



Change processes underlying “good outcome”: A qualitative study on recovered and improved patients’ experiences in psychotherapy for major depression

Melissa Miléna De Smet, Reitske Meganck, Femke Truijens, Rosa De Geest,
Shana Cornelis, Ufuoma Angelica Norman & Mattias Desmet

To cite this article: Melissa Miléna De Smet, Reitske Meganck, Femke Truijens, Rosa De Geest, Shana Cornelis, Ufuoma Angelica Norman & Mattias Desmet (2020) Change processes underlying “good outcome”: A qualitative study on recovered and improved patients’ experiences in psychotherapy for major depression, *Psychotherapy Research*, 30:7, 948-964, DOI: [10.1080/10503307.2020.1722329](https://doi.org/10.1080/10503307.2020.1722329)

To link to this article: <https://doi.org/10.1080/10503307.2020.1722329>



Published online: 05 Feb 2020.



Submit your article to this journal [↗](#)



Article views: 749



View related articles [↗](#)







View Crossmark data [↗](#)



Citing articles: 4 View citing articles [↗](#)

EMPIRICAL PAPER

Change processes underlying “good outcome”: A qualitative study on recovered and improved patients’ experiences in psychotherapy for major depression

MELISSA MILÉNA DE SMET , REITSKE MEGANCK , FEMKE TRUIJENS ,
ROSA DE GEEST, SHANA CORNELIS, UFUOMA ANGELICA NORMAN, &
MATTIAS DESMET 

Department of Psychoanalysis and Clinical Consulting, Ghent University, Ghent, Belgium

(Received 21 May 2019; revised 15 January 2020; accepted 21 January 2020)

Abstract

Aim: Exploring change processes underlying “good outcome” in psychotherapy for major depression. We examined the perspectives of patients who “recovered” and “improved” (Jacobson & Truax) following time-limited CBT and PDT. **Method:** In the context of an RCT on the treatment of major depression, patients were selected based on their pre–post outcome scores on the BDI-II: we selected 28 patients who recovered and 19 who improved in terms of depressive symptoms. A grounded theory analysis was conducted on post-therapy client change interviews, resulting in an integrative conceptual model. **Results:** According to recovered and improved patients, change follows from an interaction between therapy, therapist, patient, and extra-therapeutic context. Both helping and hindering influences were mentioned within all four influencing factors. Differences between recovered and improved patients point at the role of patients’ agency and patients’ internal and external obstacles. However, patients marked as “improved” described heterogeneous experiences. CBT- and PDT-specific experiences were also observed, although our findings suggest the possible role of therapist-related influences. **Conclusion:** From patients’ perspectives, various change processes underlie “good outcome” that do not necessarily imply an “all good process”. This supports a holistic, multidimensional conceptualization of change processes in psychotherapy and calls for more fine-grained mixed-methods process-outcome research.

Keywords: process research; outcome research; qualitative research methods; cognitive behaviour therapy; psychoanalytic/psychodynamic therapy

Clinical or methodological significance of this article: Clinically, this study offers unique insight into change processes underlying successful outcome from the patients’ point of view. Patients describe how both positive and negative influences related to therapy, therapist, and themselves in relation to the context outside of therapy interact to produce effects. Methodologically, this study presents a large-scale qualitative study in the context of a randomized controlled study, uniquely presenting patients’ perspectives within the widely-used statistical outcome definitions of “good outcome,” “recovery,” and “improvement”.

While an abundance of evidence supports the efficacy of psychotherapy, the processes underlying these beneficial results largely remain a black box (Cuijpers, van Straten, Andersson, & van Oppen, 2008; Cuijpers et al., 2014; Kazdin, 2009). Outcome studies, and Randomized Controlled Trials (RCTs) in particular, are challenged to increase their value for clinical practice (Westen, Novotny, & Thompson-Brenner, 2004), as it is not only important

whether treatment produces good outcome, but also *how* and *why* positive changes come about (Greenberg, 1999; Kazdin, 2009). Some features of the patient (e.g., therapy expectations), the therapist and their interaction (e.g., the therapeutic relationship) have been identified as possible predictors of therapy outcome (Bohart & Wade, 2013; Zilcha-Mano, 2017). Nonetheless, a thorough evidence-based explanation of the mechanisms through

*Correspondence concerning this article should be addressed to Melissa Miléna De Smet, Department of Psychoanalysis and Clinical consulting, Ghent University, Henri Dunantlaan 2, 9000 Gent, Belgium. Email: melissa.desmet@ugent.be

which treatments produce change is lacking (Cuijpers, Reijnders, & Huibers, 2019; Kazdin, 2009). This dearth of knowledge has particularly been signalled with regard to good outcome in the case of major depression. Rottenberg, Devendorf, Kashdan, and Disabato (2018) argue that a dominant perception of depression as a *chronic* mental illness with poor prognosis has limited the attention for high functioning patients. Consequently, the mechanisms of overcoming one of the most prevalent mental conditions worldwide largely remain uncomprehended (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018; Rottenberg et al., 2018).

Studying the mechanisms of change is, however, complicated by the inherent complexity of process-outcome relationships: one influence can have multiple outcomes and similar outcomes can be reached via distinct pathways (Kazdin, 2009; Tryon, 2005). Identifying such potential pathways and gaining insight into complex phenomena like change processes through the use of explorative qualitative research (e.g., Qualitative Helpful Factors Design in order to identify helping and hindering factors; Elliott, 2010; McLeod, 2013) is therefore considered a particularly fruitful starting point. Qualitative analysis allows for the contextualization of research findings within, for instance, patients' daily lived experiences, offering a direct link to clinically meaningful implications of the observed outcome findings. As noted by Rodgers (2003), qualitative inquiry allows grasping the possible reasons *behind* the observed findings and is therefore considered an important enrichment to outcome research, RCTs in particular (Dattilio, Edwards, & Fishman, 2010; Midgley, Ansaldi, & Target, 2014). Moreover, as patients can be considered "the site of change" (Greenberg, 1991, p. 10) rather than the passive recipients of treatment, their perspective on the processes that lead to change is of indispensable value for both research and clinical practice, for example as a means of identifying helping and hindering factors (see Elliott, 2010; McLeod, 2013). A meta-synthesis by Levitt, Pomeroy, and Surace (2016) on patients' experiences with psychotherapy found for instance that, from patients' perspectives, "being known and cared for supports clients' ability to agentically recognize obstructive experiential patterns and address unmet vulnerable needs" (p. 817). These findings suggest the importance of the (professional role of the) therapist, the stimulation of patients' agency and adjustment of interventions to patients' needs as well as discussing differences between patient and therapist. Also, qualitative interviews with satisfied and dissatisfied patients have highlighted therapy-specific experiences, offering suggestions for why some patients

fare better in explorative psychodynamic therapy (PDT) and others value a more directive (CBT) approach (see Nilsson, Svensson, Sandell, & Clinton, 2007). Such insights help to formulate answers to the central question "what works for whom" (and "why"), grounded in patients' perspectives (Elliott, 2010). Generally, qualitative exploration of patients' voices can inform further theory-building and experimental studies on potential operating mechanisms in psychotherapy¹ and hence form an important step in uncovering how and why psychotherapy works (Kazdin, 2009).

In psychotherapy outcome research, whether psychotherapy works for an individual patient is typically expressed in terms of "recovery" or "improvement" (i.e., clinically significant change; Jacobson & Truax, 1991). In the case of major depression, this is predominantly defined in terms of reliable and clinically significant pre-to-post symptom reduction (see De Smet, Meganck, et al., 2020; cf., *infra*).² However, the voices of those patients represented *within* these outcome classifications are only seldomly consulted as a means to gain insight into the change processes that lay beyond "good outcome" findings. However, it is generally assumed that "deterioration" and "a lack of change" are caused by different mechanisms in the case of "poor outcome" (Lambert, 2011), while it remains unclear whether the same applies to the positive end of the outcome continuum. A comparative study on the perspectives of patients showing "good" and "poor" outcome found relevant similarities in patients' experiences of psychotherapy (McElvaney & Timulak, 2013), generally calling for more specified research into the relationship between these outcome classifications on the one hand and patients' underlying experiences on the other.

Therefore, in the present study, we explore the change processes as experienced by patients who show good psychotherapy outcome in an RCT on the treatment of major depression, which is utilized as a representative case (cf., Rottenberg et al., 2018). Relying on the widely used classification by Jacobson and Truax to identify good outcome, we examine the perspectives of those patients who fall within the categories of "recovery" (i.e., reliable change and evolution to the non-clinical range) and "improvement" (i.e., reliable change but remaining in the clinical range) based on self-reported depression symptoms.³ In doing so, the study complements earlier analyses, using the same sample of recovered and improved patients, which focused on patients' perspectives on outcome and experienced changes; the findings are reported in De Smet, Meganck, et al. (2020). It was found that after therapy, recovered and improved patients felt

empowered, found personal balance but also encountered ongoing struggle. From patients' perspectives, "good outcome" thus seemed an *ongoing process*. Variation in experiences was moreover observed, especially among patients showing an improved outcome in symptom scores (i.e., outcome experiences ranged from feeling well to not at all). In order to gain better understanding of the underlying processes leading to change for patients' showing successful outcome, and particularly, how observed variation within patients' experiences might be explained, the present study addresses two additional research questions: (i) what do patients, who show recovered and improved outcome after CBT and PDT for major depression, report as contributions to change? (ii) what differences can be observed between experiences of patients classified as either recovered or improved?

With the first research question, we aim to build onto the line of research looking into patients' experiences of psychotherapy (e.g., helping and hindering aspects; McLeod, 2013). Yet, as change processes are not necessarily exclusively happening within or due to the treatment (Carey, Carey, Mullan, Murray, & Spratt, 2006; De Smet & Meganck, 2018), we expand the focus to include patients' experiences of what occurs outside of therapy as well. The second research question addresses the need for more insight into how standard statistical outcome classifications relate to patients' experiences (cf., De Smet, Meganck, et al., 2020; McElvaney & Timulak, 2013). Finally, as previous findings have identified interesting differences in patients' experiences in more directive (e.g., CBT) and explorative (e.g., PDT) treatments (see Nilsson et al., 2007), also in the present study we will look into the potential role of the type of treatment (i.e., CBT or PDT) in patients' experienced change processes. Ultimately, this study aims to give insight into the *change processes* associated with successful (pre-to-post) RCT outcome findings from patients' perspectives.

Method

Setting

This study is situated within the Ghent Psychotherapy Study (GPS; Meganck et al., 2017), an RCT on the treatment of major depression. The primary hypothesis being tested in the GPS, is the interaction effect between therapy approach (i.e., directive/pre-structured versus explorative) and patients' personality style (i.e., dependent versus self-critical). Particularly, preliminary findings suggest that more directive interventions yield significantly better outcome in dependent depressed patients whilst more explorative

interventions yield significantly better outcome in self-critical depressed patients (e.g., Blatt & Shahar, 2004). In order to test this hypothesis, a pragmatic stratified (dependent and self-critical patients) parallel trial was conducted from 2015 onwards⁴; data collection has been completed and analyses are ongoing (interested readers are referred to the study protocol, Meganck et al., 2017 and Open Science Framework, osf.io/ehsy2).

The main inclusion criterion for participants of the GPS was a diagnosis of Major Depressive Disorder (APA, 2013). Exclusion criteria comprised a primary diagnosis of substance abuse, acute psychosis and suicidal ideations. One hundred patients were randomized to time-limited CBT (i.e., directive therapy condition; $n = 50$) and PDT (i.e., explorative therapy condition; $n = 50$). Patients' progress was evaluated using questionnaires accompanying every therapy session, interviews were conducted prior to treatment, around the eighth therapy session and after treatment termination. The follow-up period of the study spanned two years and consisted of four interviews and quantitative assessments. This trial is registered with the ISRCTN register number ISRCTN17130982. This study was approved by the Ethical Committee of the University Hospital of Ghent University (Belgium; EC/2015/0085). All participants gave written informed consent prior to participating in the study.

Treatment

The treatment provided in the GPS consisted of CBT and PDT for major depression, two types of therapy that can be distinguished based on their directive (i.e., CBT) and explorative (i.e., PDT) style of interventions. Both treatments were manualized and consisted of 16–20 weekly sessions of 45 min. The CBT manual was based on the Cognitive-Behavioural Protocol for Depression (Bockting & Huibers, 2011). The PDT manual was based on the Supportive-Expressive Time Limited manual for Major Depressive Disorder by Luborsky (1984; Leichsenring & Schauenburg, 2014).

Participants

From the one-hundred participants included in the RCT, seventy-four provided complete post data and were thus considered for the current sample selection. All patients showing recovery and improvement on the BDI-II (van der Does, 2002) at treatment termination were selected (i.e., purposeful sample and total population sampling strategy). Patients with a pre-score ≤ 11.3 (i.e., clinical cut-off) and patients

who dropped out (i.e., patient-initiated premature termination of therapy) within four sessions of treatment (in line with Barrett et al., 2008), were excluded ($n = 2$). This resulted in a sample of 28 recovered participants (CBT: $n = 20$; PDT: $n = 8$) and 19 improved patients (CBT: $n = 7$; PDT: $n = 12$).

The recovered sample consisted of 18 women and ten men, ranging in age between 20 and 60 ($M = 33$; $SD = 10.8$). Out of the 28 patients, 17 were employed, four were unemployed and three patients had temporarily interrupted their work due to sick leave. The improved sample consisted of twelve women and seven men, ranging in age between 21 and 61 ($M = 40$; $SD = 12.6$). Out of the nineteen patients, twelve patients indicated they were employed, one patient was unemployed, and one had interrupted work due to sick leave. In both samples, previous treatment consisted of psychotherapy (for 22 recovered and 16 improved patients) and medication (for nine recovered and six improved patients). During the trial, the average number of therapy session was 16 (range 7–20) in the recovered sample and 18 (range 6–20) in the improved sample. All patients had a primary diagnosis of Major Depression Disorder at the start of treatment. Main secondary diagnoses were (as observed in the recovered and improved sample respectively): Anxiety ($n = 6$; $n = 5$), Phobias ($n = 7$; $n = 4$), PTSD ($n = 0$; $n = 4$) and OCD ($n = 1$; $n = 4$).⁵

Therapists

Eight therapists (three men and one woman in each condition) with an average age of 33 ($SD = 9.6$) provided the treatments. At the start of the study, the therapists had three to eight years of relevant clinical experience and training in CBT or PDT. During the study, they additionally received two days of training in the respective manuals, a patient to practice the treatment manual and research procedure under supervision, and bi-weekly supervision sessions. Table I shows the number of patients treated by each therapist in the RCT (i.e., based on the total RCT sample) and in the present study (see participants).

Instruments⁶

Beck Depression Inventory. The Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996; van der Does, 2002) is a measure of self-reported depression severity. The questionnaire consists of 21 items that are scored on a scale of 0–3 and is divided into a cognitive, somatic and affective subscale. The Dutch version of the questionnaire,

BDI-II-NL, shows good validity and reliability (van der Does, 2002).

Semi-structured interview. An adjusted version of the semi-structured Client Change Interview (CCI; Elliott, Slatick, & Urman, 2001) was administered to explore participants' experiences of therapy, the changes that occurred during therapy, and what they believe influenced these changes. Examples of some questions are: "What changes have you noticed since the start of therapy (e.g., in relation to others, at school/work, in your emotional well-being)?" and "How did therapy contribute to these changes?" All interviews were conducted by a research assistant at the university, approximately one week after therapy termination. Interviews were audiotaped for the purpose of verbatim transcription. Transcripts were analysed using Nvivo 11 and 12 (QSR International).

Research Team

The study was led by the first author, who conducted both the quantitative (i.e., sample selection) and qualitative analyses for this study. The second author functioned as an auditor throughout the process; the fourth author was closely involved in data gathering and coding of the narrative material (see qualitative analyses). The first author is an early career researcher, trained in qualitative, mixed methods and quantitative research, and her main expertise is process-outcome research in psychotherapy, depression, and ADHD. The second author and auditor during the analysis, is an associate professor and an experienced researcher trained in quantitative, mixed methods and qualitative research. She was involved in the conception and development of the design of this study and the Ghent Psychotherapy Study. The fourth author is an early career researcher, trained in qualitative and quantitative research, with a main interest in the role of time restrictions in therapy and therapists' experiences. All three researchers are white female (age 28–37), clinical psychologists and psychotherapy researchers, with 3–12 years of clinical experience at the time of the study. The first and fourth author have experience in solution-focused individual and group-therapy (adolescents and adults); the second and fourth author have been additionally trained in psychoanalytic psychotherapy.

Design

In sequential order, a statistical test of clinical significance in measured symptom changes and a

Table I. Number of patients treated per therapist.

	Th1	Th2	Th3	Th4	Th5	Th6	Th7	Th8
Treatment condition	PDT	PDT	PDT	PDT	CBT	CBT	CBT	CBT
Number of patients treated in RCT ^a	6	12	8	8	6	7	15	12
Number of patients treated in this study (recovered/ improved) ^b	3 (1/2)	10 (5/5)	3 (0/3)	4 (2/2)	4 (2/2)	4 (4/0)	8 (6/2)	11 (8/3)

Note. Th = therapist.

^aNumber based on all included patients in the RCT with > 4 sessions of treatment and complete post data ($N = 74$).

^bNumber based on patients included in this study with BDI as outcome measure (see participants; $n = 28$ recovered / $n = 19$ improved).

qualitative analysis of patients' perspectives on change processes were conducted (Figure 1). In accordance with the mainstream primary outcome method (De Los Reyes, Kundey, & Wang, 2011), a psychometrically sound outcome measure was used to determine patients' outcome (see instruments) as primary criterion to select the samples of good outcome patients (see participants). Both quantitative and qualitative data were gathered simultaneously; the main focus of the analyses was patients' experiences as narrated during the interviews (i.e., explanatory or in-depth understanding; cf., Hesse-Biber, 2010). Recovered and improved patients' interviews were studied separately and consecutively in order to investigate patients' experiences within these statistically differentiated outcome groups. In a final stage, an integrative conceptual model was built, based on the analyses of both samples (see qualitative analysis below).

Quantitative Outcome Classification

Patients self-reported symptom severity was measured prior to therapy and one week after

treatment ended and compared to Dutch norms (van der Does, 2002). The Jacobson and Truax (1991) method for outcome classification was used to classify participants in terms of improvement (i.e., reliable change) and recovery (i.e., clinically significant change). In order to reach reliable change for the BDI-II total score, a person must show a decrease in scores equal to or larger than 9.6. The cut-off between the clinical and nonclinical population for the Dutch BDI is set at 11.3 (based on the internal consistency of 0.92; van der Does, 2002). Thus, recovered patients showed a decrease in scores ≥ 9.6 and post-treatment score < 11.3 ; improvement implied a decrease in scores ≥ 9.6 . Additionally, a post-hoc independent samples t-test was conducted to compare the mean depression pre-scores for the recovered and improved group. Table II summarizes the average score on the BDI-II (Beck et al., 1996; van der Does, 2002) pre- and post-therapy in the recovered and improved sample. A statistically significant difference in scores for the recovered ($M = 29.18$, $SD = 7.42$) and improved ($M = 38.52$, $SD = 7.14$) group; $t(45) = -4.30$, $p = .00$ (two-tailed) at the start of treatment indicates that the improved

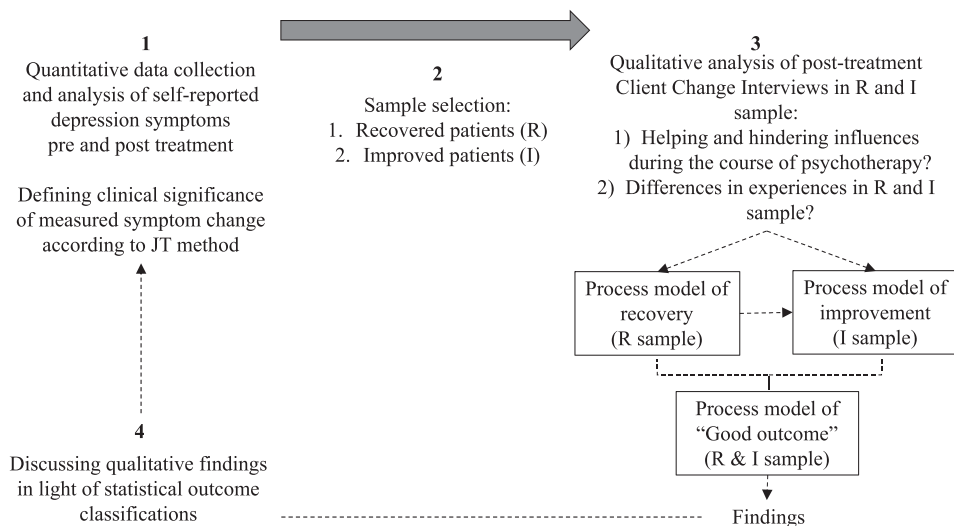


Figure 1. Explanatory sequential design.

Table II. Pre-Post Outcome Scores on the BDI-II: Recovered and Improved Sample.

	Recovered sample						Improved sample					
	Total		CBT		PDT		Total		CBT		PDT	
	(n = 28)		(n = 20)		(n = 8)		(n = 19)		(n = 7)		(n = 12)	
Total scores	M	SD (range)	M	SD (range)	M	SD (range)	M	SD (range)	M	SD (range)	M	SD (range)
Start therapy	29.2	7.4 (16–46)	29.7	7.2 (16–46)	28	7.37 (20–38)	38.5	7 (30–53)	36.3	4.6 (30–45)	39.8	7.6 (30–53)
End therapy	4.7	3 (0–9)	4.5	2.8 (0–9)	5.1	3.30 (0–9)	22.4	7.9 (13–41)	19.7	4.4 (13–22)	24	8.8 (14–36)

Note. Total scores on the BDI-II (van der Does, 2002): 0–13: minimal depression, 14–19: mild depression, 20–28: moderate depression, 29–63 severe depression. RCI: ≥ 9.6 ; clinical cut-off: < 11.3 .

sample scored significantly higher prior to therapy. The magnitude of the differences in the means (mean difference = -9.35 , 95% CI: -13.72 to -4.97) was large (Cohen's $d = 1.28$). At the end of treatment, all recovered patients scored below the clinical cut-off (indicating minimal depression); the improved patients ranged from severely depressed to mildly depressed (resulting in a moderate depression mean score).

Qualitative Analysis

The explorative and interpretative method of grounded theory provided the main principles for the qualitative analysis, as it allows for the construction of new rationales grounded in patients' interview data, which corresponds to our aim of understanding change processes (Charmaz, 2014; Glaser & Strauss, 1987). Analyses were conducted by the first author in dialogue with the fourth author; the second author functioned as auditor throughout the process. A consensual process was applied throughout the phases of analysis, in accordance to a consensual qualitative approach (Hill, Thompson, & Williams, 1997; Hill et al., 2005; see below). The first author selected the samples and interviews corresponding to the sequential explanatory design outlined above (see Figure 1). The second and fourth author were aware of the focus of the study (i.e., good outcome cases and the existence of a recovered and improved sample of patients), but unaware of patients' specific outcome classification (i.e., whether patients belonged to the recovered or improved sample, nor raw BDI-II scores) during the open coding phase of the data analysis. This measure was taken to ensure that the researchers' perspectives remained open to findings contrasting potential pre-existing expectations. From the axial coding phase on (see below), all researchers were conscious of which themes belonged to the recovered or improved group.

Pertaining to the characteristics of grounded theory, several stages of analysis were completed in a cyclic manner before arriving at the final results (Charmaz, 2014). Analyses were first conducted on interviews of the recovered sample; interviews of the improved group were analysed subsequently. Categories were rephrased iteratively, or new ones were created to ensure that particular experiences in both samples were not overlooked. In the final stage of the analyses, central themes of both samples were defined to convey the experiences (see Figure 1). The *open coding phase*, consisted of extensively reading transcripts from patients' interviews to identify relevant parts (i.e., meaning units; Giorgi & Giorgi, 2003) relating to the research questions. This phase resulted in an initial list of codes, formulated with the intent to remain close to the narrative of patients. In the *axial coding phase*, these codes were thematically organized. In both samples, several "influencing factors" (hereafter referred to as "factors") were extracted, referring to the role of therapy, therapist, patient, context and situational aspects. The *selective coding phase*, during which the theory was further refined by assembling the themes in four main factors (i.e., therapy, therapist, patient, and extra-therapy context), resulted in a specification of the different influences, referred to as "change processes" observed within each factor. First, sample-specific subthemes were constructed aiming to grasp the experiences expressed in each sample (see Figure 1). In a next step, the resulting main and subthemes from both samples were strategically compared in order to formulate overarching factors and themes that could grasp the experiences of both the recovered and improved patients (i.e., underlying "good outcome"). Ultimately, a conceptual model (see Figure 2) was constructed, depicting the explicit purpose and findings of the study, i.e., elucidating the processes underlying "good outcome" within the sample of patients classified as "recovered" and

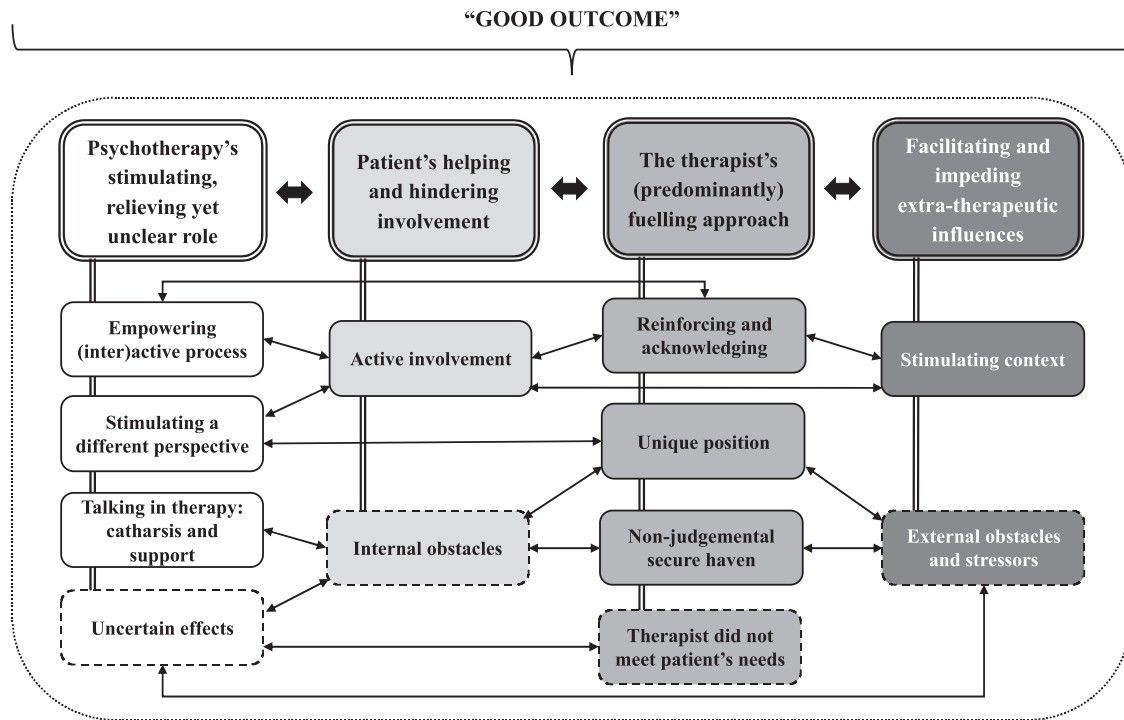


Figure 2. Conceptual model of change processes underlying "good outcome".

Note: The four main factors are depicted on the upside of the figure (i.e., rectangles surrounded by double lines). Change processes are depicted underneath the main factors and indicated by a corresponding tone of colour and connected with a double line. Dotted lines highlight the hindering influences within each factor. Bidirectional arrows show that mutual influences are assumed.

"improved". The results were outlined using illustrative quotes (recovered patients were indicated by numbers 1–28 and improved patients were given the letters A to S to guarantee anonymity). The salience of the resulting factors and change processes (presented in Table II) were indicated by means of the nomenclature proposed by Hill et al. (2005) and criteria for larger samples by Knox, Schlosser, Pruitt, and Hill (2006): General: $\geq 90\%$ of the participants (25–28 and 17–19 recovered and improved patients respectively); Typical: $\geq 50\%$ and $< 90\%$ (14–24 and 10–16 patients); Variant: $\geq 20\%$ and $< 50\%$ (6–13 and 4–9 patients); Rare: $< 20\%$ (1–5 and 1–3 patients).

Credibility checks were held at several stages of data analysis. The research team conducting the analyses was specifically assembled to ensure a balance in terms of familiarity with the interviews, academic and clinical training background and career phase, enabling a horizontal and open dialogue (see research team; Parker, 2007). Potential biases could have resulted from the analysts' academic, theoretical and clinical background. For instance, the researchers are mainly acquainted with psychodynamic theory, which may have guided the interpretation of patients' narratives. This influence was countered by remaining close to patients' own words (i.e., using their own

descriptions) following a grounded theory bottom-up approach, rather than a theoretical interpretation of patients' narratives. An interest in idiosyncratic experience and multi-faceted understanding of psychotherapy and change clearly led the study, and it can be expected that individual differences were more easily observed due to this focus. By making this an explicit aim of the study, consequences of implicit guiding assumptions were precluded as much as possible. Further strategies were applied to ensure own preconceptions were left as side as much as possible (i.e., "bracketing"): focused interviewing strategies were applied in order to elucidate patients' experiences and reflective diary and memo writing (e.g., in Nvivo) helped reflecting on own ideas during the analyses (e.g., own judgements regarding the effects of treatment for a patient). The second author participated as independent researcher (i.e., not involved in conducting and analysing the interviews) and audited the process to actively test assumptions (e.g., perceived differences and similarities between the samples were challenged using critical questions) in a consensual process. Generally, data analyses were guided by a contextual perspective, departing from the assumption that the broader social context influences how patients give meaning to their experiences (Boyatzis, 1998).

Results

The findings of the qualitative analysis are visually presented in the conceptual model in Figure 2. Twelve operating processes resulted from the analyses and were subsequently clustered into four main influencing factors. Recovered and improved patients described: *I. Psychotherapy's stimulating, relieving yet unclear role, II. Patient's helping and hindering involvement, III. The therapist's predominantly fuelling approach, and IV. Facilitating and impeding extra-therapeutic influences.* These factors and underlying change processes must be understood as interconnected and non-mutually exclusive, meaning that all patients mentioned multiple processes operating at the same time. This implies that an interplay of processes facilitated change according to recovered and improved patients' perspectives, showing mutual influences rather than unidirectional causalities (see bidirectional arrows in Figure 2).

Table III presents the taxonomy of the main factors and change processes; they will be further described below. For both the recovered and the improved sample, the salience of the main factors and change processes is indicated with "general", "typical", "variant" or "rare" depending on the number of cases to which they apply (based on Knox et al., 2006).⁷ Making it possible to address both important cross-sample similarities and within-sample particularities. We refer to recovered and improved samples across therapy conditions; when notable differences were observed for patients in CBT and PDT this is mentioned explicitly.

Main Factor I: Psychotherapy's Stimulating, Relieving yet Unclear Role

Four therapy-related processes were described by recovered and improved patients, illustrating that in patients' experience, therapy on the one hand operated via tangible *stimulating* and *relieving* processes, yet on the other hand, the effects of therapy were sometimes also *unclear*. The different therapy processes are described in more detail hereafter.

Therapy stimulates a different perspective in multiple ways. Typically mentioned by both recovered and improved patients, therapy offered insights (e.g., regarding their relationships, past, problems) via the general process of *talking*, therapist's (*specific*) *questions* and *reflection*. It was important for patients to talk openly about their issues, to be asked stimulating questions about them by the therapist on which they then reflected on, in or outside of the therapy sessions. One patient describes gaining insight as follows:

I think especially by actually talking about things, which I don't normally do. I typically form an idea in my head and keep on repeating it in my head, yet never say it out loud. And now, by doing precisely that, I start thinking about it in a different way. (Patient C; PDT; Improved)

Two more specific processes were described, predominantly in the recovered sample and in rare cases by patients who improved. First, therapy typically presented recovered patients with a *confronting mirror*, generally mentioned in PDT and variantly in

Table III. Taxonomy of Change Processes Underlying "Good Outcome".

Change processes clustered into four overarching main factors	Recovered	Improved	*
I: Psychotherapy's stimulating, relieving yet unclear role	General	General	
Therapy stimulates a different perspective via multiple ways:	Typical	Typical	
<i>Insights through talking, specific questions and reflection</i>	Typical	Typical	
<i>A confronting mirror</i>	Typical	Rare	*
<i>Making connections and overviews</i>	Variant	Rare	*
Empowering (inter)active process	Typical	Variant	*
Talking leads to catharsis and gives support	Typical	Variant	*
Uncertain effects: insufficient, combined or unclear process	Typical	Typical	
II: Patients' helping and hindering involvement	Typical	General	*
Active involvement	Typical	Rare	*
Internal obstacles	Variant	Typical	*
III: The therapist's predominantly fuelling approach	General	Typical	*
Acknowledgement and reinforcement	Typical	Variant	*
Non-judgemental secure haven	Variant	Variant	
Unique position as person and professional	Rare	Variant	*
Therapist did not meet the patient's needs	Rare	Variant	*
IV: Facilitating and impeding extra-therapeutic influences	Typical	General	*
Stimulating context	Typical	Typical	
External obstacles or (situational) stressors	Variant	Typical	*

Note. *: highlights the differences between the recovered and improved sample in terms of the salience of the processes (according to Knox et al., 2006).

CBT. Patients stated that the therapist challenged them (e.g., certain preconceptions), which was deemed helpful to realize certain aspects of themselves that they had been unaware of. In that sense, the therapist and therapy were considered necessary to reveal one's blind spots.⁸

Another confrontation I received was like the sixth or seventh time [session] uhm, I sat there like very closed off, [answering] the therapist's questions. And she [said] I was not giving freedom to the process to find something else than the things I already knew. (Patient 5; PDT; Recovered)

Moreover, therapy made patients see certain *connections* between previously diffused elements in their lives, and offered patients with *an overview*, typically for recovered patients, both in CBT and PDT. For instance, patients learned to see connections between their past and current problems (typically in PDT). Like one patient said: "The therapist basically helps you make the connections." Problems were visualized and outlined, and a more coherent story was built. In CBT this visualization was often made explicit via the use of schematic overviews.

An empowering (inter)active process. Therapy was valued for its active nature, as was typically mentioned by recovered patients, and variantly by patients in the improved sample. In CBT (generally) and PDT (typically), patients explained how they were actively involved in therapy (i.e., stimulated by the therapist) or it was considered empowering to take the lead in the therapy process. Especially patients in CBT (in both the recovered and improved sample) valued therapy for being *interactive*. The therapist participated actively and offered concrete tools and guidance.

In my previous treatment it was only action from my side, no response. (...) I need the interaction; therapists need to work *with* me. (Patient 7; CBT; Recovered)

Talking leads to catharsis and gives support. Attention was drawn to the importance of the simple act of talking during therapy, typically mentioned by patients who recovered and variantly by patients who improved. Recovered patients stated that, through talking in therapy, Pandora's box was opened, emotions were set free and patients felt relieved. This effect of therapy was generally mentioned by patients in PDT and variantly by those in CBT.

A lot "came loose". (...) I was completely stuck when I started therapy, I shed a lot of tears in therapy. (...)

I'm less stuck now, things became more disentangled. (Patient 9; PDT; Recovered)

Apart from the relieving effect, improved patients also stated that talking in therapy gave them support (i.e., mentioned variantly), for instance, therapy was valued in terms of "finally" having *the opportunity and space* to talk freely (cf., unique position of the therapist): "It was important just to have someone to talk about it with every week, a sort of sounding board." (Patient F; PDT; Improved).

Uncertain effects: insufficient, combined or unclear process. Despite the aforementioned positive effects of therapy, negative experiences were also voiced. In both samples, patients variantly expressed disappointment. For instance, CBT was experienced as too superficial (e.g., only focused on the present), PDT was seen as offering too little guidance (e.g., missing concrete tools) or overall, sessions were experienced as being too short, too repetitive or "just talking". In the improved sample, patients variantly stated they were not sure how therapy had helped, describing a rather subtle process (e.g., "I feel therapy has helped, just no idea how"), most often in PDT (i.e., variantly versus rarely in CBT). Also, patients stated therapy had a rather variable impact, as formulated by one patient: "sometimes it's about relevant things, sometimes it isn't, and you can only gain from those relevant things." (Patient I; PDT; Improved).

Both recovered (typically) and improved (variantly) patients indicated that therapy helped *in combination with other factors*. For instance, doing sports or yoga, taking time for oneself (e.g., during sick leave) and medication: "What lead to success for me personally, was a combination of things: psychotherapy, the psychiatrist and medication." (Patient 10; CBT; Recovered). Also, situational changes (e.g., finding a new partner; a new job; cf., extra-therapeutic influences) were mentioned as the main reasons for improvement, regardless of the effect of therapy: "It's not really therapy that helped me. (...) especially the situation I'm in improved." (Patient 20; CBT; Recovered).

Main Factor II: Patients' Helping and Hindering Involvement

Patients also reflected on their own role in the therapy and change process. This was characterized by *active involvement* (i.e., in the therapy and change process) and by hindering *internal obstacles*. As mentioned above, patients first of all felt actively involved in therapy (cf., (inter)active process). Second, and

typically for recovered patients, an active position was reflected in the undertaking of other helping actions outside of therapy, for instance, doing sports, taking courses, deciding to take a break from work, which actively contributed to their own improvement (see combined effect of therapy, *supra*). This was only rarely the case for patients who were classified as “improved”.

The therapist did not give me assignments, but during the sessions, you start making your own tasks, like you arrive at the point: what am I going to do with this [i.e., what is discussed in therapy]. (Patient 26; CBT; Recovered)

However, patients were also hindered by *internal obstacles*. For instance, patients were convinced that it was impossible to change (e.g., the belief that problems are fundamental in nature), which was found variantly in recovered cases and typically for improved patients. Also, both the recovered and improved sample, variantly stated they had been unable to fully engage in therapy (e.g., difficulties with opening up), which was seen as hindering the therapy and change process. For instance, one patient stated: “I don’t really have time to participate in something like this [therapy].”

Main Factor III: The Therapist’s Predominantly Fuelling Approach

Although the role of the therapy and therapist are clearly intertwined, the person of the therapist was mentioned explicitly with regard to three benevolent processes. First, typically mentioned by recovered patients and variantly by patients who improved, the therapist was attributed the role of *acknowledging* one’s suffering and *reinforcing* one’s growth, which was experienced as empowering (together with therapy as an (inter)active process)

The therapist could tell me at times, “that’s not just nothing you’ve been through there, that’s a lot to bear” and yeah I thought indeed, perhaps, I never realized how heavy that was, and the therapist was able to put it into words. (Patient 27; CBT; Recovered)

Variantly in both samples, patients valued that the therapist *did not judge*, which allowed them to speak openly and show their true self. This *safe haven* in turn seemed to set the right condition for engaging in therapy (e.g., to be able to offer patients a confronting mirror).

[The therapist] could look at the situation in a neutral way, like telling me “it just happened, whether it was a good or bad thing, there are other lessons to be

drawn from it than feeling guilty”. (...) I really needed to hear that. (Patient 21; CBT; Recovered)

Moreover, the therapist was described as being in a *unique position*, variantly mentioned by the improved patients, yet only rarely stated by recovered patients. For instance, the therapist was that one person who (finally) understood them, or the therapist as “a professional” was differentiated from normal social relationships. However, in contrast was the unclear or sometimes disappointing effect of therapy, *therapists were not always able to meet patients’ needs* (rarely mentioned by recovered patients; variantly the case for improved patients). For instance, one patient said the therapist came across as inexperienced: “It was like she did not always know what to do with me.” Others did not fully understand a therapist’s opinion, had difficulty with the therapist’s approach (e.g., abrupt ending of the sessions when “the time was up”), or generally expected more from their therapist.

Main Factor IV: Facilitating and Impeding Extra-therapeutic Influences

Finally, patients in both samples talked about influences outside of the therapy room, again characterized by positive and negative aspects. *External obstacles or stressful circumstances* were seen as hindering to therapy, or as influencing patients’ current mood (i.e., post-therapy)—typically mentioned by patients in the improved sample (typically in PDT and variantly in CBT). For instance, arguments with family members, employment uncertainty, chronic illness, or divorce, were ongoing during treatment and complicated the therapy and recovery process. Similar difficulties were variantly mentioned by recovered patients. However, social circumstances were also experienced as facilitating. Recovered and improved patients typically mentioned the importance of being *supported* by significant others during the therapy process and difficult times (e.g., having someone to lean on).

If didn’t have my boyfriend, I would not have started this [treatment] and then I still would have been feeling bad. (Patient D; PDT; Improved).

Also, patients felt *empowered* by the positive responses they received on their changes (e.g., “my colleagues dare to trust me again, they feel I’ve calmed down”; Patient H; PDT; Improved). Moreover, patients’ professional life took a central place in these extra-therapeutic experiences (both for the recovered and improved sample). For instance, work (e.g., having a job again) added meaning to patients’ lives: “I

have a goal again, a valuable way to spend my time.” (Patient 4; PDT; Recovered). In rare cases, a lack of support (or even negative comments on being in therapy and becoming “different”) caused patients unhelpful distress (see External obstacles).

In sum, mutual influences are assumed between the four main factors that together influenced change according to recovered and improved patients (Figure 2). Moreover, multiple processes within each factor were described, showing that both positive and negative influences underlie “good outcome” in psychotherapy for major depression. The implications of these findings will be discussed hereafter.

Discussion

This study explored change processes associated with “good outcome”, based on experiences of patients whose outcome indicated recovery and improvement after time-limited CBT and PDT for major depression. In doing so, we expanded the understanding of the processes underlying successful (pre-to-post) RCT outcome findings (Elliott, 2010; Kazdin, 2009), complementing previous analyses of recovered and improved patients’ outcome experiences (De Smet, Meganck, et al., 2020).

First and foremost, patients mentioned a broad range of change processes, in line with previous qualitative research findings (McLeod, 2013). Moreover, besides the influence of therapy, patients acknowledged their own role, the therapist, and the influence of external obstacles and personal context outside of therapy (in line with De Smet & Meganck, 2018). As such, our findings show that the observation of good pre-to-post psychotherapy outcome yields an interplay of multiple change processes, which supports a holistic and multidimensional understanding of change in psychotherapy (Levitt et al., 2016; McLeod, 2013). Although we studied patients showing good psychotherapy outcome, also negative experiences were mentioned. Thus, corresponding the observation that recovered and improved patients experienced their outcome as an *ongoing process* (De Smet, Meganck, et al., 2020), “good outcome” did not necessarily imply an “all good process”.

Contributing to the line of research concerned with helping processes and significant events in psychotherapy (see McLeod, 2013), the patients in this study highlighted three central therapy-related processes. First of all, therapy stimulated a different perspective or insight, for instance, by means of specific questions, confrontation, seeing connections (e.g., between present and past events) and offering an overview. This corresponds to “pattern identification”, the importance of “analysis of thoughts and

assumptions” and “reflexivity” as found by Levitt et al. (2016). Second, therapy was experienced as an active and interactive process, which reflects the more practical component of therapy or “collaborative process” (Levitt et al., 2016) and the importance of empowerment (Timulak, 2007). Finally, therapy was experienced as relieving, especially through the cathartic act of talking (cf., Timulak, 2010).

Besides the role of therapy more generally, patients in this study explicitly referred to their therapist as a unique influencing factor. The therapist appeared to be the one setting the right condition for therapy to be helpful. For instance, therapists were experienced as reinforcing and acknowledging, and as such contributed to the empowering role of therapy. A “non-judgemental safe haven” or unique position on the other hand seemingly allowed patients to engage in the more difficult therapeutic work (e.g., confrontational insights; opening Pandora’s box). Generally, the therapeutic relationship and the understanding and accepting role of the therapist are two important common factors in psychotherapy (e.g., trust, empathy; cf., Cuijpers et al., 2019) that were represented across both the recovered and improved sample in this study. A minority of the patients, however, felt their needs were not heard by the therapist, suggesting the occurrence of a rupture in the alliance (see Safran, Muran, & Eubanks-Carter, 2011).

When comparing recovered and improved patients’ experiences, cross-sample resemblances suggest that similarities in experiences may outweigh the differences, as previously observed by McElvaney and Timulak (2013) when comparing good and poor outcome cases. However, notable differences between the samples point at the particular influence of patients’ active involvement as well as internal and external obstacles. Regarding the former, especially recovered patients took on a more active role in their therapy and change process, similar to an “agentic activity” that is considered one of the most important patient characteristics related to outcome (see Bohart & Wade, 2013, p. 245). As noted by McElvaney and Timulak (2013) we can wonder whether the position of the patients was facilitated through therapy or by the therapist (e.g., recovered patients mentioned more often that the therapist encouraged them; see Williams & Levitt, 2007 for agency facilitating principles), or whether recovered patients were already more empowered and ready to change before the start of therapy, in line with stages of change models. For instance, Norcross, Krebs, and Prochaska (2011) differentiate an action stage “in which individuals modify their behaviour, experiences, and/or environment to overcome their problems” from contemplation in which patients

are “still struggling to initiate change” (p. 144). Internal and external obstacles (e.g., life circumstances) were more often mentioned by improved patients as interfering with the therapy process, potentially withholding patients from engaging in and benefitting fully from therapy (see Kazdin, Holland, Crowley, & Brenton, 1997).

Second, patients in the recovered sample provided more concrete processes with regard to the helping role of therapy (e.g., confronting mirror, connections, and overview), which relates to the ability of “storying” psychotherapy experiences that has been suggested as important for sustaining positive therapy effects (see Adler, Wagner, & McAdams, 2007, on the role of narratives, p. 1195). Patients in the improved sample, in contrast, described therapy in more general terms as being enriching, with more subtle effects, uncertain or even unclear contributions. The fact that the majority of patients in the improved sample had engaged in PDT while recovered patients predominantly engaged in CBT, may offer an explanation here. As observed by Nilsson et al. (2007), treatment results were most clear to patients in CBT while the effects of PDT were less easy to grasp and more ambivalent, although both samples showed improvement. This points at differences in experiences depending on the directive (i.e., CBT) and explorative nature (i.e., PDT) of the treatments. Nonetheless, patients who engaged in PDT and were classified as recovered provided clearer influences than did the improved patients in this study, again suggesting the importance of the patient’s active involvement for understanding treatment effects.

Differences in experiences were also observed between patients who engaged in CBT and PDT, resembling previous findings. First, for both recovered and improved patients in CBT, the interactive nature of therapy was valued and experienced as empowering, in line with what Nilsson et al. (2007) described as the focused and active description of a directive therapy/therapist. Second, both CBT and PDT stimulated patients’ insight, via schematic overviews in CBT and by connecting parts of patient’s story into a more coherent narrative in PDT (i.e., a focus on “self-understanding”; Messer & McWilliams, 2007), and by confronting patients with aspects of themselves by critical questions, both in CBT and PDT. The latter was especially found in PDT in the study by Nilsson and colleagues. The catharsis effect of talking, as typically mentioned in PDT, might resonate with the emotional processing in psychotherapy (Watson & Bedard, 2006), which is considered a crucial link between gaining insight and obtaining a positive outcome (Messer & McWilliams, 2007). While this was not explicitly described by Nilsson et al. (2007), they found patients valued

PDT for “getting to the roots of things” in a working-through fashion.

Beyond the differences observed for patients in CBT and PDT, a remark should be made regarding the role of the therapist for interpreting our findings. Three out of eight therapists (one PDT- and two CBT-therapists) treated more than half of the patients included in this study, suggesting the possible importance of the influence of the *therapist* rather than the type of therapy. A closer look at therapists’ treated patients (see Table I) shows variation in the number of improved and/or recovered patients (across CBT and PDT therapists), for example. As we did not study specific therapist effects, interpreting these observations warrants caution. Our findings based on patients’ experiences particularly highlight the multitude of interconnected influences, both helpful and hindering. Also, notable similarities between recovered and improved patients’ experiences show that the differentiation between these outcome classifications may not be that straightforward (see also De Smet, Meganck, et al., 2020 on the limitations of the JT classifications). The specific role of the therapist hence requires further exploration, nonetheless it can be argued that in order to expand the historical discussion on which psychotherapy works best, the therapist-level of analysis should be given a more central focus in future outcome research (see Baldwin & Imel, 2013, for a discussion on therapist effects).

Patients in this study showed successful treatment outcome in terms of measured symptom reduction, yet the effects of psychotherapy were not always clear (or sometimes even disappointing) to them. This may explain why previous analyses found that not all recovered and improved patients felt “improved” and ongoing struggles were generally expressed in both the improved and recovered group. In terms of outcome experiences, especially the improved patients showed to be characterized by heterogeneity (ranging from feeling improved to not doing well at all), which questioned the classification of “good outcome” for a part of the patients (see De Smet, Meganck, et al., 2020). When interpreting the (general) differences in underlying change processes between recovered and improved patients in the current study, the heterogeneity among improved patients must thus be taken into account (note for instance that the salience of the processes in the improved sample were often mentioned “variantly”, rather than typical or general, illustrating the variety in experiences across the sample).

Our findings raise several questions regarding the relationship between outcome (based on standardized, symptom-based outcome measures pre-post therapy) and patients’ experiences of how changes

came about (cf., McElvaney & Timulak, 2013). First, the observed differences within the samples in this study challenge the idea that all patients can be considered as moving towards a similar outcome following a similar (linear) trajectory of change (cf., Carey et al., 2006; Kazdin, 2009). For instance, differences in patients' position in therapy or readiness for change prior to treatment (Norcross et al., 2011), life circumstances (Kazdin et al., 1997) and symptom severity (cf., the improved sample scored significantly higher prior to therapy; Clarkin & Levy, 2004) challenge the comparability of patients between and within samples. We can indeed wonder whether patients suffering from ongoing difficulties like chronic illness or divorce (as was the case for some patients showing improvement) should aim towards the same outcome and require the same therapeutic processes as patients with different personal and contextual demands. Typically, this type of contextualizing information is omitted in RCTs in which randomization and standardization are assumed to rule out any confounding influences, however in doing so, the clinically meaningful context is also overlooked (Evans & Fletcher, 2013; Truijens, Desmet, De Coster, Uyttenhove, & Deeren, 2019).

Second, both samples, but especially the improved patients, challenged the idea that "good outcome" reflects "good therapy". For several patients, therapy was not considered helpful, or only in combination with other means. Moreover, these findings resemble the experiences of *non-improved* depressed patients examined within the Ghent Psychotherapy Study (i.e., no reliable change in depression scores on the BDI; see De Smet, Meganck, Vannieuwenhove, Truijens, & Desmet, 2019). According to these non-improved patients, therapy provided insights yet hit a certain limit (e.g., inability to change) and as for the improved patients, internal and external obstacles were mentioned as important hindering influences. Comparison of these patients' experiences thus suggests that symptomatic change in itself may not be a sufficient criterion to differentiate samples of patients when aiming to elucidate the processes that lead to meaningful change. Indeed, symptom reduction has shown to be only minimally meaningful to patients themselves (De Smet et al., 2019; Zimmerman et al., 2012). Conversely, patients who deteriorated in depressive symptom severity did not necessarily consider therapy as failing, nor experienced symptom increase straightforwardly as a negative evolution (see De Smet et al., *forthcoming*).

Consequently, if we wish to unravel which processes lead to successful outcome and how the role of therapy, therapist, patient and external context

could be best organized for optimal treatment results, it is of essence to study the relationship between processes and outcome in more detail. This goes back to the recommended refinement of research questions suggested by Kiesler (1966) (e.g., "which therapist behaviors are more effective with which types of patients?"; p. 113) who challenged the uniformity assumptions in psychotherapy research. In the specification of such moderators and mediators (see Kazdin, 2009), systematic case studies offer an important contribution, as they allow for the idiosyncratic contextualization of outcome and change processes (Dattilio et al., 2010). However, a crucial—but often overlooked—link in this endeavour is the conceptualization of outcome or meaningful change in psychotherapy itself (see Carey et al., 2006). As argued by Evans and Fletcher (2013), "only if you know what outcome you want, you can evaluate whether the treatment has achieved it or not" (p. 117). Hence, if the patient can be considered "the site of change" (Greenberg, 1991, p. 10), a multi-dimensional study and holistic approach to process-outcome research seems warranted, in accordance to patients' holistic experience of change (cf., De Smet et al., *forthcoming*; Levitt et al., 2016) and psychotherapy (cf., present study).

Strengths, Limitations and Future Directions

This study does not allow or aim to draw causal conclusions regarding the mechanisms that lead to good outcome. Rather, it builds on the tradition of change process research that aims to bridge the gap between outcome research on the one hand and process research on the other (Elliott, 2010). We particularly address the highly influential framework of the JT classification of clinical significance as a means to offer a patient-centered indication of clinical meaningfulness. In that sense, the present study is the first large-scale systematic study focusing on both subgroups of "good outcome" (i.e., "recovery" and "improvement") to explore the underlying change processes. This contributes to the construction of more specified knowledge that is currently lacking in understanding the processes underlying significant outcome (in general, McElvaney & Timulak, 2013; and in the particular case of major depression, Rottenberg et al., 2018). The resulting tentative conceptual model offers suggestions for further research and contributes to the conceptualization or theory-building regarding the important mechanisms in psychotherapy. Complementing previous observations, our findings build onto meta-analytic knowledge (see Levitt et al., 2016; Timulak, 2007, 2010) yet broadens its focus by offering a contextualized

perspective on influences that expand the therapeutic context. While the present study aimed at giving voice to patients at the good end of the outcome continuum, a next step would be the critical integration and comparison of patients' experiences across the continuum ranging from good to poor outcome in a meta-synthesis. Systematic comparative case studies, on the other hand, could be of great value to further scrutinize the relationship between standard statistical outcome evaluation (indicating good or poor outcome; cf., McElvaney & Timulak, 2013) and underlying processes as experienced by patients in more detail (Dattilio et al., 2010).

In the present study, therapy was provided in context of a standardized RCT setting, which inevitably influenced the findings in comparison to a naturalistic setting (Westen et al., 2004). Nonetheless, the participants in our study correspond to a representative outpatient population seeking psychotherapy in private practice for what can be considered one of the most prevalent mental health problems worldwide. Specific (e.g., cultural, ethnic) or more diverse groups of patients could be the focus of complementing research. Similarly, given the exclusion criteria of the study, we cannot draw conclusions regarding more severe and acute psychopathologies, although a significant number of patients in our study showed comorbid disorders, which resembles clinical practice (cf., Hirschfeld, 2001). Interestingly, our findings show resemblances to what was mentioned by patients showing successful outcome in a naturalistic study (see Ekroll & Rønnestad, 2017).

The present study departed from one outcome measure to define patients pre-post outcome in accordance with common practices in standard outcome research (see De Los Reyes et al., 2011). The influence of the selected measure (i.e., BDI) on our findings is inevitable, as we can for instance expect that this symptom-based measure benefitted the outcome evaluation of patients in CBT over those in PDT given the more explicit focus on symptom reduction in the former treatment (see Levitt, Stanley, Frankel, & Raina, 2005). A slightly different constellation of "good outcome cases" could have been included in the study if different measures were used. Replication with other measures and other selection criteria could thus be a valuable complement to our observations; for instance, if we wish to elucidate therapy-specific processes and their relation to outcome more therapy-congruent measures are advisable (Levitt et al., 2005). Conclusions on the relation between quantitative measures and patients' (qualitative) experiences also do not speak for the entire field of quantitative outcome evaluation that undoubtedly has broadened its focus (beyond symptom-evaluation) in the past

decades (see for instance the development of personalized questionnaires, e.g., Elliott, Mack, & Shapiro, 1999). Nonetheless, we can consider the choice for the BDI as purposive in this case, as it is one of the most frequently used measure of depression symptom severity in outcome studies. Furthermore, our conclusions can be informative on consequences related to pre-post standard outcome evaluation in general and the relevance of including underlying patients' experiences. The findings of this study are however limited by the retrospective nature of the used interviews. Future research aiming to identify change processes would benefit from using other techniques, like interpersonal recall interviews (e.g., video-assisted recall of the therapy session and experiences, for instance, inquired post-session), that allow capturing more in-the-moment experiences (Larsen, Flesaker, & Stege, 2008). Finally, complementing the perspectives of patients in this study, future research must aim at the incorporation of multiple perspectives (e.g., the therapist, researcher, society or family; Altimir et al., 2010) in order to obtain a more complete understanding of the processes operating in and outside the context of psychotherapy.

Conclusion

From patients' perspectives, "good outcome" does not correspond to an "all good process". Recovered and improved patients described various therapy, therapist, patient and external contextual processes as operating at the same time, moreover, characterized by both helping and hindering influences. This supports a holistic, multidimensional conceptualization of change processes in psychotherapy and calls for more fine-grained mixed-methods research on the relationship between change processes and outcome.

Acknowledgements

We want to thank the patients and therapists who participated in this study. Acknowledgements for their help in the data gathering process go to Goedeke Hermans, Kimberly Van Nieuwenhove, Ruth Inslegers, and Vicky Hennissen. We want to thank Andrzej Werbart and Camilla von Below for their instructive feedback on this work.

Funding

This work was supported by Fonds Wetenschappelijk Onderzoek [Grant No. 1127118N].

Notes

- ¹ Throughout this manuscript we deliberately differentiate “processes” from “mechanisms”. The present study aims to explore change processes according to patients’ experiences, which in a later step could inform research on potential operating (causal) mechanisms that could be experimentally tested (cf., Kraemer, Wilson, Fairburn, & Agras, 2002).
- ² We rely on the widely used classification as defined by Jacobson and Truax (1991; see below; Note 3).
- ³ The Jacobson-Truax classification (1991) is the most widely used definition of “clinical significance”, which is a statistical indication of the clinical relevance of measured change in scores on an individual-patient level (i.e., whether a decrease in symptoms would be noticeable in actual clinical care). The JT-method relies on a twofold evaluation of outcome: Reliable change in pre-to-post treatment scores and evolution from dysfunctional to functional distribution (i.e., passing the clinical cut-off). Accordingly, patients are classified into four possible outcome categories: “Recovery” (reliable change and passing the clinical cut-off), “Improvement” (reliable change but remaining in the clinical range), “Non-improvement” (no reliable change) or “Deterioration” (reliable change in the negative direction).
- ⁴ Note that the present study is situated within the context of the GPS (Meganck et al., 2017), yet addresses different research questions and therefore differs somewhat from the original design. Firstly, the present study relied on the BDI-II as primary outcome measure (see also footnote 6), while the GPS relies on the interview-based Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967). Findings on patients’ individual outcome could thus differ depending on the measure used. Secondly, given the focus on outcome more generally, the present study did not include patient personality style in the analysis and interpretation of findings. We refer interested readers to more specific literature on this topic (e.g., Werbart, Hägertz, & Nadja Borg, 2018).
- ⁵ Other Axis 1 diagnoses present in one or two patients in the recovered group included: secondary substance abuse, eating disorder, dysthymia; and in the improved group: eating disorder, secondary substance abuse, somatic symptoms, pain disorder, hypochondria (according to SCID for DSM-IV-TR; First, Spitzer, Gibbon, & Williams, 2002).
- ⁶ A complete overview of the measures used in the GSP can be found in the study protocol of the RCT (Meganck et al., 2017). Given the focus of the current study on patients being treated for major depression, the Beck Depression Inventory (Beck et al., 1996; van der Does, 2002) was selected as the outcome measure for this particular study. As our main focus in this study is on patients’ perspectives, this self-report measure was preferred over the interview-based HRSD.
- ⁷ General: $\geq 90\%$ of the participants (25–28 and 17–19 recovered and improved sample respectively); Typical: $\geq 50\%$ and $< 90\%$ (14–24 and 10–16 patients); Variant: $\geq 20\%$ and $< 50\%$ (6–13 and 4–9 patients); Rare: $< 20\%$ (1–5 and 1–3 patients).
- ⁸ Note: “confronting mirror” is differentiated from the specific questions mentioned in “insights through talking, (specific) questions and reflection” given the explicit experience of being *confrontational*, which was not characteristic of the insight-stimulating questions.

ORCID

Melissa Miléna De Smet  <http://orcid.org/0000-0002-8753-1757>

Reitske Meganck  <http://orcid.org/0000-0002-9052-0100>
 Femke Truijens  <http://orcid.org/0000-0003-0790-7003>
 Mattias Desmet  <http://orcid.org/0000-0002-7954-6078>

References

- Adler, J. M., Wagner, J. W., & McAdams, D. P. (2007). Personality and the coherence of psychotherapy narratives. *Journal of Research in Personality*, 41(6), 1179–1198.
- Altimir, C., Krause, M., de la Parra, G., Dagnino, P., Tomacic, A., Valdés, N., ... Vilches, O. (2010). Clients’, therapists’, and observers’ agreement on the amount, temporal location, and content of psychotherapeutic change and its relation to outcome. *Psychotherapy Research*, 20(4), 472–487.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects. Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield’s handbook of psychotherapy and behaviour change* (6th ed., pp. 258–297). Hoboken, NJ: Wiley.
- Barrett, M. S., Chua, W.-J., Crits-Cristoph, P., Gibbons, M. B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy (Chicago Ill)*, 45(2), 247–267.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory–II*. San Antonio, TX: Psychological Corporation.
- Blatt, S. J., & Shahar, G. (2004). Psychoanalysis: With whom, for what, and how? Comparison with psychotherapy. *Journal of the American Psychoanalytic Association*, 52, 393–447. doi:10.1177/00030651040520020401
- Bockting, C., & Huibers, M. (2011). Protocollaire behandeling van patiënten met een depressieve stoornis. In G. Keijsers, A. van Minnen, & K. Hoogduin (Eds.), *Protocollaire behandelingen voor volwassenen met psychiatrische klachten* (Vol. 1, pp. 251–288). Amsterdam: Boom.
- Bohart, C. A., & Wade, A. M. (2013). The client in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield’s handbook of psychotherapy and behaviour change* (6th ed., pp. 219–257). Hoboken, NJ: Wiley.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. London: Sage.
- Carey, T. A., Carey, M., Mullan, R. J., Murray, L. K., & Spratt, M. B. (2006). Psychological change: What changes and how does it occur? A critical review. *Psychological Change*, 9, 28–38.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Clarkin, J. F., & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield’s handbook of psychotherapy and behavior change* (5th ed., pp. 194–226). Hoboken, NJ: Wiley.
- Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S. D., & van Straten, A. (2014). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis. *Journal of Affective Disorders*, 159, 118–126.
- Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcomes. *Annual Review of Clinical Psychology*, 15, 207–231.
- Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology*, 76(6), 909–922. doi:10.1037/a0013075

- Dattilio, F. M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training*, 47(4), 427–441.
- De Los Reyes, A., Kundey, S. M. A., & Wang, M. (2011). The end of the primary outcome measure: A research agenda for constructing its replacement. *Clinical Psychology Review*, 31(5), 829–838.
- De Smet, M. M., Cornelis, S., Acke, M., Meganck, R., Truijens, F., & Desmet, M. (forthcoming). *Making sense of deterioration in psychotherapy: An interpretative phenomenological analysis of depressed patients' perspectives*. Manuscript submitted for publication.
- De Smet, M. M., Meganck, R., De Geest, R., Norman, U. A., Truijens, F., & Desmet, M. (2020). What "good outcome" means to patients: Understanding recovery and improvement in psychotherapy for major depression from a mixed-methods perspective. *Journal of Counseling Psychology*, 67(1), 25–39. doi:10.1037/cou0000362
- De Smet, M., & Meganck, R. (2018). Understanding long-term outcome from the patients' perspective: A mixed methods naturalistic study on inpatient psychotherapy. *Psychologica Belgica*, 58(1), 276.
- De Smet, M., Meganck, R., Vannieuwenhove, K., Truijens, F., & Desmet, M. (2019). No change? A grounded theory analysis of depressed patients' perspectives on non-improvement in psychotherapy. *Frontiers in Psychology*, 10, 588. doi:10.3389/fpsyg.2019.00588
- Eckroll, V. B., & Rønnestad, M. H. (2017). Processes and changes experienced by clients during and after naturalistic good-outcome therapies conducted by experienced psychotherapists. *Psychotherapy Research*, 27(4), 450–468.
- Elliott, R., Mack, C., & Shapiro, D. (1999). *Simplified personal questionnaire procedure*. Toledo, OH: University of Toledo.
- Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*, 20(2), 123–135.
- Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D. L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69–111). Lengerich: Pabst Science.
- Evans, I. M., & Fletcher, A. (2013). Focus on change: Implication for understanding and evaluation of psychological interventions. *Psychologia*, 56(2), 113–130.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured clinical interview for DSM-IV-TR Axis I disorders, research version, patient Edition. (SCID-I/P)*. New York: Biometrics Research, New York State Psychiatric Institute.
- GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, 392(10159), 1789–1858.
- Giorgi, A., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methods and design* (pp. 243–274). Washington, DC: American Psychological Association.
- Glaser, B. G., & Strauss, A. L. (1987). *The discovery of grounded theory: Strategies for qualitative research*. Hoboken, NJ: Transaction.
- Greenberg, L. S. (1991). Research on the process of change. *Psychotherapy Research*, 1(1), 3–16.
- Greenberg, L. S. (1999). Ideal psychotherapy research: A study of significant change processes. *Journal of Clinical Psychology*, 55(12), 1467–1480.
- Hamilton, M. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology*, 6, 278–296.
- Hesse-Biber, S. N. (2010). *Mixed methods research, merging theory with practice*. New York, NY: Guilford Press.
- Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology*, 52, 196–205.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, 25, 517–572.
- Hirschfeld, R. M. A. (2001). The comorbidity of major depression and anxiety disorders: Recognition and management in primary care. *Primary Care Companion to The Journal of Clinical Psychiatry*, 03(6), 244–254.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12–19.
- Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, 19(4–5), 418–428.
- Kazdin, A. E., Holland, L., Crowley, M., & Brenton, S. (1997). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry*, 38, 1051–1062.
- Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin*, 65(2), 110–136.
- Knox, S., Schlosser, L. Z., Pruitt, N. T., & Hill, C. E. (2006). A qualitative examination of graduate advising relationships: The advisor perspective. *The Counseling Psychologist*, 34, 489–518.
- Kraemer, H. C., Wilson, G. T., Fairburn, C. G., & Agras, W. S. (2002). Mediators and moderators of treatment effects in randomized clinical trials. *Archives of General Psychiatry*, 59(10), 877–883.
- Lambert, M. J. (2011). What have we learned about treatment failure in empirically supported treatments? Some suggestions for practice. *Cognitive and Behavioural Practice*, 18, 413–420.
- Larsen, D., Flesaker, K., & Stege, R. (2008). Qualitative interviewing using interpersonal process recall: Investigating internal experiences during professional-client conversations. *International Journal of Qualitative Methods*, 7(1), 18–37. doi:10.1177/160940690800700102
- Leichsenring, F., & Schauenburg, H. (2014). Empirically supported methods of short-term psychodynamic therapy in depression – towards an evidence-based unified protocol. *Journal of Affective Disorders*, 169, 128–143.
- Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*, 142(8), 801–830.
- Levitt, H. M., Stanley, C. M., Frankel, Z., & Raina, K. (2005). An evaluation of outcome measures used in humanistic psychotherapy research: Using thermometers to weigh oranges. *The Humanistic Psychologist*, 33(2), 113–130.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive expressive treatment*. New York, NY: Basic Books.
- McElvaney, J., & Timulak, L. (2013). Clients' experience of therapy and its outcomes in 'good' and 'poor' outcome psychological therapy in a primary care setting: An exploratory study. *Counselling and Psychotherapy Research*, 13(4), 246–253.
- McLeod, J. (2013). Qualitative research: Methods and contributions. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook*

- of psychotherapy and behavior change (6th ed., pp. 49–84). New York, NY: Wiley.
- Meganck, R., Desmet, M., Bockting, C., Inleegers, R., Truijens, F., De Smet, M. M., ... Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials*, 18(1), 126.
- Messer, S. B., & McWilliams, N. (2007). Insight in psychodynamic therapy: Theory and assessment. In L. G. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 9–29). Washington, DC: American Psychological Association.
- Midgley, N., Ansaldi, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy*, 51(1), 128–137.
- Nilsson, T., Svensson, M., Sandell, R., & Clinton, D. (2007). Patients' experiences of change in cognitive-behavioural therapy and psychodynamic therapy: A qualitative comparative study. *Psychotherapy Research*, 20, 37–41.
- Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 279–300). New York, NY: Oxford University Press.
- Parker, I. (2007). Critical psychology: What it is and what it is not. *Social and Personality Psychology Compass*, 1(1), 1–15.
- Rodgers, B. (2003). An exploration into the client at the heart of therapy: A qualitative perspective. *Person-Centered and Experiential Psychotherapie*, 2(21), 19–30.
- Rottenberg, J., Devendorf, A. R., Kashdan, T. B., & Disabato, D. J. (2018). The curious neglect of high functioning after psychopathology: The case of depression. *Perspectives on Psychological Science*, 13(5), 549–566.
- Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy*, 48(1), 80–87.
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, 17, 305–314.
- Timulak, L. (2010). Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, Research and Practice*, 83(4), 421–447.
- Truijens, F. L., Desmet, M., De Coster, E., Uyttenhove, H., & Deeren, B. (2019). When quantitative measures become qualitative story books: A phenomenological case analysis of the validity and performativity of questionnaire administration in psychotherapy research. *Qualitative Research in Psychology*. doi:10.1080/14780887.2019.1579287
- Tryon, W. W. (2005). Possible mechanisms for why desensitization and exposure therapy work. *Clinical Psychology Review*, 25, 67–95.
- van der Does, A. J. W. (2002). *BDI-II-NL. Handleiding. De Nederlandse versie van de Beck Depression Inventory* (2nd ed.). Lisse: Harcourt Test Publishers.
- Watson, J. C., & Bedard, D. L. (2006). Clients' emotional processing in psychotherapy: A comparison between cognitive-behavioral and process-experiential therapies. *Journal of Consulting and Clinical Psychology*, 74(1), 152–159.
- Werbart, A., Hägertz, M., & Nadja Borg, O. (2018). Matching patient and therapist Anaclitic-introjective personality configurations matters for psychotherapy outcomes. *Journal of Contemporary Psychotherapy*, 48(4), 241–251. doi:10.1007/s10879-018-9389-8
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130(4), 631–663.
- Williams, D. C., & Levitt, H. M. (2007). Principles for facilitating agency in psychotherapy. *Psychotherapy Research*, 17(1), 66–82.
- Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist*, 72, 311–325.
- Zimmerman, M., Martinez, J. A., Attiullah, N., Friedman, M., Toba, C., Boerescu, D. A., & Rahgeb, B. (2012). Why do some depressed outpatients who are in remission according to the Hamilton Depression Rating Scale not consider themselves to be in remission? *Journal of Clinical Psychiatry*, 73(6), 790–795.