Pathways towards different long-term outcomes after psychotherapy: An explorative mixed methods project

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Summary

Former psychotherapy research has accumulated a large amount of knowledge on short-term outcomes of psychotherapy, and processes of relevance to this. Less is known regarding long-term effects. Relatively few studies have explored what kinds of processes or changes are most relevant for producing outcomes that are maintained years after termination of therapy. Furthermore, results from studies that have actually attempted this seem rather divergent at the moment. As a response to the state of the current knowledge base, the thesis at hand explores factors of potential relevance for long-term outcome, inductively and from a client perspective. Experiences of clients during and after naturalistic psychotherapy with experienced clinicians are explored through a 3-stage mixed methods project, leading up to suggestions of some possible pathways towards different long-term outcomes.

The data used in this thesis were collected from a larger study called "An intensive process-outcome study of the interpersonal aspects of psychotherapy" (Rønnestad, 2009). From this overarching study, 16 to 32 therapies, varying in post-therapy development, were included in the papers making up the thesis. Content (i.e., processes and changes) were extracted from clients' open-ended reports of important aspects during therapy (i.e., session evaluation forms), and semi-structured interviews conducted at treatment termination and follow up 3-4 years later. This material was organized through a taxonomy, in a way that allowed for both qualitative and quantitative descriptions and analyses. Clients' reported content was then seen in relation to their long-term development on a standardized outcome measure (Outcome Questionnaire-45.2 (OQ-45), by Lambert et al., 1996a), up until 4 years after termination of treatment.

In the first stage of this project, processes and changes emphasized by clients showing improvement at treatment termination were explored in a long-term perspective (through session evaluation forms, and interviews at termination and 3-4 years after ending therapy), and organized in a taxonomy. In addition to describing content, the prevalence or frequency of reported meaning units from different codes and categories were explored. The clients as a group appreciated a broad range of different processes and changes. Furthermore, each individual client reported material from within more than half of the categories in our taxonomy, implying that the therapies at hand typically operated through a broad range of intervention strategies. Most clients reported that therapy processes had somehow continued in the follow-up period, and/or that they still carried something (e.g., tools) from therapy with them afterwards. Changes like *more understanding* and *more autonomy* were often still

reported as important, years after termination. Furthermore, reports of *better regulation of affects, changed attitudes, improved interpersonal relations* and *clients benefitting more from others* were more prevalent in interviews at follow-up than earlier.

In the second stage, associations between reports of material from different codes and categories in the taxonomy created in stage 1 and variation in clients' post-therapy development on OQ-45 were explored through regression- and correlational analyses. Reports of material related to relational aspects (e.g., therapeutic alliance and therapists' relational form) were recurrently associated with post-therapy improvement at a group level. Material suggesting that therapy was not experienced as fully completed showed an opposite pattern. More specifically, themes concerning the therapeutic bond and the therapist being active were recurrently linked to positive post-therapy-movement, while reports of more positive affect, treatment effects being experienced as superficial, or some part wanting more therapy was linked to later deterioration after temporary improvement at treatment termination.

In the third and final stage, individual cases were analyzed in a more integrated, and temporally sensitive way, sensitized by findings from the previous stages. Potential developmental patterns re-emerging across cases were identified and explored in light of the OQ-45 trajectories of clients providing them. From this, 6 specific pathways towards different long-term outcomes were suggested. Patterns entitled "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»" reappeared across several cases with maintained treatment effects, while "Residual problems grow and overshadow progress", and "Core problems remain beneath superficial change" reappeared across several clients deteriorating after termination of therapy.

In addition to describing what processes and changes clients initially improving after naturalistic therapy with experienced therapists appreciated, during and after therapy, this thesis suggest some possible associations between such reported qualitative material and long-term outcomes on a standardized measure. The analyses do not allow for strong claims of causation or generalization, but we note that reports of certain forms of processes and changes seemed like better indicators of lasting treatment effects than others. When explicating this in the final stage of the project, 4 developmental patterns reoccurring in clients with good long-term outcome, and 2 reoccurring in patients that deteriorated after therapy, are presented. The former are considered as some possible pathways towards enduring good outcome, while the latter are suggested as patterns to avoid for therapy gains not to be only temporary.

List of papers

Paper 1:

Ekroll, V. B., & Rønnestad, M. H. (2016). Processes and changes experienced by clients during and after naturalistic good-outcome therapies conducted by experienced psychotherapists. *Psychotherapy Research, 27*, 450–468.

Paper 2:

Ekroll, V. B., & Rønnestad, M. H. (2017). Exploring associations between therapy factors and post-therapy development after naturalistic psychotherapies. *Journal of Contemporary Psychotherapy*. https://doi.org/10.1007/s10879-017-9366-7

Paper 3:

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General introduction

Sixty-five years after Eysencks' (1952) infamous critical evaluation of the effectiveness of psychotherapy, a vast majority of studies now concur on the general utility of this practice (see Lambert & Ogles, 2004; Lambert, 2013; Smith & Glass, 1977). After comparisons using various control conditions, including waiting-list, placebo, treatment as usual, and active control, effects of psychological treatments are now generally held to be both statistically reliable and clinically meaningful for clients (Lambert, 2013). Several types of psychotherapy have been found to be effective in relieving clients of various psychological problems (e.g., Barber, Muran, McCarthy & Keefe, 2013; Elliott, Greenberg, Watson, Timulak & Friere, 2013; Hollon & Beck, 2013; Roth & Fonagy, 2005).

The relative importance of different forms of changes and how such changes are produced is still debated, however. At one level, general meta-theories for understanding change are discussed, with medical, somatic or "mechanical" models being contrasted with more humanistic or contextual alternatives (Wampold & Imel, 2015). At another level, different research designs, including randomized controlled trials, have been used to study the effectiveness of different operationalizations or models of psychotherapy in treating psychological problems of various forms. Results of studies addressing the comparative effectiveness of different psychotherapy models have generally indicated that differences between such models account for only a small part of variation in clients' outcomes (e.g., Lambert & Ogles, 2004; Lambert, 2013; Wampold & Imel, 2015). This finding can be interpreted in several ways. The results can be attributed mainly to the importance of common factors being present across different forms of psychotherapy (Hubble, Duncan, & Miller, 1999), to limitations in applied research methodology making it hard to capture potential differences (Kazdin & Bass, 1989; Tolin, 2014), to effects of individual "specific" factors cancelling each other out (Beutler & Harwood, 2000; Blatt & Shahar, 2005), or to some combination of these. One way to shed more light on these issues is to also study psychotherapy processes. At this level, instead of simply comparing the effects of different "treatment packages", the actual content of psychotherapy are studied in a more fine-grained way. This can further be linked with variation in outcome, through process-outcome research.

A vast amount of studies aiming to link processes to outcome has already been conducted, and results from these have been accumulated (see Crits-Christoph, Gibbons & Mukherjee, 2013; Orlinsky, Rønnestad & Willutzki, 2004). Analyses and reviews have concluded that the most robust process-outcome findings link interpersonal aspects of the

therapeutic relationship, and in particular the therapeutic alliance to outcome (Horvath, Del Re, Flückinger & Symonds, 2011; Norcross & Lambert, 2011; Norcross & Wampold, 2011; Orlinsky, Rønnestad & Willutzki, 2004). In general, a significantly larger proportion of variation in client outcome has been attributed to these kinds of variables than to what specific type of psychotherapy method are being used (Lambert & Ogles, 2004; Lambert, 2013;Wampold & Imel, 2015). The latter corresponds with reviews of "dismantling studies", testing the consequences of adding or removing specific technical components of treatments, and attempts to find optimal matches between treatment types and target deficits, concluding that neither have provided many convincing findings so far (Wampold & Imel, 2015).

Especially in recent years, researchers have also attempted to link more "isolated[1]" attributes of the therapist (see Baldwin & Imel, 2013) and client (see Bohart & Wade, 2013) to outcome. Therapists' level of empathy (Elliott, Bohart, Watson, & Greenberg, 2011) and (observer rated) facilitative interpersonal skills (Anderson, Ogles, Patterson, Lambert & Vermeersch, 2009) in general, as well as therapists being psychologically rather than biologically minded in relation to the therapy process (Blatt, Sanislow III, Zuroff, & Pilkonis, 1996) are examples of the former. Clients' motivation, attachment style, access to emotions/experiencing, and therapy preferences (see Bohart & Wade, 2013) are examples of the latter. Also variables like these have been suggested to be more important for variation in outcome than which specific model of psychotherapy are being used (see Bohart & Wade, 2013; Wampold & Imel, 2015).

Former studies have also explored the relationship between "dosage" of psychotherapy and treatment effects. Initially, Howard, Kopta, Krause and Orlinsky (1986) illustrated a stable pattern across studies, showing a positive relationship between number of sessions and improvement, with diminishing returns at higher doses. Their finding of substantial gains early in therapy indicated effects that clearly surpass spontaneous remission rates (Lambert, 2013). Findings like these may tempt policy makers to use time limits as a way to make therapy deliverance more cost-effective. However, one should keep in mind that the findings above are based on aggregated scores. A given proportion of clients showing improvement after a given number of sessions does not indicate that these clients have achieved maximum treatment effects (Howard et al., 1986). Furthermore, Baldwin, Berkeljon, Atkins, Olsen and Nielsen (2009) illustrated that there is a significant degree of individual variation in speed of

[1] In practice these will often be closely related to therapy processes (and therapist attributes needs to somehow influence the client to be important), but they can also been studied more separately, as for instance predictors or moderators of change.

recovery, largely explaining the "diminishing returns" pattern observed at an aggregated level. This corresponds with a notion by Barkham et al. (2006) that it is mainly the clients' rate of change that determines the dose of therapy given (rather than the other way around), with clients typically receiving therapy until they achieve a "good-enough" outcome. A general conclusion from this literature is that uniform time limits do not seem to adequately serve clients' needs (Baldwin et al., 2009; Barkham et al., 2006; Lambert, 2013).

Among the large number of previous studies exploring how treatment type, treatment processes, therapist/client variables, or treatment duration can be linked to outcome, only a minority have included follow-up measures from more than one year after treatment termination. There are some research that can provide information on the general endurance of results achieved in psychotherapy, which for the most part paint a relatively promising picture (see Lambert, 2013), but few studies have more specifically explored potential predictors, moderators or mediators of long-term outcome. Thus, as I will return to, knowledge on factors or processes related to variation in long-term-outcome is still limited.

Also, at the expense of exploring the subjective experience of clients, psychotherapy researchers have often relied exclusively on standardized questionnaires measuring predefined variables, and typically symptoms (e.g., McLeod, 2011). Alternatively, more analyses could have been grounded in what clients emphasize when given the chance to report more openly about their own therapy experiences. There are pros and cons to prioritizing different observational perspectives and methods of assessment, however. Each perspective and assessment methods has its limitations and advantages depending on the research questions asked. Therapists have more theoretical knowledge of psychotherapy than clients, and an outside observer can be more "objective". Still, it has been suggested that it is the client more than the therapist who implements the change process (Altimir et al., 2010; Bergin & Garfield, 1994), and that clients' accounts of therapy processes are often more highly correlated with outcome than accounts from other observational perspectives (Greenberg & Pinsof, 1986; Orlinsky, Rønnestad, & Willutzki, 2004). Furthermore, data from structured questionnaires might be easier to analyse and compare than answers to open-ended questions, but at the same time, the former will also limit the scope of the analysis to variables that are already included in the questionnaire (see Krause, 2015). Regarding an open-ended client perspective, limiting ones observational lens to clients reported experiences implies a risk of missing material outside of clients' focus and awareness, and applying questions with an open-ended response format can make quantitative analyses harder to conduct and interpret. However, the severity of the latter limitations may be abated by findings suggesting that client reports of therapy

processes can be relatively good predictors of outcome (Altimir et al., 2010, Horvath et al. 2011; Greenberg & Pinsof, 1986; Orlinsky, Rønnestad, & Willutzki, 2004), and that a client perspective collected in an open ended response format may be suited to illuminate potential qualitative nuances that might be overlooked in studies focusing exclusively on quantitative scores from fixed-format measures (Nilsson, Svensson, Sandell & Clinton, 2007). It can also be argued that clients' experiences are valuable in themselves, regardless of links with (standardised) outcome. Pleas for more research taking the subjective experience of clients into account have been articulated (e.g., Bohart & Wade, 2013).

The above presentation of the current state of knowledge in psychotherapy research can be interpreted as indicating a need for more studies exploring therapy factors (like processes and different types of changes) in relation to long-term outcome. Furthermore, it also suggests that there are room for studying psychotherapy from a theoretically neutral, open-ended client perspective. Next, a few central concepts, as well as earlier research of specific relevance for the theme of the thesis at hand will be presented in more detail.

Central concepts

Before moving on to a more detailed presentation of findings from earlier psychotherapy research taking an open-ended client perspective, and then factors of potential relevance for variation in long term outcome, some central concepts that reoccur throughout this thesis introduction and the included papers will be clarified shortly.

Changes are understood as any form of impact, intermediate change or outcome being experienced in or after therapy. By *processes* we mean events, activities or therapeutic work of potential relevance for such changes at any level. This operationalization is compatible with the distinction made by Doss (2004) between change processes and change mechanisms, with the former being categorized as processes and the latter as changes in the papers of the present thesis. Next, *Long-term outcome* refers to outcome measured more than one year after termination of therapy. The related concept of *post-therapy-movement* refers to further development or change in outcome taking place after therapy has ended. *Factors* are used when generally referring to any variable, including (but not limited to) process- and change variables, that can be used to predict variation in long-term outcome or post-therapy-movement.

"Outcome" is a contested term in its own right, however. The authors of the included papers acknowledge the existence of several forms of outcome that can be emphasized differently by individual researchers, theorists, society at large, clinicians and clients. In

addition to who is the best informant (client vs. therapist vs. other), one can debate how much weight should initially be given to changes in for instance symptoms, personality structure, interpersonal relations, functioning or reported quality of life. Strupp & Hadley (1977) illustrates how different perspectives on outcome may conflict with each other, for instance by clients feeling good, but not functioning well or not having changed deeper organizing psychological structures. Another possibility is a client having managed to change such a structure, but as a result feel worse, as this might imply less use of reality-distorting defenses (e.g., denial or wishful thinking). Conflicts between perspectives on outcome are thought to be less likely when taking a long-term perspective, when therapists are experienced, and when treatments are not very short, however (Strupp & Haldley, 1977). As all of these conditions are present in the studies of the current thesis, the authors settled on a pragmatic stance regarding the form of outcome used as a dependent variable. By operationalizing this through the (development in) total scores on a rather general outcome measure (OQ-45, tapping into both symptomatic distress, interpersonal relations, and social role functioning) being answered by clients up until 4 years after termination of therapy (with experienced therapists and no restrictions in length), we hoped that our findings would be deemed relevant by most readers. Studies of concurrent validity, showing that the total score on OQ-45 correlates moderately to highly with separate measures of both anxiety, depression, global distress, interpersonal problems and social adjustment supports this assumption (Lambert et al., 1996b). Studies have also shown high intercorrelations between the different subscales of the OQ-45 (Umpress, Lambert, Smart, Barlow & Clouse, 1997). Other pragmatic reasons for choosing to operationalize outcome through the total score on OQ-45 is that it has a defined criterion for reliable change, and that it is widely used. The latter enables comparison with other studies.

Psychotherapy research emphasizing the clients' subjective experience

The backbone of this thesis consists of a content analysis based on open ended reports from clients. Even though it can be argued that such a perspective has been neglected in many later psychotherapy studies, the importance of clients' subjective experiences was early recognized by Carl Rogers. In his classic article on the necessary and sufficient conditions for change, Rogers (1957) explicitly states that the client must perceive, to a minimal degree, the therapist's genuine acceptance and empathy for these conditions to be helpful. Thereby, he validated the client's perspective as a relevant research focus. Within qualitative psychotherapy research, a relatively high proportion of studies do employ an open-ended client perspective (McLeod, 2013). For instance, clients are sometimes invited to reflect

retrospectively on a therapy they have been a part of, through semi-structured interviews. Studies using such procedures have suggested that clients appreciate themes like emotional support and coping (Paulson, Truscott, & Stuart, 1999; Nilsson, Svensson, Sandell & Clinton, 2007), manifestations of new behaviors and emotions (Altimir et al., 2010; Carey et al., 2007), aspects of the therapeutic relationship (Carey et al., 2007; Levitt, Butler & Hill, 2006; Llewelyn, 1988; Paulson, Truscott, & Stuart, 1999), gaining "tools", skills or knowledge (Carey et al., 2007; Paulson, Truscott, & Stuart, 1999; Perren, Godfrey & Rowloand, 2009), forms of relief (Carey et al., 2007; Paulson, Truscott, & Stuart, 1999) and changing thoughts/assumptions (Binder, Holgersen & Nielsen, 2009; Carey et al., 2007). When reviewing similar literature, McLeod (2013) highlights forms of learning that enhance personal agency and acquisition of a benign or wise internal representation of the therapist as central themes. This further resembles the core category being proposed after a qualitative meta-analysis by Levitt, Pomerville & Surace (2016), called "*being known and cared for supports clients' ability to agentically recognize obstructive experiential patterns and address unmet vulnerable needs*". McLeod has also noted that, opposed to some mental health professionals and RCT-researchers, clients often evaluate the success of their therapy through other terms than symptom reduction (McLeod, 2011).

Another form of qualitative psychotherapy studies emphasizing an open-ended client perspective focus on segments of therapy sessions in which a meaningful degree of help or change is being experienced (Elliott, 2010; Elliott & Shapiro, 1988). It has been assumed that these are the moments where most fruitful therapeutic work takes place (Timulak, 2007). Identification of such "significant events" can be used both to probe for therapeutic interactions worthy of further scrutiny and as a way to explore important therapy content across sessions in an efficient way (see Timulak, 2010). For the current thesis, the latter is of most relevance. Former studies doing this have often used small open-ended forms, like the "Helpful Aspects of Therapy" (HAT) form by Llewelyn (1988), to collect samples of salient therapy impacts and events from every session throughout therapy. Earlier research using this procedure have suggested that clients frequently report (and appreciate) forms of reassurance/relief (Booth, Cushway & Newnes, 1997, Llewelyn, 1988), awareness (Castonguay et al., 2010), problem solution (Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozens, 1988), as well as emotional experience and relational impacts (Moreno, Furhiman & Hileman, 1995) as important during therapy. Findings in this area have been collected and synthesized by Timulak (2007), through a qualitative meta-analysis of studies presenting clients' reported impacts of helpful events in psychotherapy. In his analysis, nine core

categories of such therapeutic impacts were identified, each one found to reappear across three or more studies. These are called: (a) awareness/insight/self-understanding; (b) behavioral change/problem solution; (c) empowerment; (d) relief; (e) exploring feelings/emotional experiencing; (f) feeling understood; (g) client involvement; (h) reassurance/support/safety; and (i) personal contact (Timulak, 2007).

The latter findings imply that clients (across studies) may appreciate a broad range of different impacts. The number of categories present within individual studies varies somewhat, however. In addition to simply illustrating what clients report as important, findings like the ones above can also be applied in debates regarding whether there seem to be (at least from a client perspective) many different pathways towards a good treatment outcome, or if a limited set of processes and change mechanisms are sufficient to achieve and understand positive change (see McLeod, 2013). Not all of the studies presented here have linked reports of impacts/changes or events/processes to measures of outcome, however, and few have done this in a long-term perspective.

Research on factors of relevance for long-term outcome

Understanding variation in long-term outcome or further development after termination of therapy is of great importance. Achieving lasting positive changes is of paramount importance from both a social-economic macro perspective and from the perspective of individual clients who wish to maintain gains they have achieved in therapy. Furthermore, enhanced knowledge on this subject may also inform theoretical understanding of change and psychotherapy. Proponents from several psychotherapy traditions have suggested that their orientation could in theory be appropriate for facilitating lasting changes in clients. Psychodynamic therapy might obtain this through for instance structural changes and self-analytic function (see Stäinicke, 2010), cognitive therapy through for instance change in core beliefs and information-processing propensities (Hollon, Stewart & Strunk, 2006), and humanistic therapies through for instance realization of clients inherent potential for growth (Angus et al., 2014). Research on factors of relevance to long-term outcome or variation in further development after termination of therapy have so far been relatively scarce, however. Furthermore, the studies that have been conducted seem to diverge considerably both in form and in conclusions. Still, an attempt to sum up what can be extracted from this literature at the present moment follows. First, research on long-term outcome of different forms of therapy (e.g., Leichsenring et al., 2014) will be presented. Thereafter I will present research on potential predictors or moderators of long-term outcome (see Ludgate, 2009), and finally

processes or mechanisms that might help explain clients differing post-therapy-movement (e.g., Høglend, Dahl, Hersoug, Lorentzen & Perry, 2011).

Forms of Treatment. In some studies, the long-term effects of psychotherapy have been compared to those of pharmacological treatment. A recurrent finding from such studies is that clients to a larger degree tend to maintain treatment gains achieved through psychotherapy than through medication alone (e.g., De Maat, Dekker, Schoevers, & De Jonghe, 2006; Imel, Malterer, McKay & Wampold, 2008). In many of these trials, researchers have compared medical treatments to cognitive behaviour therapy (CBT) for clients with depression. These different forms of treatment often achieve a similar response rate (i.e., number of clients achieving significant symptom reduction) at termination, before clients treated exclusively with medication tend to show a steeper relapse rate thereafter (e.g., Hollon, Stewart & Strunk, 2006). From this, it can be inferred that psychotherapy (in contrast to, or at least to a larger extent than, studied medications) seems able to offer something more than immediate relief of distress.

One can also focus on the absolute direction of clients' further development or movement after termination of therapy. For clients treated with CBT, most reviews conclude that treatment effects on average remain relatively stable (Butler, Chapman, Forman & Beck, 2006). Not everyone agrees with this, however. For instance, Durham et al. (2005) interpret their findings as indicating that the effects of CBT tend to erode away with time. From the psychodynamic tradition, there have been several reports of clients not only maintaining treatment gains, but also continuing to grow after termination of therapy (e.g., Shedler, 2010; Knekt et al., 2008). In their meta-analysis, Town et al. (2012) consider this to be a valid and reliable observation following several trials of psychodynamic treatment. Psychodynamic therapy may not hold a monopoly on post-therapy growth, however. Increasing effect sizes have also been observed after for instance humanistic treatment (see Elliott et al., 2013).

In sum, these studies paint a rather optimistic picture of the long-term effects of psychological treatment, consisted with what is provided in general reviews like Lambert (2013). Still, a lot remains to be learned. First, even though proponents of several schools of therapy have made claims of good long-terms effects, and support for this can be found in empirical studies, there have been few direct long-term comparisons between different forms of psychotherapy. Recently, Kivlighan III et al. (2015) performed a meta-analysis on available studies comparing maintenance of effects after bona fide psychodynamic- vs. other bona fide treatments. They concluded with absence of significant differences, but were only able to

include 3 studies with follow-up periods of 2 years or longer in their analyses. Furthermore, in addition to possible variation between treatment methods, we can expect variation within methods as well. In line with specific methodological aspects typically not being able to account for a large proportion of outcome variance (e.g., Wampold & Imel, 2015), individual clients may show different long-term trajectories, even when given the same form of psychotherapy. Factors of importance for long-term outcome or post-therapy development might not follow established theoretical boundaries in consistent ways. Thus, it seems important to also study other factors besides treatment orientation.

Predictors and Moderators. One of the factors repeatedly found to moderate long-term effects of psychotherapy is clients' type of distress. For example, it seems to be harder to attain lasting changes after treatment of addiction or depression than anxiety (Ludgate, 1998). Furthermore, comorbidity seems to be a relevant factor as well. A high degree of comorbidity, typically through the presence of personality problems in addition to axis-I disorders (e.g., Svanborg, Wistedt, & Svanborg 2008), has been associated with poorer maintenance of treatment effects. Of possible relevance to this, supplying classic CBT with interpersonal and emotional interventions has in some studies been suggested to improve long-term outcome (e.g., Newman et al., 2008). Bell et al., (2013) went on to suggest a general association between added treatment components and the presence of a form of delayed positive "sleeper effect" after therapy. The methodology used in this latter study has later been criticized, however (see Fluckinger, Del Re & Wampold, 2015). Furthermore, also residual problems have been linked to long-term outcome (Ludgate, 1998; Ludgate, 2009). Presence of residual symptoms at termination of therapy has recurrently been found to predict later deterioration (e.g., Fava, Zielezny, Savron & Grandi, 1995; Paykel, 2008). Studies have also associated a higher risk for future episodes of depression (including after therapy) with more previous episodes, as well as more life stressors (e.g., Bockting, Spinhoven, Koeter, Wouters, & Schene, 2006).

Also treatment length has been studied in relation to long-term outcome. Some studies have suggested that longer therapies produce better results in the long run (e.g., Knekt, Lindfors, Sares-Jäske, Virtala & Härkänen, 2013; Lorentzen, Fjeldstad, Ruud & Høglend, 2015). Still, the relationship between treatment length and long-term outcome seem a bit complicated. Some studies suggest that this relationship may further depend on other variables, like the form and strength of clients' distress, frequency of sessions, and what type of treatment is offered (Høglend, 2003; Leichsering & Leibing, 2003; Sandell et al., 2000).

A few studies have also explored potential links between alliance quality and long-term outcome. This has provided few robust findings so far, however. Lindgren, Werbart & Philips (2010) found a negative correlation between alliance and long-term outcome for clients with high levels of symptoms at intake, Durham et al. (2005) found no relationship, while others have initially found a positive relationship, for then to see this disappear when controlling for other variables (Hersoug, Høglend, Gabbard, & Lorentzen, 2013; Weck et al., 2012).

Furthermore, the shape of clients' growth-trajectories has been suggested as a potential predictor of long-term outcome. Tang et al. (2007) found that clients experiencing sudden gains had an increased likelihood of achieving maintained treatment effects. Still, generalizations of this finding are contested. In other samples and studies, different growth-trajectories may predict the best long-term outcomes. For instance, in Rønnestad et al. (2014) a subgroup of the clients showing good long-term outcome were reported to have gone through a period of temporary increase in symptomatic distress, interpreted as a "working through phase", before achieving lasting change. It should be noted that within this latter study, despite the temporary symptomatic increase, clients rated alliances highly throughout their therapies.

Finally, a couple of studies have looked at therapist or client variables in a long term-perspective. Regarding therapist effects, Nissen-Lie et al. (2015) explored the intersection between professional and personal functioning, and found a pattern that can be summarized as therapists "*loving themselves as a person, but doubting themselves as a therapist*" to be related to good long-term outcome on interpersonal measures. Furthermore, also Heinonen, Knekt, Jääskeläinen & Lindfors (2014) found that several aspects of therapists professional and personal self-experiences could predict long-term outcome, some interacting with treatment type. As the specifics of the latter findings are hard to summarize in a short and simple way, interested readers are referred to the original article. More studies have linked client variables to long-term outcome. Client attributes, like dysfunctional beliefs (Ludgate, 2009) as well as level of mastery, self-efficacy or attribution style (Liberman, 1978; Powers, Smits, Whitley, Bystritsky, & Telch, 2008) have been suggested to influence long-term effects and the degree to which achieved changes are maintained after termination. However, instead of thinking that long-term effects are determined in advance by such client attributes, one might consider changing them as a central task of therapy. Thus, these concepts may also be seen as parts of therapy processes or -mechanisms potentially leading towards better or worse post-therapy development and long-term outcomes.

Suggested processes and mechanisms. Former studies discussing potential processes and mechanisms of relevance to understanding differences in long-term outcome and post-therapy development seem to vary quite a lot. They are diverging both in form and conclusions being drawn. In some studies, suggestions are made somewhat speculatively when finding a certain long-term effect after a certain form of therapy. In others, mediation analyses are performed after including process variables in randomized controlled trials. In still others, suggestions are based on qualitative in-depth analyses of single cases. Despite evaluating this research domain as for the moment being somewhat untidy, below I have formulated some themes that can be extracted from the available literature. These can be considered as processes or changes/mechanisms suggested to facilitate good long-term outcome: a) Making the client an active contributor to global changes in and around him/herself, with awareness of future challenges (e.g., Ludgate, 2009); b) Promoting more autonomy/mastery/self-efficacy/internal attributions in clients (Lieberman, 1978; Powers et al., 2008; Ulberg, Høglend, Marble & Sørbye, 2009); c) Clients acquiring general skills that are still used after treatment (Dugas et al., 2010; Ludgate, 2009); d) Clients gaining insights and/or self-analytical function (Falkenström, Grant, Broberg & Sandell, 2007; Høglend et al, 2011); e) Clients learning active (top-down) regulation of emotions (e.g., DeRubies, Siegle & Hollon, 2008). The content of processes and changes or mechanisms proposed in earlier literature range from changing stable structures of clients' personality on the one hand, to teaching clients compensatory skills at the other. To gain a better understanding of what contributes to differences in post-therapy development, more research is needed.

Aims of the present thesis

The overall aim of this thesis is to suggest and describe some possible pathways leading towards different long-term outcomes after psychotherapy. Processes and types of changes reported by clients receiving naturalistic therapy with experienced therapists are explored in a long-term perspective, and linked to development on a structured outcome measure (OQ-45). As advised when studying topics where earlier findings are few or scattered, this is initially done in an inductive fashion (see Elliott & Timulak, 2005; Elo & Kungäs, 2007). Our procedures and analyses can more specifically be separated into 3 stages, each with subsidiary aims. These stages correspond to the 3 different papers that are included in this thesis. The different papers can be seen as building on each other, with earlier papers paving the way for later ones.

Aims of paper 1: ***Processes and changes experienced by clients during and after naturalistic good-outcome therapies conducted by experienced psychotherapists.*** In our first stage, we aimed to explore processes and changes experienced by clients during and after successful naturalistic therapy conducted by experienced psychotherapists. A taxonomy of processes and changes was built and presented, enabling description of salient therapy content reported by our group of clients. As our procedure allowed for quantification of the reported content, we also intended to perform a few simple descriptive analyses, exploring the prevalence/frequency, range, and variation of different classes of content in our sample. The procedures performed at this stage was furthermore intended to enable later exploration of potential links between therapy content and post-therapy development on a structured outcome measure in subsequent stages of the project.

Aims of paper 2: ***Exploring associations between therapy factors and post-therapy development after naturalistic psychotherapies.*** In our second stage, we wanted to explore possible associations between reports of material from different codes and categories in the taxonomy created in stage 1, and variation in clients' post-therapy-development on OQ-45 at a group level. Thus, our purpose was to explore whether classes of material from our taxonomy could act as factors predicting post-therapy-movement, indicating that these may be relevant for understanding more about differences in maintenance of treatment effects achieved at termination.

Aims of paper 3: ***Pathways towards different long-term outcomes after naturalistic psychotherapy.*** In this third and final stage, we aimed to identify some potential developmental pathways leading towards better or worse long-term outcomes for clients initially showing improvement on OQ-45 at treatment termination. We wanted to analyze individual cases in a more fine-grained, integrated and temporally sensitive fashion, sensitized by the (group-level) findings from our previous stages. Following this, we wanted to see whether any developmental patterns re-emerged across cases, and present these in light of the OQ-45 trajectories of clients providing them. In a way, our thesis as a whole can be seen as a 3-stage mixed methods project, leading up to and culminating in this final exploration.

Methods

Overarching psychotherapy research study

The data included in this thesis is collected from a larger psychotherapy research project called “An intensive process-outcome study of the interpersonal aspects of psychotherapy” (Rønnestad, 2009), supported by the Norwegian Research Council and the Department of Psychology, University of Oslo. This project is known for its sample of 18 highly acknowledged and experienced psychotherapists, being studied in naturalistic out-patient settings without restrictions regarding treatment length or form of psychotherapy used. These therapists all have extensive experience as teachers of psychotherapy as well. With this background one may expect that they have acquired theoretical and reflective competence. The therapists vary some in favored theoretical orientation, with many reporting to be influenced by more than one tradition.

A total of 48 clients participated in the overarching study. Clients were recruited from the therapists’ practices. Exclusion criteria were: psychosis, a drug diagnosis, known neuropsychological damage and age below 18. It was ensured that a sufficient number of clients typically considered “difficult to treat” (Lippe, Oddli & Halvorsen, 2014) were included. Informed consent and anonymity for all participants have been secured, and the project is approved by the Norwegian regional ethical review board (REK).

A vast amount of both qualitative and quantitative data was collected from the studied therapies. The data was collected continuously and from different perspectives throughout therapy, and for some measures up until 4 years post-therapy. Measures tapping into both common therapy outcome (featuring both standardized quantitative instruments and qualitative interviews), therapy processes (featuring both a standardized alliance measure and open-ended perceptions on helpful aspects of therapy) and client/therapist background (e.g., reports of target problems and therapists favored orientations) were applied. More specific descriptions of the therapists, clients and instruments being used in the papers included in this thesis follow.

Participants

Clients. Clients included in the papers making up this thesis were selected from within the larger practice-based study of psychotherapy (Rønnestad, 2009) described above. Here, all clients except for one (who was in a public outpatient clinic) were treated in private practice. From the overall sample of 48 clients in the overarching project, those who also met the

following criteria were included in papers 1 and 3 of this thesis: *a)* reliable improvement (measured with OQ-45) at termination of therapy (included clients varied in later post-therapy-movement), and *b)* complete follow-up (3-4 years post-therapy) data available at the initiation of the first study (paper 1). This totaled 16 clients (10 women, mean age 39). Most exclusions were due to follow-up data not being in yet. These clients' average number of sessions was 42.6 (*SD* = 32.7). Their average OQ-45 total score was 66.3 (*SD* = 19.8) at first assessment and 39.5 (*SD* =18.7) at termination, and 45.1 (*SD* =18.3) at follow-up. Depression was the most frequently reported target problem. For paper 2, we were able to add 4 more cases (showing reliable improvement by treatment termination) to be included in explorative correlational analyses. Here, we also conducted a multiple regression analysis featuring 32 cases from the overarching project. In the latter analysis, the reliable improvement criterion (criterion a) was dropped, as we instead controlled for change during therapy in the regression model.

Psychotherapists. Of the 18 psychotherapists in the overarching project, 15 were psychologists and 3 were psychiatrists. Their therapy experience averaged at 30 years. Their mean number of years being a teacher of psychotherapy was 20. Many also had experience of being the therapist for other therapists. As mentioned, the theoretical orientation of therapists varied some, and most indicated that their current practice (all but one in private practice) was moderately to strongly influenced by at least three major theoretical orientations. The three orientations that received the highest mean endorsement on a scale of 0-5 were, in rank order: humanistic/existential, psychoanalytic/dynamic and cognitive, with mean endorsement at 3.3, 3.2, and 3.1 respectively (Rønnestad et al., 2014). In spite of therapists' private practitioner role, they were part of the public health care system with state reimbursement for a substantial proportion of their fees. For clients, this implied that therapy was provided at a low cost. From the overall 18 therapists, 10 were involved in treating the clients selected for papers 1 and 3 in our thesis. The highest mean endorsement ratings for these 10 therapists were: Psychoanalytical/dynamic = 3.5, humanistic/existential= 2.8, and cognitive = 2.7.

Researchers. The first author of the included papers and single author of this thesis introduction 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. At this project started, he had a total of 2.5 years of supervised clinical practice experience with adult clients, where 1 year had 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 on the three included papers 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) (Lambert et al., 1996a). The OQ-45 was used to track the level and development of clinical distress (outcome) 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 (a= .93) and concurrent validity (Lambert et al., 1996b; Umpress, Lambert, Smart, Barlow & Clouse, 1997).

Session evaluation forms. The session evaluation forms were constructed by the research group in the overarching project (see Rønnestad, 2009), inspired by Llewelyns' (1988) Helpful Aspects of Therapy (HAT) form. These forms consisted of two open-ended questions, intended to obtain information on change events/processes and impacts/changes that were experienced and appreciated 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 appreciated 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, the status at the time of the interview, what they found helpful and not in therapy, how experienced changes might have

been related to therapy content, thoughts about the future etc. For 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/not helpful?), but interviewers were allowed to adapt interviews to the individual clients. Interviews were audio-taped. Transcripts of the audio-tapes were used in our analyses.

Data Collection

The session evaluation data was collected by the psychotherapists in the project. They 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. The latter 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/Analyses

Overall, and as described above, this thesis can be considered as a three-stage mixed methods project. It is considered "mixed" as it combines and integrates both quantitative (from OQ-45) and qualitative (from session evaluations and semi-structured interviews) data, as well as both qualitative and quantitative forms of analysis (see Creswell & Plano Clark, 2007).

For the initial construction of a taxonomy of content, through inductive analyses of client reports of processes and changes, we were inspired by elements from grounded theory (Glaser & Strauss, 1967/2006), the significant events paradigm (Timulak, 2010), inductive content analysis (Elo & Kyngas, 2007), and consensual qualitative research (Hill et al., 2005). We write "inspired" by and "elements" since we did not follow a specific recipe. Instead, we made compromises between ideal forms of analyses from the methodological literature, and what made sense to us when wanting to explore long-term effects of psychotherapy in an interesting way, using the data material at our disposal. For example, even though we believe our project can be placed within a grounded theory tradition, already from the start we departed from this methods ideal of "theoretical sampling" (Charmaz, 2006; Glaser & Strauss,

1967/2006). Instead of letting our focus emerge from the analysis and the further sampling process follow thereafter, we started out with a certain theme we wanted to explore and with data that was already collected. In practice, because of the amount of available data of apparent relevance to our focus, we did not find this to be too much of a disadvantage. We also experienced a satisfying degree of "saturation" (i.e., a minimum of new codes needed to be added from the last cases being analyzed) when having analyzed most of our cases, indicating that our sample and material were adequate for the conducted analyses. The significant events paradigm mainly inspired us to use session evaluation material for effective analysis of content from throughout therapy. We were also curious as to whether this could be a useful way of adding to the information obtained through semi-structured interviews, this as a form of triangulation. Inductive content analysis both contributed to our rationale for choosing a bottom-up procedure, as well providing concrete suggestions for how to operationalize such analyses. From consensual qualitative research, we mainly borrowed the use of dialogue between different persons involved in the research process to make decisions and forming interpretations through consensus.

The choice of starting with an inductive analysis of content, instead of relying on some existing taxonomy or coding system, was based on two arguments. First, as the literature on factors of potential relevance for long-term outcome or post-therapy-movement seemed rather scarce and scattered, we thought more inductive exploration could be useful before closing in on specific hypotheses (e.g., Elliott & Timulak, 2005; Elo & Kungäs, 2007). Furthermore, when analyzing the material, we wanted to stay as close to the data (i.e., client reports) as possible, taking an open and "pan-theoretical" stance. We did not want to limit our perspective to variables already defined within a certain established coding system or restrict our analyses to within a given theoretical tradition (see Krause, 2015). We realize, however, that despite these intentions, a completely "neutral" analysis is an unrealistic ideal (e.g., Charmaz, 2006). Still we hope our focus on client reports on open-ended measures, as well as basing decisions on consensus between different researchers/clinicians, and trying to keep an open stance (despite of course carrying some implicit assumptions), have somewhat reduced bias.

At later stages of our project, results of the qualitative analyses providing us with a taxonomy of content is integrated with quantitative material from our standardized outcome measure (OQ-45), and included in quantitative correlational and multiple regression analyses. Some might regard this as a clash of research traditions. But as the authors of the included papers hold an open stance towards both qualitative and quantitative research, we hoped that

this would be mostly enriching. Firstly, we consider the OQ-45 trajectories as general quantitative measures indicating *how much* and in what direction clients have changed at any given time, while assigned codes and categories from our taxonomy can indicate *what forms* of processes and changes are emphasized by different clients. Quotes from the raw material can serve to illustrate qualitative aspects in an even more nuanced and fine-grained way. Secondly, as correlational- and regression analyses are normally deployed within a general linear inferential statistics paradigm (see Tabachnick & Fidell, 2013), we took precautions to limit violations of basic conditions from this. Before conducting quantitative analyses we checked that residual scores were normally distributed, checked for extreme outliers, checked for multicollinearity (in the regression model), created different elements of our taxonomy to be different from other elements at the same level of abstraction, and adapted procedures and interpretations to the risk of type 1 vs. type 2 error that followed from our sample size and number of variables. Procedures and analyses used in each one of our three papers/stages will be explicated in more detail below.

Stage 1. For the first paper included in this thesis, we created a procedure for abstracting, organizing and describing our qualitative data through a taxonomy. This procedure can be summed up in five steps: 1) Identifying relevant meaning units; 2) Constructing codes from meaning units; 3) Organizing codes under categories, clusters and levels; 4) Establishing agreement between coders; 5) Assigning meaning units with final codes.

Initially, the first author and an assistant (a licensed psychologist) together looked through the qualitative raw material for text that could be read as reports of *processes* and/or *changes*, as this was our focus. Every time we came across this, we noted it as a meaning unit, and discussed how it could be abstracted into a code. If material fitted well into any of the codes we had already established, it was ascribed to this, if it did not, we created a new code. In some cases, a given formulation seemed to contain meaning that corresponded to more than one process or change. Using our joint judgment and available contextual information, we decided on what we thought the client was trying to communicate. If we thought that a statement referred to more than one relevant phenomenon (process or change), more than one code were ascribed (or created). As the list of tentative codes grew, overlapping ones were collapsed and codes with incohesive content were split up. At an early stage, changes were made often, but as we worked through more material, the list of suggested codes became more "stable". Towards the end, we experienced a form of saturation, with few new codes emerging

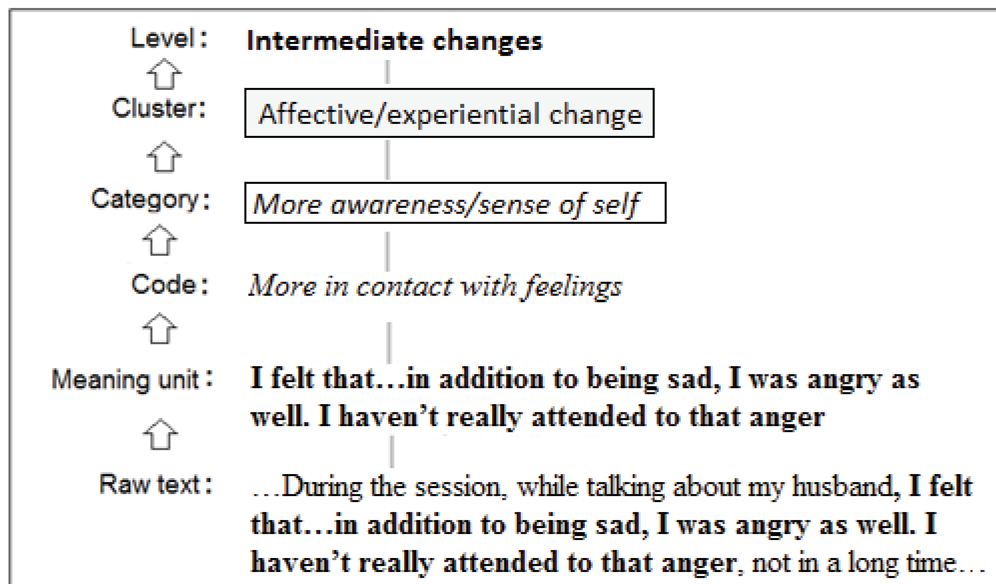
and several meaning units placed under most codes.

The first author and the assistant then started working on suggestions for how to organize the codes under different categories, based on conceptual similarities at a higher level of abstraction. Proposed structures of organization were presented to an auditor (second author on included papers) who challenged the fit between suggested categories, codes, meaning units and raw material. Codes, categories and structure were modified where/when the fit was poor. After having worked through all the raw-material once, with several rounds of restructuring, we arrived at an initial taxonomy of codes and categories. Categories where then sorted into clusters at different levels, based on similarities at even higher levels of abstraction (see Figure 1 for example of how material could be abstracted). Different structures were suggested and discussed among the first author and assistant, with the most promising ones being presented to -and challenged by- the auditor. After this we presented the structure(s) that seemed most promising at this stage to the larger research group from Rønnestad (2009), consisting of therapists and researchers with various backgrounds. They gave feedback on our suggestions, and more moderations were made, followed by testing of fit. We finally settled on a tentative taxonomy.

Thereafter, we tested if level of agreement between the first author and assistant when separately assigning new text-material to categories using this organization was satisfactory. The coders had 81–82% agreement on which words to be included in meaning units, and Kappa values of .76–.80 (which according to Fleiss (1981) is excellent) for agreement on category assignment when coding identical segments separately. After having established agreement, we went over all of the material again, assigning meaning units to final codes/categories (under different clusters and levels) according to our final taxonomy.

This procedure allowed us to organize and describe content (processes and changes reported by clients) from our selected therapies. It also enabled exploration of how prevalently or frequently material from different categories was reported, across assessment levels and cases, using simple descriptive statistics.

Figure 1. Example to illustrate construction and organization of taxonomy.



Note. Higher levels in figure are constructed (bottom-up) from lower levels.

Stage 2. For our second paper, we explored associations between frequency or prevalence of reported material from different codes and categories in our taxonomy[2] and variation in post-therapy-movement measured with OQ-45. We considered doing this through splitting our sample into groups with different post-therapy-movement, but since this variable was continuous, and the splitting that would have made most sense (reliable improvement vs. no reliable change vs. reliable deterioration) would have provided few cases in some of the cells, the sample was instead analyzed as a whole. We also considered a more "qualitative" comparison, noting codes and categories being "typical" for clients with positive post-therapy development and "rare" in clients with negative (and vice versa). However, we concluded that this would basically entail a reduction of nuances in our data (especially for session evaluation data, which otherwise allowed for analyses where both dependent and independent variables were continuous). Thus, we settled for using correlational analyses, holding on to continuous scores where these were available. This procedure also allowed for using an external/neutral/objective threshold when judging levels of association, through demanding that these should be significant at a conventional alpha level. Due to the unconventionality of our data, as well as low *N* and lack of control for third variables in some of the analyses, interpretation of findings had to be done with great caution, however.

[2] A few additional categories excluded from the previous step for not strictly addressing "processes" or "changes" were included as well.

In order to enable quantitative analyses featuring independent variables based on qualitative material, we transformed the latter. When doing this, material from session evaluation forms was quantified to continuous scores representing the proportion (percentage) of total reported meaning units within cases stemming from each code/category. This procedure reduced potential bias caused by different cases varying in total number of sessions, and thereby also number of session reports and extracted meaning units. Material from interviews at termination and follow-up was quantified in a dichotomous manner, so that presence of material from within a code/category in a given interview was coded “1”, while absence of such material was coded “0”. The dependent variable, called “post-therapy-movement”, is a continuous quantitative variable that was calculated by subtracting clients’ OQ-45 score at follow-up from their score at termination (positive value indicate improvement, negative value indicate deterioration).

In the first part of this paper, material from within overarching domains (from paper 1) called “relational aspects” and “therapeutic operations”, together with a variable representing change on OQ-45 during therapy, were entered in a multiple linear regression model predicting post-therapy-movement (alpha-level set at < .05). This analysis featured data from all 32 clients available for the analysis. Rather than using interview data, the independent variables of *relational aspects* and *therapeutic operations* were based exclusively on session evaluation material. We focused on session evaluation data here, as these are continuous, and allow for meaningful aggregation of scores, even when using overarching categories. The *Therapeutic operations* variable was derived directly from paper 1, consisting of the subordinate categories of: *Expert interventions*, *monitoring progress*, *exploration*, *working with affects*, and *other interventions.* The *Relational aspects* variable is based on an overarching process category, consisting of subcategories concerning *relational quality* (as well as the corresponding change category *improved/good relationship*) and *relational form.* The variables to be included in the regression model were chosen to enable a general and theoretically interesting analysis of whether client reports of significant therapy events/impacts related to either aspects of the therapeutic relationship or more technical aspects seemed related to post-therapy-movement on a standardized outcome measure.

The second part of paper 2 is more inductive and explorative. Thus, here the prevalence/frequency of material from all available codes and categories (where at least two cases had scores above zero) was initially assessed for correlation with post-therapy-movement on OQ-45 (as advised by Glaser & Strauss, 1967/2006). Twenty clients showing reliable improvement on OQ-45 at treatment termination as well as having complete

qualitative data available was included in the current analyses. Standard Pearson's *r* correlations (as well as Kendalls Tau for the few variables not having normally distributed residuals) were applied for session evaluation material and Point-Biserial correlations for interview material. In line with a mixed methods procedure described in Creswell & Clark (2007), codes/categories showing significant correlations (alpha level set at < .05) with post-therapy-movement were then chosen for further exploration. These codes and categories were sorted according to their content and whether the correlations were in a positive or negative direction. Associations between post-therapy-movement and codes/categories showing significant correlations in the same direction at several different assessment levels (i.e., session evaluations/interviews at termination/follow-up interviews) or fitting into "themes" with other conceptually similar variables also being significantly correlated in the same direction, were considered less likely to be products of type-I error. As these are seen as potentially relevant for understanding more about variation in post-therapy-movement, such themes were described and illustrated with qualitative material.

Stage 3. After having conducted analyses at a group level in the previous stages, in paper 3 we revisited all the available material from our selected therapies (from stage 1), case by case. We both mapped out what kind of processes and changes (from our taxonomy) individual clients had reported when (i.e., during therapy, immediately following treatment termination, and at 3-4 year follow-up), and explored the sum of qualitative raw material provided by each case, looking for patterns of potential importance for clients' long-term development. In this process, we were also informed by available contextual information regarding clients' target complaints, demographics, work and relationship status etc.

The coding from stage 1 enabled processes and changes reported by individual clients at different assessment points to be mapped out, thereby visualizing potential temporal patterns within cases (i.e., sequences of processes and changes). The first author also re-read all of the qualitative material from the cases at hand, summarizing and noting content that seemed salient for their long-term development. 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 to surface. Extractions of salient content and suggestion of temporal patterns were discussed with fellow-researchers from within the overarching psychotherapy project. Through a procedure resembling ideal type analysis (see Gerhart, 1994; McLeod, 2011), different cases were then compared to each other, in search of similarities and differences. Patterns re-emerging across several cases were noted. An auditor (second author) controlled that these were sufficiently founded in the raw material. These recurrent

patterns were then presented, in light of the group level findings from stage 2 and OQ-45 trajectories of the cases providing them, as possible pathways towards different long-term outcomes.

Findings

Findings from the 3 papers included in this thesis will first be presented individually, before a more general summary of the findings most closely related to the main theme of the thesis is offered.

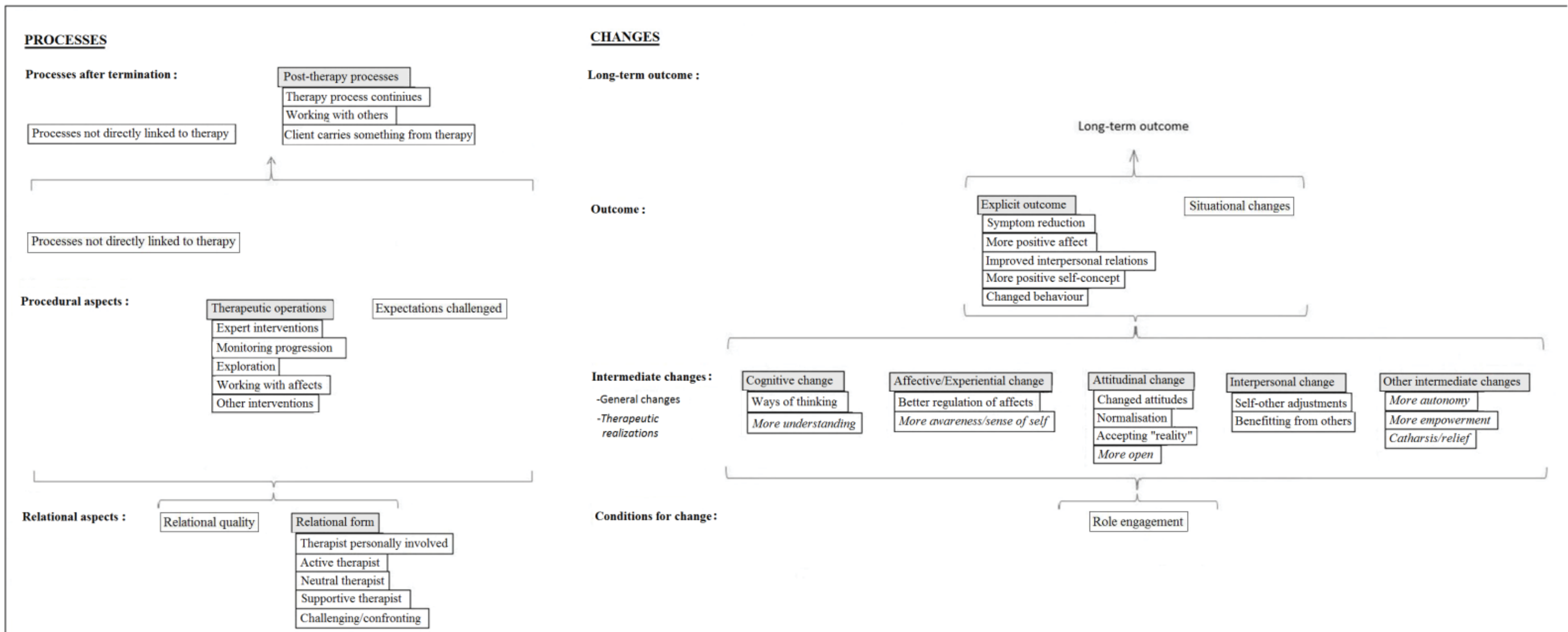
Summary of findings from paper 1

In this study, processes and changes reported by 16 clients showing reliable improvement at treatment termination are extracted from session evaluation forms and interviews conducted at termination and follow up. The extracted material is organized through a tentative taxonomy of processes and changes experienced by clients in naturalistic good-outcome therapy. Emerging categories of processes and changes are illustrated in Figure 2, as they are organized in clusters at different levels.

The content emerging from clients' accounts, amounting to a total of 36 different categories (most containing several codes) and reproducing most themes found in earlier studies, suggests a considerable range in types of processes and changes appreciated by this privileged group of clients. Furthermore, all of our included cases reported material from a rather large share of categories, suggesting that these good outcome naturalistic therapies featuring experienced clinicians typically operated through a broad spectrum of intervention strategies. From the session evaluation forms (during therapy), the most frequently reported processes and changes belonged to categories called *exploration* and *more understanding.* In interviews at termination, material from the process category of *relational quality* and the change categories of *ways of thinking* and *more understanding* were reported most prevalently. In follow-up interviews, *therapy process continues* and *situational changes* were most prevalently emphasized. This indicates that processes and changes related to the categories above were often appreciated by our clients (an overview of frequencies/prevalence of material from different change- and process categories, at different assessment levels, are illustrated in Tables 1 and 2). Furthermore, limited variation between individual therapies suggested a fair amount of similarity in therapeutic processes and changes appreciated across cases, notably within forms of therapeutic operations, categories related to the quality of the

therapeutic bond, as well as a range of therapeutic realizations. Some individualized pathways emerged as well, however, for instance regarding forms of relational stance between therapist and client, attitudinal changes and types of outcome being reported as important.

Figure 2. Diagram with categories of processes and changes reported by clients, organized in clusters at different levels.



Note. White boxes = Categories. Grey boxes = Clusters. *Italic* = "Therapeutic realizations". **Bold** = levels.

Table 1. Prevalence and frequencies (proportional) of processes reported after sessions, at termination and at follow-up.

	After sessions: *Proportion* of total processes in SE-data*		At termination: *Present in proportion of 1. Interviews*		3-4 year follow-up: *Present in proportion of 2. Interviews*	
Category	%	Rank	Present/Total	Rank	Present/Total	Rank
Relational aspects	20.5		16/16		-	
Relational quality	**6.3**	**6**	**11/16**	**1**	**-**	**-**
-Relational form	14.2		16/16		-	
Therapist Personally involved	**1**	**9**	**6/16**	**11**	**-**	**-**
Active therapist	**6.1**	**7**	**9/16**	**5**	**-**	**-**
Neutral therapist	**0.5**	**12**	**9/16**	**5**	**-**	**-**
Supportive therapist	**5.6**	**8**	**10/16**	**3**	**-**	**-**
Challenging/confronting	**1**	**9**	**4/16**	**12**	**-**	**-**
Procedural aspects	63.8		16/16		-	
Expectations challenged	**0.6**	**11**	**9/16**	**5**	**-**	**-**
-Therapeutic operations	63.2		16/16		-	
Therapist as expert	**7.2**	**5**	**10/16**	**3**	**-**	**-**
Monitoring progress	**8.8**	**4**	**1/16**	**13**	**-**	**-**
Other interventions	**10.2**	**3**	**9/16**	**5**	**-**	**-**
Exploration	**28.8**	**1**	**11/16**	**1**	**-**	**-**
Working with affects	**12.9**	**2**	**8/16**	**9**	**-**	**-**
Processes after termination	-		-		16/16	
Processes not link. to ther.[a]	**-**	**-**	**6/16**	**11**	**9/16**	**3**
-Post-therapy processes	-		-		15/16	
Therapy process continues	**-**	**-**	**-**	**-**	**13/16**	**1**
Working with others	**-**	**-**	**-**	**-**	**3/16**	**4**
Carries something from t.[b]	**-**	**-**	**7/16**	**10**	**12/16**	**2**

Note. *Adjusted for variation in amount of processes reported in different therapies. SE = Session evaluation. **Bold** = categories. Sum in first column < 100 as categories outside our focus is excluded. Rank order estimated only for categories, not clusters or levels. [a] = *Processes not directly linked to therapy*. [b] = *Client carries something from therapy*

Table 2. Prevalence and frequencies (proportional) of changes reported after sessions, at termination, and at follow-up.

	After sessions: Proportion* of total impacts in SE-data		At termination: Present in proportion of 1. Interviews		3-4 year follow-up: Present in proportion of 2. Interviews	
Category	%	Rank	Present/Total	Rank	Present/Total	Rank
Improved conditions for change	5.7		10/16		-	
-Role engagement	**5.7**	**6**	**10/16**	**7**	-	-
Intermediate changes	76.3		16/16		16/16	
-Cognitive change	31.4		14/16		14/16	
More understanding	**30.3**	**1**	**12/16**	**1**	**13/16**	**2**
Ways of thinking	**1.1**	**13**	**12/16**	**1**	**6/16**	**11**
-Affective/Experiential change	17.2		10/16		11/16	
More awareness/Sense of self	**17.1**	**2**	**7/16**	**12**	**8/16**	**6**
Better regulation of affects	**0.1**	**16**	**6/16**	**13**	**7/16**	**9**
-Interpersonal change	-		1/16		9/16	
Benefiting from others	-	-	**1/16**	**19**	**6/16**	**11**
Self-other adjustments	-	-	-	-	**3/16**	**15**
-Attitudinal change	6.3		10/16		10/16	
Changed Attitudes	**0.2**	**14**	**3/16**	**17**	**7/16**	**9**
Normalisation	**0.2**	**14**	**2/16**	**18**	**3/16**	**15**
Accepting reality	**1.6**	**11**	**8/16**	**9**	**8/16**	**6**
More open	**4.3**	**7**	**4/16**	**16**	**4/16**	**14**
-Other intermediate changes	21.4		16/16		14/16	
More Autonomy	**8.7**	**3**	**11/16**	**3**	**12/16**	**3**
Empowerment	**6.2**	**5**	**11/16**	**3**	**6/16**	**11**
Catharsis/Relief	**6.5**	**4**	**8/16**	**9**	-	-
Outcome	9.4		16/16		16/16	
Situational changes	-	-	**8/16**	**9**	**15/16**	**1**
-Explicit outcome	9.4		15/16		13/16	
Symptom reduction	**2.8**	**9**	**11/16**	**3**	**9/16**	**5**
Improved interpersonal relations	-	-	**5/16**	**15**	**10/16**	**4**
More positive affect	**1.8**	**10**	**9/16**	**8**	**8/16**	**6**
More positive self-concept	**3.2**	**8**	**11/16**	**3**	**8/16**	**6**
Changed Behaviour	**1.6**	**11**	**6/16**	**13**	**3/16**	**15**

Note. *Adjusted for variation in amount of impacts reported in different therapies. SE = Session evaluation. *Italic* = therapeutic realizations. **Bold** = categories. Sum in first column < 100 as categories outside our focus is excluded. Rank order estimated only for categories, not clusters or levels.

Summary of findings from paper 2

This is a study of possible associations between reported content from our taxonomy and variation in clients' post-therapy-movement on OQ-45. In the first part of the study, material from two overarching themes called *relational aspects* and *therapeutic operations* are included in a regression analysis of data from 32 clients. In the second part, more nuanced associations between material from different change- or process categories and post-therapy-movement are explored using data from 20 clients that show reliable improvement at treatment termination but varies in later development.

The results showed that reports of *Relational aspects*, but not *therapeutic operations*, significantly predicted positive post-therapy-movement in our multiple regression model (see table 3). Furthermore, our correlational analyses indicated clients reporting aspects of the therapeutic alliance and relational form between therapist and client as important, to be unequivocally correlated with post-therapy improvement in our sample. Reports of therapy not being experienced as complete were associated exclusively with post-therapy deterioration. More specifically, variables found to correlate significantly with post-therapy-movement can be seen as mainly converging around a few themes (see table 4). Codes and categories related to the therapeutic bond and the therapist being active were recurrently associated with post-therapy improvement. Codes and categories related to more positive affect, superficial change and need for more therapy were recurrently associated with post-therapy deterioration.

Table 3. Regression model predicting post-therapy-movement from change during therapy, *Relational aspects*, and *Therapeutic operations.*

Predictor Variables	*B*	*SE B*	β	*t*	*P*
Change during therapy	-.440	.173	-.395	-2.549	.017*
Relational aspects	.469	.202	.483	2.326	.027*
Therapeutic operations	.153	.165	.190	.927	.362

Note. Dependent Variable: Post-therapy-movement. * = significant at alpha level < .05. Analysis is based on 32 cases.

Summary of findings from paper 3

Building on the previous content- and correlational analyses, in this study, individual cases was further explored in search for salient developmental patterns. Patterns reemerging across several cases were then described in light of the OQ-45 trajectories of clients providing them, as potential pathways leading towards different long-term outcomes.

Six specific pathways are suggested. “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»” reappear across several cases with positive long-term outcome. “Residual problems grow and overshadow progress”, and “Core problems remain beneath superficial change” reappear across clients deteriorating after therapy. The former pathways are considered as possible routes towards enduring good outcome, and the latter as potential patterns to avoid in order to ensure that therapy gains will not be only temporary.

Table 4: Codes and categories correlated with post-therapy-movement

Session evaluation data				Termination interview data				Follow-up interview data			
Variables	R	M	SD	Variables	R	M	SD	Variables	R	M	SD
Improved/good relationship	+.68	2.49	4.22	**Feeling done with therapy**	+.45	.40	.50	**More of a pleasant emotion**	-.52	.10	.30
Less concerned with				Catharsis	-.51	.35	.49	**Temporary change**	-.47	.20	.41
evaluation from others	+.46	1.22	2.00	***More positive affect***	-.63	.45	.51	**Destructive pattern persists**	-.66	.10	.31
Symptom reduction	+.57	2.77	4.21	**More of a pleasant emotion**	-.62	.15	.37	**Residual problems-affect**			
Less anxiety/unease	+.60	2.46	3.79	Methods fitting with client preferences	+.52	.30	.47	**regulation**	-.52	.10	.31
Ways of thinking	-.46	1.27	2.28	**Building of bond/trust**	+.48	.55	.51	**Core-problem not solved**	-.56	.15	.37
Therapist is active*	+.41	2.78	3.08	***Active therapist***	+.50	.50	.51	**Wish for more treatment**	-.58	.30	.47
Therapist gives explicit praise	+.49	.32	.93	Learning/practicing behaviour	+.56	.10	.31				
(Therapist) sharing of own				Specified interventions	+.46	.25	.44				
experiences	+.53	.11	.35	*Expectations challenged*	+.45	.60	.50				
Expressing affects	-.49	2.85	4.46	**Invitation to contact t. a. termination**	-.48	.45	.51				

Note. Analyses are based on 20 cases. All included correlations are significant at $p < .05$ level. **Bold** = part of recurrent theme. * = Calculated using Kendall's tau. *Italics* = category. "." = text abbreviated. *Symptom reduction* and *Less anxiety/unease* are not considered a recurring theme as these variables are based mainly on the same observations.

Overall summary of most relevant findings

Some findings that seem especially relevant for the main theme of this thesis can be illuminated. At follow up, we found that most clients reported that therapy processes had somehow continued and/or that they had carried something with them from therapy through the period after termination. Furthermore, in addition to many clients reporting *situational changes*, a large share still appreciated changes like *more understanding* and *more autonomy* three years after termination. Also, reports of *better regulation of affects, changed attitudes, improved interpersonal relations* and *clients benefitting more from others* were more prevalent for the period after termination than during therapy. In addition to illustrating that for most of our clients, processes of therapy somehow continued after termination, these findings give some indications as to what forms of changes seem most relevant to clients at follow-up. This is followed by findings indicating that reports of certain relational variables were correlated with positive post-therapy-movement, while indications of therapy somehow not being "complete" at termination were associated with later deterioration. Findings also suggested that reporting *more positive affect* might be a poor indicator of lasting changes. Through more fine-grained, integrated and temporary sensitive analyses of single cases, we specified 6 patterns reoccurring in clients with differing long-term outcomes. Four of these (one containing mainly cognitive aspects, two focused around the therapeutic relationship, and one related to acceptance) are viewed as possible developmental pathways towards lasting change, while two (describing therapy apparently resulting in too narrow or too "shallow" changes) are associated with determination after therapy.

Discussion

This discussion will first attend to findings from the 3 different stages of our mixed methods project in chronological order. From our first stage, findings regarding range and variation in therapy content collected from our clients, as well as forms of content emphasized in the follow-up period will be discussed. From our second stage, I will discuss what kinds of factors seem most relevant for understanding more about variation in post-therapy movement, and how to make sense of this. Then, from our third stage, potential developmental pathways that stood out when analyzing clients initially responding to therapy, but varying in later post-therapy development will be discussed. After that, I will reflect on some methodological questions and limitations. Finally, the findings of most relevance to the main theme of this

thesis will be discussed at a more general level, with suggestions of some possible implications.

Range and variation in processes and changes appreciated by our clients

From paper 1, one can read that our clients as a group appreciated a broad range of processes and changes, and furthermore that each individual client appreciated material from within more than half of the categories in our taxonomy. We have several reasons for interpreting the range of reported material as broad. First, we think that the mere visual impression of our 36 categories as organized in a diagram (see Figure 2) communicates that it is based on a rather comprehensive taxonomy. Keeping in mind that most of the 36 illustrated categories actually contain several codes, each referring to more specific processes and changes within the domains of the visualized categories, underlines this point. The fact that practically every theme being emphasized in reviewed earlier studies (e.g., Carey et al, 2007; Castonguay et al.,2010; Levitt, Butler & Hill, 2006; Llewelyn, 1988; Perren, Godfrey & Rowland, 2009; Timulak, 2007) exploring therapy processes, changes, events or impacts from a client perspective could be recognized in our data, further supports this interpretation. Furthermore, a recent paper on helpful aspects reported by clients in therapies using CBT and metacognitive (MCT) protocols indicates that these clients, especially those receiving MCT, experienced a more narrow range of processes and changes than clients in our study did (see Straarup & Poulsen, 2015).

If positive change in psychotherapy generally can be achieved and sufficiently understood through some certain few specified processes and mechanisms, much of the material appreciated by our good-outcome clients may be considered as redundant. Alternatively, one could trust our clients' ability to understand and report what is of importance for their own change process, and take our findings as support for the notion that theories or models exclusively prioritizing a few highly specified processes and change mechanisms are too narrow to adequately capture what psychotherapeutic change in general is about (e.g., Krause, 2015; McLeod, 2013). To shed more light on this issue, more inductive explorations of what clients receiving controlled and strictly operationalized manualized therapy appreciate when giving open-ended reports of the same kind is welcome. It would also have been interesting to compare our findings with reports from clients receiving naturalistic therapies similar to the ones we studied, only without showing improvement at termination.

When looking at the patterns of variation being displayed by our clients, we found

little variation between cases regarding presence of material from *relational quality* and *therapeutic operations* categories reported during or at termination of therapy. The same goes for *role engagement* and most categories organized at the *intermediate changes* level of our taxonomy (see Figure 2). Material from categories related to *therapeutic operations*, the quality of the therapeutic bond (i.e., *relational quality* and *role engagement*), and most *therapeutic realizations* categories was reported by almost all clients, resembling a pattern to be expected from "common factors". Some variation between cases was observed as well, however, notably within *relational form*-, *attitudinal change*-, and *explicit outcome* categories. When interpreting this, we should keep in mind that exploration of variation was conducted at a category level. As this level of abstraction seems to correspond to Goldfrieds' (1980) level of "clinical strategies", where he suggest common factors are to be found, it was not surprising that a fair amount of our categories were reported across several cases. Alternatively, variation could have been explored at a code-level. This level is probably more similar to Goldfrieds level of "specific techniques". Thus, following Goldfried, we would expect the latter form of analyses to yield more variation and lower prevalence across cases. Due to the large amount of codes, these analyses were not explicitly conducted in our study, however. Furthermore, when looking at raw-text from clients there may be even more layers of variation, with conceptually converging content hiding further qualitative nuances. In theory one could also continue zooming in, finding even more nuances and differences, for instance via tones of voice etc. The point is that arguments around common- vs. specific factors will depend on the level of analyses used. At a very abstract level, much is common, while at a very concrete level, there will be more differences. If one is focusing on the specific nature of how interventions is performed, one would probably find a lot of variation, while a more general focus on therapy principles would provide a picture of more similarity. It might be that some disagreement on how to interpret psychotherapy findings, like whether to attribute finding equality in outcome between methods to either common factors or different but equally effective individual factors, can stem from different researchers focusing at different levels of abstraction.

With the above caveats in mind, we still find it worth mentioning that our clients seemed to vary more with regard to what categories of relational form they reported material from, than what types of therapeutic operations they experienced and appreciated. At a category level of abstraction, all forms of therapeutic operations were reported in most cases, suggesting that all therapists had intervened in relatively similar ways. On the other hand, the variation in reports from relational form categories suggests that all relational aspects cannot

be lumped together as "common factors". Categories directly related to the presence -or building- of a therapeutic bond (i.e., *role engagement* and *relational quality*) acted like common factors, but categories related to relational form did not. This differentiation can be seen as a reminder that there are more to therapeutic relationships than merely how good the alliance or bond is perceived to be. Our findings further suggest that general notions about operational aspects of therapy being "specific" and relational aspects being "common" are too simple (see also Weinberger, 2014).

Processes and changes emphasized in the follow-up period

I will now take a closer look at what processes and changes were appreciated by our clients, and to close in on the main theme of this thesis, the focus will be those that were emphasized after -rather than during- therapy. As can be read from Tables 1 and 2, in the follow-up interviews, continuation of therapy processes, as well as the client "carrying" something from therapy were reported relatively prevalently. This tells us that most of our clients still engaged in some kind of therapeutic work on their own after termination of therapy, by for instance still practicing things learned in therapy or continuing to challenge- or reflect on themselves. This resembles processes emphasized in earlier literature, like attaining "self-analytical function" (e.g., Falkenström, Grant, Broberg & Sandell, 2007) and clients acquiring skills that are still used after treatment (Dugas et al., 2010; Ludgate, 2009).

When it comes to types of changes being appreciated in the follow-up period, material from the categories of *more understanding* and *more autonomy*, in addition to *situational changes*, were reported by many clients. The high prevalence of more understanding suggests that quite a few of our clients have achieved some form of lasting insights. This resonates with earlier research suggesting a link between insight and long-term outcome (Høglend et al, 2011). Also attaining more autonomy has been linked to positive long-term outcome in previous studies (e.g., Ulberg, Høglend, Marble & Sørbye, 2009). Finding that many clients report situational changes after termination of therapy might be a result of the long time span of the follow-up period.

Furthermore, reports of *better regulation of affects, changed attitudes, improved interpersonal relations* and *clients benefitting more from others* were reported more prevalently at follow-up than earlier, suggesting that these may be of specific relevance for post-therapy development. As presented in the introduction, better regulation of affects or emotions is one of the mechanisms that has been linked to positive long-term effects in earlier studies (DeRubeis, Siegle & Hollon, 2008). Furthermore, some of the material under our

changed attitudes category may be considered as indicating changes in rather stable traits, "core beliefs" or even psychological "structures". Also this has been linked to long-term outcome in earlier studies (see Grande, Keller & Rudolf, 2012; Hollon, Stewart & Strunk, 2006). Finally, *improved interpersonal relations* and *clients benefitting more from others* both deal with clients' interpersonal resources after termination. This resonates with a notion by Ludgate (1998; 2009) about the importance of including clients' interpersonal systems to secure that changes are maintained after therapy.

All in all, elements from each of the 5 themes suggested from our review of earlier research on potential processes and mechanisms of relevance to understanding post-therapy-movement can to some degree be recognized in our follow-up material. Reproduction of such themes through inductive analyses of client statements supports their validity. Awareness of future challenges and acquired skills being "general" (see Ludgate, 2009) were not explicitly pronounced in our initial content analysis, however.

Associations between reported material and post-therapy-movement

When we in paper 2 explored associations between post-therapy-movement and material from different codes and categories from our taxonomy, we found that material addressing certain themes recurrently seemed associated with either further growth or deterioration after treatment. At a general level, frequent reports of *relational aspects*, unlike *therapeutic operations,* significantly predicted positive post-therapy-movement. Material from codes and categories related to the therapeutic alliance and relational form, especially therapeutic bond and the therapist being active, were recurrently found to correlate with continued growth after therapy. No relational variables were found to correlate with deterioration after therapy. We must interpret these findings with caution, but taken at face value the results seem to indicate either that there were more relational processes and changes in therapies showing continued growth, that clients in such therapies for some reason emphasized this more than others, or some combination of these.

There has not been much earlier research on the role of relational aspects in post-therapy-movement or long-term outcome. And even though Nissen-Lie et al. (2015) and Heinonen et al. (2014) touches upon related topics, we do not know of any studies exploring the effects of therapist stances, like the therapist being active, in a way similar to ours. A few studies have investigated links between alliance and long-term outcome, however. Lindgren, Werbart & Philips (2010) found a negative correlation for some clients, Durham et al. (2005) found no relationship, and others have found a positive relationship that disappeared when

controlling for other variables (Hersoug, Høglend, Gabbard, & Lorentzen, 2013; Weck et al., 2012). Considering the nature of our design and analyses, we can't rule out that also some of the associations suggested by our data could actually be caused by some third variables. Still, we note a tentative relation between relational factors and post-therapy-movement.

Material from codes and categories related to therapy somehow not being experienced as complete, and especially changes being described as superficial in some ways, were recurrently correlated with post-therapy-deterioration. In a way, reports of this in the follow-up period from clients deteriorating on OQ-45 could simply be viewed as qualitative confirmations of what is observed from the quantitative outcome trajectories. However, even though all clients included in these analyses initially showed improvement on OQ-45, indications of residual problems were present already in the interviews at treatment termination for clients that later deteriorated. This corresponds with earlier studies showing that residual problems at termination can predict later deterioration (e.g., Ludgate, 1998; Ludgate, 2009; Paykel, 2008). Furthermore, the content of the variables "describing" the deterioration may be of importance. Some of these refer to core problems not being solved and destructive patterns persisting, despite the presence of more "superficial" changes. For instance, a representative client reported that despite improvement through being better able to cope with rumination, a maladaptive interpersonal pattern and problems with regulating affects persisted and caused more problems in the follow-up period.

Also clients emphasizing *more positive affect* as a central form of change tended to deteriorate after initially showing improvement on OQ-45 at termination. Even though we surely do not consider achieving positive affect as negative, the observation of this association in our sample may suggest something for therapists and researchers to be aware of, i.e. that reports of positive affect could be an expression of a relatively "superficial" kind of change. Client reports of positive affect may in other words not necessarily indicate that deep and lasting changes have taken place. Alternatively, reports of more positive affect could be considered as mainly referring to changes in temporary mood states rather than in more stable traits. In continuation of this, related qualitative material from our clients seemed to point more towards temporary hedonic rewards, rather than more sustaining eudaimonic happiness (e.g., Waterman, 2007). Furthermore, feeling more positive does not necessarily stem from "objective" indications of changing actual problems, transcending into the outside world. A more positive mood could for instance instead be achieved by replacing reality testing with wishful thinking (e.g., Hollon, Stewart & Strunk, 2006). A more positive mood could also be achieved by selectively focusing on what is positive. The latter could imply restricting ones

affective range, and thereby limiting access to other affects, like anger or sadness, that can be considered as adaptive, appropriate and healthy responses to given situations (e.g., Izzard, 2009). Coping through processes like these can prove counterproductive when trying to battle problems and improve well-being and functioning in a long term perspective (e.g., Oettingen, Mayer & Portnow, 2016).

Potential pathways towards different long-term outcomes

In the final stage of our project (paper 3), we explored developmental patterns re-emerging across cases with different long-term outcomes, after combining the knowledge gained from earlier stages with more in-depth qualitative analyses of single cases. We suggested and described 6 potential pathways. 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»" seemed to lead towards good long-term outcome.

The first of these pathways resembles notions of well-known "cognitive" therapy processes envisioned in both CBT (e.g., Hollon & Beck, 2013) and mentalization-based treatment (Bateman & Fonagy, 2006), perhaps also overlapping somewhat with aspects of self-analytical function (Falkenström, Grant, Broberg & Sandell, 2007). The clients at hand typically described being more able to "take a step back" and avoid losing control in situations triggering affect after treatment, and that this form of regulating affect seemed to have been achieved by learning to reflect (and gain perspective) on the situation and one's own reactions. This also corresponds with neurological explanations of how structures of the limbic system can be regulated (from the "top-down") through connections with the prefrontal cortex (DeRubies, Siegle & Hollon, 2008).

If the first pathway can be viewed as a "cognitive" or "reflective" route towards good long-term outcome, the next two pathways seem to represent more "relational routes". "Gaining autonomy through a secure holding relationship" was typically manifested through clients emphasizing relational aspects and a strong alliance during therapy, followed by reports of improved autonomy after termination, as if the (safe) therapeutic relationship had allowed them to push limits and practice standing up for themselves. At some level, this relationship between communion and autonomy may seem paradoxical. Still, it resembles earlier notions from for instance attachment- (Bowlby 1969, 1988; Fonagy, Gergely & Target, 2007), interpersonal- (Horowitz, Alden, Wiggins & Pincus, 2000; Kiesler, 1996; Leary, 1957) and family therapy (e.g., Grotevant, 1986) traditions. Having a safe bond to an important

other (e.g., the therapist) can provide the courage needed for appropriate exploration and assertion, spilling over to other relationships and situations after termination of therapy. The end product of more autonomy also resembles themes linked to good long-term outcome in earlier studies (e.g., Ulberg, Høglend, Marble & Sørbye, 2009). The second "relational" pathway is called "Opening up as a new relational/emotional experience". This typically unfolded through clients emphasizing how they managed or dared to override interpersonal scripts together with their therapist, opening more up, sharing experiences and gradually becoming less afraid of what the therapist might think of them. Later, similar behavior was reported as easier to practice outside of the therapy room as well. This resembles corrective emotional experiences (Alexander & French, 1946; Castonguay & Hill, 2012) were clients find that contrary to their expectations, it may be both possible, safe and pleasant to share their inner experiences with another, something that later can also be generalized to other relationships. The literature review in the introduction suggests that there is little earlier research linking relational processes like these specifically to long-term outcome.

Our last suggested pathway towards good long-term outcome is called "Lasting acceptance of «reality»". Clients showing this pattern seem to have achieved a form of enduring acceptance of their current situation or past, after having worked through something distressing and/or gained more understanding (typically of an existential kind). This differs from the simple and uncritical positive focus discussed earlier, by attending earnestly and openly to conditions that cannot be changed. Notions of the value of accepting ones basic conditions can be traced back all the way to stoic (e.g., Aurelius, 2003), and later existential (Camus, 1955) philosophy. It can also be recognized in both psychoanalytical (Freud, 1911), existential (Yalom, 1980), and mindfulness based (Harris, 2006) psychotherapy traditions. Therapy within the mindfulness tradition have earlier been suggested to prevent relapse after treatment for depression (Ma & Teasdale, 2004), while as mentioned earlier, research on modernized versions of therapy from the psychoanalytic tradition have suggested that (lasting) insights might be linked to good long-term outcome (Høglend et al., 2011).

Two pathways, "Residual problems grow and overshadow progress", and "Core problems remain beneath superficial change" seemed associated with later deterioration after initial improvement. These are related to therapy somehow not having provided the client with changes that are sufficiently complete, that is broad enough to include everything of relevance or deep enough to reach to the core of what is making life difficult. The first of these pathways depicts clients reporting some residual problems at treatment termination, despite in general showing improvement on OQ-45. Later, through the follow-up period, these

problems seem to grow and overshadow the progress made. This seems to be a relatively straightforward example of residual problems at termination predicting later deterioration through "persistence of illness", as emphasized in earlier literature (Ludgate, 1998; Ludgate, 2009; Paykel, 2008). The second pattern extracted from deteriorating clients also seems related to residual problems, but in a more specific way. This pathway was evident through clients describing some deeper problem to persist, despite feeling more positive, reporting experiences of cathartic relief and/or having acquired techniques to handle symptoms from therapy. They seemed to mainly have achieved "superficial changes" at the expense of more central/general, deep and lasting ones. The types of remaining "core problems" typically being reported involved regulation of affects, negative self-concept or maladaptive interpersonal patterns. An aspect such core problems have in common is that not having addressed them might cause a cascade of further problems, across situations. Techniques that are useful to cope with specific situations or secondary consequences might prove insufficient in the long run if problems that are driving both these and others remain. At some level, this seems related to both an earlier notion of promoting general changes in order to secure a good long-term outcome (Ludgate, 2009), and to the classic debate around symptomatic vs. structural change (see Grande, Keller & Rudolf, 2009; Stupp & Hadley, 1977).

Methodological reflections and limitations

As this thesis is based on a mixed methods procedure, it can be criticized for not adhering to strict methodological standards of either qualitative- or quantitative research. Some claim that methods from different research paradigms can't easily be combined without losing something in the process. Mixed methods research has in general been accused of having a tendency to treat qualitative elements as secondary to quantitative, of not really being a new or unified form of methodology, and not to add anything beyond its constituent parts (see Cresswell, 2011). Our aim has not been to defend mixed methods as a valid separate paradigm, however. Instead, our choice to mix methods was a pragmatic one, as a way to optimally use available material to shed light on the theme of interest to us. Our position is that qualitative and quantitative methods can enrich each other. In this thesis we have emphasized inductive exploration more than strict deductive testing of hypotheses, however. We decided to mainly apply an inductive stance, as there was limited knowledge on the subject of long-term effects from earlier studies, and our goal was not to test a specific theory. This is in line with the logic of theory building in grounded theory (Glaser & Strauss, 1967/2006). Established theories of psychotherapy have mainly been introduced after findings

were described, to contextualize the findings. Such a procedure limits our potential to make causal and general claims, however.

By studying heterogeneous groups of clients receiving non-manualized treatments, and by not including a control group or randomizing clients to different treatment conditions, it is clear that we have given priority to external rather than internal validity. In addition to arguably increasing resemblance to “real world” practice, the study’s loss of “control” can further be seen as a tradeoff for ensuring the possibility to discover a wide range of phenomena. The latter is considered valuable when conducting qualitative analyses (Glaser & Strauss, 1967/2006), but is typically less appreciated within standard quantitative traditions (see Krause, 2015). In classical inferential statistics, less control usually allows for weaker claims of generalizability and causality (e.g. Tabachnick & Fidell, 2013). Other factors limiting the possibilities for making generalizations to outside of our sample includes our *N* being restricted to between 16 and 32 cases in different analyses. Furthermore, even though the heterogeneity in client problems and therapist orientations will probably make our sample somewhat representative of “usual” clinical practice, it will be less so for manualized therapies for specified (and not comorbid) problems, operating with restrictions in therapy duration and content. Also, reactivity -resulting from the research process with both clients and therapists answering forms, being interviewed and being aware of being observed- may have caused our therapies to diverge somewhat from “treatment as ususal”. Halvorsen et al. (2015) suggested that participation in the overarching project at hand had made the therapists more self-conscious, more “obedient”, minding therapy principles more explicitly, and contributed to more reflection.

By taking an inductive and pan-theoretical stance, as well as basing most decisions on consensus between different researchers (who are also therapists), we hope to have reduced the influence of our own personal assumptions some. Still, we do recognize that a complete lack of subjectivity is impossible (e.g., Charmaz, 2006; Mason, 2002). Our solution to this has been to try to ensure transparency (see McLeod, 2011), by both presenting the backgrounds of the main researchers and including illustrations of raw material in all of our papers. This should help readers to consider whether they agree with our interpretations or not.

Furthermore, we have applied a form of triangulation (see Denzin, 1970) by using both interviews and qualitative session evaluation methods for our content analysis. Thereby, we hope to have reduced the limitations of each method. However, as these methods may trigger different forms of client responses, combining them also introduces some uncertainty when interpreting variation across assessment levels. Session evaluation data are based on

clients' assessment of important aspects of individual sessions. These assessments are in a strict sense retrospective, but as the assessments are made immediately following each session, the temporal frame for making the assessment is short. This is different from the more extended temporal frame when client assessments are made during the semi-structured interviews at termination and at follow-up. Here, clients rather base their answers on how they at the moment of the interview consider the therapy or follow-up period as a whole, with the time frame for assessment being considerably longer.

Our choice of basing our analyses on self-reports from clients also has some implications. As mentioned, this limits our focus to what clients are aware of and choose to communicate. For our outcome measures we used a structured and standardized instrument, with several forms of reliability and validity having been confirmed in previous studies. Still, different researchers and clinicians, emphasizing different forms of outcome, might disagree on how relevant results based on this measure are. Furthermore, the data used in our content analysis was not only based on self-report, but also on open-ended measures. Even though this enables a wide range of material to emerge, and is ideal for qualitative analyses, it will lack some properties of standardized questionnaires. One important limitation is that by not asking clients to specifically rate whether content from every code and category was present or not, we must rely on the clients' ability to spontaneously report salient material. This may have influenced the distribution of data featured as independent variables in correlational analyses in paper 2 some, introducing a possibility for codes/categories to be underreported and a somewhat unconventional distribution with a considerable amount of "0" scores as well as relatively large standard deviations. We tested whether residual scores from separate regression analyses of our independent variables (frequency of meaning units from different codes/categories) on our dependent variable (post-therapy-movement on OQ-45) was severely skewed or kurtosed, however, and deployed non-parametric tests (Kendalls' tau) for the few variables where this actually was the case. Still, the unconventionality of some of our quantitative data adds to the argument that interpretations should be done with extra caution, even though inspections of the raw-data/scores from variables included in correlation analyses confirmed that suggested associations seemed to make sense.

Further limitations regarding the correlational analyses of paper 2 is that the simple statistical analyses conducted do not control for third variables (the regression analysis does to some extent) and cannot identify curvilinear relationships or interaction effects between different variables. Furthermore, the combination of relatively low N and a high number of independent variables in the second part of paper 2 implies a risk that some significant

correlations actually represent Type-I errors, and that some variables that are actually related fail to reach significance because of low power (i.e., type-II errors). We were most worried about the risk for Type-I errors. To counter this, we both set our alpha value at a level that is rather strict for an explorative study (< .05), and furthermore restricted our focus to themes based on recurrent correlations featuring predictor variables with similar (when viewed from a higher level of abstraction) content. But again, this analysis only permits us to make tentative suggestions.

Finally, we will repeat here that even though we were inspired by both grounded theory and consensual qualitative research, we did not follow all the procedures specified by such methods. For instance, we did not conduct "theoretical sampling" as prescribed in grounded theory (Glaser & Strauss, 1967/2006), and we did not involve therapy participants (i.e., the therapists or clients being studied) actively in the interpretive process as suggested in consensual qualitative research (Hill et al., 2005).

General discussion and implications

In spite of the limitations presented above, I will still suggest some general implications from the findings in this thesis. But first off, a few overarching themes that recurred throughout the discussion of findings from different stages of the project will be accentuated. A main theme has been whether some forms of processes or changes might be related to more lasting outcome than others. This can be linked to theoretical questions regarding potential differences between achieving change in states vs. change in traits, assimilation vs. accommodation, and (only) symptomatic vs. structural changes in psychotherapy. Also relational and operational processes of therapy have been compared, with indications of the former being more closely related to post-therapy-growth than the latter at a group level. Finally, some potential developmental routes towards good long-term outcome have been suggested and discussed, and levels of completion -including reports of residual problems- have been suggested as potentially related to post-therapy deterioration.

It is natural to expect potential changes in traits to be more enduring than changes in states, as the former by definition refer to characteristics that are relatively stable across time and situations. Some theorists further consider traits as internal properties of persons, that can cause behavior and mood states (see Larsen & Buss, 2008). Similarly, also structural changes can be understood as change in some rather enduring dispositions within clients (e.g., Stäinicke, 2010). Furthermore, similar to the distinction between traits and states, structures can be contrasted with symptoms. While a symptom can be understood as a typical end

product, often an unwanted consequence of something else, a structure can be seen more as an integrated part of a clients' personality, potentially causing problems and symptoms (see Strupp & Hadley, 1977). Changes in structure or traits may further be seem in relation to Jean Piagets' concept of accommodation used to describe psychological change or learning where ones organizing schemas are altered, as opposed to assimilation, where new information is fitted into existing schemas (see Inhelder & Piaget, 1958). Our findings suggesting that reports of feeling more positive affect -as well as absence of changes in core-problems or destructive patterns- were associated with achieving only temporary improvement, suggests a possibility of distinguishing between more lasting and only temporary types of changes. Closer analysis of our cases suggested that in deteriorating clients, initial changes often seemed limited to mood states and isolated symptoms rather than for instance change in capacity for affect-regulation or self-concept. Within these cases there were also examples of attained coping strategies being experienced as helpful yet insufficient to deal with remaining maladaptive interpersonal patterns after therapy. This is in concordance with differentiation between deeper (i.e., changing aspects that are general, causing other problems, not necessarily understood by clients before therapy) and more superficial (i.e., changing states, gaining techniques to handle isolated symptoms) changes, with the deeper ones being associated with more stable positive outcomes, even when measured with an instrument where symptomatic distress forms a central part. Whether one might call the former changes in "traits", "structures", or possibly "accommodation" is up for debate. At least, such changes seem to converge in some respects, and to correspond with certain factors being suggested in earlier research as related to good long-term outcome, like improved capacity for regulation of affects (DeRubies, Siegle & Hollon, 2008), change in self-image (Halvorsen, 2006), gaining insight (Høglend et al., 2011), gaining autonomy (e.g., Ulberg, Høglend, Marble & Sørbye, 2009), and making global or general changes (Ludgate, 1998; Ludgate, 2009).

Another distinction being touched upon in this thesis is one between relational and operational aspects of therapy. Unlike some of the concepts presented above, it is not conceptually implied that these should relate differently to long-term outcome. Empirical investigations may suggest that they actually do, however. Before revisiting this, a clarification is in order. To some extent, we have so far in this thesis treated relational- and operational aspects as separate. In reality, these are probably intertwined in intricate ways. All operational interventions can be viewed as performed in a given relational context, and relational aspects are also likely to be influenced by the more technical interventions that are performed and the changes that are achieved. Furthermore, relational aspects can vary across

treatment forms, so that also these may be conceptualized as "specific interventions". It can be added that some forms of "therapeutic operations" was reported in all our therapies, so a simple stereotype of some therapists "only emphasizing the alliance" was not recognized in our material. Furthermore, our cases varied in reports of certain types of relational aspects, supporting that it does not make sense to simply consider operational aspects as "specific" and relational aspects as "common". When exploring correlations with post-therapy-movement, reports of material from relational codes and categories seemed to be associated exclusively with growth (i.e., never with deterioration) after treatment termination. Operational/procedural- and other change codes/categories showed more diverging patterns of correlation[3] (see Tables 3 & 4). Thus, despite a plausible interconnectedness, it is tempting to associate "deeper" lasting changes more with therapies emphasizing relational aspects, in contrast to therapies were mostly operational elements are emphasized. Some support for this also appeared when analyzing individual cases in our final stage. Forms of corrective emotional experiences related to relational aspects of therapy seemed central in two suggested developmental patterns, based on several cases with good long-term outcomes. Our design and analyses do not allow us to make strong general claims, however. Still, this was an interesting observation, as relational processes or mechanisms seem not to have had a prominent position in earlier literature on what promotes positive long-term effects.

It should be noted that other potential pathways towards lasting change emerged in our material as well. Together, our proposed pathways suggest that lasting positive change might be achieved through either enhanced reflection and regulation of affects, pushing limits or opening more up to gain autonomy or new experiences within a safe relationship, or through achieving acceptance by "working through" or gaining more understanding. Such pathways could also be compared on other parameters besides whether they seem to be mainly "relational" or "operational". For instance, while "reflective route towards regulation of affects" involves using reflection to reduce uncontrolled affect, "Gaining autonomy through a secure holding relationship" and to a certain degree also "Opening up as a new relational/emotional experience" rather seem to be about allowing more (inhibited) affect to surface. Conceptually, these pathways are not necessarily incompatible, however, as they may be united under broader categories like "integration of affect" (see Solbakken, Hansen & Monsen, 2011). Still, they suggest that different clients, with different challenges, might gain lasting effects through somewhat different routes.

[3] As these analyses where conducted at both code and category levels, and at separate assessment points, the findings are not simply explained by restrictions of range.

In general, our findings suggest that limited completion of therapy, including reports of residual problems at termination, may be associated with negative post-therapy development. This has already been discussed in relation to earlier research and the relationship between “core” changes and more superficial ones. One aspect that has not yet been addressed, however, is the relative contribution of the client vs. therapist when falling into potential negative patterns and not achieving sufficient and lasting change. Even though the included papers are not designed to answer this, some hypotheses could be made based on the content of our qualitative material. Judging from the semi-structured interviews at termination and follow-up, clients or practical circumstances often seemed to play a considerable part in either avoidance of addressing certain topics or terminating therapy prematurely. For example, some clients reported holding certain topics back from the therapist, and some reported deciding to end therapy at a time that the therapist suspected to be too early. In still other cases, circumstances beyond the control of the parties involved (like one part having to move to another city) caused premature endings. Thus, if one should judge from the instances available in our sample, the initiative to avoid addressing certain problems or to end before problems were completely worked through for the most part came from clients or outer circumstances. To try to avoid deterioration, an important task of the therapist may therefore be to do what is possible to ensure that clients are sharing everything of importance and that improvements reflect complete, broad, deep and salient (enough) changes that go beyond temporary positive feelings and use of simplistic techniques before terminating therapy.

To sum up, if I am to suggest some implications of this thesis, despite the low *N* and limited knowledge on causality, these can be formulated as follows: On a general level, not all forms of changes or processes appreciated during- or after therapy seem to be equally good indicators of lasting positive outcome. Achieving “deeper” forms of changes and emphasizing relational aspects in therapy can be suggested as factors that might be more likely to be linked with positive development after therapy. Still, there are probably several different pathways that might lead towards good long-term outcomes for individual clients. Some seem to be mainly cognitive, others to be more relational, and still others to involve lasting acceptance. We have by no means provided a finite list of possible pathways, but we have illustrated some that stood out from our material. If I should to try to extract some clinical knowledge (or hypotheses) from our deteriorating cases, this would be that for therapists to reduce the chances of improvement achieved at termination being lost, they are advised to ensure that treatment is: a) open enough to address all relevant problems; b) deep enough to capture the

core of what makes life difficult; and c) complete enough to have minimized residual problems at termination.

In a time where many policymakers are pushing for “effectiveness” through for instance limiting the number of sessions being offered or financed, and restricting available or financed therapy to specific “evidence based” treatment packages, our findings may also be seen as a warning, both against simplifying understandings or operationalizations of therapy to a few highly specified techniques, and standardizing treatment length in ways that enhance the risk of premature terminations. This converges with earlier studies suggesting that uniform time-limits are unfortunate (e.g., Baldwin et al., 2009), specific techniques account for a relatively small proportion of variation in outcome (e.g., Lambert, 2013; Wampold & Imel, 2015), and that residual problems at termination predict later deterioration (e.g., Ludgate, 1998; Ludgate, 2009; Paykel, 2008). Based on the current knowledge situation, I believe that prescribing a narrow therapy focus for large groups of clients is at best premature, and that letting external factors decide treatment length will often prove to be a mistake in the long run.

Concluding remarks

The overall aim of this thesis has been to suggest some possible routes towards different long-term outcomes after psychotherapy. This was gradually explored through 3 stages. First, processes and types of changes appreciated by clients receiving naturalistic therapy with experienced therapists were analyzed in a long-term perspective. Then, associations between reports of material from different codes and categories from the first stage and variation in clients’ post-therapy-movement on OQ-45 were explored. Finally, individual cases were analyzed in a more fine-grained, integrated and temporarily sensitive fashion. Informed by findings from the previous stages, we explored developmental patterns emerging within cases with different post-therapy trajectories. This led to the suggestion of six potential pathways reappearing in clients with different long-term outcomes. “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»” reappeared across several clients with positive long-term outcome, while “Residual problems grow and overshadow progress”, and “Core problems remain beneath superficial change” reappeared across clients deteriorating after initially improving at treatment termination.

Our findings suggest that different types of processes and changes might be more associated with either only temporary or lasting treatment effects. At a group level, relational aspects appear to be especially important for positive development after termination of therapy. Still, there seems be several possible routes towards a good long-term outcome. Furthermore, earlier findings of residual problems at termination being associated with later deterioration could be recognized in our data as well, and we have suggested neglecting "deeper" core problems for more superficial changes as a specific form this can take. Further research, using other methods and/or samples, is needed to allow for more final conclusions.

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