill) mother has lived a lot longer than me, and that I have my own life as well...I have gotten more used to her being the way she is...*

And finally, from the interview years after termination, the same client expressed herself in ways that suggested that the achieved acceptance had lasted thorough the follow-up period as well: *-I was thinking "if I just do enough, everything will work out". The therapist helped me understand that...I can't make that situation so much...I can't cure her illness.*

“Residual problems grow and overshadow progress”. Residual problems were to some extent linked to post-therapy deterioration in Ekroll & Rønnestad (2017). All clients that showed reliable deterioration after therapy reported presence of some residual problems at termination, in spite of initially improving on OQ-45 (vs. 37,5 % of non-deteriorating clients). For these deteriorating clients, the residual problems seemed to continue or grow during the follow-up period. Even though some positive changes were still reported at follow-up, the clients deteriorating OQ-scores suggests that these were gradually overshadowed by the growing residual problems. It might be of relevance that in 75% of the cases deteriorating (reliably) after termination, either the client or the therapist at some point suggested that therapy had been terminated too early. Below are some text examples from a deteriorating client (ID13) illustrating the current pattern. In the interview at termination of therapy, the client reports feeling some improvement, as she is coping better with her problems. Still, she

is not all “cured”: *-Sometimes I have bad episodes, where I feel worse again. Earlier I would have felt that the world was going under, and that I could dig myself all the way down. I can still have that feeling and struggle, but (now) I manage to move on a little more. I still think it’s hard sometimes, but I challenge myself.*

Later, in her follow-up interview, the client confirms without modifications that she is still struggling. *-Now I feel that I...still struggle with the same. Eh, it feels like maybe I always will, in a way.*

“Core problems remain beneath superficial change”¹. The relevance of this pattern was suggested by the theme “superficial change” being associated with post-therapy deterioration at a group level in Ekroll & Rønnestad (2017). Despite showing improvement on OQ-45 at termination, clients that reported material consistent with their core problems not being solved, destructive patterns persisting, or achieved changes somehow being superficial, tended to deteriorate in the follow-up period. This was clearly evident in 4 cases. These typically reported relatively little material related to *relational aspects* of the therapy process, but rather reported material related to *therapeutic operations* and *inclusion of positive material* as being important during therapy. Furthermore, they often reported *catharsis* and *more positive affect* as important changes. At follow up, these clients typically still applied some tools from therapy, but also reported residual problems related to regulation of affects, self-concept or close interpersonal relations. Qualitatively, the pattern at hand was evident through the mentioned clients describing some deeper problem to persist, despite feeling more positive and/or gaining techniques to handle symptoms. Text examples from a deteriorating client (ID15) follow. During therapy the client reports gaining and holding on to a more positive focus as important: *- (Its been important) to stay on track... to keep focusing on*

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¹ This pattern is somewhat intertwined with the former, but they are initially presented separately.

what's positive...

In the interview at termination, this is explicated, as the same client emphasized a technique she has picked up from a film: - *Inspired by a movie I saw, I started writing a «positive book». When I go to bed, I think through what have been positive during the day. At first it was hard to fill it up, now it's easy.*

In the follow-up interview, the client reports that despite her still managing to think more positively and also ruminating less in the period after therapy, she realizes that a more central maladaptive interpersonal pattern, linked to feeling insecure, still persists: - *I thought I was able to handle things (by ruminating less and thinking more positive), but I see now that I'm not. Because the same pattern persists...I am very good at sabotaging myself...I have an insecurity inside me...in certain situations (when relating with boys) I get desperate and do stupid things...panicking, trying to find out things...doing stupid stuff...then boys think I'm coco, and I get even more desperate.*

Discussion

This study aimed to provide a relatively nuanced, integrated and temporally sensitive picture of how content from our studied therapies might be linked to clients' varying long-term development. We did this by presenting 6 observed patterns re-emerging across cases, suggested as possible developmental pathways towards different long-term outcomes. One of these mainly contains cognitive processes, two are more relational, one describes lasting acceptance, and two deals with therapy apparently resulting in incomplete (i.e. too narrow or too shallow) changes. Our findings both support and extend on processes linked to long-term outcome in earlier studies, like residual problems at termination (Paykel, 2008; Ekroll & Rønnestad, 2017), autonomy (Ulberg et al., 2009), skills applied after termination (Strunk et al., 2007), insight (Høgland et al., 2011) and emotion regulation (DeRubeis, Siegle & Hollon,

2008).

Starting with the pattern entitled “reflective route towards regulation of affects”, this resembles classical therapy processes envisioned in both CBT (DeRubies, Siegle & Hollon, 2008) and mentalization-based treatment (Bateman & Fonagy, 2006), perhaps also touching upon psychodynamic notions of insights and self-analytical function (Falkenström, Grant, Broberg & Sandell, 2007; Høglend et al, 2011). A recent study, suggesting a link between insight and long-term interpersonal functioning to be mediated through increased affective awareness (Høglend et al., 2015), seems especially relevant. Even though content related to *ways of thinking* and *reflection* was not linked to positive post-therapy-development when analyzed at a group level (Ekroll & Rønnestad, 2017), the pattern at hand suggests that for some clients, this could form part of a route towards maintained or growing treatment effects.

The patterns of “Gaining autonomy through a secure holding relationship” and “Opening up as a new relational/emotional experience” share some common features. They both illustrate relational routes, and in a way can both be considered as implying that clients may have experienced some form of corrective emotional experience (see Alexander & French, 1946; Castonguay & Hill, 2012) together with their therapist. Developing autonomy through a supportive relationship with another person might from one vantage point sound paradoxical. However, this perspective has been acknowledged by writers within different theoretical traditions. A conceptual foundation for autonomy and interpersonal relatedness as two cardinal features of human interaction can be found among theoreticians/researchers within an interpersonal theory tradition such as Horowitz, Alden, Wiggins, Pincus (2000), Kiesler (1996) and Leary (1957). The concept of *related individuation* within the family therapy tradition (e.g., Grotevant, 1986; Imamoglu, 2003) articulates both the autonomy and the relatedness aspect of healthy psychological functioning. Within attachment- and developmental theory, authors such as Bowlby (1969, 1988), and later Fonagy,

Gergely and Target (2007), have emphasized similar processes. Furthermore, Killingmo (2005) has highlighted the role of affirmative interventions, supplementing classical interpretation in psychoanalysis. In response to “deficit” pathology, these are suggested to help the client sustain an inner feeling of a strategic “I”, and self-representation as a stable center of reference and agency (Killingmo, 2005).

The latter patterns and related literature suggest that having a safe bond to an important other can provide a context for enhancing a sense of self, and the courage needed for appropriate exploration and expression. Likewise, experiencing an affirmative therapy-relationship that doesn’t break, even though the client is being openly honest and/or assertive, may provide the courage needed to exercise this, both in therapy and eventually in other relationships as well. If the latter is followed through, this may entail a continuing process, with the potential of facilitating further growth as ever more corrective experiences may accumulate.

Also our “Lasting acceptance of «reality»” pattern seems related to gaining of insights (see Castonguay & Hill, 2007), which Høglend et al. (2011) have previously linked to good long-term outcome. Furthermore, this pattern reminds us that an important goal of therapy can be to relate to the world in a more mature and realistic way. The latter overlaps with formulations found in psychoanalytic theory (see Mitchell & Black, 1995), that can be traced back to Freuds’ (1911) concept of the reality principle. It can also be linked to stoic (e.g., Aurelius, 2003) and later existential thoughts of accepting initially meaningless conditions of life (Camus, 1955; Yalom, 1980). The theme of lasting acceptance of «reality» can furthermore be seen as resonating with newer mindfulness-based psychotherapy traditions (e.g., Harris, 2006; Segal, Teasdale & Williams, 2002), that have arrived at an emphasis on acceptance through inspiration from eastern thought traditions. The latter kind of therapy has shown some promise in prevention of relapse after treatment for depression (Ma & Teasdale,

2004).

The final two patterns, “Residual problems grow and overshadow progress” as well as “Core problems remain beneath superficial change” are considered potential routes towards deterioration rather than good long-term outcome. These patterns concern residual problems, and imply that changes have not been broad enough to include all that is relevant, or “deep” enough to reach the core of what is making life difficult. Accordingly, clients showing these patterns often suggested that treatment was terminated too early, and/or that some central problem was not given enough attention. Avoiding important topics or terminating too early rarely seemed to be initiated by our therapists, however. Instead, external circumstances or clients wishes -or whims- were typically reported to cause terminations that were later interpreted as premature. Also avoidance of certain topics mostly seemed to be the clients’ choice. Thus, an important task for therapists wishing to steer clear of such patterns might be to discover whether clients are holding back something of importance, and ensure that clients’ reported improvements are based on broad, deep and salient changes, beyond temporary positive feelings and use of simplistic techniques. In other words, therapists might be advised to strive for therapy to be open and broad enough to address all relevant problems, deep enough to reach to the core, and complete enough that residual symptoms are minimized by termination.

As illustrated so far in this discussion, our suggested pathways contain several themes that are overlapping with known concepts from across different theoretical orientations. If we should go on to consider the relationship between our pathways more closely, both commonalities and differences are interesting. As mentioned, certain similarities can be found across patterns, like two of our suggested pathways towards lasting improvement involving corrective relational processes, and both of the deteriorating pathways involving residual problems. But some theoretically interesting differences could be pointed out as well.

Considering the suggested pathways towards good long-term outcomes, these seem to contain a set of rather diverse themes. They suggest that lasting positive change after psychotherapy might be achieved either through enhanced reflection and regulation of affects, pushing limits or opening more up to gain new experiences within a safe relationship, or through achieving acceptance by “working through” or gaining more understanding. Some patterns even seem to involve processes that might at some level be considered as contrasting each other. While “reflective route towards regulation of affects” involves using reflection to reduce uncontrolled affect, the pattern “Opening up as a new relational/emotional experience” rather suggests that more affect should be allowed to surface. Even though such processes might be subsumed under broader concepts like “integration of affect” (see Solbakken, Hansen & Monsen, 2011), this still suggests that different clients, with different challenges, might gain lasting effects through somewhat different routes. Similarly, while some routes seemed to be closely related to interpersonal experiences in the therapeutic relationship, others seemed to be more about gaining insights or skills. These routes are not necessarily strict opposites, as also gaining insight or skills are achieved in the context of a therapy relationship, but our findings still suggest that relational factors might play different parts in different pathways, acting as a main character in some and more of a facilitator in others.

A theoretically interesting distinction between our two suggested deteriorating pathways is that while the first (Residual problems grow and overshadow progress) can be considered as simply referring to “persistence of illness” (e.g., Paykel, 2008), the second one (Core problems remain beneath superficial change) suggests that achieving some “deeper” forms of changes (like change in regulation of affects, self-concept or interpersonal relationship patterns) might be linked to more lasting outcome than other, more superficial ones (like achieving catharsis, feeling more positive or gaining techniques limited to handling specific symptoms). While the former pattern simply implies that therapy should be continued

until residual problems are minimized, the second one further suggests that qualitative differences of relevance to further post-therapy development might hide behind quantitatively (as indicated by the total score on a standardized outcome measure) similar outcomes at termination. Together, these final pathways attest to the potential importance of therapy both reaching to the core of clients' problems, and being complete enough that residual symptoms are minimized by termination.

Limitations

The design of our study does not allow for confident claims of causality. All we can do is to suggest plausible connections between reported processes, changes and outcome trajectories. Also, the low N of the study limits generalization from the results. Thus, our proposed patterns are to be viewed as some possible pathways, rather than as an exhaustive list of what can be expected across samples. We have initially operationalized improvement and post-therapy-movement using clients' scores on the OQ-45 questionnaire. Using other methods might have resulted in different evaluations of the degree to which different clients are improved at termination and maintain their gains thereafter. Also, as our raw material mainly consists of client reports from open-ended forms and semi-structured interviews, we have trusted clients' ability to recognize and communicate salient material. Other perspectives might have provided different findings. We hope that our inductive and trans/pan-theoretical starting point has reduced the influence of personal assumptions some, but recognize that a complete lack of subjectivity is impossible. We have further dealt with the latter by striving for consensus between several researchers at different levels of the research process, providing transparency through presentation of raw material, and informing about the most involved researchers' backgrounds.

Conclusions

Building on earlier analyses of processes and changes potentially linked to the post-therapy-movement of clients initially responding to naturalistic therapies with experienced therapists, we have suggested 6 developmental pathways to shed light on clients' different long-term outcomes. Four of these, "Reflective route towards regulation of affects", "Gaining autonomy through a secure holding relationship", "Opening up as a new relational/emotional experience", and "Lasting acceptance of «reality»" re-emerged in clients showing maintained treatment effects. Two pathways, entitled "Residual problems grow and overshadow progress", and "Core problems remain beneath superficial change", seemed linked to deterioration after termination of therapy instead. We consider the former pathways as some possible routes towards enduring good outcomes, and the latter as some patterns to avoid when trying to secure that therapy gains will not be only temporary.

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Key Practitioner Message:

- Clients showing improvement at treatment termination differ in further post-therapy development
- “Reflective route towards regulation of affects”, “Gaining autonomy through a secure holding relationship”, “Opening up as a new relational/emotional experience”, and “Lasting acceptance of «reality»” seem to be some pathways leading towards good long-term outcomes.
- Therapy not reaching to the core of clients’ problems, relevant issues being ignored, or failure to minimize residual symptoms by termination of treatment seem linked to deterioration thereafter.

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Appendix. Diagram of process- and change categories from Ekroll & Rønnestad (2016). Each category contains several codes.

Note. White boxes = Categories. Grey boxes = Clusters. *Italic* = “Therapeutic realisations”. **Bold** = levels.